



Public Health
England

Protecting and improving the nation's health

Bystander interventions to prevent intimate partner and sexual violence

Prevention research and good practice resource

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1. Introduction

National context

The **National Crime Survey for the year ending in March 2020** estimated that 2.3 million adults experienced domestic abuse. A higher percentage of adults experienced abuse carried out by a partner or ex-partner than a family member. The impact of any form of intimate partner violence can be devastating and lifelong for individuals, families and communities. The harmful effects to health of these types of violence are well-documented, including injury and impacts to physical health, sexual and reproductive health problems, poor mental health, behavioural problems such as alcohol and drug misuse, and an increased use of health services (1).

Intimate partner violence and sexual violence can often be crimes which occur behind closed doors and out of sight. Unfortunately, the restrictive measures put in place to contain the spread of COVID-19 have meant that for some victims, domestic abuse has been worse and their ability to escape and access to support networks has been restricted. At the **Hidden Harms Summit in June 2020**, the Prime Minister outlined the government's commitment to supporting the vulnerable and protecting those at risk of harm.

To successfully prevent violence in the future it is essential to tackle the root causes of violence, which includes challenging societal and cultural norms that can foster violence and its harmful effects. This resource provides evidence and information about implementing bystander interventions which seek to do that.

Since 2019, Violence Reduction Units have been set up in the 18 areas most affected by violent crime in England and Wales. These units have taken a strategic approach to tackling and preventing violence as it affects their local areas. By going beyond organisational boundaries and involving the whole system alongside local communities in their approaches, they are working to change the narrative on violence.

With the introduction of the serious violence legal duty, all areas may adopt a whole-system multi-agency approach to violence prevention in the future. This resource will be useful for any system leader hoping to tackle the root causes of violence and change behaviours that bring about violence.

Violence prevention strategy

Intimate partner and sexual violence and abuse are important public health issues which place significant burdens on the health and wellbeing of individuals, families, communities and services.

In recent decades, the violence prevention field has expanded from a focus on responding to the needs of victims and perpetrators after violence has occurred, to an increased focus on prevention. This includes addressing the determinants that enable violence, both at a societal and individual level, and implementing interventions that seek to prevent violence before it occurs (2). This is in recognition that “prevention approaches must go beyond changing individuals to changing the system that creates and maintains [sexual] abuse” (3).

Primary prevention strategies now focus on the role and responsibility of the community as a whole (4, 5), as do bystander programmes which are ‘peer-led’. This is reflected in a new policy context in the UK, which encourages the local implementation of a whole system approach to violence prevention and a shift to focus on community resilience and empowerment. This approach prioritises multi-agency collaborative working, evidence based practice, co-production, and a focus on the aetiology of violence with the aim of preventing violence before it occurs (6).

Bystander programmes

Bystander programmes focus on giving people the skills to recognise and safely respond to problematic attitudes and behaviours that contribute to a culture where violence occurs. This document provides a practical toolkit for the implementing and evaluating bystander interventions to prevent violence and abuse, with a focus on intimate partner and sexual violence and abuse. The document explores the policy context and evidence base, provides case studies, and discusses lessons learnt and the evaluation of bystander interventions.

Much of the academic work to develop the evidence base for bystander interventions has been undertaken in the United States (US) with a focus on addressing violence against women and girls in student populations (7). However, the approach has also been useful for addressing different types of violence, including bullying and male-on-male interpersonal violence (7).

In recent years bystander interventions have been increasingly developed, implemented and evaluated in the UK. Public Health England (PHE) and partners have played an active role in developing these interventions, particularly in the context of intimate partner and sexual violence.

This resource provides an overview of this collaborative work and seeks to improve understanding of bystander interventions and guide evidence-based implementation as bystander interventions becomes more commonplace in the UK.

There are 4 case studies of bystander interventions that have been developed and implemented collaboratively in the UK by academic, public health, voluntary and public-sector partners. These include 2 widely adopted programmes with student populations, The Intervention Initiative and Mentors for Violence Prevention. The other 2 are pilot studies in community settings, showing promising results: Football Onside and Active Bystander Communities (8-10).

This resource is intended to complement 'Preventing serious violence: a multi-agency approach' (11), which is guidance to help improve local partners' understanding and response to serious violence affecting their local communities.

2. Intimate partner and sexual violence

2.1 Violence definition and typology

Definitions

Violence is defined by the World Health Organisation (WHO) as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a higher likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (1).

The WHO world report on violence and health divides violence into 3 categories according to who has committed the violence:

- 1 Self-directed violence
- 2 Interpersonal violence
- 3 Collective violence

The violence is then divided into 4 further categories according to the nature of violence:

- 1 Physical violence
- 2 Sexual violence
- 3 Psychological violence
- 4 Violence involving deprivation or neglect

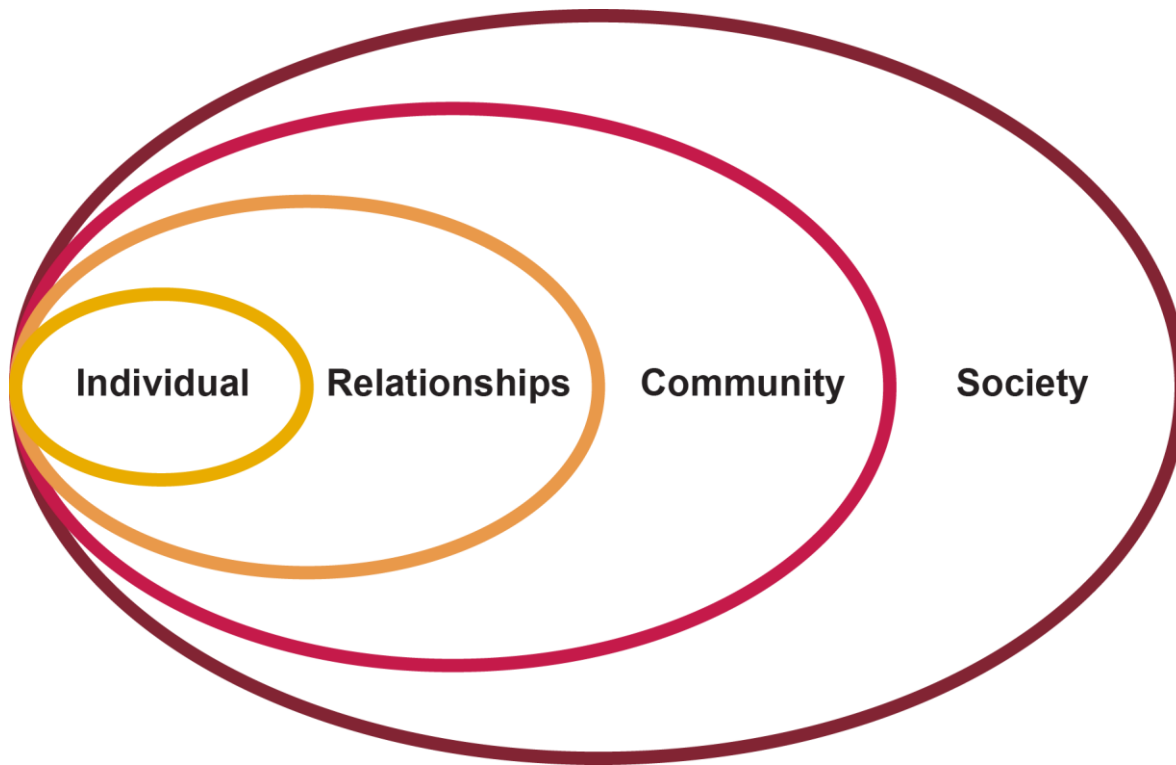
The different forms of violence are not mutually exclusive and often occur simultaneously (1).

There are many factors that can either function as 'risk factors', making violence more likely, or 'protective factors' which mitigate against victimisation or perpetration of violence (12). These risk and protective factors can interact to either decrease or increase the risk of violence or the harm caused by violence.

WHO ecological framework for violence prevention

The WHO's 'ecological framework' of violence prevention (figure 1) is based on the evidence that no single risk or protective factor can explain why a person, or groups of people, are at higher risk of violence than others (13, 14). The framework considers violence to be the result of many risk factors at the individual, relationship, community and societal level, and treats interaction between factors at different levels with equal importance (13, 14).

Figure 1: The WHO ecological framework for violence



Based on this knowledge, violence prevention strategies can function at one or more of these levels, targeting universally or specific populations at higher risk of violence. For example, bystander programmes aim to empower people to challenge attitudes and behaviours that are supportive of violence within their peer group or community. In doing so, they aim to change behaviour and decrease the likelihood of violence occurring.

2.2 Intimate partner and sexual violence and abuse

This resource has a focus on intimate partner and sexual violence and abuse and associated forms of violence such as stalking, harassment and bullying. These forms of violence are often described as ‘violence against women and girls’ or ‘gender-based violence’. Boys and men can be victims, and abuse does happen within same-sex relationships as well as within family relationships and against transgender men and transgender women. However, in terms of the scale of the social problem being addressed with bystander programmes, perpetrators tend overwhelmingly to be male and victims are mainly female.

Tackling sexual and domestic violence requires an appreciation that they are forms of behaviour that are rooted in gender relations and the social policing of gender roles in our society (15). It is important to acknowledge that domestic abuse and sexual coercion are part of a social pattern of violence against women and are both a cause and a consequence of gender inequality.

Analysis of the risk factors that promote violence against women and girls suggests that social norms and attitudes that are supportive of traditional or unequal gender roles (such as hyper-masculinity, weak community sanctions against violence, hostility towards women, association with sexually aggressive peers, weak laws and policies relating to violence and gender equality) are in turn supportive of violence. Seeking to modify these contextual risk factors is a central premise of bystander approaches (12, 16).

This is reflected in the Istanbul Convention, which states that the convention:

"... is grounded in the understanding that gender inequality is a cause and consequence of violence against women ... This means recognising the gendered nature of violence against women as rooted in power imbalances and inequality between women and men" (17).

At the same time, sexuality, age, class, race and disability intersect with gender and create different experiences and outcomes. For example, surveys show that age intersects with gender such that violence and abuse appear to be more intense for younger age groups, especially under 25 (18, 19). Further to this, many of the risk factors that are associated with gender-based violence are also linked with other forms of violence such as serious youth violence. So, preventative interventions designed to target one form of violence may have the effect of reducing other forms of violence at the same time.

Intimate partner violence (IPV)

The term 'intimate partner violence' (IPV) describes actual or threatened physical, sexual or psychological violence that occurs within a relationship or is perpetrated by a current or former partner or spouse (20). Saltzman further defines the components of intimate partner violence as:

- physical violence involving the intentional use of physical force with the potential for causing death, disability, injury or harm
- threats of physical or sexual violence using words, gestures or weapons to communicate the intent to cause death, disability, injury or physical harm
- psychological and emotional violence involving trauma to the victim caused by acts, threats of acts or coercive tactics

It is suggested that both IPV and sexual violence and abuse are prevalent in this adolescent relationships (21). Although not commonly used in the UK, the term 'dating violence' is frequently referred to in the literature. This is a term used in the US to refer to IPV in adolescent and young people's relationships, and relationships that are of a more casual or short-term nature.

Sexual violence and abuse (SVA)

It is important to recognise that sexual violence and abuse can occur both within intimate partner relationships and outside of them, perpetrated by either an acquaintance or a stranger to the victim.

The definition for SVA used in the [World report on violence and health](#) is:

"Any behaviour perceived to be of a sexual nature, any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality - which is unwanted and takes place without consent and understanding, by any person regardless of their relationship to the victim, in any setting" (1).

Salzman divides sexual violence into 3 categories:

- 1 The use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed.
- 2 Attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, for example because of illness, disability, or the influence of alcohols or other drugs, or because of intimidation or pressure.
- 3 Abusive sexual contact.

2.3 Prevalence and impact

Violence and abuse against women and girls is a human rights issue, recognised in national and international treaties and conventions, a criminal justice issue, and a public health issue.

The prevention of violence against women is a priority for:

- the United Nations (UN), through the 'Convention on the Elimination of All Forms of Discrimination against Women' (22)
- the EU through the 'Istanbul Convention' (17)
- the UK government through the 'Strategy to End Violence Against Women and Girls 2016-2020' (23)

Living without fear of violence is a fundamental requirement for people's health and wellbeing. Violence is a major cause of ill health and poor wellbeing and is strongly related to inequality. Hospital admissions for violence are 5 times higher in the poorest fifth of our society compared to the most affluent fifth (24). It impacts on individuals and

communities and is a drain on health services, the criminal justice system and the wider economy (25).

An estimated 1.9 million adults aged 16 to 59 years experienced domestic abuse (including intimate partner violence and other forms of violence between family members over the age of 16) in the year ending March 2017. Women were more likely to have experienced domestic abuse than men (7.5% compared with 4.3%). This equates to an estimated 1.2 million female victims and 713,000 male victims (26). In the same year, 12.1% of adults aged 16 to 59 had experienced sexual assault (including attempts) since the age of 16, equivalent to an estimated 4 million victims (27).

As discussed, women and girls are more likely to be victims of domestic and sexual violence, as well as experiencing gendered differences in the nature, extent, and impact of violence and abuse. These include increased risk of injury, a higher likelihood of hospitalisation or receiving medical attention and being more likely to fear for their lives. This is in addition to the abuse lasting longer and it being part of a system of power and control (28).

As a public health issue, sexual and domestic violence impacts severely on individuals and communities (29). It causes people to need a range of health and social care, and criminal justice resources. National Institute for Health and Care Excellence (NICE) guidelines state: "The cost, in both human and economic terms, is so significant that even marginally effective interventions are cost effective" (29).

A Home Office report estimating the economic and social costs of domestic abuse, placed the annual cost at £66 billion (30). Tackling violence and its root causes can improve the health and wellbeing of individuals and communities and have a wider positive impact for the economy and society.

3. Bystander interventions

3.1 Active and passive bystanders

We are all bystanders, all the time. We witness events unfolding around us constantly. Sometimes we recognise events as being problematic. When this happens, we might decide to do or say something, becoming an active bystander (either in the moment or at a later stage), or to do nothing and remain a passive bystander.

There are many factors that will influence why we decide to intervene or not. When we do decide to intervene, we are sending a clear message to the wrongdoer that their behaviour is socially unacceptable. Social norms determine the rules of behaviour for given social groups or social situations. So, if messages about certain behaviours being unacceptable are constantly sent and reinforced within a community or group, then the boundaries of what is considered acceptable behaviour will shift (31).

3.2 Empowering people to be active bystanders

Shifting the social norm to challenge undesirable behaviour can be achieved by empowering people to become active bystanders. This method of behaviour change through social means is evidence-based and can be a powerful tool for preventing sexual and domestic violence (31).

Bystander intervention programmes are supported by a growing international evidence base and have been gaining traction in this field over the last 2 decades. Such programmes are so promising (32) that in the US, sexual assault prevention on college campuses now often focuses on training students to be prosocial bystanders (33)-(34). Prosocial means a social behaviour that benefits other people or society as a whole. US law also requires bystander programming in public and private colleges and universities participating in federal student aid programmes (35).

3.3 Theory of bystander interventions

Bystander interventions are based on the different stages required to move from inaction to action. For this to happen, the bystander must:

- notice and be aware of the event
- see the event or behaviour as a problem
- feel responsible and motivated to act
- have the necessary skills to be able to intervene safely and effectively

Integrating social norms theory into bystander intervention programming may reduce some barriers to intervention (31). The social norms approach is about correcting norms which influence behaviour, for example social norms which support bystander inaction and violence. Bystanders may believe that their perception of a behaviour as problematic is wrong if others do not intervene or are supportive of the behaviour.

This misperception leads to inaction which makes the wrongdoer think that people are supportive of their behaviour, validating the wrongdoer and empowering them to carry on. This relationship is mutually reinforcing (31, 36).

4. Systems approach to violence prevention

4.1 Violence as a public health issue

Violence is a public health issue, because living without fear of violence is a fundamental requirement for health and wellbeing. Violence is also a major cause of ill health and poor wellbeing and is strongly related to inequalities.

Interventions to prevent violence, especially interventions in early childhood, prevent people developing a propensity for violence. They also improve educational outcomes, employment prospects and long-term health outcomes. Our approach to preventing serious violence needs to shift from traditional ways of working to a whole-systems approach (11).

Taking a public health approach to violence is not new. In 1996 the World Health Assembly (WHA) declared violence a leading worldwide public health problem (37). The WHA called upon member states to give urgent consideration to the problem of violence and requested the Director General of the WHO to develop a science-based approach to understanding and preventing violence (1, 37).

4.2 The WHO 4-step process

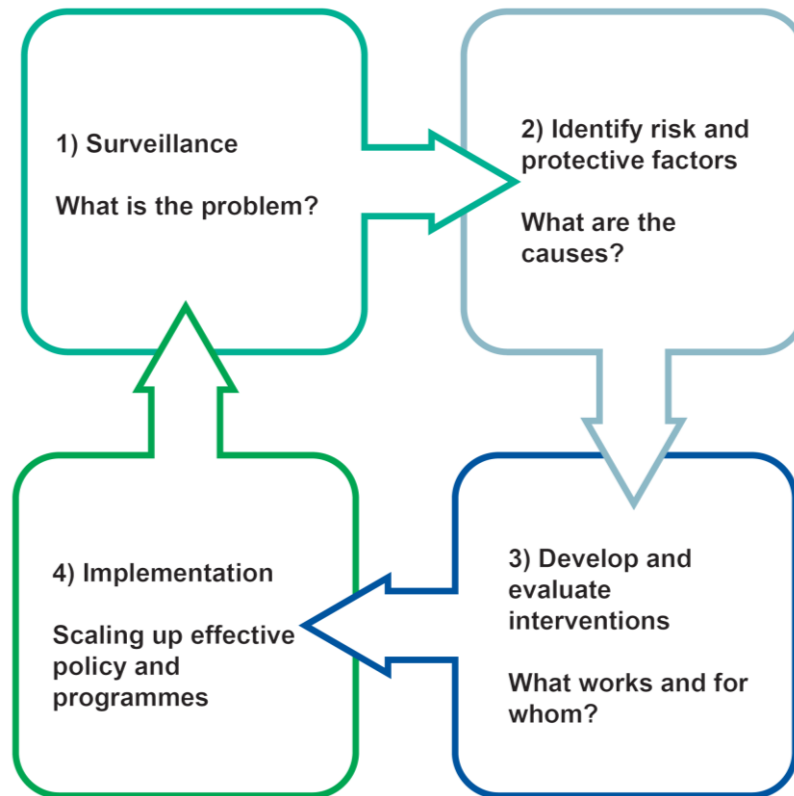
The WHO's work led to the development of its 4-step process for implementing a public health approach to violence (38).

- 1 Define the problem through the systematic collection of information about the magnitude, scope, characteristics and consequences of violence.
- 2 Establish why violence occurs using research to determine the causes and correlates of violence, the factors that increase or decrease the risk for violence, and the factors that could be modified through interventions.
- 3 Find out what works to prevent violence by designing, implementing and evaluating interventions.
- 4 Implement effective and promising interventions in a wide range of settings. The effects of these interventions on risk factors and the target outcome should be monitored, and their impact and cost-effectiveness should be evaluated.

A simplified version of this 4-stage process is shown in figure 2. This approach seeks to improve health and safety for all individuals in a population by addressing underlying risk factors that increase the likelihood that a person will become a victim or a perpetrator of violence (as detailed in the previous section).

Since 1996, public health approaches to violence have been implemented throughout the world, each considering the WHO 4-step process but with variation, depending on local systems, types of violence and factors driving increases in violence (14, 39-41).

Figure 2: The WHO 4 step process for implementing a public health approach



The WHO's public health approach seeks to identify the common risk factors that lead to violence, and the protective factors preventing violence. It encourages implementing interventions across all levels of the ecological framework: individual, relationship, community and societal, at the same time.

4.3 PHE multi-agency approach

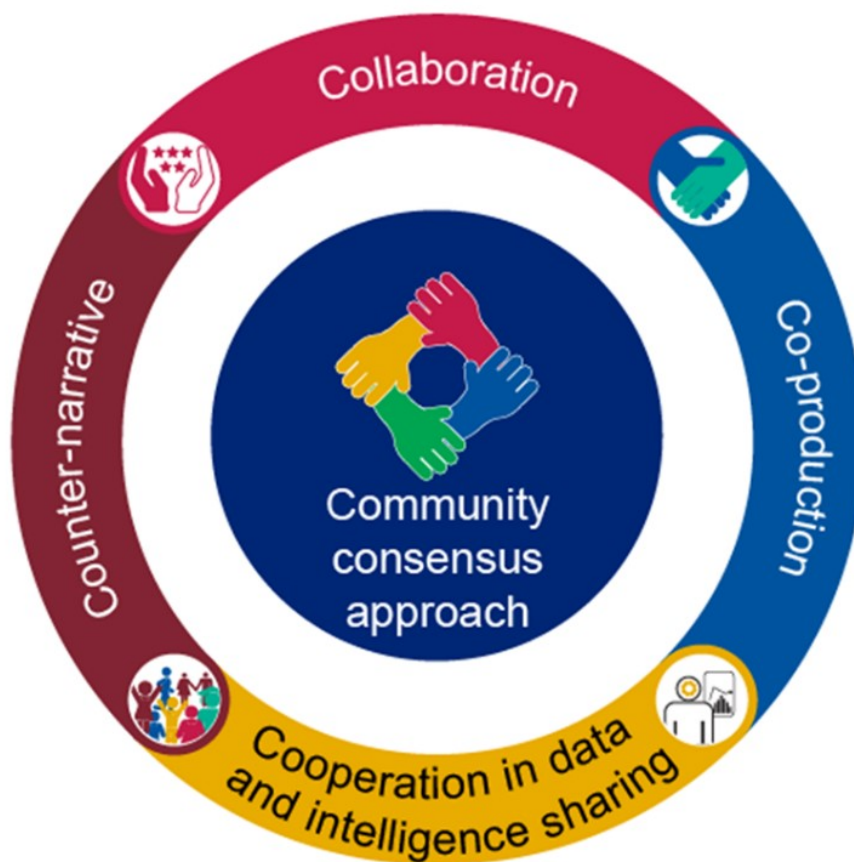
The PHE guidance 'A whole-system multi-agency approach to serious violence prevention' states that it is important to have a whole-systems approach, which brings a broad range of partners together who have the shared goal of tackling and preventing violence. (11). This requires partners to:

- form a collective understanding of a public health approach
- collectively develop and own the scope of work and ways of working which reflect the needs of the local population
- jointly identify resources that will enable effective working

The proposed approach describes a place-based public health approach to serious violence prevention and contains 5 component parts ('the 5Cs') which are also shown in figure 3. These are:

- collaboration
- co-production
- co-operation in data and intelligence sharing
- counter-narrative development
- community consensus, which is central to the approach

Figure 3: A place-based approach to serious violence



This is a framework which can be used as a to guide to address the specific needs of a local population reflecting local geographies, operating systems, existing partnerships and community assets, resources and, most importantly, need. Variation in implementing the approach in different localities is expected, but wherever the component parts of the approach are adopted, it should apply the principles of public health to prevent and tackle violence.

The 5Cs approach represents a shared vision to create a safe and healthy community, free from violence and with meaningful opportunities for everyone.

5. Primary violence prevention interventions

5.1 Principles of effective prevention

Efforts to prevent violence before it occurs are increasingly seen as critical and necessary to complement strategies aimed at preventing re-victimisation or recidivism (1). However, successful primary prevention strategies require an understanding of what works to prevent violence and abuse and how interventions will work effectively at a local level.

There has been much research in the prevention science and public health fields into effective prevention strategies. For example, Nation and others identified 9 'principles of prevention' that were strongly associated with positive effects in multiple public health programmes (42). They found that effective interventions:

- were comprehensive
- were appropriately timed
- had varied teaching methods
- provided sufficient dose
- fostered positive relationships
- had socio-cultural relevance
- involved well-trained staff
- were theory-driven
- included outcome evaluation

More detail is provided below.

Comprehensive

Comprehensive strategies should include multiple intervention components to address a range of risk and protective factors across the 'ecological spectrum' (see section 2.1 for more information about the WHO ecological framework). Prevention programmes should be complemented by strategies to improve responses and support to people who disclose experiencing violence. Strategies that are comprehensive are more likely to result in sustained positive behaviour change.

Appropriately timed

A large proportion of the bystander intervention literature (31) evaluates interventions that target school, college and university populations. Adolescent and young people are at a particularly high risk for IPV and SVA violence perpetration and victimisation, making this an important population for intervention. It is thought that sexually violent behaviour often starts in adolescence (43), and more than 40% of victims will experience

their first rape before the age of 17 (44). This is consistent with findings from Whitaker and others, suggesting that adolescence and early adulthood may be a critical window to intervene (45).

Varied teaching methods

Research indicates that preventative interventions are most successful when they include interactive instruction and opportunities for active, skills-based learning (42). Previous reviews of SVA and IPV prevention programmes also suggest that engaging participants in multiple ways (for example, writing exercises and role plays) and with greater participation may be associated with more positive outcomes. Programmes can be made more effective by integrating more active learning methods to increase the likelihood that participants acquire and retain skills and knowledge (46).

Sufficient dose

Prevention approaches must provide a sufficient 'dose' of the intervention to influence the behaviour of participants. This is measured by total exposure to programme content or contact hours. The intensity needed to be effective will vary depending on the type of approach, the needs and risk level of participants, and the nature of the targeted behaviour. Longer programmes may be more likely to achieve lasting results (42).

While it may be possible to change some behaviours with a brief, one-session strategy, it is likely that behaviours as complex as IPV and SVA will require a higher dosage to change behaviour and have lasting effects. For example, Degue and others found that interventions with consistently positive effects tended to be 2 to 3 times longer than interventions with null, negative, or mixed effects (34).

There are practical limitations on the time and resources available to implement prevention strategies in most settings. The most efficient interventions should provide a sufficient dose to achieve intended outcomes while considering the need for long-term sustainability and scalability. No matter how brief or low-cost an intervention may be, if it does not have the desired outcome, it is not an efficient or effective use of resources (46).

Fosters positive relationships

Strategies that foster positive relationships (often called prosocial interventions) between participants of all ages and their parents, peers, or other adults have been associated with better outcomes in past prevention research. Well-delivered bystander intervention strategies use existing peer networks to promote positive social norms and messages about dating and sexual violence (31).

Socio-cultural relevance

Prevention programmes that are sensitive to and reflective of community norms and cultural beliefs may be more successful in recruiting and retaining participants and achieving outcomes. Nation and others note in their research that involving members of the target population in developing and implementing prevention strategies may improve the perceived relevance to the community's needs (42).

For example, the Football Onside programme discussed later in this document, worked with football players and coaches to develop case studies that were culturally relevant to the setting in which the programme was delivered.

Well-trained staff

Effective programmes tend to have staff or implementers that are stable, committed, competent, and can connect effectively with participants. Sufficient buy-in to the programme model is also important to credibly deliver and reinforce programme messages. The IPV and SVA prevention field would benefit from more extensive research into programme staff, and training and implementation to determine characteristics that may enhance the preventative effects of programmes (42).

Theory-driven

Theories about causation are very valuable as a basis for prevention development, particularly if they identify points for intervention in the development of health risk behaviours. This is especially true when supported by evidence that the factors identified represent causal influences in a theoretical model, such as the theory of change (42).

In a systematic review of interventions to prevent SVA, Tharp and others found that the most common risk factors were knowledge and attitudes. However, interventions were not clear about the assumptions which underpinned this focus on certain risk factors. For example, there is limited evidence linking legal or sexual knowledge to SVA perpetration, and no reason to believe that rape is caused by a lack of awareness about laws prohibiting it. However, education about rape laws and statistics are a common component of sexual violence prevention strategies (47).

Attitudes are also commonly included in intervention because they are relatively easy to measure and assess for change in the short-term. However, more research is needed to establish knowledge and attitudes as functional factors in violence development. Well-developed, integrative theories are needed to explain the role of attitudes and their potential value as primary prevention targets. On the other hand, cognitive factors, including hostility toward women, traditional gender role adherence, and hyper-masculinity, have shown consistent links to intimate partner violence and sexual violence and assault perpetration (47).

Strategies that involve working with young men to shape and support healthy views of masculinity and relationships, such as Coaching Boys into Men, are promising examples of interventions that focus on building healthy relationships (48). Skill building is regularly discussed in the literature as an important aspect of prevention programming (49). This is where a reduction in IPV and SVA perpetration and victimisation is expected to be the result of a chain of events that includes increasing knowledge and shifting attitudes that could then support skills and behaviour change.

Fenton and Mott discuss the Intervention Initiative which is based on a theory of behaviour change that sees behaviour as part of a chain of events as opposed to a simple bivariate relationship. So, a logic model provides a useful illustration of the components necessary to impart behaviour change (50).

The Intervention Initiative implements activities that are intended to shift gender-role norms and increase skills to challenge social norms that are supportive of violence (51). So, behaviour change occurs because of both attitude change and skill building.

Evidence from literature on sexual violence prevention has shown that programmes focusing exclusively on attitude or educational components will likely not be effective in changing behaviour (49). The skill building component of the Intervention Initiative is a crucial component of the chain of events that can lead to positive outcomes. Similarly, evaluation of Active Bystander Communities found theoretically indicated core components interacted in multiple directions, suggesting that individual elements of bystander programmes should not be delivered in isolation.

Includes outcome evaluation

Programmes should be evaluated in accordance with the theoretical aims underpinning its design, to assess changes in both the desired and undesired direction (backlash) using validated measures where possible. The Intervention Initiative, Football Onside and Active Bystander Communities studies used a pre-post evaluation design and qualitative interviewing to do this.

6. Preventing intimate partner and sexual violence

6.1 PHE evidence review

A central element of a systems leadership approach to violence prevention is the importance of evidence-based interventions that stop violence and abuse before it occurs, rather than seeking to minimise harm or respond to violence after it has occurred. These are known as primary prevention interventions.

In spring 2019, PHE undertook a rapid evidence review exploring what interventions are effective in preventing intimate partner and sexual violence (51).

Many of the effective interventions that were identified were bystander interventions or included core elements that used bystander methods. Some of the studies from the US (Green Dot, Coaching Boys into Men) are randomised control trials looking at behaviour change. UK-based interventions such as Stop SV are studying modifications to risk factors (awareness, knowledge, attitudes) as part of a theory of change. They were evaluated using a similar approach and found similar results to the other UK-based interventions included in the literature review. Examples of these programmes are outlined below.

This rapid review complements an evidence review commissioned by PHE in 2014 which reviewed the evidence for bystander intervention to prevent sexual and domestic violence in universities (31).

STOP Dating Violence

This is an online intervention developed to educate students in the US about dating violence and appropriate bystander interventions on college campuses (50).

Coaching Boys into Men is an evidence based prevention programme that trains and motivates high school coaches in the US to teach their young male athletes healthy relationship skills (52).

One Act

This US programme teaches university students bystander skills to intervene in low and high risk IPV situations. A study evaluating this intervention found “a larger positive impact on bystander confidence among students who participated in the bystander prevention training compared with the response training” (53).

The Intervention Initiative

This is a facilitated bystander intervention educational programme commissioned by PHE, for use by all UK universities. The aim is to prevent violence, abuse, and coercion in university settings (54). Preliminary evaluations found potential for effectiveness with significant decreases in myth acceptance and significant increases in readiness, confidence and willingness to help (8).

Green Dot

This is a bystander intervention programme that has been adapted for high school students and is delivered by trained Rape Crisis Centre educators in the US. It was found to be an effective intervention for reducing sexual and dating violence in school-age students (18-20). Violence perpetration rates were lower among males attending the campus where the Green Dot Bystander Intervention programme was implemented (55).

STOP-SV project

Staff Training on Prevention of Sexual Violence (STOP-SV) is a training programme evaluated in the UK that aims to increase the capacity of staff working in nightlife settings (for example, bar staff and security) to recognise and prevent nightlife related sexual violence, and increase their ability and willingness to respond through positive bystander intervention (9).

During this work, the project team found that sexual violence in nightlife was not often recognised as violence, and so was socially accepted. The STOP-SV nightlife worker training programme is associated with improvements in knowledge, improved understanding of what sexual violence is, and greater confidence to intervene when sexual violence is taking place.

The programme has 4 core objectives:

- 1 To raise awareness of the nature of sexual violence in nightlife settings, its consequences and associated risk factors.
- 2 To promote the unacceptability of all forms of sexual violence.
- 3 To improve awareness of ways to identify, prevent and respond to sexual violence in nightlife settings.
- 4 To develop individuals' skills to enable safe bystander engagement to prevent or respond to sexual violence.

6.2 Case studies

This section has information on 4 case studies of bystander interventions that have been developed and implemented collaboratively in UK settings by academic, public health, voluntary and public-sector partners. Lessons learned from these programmes and considerations for practitioners are discussed below.

These include 2 widely adopted programmes with student populations: the Intervention Initiative and Mentors for Violence Prevention. There are also 2 pilot studies in community settings which show signs of promising results (with results pending in peer-reviewed journals): Football Onside and Active Bystander Communities.

Case study 1: The Intervention Initiative

Introduction

The Intervention Initiative is a free resource for universities and further education settings in England, developed in 2014 at the University of the West of England after receiving a grant from PHE. It is an evidence-based educational programme for the prevention of sexual coercion and domestic abuse in university settings, through empowering students to act as prosocial citizens.

The Intervention Initiative is an 8-hour programme, designed to be delivered over time, by a trained facilitator in face-to-face small group settings. The content of every session is evidence-based and the theoretical underpinnings including the theory of change have been published (31, 54).

The development was carried out in conjunction with a student advisory group and a regional and national stakeholder advisory group. The programme takes participants through the stages for change, focusing on:

- attitude and belief changes around gender norms and rape, and domestic violence myths
- impact of behaviours along the continuum of violence
- knowledge and awareness about sexual and domestic violence and risk factors;
- understanding of social norm misperceptions
- empowerment and motivation to act
- detailed skills leadership training in different scenarios

Partners

The partners in the project were the University of the West of England, the University of Exeter and PHE.

Method and delivery

The preliminary evaluation study has been published (8). The intervention was delivered within a core module for first year law students at a large South West university in 4 2-hour sessions over 4 months. A total of 213 students completed the course evaluation feedback alongside 131 students who completed pre and post questionnaires to form a questionnaire study sample.

Results from course feedback evaluation

All learning outcomes received a mean score of more than 4 on a 5-point rating scale with 5 being excellent. There was no difference in ratings by gender or facilitator. The findings show a high level of engagement and this is particularly important for acceptability and feasibility since this was not a self-selecting group. The average for recommending the programme to others was 4.38.

Table 1: The Intervention Initiative learning outcomes

I feel that the programme met its objectives of assisting me to:	Mean (5-point rating scale)
Understand that sexual and domestic violence are a serious problem in society and in student populations	4.75
Learn and understand bystander intervention theory	4.58
Improve my knowledge about rape and sexual assault	4.50
Understand the stages for bystander intervention from noticing to acting	4.46
Understand that individuals can often be mistaken about others' beliefs and values (social norms theory)	4.46
Recognise the links between sexist attitudes, discriminatory practices and gender-based violence	4.40
Be familiar with intervention strategies	4.38
Improve my knowledge about domestic abuse	4.38
Be motivated to be a committed active bystander speaking out against violence	4.34
Identify that gender identities are socially constructed and socially policed	4.23
Increase the likelihood that I will use intervention strategies in my everyday life	4.20
Know where to go for help and/or support in cases of rape, assault or abuse	4.17
Be confident to use intervention strategies in my everyday life	4.13
Improve my communication and leadership skills for the future	4.07
Overall mean	4.38

Students who participated in the programme showed significant improvement in the desired direction, for example $p < 0.001$ showing a statistical significance in:

- rape myth acceptance
- domestic abuse myth acceptance
- bystander efficacy
- readiness to help (both denial and responsibility)

The p value is a statistical measure that indicates whether an effect is statistically significant. If the p value is 0.001 or less (less than a 0.1% probability that the results occurred by chance), the result is seen as highly significant. There's more information about the p value in [NICE's glossary](#).

Students showed significant improvement in the desired direction ($p = 0.007$) in the measure for intent to help. The effect size measured by Cohen's d was also above 0.5 for the measures of Myth Acceptance and Readiness to Help, while the effect size for efficacy was above 0.4, and above 0.2 for Intent to Help. [A research paper in Frontiers in Psychology](#) explains more about what Cohen's d is and how it's used.

There was no significant effect of the programme on the students' reported engagement in Bystander Behaviour ($p = 0.226$) and this is possibly due to lack of opportunity to operationalise learning before the post-test questionnaire was distributed and problems with the measures used.

Policy and impact

The Intervention Initiative has had significant impact on the university sector nationally and internationally and has been rolled out and cited widely, including at UN level. As the resource is freely available, however, there has not been quality control of its use and adaptation. To be effective, time and resources are required, and carefully designed interventions should not be shortened or cut without a theory of change and evidence to support it.

The study shows that bystander interventions can be successful with non-self-selecting groups. This is important because recruitment into these types of programmes can be difficult, especially when trying to engage men (31). The intervention can be successfully scheduled into the curriculum and be delivered by staff, and students will engage with it positively. Follow-up evaluation post intervention is indicated. Fenton and Mott indicate that the measures in the literature for bystander behaviour are inadequate and new measures are needed for measuring actual interventions (8).

Case study 2: Mentors in Violence Prevention

Introduction

The school-based Mentors in Violence Prevention (MVP) teaches participants to speak out against all forms of bullying, violence and abusive behaviour and uses a 'bystander' approach that empowers each participant to take an active role in promoting a positive culture and environment. The programme also helps participants look at the negative attitudes, beliefs and assumptions which can contribute to abusive behaviour seen in relationships, bullying, peer pressure, discrimination, sexting and street violence.

Within the MVP programme, young people are seen as empowered bystanders who can understand the issues which surround them, support peers and challenge inappropriate behaviour, rather than seen as potential victims or perpetrators. The programme develops leadership skills, encouraging young people to see themselves as leaders and shapers of their environments.

The peer-led programme has the potential to reduce rates of exclusions and the occurrence of violent incidents. It can also cause a change in culture within schools towards a more restorative approach to behaviour and create a safer and more settled environment. Internationally, the programme has also been delivered in sports clubs, the military and universities.

Partners

The West Midlands Violence Prevention Alliance, which has become the West Midlands Violence Reduction Unit, has provided funding to implement MVP in secondary schools across the region. The unit brings together local police, and health and education professionals to understand the causes of serious violence in the West Midlands and agree a co-ordinated response.

Method and delivery

The West Midlands Violence Reduction Unit employs 2 full-time regional coordinators to lead the work, including promoting MVP, training schools and partners and supporting schools in implementation. Interested schools must complete a 'school readiness' questionnaire to assess if they are ready to commit to the work. A rolling programme of training is delivered over the year, and each school sends representatives to a 2-day training course, which includes some action planning to prepare schools for implementation.

School staff are provided with a training manual and the 'playbook' which forms the basis of sessions. Most sessions involve scenarios where the mentors lead the group, talking through what is happening and exploring what beliefs and attitudes may be involved. Teachers (or other school-based staff) recruit and train pupil mentors who will deliver the MVP sessions to groups of pupils. The MVP coordinators are available to

support implementation and training in schools. The programme has also been taken up by some youth services and a primary school pilot has begun, with age-adapted content.

Early evidence has shown that support from a school's senior leadership is vital to prepare for and facilitate the embedding of MVP. There has been success where schools have given a staff member dedicated time to work on implementation alongside a small budget. The programme is expanding and a locally-based coordinator for each borough has been recruited to support the work and enable more schools to be trained and equipped.

Results

A 2-year evaluation programme is underway. Initial pre and post attitude surveys show positive change in prosocial attitudes. Schools that have allowed the principles of MVP to influence the way they manage behaviour and provide pastoral care have spoken about the positive influences it has had. Examples include excluding fewer pupils, a greater number of concerns being reported by young people (seen as positive action) and a reduction in fights both in and outside school. Very positive feedback is being received from pilot work in a primary school, and work is beginning in testing MVP in youth services. An evaluation is available from work in Scotland, as well as impact reports from delivery elsewhere internationally.

Policy and impact

The Scottish Violence Reduction Unit, which has already implemented the programme in secondary schools across Scotland funded by the Scottish Government, supported the West Midlands Violence Prevention Unit in developing its programme.

Case study 3: Football Onside

Introduction

Following the successful launch and implementation of the Intervention Initiative at universities around the UK, 2 pilot projects have been run to adapt and test the approach in different settings. These include the Football Onside project which is a pioneering bystander intervention programme which trains participants to notice and intervene in violence against women and girls (VAWG) in a football and sport setting.

The programme was delivered in 2019 to staff at Exeter City Football Club (ECFC) and Community Trust (ECCT) and is being evaluated by researchers at University of Exeter. The Football Onside programme takes as its premise the idea that anyone can be an 'active bystander' and anyone can intervene positively in potentially harmful situations, if given the right training. As research demonstrates, when one person intervenes it changes the 'group norm' and shows others that it's okay to speak-up and deters potential perpetrators since they fear being pulled up about their behaviour. In line with the criteria for effective prevention, Football Onside has been designed and specifically

tailored to football and sports through a series of focus groups and interviews with the staff at ECCT.

This project has come at a critical moment when VAWG is in the spotlight because of recent campaigns like #MeToo and #TimesUp, and is increasingly recognised as a global public health and human rights issue. Football and sport presents an opportunity for positive bystander work to challenge VAWG given that high profile players and coaches are often role models, especially for younger people. It is this capacity to change culture through positive example that this project seeks to harness through the collaboration with ECCT.

Partners

The project is a collaboration between University of Exeter Law School, ECCT, PHE, Devon Country Council, Devon Rape Crisis and Sexual Abuse Services and the Hollie Gazzard Trust. It was funded by the Economic and Social Research Council (ESRC).

Method and delivery

A total of 38 staff members of ECCT and ECFC were recruited for 2 experimental groups. Baseline quantitative and qualitative data was collected in July to October 2018 through focus groups, questionnaires, and interviews. This data informed the development of the programme and allowed further data analysis. As a control group, 26 staff of Plymouth Argyle filled out the questionnaires at the same time as the experimental groups but received no prevention programming. Control groups had no prior contact with the programme developers.

The programme was delivered over 3 consecutive weeks in February to March 2019 in a format of 3 two-hour sessions which included presentations, videos, group and individual activity, role play, and homework tasks. Two male and female facilitators were trained by the programme developers to deliver the training sessions. The programme evaluator assessed the programme implementation and provided feedback to the programme developers to ensure effective delivery, consistent with the goals. Post-intervention qualitative and quantitative data was collected via interviews, questionnaires, and feedback sheets. All participants were signposted to wellbeing services to receive debriefing after each session.

Results

A total of 34 ECCT and ECFC participants completed all sessions of the programme and both pre and post intervention questionnaires. The sample group was predominantly male (88.2%) heterosexual (85.3%), and between 18 and 58 years old. Sixteen participants from Plymouth Argyle completed the control group questionnaires. This group was also predominantly male (75%) heterosexual (100%), between 18 and 58 years old. The participants were compared on their beliefs in rape and domestic abuse

myths, their confidence and likelihood to intervene, readiness to change, and helping behaviour before and after the programme.

Post-test results showed a significant reduction in mean scores for rape acceptance ($p < 0.001$) and domestic abuse acceptance ($p = 0.002$). There was a significant improvement in the mean scores for intent to help ($p = 0.036$), readiness to change ($p < 0.001$), perception of peer helping ($p = 0.038$), and confidence to intervene as a bystander ($p < 0.001$) post intervention compared to baseline. Participants reported being significantly less likely to remain a passive bystander post intervention ($p = 0.041$). Sample size was too small for further analysis of gender and sexual orientation.

A male participant aged 18 years old said:

“In a changing room, someone said something. I said, 'That's too far. Enough of that now,' and no one ever made a comment like that throughout the whole day ... So, I don't think I would have done that without this [the programme] ... Knowing that I stepped in and potentially helped someone, it really did make my day, and it put a smile on my face for the rest of the day...”.

Participants' feedback and session observations indicated that the format and length of the programme were appropriate, and the content was relevant, accessible and generally well received. Programme participants appreciated various forms of content, especially videos on consent and bystander options, and the presentation on legislation related to rape, domestic abuse, consent and online stalking. Interactive tasks, such as role play discussions, were among the most frequently mentioned.

Participants said that they:

- had improved their knowledge
- were willing to do more research on this topic
- increased their interest and knowledge of legislation
- found the engaging facilitation style allowed interaction and group discussions

The programme feedback has been positive, with a mean score of 4.31 out of 5 (Table 2).

Table 2: Football Onside learning outcomes

The programme met its objectives in assisting me to:	Mean (5-point rating score)
Improve my knowledge about sexual violence/harassment and domestic abuse	4.12
Understand that violence against women is a serious problem in society	4.38
Understand that coercive control is a criminal offence	4.18
Understand that 'banter' is harmful	4.29
Know where to go for help and or support in cases of domestic abuse	4.35
Know where to go for help and or support in cases of sexual violence	4.41
Understand the stages of bystander interventions from noticing to acting	4.64
Understand that individuals can often be mistaken about others' beliefs and values	4.42
Be familiar with interventions strategies	4.29
Be confident to use intervention strategies in your everyday life	4.24
Increase the likelihood you will use intervention strategies in your everyday life	4.15
Overall mean	4.31

Further qualitative data analysis identified factors that would increase participants' likelihood to intervene, and actual bystander behaviours reported by the participants after the beginning of the programme. Knowledge of the situation and people involved, confidence to intervene, and knowledge of legislation and bystander options were among the most frequently reported facilitators of helping behaviour among participants. In contrast, lack of knowledge about the context of a situation and people, a lack of confidence and knowledge of bystander options, potential danger to oneself and others, and fear of confrontation or rejection were among the most common barriers to intervene.

The results from this pilot study indicated that the bystander programme Football Onside delivered to staff of ECCT and ECFC was effective in reducing sexual and domestic violence acceptance scores. It was also effective in increasing self-reported bystander confidence, intent to help, and perception of peer helping behaviours. The intervention feedback on the content and format has been predominantly positive.

Case study 4: Active Bystander Communities

Introduction

Active Bystander Communities (ABC) is the other pilot project that has been run to adapt and test the Intervention Initiative approach in different settings.

Violence against women and girls is pervasive. However, so far, bystander interventions have predominantly focused on college and university student populations. Evaluation of bystander programmes with populations other than students is crucial to understand the potential of bystander interventions and to recognise the challenges new contexts may bring.

Active Bystander Communities (ABC) is a domestic abuse primary prevention programme, co-produced by academics and public health and domestic abuse practitioners. Building upon the approach taken in the Intervention Initiative, the underpinning theory and process of co-production is published in a paper by Fenton and others (56).

In Autumn 2018, the continued partnership with PHE and the University of Exeter led to the recruitment of a public health specialist registrar (SpR) to evaluate a pilot of the ABC programme. The evaluation assessed the intervention's feasibility, acceptability and potential for effectiveness as a community-level intervention.

ABC is designed for delivery over 3 2-hour sessions held in one week. Groups were led by 2 co-facilitators trained in the intervention, one of which was from a domestic violence and abuse (DVA) specialist agency (57).

Partners

Partners included the University of Exeter, PHE, Devon County Council, the Hollie Gazzard Trust, Splitz, Torbay Council and Torbay United Football Club.

Method and delivery

ABC was delivered to 5 groups in the South West ranging in size from 6 to 20 participants. Four of the groups had 3 2-hour sessions delivered one week apart. One group received the same programme content delivered in one day to explore the differences in feasibility and potential for effectiveness of different models of delivery.

Qualitative and quantitative data was collected at baseline, post-programme and at a 4-month follow-up through surveys, qualitative semi-structured interviews and session feedback and observations. Qualitative and quantitative analysis were used to evaluate proof of concept, acceptability and feasibility as a community intervention.

Feedback was also sought on potential improvement to programme content, structure, and lessons for future implementation. Participants were advised about wellbeing at the

beginning of each session and were signposted to the facilitator situated within the local domestic abuse service, who was available to provide advice and support to participants during and after the sessions.

Results

A total of 70 participants attended the programme, 62 provided both pre and post data and 37 provided 4-month follow-up data. The programme was very well received with participants' scoring the programme higher than 4 out of a possible 5 across all measures (Table 3).

"I'm more determined and thoughtful about how to intervene rather than just pushing it off, saying 'it's just one of those things', I would like to say I'm more confident, I've got a good rationale, it made me more diligent, more reflective" (ABC interview participant).

"I had a conversation about someone's potentially controlling behaviour with someone I'm quite close to that I wouldn't necessarily done before, but also not necessarily had the confidence to have that sort of conversation" (ABC interview participant).

Table 3: Active bystander communities learning outcomes

The programme met its objectives in assisting me to:	Mean (5-point rating score)	95% CI
Improve my knowledge about domestic abuse	4.6	4.4 - 4.8
Understand that domestic abuse is a serious problem in society	4.7	4.6 - 4.9
Understand that coercive control is a criminal offence	4.5	4.3 - 4.8
Know where to go for help and or support in cases of domestic abuse	4.3	4.0 - 4.5
Understand the stages of bystander interventions from noticing to acting	4.7	4.5 - 4.8
Understand that individuals can often be mistaken about others' beliefs and values	4.4	4.2 - 4.6
Be familiar with intervention strategies	4.5	4.4 - 4.7
Be confident to use intervention strategies in your everyday life	4.2	4.1 - 4.4
Increase the likelihood you will use intervention strategies in your everyday life	4.4	4.2 - 4.6
Overall mean	4.5	

Participants showed significant improvement ($p < 0.001$) post intervention and at 4 months follow-up compared to baseline in their intent to help, confidence to intervene, domestic abuse myth acceptance and perception of peers' intent to help. Participants showed significant improvement ($p < 0.001$) in the desired direction post intervention compared to baseline for perception of peer myth acceptance. Improvement in this measure was maintained at 4 months follow-up, but this was not significant.

Session observations and qualitative interviews conducted post intervention found that participants engaged positively with material, the programme was acceptable and that the course delivery, content and the 3-session format were accessible and appropriate.

Qualitative interviews also identified a range of bystander interventions that have been enacted, or that participants plan to enact since attending the intervention that transcended various community identities.

Participants reported that they had or were intending to:

- raise awareness
- share knowledge
- identify DVA
- support victims
- challenge behaviours

Feedback showed that this action would take place in a range of contexts such as with friends, family, in the workplace or in the wider community.

Policy and impact

Both ABC and Football Onside interventions have been evaluated and results are under peer-review. The quantitative findings from the ABC pilot are now available (53, 58).

7. Evaluation

Employing randomised control trial designs is difficult in real-world settings and most studies adopt quasi-experimental designs. Outcome measures will be related to the theoretical aims of the specific bystander programme and the teaching methods adopted.

Evaluations should be rooted in the understanding that bystander programmes (if designed according to the theoretical literature) are complex models (31) and should be designed to evaluate the underpinning theory of change. The first aim of the model is to increase interventions made, which is achieved by bystanders going through the stages of change from noticing, feeling responsible and motivated to intervene, confident to intervene, to actually intervening in a situation.

Evaluation should assess the variables and factors that contribute to being able, ready and prepared to intervene and the likelihood of intervening (8, 10, 31), as well as actual interventions made. The second aim of the model is to change the attitudes of participants and so attitudinal changes, such as myth adherence or sexism, should be measured (8, 31).

Programmes which include a social norms component should assess changes to perceptions of peer norms. Validated measures which have been designed for bystander programmes should be used (31). Given that some interventions can worsen attitudes, change in the wrong direction (also known as 'backlash') should be measured and reported on (53).

Capturing actual behaviours is difficult in a survey design, so qualitative research may be better placed to capture data about behavioural change (55). Follow-up a few months after the intervention is useful to assess how permanent the results were, and it allows time for opportunities to intervene to arise in a real-world context for bystander behaviours to be performed.

8. Considerations for practitioners

This section contains some important considerations for practitioners who are going to be implementing bystander interventions. These are practitioners working in the field of violence prevention, who are supporting and developing community interventions like those described in this resource. Their roles will vary depending on different local contexts and commissioning arrangements.

8.1 Context specificity

As best practice indicates, interventions should be designed specifically with and for the desired audience. This is crucial for authenticity and for participant's ability to use the intervention techniques in real life.

Role plays are evidence-based and can lead to changes in the desired direction (31). They must be relevant to the participants' lived experience and real-world context. This can be achieved by using an advisory group. For example, the Intervention Initiative student advisory group helped to write role plays that were relevant to real-world student life and adapted language to how students speak.

Another method is to use focus groups. Football Onside used focus groups with staff from the intended audience to see how they understood the working context, the strengths of the group and community to undertake the programme, and scenarios they had encountered. They also helped to work out what the group wanted to get out of the programme. ABC used facilitator training and feedback to draw out real-world experiences and a men's focus group to ensure the materials were relevant to men.

The pre-survey is also a tool to make the programme context specific to the audience. A pre-survey was used in Football Onside, for example to address the myths that were most believed by this group.

8.2 Recruitment and training of facilitators

In line with best practice there are several key considerations that should inform how group facilitators are recruited, including:

- increasing local capacity to enable programme sustainability
- having a mix of facilitators to broaden the programme's appeal
- showing positive male and female working dynamics
- how to safely manage and support potential disclosures made by participants

Experience from the case studies above highlights the 2 main reasons it is important to have skilled and knowledgeable facilitators:

- 1 Participants can move the discussion away from core programme content and into relevant questions about domestic abuse and sexual violence.
- 2 Facilitators with a specialist background should be able to respond skilfully to a range of questions and discussions.

Third-party disclosures (seeking advice about how to support a friend or raising concern for a friend) are relatively common, either in the group or after the session. If domestic abuse specialist workers are co-facilitating the groups, they can provide timely and locally relevant advice, information and support as appropriate. So, local domestic abuse services with staff who are appropriately trained in the intervention are ideally placed to deliver these interventions.

Peer delivery of these interventions has not yet been explored. There are likely benefits in terms of community engagement, but practitioners and researchers will need to consider how the facilitators could deal with a wide range of questions and discussion topics and with third party disclosures.

8.3 Engaging audiences in bystander training

Bystander interventions are predominantly targeted at a non-specialist audience, to influence attitudes and beliefs about gender, violence and bystander roles (2). Issues for consideration relating to the different research projects are set out below.

The Intervention Initiative

This intervention seeks to engage all university students. Literature suggests that men are particularly difficult to engage in violence prevention and that the people who need to attend most are the ones most likely to avoid attending (31).

One issue facing educators is whether to make the intervention compulsory within the curriculum, or voluntary. One of the strengths of the evaluation is that the programme was tested with a cohort which did not self-select and therefore was not necessarily 'warm' to or 'on-board' with the programme. Given that the feedback was excellent and that significant effects were found (8), making the programme mandatory (with appropriate caution exercised for survivors) is possible.

The evaluation also found a positive effect when the programme ran alongside a students' union campaign on campus. This suggests that the Intervention Initiative can be part of a wider whole-institution approach.

Football Onside

The pilot was carried out with football coaches and players who work with diverse groups of trainees. All of the coaches had previously received training on safeguarding.

Most participants expressed an interest to participate in Football Onside to share the information in their trainee groups, and to be able to help someone they knew. Several participants (14 ECCT members or 41.2%) knew of someone who had been affected by domestic or sexual abuse and said they were motivated to learn to support their friends or relatives. Although the audience was thought to be 'warm', the results showed a significant shift in their attitudes, confidence and behaviours post-test. So, it's likely that delivering the programme in a less prosocial context would be even more beneficial and would show a greater shift in the desired direction.

Active Bystander Communities

The ABC pilot was most interested in engaging people with no previous specialist interest or role in domestic abuse prevention or services but did not exclude anyone if they had an interest. This approach resulted in a 'warm' audience with a high level of knowledge and interest at baseline. Just over half had professional reasons or interest for attending.

It is possible that a warm audience led to the training having a smaller impact than might have been the case for the general population because they had less 'distance to travel'. A number of participants said that the programme did not provide new knowledge to them but did enable them to consider a new perspective.

"As a professional, this training has not necessarily taught me new knowledge or techniques but... it has been helpful to revisit the topic from a different perspective. I think this training will be really good and impactful for members of the broader community and local culture change in public spaces" (ABC audience participant).

However, the evaluation also found that these engaged participants could be well placed to deliver cultural change through their reach into professional and community networks. Also, qualitative and observational findings suggest that participants with a professional understanding of domestic abuse felt they got enhanced benefit from the intervention on a personal level.

"As a professional I knew a lot of the technical stuff, but it was actually then thinking about how you can deal with it on a personal level... Family, friends, I think perhaps you don't actually tend to use your professional head sometimes in those scenarios" (ABC audience participant).

One participant felt the programme promotion should be explicit that the approach is to engage on a personal level to highlight relevance and benefit to a professional or knowledgeable cohort.

“That this wasn't about you in a particular role or in a scenario. It was about you as an individual and how you would perceive a particular circumstance and how you would react and act” (ABC audience participant).

Other audience considerations for both research and implementation of community bystander interventions are:

- addressing the challenge of recruiting individuals with no prior interest in DVA prevention
- exploring how effective the interventions would be for these groups
- appropriate positioning of community bystander interventions, working with a broad range of individuals and communities to prevent IPV while also reducing health inequalities

The potential for a broad spectrum of knowledge and understanding within one group raises the challenge of pitching interventions appropriately to meet the needs of all participants.

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Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000

www.gov.uk/phe

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Prepared by: Lara Snowdon, Alexa Gainsbury, Dr Rachel Fenton, Anastasiia Kovalenko, Rachel de Kam, Natalie Sims, Rachel Bath, Éamonn O'Moore, Justine Womack and Michael Heasman

For queries relating to this document, please contact:

adminhealthandjustice@phe.gov.uk

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