MENTAL HEALTH FOUNDATION

School-based anti-bullying interventions: Evidence and implications

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Authors:

Ruth Pearson

Catherine Negus, Shioma-Lei Craythorne, Emily Fu, and Susan Solomon

Contributors:

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Overview and recommendations

The challenge and context

- **Bullying has a considerable impact on mental health and is a public health priority.** Evidence consistently identifies bullying as an important risk factor for poorer mental health outcomes, including depression, anxiety, post-traumatic stress, self-harm, and suicidality[1,2,3,4,5] effects of bullying persist into adulthood, highlighting the importance of early prevention and intervention[4,4]. Although much of the evidence is observational, the consistency of findings across studies and countries suggests bullying represents an important risk factor for poorer mental health outcomes.
- **Some groups such as LGBTQ+, ethnic minority and disabled pupils are vulnerable to prejudice-driven bullying, which exacerbates mental health inequalities**[6,7,8,9,10]**.**
- **Perpetrators of bullying behaviours are also vulnerable** – and those who are both bullied and perpetrate bullying are at the greatest mental health risk[8,11].
- **Timing matters.** The mental health impact of bullying can begin quickly but takes a long time to reduce even after bullying stops. Longer and more persistent bullying also causes worse outcomes. This indicates that prevention, early intervention, sustained action and ongoing support even after bullying are all crucial[9,12].

Schools are uniquely positioned to address bullying through prevention and intervention efforts. However, uncertainty remains regarding which approaches are most effective and how best to implement them in practice. This rapid evidence assessment reviewed school-based anti-bullying interventions to evaluate effectiveness, implementation considerations, and implications for policy and practice. It confirmed that bullying is a modifiable risk factor – **efforts to prevent bullying can work and will help to reduce mental ill-health.**

Methodology

A rapid evidence review methodology was used to identify and evaluate peer-reviewed studies examining school-based anti-bullying interventions, aimed at children and young people under the age of 18. Studies were identified through systematic searches of major academic databases and screened against predefined inclusion criteria.

Given the volume of literature identified, only Randomised Controlled Trials (RCTs) were included in this review. Eligible studies were synthesised narratively, with methodological quality assessed using the Mixed Methods Appraisal Tool (MMAT).

Key findings of this review

- **Whole-school anti-bullying interventions demonstrated the strongest evidence base overall,** with the largest number of RCTs evaluating these approaches. Interventions such as KiVa and Learning Together showed promising evidence of effectiveness across multiple studies and settings.
- **Interventions associated with more positive outcomes typically included multiple coordinated components, rather than isolated activities.** Characteristics linked to stronger effectiveness and implementation included: strong staff training and engagement, leadership support, pupil participation, peer involvement, school policy change, and attention to the wider school climate and relationships, plus ongoing monitoring – rather than focusing solely on individual bullying incidents.
- **However, outcomes were not consistently positive and implementation is critical.** Variability in outcomes may partly reflect differences in implementation fidelity, staff engagement, school context, programme adaptation, and the challenges associated with delivering complex interventions in real-world educational settings.

- **Overall study quality was moderate to high. However, methodological limitations were common across the evidence base,** particularly those associated with conducting research in applied school settings, where blinding participants to intervention allocation was often not feasible.
- **Mental health outcomes and the experiences of minority groups vulnerable to bullying were infrequently examined across studies,** although one identified study of a targeted intervention found a reduction in victimisation among high-risk pupils. Evidence in secondary school settings is particularly limited. Additionally, considerable variation existed in the types of bullying assessed, with many studies focusing specifically on cyberbullying outcomes.
- **While international studies provide valuable insights, much of the current evidence base originates from outside the UK,** limiting understanding of how interventions perform within UK educational, policy, and implementation contexts.
- Thus, there are important evidence gaps. This rapid assessment however considered only RCTs. While these are methodologically sound, they may not capture insights which may be available in the larger body of literature, including qualitative, mixed methods, and participatory research.

This review has important implications for policy, practice, and future research. Findings support the continued implementation of whole-school anti-bullying approaches.

However, findings also highlighted the need for more consistent outcome measurement, greater consideration of mental health impacts, and increased attention to vulnerable and minority groups within future intervention research. Further investigation is needed to better understand which intervention components are most effective at reducing bullying and improving mental health outcomes, and how schools can be better supported to implement interventions successfully within real-world educational settings.

Recommendations for action

Schools and educational settings

1. Schools should prioritise whole-school anti-bullying approaches that address staff engagement, pupil participation, peer involvement, and school policy, climate, and relationships.
2. Schools implementing anti-bullying programmes should ensure sufficient attention is given to implementation fidelity, including staff training, leadership support, and ongoing monitoring.

Policymakers and educational organisations

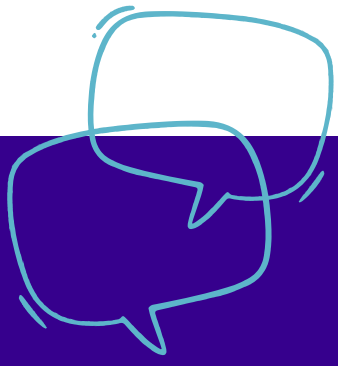
1. Policymakers and organisations supporting schools should recognise that successful implementation may require sustained resources, training, and long-term support rather than one-off intervention delivery.
2. Charities working within bullying prevention and youth wellbeing should continue supporting evidence-informed whole-school approaches, while also helping schools address barriers to implementation in practice.
3. Policymakers should develop a consistent national approach to bullying measurement and monitoring across schools. Guidance and obligations on the use of standardised bullying and wellbeing measures, plus any necessary database adaptations and support, would support more robust evaluation acknowledging that wellbeing effects may not be immediate and collection of longer-term data is key.

Recommendations for research

1. Greater investment is needed in high-quality UK-based evaluations of anti-bullying interventions. Future evaluations should place greater emphasis on understanding how, for whom, and under what conditions interventions are effective, by:
   - exploring the level of assistance, leadership support, training and resourcing required for interventions to achieve long-term effects
   - examining the relative contribution of different intervention components to bullying and mental health outcomes

   This would help schools prioritise approaches that maximise impact while remaining practical and sustainable within the constraints of real-world educational settings.
2. Greater research attention should be given to how bullying, and anti-bullying interventions, impact vulnerable and minority groups, including LGBTQ+ and ethnic minority pupils.
3. Researchers should work towards greater consistency in bullying and wellbeing outcome measurement, using validated and standardised measures, to improve comparability across studies.
4. Future studies should place greater emphasis on evaluating the mental health and wellbeing impact of anti-bullying interventions, including the longer-term effects.

In light of these recommendations, the Mental Health Foundation (MHF) welcomes a new large-scale RCT of the Learning Together initiative in English secondary schools, with publication expected in 2031. However, given the strong case for action on bullying, MHF endorses further research to tackle the many topics above, including across shorter timeframes.



Contents

Context

Children and young people's mental health is an increasing public health concern, with growing recognition of the long-term impact that mental health difficulties can have on educational attainment, social relationships, physical health, and later life outcomes[5]. Evidence links childhood victimisation to poorer mental health outcomes extending well into adulthood. Among the many factors associated with children's mental health, bullying is one of the most consistently identified and potentially modifiable risk factors.

One of the most consistent findings within the literature is the association between bullying victimisation and poorer mental health outcomes. Longitudinal studies have repeatedly found that children who experience bullying are at increased risk of developing depression, anxiety disorders, and broader psychosocial difficulties later in life. A major meta-analysis of longitudinal studies[6] found that victims of bullying were approximately twice as likely to experience depression in adulthood, even after accounting for other childhood adversities and pre-existing vulnerabilities. Similarly, research[7] using data from the British National Child Development Study demonstrated that frequent bullying in childhood predicted poorer mental health outcomes up to age 50, including increased anxiety, depression, and suicidality.

The strongest and most consistent associations are with internalising disorders, particularly depression, generalised anxiety, panic disorder, and social withdrawal. One study[8] found elevated risks of agoraphobia, panic disorder, and generalised anxiety among adults who had been bullied as children, even after controlling for family hardship and childhood psychiatric problems. Recent evidence suggests that the mental health consequences of peer victimisation may extend beyond depression and anxiety to include self-harm and post-traumatic stress symptoms[9]. Collectively, these findings suggest that bullying should be viewed not only as a safeguarding or educational concern, but also as an important social determinant of mental health and a target for prevention efforts.

The impact of bullying may be particularly significant for young people who already experience social, educational, or health-related disadvantage[10]. Research demonstrates that identity- or stigma-based bullying disproportionately targets children and young people with protected or

marginalised characteristics[11]. Specifically, those with disabilities or special educational needs and disabilities (SEND), individuals from minority ethnic backgrounds, and LGBTQ+ youth face a significantly heightened risk of peer victimisation linked specifically to their identities[12]. Similarly, pupils with SEND are highly vulnerable to social isolation, relational bullying, and reduced peer acceptance[13]. Crucially, an intersectional perspective reveals that these vulnerabilities can overlap, increasing the risk for young people holding multiple marginalised identities. As a result, bullying may contribute to poorer mental health outcomes, educational disengagement, and social exclusion, in a way which reinforces existing inequalities[14].

The evidence also suggests that the mental health impact of bullying is not confined to victims alone. Young people who bully others, and particularly those who are both perpetrators and victims ('bully-victims'), experience higher levels of adult mental health problems, including increased psychiatric hospitalisation[15]. Bully-victims consistently emerge as the group at greatest risk, showing markedly elevated rates of depression, panic disorder, and suicidality[18]. These findings suggest that involvement in bullying, regardless of role, may be associated with broader emotional and psychological vulnerabilities. This highlights the importance of early identification and intervention.

Another key finding is that the duration and persistence of bullying matter. Chronic or repeated victimisation is associated with substantially worse outcomes than occasional bullying. The literature suggests a dose-response relationship: the longer bullying continues, the greater the likelihood of long-term psychological harm. The literature[9] also highlights factors that may mediate or moderate outcomes, including rumination, hostile attribution biases, family support, and school belonging. These findings have important implications for prevention and early intervention strategies, as they highlight potentially modifiable protective factors that schools, communities, and mental health services can strengthen to reduce the long-term impact of bullying.

Importantly, evidence suggests that mental health can improve once bullying stops, but recovery is often gradual and incomplete. Evidence suggests that psychological distress rose rapidly with the onset of victimisation but declined much more slowly after bullying ended, implying that the psychological effects of bullying may persist even after victimisation has ended[16]. These findings suggest both the importance of outright prevention, and that some young people may benefit from ongoing psychological support following victimisation.

The literature is careful about causality. Most evidence comes from observational longitudinal studies rather than experimental research, meaning bullying cannot definitively be said to 'cause' later mental illness in every case. Children with pre-existing emotional vulnerabilities may be more likely both to experience bullying and to develop later psychiatric difficulties. However, the consistency of findings across countries, methodologies, and decades, even after controlling for confounding factors, strongly suggests bullying is an important and preventable contributor to poor mental health outcomes.

Overall, the evidence positions bullying as a major public mental health issue rather than simply a behavioural or educational problem. Taken together, the evidence supports viewing anti-bullying efforts as part of a broader strategy for mental health prevention, early intervention, resilience-building, and reducing long-term inequalities in wellbeing.

Although bullying is a global issue, important differences exist between educational systems, policy frameworks, cultural norms, and approaches to child protection across nations. Much of the international evidence base for anti-bullying interventions originates from countries such as Finland[17], the Netherlands[18], Italy, Australia, and the United States (e.g., the KiVa and Olweus programmes).

While these international studies provide valuable insights into intervention effectiveness, their findings may not be readily transferable to other settings[19,20]. Systemic variations in school structures, such as curriculum requirements, staff capacity, available resources, and national policy contexts, may influence both implementation and local outcomes. Within the UK, relatively few large-scale RCTs have evaluated anti-bullying interventions, creating uncertainty regarding how readily findings from international studies transfer to the UK educational landscape[21]. Consequently, while international evidence provides a critical starting point to inform practice, dedicated UK-based research remains essential to understand how these interventions perform within the specific educational, social, and statutory context of UK schools.

Aims of this review

Recent reviews have highlighted the wide range of anti-bullying interventions available internationally and the growing evidence base relating to bullying prevention[22]. However, considerable variation remains in the quality of evidence, intervention design, implementation approaches, and outcome measurement participant age groups, and definitions of bullying. As a result, it remains challenging to determine which approaches are most effective, for whom, and under what circumstances. Furthermore, relatively little attention has been paid to how interventions are implemented within real-world educational settings and the practical factors that may influence their effectiveness. This review therefore sought to provide a focused synthesis of high-quality evidence from randomised controlled trials (RCTs), while also considering implementation issues and implications for policy and practice.

Evidence also suggests that bullying is an important risk factor for poorer mental health outcomes. However, mental health and wellbeing outcomes are not consistently assessed within intervention studies, limiting understanding of the extent to which anti-bullying interventions contribute to broader improvements in mental health and wellbeing (although these would still need interpreting with caution given that effects may be long-term.)

This rapid evidence assessment was undertaken to provide an accessible, structured, and policy-relevant synthesis of the evidence relating to school-based anti-bullying interventions. The review sought to:

- Assess the strength and quality of the current evidence base, and identify evidence gaps
- Identify intervention characteristics and implementation factors evidenced to be associated with positive outcomes
- Explore their impact on mental health and wellbeing outcomes where these outcomes were reported
- Identify implications for policy, practice, and future research.

To address these aims, the review considered the following questions:

1. What evidence exists regarding the effectiveness of school-based anti-bullying programmes and policies in reducing bullying behaviours among children and young people?
2. What evidence exists regarding the impact of school-based anti-bullying interventions on mental health and wellbeing outcomes, where these outcomes are reported in addition to the primary bullying outcomes?
3. What evidence exists regarding interventions designed to reduce bullying towards specific groups of pupils, including identity-based forms of bullying?
4. Where included within broader school-based interventions, what evidence exists relating to the prevention or reduction of cyberbullying?

Glossary

RCT	Randomised Controlled Trial.
Bullying	The repetitive, intentional hurting of one person or group by another person or group, where the relationship involves a real or perceived imbalance of power.
Cyberbullying	Bullying occurring through digital technologies.
Intervention	A planned, identifiable programme or set of actions designed to achieve a specific outcome or benefit, which may be replicated in other settings.
Whole School Approach	An approach that involves all members of the school community, including pupils, staff, leadership, parents, and school policies, to create a positive and supportive environment.
Fidelity	How closely a programme is delivered according to its original design and guidance.
Statistical Significance	A result that is unlikely to have occurred by chance alone, suggesting a real effect may be present.

Methodology

Review design

A rapid evidence assessment (REA) was conducted to examine the effectiveness of school-based anti-bullying interventions and their impact on bullying and mental health outcomes among children and young people. REAs use systematic review principles while adopting streamlined methods to produce evidence within shorter time frames.

Search strategy

Searches were conducted across the following electronic databases from the last 10 years:

- PsycINFO
- PubMed
- ERIC
- Web of Science
- SCOPUS

Eligibility criteria

Search terms were developed around three key concepts:

- Bullying behaviours
- School-based settings
- Interventions and prevention programmes

Searches included combinations of keywords such as 'bully', peer victimisation', 'anti-bullying', 'intervention', 'programme', 'prevention, 'school-wide', and others.

Search strategies were adapted appropriately for each database. Full search strategies are provided in **Appendix 1.**

Screening process

Studies were screened against predefined inclusion and exclusion criteria relating to population, intervention type, outcomes, setting, and study design. Full criteria are provided in **Appendix 2.**

Given the large number of studies identified through the searches (n=9,980), the review was restricted to RCTs. This approach enabled a focus on the highest-quality evidence available regarding the effectiveness of school-based anti-bullying interventions and their impact on bullying and mental health outcomes.

Records were imported into Rayyan, a web-based systematic review management platform, where duplicates were removed and screening decisions were managed. Screening decisions were made by reviewers rather than automated software functions.

A subset of 94 studies was independently screened by a second reviewer. The small number of discrepancies identified were discussed and resolved through consensus. Most differences related to the inclusion of systematic reviews, which were subsequently excluded in accordance with the review eligibility criteria.

Following title, abstract, and full-text screening, 17 studies met the inclusion criteria and were included in the final synthesis. A flow diagram detailing the screening process is provided in **Appendix 3.**

Data extraction

Data relating to study characteristics, intervention components, outcomes, and implementation factors were extracted using a standardised extraction form.

Quality appraisal

Methodological quality was assessed using the RCTs section of the Mixed Methods Appraisal Tool (MMAT)[39]. This section evaluates five criteria: the appropriateness of randomisation, baseline comparability of groups, completeness of outcome data, blinding of outcome assessors, and participant adherence to the assigned intervention.

Fidelity and adherence were considered as part of the quality appraisal. However, broader implementation challenges affecting programme delivery are discussed separately, as these represent practical considerations relevant to intervention effectiveness rather than methodological quality alone.

Data synthesis

Due to heterogeneity across studies in relation to intervention type, outcome measures, study design, and follow-up periods, a meta-analysis was not considered appropriate. Findings were therefore synthesised narratively.

Conflict of interest

One study included within this review was co-authored by the lead reviewer. To minimise the potential for bias, methodological quality appraisal of this study was independently conducted by a second reviewer using the MMAT.

The two assessments were largely consistent, with only one difference relating to the randomisation procedure. This difference arose because additional information regarding the randomisation process was available within the main trial publication but was not reported within the specific paper included in the review. In line with the review methodology, the final rating was based on information reported within the included paper.

Professor Judy Hutchings has professional links to the KiVa programme and attended an initial project scoping meeting prior to commencement of the review. However, she was not involved in study selection, data extraction, quality appraisal, evidence synthesis, interpretation of findings, or the development of recommendations. All review decisions were made independently by the review team.

Findings

KEY

Strong evidence base | Moderate or emerging evidence base | Limited evidence base

Intervention name	Type/duration	Follow up period	Key components	Study	Outcomes	Study quality rating and considerations	Context and population studied
Learning Together	Whole-school approach / One year. Embedded within everyday school practices during implementation.	24-36 months	• Staff training in restorative practices. • Student-staff action groups. • Social and emotional skills curriculum.	Bonell et al. (2020)[23] Bonell et al. (2018)[21] Melendez-Torres, et al. (2024)[24]	• Reduction in bullying victimisation. Small effect size. • Reduction in cyberbullying perpetration. • Reduction in aggressive behaviours. • Reduction in e-cigarette use. • Reduction in aggressive behaviours. • Reduction in truancy. • Reduction in participation in school disciplinary procedures.	MMAT (3-4/4) Moderate to high quality studies. • Large sample (n=6667). • Longitudinal follow up. • Single UK RCT with multiple publications.	40 secondary schools in South-East England, UK. 6,667 pupils aged 12-15. Socioeconomically and ethnically diverse sample.
KiVa	Whole-school approach / One year. Embedded within everyday school practices during implementation.	12- 24 months	• Staff training. • Classroom lessons. • School-wide awareness activities. • Parent information. • Targeted responses to bullying incidents. • Ongoing monitoring of bullying behaviours.	Axford et al. (2020)[19] Nocentini & Menesini (2016)[25] Huitsing et al. (2020)[26] Klocek et al. (2024)[27] Hutchings et al. (2025)[28]	• Reductions in bullying perpetration and victimisation in some studies. • Positive outcomes associated with implementation fidelity and programme exposure. • Limited or non-significant effects reported in some settings.	MMAT (2-3/4) Moderate methodological quality. • Large samples (n=1588–11922). • Evaluated in different countries. • Findings influenced by implementation fidelity and contextual factors. • Mixed evidence across settings.	Primary schools in the UK, Czech Republic, Italy and the Netherlands. Pupils aged 7-11. Large international evidence base across multiple educational contexts.

Intervention name	Type/duration	Follow up period	Key components	Study	Outcomes	Study quality rating and considerations	Context and population studied
PRIMA antibullying program	Whole-school approach / One year. Embedded within everyday school practices during implementation.	Post-intervention assessment (timing not reported)	• Classroom lessons. • Teacher e-learning and training. • Antibullying norm development. • Parent involvement. • Targeted monitoring/support.	Van Verseveld et al. (2021)[29]	• Reduction in peer-reported victimisation. • Reduction in reinforcing behaviours. • Stronger effects when multiple components implemented. • No significant effects for self-reported bullying or victimisation.	MMAT (3/4) Moderate methodological quality. • Large sample (n=3135). • Detailed implementation analysis. • Findings varied by level of programme implementation. • Differences observed between peer-report and self-report outcomes.	Elementary schools in the Netherlands. 3,135 pupils aged 6-10.
LINKlusive	Whole-school / 12 weeks (study end point).	12-52 weeks	• Online training for families (4 sessions). • Online training for teachers (6 sessions). • Teacher delivered education programme for students (10 x 40 min sessions). • Intervention included socioemotional learning, diversity awareness, and targeted peer-support for identified cases of bullying.	Arango et al. (2024)[30]	• Reduction in bullying victimisation. • Improvements in depression and quality of life among pupils experiencing victimisation at baseline. • Effects not significant across the full sample.	MMAT (3/4) Moderate methodological quality. • Large sample (n=6,542). • Included mental health outcomes. • Benefits are strongest among pupils experiencing victimisation at baseline. • Limited effects across full sample.	Primary and secondary schools in Madrid, Spain. 6,542 pupils aged 10-16.

Intervention name	Type/duration	Follow up period	Key components	Study	Outcomes	Study quality rating and considerations	Context and population studied
Restorative Practices Intervention (RPI)	Whole-school approach / One year. Embedded within everyday school practices during implementation.	2 years	• Sustained relationships with adults. • Skills building. • Application of skills.	Acosta et al. (2019)[31]	• No significant school-wide effects compared with control schools. • Improved school climate and connectedness among pupils reporting greater exposure to restorative justice. • Reduced cyberbullying victimisation associated with higher programme exposure.	MMAT (2/4) Lower methodological quality. • Large sample (n=2,771) • Positive effects associated with programme exposure. • No significant overall intervention effects.	Middle schools in Maine, USA. 2,771 pupils aged 11-12 (Grades 6-7).
Friendly Schools Project (FSP	Whole School / 2 years.	2 years	• Student curriculum and skills development. • Parent engagement and transition support. • Whole-school policy and culture change. • Staff training and implementation support.	Cross et al. (2018)[12]	• Reduction in bullying victimisation and perpetration. • Reduction in loneliness, depression, anxiety, and stress. • Improved perceptions of school safety. • Benefits concentrated during the first year following transition. • Limited evidence of sustained effects in Year 2.	MMAT (2/4) Lower methodological quality. • Large sample (n=2,739) • Benefits concentrated during transition to secondary school. • Reduced implementation support may have contributed to weaker Year 2 effects.	Catholic secondary schools in Perth, Western Australia. Pupils aged 13-14 (Grades 8-9).
NoTrap! Anti-Bullying Program	Peer-led / 1 year.	1 year	• Peer-led activities. • Online components. • Whole-class prevention strategies.	Zambuto et al. (2020)[33]	• Reduction in bullying victimisation. • Reduction in bullying perpetration. • Increased defending behaviours. • Positive effects observed when peer educators were nominated by peers.	MMAT (3/4) Moderate methodological quality. • Moderate sample (n=966). • Peer educator recruitment method influenced effectiveness. • Findings highlight the importance of implementation and peer selection.	Secondary schools (middle and high schools) in Italy. Pupils aged 12-18.

Intervention name	Type/duration	Follow up period	Key components	Study	Outcomes	Study quality rating and considerations	Context and population studied
PreVenture	Targeted Intervention (2 x 90 minute sessions).	36 months	• Personality-targeted CBT activities. • Motivational interviewing. • Small group sessions.	Kelly et al. (2019/2020)[34]	• No significant effects on bullying victimisation or perpetration across the full sample. • Reduction in victimisation among high-risk pupils (pupils with elevated scores on one or more personality risk). • Reduction in suicide ideation, emotional symptoms, and conduct problems among high-risk pupils. • Findings suggest greater benefits for pupils at elevated psychological risk.	MMAT (2/4) Low to moderate methodological quality. • Large sample (n=2,638). • Benefits observed primarily among high-risk pupils. • Findings based on exploratory post-hoc analyses. • Caution required when interpreting causal effects.	Secondary schools in Australia. Pupils aged 12-18.
Boston vs. Bullies	Facilitator-led educational intervention (4 lessons).	Immediate post test	• Bullying awareness and education. • Strategies for victims and bystanders. • Assertiveness and problem-solving skills. • Facilitator-led classroom sessions.	Greif Green et al. 2020)[35]	• Limited evidence of change in bullying behaviour. • Improved bullying knowledge. • Increased assertiveness and bystander responsibility. • Improved perceptions of adult responsiveness. • Reduced acceptance of aggression and peer victimisation.	MMAT (3/4) Moderate methodological quality. • Moderate sample (n= 654). • Effects varied across schools. • Some effects weakened after accounting for school clustering. • Findings suggest school context may influence effectiveness.	Boston, Massachusetts, USA. Pupils aged 10-11 (Fifth grade). Racially and ethnically diverse urban sample.

Intervention name	Type/duration	Follow up period	Key components	Study	Outcomes	Study quality rating and considerations	Context and population studied
ACT Out! Social Issue Theater	Interactive theatre intervention (5 performances/ vignettes).	2 weeks post intervention	• Professional theatre performances. • Interactive bullying-related scenarios. • Facilitated audience discussion and reflection. • Exploration of emotions, motivations, and consequences of bullying.	Agley et al. (2021)[36]	• No significant improvement in bullying victimisation or perpetration at follow-up. • Improved social-emotional competence.	MMAT (4/4) High methodological quality. Large sample (n=1723) Evidence of effectiveness was limited by: • Small inconsistent effects. • Short follow up period. • Single study evaluation.	Elementary and middle school in Indiana, USA. Pupils aged 9-14. (Grades 4-8).
Safe at School (SAS)	Class seating intervention.	8-12 weeks	• Strategic classroom seating based on peer relationships. • Increased proximity to friends. • Reduced proximity to perpetrators.	Hoekstra et al. (2024)[37]	• No significant differences in bullying victimisation or perpetration. • No evidence of intervention effectiveness across bullying outcomes. • Implementation inconsistency limited confidence in findings.	MMAT (2/4) Low methodological quality. • Large sample (n=1746) • Difficulty implementing the intervention consistently. • Findings should be interpreted with caution.	Upper elementary school in the Netherlands. Pupils aged 9-12 (Dutch Grades 4-6).

Discussion of findings

Overview

This rapid evidence assessment examined the effectiveness of school-based anti-bullying interventions and their impact on bullying and mental health outcomes among children and young people. Overall, findings suggested that whole-school approaches demonstrated the strongest and most consistent evidence base relative to other intervention approaches included within the review.

This conclusion was based not only on the number of studies evaluating these interventions, but also on the consistency of findings across multiple RCTs, the quality of the available evidence, the range of positive outcomes reported, and the presence of longer-term follow-up data. Interventions such as KiVa[26] and Learning Together[21,23,24] demonstrated reductions in bullying-related outcomes across multiple studies and settings, while other whole-school approaches, including PRIMA[29] and LINKlusive[30], also reported positive effects for some bullying, wellbeing, and school climate outcomes. Although findings were not universally positive, the overall pattern of evidence suggested that interventions seeking to influence multiple aspects of the school environment were associated with the most promising outcomes.

However, this does not imply that non-whole-school approaches were ineffective. Several targeted and component-based interventions demonstrated promising findings, including improvements in bullying-related outcomes, school climate, social relationships, and outcomes among vulnerable groups. For example, restorative practices, peer-led approaches, and targeted interventions such as Preventure[34] were associated with positive effects in some studies. Although the evidence base for these approaches was more limited, the findings suggest that specific intervention components may contribute to positive outcomes and warrant further investigation.

Among the interventions reviewed, KiVa[19,25-28] and Learning Together[21,23,24] had the largest evidence base in terms of the number of RCTs and associated publications identified within the review. However, important differences existed between these evidence bases. The Learning Together findings were derived primarily from multiple papers associated with a single large-scale RCT, whereas KiVa has been evaluated across multiple countries and educational contexts. This broader evidence base may provide greater insight into how intervention effectiveness varies across settings and implementation conditions.

More broadly, these findings are important from a public mental health perspective because bullying is one of the most consistently identified risk factors for later mental health difficulties[21,23,26] yet relatively few intervention studies directly assessed whether reductions in bullying translated into improvements in psychological wellbeing.

Whole-school approaches

Findings from this review generally support existing evidence suggesting that whole-school approaches were associated with more positive outcomes than isolated or single-component interventions. Many of the interventions associated with positive outcomes incorporated multiple elements, including teacher and staff training, curriculum components, pupil participation, peer involvement, school policy changes, and activities designed to influence the wider school climate and relationships – as well as ongoing monitoring. The stronger evidence observed for whole-school approaches may reflect the fact that these interventions target multiple aspects of the school environment simultaneously.

Programmes such as KiVa, Learning Together, PRIMA, and LINKlusive combined multiple intervention elements and generally reported more promising outcomes than interventions focused on a single activity or delivery component. However, the available evidence does not allow firm conclusions regarding which specific components are most important or whether particular combinations of components drive effectiveness.

The findings also highlight the complexity of evaluating intervention effectiveness. Although several studies reported improvements in bullying-related outcomes, evidence relating to intermediate outcomes such as bystander behaviour, peer relationships, social skills, or school climate was more variable. Furthermore, changes in these intermediate outcomes did not always correspond with clear reductions in bullying perpetration or victimisation. This suggests that, while such factors may play an important role in bullying prevention, improvements in intermediate outcomes alone should not necessarily be assumed to translate directly into reductions in bullying behaviour.

Despite the relative strength of evidence supporting whole-school approaches, findings were not universally positive. Several studies reported limited or non-significant intervention effects, including some evaluations of well-established programmes such as KiVa. These inconsistencies suggest that intervention effectiveness may depend not only on programme design, but also on how interventions are implemented within schools.

Implementation and intervention fidelity

Implementation emerged as a significant factor across the evidence base and was frequently discussed within studies as a potential explanation for limited or inconsistent intervention effects. Several studies highlighted challenges relating to intervention fidelity, staff engagement, training, resource limitations, and variability in programme delivery across schools. Importantly, most of the evidence included in this review originated from outside the UK, with only a small number of studies evaluating interventions within UK school settings. This may limit confidence regarding how readily findings transfer to the educational, policy, and resource contexts of UK schools.

These findings are important because they suggest that even interventions with strong theoretical foundations and promising evidence may fail to produce meaningful outcomes if implementation is inconsistent or incomplete. In practical terms, successful implementation appeared to depend on factors such as adequate staff training, leadership support, sufficient time and resources, staff engagement, and ongoing monitoring of programme delivery.

For example, implementation of the Learning Together intervention involved staff training, regular action group meetings involving both staff and pupils, review of school policies, delivery of curriculum materials, and the use of restorative approaches by staff. This illustrates that successful implementation extends beyond simply introducing a programme and requires sustained engagement across multiple aspects of school life.

In some evaluations of KiVa[19], variability in implementation fidelity was identified as a potential explanation for inconsistent findings. This included differences in the extent to which schools delivered the full range of programme activities and embedded anti-bullying practices within everyday school life.

One UK evaluation suggested that schools may have required more intensive and responsive implementation support than was provided, noting that support offered in Finnish and Italian evaluations appeared more extensive. This highlights the possibility that differences in implementation support, rather than programme content alone, may contribute to variation in outcomes across settings.

The realities of school environments, including workload pressures, staffing challenges, competing priorities, pupil absenteeism, and wider contextual disruptions, may all influence schools' ability to deliver interventions as intended. In some studies, implementation challenges were also influenced by wider contextual factors, including the COVID-19 pandemic.

The level of long-term attention to programme implementation may also influence outcomes, but can be difficult to compare across studies. Many whole-school approaches were not delivered as discrete programmes with clearly defined end points. Instead, interventions such as KiVa and Learning Together were designed to become embedded within school systems, relationships, and everyday practices. As a result, whether there are longer-term outcomes may reflect the level of both sustained intervention delivery and enduring changes to school climate. This raises important questions regarding the level of support, time commitment, and organisational change required to implement whole-school approaches successfully and sustain benefits over the longer term.

The findings highlight the importance of moving beyond questions of whether interventions work, towards understanding how schools can be better supported to implement interventions successfully in practice. Given that much of the UK evidence base is limited and some evaluations were conducted during periods of significant educational disruption, additional UK-based trials may help clarify intervention effectiveness and implementation requirements under more typical school conditions. There is also a need for further research in secondary school settings, where the evidence base remains comparatively limited.

Mental health outcomes and vulnerable groups

Although bullying is widely associated with poorer mental health outcomes, mental health measures were inconsistently reported across the included studies. Many interventions focused primarily on reductions in bullying perpetration or victimisation, with relatively few studies directly examining whether reductions in bullying translated into measurable improvements in mental health and wellbeing. It is important to recognise that improvements in mental health may emerge over a longer timeframe than changes in bullying behaviour, making them more challenging to capture within the follow-up periods typically used in intervention studies.

Similarly, limited evidence was identified relating to minority or marginalised groups who may experience increased risk of bullying, including LGBTQ+ young people, ethnic minority pupils, and pupils with additional needs. Where subgroup analyses were included, findings were often limited or exploratory, and many studies were not designed or powered to examine intervention effectiveness within specific populations. Notably, some targeted interventions, such as Preventure, demonstrated benefits among specific groups of young people considered at elevated risk of adverse outcomes, suggesting that targeted approaches may have an important role alongside universal whole-school strategies.

The limited evidence relating to marginalised groups represents an important gap within the literature because identity-based bullying may differ from more general forms of bullying. Experiences such as homophobic, racist, disability-related, or other prejudice-based bullying are often rooted in broader social attitudes, stereotypes, and discrimination[15,16].

As a result, it cannot necessarily be assumed that interventions which reduce bullying overall will be equally effective in reducing identity-based forms of bullying. Future research should therefore explore whether generic anti-bullying approaches require explicit anti-discrimination, inclusion, or equity-focused components to address the specific experiences of marginalised groups.

Methodological considerations

Among the RCTs which were the focus of this review, overall study quality was generally moderate to high. However, several methodological limitations were common across the evidence base. Due to heterogeneity across interventions, measures, and study designs, caution should be exercised when interpreting overall intervention effectiveness.

One of the most consistent limitations related to the practical challenges of conducting intervention research within applied school settings. In many cases, blinding participants to intervention allocation was not feasible, which may increase the risk of response bias. Follow-up periods also varied substantially, ranging from short-term post-intervention assessments to evaluations conducted several years after implementation[9].

The focus on RCTs strengthened confidence in findings relating to intervention effectiveness, Further review of complementary qualitative, mixed-methods, and implementation-focused research may help explain why interventions appear effective in some settings but not others, considering questions of implementation, adaptation, acceptability and context.

A substantial proportion of studies focused specifically on cyberbullying outcomes, while others examined bullying more broadly. This variation further complicated direct comparison between interventions and may reflect wider shifts in how bullying is experienced within contemporary school environments.

Variation in definitions of bullying and outcome measures limited comparability across studies. Studies differed considerably in whether they assessed bullying perpetration, victimisation, bystander behaviour, cyberbullying, or broader school climate outcomes, and used a range of self-report, peer-report, teacher-report, and observational measures.

Each approach has inherent strengths and limitations. For example, self-report measures may be influenced by social desirability or recall bias, peer reports may not capture all bullying experiences, and observational methods may alter behaviour through the presence of an observer. No single approach provides a complete picture of bullying behaviour, and greater confidence may be achieved when findings are supported across multiple sources of information.

The findings also highlight the importance of using validated and developmentally appropriate measures. Where new or adapted measures are used, researchers should ensure that appropriate reliability and validity testing is undertaken. Particular attention may be needed when measures are translated across languages or used with younger children, as differences in language comprehension and interpretation may influence how questions are understood and answered.

In some studies, low baseline levels of bullying or relatively positive wellbeing outcomes may have reduced the potential for measurable intervention effects, making further improvements more difficult to detect. Interpretation of intervention effectiveness should consider baseline conditions within participating schools.

A further limitation was the inconsistent reporting of intervention effect sizes across studies, which made direct comparison of intervention impacts challenging. Future evaluations would benefit from standardised reporting of effect sizes and confidence intervals to facilitate evidence synthesis and comparison across interventions.

This REA finds that Learning Together (alongside other whole school approaches) shows some of the strongest evidence of effectiveness, from a 2014-2017 RCT involving 40 secondary schools and 6,667 pupils in South East England. Likewise, the Educational Endowment Fund (EEF) and several leading research and young people's organisations have determined that Learning Together shows 'great promise'. They are therefore beginning a larger scale, wider geographical RCT across secondary schools in England in summer 2026, with publication expected in 2031[38].

Bullying reduction is one of several wide-ranging goals for the programme, and the specific focus and actions will depend on individual school needs. The level of focus on mental health in this study is promising. It will include annual surveys about the experience of implementing the programme, plus case studies of some schools.

Implications for policy, practice, and research

The findings from this review support the continued development and evaluation of whole-school anti-bullying approaches within educational settings.

Schools should prioritise whole-school anti-bullying approaches addressing many dimensions of the school environment through multiple components, implemented with fidelity to their model.

Policymakers and organisations supporting schools should recognise that successful implementation may require sustained resources, training and support. Further emphasis should be placed on developing consistent measurement practices and frameworks nationwide.

Variability in outcomes across studies highlights remaining gaps in the current evidence base and areas requiring further attention. Future research should move beyond establishing whether anti-bullying interventions work, towards understanding how they can be implemented effectively, adapted for different contexts and populations, and sustained over time.

This would involve:

- Greater investment in UK-based evaluations to improve understanding of intervention effectiveness and implementation within UK educational contexts.
- Examination of intervention components and implementation burden to identify which elements are most strongly associated with positive outcomes and are feasible to sustain in practice.
- Improved understanding of implementation processes, including the level of ongoing support required for successful delivery.
- Increased attention to vulnerable and marginalised pupil groups, including research examining the effectiveness of interventions for identity-based forms of bullying.
- Direct evaluation of mental health outcomes alongside bullying outcomes to better understand whether reductions in bullying translate into meaningful improvements in wellbeing and psychological distress.
- Greater consistency in the measurement of bullying and mental health outcomes, including the use of validated and developmentally appropriate measures.
- Research in secondary school settings, where the evidence base remains comparatively limited.

Conclusion

This rapid evidence assessment examined the effectiveness of school-based anti-bullying interventions and their impact on bullying and mental health outcomes among children and young people. Overall, the findings suggest that whole-school approaches currently demonstrate the strongest evidence base, with interventions such as KiVa, Learning Together, PRIMA, and LINKlusive showing the most promising and consistent outcomes across studies.

However, intervention effectiveness was not consistent across all studies or settings. Findings across the review suggest that implementation plays an important role in determining intervention success, with factors such as staff engagement, training, leadership support, implementation support, and wider school context influencing outcomes. This highlights the importance of moving beyond questions of whether interventions work towards understanding how they can be implemented effectively and sustainably within real-world school environments.

Overall, the findings support the continued use and development of whole-school anti-bullying approaches while highlighting the need for further research examining which intervention components are most effective, how interventions can be implemented successfully within diverse school settings, and how outcomes relating to wellbeing and vulnerable pupil groups can be more consistently addressed.

Given the substantial evidence linking bullying involvement to poorer mental health outcomes across the life course, anti-bullying interventions should be considered not only as educational or safeguarding initiatives, but also as important components of broader public mental health and prevention strategies.

Methodology appendices

Appendix 1: Search strategy

The search strategy has been structured around three core concepts: **bullying**, **school context**, and **intervention**.

Following initial testing, the strategy was refined to improve relevance. In particular, intervention-related terms are restricted to the **title field,** which helps prioritise studies that explicitly evaluate or describe interventions, rather than those that only mention them.

(bully* OR "peer victimisation" OR "peer victimization" OR "bullying perpetration")

AND

(school* OR "primary school*" OR "secondary school*" OR pupil* OR student*)

AND

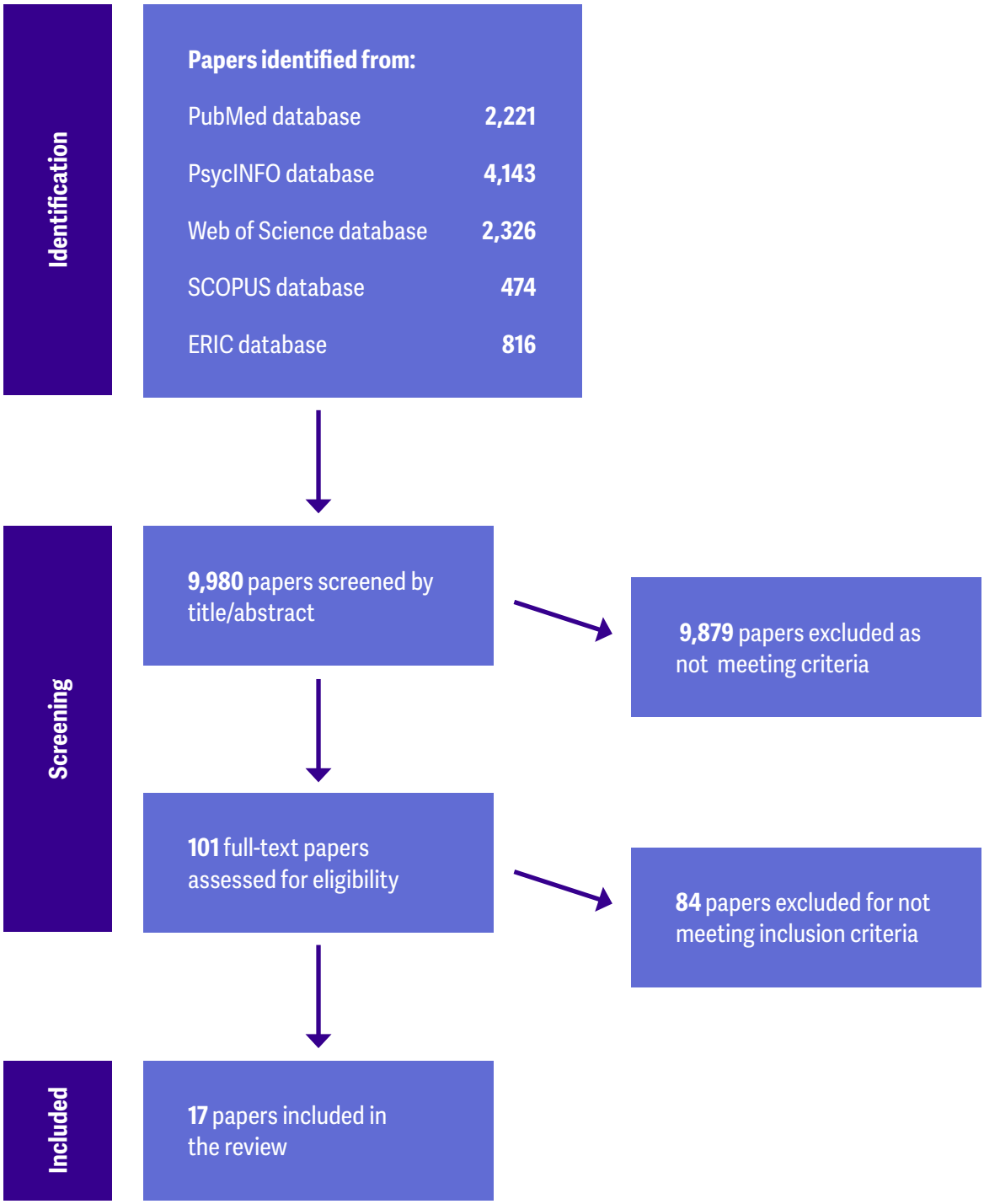
TITLE (intervention* OR program* OR programme* OR prevention OR "anti-bullying" OR "whole school" OR "school-wide")

The search remains intentionally broad in terms of geography. UK relevance will be assessed during screening and data extraction, allowing inclusion of evidence from comparable contexts where appropriate.

Appendix 2: Inclusion and exclusion table

Category	Inclusion criteria	Exclusion criteria
Population	Children and young people aged under 18 attending educational settings (e.g. primary, secondary, and further education colleges).	Adults (18+) and non-educational populations.
Intervention	School-based anti-bullying interventions, including whole-school approaches and other structured activities (e.g. classroom programmes, awareness initiatives, campaigns, policies, tools).	Non-school interventions, purely clinical. Broad non-replicable non-intervention factors such as 'school-culture.
Outcomes	Must include a measure of bullying behaviour or victimisation. Mental health and type of bullying outcomes will be extracted where reported.	No bullying related outcomes.
Study type	Peer-reviewed empirical studies (quantitative, qualitative, or mixed methods) with accessible full texts.	Grey literature, opinion pieces, conference abstracts, editorials.
Setting	Delivered within or through school settings (including state, private, and special education schools).	Interventions delivered exclusively outside school settings.
Bullying concept	Studies that define or align with recognised conceptualisations of bullying (e.g. repetition, intent, power imbalance).	Studies that do not define or align with recognised conceptualisations of bullying (e.g. studies focusing solely on general aggression or conflict without reference to bullying).
Focus	Whole school or targeted interventions.	Interventions delivered out of school contexts.
Language	English.	Non-English.
Location	Schools in developed economies e.g. Europe, North America, Australasia.	Schools in developing economies.
Timeframe	Last 10 years.	Outside timeframe.

Appendix 3: Screening flowchart



References

1. Hawker, D. S., & Boulton, M. J. (2000). Twenty years' research on peer victimization and psychosocial maladjustment: A meta-analytic review of cross-sectional studies. *The Journal of Child Psychology and Psychiatry and Allied Disciplines,* 41(4), 441-455.
2. Moore, S. E., Norman, R. E., Suetani, S., Thomas, H. J., Sly, P. D., & Scott, J. G. (2017). Consequences of bullying victimization in childhood and adolescence: A systematic review and meta-analysis. *World journal of psychiatry,* 7(1), 60.
3. Midgett, A., & Doumas, D. M. (2019). Witnessing bullying at school: The association between being a bystander and anxiety and depressive symptoms. *School mental health,* 11(3), 454-463.
4. Hunter, S. C., & Boyle, J. M. (2002). Perceptions of control in the victims of school bullying: The importance of early intervention. *Educational research,* 44(3), 323-336.
5. McGorry, P., Gunasiri, H., Mei, C., Rice, S., & Gao, C. X. (2025). The youth mental health crisis: analysis and solutions. *Frontiers in Psychiatry,* 15, 1517533.
6. Ttofi, M. M., Farrington, D. P., Lösel, F., & Loeber, R. (2011). Do the victims of school bullies tend to become depressed later in life? A systematic review and meta-analysis of longitudinal studies. *Journal of aggression, conflict and peace research,* 3(2), 63-73.
7. Takizawa, R., Maughan, B., & Arseneault, L. (2014). Adult health outcomes of childhood bullying victimization: evidence from a five-decade longitudinal British birth cohort. *American journal of psychiatry,* 171(7), 777-784.
8. Copeland, W. E., Wolke, D., Angold, A., & Costello, E. J. (2013). Adult psychiatric outcomes of bullying and being bullied by peers in childhood and adolescence. *JAMA psychiatry,* 70(4), 419-426.
9. Giuliani, A., Petruccelli, I., & D'Urso, G. (2025). Longitudinal Evidence on Peer Victimisation and Persistent Mental Health Outcomes in Youth: A Systematic Review. *Behavioral Sciences,* 15(12), 1734.
10. Lawrence, S. E., McMorris, B. J., Simon, K. A., Gower, A. L., & Eisenberg, M. E. (2023). Bullying involvement at the intersection of gender identity/modality, sexual identity, race, ethnicity, and disability: Prevalence disparities and the role of school-related developmental assets. *LGBT health,* 10(1_suppl), S10-S19.
11. Earnshaw, V. A., Reisner, S. L., Menino, D. D., Poteat, V. P., Bogart, L. M., Barnes, T. N., & Schuster, M. A. (2018). Stigma-based bullying interventions: A systematic review. *Developmental review,* 48, 178-200.
12. Salafia, C., Renley, B. M., Simon, K. A., Brousseau, N. M., Eaton, L., & Watson, R. J. (2024). Bias-based bullying among sexual and gender minority youth living with disabilities. *Annals of LGBTQ Public and Population Health,* 5(3), 318-334. doi.org/10.1891/lgbtq-2023-0033
13. Bayram Özdemir, S., Caravita, S. C. S., & Thornberg, R. (2024). Bias-based harassment and bullying: addressing mechanisms and outcomes for possible interventions. *European Journal of Developmental Psychology,* 21(4), 505-519. doi.org/10.1080/17405629.2024.2376047
14. Gorman, E., Harmon, C., Mendolia, S., Staneva, A., & Walker, I. (2021). Adolescent school bullying victimization and later life outcomes. Oxford Bulletin of Economics and Statistics, 83(4), 1048-1076. doi.org/10.1111/obes.12432
15. Sigurdson, J. F., Undheim, A. M., Wallander, J. L., Lydersen, S., & Sund, A. M. (2015). The long-term effects of being bullied or a bully in adolescence on externalizing and internalizing mental health problems in adulthood. Child and adolescent psychiatry and mental health, 9(1), 42.
16. Jantzer, V., Ossa, F. C., Eppelmann, L., Parzer, P., Resch, F., & Kaess, M. (2022). Under the skin: does psychiatric outcome of bullying victimization in school persist over time? A prospective intervention study. *Journal of Child Psychology and Psychiatry,* 63(6), 646-654.
17. Salmivalli, C., Kärnä, A., & Poskiparta, E. (2011). Counteracting bullying in Finland: The KiVa program and its effects on different forms of being bullied. *International Journal of Behavioral Development,* 35(5), 405-411.
18. Fekkes, M., Pijpers, F. I., & Verloove-Vanhorick, S. P. (2006). Effects of antibullying school program on bullying and health complaints. *Archives of pediatrics & adolescent medicine,* 160(6), 638-644.
19. Axford, N., Bjornstad, G., Clarkson, S., Ukoumunne, O. C., Wrigley, Z., Matthews, J., ... & Hutchings, J. (2020). The effectiveness of the KiVa bullying prevention program in Wales, UK: Results from a pragmatic cluster randomized controlled trial. *Prevention science,* 21(5), 615-626.

20. Clarkson, S., Bowes, L., Coulman, E., Broome, M. R., Cannings-John, R., Charles, J. M., Edwards, R. T., Ford, T., Hastings, P., Hayes, R., Patterson, P., Segrott, J., Townson, J., Watkins, R., Badger, J., Hutchings, J., Fong, M., Gains, H., Gosalia, H., Jones, A., Longdon, B., Lugg-Widger, F., Mitchell, S. B., & Murray, C. (2022). The UK stand together trial: Protocol for a multicentre cluster randomised controlled trial to evaluate the effectiveness and cost-effectiveness of KiVa to reduce bullying in primary schools. *BMC Public Health,* 22(1). doi.org/10.1186/s12889-022-12642-x

21. Bonell, C., Allen, E., Warren, E., McGowan, J., Bevilacqua, L., Jamal, F., ... & Viner, R. M. (2018). Effects of the Learning Together intervention on bullying and aggression in English secondary schools (INCLUSIVE): a cluster randomised controlled trial. *The Lancet,* 392(10163), 2452-2464.

22. Hikmat, R., Yosep, I., Hernawaty, T., & Mardhiyah, A. (2024). A Scoping Review of Anti-Bullying Interventions: Reducing Traumatic Effect of Bullying Among Adolescents. Journal of Multidisciplinary Healthcare, 17, 289-304.

23. Bonell, C., Dodd, M., Allen, E., Bevilacqua, L., McGowan, J., Opondo, C., ... & Viner, R. M. (2020). Broader impacts of an intervention to transform school environments on student behaviour and school functioning: post hoc analyses from the INCLUSIVE cluster randomised controlled trial. *BMJ open,* 10(5), e031589.

24. Melendez-Torres, G. J., Allen, E., Viner, R., & Bonell, C. (2022). Effects of a whole-school health intervention on clustered adolescent health risks: Latent transition analysis of data from the INCLUSIVE trial. Prevention Science, 23(1), 1-9.

25. Nocentini, A., & Menesini, E. (2016). KiVa anti-bullying program in Italy: Evidence of effectiveness in a randomized control trial. *Prevention science,* 17(8), 1012-1023.

26. Huitsing, G., Lodder, G. M., Browne, W. J., Oldenburg, B., Van der Ploeg, R., & Veenstra, R. (2020). A large-scale replication of the effectiveness of the KiVa antibullying program: A randomized controlled trial in the Netherlands. *Prevention science,* 21(5), 627-638.

27. Klocek, A., Kollerová, L., Havrdová, E., Kotrbová, M., Netík, J., & Pour, M. (2024). Effectiveness of the KiVa anti-bullying program in the Czech Republic: A cluster randomized control trial. *Evaluation and program planning,* 106, 102459.

28. Hutchings, J., Pearson, R., Babu, M., Clarkson, S., Williams, M. E., Badger, J. R., ... & Bowes, L. (2025). Participants' roles in bullying among 7–11 year olds: Results from a UK-wide randomized control trial of the KiVa school-based program. *Behavioral Sciences,* 15(2), 236.

29. van Verseveld, M. D., Fekkes, M., Fukkink, R. G., & Oostdam, R. J. (2021). Effects of implementing multiple components in a school-wide antibullying program: A randomized controlled trial in elementary schools. *Child development,* 92(4), 1605-1623

30. Arango, C., Martín-Babarro, J., Abregú-Crespo, R., Huete-Diego, M. Á., Alvariño-Piqueras, M., Serrano-Marugán, I., & Díaz-Caneja, C. M. (2024). A web-enabled, school-based intervention for bullying prevention (LINKlusive): a cluster randomised trial. *EClinicalMedicine,* 68.

31. Acosta, J., Chinman, M., Ebener, P., Malone, P. S., Phillips, A., & Wilks, A. (2019). Evaluation of a whole-school change intervention: Findings from a two-year cluster-randomized trial of the restorative practices intervention. *Journal of youth and adolescence,* 48(5), 876-890.

32. Cross, D., Shaw, T., Epstein, M., Pearce, N., Barnes, A., Burns, S., ... & Runions, K. (2018). Impact of the Friendly Schools whole school intervention on transition to secondary school and adolescent bullying behaviour. European Journal of Education, 53(4), 495-513.

33. Zambuto, V., Palladino, B. E., Nocentini, A., & Menesini, E. (2020). Voluntary vs nominated peer educators: A randomized trial within the NoTrap! Anti-Bullying Program. *Prevention Science,* 21(5), 639-649.

34. Kelly, E. V., Newton, N. C., Stapinski, L. A., Conrod, P. J., Barrett, E. L., Champion, K. E., & Teesson, M. (2020). A novel approach to tackling bullying in schools: personality-targeted intervention for adolescent victims and bullies in Australia. *Journal of the American Academy of Child & Adolescent Psychiatry,* 59(4), 508-518.

35. Greif Green, J., Holt, M. K., Oblath, R., Robinson, E., Storey, K., & Merrin, G. J. (2020). Engaging professional sports to reduce bullying: An evaluation of the Boston Vs. Bullies program. *Journal of school violence,* 19(3), 389-405.

36. Agley, J., Jun, M., Eldridge, L., Agley, D. L., Xiao, Y., Sussman, S., ... & Gassman, R. (2021). Effects of ACT Out! Social issue theater on social-emotional competence and bullying in youth and adolescents: Cluster randomized controlled trial. *JMIR mental health,* 8(1), e25860.

37. Hoekstra, N. A., van den Berg, Y. H., Lansu, T. A., Peetz, H. K., Mainhard, M. T., & Cillessen, A. H. (2024). Can classroom seating arrangements help establish a safe environment for victims? A randomized controlled trial. *Aggressive Behavior,* 50(5), e22173.

38 . Place2Be, *Learning Together for Mental Health Programme.* www.place2be.org.uk/our-services/schools/learning-together-for-mental-health/ (accessed 1st July 2026)

39 . Hong QN, Pluye P, Fàbregues S, Bartlett G, Boardman F, Cargo M, Dagenais P, Gagnon M-P, Griffiths F, Nicolau B, O'Cathain A, Rousseau M-C, Vedel I. *Mixed Methods Appraisal Tool (MMAT), version 2018.* Registration of Copyright (#1148552), Canadian Intellectual Property Office, Industry Canada.

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