Evaluating Healing Together: A Pre–Post Study of Trauma-Informed and Domestic Abuse Training for Practitioners Working with Children and Young People Affected by Domestic Abuse

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Abstract

Background: Children and young people affected by trauma and domestic abuse (DA) require practitioners who have the knowledge, confidence and relational skills to respond appropriately. Workforce training is widely recommended as a foundation for trauma-informed and DA-informed practice, but robust evaluations are limited.

Aim: To evaluate practitioner-reported change in knowledge and confidence following two linked components of the Healing Together training programme: a two-day trauma-informed core training and a domestic abuse-focused self-directed learning programme.

Method: A total of 579 practitioners working across education, health and social care settings completed three-item pre- and post-training scales (rated 1–10) measuring knowledge and confidence, alongside post-training satisfaction and behavioural intention items. Internal consistency was assessed using Cronbach's alpha. Pre-post differences were analysed using Wilcoxon signed-rank tests, with effect sizes calculated as r.

Results: Both scales were reliable measures of the constructs they assessed. Practitioners reported markedly higher levels of knowledge and confidence after training than before it, for both the core training and the domestic abuse training, with the size of this improvement large in both cases. The large majority of participants said they were more likely to adopt a trauma-informed approach in their work as a result of the core training, and almost all participants said they would recommend either training to colleagues.

Conclusion: The Healing Together training programme was associated with large, statistically significant increases in practitioners' self-reported trauma-informed and domestic abuse-related knowledge and confidence, alongside high levels of satisfaction. Findings support continued investment in structured, trauma-informed workforce training, while highlighting the need for more robust assessment to establish sustained practice change.

Introduction

Exposure to childhood trauma, including domestic abuse (DA), is associated with a wide range of adverse outcomes across emotional, cognitive, physical and relational development (Felitti et al., 1998; Holt, Buckley, & Whelan, 2008). Children who live with DA may experience chronic fear, disrupted attachment relationships and dysregulated stress responses, with effects that can persist into adulthood if unaddressed (Holt et al., 2008; Teicher & Samson, 2016). Advances in neuroscience have clarified how repeated or prolonged threat during childhood alters the developing brain and body, reinforcing the case for responses that are relational and body-based rather than purely cognitive or behavioural in focus (Teicher & Samson, 2016).

Trauma-informed approaches have consequently become a central organising framework across children's services. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) describes a trauma-informed approach as one in which an organisation realises the widespread impact of trauma, recognises the signs and symptoms of trauma in those it works with, and responds by integrating knowledge about trauma into policies and practice while actively resisting re-traumatisation. Translating this framework into frontline practice depends heavily on the workforce: practitioners in education, health and social care are frequently the first point of contact for children and young people affected by trauma and DA, yet many report limited pre-qualification training in this area and correspondingly low confidence in responding effectively (Turner et al., 2017).

A systematic review by Turner et al. (2017) of interventions to improve professionals' responses to children exposed to DA found that training was generally associated with improvements in practitioner knowledge, attitudes and confidence, but concluded that the evidence base was limited by small samples, an absence of validated outcome measures, and a lack of statistical rigour in reported evaluations. More recent evaluations of trauma-informed training for children's workforce practitioners have reported similar improvements in self-reported knowledge and confidence following training (Lotty, 2026; Marshall, Gregory, Donnelly, & Hoshi, 2026), reinforcing the plausibility of training as a mechanism for practice change, while continuing to call for evaluations that report psychometric properties of the measures used and appropriate inferential statistics.

Evaluations of workforce training are often situated within Kirkpatrick's (1994) four-level model, which distinguishes participants' reaction to training (Level 1), the knowledge, skills or attitudes gained (Level 2), the transfer of learning into changed behaviour (Level 3), and the

ultimate results or outcomes achieved, such as improved wellbeing among the people practitioners support (Level 4). Much existing training evaluation, including the present study, is necessarily concentrated at Levels 1 and 2, as behaviour change and downstream outcomes require longer-term, resource-intensive follow-up designs (Kirkpatrick, 1994).

Healing Together is a trauma-informed intervention for children and young people affected by domestic abuse, delivered across six weekly sessions by trained frontline practitioners working in education, health and social care, including children's homes, domestic abuse services, youth organisations and early help settings. Practitioners are prepared to deliver the programme through two linked training pathways developed and delivered by Innovating Minds. The first is a two-day, live online core training, facilitated by trauma-informed experts and structured around interactive whole-group and small-group learning, which builds a shared understanding of childhood trauma, its neurobiological and relational impact, and the rationale for body-based, relational practice. The second is a six-module, self-directed domestic abuse programme, completed independently over approximately five hours, which builds on the core training to deepen practitioners' understanding of the impact of DA on children and young people and how to apply trauma-sensitive, relational and body-based approaches when supporting them. The child-facing Healing Together programme delivered by trained practitioners has itself demonstrated significant, replicated improvements in children's emotional awareness across two independent evaluations (Cunneen, Patel, & Fox, 2025, 2026), providing part of the rationale for formally evaluating the workforce training that prepares practitioners to deliver it.

As part of its routine training quality assurance, Innovating Minds collects practitioner reported pre- and post-training ratings of knowledge and confidence for both training pathways, alongside satisfaction and behavioural intention indicators. The present study reports a formal evaluation of these data. Specifically, the study aimed to: (1) assess the internal reliability of the pre- and post-training knowledge and confidence scales used for the core and domestic abuse training; (2) evaluate change in practitioner-reported knowledge and confidence from pre- to post-training for each training component, using statistical tests appropriate to the distribution of the data; and (3) report practitioner satisfaction and behavioural intention following each training component.

Method

Design

This study used a single-group, pre-post evaluation design, drawing on practitioner-reported outcome data collected as part of Innovating Minds' routine training evaluation processes. As a non-experimental service evaluation without a comparison group, the design supports description of change associated with training but does not, on its own, establish causal attribution.

Participants

The sample was N = 680. From this, a total of N = 101 were removed for incomplete data, meaning the dropout rate was 14.85%. The final sample was N=579. These participants were practitioners who completed both a pre- and post-training questionnaire in relation to the Healing Together core training and the domestic abuse (DA) training. Participants were drawn from frontline practitioners working in education, health and social care settings, including children's homes, domestic abuse services, youth organisations and early help services.

Procedure and training content

The core training was delivered live online via Zoom over two days, facilitated by trauma-informed experts using an interactive style that combined whole-group teaching, breakout group discussion, video content and reflection on real-life practice examples. Participants received a training workbook in advance containing slides, reflective exercises and links to further resources. Day 1 covered the nature, origins and impact of childhood trauma, the rationale for body-based rather than purely cognitive or punitive responses, and the identification of trauma triggers and safe environments. Day 2 focused on the structure and principles of the Healing Together programmes, the practitioner's role in shaping children's experience of support, the distinction between 'being with' and 'doing to' children, and self-regulation in practice.

The DA training comprised six self-directed online learning modules, requiring approximately five hours to complete in total, with a 30-day completion window (extensions available on request). Modules covered the definition and forms of domestic abuse and violence, children's ongoing experiences of fear, uncertainty and loss, the influence of parents' experiences on family dynamics, and the application of trauma-sensitive, relational and body-based approaches to supporting children affected by DA. Each module included reflective activities

and a short assessment, with progress monitored via an online platform. Following completion of the core training and, where relevant, the DA modules, practitioners were equipped to deliver the six-session Healing Together programme directly with children and young people, supported by an online practitioner portal, video demonstrations, and ongoing one-to-one and group coaching.

Measures

Knowledge and confidence were assessed using two three-item scales, each rated on a scale from 1 (low) to 10 (high) and administered immediately before and immediately after training. The core training scale asked participants to rate their knowledge and understanding of the theory and research underpinning the trauma-informed approach, their confidence working with children and young people using a trauma-informed approach, and their confidence using a body- and relationship-focused approach.

The DA training scale asked participants to rate their confidence supporting children affected by DA, their knowledge and understanding of the impact of DA on children, and their confidence supporting children affected by DA using a trauma-informed approach. A mean score across the three items was computed for each scale at each time point.

Post-training, participants also completed satisfaction and behavioural intention items: agreement (on a five-point scale from strongly disagree to strongly agree) that they were more likely to adopt a trauma-informed approach to the rest of their work (core training only); a five-point rating of the trainer (very poor to very good); and a yes/no item indicating whether they would recommend the training to others.

Data analysis

Internal consistency of the three-item pre- and post-training scales was assessed using Cronbach's alpha, with values of .70 or above interpreted as indicating satisfactory reliability (Tavakol & Dennick, 2011). Given the bounded, ceiling-affected and non-normally distributed nature of self-rated 1–10 scores typical of post-training data, pre- to post-training differences in mean scale scores were analysed using the Wilcoxon signed-rank test, a non-parametric test for paired data. Effect sizes were calculated as $r = z / \sqrt{N}$ and interpreted using conventional benchmarks, whereby $r \geq .10$ indicates a small effect, $r \geq .30$ a medium effect, and $r \geq .50$ a large effect (Fritz, Morris, & Richler, 2012). Satisfaction and behavioural intention items are reported descriptively as percentages. Analyses were conducted in IBM SPSS Statistics.

Ethics

Data were collected as part of Innovating Minds' standard training evaluation and quality assurance processes, and participants were informed that anonymised, aggregate data might be used for evaluation and service improvement purposes. As a retrospective analysis of routinely collected, anonymised service evaluation data, the study did not require additional research ethics committee approval; data handling followed relevant data protection principles and professional guidance.

Results

Complete pre- and post-training data were available for 579 practitioners for the core training scale and for the DA training scale.

Reliability of the pre- and post-training scales

Cronbach's alpha for the three-item core training scale was .84 at pre-training and .91 at post-training. For the three-item DA training scale, Cronbach's alpha was .94 at both pre- and post-training. All values exceeded the .70 threshold for satisfactory internal reliability (Tavakol & Dennick, 2011), indicating that both scales measured a coherent underlying construct at each time point (see Table 1).

Table 1

Items comprising the Core Training and Domestic Abuse Training scales, and reliability coefficients at pre- and post-training

Scale	#	Item (rated 1–10)	Pre-training α	Post-training α
Core Training	1	How would you rate your knowledge and understanding of the theory and research that underpins the trauma-informed approach?	.84	.91
	2	How confident do you feel about working with children and young people using a trauma-informed approach?		
	3	How confident do you feel with using a body- and relationship-focused approach with children and young people?		
Domestic Abuse Training	1	How confident do you feel about supporting children affected by domestic abuse?	.94	.94
	2	How would you rate your knowledge and understanding of the impact domestic abuse has on children?		
	3	How confident do you feel about supporting children affected by domestic abuse using a trauma-informed approach?		

Change in knowledge and confidence

For the core training, scores were significantly higher after the training (Mdn = 8.33) than before it (Mdn = 6.00), $z = 20.26$, $p < .001$, with a large effect size, $r = .60$.

For the DA training, scores were also significantly higher after training (Mdn = 9.00) than before it (Mdn = 7.67), $z = 19.00$, $p < .001$, with a large effect size, $r = .56$. Descriptive statistics and test results are summarised in Table 2, and pre- and post-training medians are illustrated in Figures 1 and 2.

Table 2

Pre- and post-training scores and Wilcoxon signed-rank test results

Training component	N	Pre-training Mdn	Post-training Mdn	z	p	r
Core Training	579	6.00	8.33	20.26	< .001	.60
Domestic Abuse Training	579	7.67	9.00	19.00	< .001	.56

Note. Mdn = median; r = effect size (z / √N).

Figure 1

Pre- and post-training median scores for the Core Training

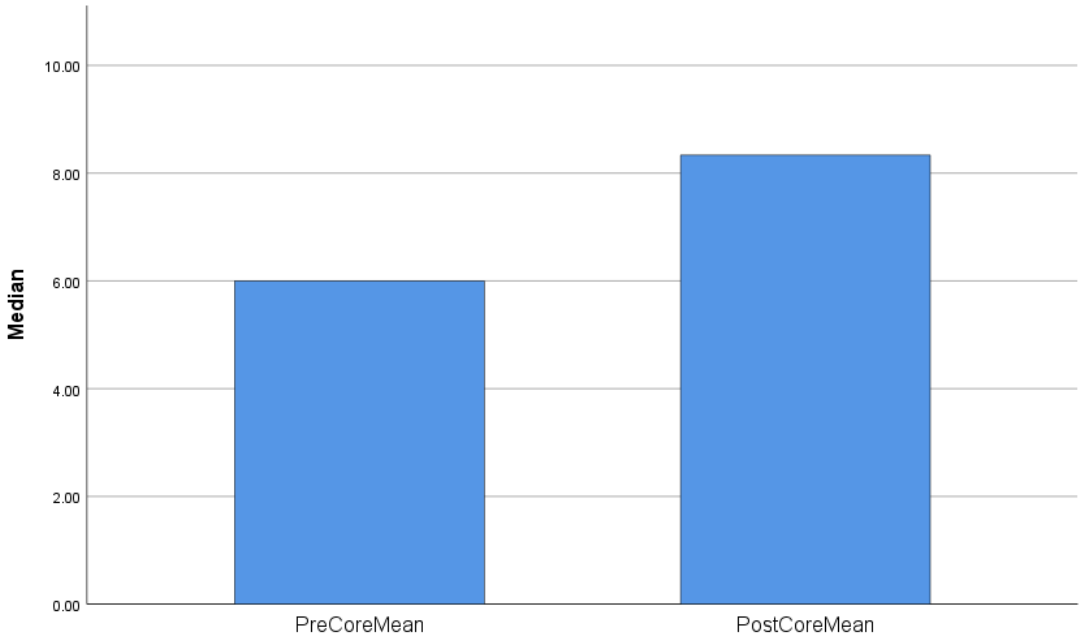
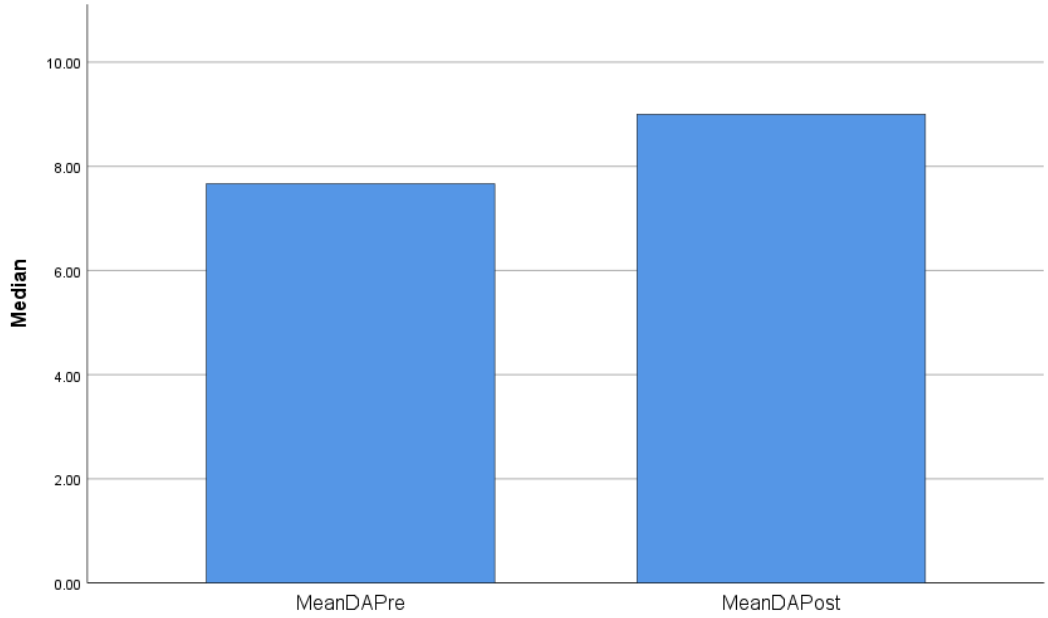


Figure 2.

Pre- and post-training median scores for the Domestic Abuse Training



Satisfaction and behavioural intention

Of the 579 respondents, 94% agreed or strongly agreed that they would be more likely to adopt a trauma-informed approach to the rest of their work following the core training.

98% rated the core training trainer as good or very good, and 97% would recommend the core training to others.

For the DA training, 96% rated the trainer as good or very good, and 98% would recommend the training to others (see Table 3).

Table 3

Practitioner satisfaction and behavioural intention following training

Indicator	Core Training	Domestic Abuse Training
More likely to adopt a trauma-informed approach (agree/strongly agree)	94%	–
Trainer rated good/very good	98%	96%
Would recommend the training	97%	98%

Discussion

This evaluation found that practitioners' self-reported knowledge and confidence increased significantly, with large effect sizes, following both the Healing Together core trauma-informed training and the domestic abuse-focused training. These improvements were accompanied by high levels of satisfaction and a strong stated intention to change practice, with the large majority of practitioners indicating they were more likely to adopt a trauma-informed approach and would recommend the training to colleagues. The pattern and magnitude of change are broadly consistent with recent evaluations of trauma-informed workforce training reporting improved practitioner knowledge and confidence (Lotty, 2026; Marshall et al., 2026), and extend this literature by providing evidence of good to excellent scale reliability and appropriately powered non-parametric testing, addressing methodological gaps identified in earlier reviews of professional training for responding to children exposed to DA (Turner et al., 2017).

Considered within Kirkpatrick's (1994) framework, the present findings provide reassuring evidence at the level of participant reaction (high satisfaction and recommendation rates) and self-reported learning (significant, large pre-post gains in knowledge and confidence ratings). Evidence in support of Kirkpatrick's Level 3 (behaviour) and Level 4 (results) comes from linked evaluations of the Healing Together programme itself, the six-session intervention that trained practitioners go on to deliver directly with children and young people using the resources, coaching and CPD made available to them on completion of training. Cunneen, Patel and Fox (2025) evaluated outcomes for 327 children and young people who received the Healing Together programme from trained facilitators, finding significant pre- to post-intervention improvements across all three subscales of the Emotion Awareness Questionnaire (Rieffe et al., 2008): differentiating emotions, verbally sharing emotions, and not hiding

emotions. A larger-sample follow-up evaluation by Cunneen, Patel and Fox (2026), drawing on 1,097 children and young people aged 5 to 16 who received the programme through councils, education settings, voluntary and community sector organisations, and domestic abuse services between July 2023 and May 2026, replicated these findings: emotional awareness improved significantly from pre- to post-intervention across all three EAQ subscales (all ps < .001), regardless of whether the programme was delivered in a group or one-to-one format and regardless of the child's age group. Taken together, these evaluations provide direct evidence that practitioners who complete the training evaluated in the present study go on to apply their learning by delivering the Healing Together programme with children and young people (Level 3), and that this delivery is associated with measurable, replicated improvements in children's emotional awareness, a protective factor against internalising difficulties such as anxiety and depression (Level 4; Rieffe et al., 2008). This directly evidences Innovating Minds' broader monitoring and evaluation framework, which tracks outcomes across both training and programme delivery to demonstrate impact for children and young people.

It should be noted that, like the present training evaluation, these child-outcome evaluations used single-group pre-post designs without control groups and did not include delayed follow-up (Cunneen et al., 2025, 2026); nonetheless, the consistency of significant, replicated findings across two independent, well-powered samples of children strengthens confidence that the workforce training evaluated here translates into applied practice and measurable benefit.

Strengths and limitations

This evaluation draws on a substantial sample of 579 practitioners and reports both the internal reliability of the outcome measures and an effect size alongside significance testing, addressing common shortcomings of prior training evaluations in this field (Turner et al., 2017). Several limitations should nonetheless be considered when interpreting the findings. First, the single-group pre-post design lacks a comparison or control group, meaning that improvements cannot be unambiguously attributed to the training itself rather than to other factors such as regression to the mean, maturation, or general expectancy effects associated with completing a course.

Second, all measures were based on practitioner self-report, collected immediately before and after training; such measures are susceptible to social desirability bias and may be inflated by participants' motivation to justify the time invested in training, and they do not constitute an objective test of knowledge or observed practice.

Third, the absence of longer-term follow-up within this specific dataset means it is not possible to determine whether the observed gains in confidence and self-rated knowledge are sustained over time at the level of the individual practitioner, although linked evaluations of the Healing Together programme itself provide separate, replicated evidence that trained practitioners' delivery of the programme is associated with measurable benefit for children (Cunneen et al., 2025, 2026; see Discussion).

Fourth, participants were not randomly sampled but comprised practitioners whose employing organisations had commissioned Healing Together training, which may limit generalisability to the wider children's workforce. Fifth, post-training scores approached the upper end of the 1–10 rating scale (post-training medians of 8.33 and 9.00), raising the possibility of ceiling effects that could constrain the detectable size of further gains.

Implications and future research

These findings support continued investment in structured, trauma-informed and DA-specific training as a foundation for workforce development to support children and young people affected by domestic abuse and work from a child-centre approach. The demonstrated reliability of brief, three-item pre-post scales suggests they offer a practical and psychometrically defensible tool that other organisations could adopt for routine training evaluation, without the burden of lengthy instruments.

Future research should prioritise designs capable of directly linking individual practitioners' training outcomes to the fidelity and outcomes of the programme they subsequently deliver, including waitlist-controlled or stepped-wedge designs and longer-term, delayed follow-up at three, six and twelve months post-training and post-programme. Qualitative research exploring practitioners' experiences of applying their learning, and any barriers encountered in embedding trauma-informed, body-based approaches within their organisational context, would also usefully complement the quantitative findings reported here and those reported for the Healing Together programme itself (Cunneen et al., 2025, 2026).

Conclusion

In a sample of 579 practitioners working across education, health and social care, the Healing Together core trauma-informed training and domestic abuse-focused training were each associated with large, statistically significant increases in self-reported knowledge and confidence, measured using reliable three-item scales, alongside high satisfaction and strong intention to change practice. Considered alongside separate, replicated evidence that children and young people show significant improvements in emotional awareness following delivery of the Healing Together intervention delivered by trained practitioners (Cunneen et al., 2025, 2026), these findings offer encouraging evidence that the workforce training evaluated here supports practitioners not only to learn, but to put that learning into practice in ways associated with meaningful benefit for children and young people affected by domestic abuse. A more rigorous evaluation using controlled and longitudinal designs that directly link individual practitioners' training outcomes to the fidelity and impact of the intervention they go on to deliver with children and young people would further strengthen this evidence base.

Declarations

Funding

This evaluation was conducted as part of Innovating Minds' routine training quality assurance activity. No external funding was received for this study.

Conflicts of interest

Dr Asha Patel is affiliated with Innovating Minds, the organisation that designed and delivered the Healing Together training evaluated in this study, which represents a potential conflict of interest. Claire Fox conducted the data analysis, and had no role in the design or delivery of the training programmes evaluated.

Author contributions

Professor Claire Fox analysed the raw data and interpreted the results. Dr Asha Patel provided clinical oversight and contributed to the writing of the manuscript. Both authors read and approved the final manuscript.

References

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.

Cunneen, K., Patel, A., & Fox, C. (2026). Evaluation of the Healing Together programme supporting children and young people affected by domestic abuse [Unpublished manuscript]. Innovating Minds.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14(*4), 245–258.

Fritz, C. O., Morris, P. E., & Richler, J. J. (2012). Effect size estimates: Current use, calculations, and interpretation. *Journal of Experimental Psychology: General*, *141(1),* 2–18.

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 & Neglect, 32(8)*, 797–810.

Kirkpatrick, D. L. (1994). Evaluating training programs: The four levels. Berrett-Koehler.

Lotty, M. (2026). Child welfare professional education in trauma-informed care: A mixed-methods evaluation study. Child Abuse Review. Advance online publication.

Marshall, C., Gregory, J., Donnelly, K., & Hoshi, R. (2026). Impact of an attachment- and trauma-informed training intervention for social care professionals. *Developmental Child Welfare, 8(1*), 22–39.

Rieffe, C., Oosterveld, P., Miers, A. C., 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.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach (HHS Publication No. SMA 14-4884). U.S. Department of Health and Human Services.

Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. *International Journal of Medical Education, 2*, 53–55.

Teicher, M. H., & Samson, J. A. (2016). Annual research review: Enduring neurobiological effects of childhood abuse and neglect. *Journal of Child Psychology and Psychiatry, 57(3)*, 241–266.

Turner, W., Hester, M., Broad, J., Szilassy, E., Feder, G., Drinkwater, J., Firth, A., & Stanley, N. (2017). Interventions to improve the response of professionals to children exposed to domestic violence and abuse: A systematic review. *Child Abuse Review, 26(1)*, 19–39.