July 2026

The Domestic Abuse Commissioner's response to inform the open call for evidence for the mental health strategy for England.

About the Domestic Abuse Commissioner

The Domestic Abuse Commissioner is the independent voice for all victims and survivors of domestic abuse across England and Wales. Engaging at the highest levels of government, the Commissioner presses for survivors to be heard so they get the right help, at the right time.

Through research, campaigning and collaboration, the Commissioner highlights the changes needed to tackle and prevent domestic abuse – so perpetrators are held to account, and survivors get the specialist support to rebuild and thrive.

Acknowledgements

The Domestic Abuse Commissioner wishes to express her sincere gratitude to every victim-survivor who has shared their experiences of domestic abuse and its impact on their mental health with the Office. Whether through correspondence or participation in roundtables, your courage in speaking out has been invaluable in shaping this consultation response and helping to ensure that the Government's mental health strategy is grounded in survivors' voices and the changes they want to see.

The Office also extends its sincere thanks to representatives from independent specialist domestic abuse services that so generously shared their expertise. Your insight and experience of working directly with and for victim and survivors have been instrumental in informing and strengthening this consultation response.

Overarching position

Domestic abuse is a major and preventable driver of mental ill health, yet it remains insufficiently recognised or addressed within the mental health system. Survivors continue to face fragmented pathways, inconsistent access to trauma-informed care, and significant unmet need, while specialist domestic abuse services are left to absorb statutory demand without sustainable funding or formal integration. Without a stronger, system-wide response to domestic abuse as a core determinant of mental health, the Government's ambitions for prevention, community-based care, and improved outcomes will not be achieved.

There is already a strong foundation of good practice on which to build. Evaluations of health-based Independent Domestic Violence Adviser (IDVA) roles have shown that embedding specialist domestic abuse practitioners within healthcare settings improves the identification of abuse, strengthens referral pathways, and enables survivors to access support at the point of need, including those experiencing significant trauma and mental health impacts as a result of abuse.[1] Healthcare professionals involved in these models reported increased confidence in recognising and responding to domestic abuse, while survivors benefited from more coordinated and accessible support.[2] Emerging evidence from maternity-based health IDVA services similarly demonstrates the value of integrating specialist domestic abuse expertise into routine healthcare pathways, improving early identification and access to support for those at heightened risk.[3] Together, these approaches provide practical, evidence-based models that could be adapted and expanded across mental health services to strengthen support for survivors and improve outcomes.

[1] SafeLives (n.d.) *A Cry for Health: Why we must invest in domestic abuse services in hospitals*.

[2] Dheensa, S., Halliwell, G., Daw, J., Jones, S.K. and Feder, G. (2020) 'From taboo to routine: a qualitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse',

[3] RIVA Study (n.d.) *Evaluating models of healthcare-based Independent Domestic Violence Adviser (IDVA) provision in maternity services*.

The mental health strategy must commit to addressing domestic abuse through routine enquiry and trauma-informed practice across all services; sustained investment in and integration of specialist provision; improved data collection to make survivors visible in the system; and commissioning models that support long-term, joined-up care. Positioning domestic abuse as a central public health issue is essential to reducing pressure on acute services, tackling inequalities, and delivering a more effective, preventative mental health system.

Defining trauma and establishing a trauma-informed system approach

Throughout this consultation response, the Commissioner references trauma and trauma-informed care. To ensure clarity and consistency, the Commissioner wishes to set out a clear position on how trauma and trauma-informed approaches should be understood and applied within mental health systems.

The Commissioner adopts the SAMHSA definition of trauma as: *"an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on an individual's functioning and mental, physical, social, emotional or spiritual well-being."*[4]

This definition reflects the breadth and depth of trauma experienced by victim and survivors, particularly in the context of domestic abuse. It recognises that trauma is not a single incident, but often cumulative and enduring, with far-reaching impacts across health, relationships, economic stability, and wider life outcomes.[5]

The Commissioner supports a whole-system, trauma-informed approach, aligned with both the UK Government's working definition[6] and SAMHSA principles.[7] This requires services to:

- **Recognise** the widespread impact of trauma and its manifestations across mental and physical health.
- **Realise** how trauma shapes behaviour, engagement, and presentation.
- **Respond** by embedding this understanding into all policies, pathways and professional practice.
- **Resist re-traumatisation** by actively designing services that promote safety, trust, choice and empowerment.

Central to this is an explicit focus on preventing re-traumatisation. Re-traumatisation occurs when individuals are exposed to experiences that replicate the powerlessness, fear or harm of previous trauma. Within healthcare settings, this can include both physical practices (such as restraint, seclusion or forced treatment) and relational dynamics (such as dismissing disclosures, removing choice, or failing to ensure safety).[8]

A trauma-informed system must therefore move beyond individual practice to embed these principles at organisational and system level, ensuring that all interactions, environments and pathways prioritise safety, dignity, and long-term recovery.

Summary of recommendations

1. DHSC should lead a cross-system review of funding streams, demand, and data use within domestic abuse services providing mental health and recovery support, to establish a coherent, evidence driven framework for sustainable investment and improved system response.
2. DHSC should draw on and further promote existing sector-led resources, including the Pathfinder Toolkit, which was developed through a national pilot to transform health sector responses to domestic abuse. The Pathfinder model demonstrates how domestic abuse can be embedded as a core health

[4] Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Rockville, MD: SAMHSA.
[5] Violence and Mental Health Network (VAMHN) (n.d.) *Policy Lab Briefing Pack*.
[6] Department of Health and Social Care (2022) *Working definition of trauma-informed practice*.
[7] Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Rockville, MD: SAMHSA.
[8] Violence and Mental Health Network (VAMHN) (n.d.) *Policy Lab Briefing Pack*.

and public health issue through clear leadership, consistent data collection, training, specialist advocacy and coordinated partnership working.

3. DHSC should mandate trauma-informed, culturally competent care as a core standard across all mental health services, supported by compulsory training, routine enquiry of domestic abuse, and clear accountability frameworks. This should include a clear expectation that services recognise and respond to the intersecting impacts of factors such as race, ethnicity, gender, disability, class, and immigration status on individuals' experiences of abuse and access to support, drawing on an intersectional approach. Services must move beyond one-size-fits-all models to deliver equitable, responsive care that addresses systemic inequalities and reduces barriers to disclosure, engagement, and recovery.
4. DHSC should consider introducing a clear national expectation that all health and care systems adopt evidence-based whole family domestic abuse models, such as Safe & Together, embedded through commissioning, workforce training and integrated pathways to reduce fragmentation and improve safety and recovery outcomes.
5. DHSC should embed trauma-informed digital transformation as a core principle within the mental health strategy, mandating that all digital services and AI tools incorporate safeguarding for domestic abuse, address digital exclusion, and provide choice-based access alongside in-person care. This should be supported through national service standards, workforce training, and strengthened oversight to ensure digital innovation improves outcomes without increasing risk or inequality.
6. DHSC should introduce the routine collection of domestic abuse indicators within all mental health datasets, alongside survivor centred outcome measures, and establish a national, trauma-informed data-sharing framework to enable proactive identification, equitable commissioning, and improved recovery outcomes.
7. DHSC should invest in the national expansion of co-located IDVA and Mental Health IDVA provision across acute, primary and mental health services, embedding them as core components of community mental health pathways to enable early intervention, prevent escalation, and reduce demand on crisis care.
8. DHSC should renew and strengthen the national suicide prevention strategy by explicitly recognising domestic abuse as a key driver of suicide risk. This must include mandating safe routine enquiry across health settings, embedding specialist domestic abuse advocacy within mental health pathways, and ensuring continuity of relational, survivor-centred support through robust cross-system accountability and integrated commissioning arrangements.
9. DHSC should move beyond a single pathway model by expanding access to trauma specific, multi-disciplinary support for the "missing middle", including commissioning integrated pathways that combine psychological therapies with specialist domestic abuse support, advocacy and practical interventions, ensuring care is flexible, needs-led, and not contingent on "readiness" for therapy.
10. DHSC should lead the transition from short-term competitive procurement to long-term, partnership-based commissioning, embedding specialist services as core system infrastructure, aligning funding across sectors, and strengthening national and local accountability frameworks to ensure integrated, trauma-informed care that delivers improved recovery and needs led outcomes.

Full response

Consultation question 1 (Hospital to community): *How can mental health services work more effectively across these areas? (maximum 300 words)*

Domestic abuse constitutes a major and preventable driver of population health inequality, affecting an estimated 3.8 million adults annually and impacting one in four adults and one in five children over their

lifetime.[9][10][11] This creates significant and sustained demand on health services, as evidence has shown domestic abuse is a major driver of long-term mental health issues.[12][13]

In response to this need, specialist domestic abuse services have evolved to deliver needs-led, trauma-informed and recovery-focused support within the community, including support for individuals with multiple health and social care needs. However, this system adaptation has occurred despite, not because of, current commissioning arrangements. Domestic abuse services are operating in a context of rising demand, increasing case complexity, and chronic underfunding, with many delivering core therapeutic and recovery support without dedicated resource.[14]

Evidence from the Commissioner's A Patchwork of Provision report (2022) highlights the scale of unmet demand, with survivors identifying counselling (83%) and mental healthcare (77%) as priority needs[15]. Yet community provision remains unable to meet this demand due to limited capacity and fragmented commissioning, resulting in a persistent postcode lottery in access to support. Current system design reinforces crisis driven responses. Early intervention and recovery services are often not sustainably funded, meaning survivors face long waiting times or no access to support until need escalates. This increases reliance on acute and inpatient care, undermining the Government's ambition to shift from hospital to community care.

In effect, the specialist sector is increasingly absorbing unmet need from statutory mental health services. Compounding this at a system level, Integrated Care Boards (ICBs) and NHS trusts continue to not consistently recognise domestic abuse services as equal strategic partners, with engagement often informal rather than embedded within governance, commissioning and delivery structures.

Recommendation: DHSC should lead a cross-system review of funding streams, demand, and data use within domestic abuse services providing mental health and recovery support, to establish a coherent, evidence driven framework for sustainable investment and improved system response.

Recommendation: DHSC should draw on and further promote existing sector-led resources, including the Pathfinder Toolkit, which was developed through a national pilot to transform health sector responses to domestic abuse. The Pathfinder model demonstrates how domestic abuse can be embedded as a core health and public health issue through clear leadership, consistent data collection, training, specialist advocacy and coordinated partnership working.[16]

Consultation question 2 (Hospital to community): *What further support should be provided for people with severe and enduring mental illness? (maximum 300 words)*

Domestic abuse statutory guidance is clear that victims and survivors must not be disadvantaged in accessing both health and mental health services, and that professionals should be equipped to identify and respond to abuse.[17] However, insights from the Commissioner's engagement with survivors, alongside engagement with practitioners and system leaders, indicate that this ambition is not yet consistently embedded in practice.

For many adults and children, domestic abuse and trauma are central to both the onset and persistence of mental ill health, shaping risk, complexity and recovery.[18][19] Survivors consistently emphasise that safety, consent and autonomy must underpin effective care. Without these foundations, individuals are less likely to engage, disclose abuse, or sustain recovery.[20]

[9] Office for National Statistics (ONS). *Domestic abuse prevalence and trends, England and Wales: year ending March 2025*
[10] ONS. *Domestic abuse in England and Wales overview: November 2025*
[11] Foundations. *REACH* Breakthrough trials begin to address longstanding evidence gap in what works to support children who experience domestic abuse, says Foundations - Foundations
[12] Trevillion, K., Oram, S., Feder, G., & Howard, L.M. (2012). Experiences of domestic violence and mental disorders: A systematic review and meta-analysis. PLOS One, 7, e51740.
[13] Refuge (2023). *Local Lifelines research*
[14] WAFE, The Domestic Abuse Report 2024: The Annual Audit
[15] Domestic Abuse Commissioner (2022). *A Patchwork of Provision*
[16] Standing Together Against Domestic Abuse. (2020). Pathfinder Toolkit
[17] HM Government (2022). *Domestic Abuse Act 2021 Statutory Guidance*
[18] Chandan et al. (2020). *British Journal of Psychiatry*
[19] Lancet Psychiatry Commission (2022)
[20] Woman's Trust (2025). *Living Without Hope*

To address this, mental health services must move beyond standardised pathways and adopt trauma-informed care as a universal baseline. This requires recognising the long-term impact of domestic abuse on both mental and physical health, and understanding how risk and need evolve over time, particularly for individuals navigating multiple systems, including housing pathways, family courts and the criminal justice system.[21] Without a coordinated, system-aware approach, care will remain fragmented and fail to address underlying drivers of mental health conditions, ultimately placing further burden on NHS services.

Delivering effective support does not rely solely on additional infrastructure, but on leadership, workforce capability, and cultural change. Trauma informed care must be centred on safety, trust, collaboration and empowerment as this has the potential to significantly improve engagement, reduce re traumatisation, and support sustained recovery. Moreover, this must be accompanied by a stronger focus on intersectional inequalities, as survivors from migrant and minoritised communities frequently experience unsafe or culturally inappropriate responses, further undermining trust and access to care.[22]

Recommendation: DHSC should mandate trauma-informed, culturally competent care as a core standard across all mental health services, supported by compulsory training, routine enquiry of domestic abuse, and clear accountability frameworks. This should include a clear expectation that services recognise and respond to the intersecting impacts of factors such as race, ethnicity, gender, disability, class, and immigration status on individuals' experiences of abuse and access to support, drawing on an intersectional approach. Services must move beyond one-size-fits-all models to deliver equitable, responsive care that addresses systemic inequalities and reduces barriers to disclosure, engagement, and recovery.

Consultation question 3 (Hospital to community): *What are the main barriers to continuity of care across transitions between hospital and community services, and between different levels of care, including child to adult services? (maximum 300 words)*

Barriers to continuity of care between hospital and community domestic abuse services are too often driven by fragmented, siloed systems that fail to take a whole family approach to domestic abuse. Too often, children's services focus solely on the child without considering the safety and needs of the non-abusive parent, while adult services fail to identify or respond to the experiences of child victims. This results in disjointed care, where risks are assessed in isolation rather than understood cumulatively.[23][24]

A lack of effective multiagency working is a persistent and well evidenced barrier. HALT's analysis of DHR recommendations, found that 73% of Domestic Homicide Review recommendations identified failures in multi-agency collaboration and information sharing.[25] In practice, this means that critical information about risk is held across multiple services without being effectively joined up, leading to inconsistent responses and missed opportunities for early intervention. Poor data quality, lack of shared records, and unclear accountability can further exacerbate this, particularly at transition points such as discharge from inpatient services or movement from child to adult services.

These systemic gaps disproportionately impact families experiencing domestic abuse, where navigating multiple systems adds additional complexity. Without coordinated pathways and multi-agency support and accountability, survivors are left to manage transitions themselves, often resulting in disengagement or escalation of risk and need.

[21] HM Government (2024) Understanding domestic abuse interventions for women experiencing multiple disadvantage
[22] Imkaan, Women and Girls Network (WGN) & University of Warwick (2024) *Why Should Our Rage Be Tidy? Minoritised Survivors' Experiences of Mental Health in the Context of Violence and Abuse*
[23] Domestic Abuse Commissioner (2025) Victims in their own right?
[24] Joint Targeted Area Inspections (Ofsted, CQC, HMICFRS, HMI Probation) (2026).
[25] Domestic Abuse Commissioner / HALT Project (Manchester Metropolitan University, 2023–24)

Models such as Safe & Together demonstrate how embedding a whole family framework, centred on perpetrator accountability and strengthening the non-abusive parent–child relationship, can improve identification, risk management, and multi-agency collaboration across services.[26]

Recommendation: DHSC should consider introducing a clear national expectation that all health and care systems adopt evidence based whole family domestic abuse models, such as Safe & Together, embedded through commissioning, workforce training and integrated pathways to reduce fragmentation and improve safety and recovery outcomes.

***Consultation question 4* (Analogue to digital):** What evidence and innovative examples are there of digital and AI tools being used to achieve the nhs shift from Analogue to digital and improve mental health outcomes? *(maximum 300 words)*

Governments working definition of trauma-informed practice include 6 principles of safety, trust, choice, collaboration, empowerment and cultural consideration.[27] Whilst the shift from analogue to digital across health services presents opportunities to improve access, responsiveness and efficiency; without robust safeguards and trauma-informed design; digital transformation risks excluding and, in some cases, causing further harm to victim survivors of domestic abuse.[28]

Digital enabled tools are increasingly used to triage need, assess risk, and are increasingly relied on by victim and survivors for advice. While AI offers potential benefits, it can fail to account for the nuanced and dynamic nature of domestic abuse and wider forms of harm. For victim and survivors, their mental health recovery journey is unique, fluid and can be influenced by many additional factors, such as changing and emerging risk, multiple care and support needs, and navigating multiple systems simultaneously, such as criminal justice and family court.

Concerningly, AI systems and digital triage models may misinterpret presentations inputted by either professionals or patients, leading to potential inappropriate or unsafe responses, delayed access to support, or pathways that fail to address underlying need. Moreover, overreliance on digital-only pathways risks fragmenting access to care, particularly at crisis points or during transitions between hospital and community services. Digital triage systems may struggle to capture the fluid and evolving nature of risk, particularly where individuals are living in unsafe environments that limit opportunities to seek help safely. These approaches can also widen inequalities for those facing digital exclusion or who are unable to disclose their experiences in ways that feel safe or supported. Without consistent, relational support, individuals may be subject to repeated assessments without continuity, increasing the likelihood of unmet need, disengagement, and deterioration in health outcomes.[29]

There are however positive examples of where digital innovation can on occasion support improved outcomes, such a text based services, online platforms and translation tools which increase accessibility and enable discreet engagement for some survivors.[30] However, these approaches must remain choice-based and consent-led, not default or mandatory. The strategy must recognise that digital-only models and the introduction of the Single Patient Record (SPR) through the current Health Bill may risk excluding those with limited access or literacy, neurodivergent individuals, older people, and those for whom technology use may be unsafe or monitored by perpetrators.[31]

To deliver equitable and effective care, digital transformation must be trauma-informed, culturally competent, and safety assured, and implemented as an enhancement to and not a replacement for skilled, in-person care.

[26] Safe and Together Institute (2025) Safe & Together Model Featured as Best Practice in Landmark UK Government Report on Children as Victims of Domestic Abuse — Safe & Together Institute
[27] Office for Health Improvement and Disparities (2022). *Working definition of trauma-informed practice*
[28] NHS England (2025) *Mitigating the risks of domestic abuse in digital services*. Mitigating the risks of domestic abuse - NHS England Digital
[29] University of Oxford (2025). *AI-enabled triage in the NHS*
[30] Yu et al. (2026) Help, near and far: a systematic review of post-COVID digital mental health solutions for domestic violence victims
[31] Age UK (2023). *Digital exclusion and domestic abuse*

Recommendation: DHSC should embed trauma-informed digital transformation as a core principle within the mental health strategy, mandating that all digital services and AI tools incorporate safeguarding for domestic abuse, address digital exclusion, and provide choice-based access alongside in-person care. This should be supported through national service standards, workforce training, and strengthened oversight to ensure digital innovation improves outcomes without increasing risk or inequality.

Consultation question 5 (Analogue to digital): *How can data be used more innovatively to improve mental health and wider societal outcomes? (maximum 300 words)*

Domestic abuse data has significant untapped potential to improve mental health and wider societal outcomes; however, current collection and use across the NHS remains limited, fragmented, and insufficiently aligned with survivor need. Existing datasets are predominantly geared towards crisis response and safeguarding activity, rather than prevention, recovery, and long-term outcomes. Critically, national mental health datasets, such as the Mental Health Services Dataset (MHSDS), do not systematically capture domestic abuse exposure, limiting the ability to identify need, monitor access, or assess outcomes. While the introduction of a domestic abuse indicators within public health data based on police recorded offences is a positive step, it largely reflects criminal justice activity, not healthcare demand, service engagement, or recovery.[32]

This creates a significant evidence gap. Commissioners and system leaders lack consistent visibility of how domestic abuse drives mental health need, how survivors move through services, and whether interventions result in meaningful, sustained recovery. As a result, many victim survivors remain effectively invisible within data systems, particularly those experiencing hidden forms of abuse or facing intersecting inequalities, including migrant survivors or individuals with no recourse to public funds.[33]

These gaps constrain system improvement and perpetuate inequity. Without accurate, population level insight, resources cannot be allocated effectively, and opportunities to identify patterns of harm, such as repeat A&E, are routinely missed. Poor data integration further undermines early intervention and coordinated, cross system responses. Without urgent action, these limitations will significantly hinder progress towards the Government's ambition to halve violence against women and girls over the next decade.

To improve outcomes, there must be a fundamental shift from passive data collection to proactive, population health intelligence. This includes systematically capturing domestic abuse across healthcare datasets, embedding survivor centred outcome measures, and enabling secure, ethical data sharing across health, social care and wider multi-agency systems.

Recommendation: DHSC should introduce the routine collection of domestic abuse indicators within all mental health datasets, alongside survivor centred outcome measures, and establish a national, trauma-informed data-sharing framework to enable proactive identification, equitable commissioning, and improved recovery outcomes.

Consultation question 6 (Sickness to prevention): *Which preventative approaches have the strongest evidence for reducing incidence or severity of mental health problems and promoting good mental health? (maximum 300 words)*

There is a strong and well-established evidence base demonstrating that early identification and specialist intervention for domestic abuse, particularly through co-located Independent Domestic Violence Advisors (IDVAs) across healthcare settings, is one of the most effective preventative approaches for reducing both the incidence of abuse and the severity of mental ill health.[34]

[32] Office for Health Improvement and Disparities, *Wider determinants of health*, Fingertips Public Health Data.
[33] Imkaan, Women and Girls Network (WGN) & University of Warwick (2024) *Why Should Our Rage Be Tidy? Minoritised Survivors' Experiences of Mental Health in the Context of Violence and Abuse*
[34] Halliwell et al. (2019) *Cry for health: a quantitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse*.

Healthcare settings are often the first, and sometimes only point of contact for victim and survivors.[35] Embedding IDVAs across health care settings enables earlier identification, risk management and timely intervention, preventing escalation to crisis and reducing reliance on acute and inpatient services.[36] [37]

IDVAs are uniquely effective in reaching survivors who are not engaged with community services and are often identified earlier in the abuse trajectory. Their presence significantly improves clinician confidence and response, providing clear, immediate referral pathways and ensuring disclosures lead to action. In primary care, models such as IRIS demonstrate that linking clinicians directly to specialist advocates results in substantial increases in identification and referrals, alongside improved health and safety outcomes.[38] Crucially, IDVAs also play a central role in coordinating multiagency responses, addressing both immediate safety and the wider social determinants that drive poor mental health.

The expansion of Mental Health IDVA roles further strengthens this preventative model. By operating within mental health pathways, they provide specialist expertise at the intersection of trauma and mental illness, supporting engagement, reducing re-traumatisation, and enabling more appropriate and effective treatment. Their role is critical in bridging gaps between services and ensuring that domestic abuse is recognised as a core determinant of mental health need.[39]

Recommendation: DHSC should invest in the national expansion of co-located IDVA and Mental Health IDVA provision across acute, primary and mental health services, embedding them as core components of community mental health pathways to enable early intervention, prevent escalation, and reduce demand on crisis care.

Consultation question 7 (Sickness to prevention): *Which preventative approaches have the strongest evidence for reducing the numbers of lives lost to suicide? (maximum 300 words)*

There is a strong and growing evidence base linking domestic abuse to suicidality. Research shows that around 26% of women in contact with mental health services who died by suicide had experienced domestic abuse, with survivors significantly more likely to experience self-harm and suicidal ideation.[40] For the third year in a row, suicide is increasingly recognised as a leading cause of death among domestic abuse victims, often arising in the context of under identification, unmet need, and fragmented responses.[41] For many, suicidality occurs within ongoing experiences of trauma, coercion and fear, rather than as an isolated clinical issue.[42]

Tim Woodhouse's Churchill Fellowship report highlights that survivors often have repeated contact with health services prior to crisis, yet opportunities to safely identify and respond to abuse are frequently missed.[43] Where domestic abuse is not recognised as a core driver of distress, responses can be misaligned, focusing on symptoms rather than addressing ongoing risk, safety and control, thereby limiting their effectiveness and, in some cases, compounding harm.[44]

Preventative approaches centre on early identification, trauma-informed practice, and integrated multiagency responses. This includes routine, safe enquiry about domestic abuse across mental health, primary care and crisis settings, carried out in ways that prioritise choice, consent and safety. Embedding specialist advocacy, such as IDVAs, within healthcare pathways strengthens safety planning, supports engagement, and provides survivors with relational, trust-based support that is critical to recovery. Moreover, continuity of care and

[35] Domestic Abuse Commissioner (2022). *A Patchwork of Provision*
[36] Mason et al. (2020) *valuation of a Hospital-based Independent Domestic Violence Advisor (HIDVA) service*.
[37] Dheensa et al. (2020) *From taboo to routine": a qualitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse*.
[38] Feder G et al. (2011). Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. Lancet, 378(9805):1788-1795.
[39] SafeLives (2025) *Idva services Insights dataset*.
[40] Turnbull et al. (2025). *The Lancet Regional Health*
[41] Hoeger et al. (2026) *Domestic Homicides and Suspected Victim Suicides 2020–2025: Year 5 Report*. National Centre for Violence Against Women and Girls (NCVPP), College of Policing / NPCC.
[42] Bhavsar, V. and Dheensa, S. (2025) The impact of domestic abuse on suicide.
[43] Woodhouse, T. (2023) *The person most likely to kill a victim of domestic abuse… is themselves: 66 ways to reduce domestic abuse-related suicides*. Churchill Fellowship.
[44] Trevillion et al 2014

trusted relationships are key protective factors against suicide, while fragmented systems and poor coordination increase risk.

Reducing suicides in this context therefore requires a shift from reactive, crisis focused responses to proactive, coordinated and trauma-informed systems that recognise domestic abuse as a central determinant of mental health risk.

Recommendation: DHSC should renew and strengthen the national suicide prevention strategy by explicitly recognising domestic abuse as a key driver of suicide risk. This must include mandating safe routine enquiry across health settings, embedding specialist domestic abuse advocacy within mental health pathways, and ensuring continuity of relational, survivor-centred support through robust cross-system accountability and integrated commissioning arrangements.

Consultation question 8 (Sickness to prevention): How can services better support the 'missing middle' - those with sustained needs (that affect their participation in community life, for example, in education or work) who may not meet the criteria for NHS mental health services? *(maximum 300 words)*

While commitments to expand NHS Talking Therapies are welcome across the population level, a system overly reliant on a single, standardised therapeutic model does not meet the needs of the "missing middle" including many victim and survivors of domestic abuse and wider forms of violence against women and girls.[45] These individuals often experience sustained, complex trauma that significantly impacts their participation in everyday life, yet do not meet thresholds for secondary care and face barriers within existing primary care pathways.[46]

In practice, survivors often encounter structural and psychological barriers to accessing Talking Therapies. Many are assessed as not being "ready" for therapy, disengage due to a lack of safety or trust, or receive interventions that do not address the underlying drivers of distress.[47] Recovery from domestic abuse is rarely linear and often requires stabilisation, advocacy, and practical support alongside psychological intervention. A narrow focus on clinical therapy alone fails to reflect this complexity.

As a result, survivors' needs are frequently met outside the NHS, by specialist domestic abuse services or through private provision, highlighting a significant gap between national ambition and lived experience. Current pathways insufficiently account for trauma, risk, and social determinants of mental health, limiting engagement and reducing effectiveness.

Supporting the "missing middle" requires a shift towards flexible, trauma-informed and holistic models of care. This includes integrating therapeutic support with advocacy, safety planning, and wider social support, alongside routine identification of domestic abuse and stronger partnerships with specialist services.

Recommendation: DHSC should move beyond a single pathway model by expanding access to trauma specific, multi-disciplinary support for the "missing middle", including commissioning integrated pathways that combine psychological therapies with specialist domestic abuse support, advocacy and practical interventions, ensuring care is flexible, needs-led, and not contingent on "readiness" for therapy.

Consultation question 9 (Factors enabling good practice) *What commissioning, funding and oversight or accountability arrangements (nationally and locally) best support safe and integrated mental health services that improve outcomes across mental health, participation in work, education and community life, and social functioning? (maximum 300 words)*

[45] Oram S (2026). Violence Against Women and Girls Strategy: Implications for Mental Wellbeing, Recovery and Services. Briefing for the Department of Health and Social Care. VAMHN, London.
[46] Dunn et al. (2024), *Equity for the 'missing middle': closing the gap between primary and secondary care services*, British Journal of General Practice.

[47] National Collaborating Centre for Mental Health (2023), *Ethnic inequalities in Improving Access to Psychological Therapies (IAPT): Policy Review*, Royal College of Psychiatrists.

Safe and effective mental health services depend on commissioning, funding and accountability arrangements that support long-term, integrated, and trauma-informed care. However, current approaches remain overly reliant on short-term, competitive procurement models that prioritise cost over quality, continuity and outcomes. This model fragments provision, destabilises specialist services, and undermines the development of sustainable, community-based support.[48] [49]

Competitive tendering often forces specialist domestic abuse services to compete with larger, non-specialist providers, leading to the displacement of local expertise and the erosion of trusted, relationship-based support. It discourages collaboration, creates uncertainty for providers, and limits investment in workforce development and long-term recovery models. As a result, services are frequently commissioned in isolation, with insufficient alignment across mental health, social care, housing and justice systems. This contributes to gaps in provision, particularly for those with complex trauma, while perpetuating a postcode lottery in access and widening inequalities for marginalised and minoritised groups.

Short-term funding cycles further constrain effectiveness by prioritising immediate outputs over prevention, recovery and sustained engagement. This approach fails to recognise the non-linear nature of trauma recovery and can lead to increased system costs over time, as unmet need escalates into crisis and acute service use.[50]

To improve outcomes, commissioning must shift fundamentally from transactional procurement to strategic, partnership-based models. This includes embedding collaboration across systems, valuing specialist expertise, and aligning funding with population need and long-term outcomes. Moreover, stronger national and local accountability is also needed to ensure commissioning decisions deliver integrated, equitable services and reflect national policy intent.

Recommendation: DHSC should lead the transition from short-term competitive procurement to long-term, partnership-based commissioning, embedding specialist services as core system infrastructure, aligning funding across sectors, and strengthening national and local accountability frameworks to ensure integrated, trauma-informed care that delivers improved recovery and needs led outcomes.

[48] Women's Aid (2024). *Alternatives to Procurement Guidance*
[49] Sheaff R, Ellis Paine A, Exworthy M, Gibson A, Stuart J, Jochum V, *et al.* Consequences of how third sector organisations are commissioned in the NHS and local authorities in England: a mixed-methods study.
[50] Domestic Abuse Commissioner (2024) *Written evidence submitted to the Public Accounts Committee on violence against women and girls (VAWG0076)*.