

Evaluation of the Healing Together Programme Supporting Children and Young People Affected by Domestic Abuse

Katie Cunneen^a, Asha Patel^b, Claire Fox^c

^a Psychology Department, University of Warwick, United Kingdom

^b Innovating Minds, Birmingham, United Kingdom

^c School of Education, University of Bristol, Bristol, United Kingdom

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ABSTRACT

Background: Children affected by domestic abuse have a heightened risk of experiencing mental health related difficulties, becoming victims of youth violence, and being excluded from school due to their traumatic experiences. Development of trauma-informed interventions which aim to develop a child's emotional awareness could offer an effective early intervention approach.

Objectives: The aim was to follow-up the impact of a trauma-informed intervention (Healing Together) for children affected by domestic abuse using a second larger sample. Intervention effectiveness was measured by tracking changes in emotional awareness at pre and post-test. Focus was placed on any interaction effects of delivery-method and age-of-child.

Participants and Setting: In total, 1,097 children from the U.K. aged between 5–16 years who were involved in the Healing Together programme participated in the study. The programme took place within schools, youth organisations and early intervention services, between the dates of July 2023 to May 2026.

Method: The children completed the Emotional Awareness Questionnaire to measure Differentiating Emotions, Verbal Sharing of Emotions and Not Hiding Emotions before and after the programme.

Results: Immediately post-intervention, the Healing Together programme significantly increased children's ability to differentiate emotions, not hide emotions, and verbally share emotions. The findings demonstrated that the programme was associated with significant improvements in emotional awareness regardless of whether it was delivered in a group or 1-to-1 format and regardless of the child's age group.

Conclusion: The Healing Together programme demonstrates statistically significant improvements in emotional awareness across delivery formats and age groups. Findings support both the programme's trauma-informed theoretical foundation and its training model as a sustainable, scalable mechanism for extending early support to children affected by domestic abuse.

1. INTRODUCTION

Domestic abuse (DA) represents one of the most pervasive adverse childhood experiences in the United Kingdom. Recent estimates suggest that approximately 20% of children and young people (CYP) in the UK are exposed to domestic abuse, with Foundations (2024) estimating that 827,000 children experienced domestic abuse in England and Wales in 2023 alone. Experiencing domestic abuse can impact a child's emotional, physical, psychological and relational health (Holt et al., 2008; Radford et al., 2011). Children living with domestic abuse are at heightened risk of developing depression, anxiety, and complex post-traumatic stress disorder (PTSD), and it increases likelihood of becoming victims of criminality (Wedlock & Molina, 2020).

Central to understanding the immediate and enduring impact of domestic abuse on children is the recognition that exposure to chronic fear, threat, and unpredictability does not simply affect children at a psychological level — it fundamentally reshapes the automatic survival mechanisms of the developing body and brain. When children must continually adapt to environments that do not offer safety, this adaptation occurs at a physical, biological, emotional, and relational level. The nervous system, rather than higher-order cognitive processes, becomes the primary site of response: thinking and reasoning cannot be instantly recruited to preserve life, whereas the body's autonomic systems can. As a result, children exposed to domestic abuse frequently experience automatic nervous system states including hyperarousal, freeze, or shutdown as the body defaults to its most evolutionarily primitive means of self-protection (Porges & Porges, 2023). This process is illuminated by the concept of neuroception, developed by Dr. Stephen Porges as part of polyvagal theory, which describes how the nervous system continuously evaluates cues of safety, danger, and life threat in the environment without conscious awareness or deliberate appraisal (Porges, 2001; 2017). In the context of domestic abuse, this means a child's body is engaged in a constant, involuntary process of risk detection that, over time, reshapes the architecture of the developing brain. The work of Perry and colleagues has demonstrated that early experiences of felt threat, stress, and trauma exert both immediate and sustained effects on neurological development: "childhood abuse and exposure to domestic violence can lead to numerous differences in the structure and physiology of the brain that expectedly would affect multiple human functions and behaviors" (Perry & Pollard, 1998; Teicher, 2000, 2002, as cited in Perry et al., 2006). The Neurosequential Model of Therapeutics further articulates how these early disruptions to developmental sequencing shape a child's capacity for regulation, relationship, and reasoning across the lifespan (Perry & Dobson, 2013). As Van der Kolk (2014) has demonstrated, trauma fundamentally alters how the body and brain respond to perceived threat, often leaving children in a persistent state of hyperarousal or dissociation that impedes their capacity to recognise, differentiate, and articulate emotions.

Rieffe et al. (2008) have established robust associations between low emotional awareness and elevated internalising symptoms in children and adolescents, underscoring this capacity as a key protective factor in developmental outcomes. Recovery from early traumatic experiences is substantially enhanced when children are supported to recognise and safely experience emotions, and to learn to send signals of safety to their body and brain. Building emotional awareness is therefore a foundational condition for ongoing healing, connection, and wellbeing.

Despite the extent of need, there remains a chronic shortage of accessible, community-based services for children affected by domestic abuse in the UK (Domestic Abuse Commissioner, 2025; Foundations, 2024). McCarry et al. (2021) have highlighted the importance of early, community-level intervention for children and families affected by DA, noting that timely support can interrupt cycles of harm and build protective capacity. The evidence base further emphasises the need for any such provision to be grounded in trauma-informed principles, an approach characterised by safety, trustworthiness, choice, collaboration, and empowerment, which the Office for Health Improvement and Disparities (2022) defines as practice that recognises and responds to the widespread impact of trauma on individuals, families, and communities. Critically, trauma-informed practice with children affected by DA must go beyond symptom reduction to actively build the skills and internal resources that enable children to feel safe, understood, and capable of regulating their own emotional responses (Wilson et al., 2015; Romano et al., 2019).

This report presents findings from an evaluation of the Healing Together programme, assessing the extent to which the programme's theory of change is supported by evidence from children and young people. Drawing on quantitative data gathered pre- and post-intervention via the Emotional Awareness Questionnaire (EAQ; Rieffe et al., 2008), the report examines whether Healing Together produces measurable and meaningful change in emotional awareness, and explores the conditions and mechanisms through which this change occurs. In doing so, this evaluation contributes to a growing evidence base on effective, scalable, trauma-informed interventions to support children affected by domestic abuse (Cunneen et al., 2025).

1.2. The Healing Together Programme

The Healing Together programme was developed in 2020 and has been utilised across the U.K. with over 1,360 facilitators who already work therapeutically with children affected by DA. Facilitators receive 17 hours of training, access to ongoing coaching, and on-demand CPD sessions to support them with the implementation of the programme. The programme covers 6 sessions, delivered on a weekly basis, with each session lasting approximately 60 minutes. Facilitators conduct a pre-assessment prior to delivering the programme to identify whether the child requires a 1-to-1 or group-based modality. The programme is designed to encourage collaborative discussion, which, within the group modality can be done between children, and in the 1-to-1 modality can be completed between the child and facilitator. The Healing Together programme is designed to be offered flexibly based on the needs of the child, as well as the resources available to the organisation offering the programme. Facilitators are provided with coaching sessions and video content to ensure they maintain programme fidelity, course principles, and structure when utilising different modalities.

The Healing Together programme avoids using cognitive behaviour therapy approaches as it is noted that some children affected by trauma can be resistant to this, and neuroscientific researchers suggest trauma cannot be cognitively processed (Niles et al., 2018; Van der Kolk, 2015; D'Andrea & Pole, 2012). Instead, the Healing Together programme uses neuroscientific, attachment, and relational theories as its foundations. The evidence-base includes the Polyvagal Theory (Porges, 2001), Hand Brain Model (Siegel, 2012), Neurosequential Model (Perry & Dobson, 2013), and Safe Relational Experiences (Perry, 2013). Importantly, the programme does not ask children to talk about their traumatic experiences to minimise the risk of re-traumatisation (Innovating Minds, 2022). The programme has been studied previously, and the results found that the Healing Together programme significantly increased children's ability to differentiate emotions, not hide emotions, and verbally share emotions, with the intervention appearing more effective on a 1-1 basis and for 5-10-year-olds (Cunneen et al., 2025).

The Healing Together programme utilises the body-based approach, which revolves around how emotions physically feel and how to recognise them (Van der Kolk, 2014). Another aspect of the programme involves children recognising what happens to their brain when their body is feeling unsafe and learning discreet body-based strategies (e.g. breathing exercises) to help their body and brain to feel and be safe and calm. Both characteristics aim to help the child improve their own emotional awareness and regulation. Innovating Minds offer manuals, worksheets, and trauma-informed video animations to aid the delivery of Healing Together. All above information is available in the Innovating Minds impact report and information pertaining to the copyrighted programme are available via the Innovating Minds webpage (www.innovatingmindsgroup.com).

1.3. Equality, Diversity, Inclusion, and Equity

The Healing Together programme embeds equality, diversity, inclusion, and equity (EDIE) principles across every dimension of its design and delivery, reflecting a commitment to ensuring that all children and young people affected by domestic abuse can access meaningful, culturally responsive support. The programme explicitly includes those with protected characteristics such as hearing difficulties, disabilities, and English as an additional language. Equity is operationalised through the programme's multilingual accessibility. Core materials and video animations have been translated into Arabic, Bengali, and Polish, removing significant language barriers to engagement for families for whom English is not a first language. Inclusion is further embedded in the visual design of the programme resources. The worksheets and video animations feature illustrations that are representative across disability, ethnicity, and gender, ensuring that children can see themselves reflected in the materials. Accessibility for Deaf and hard-of-hearing children is addressed through the provision of British Sign Language interpretation and subtitles across all video animations, ensuring that hearing differences do not limit participation.

1.4. Rationale, Aims, and Hypotheses

This study was designed to explore whether the findings from Cunneen et al. (2025) were replicable using a second, larger, and more up-to-date sample. It was predicted that there would be significant improvements in children's emotional awareness from pre to post-test. In addition, possible interactions with age-group and delivery-method were explored based on previous findings.

The primary author of this paper had no part in the development or design of the programme. The secondary author is a qualified Clinical Psychologist and the CEO of Innovating Minds and founder of the Healing Together programme; they were not involved in the data analysis, and the third author independently reviewed the results and acted as a research advisor.

2. METHODOLOGY

All data used within the research is secondary data collected by Innovating Minds whose data collection is ongoing. Innovating Minds have an online platform where facilitators access resources, including the questionnaires used to assess children's emotional awareness. The children complete these pre- and post-programme, which facilitators then submit to the platform, where they are anonymously analysed (facilitators assign children a unique participant code). Children and guardians gave initial consent through their facilitators and Innovating Minds for the child(ren) to take part in the Healing Together programme, and have their data recorded, analysed, and reported by Innovating Minds.

2.1. Participants

Children receiving the Healing Together programme were identified using a convenience-sampling method by the school/service/organisation as requiring support. The only inclusion criteria were to be 5–16 years old (school age) and have been referred for DA. Children were referred by the existing services' referral pathways, for example early help teams would have received referrals from children in need plans, and schools would have referred children if DA was identified via safeguarding processes or data shared via the police (such as Operation Encompass). During this process, the consent forms and pre-assessment would have been completed before the Healing Together programme commenced.

A preliminary power-analysis was not calculated for this evaluation. A previous power-analysis calculation revealed a sample of $N=113$ as acceptable to reach adequate power (Cunneen et al., 2025). The sample was $N = 1,183$. From this, a total of $N = 86$ were removed for incomplete data. Only $N = 33$ of these data sets were missing pre-or-post-emotional awareness data (as opposed to grouping data – Age or Delivery-Method), meaning the dropout rate was 2.8%. The final sample was $N=1,097$. Children were offered the programme on a group or 1-to-1 basis based on the child's need at pre-assessment and the resources available to the organisation. Children received the Healing Together programme from various sources, illustrated in Table 1.

Table 1

Delivery Organisation Breakdown

Organisation Type	<i>N</i>	Percent of Whole Sample
Council or Local Authority	358	32.63%
Educational Setting	318	28.98%
VCSEs	268	24.43%
Domestic Abuse Services	153	13.94%
Total = 1097		

Note: All decimals shown to the nearest two-decimal-points; N=Sample Size.

2.2. Materials and Procedure

Innovating Minds selected the Emotion Awareness Questionnaire (EAQ; updated version) by Rieffe et al. (2008) to measure the impact of the programme in increasing levels of emotional awareness. Only three constructs from the original six are actively utilised: Differentiating Emotions, Verbal Sharing of Emotions, and Not Hiding Emotions. The EAQ uses a three-point response scale (1 = not true, 2 = sometimes true, 3 = often true). The Differentiating Emotions subscale contains 7 items, all reverse-scored, yielding a possible range of 7 to 21; a higher score indicates a greater ability to identify and distinguish between different emotional states. The Verbal Sharing of Emotions subscale contains 3 items with two items reverse-scored, yielding a range of 3 to 9; a higher score reflects a greater tendency to communicate one's emotional experiences to others. The Not Hiding Emotions subscale contains 5 items, all reverse-scored, yielding a range of 5 to 15; a higher score reflects a greater tendency to express rather than suppress or conceal one's emotions. Across all three subscales, higher scores are associated with fewer internalising symptoms such as social anxiety, depression, and worry/rumination (Rieffe et al., 2008).

The EAQ and these constructs were chosen as they coincide and relate to the trauma-informed care outcomes of interest, which are understanding and differentiating between emotions, and being able to share emotions with trusted others. The EAQ and chosen constructs were also reviewed and approved by a research expert in childhood trauma and DA for their reliability, validity, and suitability for the programme's intended outcomes. The EAQ constructs used show adequate Cronbach-alpha scores ranging from $\alpha = .68$ to $\alpha = .77$ (Rieffe et al., 2008). The data utilised in this study was collected between July 2023 and May 2026.

As almost all participants were below 16 years of age, accredited Healing Together facilitators gathered initial consent from parents/guardians with secondary assent from children, as per BPS (2018) guidelines. Both the child and parent/guardian could withdraw this consent at any time. Before the first session, children were asked to complete the EAQ and then again immediately after the last session at week six (pre-post design). Facilitators created participant numbers and submitted the data to Innovating Minds, alongside information about the child's age and delivery method.

2.3. Data Analysis

The hypotheses were tested using a Mixed within / between Multivariate Analysis of Variance (MANOVA). The MANOVA followed a $2 \times 2 \times 2$ design: Delivery Method (Group $\times$ 1-to-1) $\times$ Age of Child (5–10 $\times$ 11–16) $\times$ Time (pre $\times$ post Healing Together) and was completed using IBM SPSS version 31.

2.4. Ethics

Formal ethical approval was not applied for, given this is classified as an evaluation and not research; however, ethical standards were maintained and conducted in compliance with the BPS 'Code of Ethics' (2018).

3. RESULTS

3.1. Reliability Tests

Internal consistency of the Emotional Awareness Questionnaire (EAQ) subscales was assessed using Cronbach's alpha. Reliability coefficients for each construct by age group are presented in Table 2. Differentiating Emotions demonstrated acceptable internal consistency among older participants (11–16 years; $\alpha = .78$) and slightly lower reliability among younger participants (5–10 years; $\alpha = .67$). Similarly, Not Hiding Emotions showed good reliability for the older age group ($\alpha = .80$) and moderate reliability for younger participants ($\alpha = .67$). Verbal Sharing of Emotions demonstrated acceptable reliability among 11–16-year-olds ($\alpha = .72$), but lower internal consistency among 5–10-year-olds ($\alpha = .51$).

Overall, reliability estimates were stronger among the older age group across all three subscales. While the reliability coefficients for the 5–10-year-old group were below the conventional .70 threshold for some constructs, this pattern is consistent with previous research using the EAQ, which has reported lower reliability among younger children due to developmental differences in emotional understanding and self-reporting ability (Rieffe et al., 2008).

Table 2

Cronbach's alpha breakdown

Construct	Age Group	α
Differentiating Emotions	5-10	.67
	11-16	.78
Not Hiding Emotions	5-10	.67
	11-16	.80
Verbal Sharing of Emotions	5-10	.51
	11-16	.72

Cronbach's alpha breakdown. Note: All decimal places shown to two decimal points; α = Cronbach's alpha.

3.2. Descriptive Statistics

The final sample consisted of 1,097 participants, see Table 3 and 4 for sample breakdown. The majority of participants were aged 5–11 years ($n = 819$, 74.7%), with 278 participants aged 11–16 years (25.3%). The mean age of participants in the younger age group was 8.01 years ($SD = 1.46$), while the mean age of participants in the older age group was 12.25 years ($SD = 1.39$). Gender was broadly balanced, comprising 558 females (50.9%), 536 males (48.9%), and three participants identifying as non-binary or transgender (0.3%). Participants were distributed relatively evenly across delivery formats, with 554 children (50.5%) receiving the intervention on a one-to-one basis and 543 (49.5%) participating in group-based delivery. Table 4 presents the gender and age-group breakdown by delivery method.

Ethnicity data were collected using an open-response format, resulting in a large number of unique categories. The sample was predominantly White British ($n = 763$, 69.9%), with a further 117 participants (10.7%) not disclosing. The remaining participants represented a wide range of ethnic backgrounds, described in Table 5.

Table 3

Sample Breakdown

Group	Category	<i>N</i>		
Delivery-Method	1:1	554		
	Group	543		
Age-of-Child			Mean	Standard Deviation
	5-10	819	8.01	1.46
	11-16	278	12.25	1.38
	All Ages	1,097	9.08	2.34

*Note: All decimals shown to the nearest two-decimal-points; *N*=Sample Size*

Table 4*Gender and Age Breakdown by Delivery Method*

Between-Factor IVs	Female	Male	Non-Binary/ Other	5-10 Years	11-16 Years
Overall Sample (N=1097)	558 (50.9%)	536 (48.9%)	3 (.03%)	819 (74.7%)	278 (25.3%)
Group Delivery (N=543)	286 (52.7%)	255 (47%)	2 (.04%)	404 (74.4%)	139 (25.6%)
1to-1 Delivery (N=554)	272 (49/1%)	281 (50.7%)	1 (.02%)	415 (74.9%)	139 (25.1%)
5-10 Years (N=819)	413 (50.4%)	406 (49.6%)	0 (0%)		
11-16 Years (N=278)	145 (52.2%)	130 (46.8%)	3 (1.1%)		

*Gender and Age Breakdown by Delivery Method. Note: Percentages are calculated within each subgroup and rounded to one decimal place.***Table 5***Ethnicity of Overall Sample.*

Ethnicity Category	N =	%
White British	763	69.9%
Not stated	117	10.7%
White other	62	5.7%
Dual Heritage	50	4.6%
Black/Black British/African	37	3.4%
Asian / Asian British	33	3.0%
White Irish	19	1.7%
Middle Eastern/Arab	10	0.9%

3.3. MANOVA

A Mixed 2×2×2 MANOVA was conducted to examine the effects of Time (pre versus post intervention), Delivery Method (1-to-1 versus group), and Age Group (5–10 years versus 11–16 years) on three measures of emotional awareness: Differentiating Emotions (DE), Not Hiding Emotions (NHE), and Verbal Sharing of Emotions (VSE). Means and standard deviations are presented in Table 6.

Table 6*Means and standard deviations for emotional awareness outcomes by delivery method, age group, and time*

	5-10 Years		11-16 years		Total	
	Pre	Post	Pre	Post	Pre	Post
DE						
1-to-1	13.26 (3.01)	14.69 (3.25)	13.40 (3.47)	15.14 (3.31)	13.29 (3.13)	14.81 (3.27)
Group	13.36 (3.21)	14.65 (3.10)	13.22 (3.31)	14.22 (3.68)	13.32 (3.23)	14.54 (3.26)
Total	13.31 (3.11)	14.67 (3.17)	13.31 (3.39)	14.68 (3.52)	13.31 (3.18)	14.68 (3.26)
NHE						
1-to-1	9.47 (2.63)	10.65 (2.59)	8.78 (2.89)	10.00 (2.65)	9.29 (2.71)	10.49 (2.62)
Group	9.26 (2.58)	10.26 (2.73)	8.19 (2.33)	8.96 (2.78)	8.99 (2.56)	9.93 (2.80)
Total	9.36 (2.61)	10.46 (2.67)	8.49 (2.64)	9.48 (2.76)	9.14 (2.64)	10.21 (2.72)
VSE						
1-to-1	5.56 (1.74)	6.26 (1.63)	5.53 (1.88)	6.17 (1.83)	5.56 (1.77)	6.24 (1.68)
Group	5.58 (1.59)	5.99 (1.64)	5.06 (1.76)	5.63 (1.79)	5.45 (1.65)	5.90 (1.69)
Total	5.57 (1.66)	6.13 (1.64)	5.29 (1.83)	5.90 (1.83)	5.50 (1.71)	6.07 (1.69)

Means and Standard Deviations for Emotional Awareness Outcomes by Delivery Method, Age Group, and Time. Note. DE = Differentiating Emotions; NHE = Not Hiding Emotions; VSE = Verbal Sharing of Emotions. Significant improvements from pre-to-post-intervention were observed for all three outcome measures (all ps < .001).

Prior to analysis, assumptions were checked. Box's Test of Equality of Covariance Matrices was significant, Box's M = 119.79, F(63, 739693.44) = 1.88, $p < .001$, indicating that the assumption of equality of covariance matrices was violated. Therefore, Pillai's Trace was used for interpretation of the multivariate effects. Some Levene's tests were significant, indicating some violation of homogeneity of variance; however, given the large sample size, the analysis was considered sufficiently robust.

The multivariate analysis revealed a significant main effect of Time, Pillai's Trace = .133, F(3, 1091) = 55.66, $p < .001$, $\eta^2p = .133$, indicating significant overall change in emotional awareness from pre-to-post-intervention. Significant multivariate main effects were also found for Delivery Method, Pillai's Trace = .015, F(3, 1091) = 5.563, $p < .001$, $\eta^2p = .015$, and Age Group, Pillai's Trace = .038, F(3, 1091) = 14.52, $p < .001$, $\eta^2p = .038$.

There was no significant Delivery Method x Age Group interaction, Time X Delivery Method interaction, and Time x Delivery Method x Age Group interaction.

Follow-up univariate analyses demonstrated significant improvements across all three emotional awareness outcomes. There was a significant effect of Time for Differentiating Emotions, $F(1, 1093) = 117.66$, $p < .001$, $\eta^2p = .097$; Not Hiding Emotions, $F(1, 1093) = 99.78$, $p < .001$, $\eta^2p = .084$; and Verbal Sharing of Emotions, $F(1, 1093) = 73.76$, $p < .001$, $\eta^2p = .063$.

Inspection of estimated marginal means indicated significant improvements across all three outcomes from pre-to-post-intervention. Mean Differentiating Emotions scores increased from 13.31 to 14.68, Not Hiding Emotions scores increased from 8.92 to 9.97, and Verbal Sharing of Emotions scores increased from 5.43 to 6.01.

Significant between-subjects effects of Delivery Method were observed for Not Hiding Emotions, $F(1, 1093) = 13.57$, $p < .001$, $\eta^2p = .012$, and Verbal Sharing of Emotions, $F(1, 1093) = 10.83$, $p = .001$, $\eta^2p = .010$, but not for Differentiating Emotions, $F(1, 1093) = 2.02$, $p > .05$, $\eta^2p = .002$. Across time points, participants receiving the intervention on a one-to-one basis reported higher levels of Not Hiding Emotions compared to those participating in the group-based format.

Significant between-subjects effects of Age Group were found for Not Hiding Emotions, $F(1, 1093) = 37.58$, $p < .001$, $\eta^2p = .033$, and Verbal Sharing of Emotions, $F(1, 1093) = 6.83$, $p < .05$, $\eta^2p = .006$, whereas age differences were not significant for Differentiating Emotions, $F(1, 1093) < .01$, $p > .05$, $\eta^2p < .001$. Across time points, children aged 5–10 years reported higher levels of Not Hiding Emotions and Verbal Sharing of Emotions than those aged 11–16 years.

Importantly, no interactions involving Time were significant for any of the outcome measures (all $ps > .05$), indicating that improvements from pre-to-post-intervention were comparable across delivery methods and age groups. These findings suggest that the Healing Together programme was associated with significant improvements in children's emotional awareness, and that these improvements were evident regardless of whether the intervention was delivered in a group or in a one-to-one format and regardless of child age group.

4. DISCUSSION

This study set out to follow-up the Healing Together programme's overall effectiveness for supporting children affected by DA using a second, larger sample. The findings suggest that immediately post-intervention, the Healing Together programme significantly increased children's ability to differentiate emotions, not hide emotions, and verbally share emotions. In addition, the findings demonstrated that the programme is associated with significant improvements in emotional awareness regardless of whether it is delivered in a group or 1-to-1 format and regardless of the child's age group.

The initial evaluation by Cunneen et al. (2025) found that immediately post-intervention, the Healing Together programme significantly increased children's ability to differentiate emotions, not hide emotions, and verbally share emotions. In addition, the effectiveness varied by age, and whether the intervention was delivered on a 1–1 or group basis. The intervention appeared to be more effective on a 1–1 basis and for 5–10-year-olds.

The data has reinforced that the Healing Together programme is an evidence-based intervention that can provide access to early help to support children affected by domestic abuse. The study has reproduced the effect seen in the previous study, giving greater confidence in the findings.

4.1. Implementation within Community, Early Help & Social Care

This study has demonstrated that the Healing Together model of training frontline practitioners working within education, health, and social care to deliver the programme is effective in supporting children affected by domestic abuse. This sustainable and scalable model does not rely on commissioning external specialist services and has the ability to prevent children and families requiring more intense and costly support from social care, while reducing demand on specialist mental health services such as CAMHS.

The Healing Together programme and its associated training model are closely aligned with the statutory framework and delivery expectations set out by the Families First Partnership (FFP) programme (DfE/HO/DHSC, 2026). The FFP programme represents a national reset of children's social care, built on the principle that "children and families should not be left waiting for help" and that the system should "respond flexibly and wrap support around them at the earliest point of need" (DfE/HO/DHSC, 2026, p. 8). Domestic abuse is explicitly named within the FFP framework as a key risk factor triggering the need for Family Help, with the programme guide identifying domestic abuse as a priority harm profile to which multi-disciplinary teams must be equipped to respond (DfE/HO/DHSC, 2026). Healing Together directly addresses this imperative as a structured, community-based intervention designed specifically for children and young people aged 5 to 16 years affected by domestic abuse. Furthermore, the FFP framework specifies that a trauma-informed, non-judgemental, child-centred response is essential when working with children who have experienced adverse childhood experiences (DfE/HO/DHSC, 2026), a requirement that Healing Together is explicitly designed to meet through its grounding in neuroscience, body-based approaches, and relational practice (Innovating Minds, 2025a).

The alignment also extends to the FFP's workforce development model. The FFP programme guide requires safeguarding partners to develop multi-agency workforce development plans that equip practitioners across education, health, and social care with the knowledge, skills, and experience to respond to the full continuum of family need (DfE/HO/DHSC, 2026). The Healing Together training model responds to precisely this requirement by training frontline practitioners across these same sectors to deliver a standardised, evidence-informed domestic abuse intervention with fidelity, supported by on-demand CPD, coaching, and reflective supervision (Innovating Minds, 2025b). The FFP framework further emphasises the importance of community-based, low-stigma delivery within familiar settings such as Best Start Family Hubs, schools, and health services (DfE/HO/DHSC, 2026); Healing Together's flexible, practitioner-embedded delivery model is designed to function within precisely these settings. Both Healing Together and the FFP programme also share a commitment to whole-family working: while Healing Together centres the child, it explicitly includes parents and carers as part of the intervention, directly mirroring the FFP principle that effective support must address the needs of the whole family (DfE/HO/DHSC, 2026).

Taken together, this alignment positions Healing Together as a strategically relevant and practically deployable component of the FFP delivery infrastructure, offering local safeguarding partnerships a trained, practitioner-embedded, trauma-informed response to one of the most prevalent and harmful drivers of child vulnerability.

4.2. Limitations

There are important limitations to discuss that were also identified by Cunneen et al. (2025). Although falling in line with previous EAQ scores, and within Churchill's (1979) standards, the Cronbach's alpha scores relating to the younger age group did not meet various other guidelines stating .70 to be the lowest adequate level (DeVellis, 2003; Nunnally & Bernstein, 1994).

There was also a lack of a control group to provide a critical comparison and help increase power and limit bias (Malay & Chung, 2012). Therefore, the absence of the control group means we cannot assess what would occur in the absence of the intervention, or whether children's emotional awareness increased due to other factors such as passage of time. However, due to sampling constraints and ethical considerations, having a control group was not possible for the current evaluation, but future research will consider implementing a control group within ethical guidelines, such as comparing to a waitlist control. Additionally, a convenience sampling technique was used, whereby facilitators who felt the programme could be beneficial for the children utilising the service were referred. The largest drawback of such an approach is the introduction of sampling bias (Golzar & Tajik, 2022).

A further weakness is that no delayed follow-up tests were completed. This was due to risks associated with maintaining contact with families who may continue to be victims of domestic abuse, and many organisations who offered the programme do not maintain contact with families once they have completed the programme. This means claims can only be made on the increase of emotional awareness immediately following programme delivery.

An additional weakness is the sole focus on emotional awareness, which excludes other psychological and behavioural factors, limiting the conclusions of the findings in terms of impacts on other potential outcomes. Innovating Minds continues to review the outcome measures used and will explore the Measures Database produced by Foundations to identify whether additional measures can be introduced to measure associated outcomes, while minimising participant burden.

5. CONCLUSION

The findings presented in this report indicate that the Healing Together programme is associated with statistically significant improvements in emotional awareness across both group and one-to-one delivery formats, and across the age range of children who participated. These results hold notwithstanding the methodological limitations acknowledged in the preceding section, and are consistent with the programme's theoretical proposition that structured, trauma-informed intervention can meaningfully develop emotional awareness in children affected by domestic abuse, irrespective of the modality through which it is delivered.

Notably, the data also provides support for the programme's training model as an effective mechanism for extending the reach of early, trauma-informed help to children who might not otherwise access specialist support. The findings demonstrate that the model of training frontline practitioners working across education, health, and social care to deliver the Healing Together programme with sufficient fidelity can produce measurable outcomes. The model therefore offers a sustainable and affordable solution to providing a community-based response to supporting children affected by domestic abuse in accessing early, trauma-informed and domestic-abuse-informed support.

REFERENCES

- BPS, British Psychological Society (2018). Code of Ethics. Available at: <https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf>
- Churchill, G. (1979). A paradigm for developing better measures of marketing constructs. *Journal of Marketing Research*, 16(1), 64–73. <https://doi.org/10.2307/3150876>
- Cunneen, K., Patel, A., & Fox, C. L. (2025). The impact of the healing together programme for children and young people affected by domestic abuse. *Children and Youth Services Review*, 173, Article 108286. <https://doi.org/10.1016/j.childyouth.2025.108286>
- D'Andrea, W., & Pole, N. (2012). A naturalistic study of the relation of psychotherapy process to changes in symptoms, information processing, and physiological activity in complex trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(4), 438–446. <https://doi.org/10.1037/a0025067>
- Department for Education, Home Office, & Department of Health and Social Care. (2026). Families First Partnership programme guide: Delivery expectations for statutory safeguarding partners in England — Year 2 (2026 to 2027). HM Government. https://assets.publishing.service.gov.uk/media/69de5281b0b0b9305e04f92/Families_first_partnership_programme_guide_year_2.pdf
- DeVellis, R. F. (2003). *Scale development: Theory and applications* (2nd ed., Vol. 26). Sage Publications.
- Domestic Abuse Commissioner. (2025). Victims in their own right? Babies, children and young people's experience of domestic abuse. https://www.domesticabusecommissioner.uk/wp-content/uploads/2025/06/dac_bcyp_main-report_V8-DIGITAL.pdf
- Foundations. (2024). The Reach Plan: Going further than ever to prevent domestic abuse and support child victims. <https://foundations.org.uk/the-reach-plan-going-further-than-ever-before-to-prevent>
- Golzar, J., & Tajik, O. (2022). Convenience sampling. *International Journal of Education and Language Studies*, 1(2), 72–77. <https://doi.org/10.22034/ijels.2022.162981>
- Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse and Neglect*, 32, 797–810. <https://doi.org/10.1016/j.chiabu.2008.02.004>
- Innovating Minds. (2022). Healing Together Impact Report: May 2022. Retrieved from <https://f.hubspotusercontent20.net/hubfs/7042324/HT%20Impact%20.pdf>
- Innovating Minds. (2025a). Healing Together Core Training: Learning Style, Content & Objectives. Innovating Minds.
- Innovating Minds. (2025b). Healing Together Supporting Children & Young People Affected by Domestic Abuse: Learning Style, Content & Objectives. Innovating Minds.
- Malay, S., & Chung, K. (2012). The choice of controls for providing validity and evidence in clinical research. *Plastic and Reconstructive Surgery*, 130(4), 959–965. <https://doi.org/10.1097/PRS.0b013e318262f4c8>
- McCarry, M., Radford, L., & Baker, V. (2021). What helps? Mothers' and children's experiences of community based early intervention programmes for domestic violence. *Child Abuse Review*, 30(2). <https://doi.org/10.1002/car.2671>

- Niles, B. L., Mori, D. L., Polizzi, C., Pless Kaiser, A., Weinstein, E. S., Gershkovich, M., & Wang, C. (2018). A systematic review of randomized trials of mind-body interventions for PTSD. *Journal of Clinical Psychology*, 74(9), 1485–1508. <https://doi.org/10.1002/jclp.22634>
- Nunnally, J. C., & Bernstein, I. H. (1994). *Psychometric theory* (3rd ed.). McGraw-Hill.
- Office for Health Improvement & Disparities. (2022). Working definition of trauma-informed practice. <https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice>
- Perry, B. (2013). Bonding and attachment in maltreated children: Consequences of emotional neglect in childhood. Child Trauma Academy Press.
- Perry, B., & Dobson, C. (2013). The Neurosequential Model of Therapeutics. In J. Ford & C. Courtois (Eds.), *Treating complex traumatic stress disorders in children and adolescents* (pp. 249–260). Guilford Press.
- Perry, B. D. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children: The Neurosequential Model of Therapeutics. In N. B. Webb (Ed.), *Traumatized youth in child welfare* (pp. 27–51). Guilford Press.
- Perry, B. D., & Pollard, R. (1998). Homeostasis, stress, trauma, and adaptation: A neurodevelopmental view of childhood trauma. *Child and Adolescent Psychiatric Clinics of North America*, 7(1), 33–51.
- Porges, S. W. (2001). The polyvagal theory: Phylogenetic substrates of a social nervous system. *International Journal of Psychophysiology*, 42(2), 123–146. [https://doi.org/10.1016/S0167-8760\(01\)00162-3](https://doi.org/10.1016/S0167-8760(01)00162-3)
- Porges, S. W. (2017). *The pocket guide to the polyvagal theory: The transformative power of feeling safe*. W. W. Norton & Company.
- Porges, S. W., & Porges, S. (2023). *Our polyvagal world: How safety and trauma change us*. W. W. Norton & Company.
- Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N., & Collishaw, S. (2011). Child abuse and neglect in the UK today. NSPCC.
- Rieffe, C., Oosterveld, P., Miers, A., Meerum Terwogt, M., & Ly, V. (2008). Emotion awareness and internalising symptoms in children and adolescents: The Emotional Awareness Questionnaire revised. *Personality and Individual Differences*, 45(8), 756–761. <https://doi.org/10.1016/j.paid.2008.08.001>
- Romano, E., Weegar, K., Gallitto, E., Zak, S., & Saini, M. (2019). Meta-analysis on interventions for children exposed to intimate partner violence. *Trauma, Violence and Abuse*, 22(4). <https://doi.org/10.1177/1524838019881737>
- Siegel, D. (2012). *Pocket guide to interpersonal neurobiology: The integrative handbook of the mind*. Mind Your Brain Inc.
- Teicher, M. H. (2000). Wounds that time won't heal: The neurobiology of child abuse. *Cerebrum*, 4, 50–67.
- Teicher, M. H. (2002). Scars that won't heal: The neurobiology of child abuse. *Scientific American*, 286(3), 68–75.
- Van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin.
- Van der Kolk, B. (2015). *The body keeps the score: Brain, mind and body in the healing of trauma*. Penguin Publishing Group.
- Wedlock, E., & Molina, J. (2020). *Sowing the seeds: Children's experience of domestic abuse and criminality*. Office of the Victims' Commissioner. <https://victimscommissioner.org.uk/published-reviews/sowing-the-seeds-childrens-experience-of-domestic-abuse-and-criminality/>
- Wilson, J., Fauci, J., & Goodman, L. (2015). Bringing trauma-informed practice to domestic violence programs: A qualitative analysis of current approaches. *American Journal of Orthopsychiatry*, 85(6), 586–599. <https://doi.org/10.1037/ort0000098>