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access to psychological therapies' (IAPT)[10]. However, parents are often not entitled to accelerated access to mental health services, unless acutely unwell, and there is underprovision of mother-baby units and other specialist perinatal mental health services.

Benefits of multi-disciplinary teams carrying out intensive assessment and therapeutic work with families at-risk of child entry into care has been demonstrated in Family Drug and Alcohol Courts (FDAC).[11]

: It is vital that parents/carers and parents-to-be can access effective and timely mental health care, especially when these parents are involved in care proceedings.

Our research identified three approaches for responding to parental mental health, domestic violence or addiction within healthcare settings which have been embedded into health care services[12]

In some emergency departments health care professionals routinely ask all adults who present with problems relating to violence, mental health (including self-harm) or addiction if they have dependent children and provide clear referral pathways for the parents and children to access support[12]. Alternatively, HCPs can routinely ask all parents and carers about their own experiences of violence, mental health problems and addiction when they bring their children in for check-ups[12].

: In-patient hospital admissions, including in maternity units, have been used as an opportunity to provide educational material designed to help parents better manage stressful events or situations, such as crying babies or intensive care stays[12].

The most common way of health professionals helping the child living with parental health problems, mental health problems or addiction is to build and leverage a strong parent-professional relationship to encourage readiness to change and/or behaviour change in the parent[12].

Our research has found that GPs and health visitors use 'direct responses' to families in order to respond to parental mental health, alcohol misuse, violence in the household and wider determinants such as poor housing[13][14]. Direct responses include proactive review, monitoring and follow-up of 'vulnerable' families, offering opportune healthcare to children and coaching parents to recogG[c5 842TQreW*nBT/F170 1 5195.25 842 reW*

Our research has shown that adolescents admitted to hospital with adversity were more likely (61% more likely for girls and 113% more likely for boys) to have died within 10 years than peers hospitalised with accidental injuries[18].

Primary care professionals such as GPs and health visitors can provide a family health service, which can address the health and wellbeing of children and their parents or carers, especially mental health, which is critical to parents' capacity to care for their children[21]. But pressures on primary care and erosion of continuity of care undermine a family approach.

: The Government needs to address low levels of funding for primary care and the erosion of the GP and health visitor work force.[22]

Using data recorded for one purpose without consent for another purpose or service to keep vulnerable children safe can threaten wider public support for the use of data and the right to privacy:

¶ Firstly, vulnerable children constitute a substantial proportion of children and families with over 40% of children estimated to have been referred to children's social care (see ).

¶ Secondly, data used to identify vulnerable children could involve data on all children (i.e. data combined from schools, social care and police, and may involve other household members as well as children). Legal clauses that waive the right to privacy for vulnerable groups may not have been intended to be used for whole populations in this way.

Limiting access for approved individuals and roles may be more acceptable but there is a need for a 'best practice' guide that local authorities and other organisations can use to justify and safely undertake linkages for operational purposes.

Linking up de-identified data, where individuals cannot be identified, can provide valuable information about service provision and inequities at a population level while maintaining trust and support for wider use of data. If access to data and outputs are controlled, there is minimal risk to privacy and use can be restricted to purposes with clear public benefits. The data can provide powerful evidence to reduce inequities and to target interventions to improve health, education and social care services. For example, the ECHILD database links de-identified data from all hospitals, schools and social care services in England for 15 million children followed over two decades[23].

Linking de-identified data across public services would allow researchers to provide policy-makers with answers about how children and families use multiple public services across their lives and investigate how interventions in one sector (e.g. schools) influence outcomes in another (e.g. health).

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