A review of evidence for prevention

from the UK focal point for violence and injury prevention

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About the UK focal point for violence and injury prevention

The 49th World Health Assembly (1996) declared violence a major and increasing global public health problem. In response, the World Health Organization (WHO) published the *World Report on Violence and Health* and initiated a major programme to support and develop violence and injury prevention work globally. As part of this programme, each member state has designated a national focal point for violence and injury prevention. The network of focal points works with the WHO to promote violence and injury prevention at national and international levels, develop capacity for prevention, and share evidence on effective prevention practice and policy.

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A summary of evidence: successful or promising interventions to prevent sexual violence

Education programmes: There is good evidence from the US for the use of Safe Dates (a school-based programme to promote healthy dating relationships for teenagers) in reducing sexual violence in dating relationships. There is some evidence for programmes that develop safety skills and behaviours among children (e.g. the ability to recognise harmful situations) in reducing the likelihood of sexual abuse. Other promising interventions include programmes that challenge social norms and concepts of masculinity, and those that educate bystanders about how to protect their peers from sexual abuse. Although higher quality research is needed, both of these programmes have been found to improve attitudes towards violence, as well as self-reported behaviours.

Restricting availability of alcohol: Restricting the availability of alcohol (e.g. through increasing price) has been associated with reductions in intimate partner violence and child maltreatment, which may include sexual abuse. However, no studies have looked specifically at its impact on sexual violence.

Sex offender treatment: There is some good evidence that the use of sex offender treatment programmes (particularly cognitive behavioural therapy) can reduce levels of recidivism.

Sexual violence is any unwanted sexual act or contact (or attempt to obtain a sexual act). It includes behaviours such as rape, sexual assault, unwanted touching, sexual exploitation, forced prostitution and sex trafficking. In England and Wales, the British Crime Survey suggests that around 20% of women and 3% of men aged 16-59 have experienced some form of sexual assault (including attempts) since the age of 16, and around 3% and 0.5% respectively in the last 12 months (2008/09 [1]).

Sexual violence: some facts

- In 2009/10, 54,509 sexual offences were reported to the police in England and Wales (2);
- There has been a slight decrease in the prevalence of sexual assault in England and Wales since 2004/05 (1);
- For both males and females, severe sexual violence is most likely to be carried out by someone known to the victim (e.g. a partner), and less severe sexual abuse by a stranger (8);
- Around half (46%) of victims of less serious sexual assault believe the offender was under the influence of alcohol, and 10% under the influence of drugs (14);
- Around 11% of victims experiencing a serious sexual assault reported it to the police (14).

Experiencing a sexual assault can be physically and emotionally traumatic. Abuse can cause injuries such as bruising and bleeding, sexually transmitted infections including HIV and, in some instances, unwanted pregnancy (3). It can lead to emotional problems such as depression,

guilt and anxiety, and in more severe cases, post-traumatic stress disorder and suicidal thoughts (4,5). Experiencing sexual violence can impact heavily on current and future relationships, where it can affect the ability to trust and lead to sexual dysfunction (4,5). Furthermore, experiencing sexual abuse (particularly as a child) has been associated with subsequent risky behaviours such as alcohol use, drug use (4), greater unprotected sex and multiple partners (6). Economically, the costs of sexual assaults can be immense. For instance, in 2003/04, the estimated cost of an average sexual assault case was £31,438, which included costs to health and criminal justice services, lost output and the cost of emotional and physical impacts on the victim (7).

Certain groups of people are more likely to become victims of sexual assault than others. These include females, those who are single or separated and those of a younger age (8). For a variety of reasons, the use of alcohol and drugs is associated with being both a victim and perpetrator of sexual abuse (e.g. by affecting cognition, increasing sexual desire or increasing aggression [9]). For children, unsupervised use of internet chat rooms can increase their potential to come into contact with paedophiles and consequently their vulnerability to sexual abuse through sexual grooming (10).

Perpetrators of sexual abuse are most likely to be male, with perpetration associated with factors such as personality (e.g. lacking the ability to empathise or showing hostility) and previous experience of violence in the family (e.g. experienced or watched domestic violence when growing up [5,11]). Certain attitudes towards sex (e.g. pro-rape attitudes or expectations for sex early in a relationship) and gender roles (e.g. greater stereotypical attitudes) have been related

to sexually abusive or coercive behaviour (11,12). At a societal level, victim-blaming attitudes towards rape and sexual assault is also an important factor, since they allow such acts to be tolerated or at least partly justified. These include, for instance, beliefs that a woman who wears revealing clothes is at least partly responsible for becoming a victim of sexual assault (13).

A variety of initiatives have been implemented to help prevent and reduce instances of sexual violence. This review describes the different intervention types and evidence for their effectiveness. Interventions vary in approach, with the majority being education programmes. Other approaches include restricting availability of alcohol and sex offender treatment. In some instances (e.g. where sexual violence is on-going and perpetrated by someone known to the victim), the care and support of victims may also be considered a preventative measure through reducing the likelihood of revictimisation. For more information on the care and support of victims see the *Intimate Partner Violence, Child Maltreatment,* and *Elder Abuse* reviews in this series.

Care and support for victims

The care and support of victims is essential in addressing the physical injuries and psychological distress caused by violent behaviour, stopping any on-going violence and increasing the likelihood that a perpetrator is charged (e.g. through providing forensic services). There are a variety of support and care services available to those who have experienced violence generally and sexual violence specifically. These include: counselling and therapy; helplines; advocacy services; and women's shelters (15). For sexual abuse, some areas of the UK have Sexual Assault Referral Centres (SARCs [16]). These offer health care and forensic examinations, legal help and counselling in the one location, through the use of specially trained health professionals known as Sexual Assault Nurse Examiners (SANEs, also known as Forensic Nurse Examiners).

1. Education programmes

Education programmes are commonly used to address sexual violence victimisation and perpetration. Target groups can include potential (or actual) victims, potential (or actual) perpetrators, bystanders and the general public. Methods vary, but can include: increasing safety skills; encouraging healthy, non-abusive relationships; challenging social norms; encouraging bystanders to speak out about sexual abuse; and raising general awareness of sexual abuse as an issue.

1.1 Developing safety skills for children

Child sexual abuse prevention programmes are designed to develop personal safety skills, including the ability to recognise harmful situations, the ability to distinguish appropriate and inappropriate touching, and strategies to

get out of threatening situations. In addition, they encourage disclosure of abuse to a trusted adult. With increasing access to the internet, some programmes teach safe use of internet chat rooms and the dangers of 'virtual friends' (10). Programmes are usually based in school settings, with some offering additional parent workshops or materials. There is good evidence for their effectiveness in improving levels of knowledge and protective behaviours in the short term, and in some cases, encouraging disclosure (10,17-22). Although less is known about the effects on sexual abuse, some positive results have been reported. For instance, in the US, undergraduate students were surveyed about their childhood sexual experiences and asked about previous participation in school education programmes that had taught "good touch and bad touch". Students who had not participated in any programme were twice as likely to report having been sexually abused as a child than those who did participate (23). There have been some negative criticisms of safety education programmes for younger children (17,18), including their potential for making children anxious and wary of adults. However, on the whole, findings remain positive and the approach is regarded as promising and worthy of further evaluation.

The Stay Safe education programme

In Ireland, the Stay Safe education programme teaches personal safety skills to primary school aged children (up to age 11) within normal lessons. Five main topics are covered: feeling safe and unsafe; bullying; wanted and unwanted touches; telling adults about negative interactions with victimisers and bullies; and dealing with strangers. In addition, the course content develops children's self-esteem and assertiveness. A variety of methods are used, including class discussions, worksheets, video and audio tapes and role play. Parents and guardians are offered training on identifying child sexual abuse and supporting a child when abuse is disclosed. Parents are also encouraged to discuss the topics covered with the child later at home. Evaluations of the Stay Safe programme have reported improved levels of safety knowledge and skills at a three month follow up with effects greater for those from higher socio-economic backgrounds (21). In addition, there was greater disclosure of suspected sexual abuse compared to a control group (24).

1.2 Promoting healthy dating relationships

For teenagers and young adults, the promotion of healthy, non-abusive dating relationships has been used to prevent sexual (and other) violence occurring within current and future relationships. These programmes are based in schools and colleges and use a range of methods, including: the discussion and challenge of gender stereotypes; education about dating violence and sexual consent; and the development of skills for healthy relationships (e.g. good communication). Evaluations are often mixed, but some positive benefits have been reported (25). The programme with the best evidence for effectiveness is Safe Dates, a US initiative based in the school and community, and designed for both potential perpetrators and victims. An evaluation in

North Carolina, US, reported less sexual, physical and psychological violence perpetrated against current dating partners one month after the programme ended and four years later (compared to controls [26,27]).

The Safe Dates education programme

Developed in the US, the Safe Dates programme targets 12 to 18 year olds and aims to encourage healthy relationships through: developing skills such as conflict resolution; changing social norms around dating violence; addressing gender stereotypes; and promoting community resources for those who want support and advice. A nine-session education curriculum for boys and girls is taught using group discussions, role play, games and written exercises. Alongside, it incorporates a theatre production on dating abuse, a poster contest, community service provider training, and support services for affected adolescents. Parent brochures are provided to encourage parents to become involved in the programme and discuss issues with their children.

(26,27)

1.3 Mobilising bystanders to intervene

In the US, education programmes to prevent sexual violence have been targeted at bystanders, who may be aware that abuse is about to (or currently) taking place but do not intervene. For instance, in a US university, a social marketing campaign was launched with the message “Know your power. Step in, Speak up. You can make a difference” (28). A series of posters were developed in which bystanders could be seen witnessing abusive behaviour or overhearing a friend’s intention to abuse. The posters showed bystanders safely intervening, as well as supporting friends who had been raped. An evaluation of the campaign reported greater

willingness to participate in preventative behaviours among those who saw the posters, compared to those who did not (29). Formal education sessions have also resulted in improvements in self-reported bystander behaviour and attitudes (30). However, in general, there is a lack of high-quality research, particularly outside of the US, and further evaluations are needed.

1.4 Challenging rape-supportive attitudes

Bystander programmes have also been used to challenge attitudes supportive of rape (e.g. a woman is partly responsible for rape if she is drunk or wearing revealing clothes; if a woman goes home with a man she doesn't know, it is her own fault if she is raped). Here, they have been found to improve attitudes, empathy towards victims, and behavioural intent to rape (e.g. likelihood of raping if they could be assured of not being caught or punished [30-32]). For instance, in the US, "How to help a sexual assault survivor: what men can do" is a one hour programme led by peer educators. During the programme, participants watch a video that describes a rape assault on a man. Parallels are drawn to female experiences of rape by males to develop greater empathy for female victims. Later, participants are taught how to support a rape victim and how to confront those that are being abusive to women. An evaluation of the programme found declines in rape myth acceptance and behavioural intent to rape seven months later (32).

1.5 Challenging social norms

A further educational method involves challenging social group norms (rules or expectations of behaviour within a

social group) that encourage violent behaviour within dating relationships. Young adults often have a strong influence on each other's attitudes and behaviours, and may feel pressured to conform to social group norms. These can include ideas that men should act powerfully or aggressively, or that violent or controlling behaviour within a relationship is normal. In the US, a number of college-based programmes aim to raise awareness of dating violence (including sexual violence) among males (and sometimes females), create shared norms of non-violent behaviour, and mobilise men to protect others from sexual or physical abuse (e.g. Men of Strength clubs [33]; Men Against Violence [34]; and Mentors in Violence Prevention [35]). The effect of these programmes on sexual violence perpetration has not been measured.

Some promising results have also been reported for the 'Social Norms' approach. This assumes that people have mistaken perceptions of other people's attitudes and behaviours, which adversely influence their own behaviour (36). For instance, young men are thought to underestimate the importance that most men and women place on sexual consent and the willingness of most men to intervene against sexual assault (37). In the US, the 'A Man Respects a Woman' project aimed to address common sexual misconceptions and reduce sexually coercive behaviour among college students through the use of male peer-to-peer education, a social norms marketing campaign and a theatre presentation. The programme conveyed several important messages, which were based on student information:

- A man respects a woman: nine out of ten men stop the first time their date says "no" to sexual activity;

- A man always prevents manipulation: three out of four men think it is not okay to pressure a date to drink alcohol in order to improve their chances of getting their date to have sex;
- A man talks before romance: Most men believe talking about sex does not ruin the romance of the moment. Talking about it can make sure you have consent.

Evaluation of the programme after two years found that men had become more accurate in their perceptions of other men's behaviour and reported more positive behaviours and attitudes themselves (38). However, in general, these approaches require further, higher quality evaluations before their effectiveness can be determined.

1.6 Raising public awareness of sexual abuse and its implications

Education campaigns to address sexual violence are often targeted at the general public via mass media campaigns. These use television, radio, newspapers, magazines and other printed materials to increase the amount of information available on a topic and challenge attitudes and beliefs. In the UK, a national campaign in 2006 highlighted the legal impacts of having sex without consent. It used radio and magazine advertisements and posters, and targeted mainly young men. For instance, one advertisement contained the message "Have sex with someone who hasn't said yes to it, and the next place you enter could be prison" (39). Other campaigns aim to challenge women-blaming attitudes towards sexual abuse. For example Rape Crisis Scotland run the campaign "This is not an invitation to rape me", which aims to confront and change attitudes such as: women are partly responsible for rape if they wear revealing clothing;

rape can be a woman's fault if she is known to have had many sexual partners; or, women can be partly to blame if they have been drinking alcohol (40). Evaluation of mass media campaigns is difficult and little is known about their effects on behaviour. However, they are known to offer a number of advantages in general, such as encouraging discussion and debate, and acting as a catalyst for other prevention initiatives (41).

2. Restricting availability of alcohol

There are strong associations between the use of alcohol and sexual violence victimisation and perpetration (9,42). Alcohol consumption can increase sexual desire, increasing the risk of perpetration as well as victimisation. It can impair physical and cognitive function, reducing self control and increasing aggressive behaviour. Additionally, those who drink alcohol may be seen as being "easy targets" or more sexually available than those who do not, increasing the likelihood of victimisation (9). Thus, initiatives that reduce levels of alcohol use in the community (e.g. through increasing price or restricting sales times) or encourage sensible drinking within night-time environments have the potential to protect against sexual violence. Research has examined the links between alcohol consumption and sexual assault and the effectiveness of interventions in reducing harmful drinking (43). However, little is known about how reductions in alcohol consumption can affect sexual abuse. Internationally, restricting the availability of alcohol is known to be associated with reductions in violence (44). This includes intimate partner violence and child maltreatment,

both of which may include sexual violence. For instance, in the US, it has been estimated that one less outlet per 1,000 people will reduce the probability of severe violence towards children by four percentage points (45) and that a 1% increase in the price of alcohol will decrease the probability of being a victim of wife abuse by about 5% (46).

Key legislation for sexual offences

Legislation has a key role to play in the prevention of sexual violence, through defining sexual offences and what is meant by "consent", sentencing those who offend, and sending a clear message to society that sexual abuse will not be tolerated. The main piece of legislation in the UK is the Sexual Offences Act, 2003, which updated and expanded earlier Acts such as the Sexual Offences Act, 1956 and the Sex Offenders Act, 1997. The Act highlights a wide range of sexual offences (of which some are new), including: non-consensual sexual activity; rape and assault by penetration; sexual assault including intentional sexual touching; meeting a child following sexual grooming; trafficking into, out of, and within the UK for sexual purposes; abuse of children through prostitution and pornography; and causing or inciting non-consensual sexual activity. The Act offers greater protection for vulnerable groups such as children and the disabled, and requires those convicted of a sexual offence to be placed on the sex offenders register within 72 hours.

3. Sex offender treatment

Among offenders of sexual abuse, psychological and pharmacological treatments are frequently offered to reduce the likelihood of reoffending. Psychological treatments, such as cognitive behavioural therapy or family therapy, are used to help offenders understand their behaviour, develop

empathy, build skills to encourage self-control and communication (e.g. anger management and social skills training) and help modify unwanted behaviours and habits. Pharmacological treatments such as hormonal medication aim to reduce sexual impulsivity. There is some positive evidence for the use of offender treatment in reducing recidivism rates. For instance, a systematic review of 69 studies of psychological and pharmacological treatment programmes for sexual offenders reported a reduction in recidivism of around a third following the intervention. Cognitive behavioural treatment had the most consistent evidence for effectiveness and showed most promise as a treatment method. Additionally, while there were fewer studies examining it, hormonal medication was also found to improve outcomes (47). In the UK, the Sex Offender Treatment Programme (SOTP) has been provided to imprisoned sexual offenders in England and Wales since 1991, with the aim of increasing offenders' motivation to avoid reoffending and develop the self-management skills needed to do this.

Sex Offender Treatment Programme (SOTP)

The SOTP is based on a cognitive behavioural model and incorporates four main components. The core programme offers 180 hours of treatment, with each session a minimum of two hours duration. The programme increases motivation to avoid reoffending through developing coping skills, educating about risk factors or triggers, developing victim empathy, correcting distorted thinking patterns, and encouraging responsibility for behaviour. The extended programme offers additional components such as anger management and relationship skills. The booster programme offers revision of course materials for those who may be serving long sentences. Finally, the thinking skills programme improves skills in problem solving and decision making. An evaluation of the SOTP in 2003 compared sexual reconviction during a two year period among offenders taking part in the programme with those not taking part. It found low rates of reconviction in both groups, with no significant differences. However, when sexual and violence reconviction rates were combined, those participating in the programme had lower reconviction rates, particularly for medium-risk offenders (48).

4. Summary

A variety of initiatives have been implemented in the UK and elsewhere to prevent and reduce sexual violence. Although the evidence base would benefit from greater, higher quality evaluations, some programmes have shown good evidence for effectiveness in reducing sexual abuse. These are:

- Education programmes that promote healthy relationships, such as Safe Dates;
- Psychological and pharmacological treatment for sex offenders.

There is also some evidence that programmes developing safety skills and behaviours among children can reduce the likelihood of childhood sexual abuse (as well as increase levels of knowledge and safety practices).

There is some evidence for a number of additional interventions that have not measured effects on sexual abuse directly, but rather, reported positive impacts on attitudes, knowledge or related behaviours. These are:

- Mobilising bystanders to intervene and help (can improve self reported bystander behaviour, attitudes towards rape and behavioural intent to rape);
- Challenging social norms and concepts of masculinity (can improve attitudes towards violence and self-reported behaviours);
- Restricting the availability of alcohol in the community (has been associated with related forms of violence such as intimate partner violence or child abuse, which may include sexual abuse).

However, further research would be needed to determine the effects of these interventions on sexual abuse. Finally, as with all mass media campaigns, impacts on behaviour is difficult to evaluate. There is no evidence examining the impacts of this type of intervention on sexual abuse, and effects are unknown.

All references are included in the online version of this document, available from:

www.preventviolence.info and **www.cph.org.uk**

References

1. Walker A et al. *Crime in England and Wales 2008/09*. Available from http://www.homeoffice.gov.uk/rds/pdfs09/hosb1109vol1.pdf, accessed 22 October 2009.

2. Cybulska B. Sexual assault: key issues. *Journal of the Royal Society of Medicine*, 2007, 100:321-324.

3. Maniglio R. The impact of child sexual abuse on health: a systematic review of reviews. *Clinical Psychology Review*, 2009, 29(7):647-57.

4. Krug EG et al. *World report on violence and health*. Geneva: World Health Organization, 2002.

5. Arriola KRJ et al. A meta-analysis of the relationship of child sexual abuse to HIV risk behaviour among women. *Child Abuse and Neglect*, 2005, 29:725-746.

6. Home Office. *The economic and social costs of crime against individuals and households 2003/04. Home Office Online Report 30/05*. Available from: http://www.homeoffice.gov.uk/rds/pdfs05/rdsolr3005.pdf, accessed 26 November 2009

7. Finney A. *Domestic violence, sexual assault and stalking: findings from the 2004/05 British Crime Survey. Home Office Online Report 12/06*. Available from: http://www.homeoffice.gov.uk/rds/pdfs06/rdsolr1206.pdf, accessed 21 October 2009.

8. Finney A. *Alcohol and sexual violence: key findings from the research*. Available from: http://rds.homeoffice.gov.uk/rds/pdfs04/r215.pdf, accessed 22 October 2009.

9. Davidson JC, Martellozzo E. Protecting vulnerable young people in cyberspace from sexual abuse: raising awareness and responding globally. *Police Practice and Research*, 2008, 9(4):277-289.

10. Seto MC, Barbaree HE. Sexual aggression as antisocial behavior. A developmental model. In: Stoff DM, Breiling J, Maser JD, eds. *Handbook of Antisocial Behavior*. New York: Wiley, 1997.

11. Kjellgren C et al. Sexually coercive behavior in male youth: population survey of general and specific risk factors. *Archives of Sexual Behaviour*. DOI 10.1007/s10508-009-9572-9.

12. TNS System Three. *Domestic abuse 2007/08: post campaign evaluation report*. Available from http://www.scotland.gov.uk/Publications/2008/07/18113459/0, accessed 26 November 2009.

13. Povey D et al. *Homicides, firearm offences and intimate violence 2007/08*. Available from http://www.homeoffice.gov.uk/rds/pdfs09/hosb0209.pdf, accessed 22 October 2009.

14. World Health Organization. *Violence prevention the evidence: reducing violence through victim identification, care and support programmes*. Geneva: World Health Organization, 2009.

15. Lovett J, Regan L, Kelly L. Sexual Assault Referral Centres: developing good practice and maximising potentials. Home Office Research Study 285. Available from: http://rds.homeoffice.gov.uk/rds/pdfs04/hors285.pdf, accessed 29 June, 2010.

16. Topping KJ, Barron IG. School-based child sexual abuse prevention programs: a review of effectiveness. *Review of Educational Research*, 2009, 79:431-463.

17. Finkelhor D. The prevention of childhood sexual abuse. *The Future of Children*, 2009, 19(2):169-194.

18. Zwi K et al. School-based education programmes for the prevention of child sexual abuse. *Cochrane Database of Systematic Reviews*, 2007, Issue 3. Art. No.:CD004380. DOI:10.1002/14651858.CD004380.

19. Hébert M et al. Proximate effects of a child sexual abuse prevention program in elementary school children. *Child Abuse and Neglect*, 2001, 25:505-522.

20. MacIntyre D, Carr A. Evaluation of the effectiveness of the Stay Safe primary prevention programme for child sexual abuse. *Child Abuse and Neglect*, 1999, 23(12):1307-1325.

21. Briggs F, Hawkins RMF. Follow up data on the effectiveness of New Zealand's national school based child protection programme. *Child Abuse and Neglect*, 1994, 18(8):635-643.

22. Gibson LE, Leitenberg H. Child sexual abuse prevention programs: do they decrease the occurrence of child sexual abuse? *Child Abuse and Neglect*, 2000, 24(9):1115-1125.

23. MacIntyre D, Carr A. Helping children to the other side of silence: a study of the impact of the stay safe program on Irish children's disclosures of sexual victimization. *Child Abuse and Neglect*, 1999, 23(12):1327-1340.

24. Whitaker DJ et al. A critical review of interventions for the primary prevention of perpetration of partner violence. *Aggression and Violent Behaviour*, 2006, 11:151-166.

25. Foshee VA et al. Assessing the effects of the dating violence prevention program "Safe Dates" using random coefficient regression modelling. *Prevention Science*, 2005, 6:245-257.

26. Foshee VA et al. Assessing the long-term effects of the Safe Dates program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. *Research and Practice*, 2004, 94:619-624.

27. Know Your Power. Available from: http://www.know-your-power.org /about.html. accessed 25 November 2009.

28. Potter SJ et al. Empowering bystanders to prevent campus violence against women: a preliminary evaluation of a poster campaign. *Violence Against Women*, 2009, 15:106-121.

29. Banyard VL, Maynihan MM, Plante EG. Sexual violence prevention through bystander education: an experimental evaluation. *Journal of Community Psychology*, 35(4):463-481.

30. Foubert JD, Newberry JT. Effects of two versions of an empathy based rape prevention program on fraternity men;s survivor empathy, attitudes, and behavioural intent to commit rape of sexual assault. *Journal of College Student Development*, 2006, 47(2):133-148.

31. Foubert JD. The longitudinal effects of a rape-prevention program on fraternity men's attitudes, behavioral intent, and behaviour. *Journal of American College Health*, 2000, 48:158-153.

32. Men of Strength (MOST) Clubs. Available from http://www.mencanstop rape.org/, accessed 22 October 2009.

33. Men Against Violence (MAV). Available from http://www.menagainst violence.org/, accessed 22 October 2009.

34. Mentors in Violence Prevention (MVP). Available from http://www.mvpn ational.org/, accessed 22 October 2009.

35. Berkowitz AD. An overview of the social norms approach. In Lederman LC, Stewart LP, eds. *Changing the culture of college drinking. A socially situated health communication campaign*. New Jersey: Hampton Press, 2005.

36. Fabiano P et al. Engaging men as social justice allies in ending violence against women: evidence for a social norms approach. *Journal of American College Health*, 2003, 52:105-112.

37. Bruce S. *The "A Man" campaign: marketing social norms to men to prevent sexual assault*. The report on social norms. Working paper number 5. July 2002. US: PaperClip Communications, 2002.

38. Sex consent targets men. BBC News. Tuesday 14th March 2006. Available from: http://news.bbc.co.uk/1/hi/uk/4803878.stm, accessed 29 June 2010.

39. Rape Crisis Scotland. This is not an invitation to rape me. Available from http://www.thisisnotaninvitationtorapeme.co.uk/, accessed 22 October 2009.

40. Wellings K, Macdowall W. Evaluating mass media approaches to health promotion: a review of methods. *Health Education*, 2000, 100:23-32.

41. Abbey A et al. Alcohol and sexual assault. *Alcohol Research and Health*, 2001, 25(1):43-51.

42. Babor T et al. Alcohol: no ordinary commodity. *Research and public policy*. Oxford: Oxford University Press, 2003.

43. World Health Organization. *Violence prevention the evidence: preventing violence by reducing the availability and harmful use of alcohol*. Geneva: World Health Organization, 2009.

44. Markowitz S, Grossman M. Alcohol regulation and domestic violence towards children. *Contemporary Economic Policy*, 1998. XVI: 309-320.

45. Markowitz, S. The price of alcohol, wife abuse, and husband abuse. *Southern Economic Journal*, 2000, 67: 279-304.

46. Schmucker M, Losel F. Does sexual offender treatment work? A systematic review of outcome evaluations. *Psicothema*, 2008, 20(1):10-19.

47. Friendship C, Mann R, Beech A. *The prison-based sex offender treatment programme - an evaluation*. Available from http://www.homeoffice.gov.uk/rds/pdfs2/r205.pdf, accessed 21 October 2009.

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