Open Research Online

The Open University's repository of research publications and other research outputs

Forced Marriage: Prevalence and Service Response

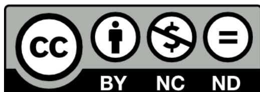
Other

How to cite:

Kazmirski, Anne; Keogh, Peter; Kumari, Vijay; Maisie, Ruth; Gowland, Sally; Purdon, Susan and Khanum, Nazia (2009). Forced Marriage: Prevalence and Service Response. Department of Children, Schools & Families (DCSF), London.

For guidance on citations see FAQs.

© 2009 National Centre for Social Research


https://creativecommons.org/licenses/by-nc-nd/4.0/

Version: Version of Record

Link(s) to article on publisher's website:
http://www.natcen.ac.uk/media/23519/forced-marriage-prevalence-service.pdf

Copyright and Moral Rights for the articles on this site are retained by the individual authors and/or other copyright owners. For more information on Open Research Online's data policy on reuse of materials please consult the policies page.

oro.open.ac.uk

Research Report DCSF-RR128

Forced Marriage

Prevalence and Service Response

Anne Kazimirski, Peter Keogh, Vijay Kumari, Ruth Smith, Sally Gowland, Susan Purdon with Nazia Khanum

National Centre for Social Research

department for children, schools and families

Research Report No
DCSF-RR128

Forced Marriage - Prevalence and Service Response

Anne Kazimirski, Peter Keogh, Vijay Kumari, Ruth Smith, Sally Gowland, Susan Purdon with Nazia Khanum

National Centre for Social Research

The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Children, Schools and Families.

© National Centre for Social Research 2009

ISBN 978 1 84775 467 7

July 2009

Contents

Acknowledgements & Authors i

Abbreviations ii

Executive Summary 1

1 Introduction 10
- 1.1 What is FM? 10
- 1.2 Aims of the study 11
- 1.3 Research design and conduct 12
  - Qualitative analysis and reporting 13
- 1.4 Qualitative case study LA profiles 14
  - Local Authority A 14
  - Local Authority B 14
  - Local Authority C 15
  - Local Authority D 15
- 1.5 Report structure 15

2 Previous research on reasons for FM and barriers to identification 16
- 2.1 Reasons for FM 16
- 2.2 Types of FM 17
- 2.3 Circumstances behind FM 18
  - Withdrawal from education 18
  - Multiplicity of perpetrators 18
- 2.4 Barriers to seeking help 18
  - Fear of speaking out 18
  - Isolation overseas 19
  - Lack of specialist services 19
  - Lack of access to services 20
- 2.5 Barriers to effective service provision 20
  - Lack of multi-agency working 20
  - Denial of problem 20

3 Profile and Prevalence of FM 21
- 3.1 Profile of FM 22
- 3.2 Prevalence of FM 24
  - FM cases known to local organisations 24
  - FM cases known to national organisations 25
  - Estimating a maximum 26
  - Estimating a minimum 27
- 3.3 Summary 27

4 The service response 29
- 4.1 Co-ordination of service response 29
  - Main drivers of FM co-ordination 30
  - FM policies 31
  - Recording FM and sharing data 32
- 4.2 Capacity-building 33

Multi-agency seminars and conferences 33
Staff training 33
Developing BME community representation and involvement 34
Information-gathering for review and planning 34
Developing multi-agency case response 35
4.3 Barriers to FM co-ordination 35

5 Detection 36
5.1 FM referrals 36
5.2 Factors preventing detection 37
Varying perceptions of FM prevalence 37
Affected communities ‘hard to reach’ 37
FM detection not a priority 38
FM as a politically and culturally sensitive issue 38
Lack of professional understanding of FM 38
Language barrier and lack of access to interpretation services 38
Lack of reporting sites and lack of local 24hour contact points 39
5.3 Factors facilitating detection 39
Perception of FM as a clear abuse of young people’s right to choose who they marry 39
Empowerment of young people through information about their rights 39
Raising awareness of FM among teachers, Learning Mentors and Personal Advisors 40
Multi-agency FM training for professionals 40
A focus on listening, signposting, and protection services 40
Information-sharing protocols between agencies 40
Using direct methods of communication with young people 40

6 Case response and management 42
6.1 Case response 42
Capacity of partner agencies 43
Taking FM seriously 43
Cultural sensitivity 43
Compartmentalisation / culture of referral 44
Attitudes / perceptions of the victim 44
Differences in partners’ expertise 44
Differences in professional practices and norms 44
6.2 Pitching the level of response 46
6.3 Case co-ordination 46
6.4 Attitudes towards the use of FMPOs 47
6.5 Barriers to effective case response and management 48
6.6 Facilitators to effective case response and management 48
6.7 Key features of good response 49
Where the case was deemed to be high-risk 49
Where the young person had left home 50
Other key aspects 50

7 Prevention & awareness-raising 51
7.1 Prevention activities undertaken 51
Activities with young people 51
7.2 Activities with parents and the wider community 52
7.3 Barriers to undertaking successful prevention activities 53
Lack of resources 53
Unclear responsibilities 53
Cultural sensitivity 54
Lack of knowledge and confidence 54
Community and gender barriers 54
Lack of trust in agencies 54
7.4 Facilitators to undertaking successful prevention activities 55
Increasing dialogue 55
Making the most of established relationships 55
Learning from and sharing good experiences 55
Sensitive contextualising 55
8 Conclusions and recommendations 56
8.1 Framing and responding to FM 56
8.2 Better co-ordination and capacity-building 56
8.3 Better resourcing of BME VCOs 58
8.4 Better engagement and understanding 58
8.5 Better prevention 59
8.6 Better detection 60
8.7 Better case management and response 61
8.8 Achieving an adequate response to FM 62
References 63

Acknowledgements & Authors

We would like to thank Joanne Harker at the Department for Children, Schools and Families, and Suzelle Dickson and Sarah Russell at the Forced Marriage Unit for their support and valuable feedback at various stages in the study.

A number of NatCen colleagues contributed to the project, and we would like to extend our thanks to Ivonne Wollny, Tricia Jessiman and Alice Reeves. We are also very grateful to all the professionals who took part in interviews, and to those who returned data questionnaires for the quantitative element of the study.

Anne Kazimirski is a Research Director in the Families and Children group at NatCen. She is a very experienced quantitative as well as qualitative researcher, specialising in families and children policy. Her main area of interest is family well-being, with specific experience in the areas of domestic violence, family separation and child maintenance.

Peter Keogh is a Qualitative Research Director in the Families and Children group at NatCen. He has specific expertise in managing mixed methods in research and evaluation as well as research for policy development. His main areas of interest are relationships and family life, sexual behaviour as well as marginalized and excluded groups.

Vijay Kumari is a very experienced Independent Consultant in Research and Evaluation. She has extensive experience of working in the HIV/AIDS, BME, and Children's sectors. She has specific experience of evaluating policy initiatives for families, children and young people.

Ruth Smith is a Senior Researcher in the Families and Children Group at NatCen. Ruth has extensive training in research methods and statistics, and has a strong interest in both quantitative research and secondary analysis. Her projects to date have focused on childcare and on the interface between work and family life.

Sally Gowland is a Researcher in the Families and Children Group at NatCen. Her research interests are in gender issues and mixed-methods research.

Susan Purdon is a Quantitative Methods Advisor in the Survey Methods Unit at NatCen. Susan has extensive experience of complex design and analysis on numerous sample surveys, social experiments, and quasi-experiments.

Nazia Khanum is the director of Equality in Diversity, an independent consultancy in management, research and training. Nazia has extensive experience of undertaking research on forced marriage affecting children and young people, and working with victims. Her latest research study in this area - 'Forced marriage, family cohesion and community engagement: national learning through a case study of Luton' - was published in March 2008.

Abbreviations

ACPO	Association of Chief of Police Officers
BME	Black and Minority Ethnic
CME	Children Missing from Education
CP	Child Protection
CPS	Crown Prosecution Service
CS	Children's Services
CSU	Community Safety Unit
DCSF	Department for Children, Schools and Families
DV	Domestic Violence
EWO	Education Welfare Officer
FCO	Foreign and Commonwealth Office
FE	Further Education
FM	Forced Marriage
FMPO	Forced Marriage Protection Order
FMU	Forced Marriage Unit
HBV	Honour-Based Violence
LA	Local Authority
LSCB	Local Safeguarding Children Board
MARAC	Multi-Agency Risk Assessment Conference
NatCen	National Centre for Social Research
NRPF	No Recourse to Public Funds
PCT	Primary Care Trust
PPU	Public Protection Unit
PSHE	Personal, Social, Health & Economic Education
VCO	Voluntary and Community Organisations

Executive Summary

1. Introduction

1.1 Research aims

The Department for Children, Schools and Families (DCSF), with the support of the Forced Marriage Unit (FMU), commissioned the National Centre for Social Research (NatCen) to carry out research on the issue of forced marriage (FM) in England.

The research had a particular focus on UK resident children and young people under 18 years of age. It aimed to inform policy across Government and to feed into new guidelines supporting statutory responsibility for FM.

There were two key research aims:

- To improve our understanding of the prevalence of FM.
- To examine the way services are currently responding to cases of FM.

An FM is a marriage in which one or both spouses do not (or, in the case of some vulnerable adults, cannot) consent to the marriage and duress is involved. The majority of FMs involve a young female victim, but young men can also be victims. Around one-third of the cases handled by the FMU involve children under 18 years of age.

The majority of FM cases take place among South Asian communities, such as Pakistani, Bangladeshi and Indian communities. However, FMs also take place among other communities, especially from Africa, the Middle East and parts of Eastern Europe. The types of abuse by which a victim of FM may be harmed are wide-ranging and include physical abuse, sexual abuse, psychological abuse, financial or material abuse, neglect, and discrimination. FM can be seen as a form of 'honour'-based violence (HBV), and may involve murder (so called 'honour killing').

1.2 Research methods

- Our methodology had four components: a literature review, a mapping study, a quantitative data sourcing and analysis exercise, and a qualitative case study element.
- Prevalence was examined using quantitative data collected through a short questionnaire distributed to local organisations across ten selected local authorities (LAs). Data was gathered from a total of 58 local organisations and analysed in conjunction with data from national organisations. The aim was to generate a broad, general estimate, given the time and budget available for this exercise.
- For the qualitative case study element, four LAs with relatively high prevalence of FM were selected, and 40 in-depth interviews carried out between January and April 2009 with key stakeholders from local statutory and voluntary organisations. The qualitative investigation aimed to identify and critically describe front-line responses to FM, prevention of FM, models of good or poor practice, and good practice impediments and facilitators.

2. Main findings

2.1 Prevalence

- Based on the data on the number of FM cases (either actual FM or the threat of FM) encountered by local organisations and the key national organisations, the national prevalence of *reported* cases of FM in England is estimated to be between 5,000 and 8,000. This estimate does not include a potentially large number of victims who have not come of the attention of any agencies or professionals, since a large general population survey would be required to estimate the prevalence of these 'hidden' victims.

- Of the FM cases reported to local organisations, almost two-thirds related to threats of marriage (62%) and just over one-third (38%) related to marriages that had taken place.

- Whilst FM is not exclusively an issue for Asian communities, 97% of those seeking help or advice relating to FM from local organisations were identified as Asian. This closely reflects the data regarding country of origin held by the FMU for the cases which have come to their attention, where in 2008 64% of cases related to Pakistani victims, 15% related to Bangladeshi victims, and 8% related to Indian victims.

- 96% of FM cases reported to local organisations related to female victims and only 4% to male victims. This represents a smaller proportion of male cases than reported by both the FMU and Karma Nirvana (the largest national organisation providing support to victims of FM) whose proportions of male cases or enquiries in 2008 were 14% and 43% respectively.

- Within local organisations, 41% of reported cases concerned victims under the age of 18.

2.2 Co-ordination of FM response

- Responsibility for co-ordinating a multi-agency local response to FM was formally situated within LA domestic violence (DV) co-ordination structures and processes.

- The quality of FM co-ordination was significantly affected by existing levels of DV resource and capacity within each of the four LAs, with under-resourced LAs tending to struggle with FM co-ordination responsibilities.

- In some LAs concerns were voiced about the level of disengagement with the DV / FM agenda from certain agencies such as Education and Housing.

- FM training did not appear to be core or mandatory for any group of professionals, and lacked co-ordination. FM training was most commonly reported to be included in DV or child protection (CP) training courses and targeted at front-line staff.

- Inconsistent levels of awareness of FM, FMU guidelines, and Forced Marriage Protection Orders (FMPOs), across agencies and among professionals within the same agency, were commonly reported. A need for more training was expressed particularly in relation to agencies' roles.

- FM co-ordination across the LA areas was largely driven by a small group of individuals, often Black and minority ethnic (BME) professionals working in the voluntary sector. In one LA, the police were at the forefront of driving a multi-agency local response to FM.

- The BME voluntary sector was perceived as performing a central role in addressing the gaps in statutory FM co-ordination, which included a wide range of activities such as capacity-building and staff training; FM prevention work with young people; supporting victims; and community development work. Such activities were commonly undertaken without LA funding or with very limited resources and capacity.

- Developing BME representation, participation and involvement was seen by several statutory agencies as an appropriate means to progressing FM-related work and developing their own cultural expertise.

- Multi-agency sharing of statistical FM data was generally not coordinated, although some agencies across all the LAs indicated they had begun to take initial steps to address this gap. Statutory agencies in particular reported that they had started an information-gathering and -sharing process to improve inter-agency understanding of the nature and scale of FM locally.

2.3 Detection

Direct reporting of FM by young people or via concerned friends was a typical way in which schools, colleges, youth agencies and the BME DV / FM voluntary sector identified cases. Direct reporting to the police was much less common with the exception of one LA where the police had experienced steady increases in direct reporting as a result of actively increasing their own capacity to detect and respond to FM. For many statutory agencies and generic DV agencies, FM tended to be hidden behind other more obvious presenting issues such as physical abuse, eating disorders or self-harm, and only transpired once professionals had started working on these.

2.3.1 Factors that may impede detection

- Varying perceptions of FM as a relatively small issue with a high profile, or as a growing problem with inadequate resources.

- Affected communities being ‘hard to reach’ and mistrusting of statutory agencies.

- FM detection not a strategic focus for LAs because of competing priorities.

- Lack of professional understanding of FM.

- Language barrier and lack of access to appropriate interpretation services.

- Lack of reporting sites and local 24 hour contact points for young people with limited freedoms.

2.3.2 Factors that may facilitate detection

- Raising awareness of FM as an abuse of young people’s rights to choose who they marry.

- Empowering young people and providing them with information on their rights.

- Raising awareness of FM among teachers, Learning Mentors and Personal Advisors.
- Multi-agency FM training for professionals.
- A focus on listening, signposting, and protection services.
- Information-sharing protocols between agencies.
- Using direct methods of communication with young people.

2.4 Case response

The nature and quality of case response and management varied between LA areas, and within areas there were differences in understanding of what might constitute a case of FM and differences of opinion and perspective on what, in turn, an appropriate case response might be. The quality and character of case response depended on the following factors.

- **Capacity of partner agencies**

Agencies, particularly voluntary and community organisations (VCOs), reported limited capacity, a lack of integrated reporting and case management systems, and a lack of appropriate community interpretation services as limiting their response to FM cases.

- **Taking FM seriously & cultural sensitivity**

Key partner agencies such as Education, Welfare and Children's Services (CS) were reported by some to be non-responsive to other agencies' concerns about specific cases of FM, and reluctant to intervene in cases due to dismissing FM as a 'cultural issue'.

- **Compartmentalisation / culture of referral**

Some statutory agencies talked of partner agencies as tending to refer 'difficult' cases on, and as being unaware of CS procedures. They also identified CS as being unwilling to get involved in FM cases involving 16- and 17-year-olds who were able-bodied and mentally stable. Cases of threat of FM without associated physical abuse tended to be seen as lower priority than other DV cases. Professionals expressed specific concerns about the gap in effective case response for 16- to 18-year-old FM victims.

- **Differences in professional practices and norms**

VCOs tended to see a wider range of cases in terms of severity, and in terms of proximity to crisis, while statutory agencies were more likely to see cases which had already reached a crisis. Reflecting their wider range of cases, VCOs did not always see the possibility of FM as an imminent crisis, but variously as part of a process, as a threat or possibly as a way for parents to voice discontent with the behaviour of their children.

For cases where crisis was not deemed imminent, VCOs emphasised empowering the young person to deal with their parents' demands through understanding the meanings and motivations behind the threat of FM. Emphasis was also placed on discussing whether leaving home was the best solution, where circumstances and risk assessment meant that staying at home could be considered. This was combined with very practical strategies to support victims in seeking timely help should the situation escalate.

This approach is heavily dependent on well-informed, accurate risk-assessment, and a full understanding of CP guidance. Nevertheless, a balance needs to be reached between the potentially very high (and sometimes life-threatening) risks associated with the victim staying at home, and a recognition of the full range of FM cases, which, in turn, may require a range of appropriate case management approaches.

- **Attitudes towards the use of FMPOs**

Usage of FMPOs varied according to the area, with little use in one area, whilst in one area the police had been using FMPOs quite extensively. Opinions on the use of FMPOs in case response were mixed, with much confusion as to how they should be applied and concern that their application might be seen, in the short term, as the disproportionate use of legal powers against a minority rather than a legal remedy to a case need. Others (especially those from the voluntary sector) expressed uncertainty about their powers to use the new FMPOs, what their legal role would be and which statutory agencies they would need to involve in taking one out.

2.5 Prevention

2.5.1 Prevention activities with young people

- Schools and colleges were the main locations for prevention activities with young people. For young women with limited freedom and at risk of FM, schools and colleges were seen as potentially the only location for accessing help.

- Activities concentrated on raising awareness of the risks of FM, educating young people on their rights, providing others' testimonies and providing information on the support available. Activities included: distribution of written information and posters; web-based information; training sessions with FM film screenings followed by discussions; and using drama to explore FM.

- The benefits of prevention activities were clear, and the need for more prevention work was expressed. Activities were relatively ad-hoc and there tended to be little overall co-ordination of activities in schools.

- VCOs rather than statutory agencies tended to undertake prevention activities. Local and regional police forces had been involved in some areas, either in delivering talks, or in encouraging the Local Safeguarding Children's Board (LSCB) to plan activities. The FMU had also been directly involved in some activities.

- Some sessions were led by external professionals, while others were delivered by teachers or Personal, Social, Health and Economic Education (PSHE) co-ordinators who had received training and/or materials from external agencies.

2.5.2 Prevention activities with parents and wider community

- Agencies tended to shy away from undertaking such prevention activities, though there were some good practice examples: in one area where good relationships had been developed between the LA and the local Muslim centre, community-based prevention activities were more common. The main initiative consisted of seminars jointly organised by the LA and the local Muslim centre, including one on FM.

- The main example of reaching parents through schools was in relation to Children Missing from Education (CME) initiatives, which involved communicating to parents the importance of education and the school's disapproval of students missing classes or going on extended holidays abroad. This could have an indirect impact on the risk of FM, as such general messages could persuade parents to postpone marriage plans in order for their children to complete their education.

2.5.3 Factors that may impede prevention

- Lack of resources
- Unclear responsibilities for FM within LAs
- Cultural sensitivity
- Lack of FM related knowledge and confidence among professionals
- Community and gender barriers for white, female professionals in particular
- Lack of trust in agencies among affected communities.

2.5.4 Factors / actions that may facilitate prevention

- Increasing dialogue between the LA and affected communities
- Making the most of established community relationships
- Learning from and sharing good experiences
- Sensitive contextualising of FM and its links with wider issues such as DV.

3. Conclusions and recommendations

3.1 Framing of FM

In our four LA areas, a DV framing of FM predominated, mobilising a response involving police and the DV voluntary / statutory sector services. A CP framing (involving the response of schools and CS) appeared to be less effective, less co-ordinated, and less clearly articulated. Our report also describes a human rights response to FM that was predominantly carried out by BME VCOs. The potential for individual cases of FM to fall through the gaps between these three different approaches is great, and the task of co-ordinating these approaches to deliver an integrated response in terms of prevention, detection, case management and response, is a highly challenging one.

We conclude from this research that all three framings of FM and responses are necessary, all must be properly resourced, and effective co-ordination of all three is key to improving the quality of the overall response.

3.2 Better co-ordination and capacity-building

Local co-ordination of FM response and prevention is lacking in strategic direction. There is a need for the national FM strategy framework to focus more closely on developing local co-ordination in relation to FM.

FM is an issue that cuts across numerous policy areas, covering a wide range of statutory structures. Moreover, there is a need to integrate FM further into broader policy on violence against women. We therefore support the Government's initiative to develop a cross-departmental strategy on violence against women and girls, and its proposal to include FM within this.

There is much that could be done on a national level to support co-ordination and capacity-building. Specific national activities might include:

- Developing national training protocols[1], and 'training the trainer' interventions around FM. This should be carried out in partnership with BME voluntary sector organisations;

- Amending and developing national guidelines to address the question of prevention; to state the value of community responses to FM more clearly; to give clearer guidance on co-ordinating disparate responses to FM; and to tackle the question of lack of confidence or reticence among workers;

- Developing data collection protocols for LAs (to inform their response) - these could require the addition of an FM flag on case records and regular collection of these data by an LA-based FM co-ordinator;

- Developing a national database of good practice around preventing FM, and responding to it in a co-ordinated way;

- Considering the potential role of national capacity-building organisations (such as the Improvement and Development Agency for Local Government - IdeA - and the Centre for Excellence & Outcomes in Children's and Young People's Services) in identifying, co-ordinating and improving national, regional and local knowledge about FM.

3.3 Better resourcing of BME VCOs

We recommend additional resources be made available to support the development of FM partnerships between local statutory agencies and local BME VCOs with a strong track record of tackling FM.

3.4 Better engagement and understanding

National training protocols on FM should be accompanied by enhanced resources for the provision of such training, and need to counter inappropriate reticence, fear and cultural over-sensitivity among workers. We also recommend undertaking awareness-raising interventions within the key services. Such training and awareness-raising should provide spaces for workers to speculate on their own assumptions and fears without being judged or proscribed.

3.5 Better prevention

We recommend that prevention work is prioritised at an LA level through:

- Development and implementation of LA FM prevention strategies detailing key aims and objectives, roles and responsibilities of partners, co-ordinating mechanisms, prevention protocols, methods, approaches and outcomes;

---

[1] This is part of the FMU's 2009/10 action plan.

- Central support for local FM prevention work in the form of national prevention co-ordination activities (LA FM prevention strategy template and guidance, conferences, websites, forums, identification and sharing of good practice models etc);

- Increased resources for prevention activities within communities.

3.6 Better detection

This research indicates that better detection and identification of FM lies in young people's capacity to report it. Potential victims are often severely restricted in their movement, with educational settings the only places where they are free from the surveillance of family. We therefore recommend:

- Increasing access to reporting facilities for young people (for example, within schools and colleges, providing a 24hr facility etc.);

- Support for schools, Education Welfare Officers (EWOs) and LA CS and Education Departments to monitor the extent to which CME guidance relating to FM is being followed;

- A focus on improving FM co-ordination and joint working between all key agencies and services in relation to any FM / DV forums or protocols (schools, EWOs, LA CS and Education Departments, police and the voluntary sector);

- Awareness-raising work around FM, focusing on warning signs in schools, colleges, youth settings and within local communities.

3.7 Better case management and response

We make the following recommendations specific to improving case response.

- Increase resources (both financial and infrastructural) to BME and DV VCO sector to improve their capacity to respond to cases of FM appropriately.

- Improve national response protocols to take more account of the human rights perspective used by BME and DV VCO.

- Promote informed, careful risk-assessment, which goes beyond standard CP risk-assessment approaches, to take into account the particular risks associated with FM.

- Promote 'victim-centred' approaches to case management, where the wishes and needs of the victim are prioritised and (subject to a thorough and informed risk assessment) the victim is given more opportunity at an earlier stage to recognise and determine their own best response to the risks they perceive (this may or may not include leaving the family).

- Improve capacity for case-coordination at an LA level.

- Improve protocols for joint working to address gaps in service provision (specifically that for 16- to 18-year-olds), acknowledging that how to address the gap will need to vary according to local capacity, but that responsibilities nevertheless need to be clear.

- Improve guidance for the most appropriate use of FMPOs (in relation to the range of responses available).

- Provide training and awareness-raising for professionals in order to enable them to:

    - challenge damaging practices without being seen to challenge the culture itself;

    - take an 'end-to-end' interest in a case rather than either holding on to a case for too long or referring it on too quickly because it is difficult;

    - understand the range of appropriate ways of responding to FM.

1 Introduction

The Department for Children, Schools and Families (DCSF), with the support of the Forced Marriage Unit (FMU), commissioned the National Centre for Social Research (NatCen) to carry out research on the issue of forced marriage (FM) in England. The project aimed to improve our understanding of the prevalence of FM, and to examine the way services are currently responding to cases of FM in local authorities (LAs). This report presents findings from both the qualitative and quantitative elements of the project. The quantitative part of the project focused on prevalence of FM, while the qualitative research examined service response through a case-study approach to identify examples of best practice in dealing with cases of FM, including a focus on preventative work.

This introductory chapter explains the policy background to the study and the aims and objectives of the research. The design and methods of the study are then described, as well as the structure of the report.

1.1 What is FM?

The definition of FM agreed by the Home Office Working Group on Forced Marriage is "a marriage conducted without the valid consent of both parties, where duress is a factor" (Home Office, 2000). The Court of Appeal clarified that duress is: "[whether the mind of the applicant has been overborne, howsoever that was caused" (Magill and Lee, 2008). FM is therefore a marriage in which one or both spouses do not (or, in the case of some vulnerable adults, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure. FM is therefore distinct from arranged marriage, as in an arranged marriage the family will take the lead in arranging the match but the couples have a choice as to whether to proceed.

Various reports on FM including 'A choice by right' (Home Office, 2000) and the recent Home Affairs Select Committee Report (2008) have increased awareness of the existence of this problem. These reports also established that there is a lack of robust, clear and consistent data maintained by agencies. The Government's Forced Marriage Unit (FMU)[2] received over 1,600 enquiries about FM cases in 2008, but these are likely to represent just the tip of the iceberg.

Previous research suggests that the majority of FMs involve a young female victim, and take place among South Asian communities that display a strong commitment to a sense of 'traditional' values, such as Pakistani, Bangladeshi and Indian communities. However, it has been shown that young men can also be victims of FM, and that FMs take place among other minority communities too, especially from Africa, the Middle East and parts of Eastern Europe (Khanum, 2008).

The Home Affairs Select Committee report (2008), the Government response, the FMU's Statutory Guidance on FM (FMU, 2008) and the media have created a much higher level of awareness about FM in the country than ever before. In addition, the Forced Marriage (Civil Protection) Act 2007 which came into force on 25th November 2008 will hopefully add to this momentum and raise further awareness among victims and local agencies of the current protections in place. The elevation of the FMU's Guidance to a Code of Practice in November 2008 aims to make LAs and statutory agencies more alert to their obligations regarding FM. Multi-agency steering groups are increasingly being set up in LA areas, linked to Domestic Abuse Forums, to deal with issues of FM, child protection, cross-agency

[2] The FMU provides direct support to victims, advice and support to practitioners, and leads on Government policy.

training, information-sharing within the framework of the Data Protection Act, risk-assessment and standardised ways of recordkeeping and monitoring.

Since about a third of the cases handled by the FMU involve children under 18, educational institutions are expected to be alert to the need to protect children at risk of FM. However, the Home Affairs Select Committee raised concerns that the legal framework provided by the Child Protection Act and the guidance provided by the FMU were not being followed consistently by schools or LAs, with regard to identifying risks of FM among children at school, or among those missing or withdrawn from education.

1.2 Aims of the study

There were two key aims for this research. The first was to improve our understanding of the prevalence of FM, and the second was to examine how services are currently responding to cases of FM. The research had a particular focus on children and young people under 18, and aimed to examine FM services and protections in place for UK citizens and residents. The issues facing non-UK citizens brought to the UK for FM (such as no recourse to public funds - NRPF) were hence outside the remit of this project.

The quantitative data collection exercise aimed to improve our understanding of the prevalence and profile of FM, building up a national picture using a combination of national and local data. As there is currently no systematic collection of data on FM cases, the research aimed to explore all possible avenues to piece together the scale of the problem. As the data available was so disparate, and the sources so varied, a key objective was also to assess the quality, representativeness and coverage of the data. Ten LAs were selected for the collection of local data; the aim was to contact all organisations working with victims in those areas, to be analysed in conjunction with data from national organisations.

The key aim of the qualitative part of this project was to explore the services developed by LAs to respond to the problem of FM, with a particular focus on service provision for children and young people. Four LAs were selected for this stage of the research project. A case study approach was used in order to obtain a detailed understanding of the nature and scale of the problem of FM in each LA, the responses to it, and the extent to which the LAs themselves are tackling it. The use of case studies also made it possible to investigate how the problem of FM is ‘framed’ or described within the local context, how it is addressed by a range of key organisations and stakeholders, and how responses are co-ordinated.

The aims of the qualitative investigation were to:

Describe front-line responses to individual cases of FM and the prevention of FM within local communities

- Identify and critically describe models of good and poor practice in this respect
- Identify impediments to and facilitators of good practice.

The research aimed to inform policy across Government, with particular relevance (in addition to DCSF) to the Home Office, the Foreign Office, the Ministry of Justice, the Department for Communities and Local Government, and the Department of Health. This research was also designed to inform and improve new guidelines supporting statutory responsibility for FM, and to prove useful for voluntary sector agencies dealing with FM.

1.3 Research design and conduct

Our methodology had four components: a literature review, a mapping study, a data sourcing and analysis exercise, and a qualitative case study element.

The main purpose of the literature review and mapping study was to inform the subsequent elements of the research, and collate the information available on the profile of victims, the prevalence of FM and the types and availability of support from different agencies. The literature review was conducted using a variety of information sources which included previous research; Government papers and materials, including the Home Affairs Committee report, the Government response, consultation papers and findings, and guidance for professionals; and voluntary group reports, publications and materials.

The mapping study entailed eight interviews (telephone and face-to-face) with key professionals and experts working in the area of FM, with an average length of one hour. We interviewed a range of professionals working in national voluntary groups and national and regional voluntary and statutory agencies.

The quantitative data sourcing and analysis exercise entailed distributing a short questionnaire to a wide range of national, regional and local organisations working with FM victims (focusing on 10 LAs at the local level, with an expected range of low, medium and high prevalence of FM[3]). The questionnaire asked about the number of victims the organisation had dealt with in 2008, and collected socio-demographic profile data on victims. Organisations were identified through a combination of desk research and snowballing (organisations were asked to identify other local agencies working with victims). In total, data from 58 organisations were collected[4].

For the qualitative case study element, four LAs were selected where efforts to tackle FM were already taking place in the statutory and voluntary sectors. As our aim was to examine how services responded to FM, it was decided to focus on LAs with a relatively high prevalence of FM - this should be borne in mind in the interpretation of our findings, as there will be an inevitable slant towards greater support provision than in other areas of the country. Moreover, we chose the four LAs to provide regional variation and diversity in voluntary services networks.

Individual in-depth interviews with key stakeholders provided the bulk of data to inform the qualitative investigation (supplemented by some paired and group interviews). We undertook 40 interviews over the four LAs (each lasting 45 minutes to 1.5 hours). Fieldwork took place between January 2009 and April 2009 using a mixture of telephone and face-to-face interviewing. Each interview was exploratory and interactive in form, based on a topic guide, which listed the key themes and sub-topics to be addressed and specific issues for coverage within each. Although topic guides helped to ensure systematic coverage of key issues across interviews, they were used flexibly, to allow issues of relevance for individual respondents to be covered through detailed follow-up questioning. In this way respondents discussed the issues in their own words and with their own emphasis. All interviews were digitally recorded with the respondents' permission. This was essential for the generation of data of sufficient quality for detailed and rigorous analysis, and to prevent selective reporting. It also allowed the interviewer to concentrate completely on the respondent, picking up essential non-verbal cues and engaging fully in exploratory and responsive questioning.

---

[3] As there is no data available at the local authority level, the expected prevalence was based on anecdotal data from the FMU, and the LAs' ethnicity profile.

[4] Only around half of the organisations contacted responded. However, inspection of the non-responding organisations suggests that these were largely small organisations that would have encountered very few cases of FM if any.

In each area we consulted professionals in both statutory and voluntary agencies. The respondents included:

Statutory sector respondents

- Police - Detective Inspectors, Superintendents, Sergeants
- Domestic Violence (DV) - DV Community Safety Unit (CSU) Officers, DV Outreach Services, DV Co-ordinators
- Child Protection (CP) staff - Directors of Children's Services, Local Safeguarding Children's Board (LSCB) Co-ordinators, Safeguarding Children Co-ordinators, CP Advisors and Co-ordinators
- Education - Education Welfare Officers (EWOs), School Counsellors, Student Services Officers, Personal Advisors
- Local councillors
- Primary Care Trust (PCT) public health managers
- Housing services staff.

Voluntary sector respondents:

- Black / Minority Ethnic (BME) and DV - DV women's groups staff, refuge staff, counselling staff
- Victim Support workers
- Law centre workers
- Youth / Children's Charity workers
- Religious leaders.

Qualitative analysis and reporting

The data was analysed using 'Framework', an Excel-based qualitative analysis tool developed at NatCen that uses a thematic approach to classify and interpret all units of data. It is a systematic and transparent method of analysis which ensures that the analysis process and interpretations resulting from it are grounded in the data and tailored to the study objectives.

The key topics and issues that emerged from the data were identified through familiarisation with transcripts. A framework of key issues was then devised. A series of thematic charts, or matrices, was set up, each relating to a different thematic issue. The columns in each matrix represented the key sub-themes or topics whilst the rows represented individual participants (or groups of participants). Data from each respondent was summarised into the appropriate cell. The context of the information was retained and the page of the transcript from which it came noted, so that it was possible to return to a transcript to explore a point in more detail.

Organising the data in this way enabled the views, circumstances and experiences of all participants to be explored within a common analytical framework both grounded in and driven by their own accounts. The thematic charts allowed for the full range of views and experiences to be compared and contrasted both across and within cases, and for patterns and themes to be identified and explored.

The final stage involved analysis of the charted data in order to identify patterns. The full diversity within a given theme is reflected rather than any numerical dominance within the dataset.

Framework is a systematic and transparent approach which aids validity (the extent to which interpretation is demonstrably rooted in data) and reliability (the extent to which interpretations are shared across the research team).

1.4 Qualitative case study LA profiles

The LAs selected for the project are not identified in this report, but the four LAs selected for the qualitative element are described below.

Local Authority A

This LA is a geographically small but densely populated urban borough in a major city, with a population of around 200,000. Around one quarter of the population is aged under 18, compared with an England average of 18%.

Half of the LA's residents are from BME communities, with the largest group being the Bangladeshi community who make up more than a third of the LA's population. New communities continue to arrive in the LA. Somalis now comprise the second largest BME group and this community continues to grow.

There are dramatic inequalities between people living in the LA. A quarter of households live on less than £15,000 a year, whereas the average salary for those in work is more than £68,000.

The LA is one of the most deprived in the country, with a high unemployment rate relative to other neighbouring LAs. The community is over-represented on some indicators of deprivation, such as overcrowded housing. Overcrowding is a major issue because there are so many large and extended families in the LA.

Local Authority B

This LA is situated within a major city, with a population of around 210,000. Around a third of the LA's population is from a BME group, the largest of which is Indian, followed by Pakistani and Black African. The fastest growing community in relative terms is the Black African community.

The LA has areas of relative deprivation as well as areas of affluence. There is low unemployment, but there are many low-skilled workers and average household incomes and wages are low relative to most neighbouring LAs.

There is a large international airport situated nearby and a considerable proportion of residents are employed at the airport and in related industries. It is also a key industrial and business location, with concentrations of businesses including many multinational companies.

Local Authority C

This LA lies close to a major city. The half of the LA closest to the city is urban in character. The other half is rural and consists of small villages, moorland, hills and deep valleys.

The population of the LA is around 220,000. Population density is high in the urban area of the LA, but low and dispersed in the rural parts. People of BME background represent around 15% of this local authority's population, the largest groups being Bangladeshi and Pakistani.

There are some areas of affluence, but overall prosperity compares poorly with the rest of the country. The employment rate and average wage levels are both lower than regional and national averages.

The local economy is mainly low-skilled, with a lower proportion of professional and managerial jobs than the regional and national averages. Some manufacturing remains, including high tech industries. There is a growing further and higher education sector.

Local Authority D

This LA is a large city, with a population of around one million. The LA has a higher proportion of younger people than average, with almost half of the population aged under 30 years.

Nearly one third of the LA's residents are from BME communities (the largest communities being South Asian), and the ethnic diversity of the city is increasing with new arrivals from Africa and Eastern Europe. The Pakistani community is the biggest ethnic community in this LA. The Indian community is the second largest BME group. This LA is home to other significant BME communities including Somalis and Kurds.

The LA's communities are also diverse in their level of prosperity and well being. Inner areas of the LA and the peripheral housing estates have high levels of multiple deprivation (with the associated problems of crime, poor health and worklessness), but elsewhere there are more affluent suburbs. Local unemployment is well above regional and national averages. The national trend towards declining employment in manufacturing industries is evident locally. In particular there has been a major decline in jobs in car manufacturing.

It is also an important national transport hub for road, rail and air travel.

1.5 Report structure

In Chapter 2, previous research on the circumstances which lead to FM and barriers to identification is summarised. The findings from the quantitative data collection exercise on the prevalence and profile of FM are then provided in Chapter 3. Chapters 4 to 7 cover the findings of the qualitative element of the project, focusing first on the co-ordination of the response to FM across statutory and voluntary agencies, then on the detection of cases, followed by case response, and finally preventative, awareness-raising activities. Conclusions and recommendations are provided in Chapter 8.

2 Previous research on reasons for FM and barriers to identification

Reviews of relevant literature and policy documents were undertaken in order to inform the subsequent elements of the research and to identify key issues which may pertain to our own data. The information sources for the literature review included previous research; Government papers and materials, including the Home Affairs Select Committee report and the Government response, consultation papers and findings, guidance for professionals; and voluntary group reports, publications and materials. The literature review was designed to collate the information available on key issues in FM. These included the barriers to identification of FM at an individual, family and community level, the barriers to seeking help and bringing about change, and the circumstances which lead to FM. The results of the literature review in relation to each of these issues are summarised here.

2.1 Reasons for FM

There are a large number of reasons why FM takes place and these include:

- *Protecting 'family honour'*

  FM has been used to prevent 'unsuitable' relationships (e.g. relationships outside ethnic, cultural, religious or caste groups), and to control unwanted behaviour and sexuality (including perceived promiscuity, or being gay, lesbian, bisexual or transgender), and particularly to control the behaviour and sexuality of women. This is associated with protecting perceived cultural and / or religious ideals and reproducing caste and sectarian communities.

- *Responding to peer group or family pressure*

  Parents can come under pressure from senior relatives to marry their children off. This deference can result in FM. If parents do not agree to an FM they may be attacked themselves.

- *Attempting to strengthen family links*

  FM can be a way of ensuring land, property and wealth remain within a family. It may take place because of a long-standing family commitment or to appease an aggrieved family member. This is often associated with assisting a claim for UK residency and citizenship.

- *Ensuring daughters are married off*

  Some families believe that if their daughters become educated, men from the same ethnic or religious group, especially those brought up abroad, will be less willing to marry them. This fear of being unable to marry off their daughters can lead parents to withdraw their children from school when they approach a marriageable age.

- *Financial gain*

  FM can be a means of alleviating poverty or repaying a debt.

- *Ensuring care*

  FM can be used to ensure care for a vulnerable adult with special needs.

FM can be seen as a form of 'honour'-based violence, which occurs in communities where the concepts of honour and shame are bound-up with the expected behaviour of families and individuals, particularly that of women (Home Affairs Select Committee, 2008). The term 'honour-based violence' refers to crimes of violence (mainly but not exclusively against women) which include assault, imprisonment and murder, where the person is being punished by their family or their community. Victims are punished for actually or allegedly undermining what the family or community believes to be the correct code of behaviour. In transgressing against this correct code of behaviour, the person is perceived to have shown that they have not been properly controlled to conform by their family and this is seen to 'shame' or 'dishonour' the family (FMU, 2008).

2.2 Types of FM

A case of FM can take place in various situations. Known patterns of FM include removing young people from the UK and presenting them with a spouse/marriage abroad, bringing a would-be spouse into the UK to marry a young person against their will, or forcing a wedding between two parties who are residents in the UK. Where a British national has to act as a sponsor for their spouse's immigration to the UK, victims are compelled to support their spouse's immigration and are known as 'reluctant sponsors'. Often family members may have directly threatened them before their interview with an Immigration Officer. This fear prevents most victims from putting on record that their marriage was forced (Uddin and Ahmed, 2000). Nevertheless, the FMU has seen an increase in the number of reluctant sponsors identifying themselves as such.

Violence may be used in cases of FM, and can include murder (so called 'honour killing'). However, FMs do not necessarily involve physical violence - families will often use psychological abuse, blackmail and threats of imprisonment to force their child into marriage. Female victims of FM can be placed under pressure from many family members besides their parents, such as male siblings and extended family. The types and forms of abuse by which a victim of FM may be harmed are hence wide-ranging. They may be subject to physical abuse, sexual abuse, psychological abuse, financial or material abuse, neglect and discrimination (Brandon and Hafez, 2008).

There may be cases where a young person is unaware that a marriage is being planned for them. In cases where the parents are confident that their daughter or son will not agree to the marriage (and therefore do not inform them of their intentions) they may employ other methods to ensure the marriage without consent goes ahead. They may:

- take their daughter / son to their country of origin on the pretence of a holiday then confiscate their passport, refusing to return it unless they agree to the marriage;

- claim to the daughter / son that they will be given a choice to marry who they want, but in fact the list when presented to them constitutes of one person only that the parents have chosen;

- take the more extreme action of drugging their daughter / son to ensure that s/he travels overseas without complaint.

Coercions used to force victims into marriage may involve threats that they will be killed in order to protect the honour of the family (Muslim Arbitration Tribunal, 2008). Within FM, women and girls in particular may endure repeated rape. Resulting pregnancy and childbirth may make them feel unable to leave the marriage.

The number of minors involved in cases handled by the FMU has increased over the last few years. This may be for a variety of reasons including the fact that younger victims will be less aware of their rights and more vulnerable to being emotionally or physically bullied into marriage (FMU, 2005).

Where outside agencies have become involved in an FM case, involving the family and community (e.g. through a family conference, or placing a child with a different family member, or someone from the same community) has been associated with the risk of significant harm to the young person (sometimes resulting in murder). Guidance has hence emphasised that neither families nor communities should be approached or involved if FM is suspected (FMU, 2008).

2.3 Circumstances behind FM

Withdrawal from education

There is evidence that changes in attendance or removal from education may be an indicator of significant safeguarding issues, such as FM. One study identified cases of parents having notified the school that a child was about to undertake an extended holiday to mask plans for FM. Nevertheless, schools should not conclude that every time a young BME girl is taken abroad for an extended family visit it is a cover for forcing her into a marriage (Ofsted, 2008). A consequence of being removed from education can be that young people, especially young girls, may find themselves increasingly isolated from their peers and rarely allowed to leave the family home. This has implications for their educational achievement and future job prospects (Brandon and Hafez, 2008).

Multiplicity of perpetrators

The circumstances and arrangements behind FM can involve a range of family members. Family members are unlikely to identify FM as a problem if the rest of the family colludes in the marriage or does not see it as forced and no-one raises any objections on behalf of the victim. It is noted that it is not only older males (such as fathers or husbands) who are the perpetrators of FM, often other family members of both genders and a variety of ages may be involved.

One research study based on police cases involving FM describe these cases as involving a joint, organised effort against the victim. In roughly a quarter of cases, the victim identified the perpetrator as being their husband or partner. Many of these victims had already been forced into marriage and had come to the police as a result of their husband's behaviour, such as DV and rape / sexual assault. In one in five of the incidents, the perpetrators were female. This highlights that women can play an important part as perpetrators and co–conspirators. The broad range of the perpetrator ages, ranging from younger siblings to great grandparents, highlights how different these types of incidents are from domestic violence or any other form of violence (Homicide Prevention Unit, 2005).

2.4 Barriers to seeking help

Fear of speaking out

Victims of FM may refrain from speaking out or asking for help from someone outside their family / community due to fears of social ostracism, harassment, abuse or violence from the family and/or community. Leaving their families (or accusing them of a crime, or simply approaching statutory agencies for help) may be seen as bringing shame on their own honour and on the honour of their families in the eyes of the community. Many victims fear violent reprisals if they are deemed to have brought shame on the family (FMU, 2008).

Young people may feel that their only option to stop FM is to run away. However, leaving their families can be very hard especially if they have no experience of life away from them.

Isolation overseas

If a young person is taken overseas for the purposes of FM they face many difficulties in accessing help. As well as potentially being subjected to violence or threats of violence, there are specific problems associated with being taken overseas:

- victims may find it impossible to communicate by phone, letter or email;
- they may be denied access to their passports and money;
- they may be unable to speak the local language;
- women may not be allowed to leave the house unescorted;
- they may find themselves in remote areas where even getting to the nearest road can be hazardous;
- they may be unable to obtain assistance from the local police, neighbours, family, friends or taxi-drivers (FMU, 2008).

Lack of specialist services

Previous research has identified a lack of specialist help for victims of FM. One problem associated with services provided by charities and third sector agencies for victims of DV and FM is insufficient focus and a lack of specialised service provision for women from BME backgrounds. It has been argued that as women from BME backgrounds are more likely to suffer from honour-based violence and FM, their experiences are likely to be very different from other DV victims. One advantage of providing specialist services is that it facilitates public discourse on violence against BME women specifically and draws attention to the differences in their experiences (Gill, 2005).

There is evidence of a shortage of generic services for women fleeing DV. Moreover, DV services specifically for BME women are under provided. The network of refuges for BME women has recently had funding reduced significantly as a result of greater focus on generic services, and some refuges have been closed down due to funding cuts (Wilson, 2007).

In one recent study, it was found that some relevant agencies showed a lack of appropriate awareness of official policies and guidelines on FM. Furthermore, there was some evidence that community organisations were reluctant to discuss FM due to a fear of backlash (accusations of racism) against specialist support groups (Gangoli et al., 2006).

One report has identified certain barriers to implementing good practice in agencies which victims of FM may need or want to use (Asian Women's Resource Centre, 2005). Professionals and victims have identified some of these as:

- a lack of foreign language interpreters
- a failure by some to accept that FM is within their remit
- a lack of access to resources

- institutional racism
- a lack of training for statutory agencies
- limited access to safe accommodation
- a lack of awareness of different cultures / cultural sensitivity.

Furthermore, responses from victims noted additional gaps in service provision as:

- a lack of advocacy services to accompany women to court
- a lack of information for women when they arrive in the UK
- very little support in non-Asian areas
- the absence of a distinct service for women of a non-Asian origin
- little knowledge of the risk of FM.

Lack of access to services

Victims of FM can experience difficulties accessing services. Often they are not aware of the services that are available to them or how to access them.

Access to legal services is important for many victims of FM. However, many women experience problems accessing legal services. In cases where a woman is held against her will - either in the UK or overseas - these problems are exacerbated and women often rely on friends, relatives or women's groups to take action on their behalf (Uddin and Ahmed, 2000).

2.5 Barriers to effective service provision

Lack of multi-agency working

Some women's groups have argued that there needs to be a mainstreaming of FM within Violence Against Women and DV strategies. This would also involve increased involvement of BME communities and increased local links between statutory, voluntary and community organisations through Community Safety, Community Planning Partnerships, Racial Equality Councils, Diversity Partnerships and DV Partnerships (Scottish Women's Convention, 2007).

Denial of problem

Some community leaders have denied that FM exists, or have shown hostility towards women resisting FM and the women's organisations which represent them. Some argue that the attack on FM is an attack on certain cultural and religious heritages, or a form of racism or Islamaphobia (Siddiqui, 2003). Some members of the South Asian population have also argued that the differences between arranged marriage and FM are not understood by wider society, and that arranged marriage is often conflated with FM. Although there has certainly been confusion over the difference between arranged marriage and FM (and in some cases this has lead to a reluctance among professionals to intervene in what they perceive as a cultural practice (Khanum, 2008), it is also the case that this argument has been used to defend FM, misrepresenting it as arranged marriage (Deveaux, 2007).

3 Profile and Prevalence of FM

This chapter describes an estimate of the profile and prevalence of reported cases of FM in England, built up through analysis of the cases that are known to voluntary or statutory organisations. This part of the research was designed as a small, quick exercise to improve on the prevalence estimates currently available. Given the limitations to the information available to inform sampling, as well as to the time and budget available for the study, the aim was to generate a broad, general estimate (rather than precise, statistically significant estimates).

As such, the findings are based on data collected from local and national organisations that encounter cases of FM, rather than a population survey. For the local data we focused on ten 'case study' LAs. These LAs were purposively sampled in order to represent those with a range of prevalence of FM (low, medium and high) and varying ethnic minority populations (low, medium and high)[5]. Questionnaires were sent out to these organisations and 58 responses were received; although this represents only half of the organisations contacted, inspection of the non-responding organisations suggests that these were mostly small organisations that would have encountered very few cases of FM if any. A similar data collection questionnaire was also sent to national organisations that might encounter cases of FM. These questionnaires collected information on the number of cases that each organisation had encountered over 2008 as well as data on the profile of those cases.

The definition of FM used throughout this exercise was quite broad, covering any incident where an individual feels that they have been coerced or might be coerced into marrying someone against their will. However, since organisations have different methods of collecting and storing data, the accuracy with which they were able to recall all of the cases that they had encountered across the year is likely to vary. Furthermore, this approach only collected information about *reported* cases of FM and, as discussed in Section 2.4, it is likely that there are a large number of victims who have not come to the attention of any agencies or professionals. These 'hidden' cases are not included in our estimates. As such, the profile of *all* cases of FM may differ from those reported in this chapter if particular groups of people are less likely to report FM than others, and the total number of cases of FM across England is very likely to be higher than the estimate of reported cases provided in this chapter.

The first section of this chapter looks at the profile of reported FM cases in the ten local authorities that were involved in the data collection exercise[6]. The second section reports on our estimate of the national prevalence of cases known to local and national organisations, based on an extrapolation from the number of cases known to local organisations within nine of the LAs (too few responses were received from one of the ten LAs for the prevalence estimate to be robust) plus the cases known to national organisations.

---

[5] As there is no data available at the LA level, the expected prevalence was based on anecdotal data from the FMU and the LAs' ethnicity profile.
[6] The profile of these cases is presented whilst recognising that there may well be some double-reporting, with individuals featuring on more than one return.

3.1 Profile of FM

As can be seen from Table 3.1, the majority of FM cases reported in the ten LAs originated within Asian communities (97%) and among Pakistani families in particular (72%). This reflects the data regarding country of origin held by the FMU for the cases which have come to their attention, where in 2008 64% of cases related to Pakistani victims, 15% related to Bangladeshi victims, and 8% related to Indian victims[7].

Table 3.1 Ethnicity of FM cases in 10 LAs

Base: Cases of FM reported in LA data collection exercise

	Total %
White	+
Black	
African	1
Caribbean	1
Other	0
Asian	
Pakistani	72
Bangladeshi	13
Indian	9
Other	3
Mixed race	0
Other ethnicity	1
Base	*750*

Notes: In 23% of cases, ethnicity was unknown (excluded from the base).
+ denotes a percentage less than 0.5%

Information on whether the cases encountered by organisations related to threats of FM or actual FM was less comprehensively recorded, being unknown for 48% of cases. Nevertheless, the information available suggests that where this was known just under two-thirds of cases related to threats of FM compared to just over one-third which related to actual FM[8] (Table 3.2).

[7] Based on 1,427 cases (which includes enquiries from professionals and victims as well as cases where the FMU provided assistance). In 11% of cases, ethnicity was unknown (excluded from the base).
[8] This information is not available on FMU cases, so no comparison is possible.

Table 3.2 Nature of FM cases (in terms of marriages that had taken place versus threats of marriage) in 10 LAs

Base: Cases of FM reported in LA data collection exercise

	Total %
Marriages that had taken place	38
Threats of marriage	62
Base	*512*

Note: In 48% of cases, the nature of the case was unknown (excluded from the base).

Table 3.3 shows that the overwhelming majority of cases reported within the LA prevalence exercise involved female victims - 96% being female and only 4% being male. This represents a smaller proportion of male cases than reported by both the FMU and Karma Nirvana (the largest national organisation providing support to victims of FM) whose proportions of male cases in 2008 were 14% and 43% respectively[9]. This suggests that local organisations primarily cater for female victims and that there may be demand for services among male victims that is not currently being met at the local level.

Table 3.3 Gender of FM cases in 10 LAs

Base: Cases of FM reported in LA data collection exercise

	Total %
Female	96
Male	4
Base	*796*

Note: In 19% of cases, gender was unknown (excluded from the base).

Within local organisations, 41% of the reported cases involved minors, i.e. children aged under 18 (14% were under 16 and 26% were aged 16-17)[10], 40% involved adults aged 18-23 and 20% involved adults aged 24 or over (Table 3.4). This represents a greater proportion of minors than encountered by the FMU, as only 29% of the FMU cases related to minors[11]. This suggests that younger victims are less likely to approach the FMU than adults, and/or professionals in local organisations are less likely to involve the FMU in cases involving minors than in cases involving adults[12].

[9] FMU data is based on 1,470 cases (which includes enquiries from professionals and victims as well as cases where the FMU provided assistance). In 9% of cases, gender was unknown (excluded from the base). Karma Nirvana data is based on 2,200 cases.
[10] The percentages of the components do not add up to the total because of rounding.
[11] Based on 1,071 cases (which includes enquiries from professionals and victims as well as cases where the FMU provided assistance). In 34% of cases, age was unknown (excluded from the base).
[12] The circumstances where professionals involve the FMU are discussed further in Section 6.1.

Table 3.4 Age of FM cases in 10 LAs

Base: Cases of FM reported in LA data collection exercise

	Total %
Under 16	14
16-17	26
18-23	40
24 or over	20
Base	*643*

Note: In 34% of cases, age was unknown (excluded from the base).

Finally we can see in Table 3.5 that most of the cases of FM encountered by local organisations involved victims with UK citizenship (85%) and only 15% involved victims who were not UK citizens[13].

Table 3.5 Citizenship of FM cases in 10 LAs

Base: Cases of FM reported in LA data collection exercise

	Total %
UK citizen	85
Not UK citizen	15
Base	*651*

Note: In 34% of cases, citizenship was unknown (excluded from the base).

3.2 Prevalence of FM

The data on the number of FM cases encountered by local organisations within the ten LAs, and by Karma Nirvana and the FMU, has been used to estimate the national prevalence of the *reported* cases of FM in England. Our estimate is that the national prevalence of reported cases in 2008 was between 5,000 and 8,000 cases (of either actual FM or the threat of FM). Details about how this estimate was reached can be found in the rest of this section.

FM cases known to local organisations

To estimate the number of FM cases known to local organisations we firstly conducted analysis that looked at the relationship between the number of cases of FM reported in each LA involved in the data collection exercise and the size of the population within that LA. Given the high prevalence of FM cases among Asian communities, shown in Section 3.1, we looked at these relationships separately for the ethnic groups with the highest prevalences of FM. This meant that we looked at the relationship among five groups:

- Asian Pakistani
- Asian Bangladeshi
- Asian Indian
- Other Asian
- Other non-white ethnic groups[14].

[13] This information is not available on FMU cases, so no comparison is possible.

This analysis was conducted on nine LAs because whilst the response from local organisations was generally adequate, too few responses were received from one of the ten LAs for the prevalence estimate to be robust. These nine local authorities reported just under 970 cases of FM (which, as mentioned earlier, includes the threat of FM as well as actual FM). The findings showed statistically significant relationships across LAs between the number of cases of FM among each ethnic group and the population size of that ethnic group[15]. Therefore, based on this data, the estimated rates of FM among the different minority ethnic populations considered are shown in Table 3.6[16]. Assuming that these rates apply across England[17], this would mean that, across the country, *local* organisations encountered approximately 4,000 cases of FM in 2008.

Table 3.6 Rates of FM in different populations, and cases of FM known to local organisations

Base: Cases of FM reported in LA data collection exercise

	Rate in population per 100,000	Size of population	Cases of FM
Asian Pakistani	360	706,539	2,541
Asian Bangladeshi	308	275,394	848
Asian Indian	50	1,028,546	514
Asian other	3	237,810	7
Other non-white ethnic groups	1	2,211,181	15
Total		4,459,470	3,925

FM cases known to national organisations

The largest national agencies providing support to victims of FM are Karma Nirvana and the FMU - the number of cases they encountered in 2008 can be found in Table 3.7, which also shows the estimate of the gender breakdown of their cases, discussed in Section 3.1.

[14] White individuals were not included in the analysis because only one case was reported among this ethnic group.

[15] The relationships were significant for Asian Pakistani, Asian Bangladeshi and Asian Indian groups.

[16] These rates represent the regression coefficients from a weighted linear regression analysis of LAs where the dependent variable was the number of local cases of FM within an ethnic group, and the independent variable was the local population of individuals in that ethnic group.

[17] For instance that the rates apply equally to LAs with a small minority ethnic population as well as to those with a large minority ethnic population, and to areas with different socio-economic profiles to the LAs involved in the data collection exercise.

Table 3.7 Cases of FM known to national agencies

	Cases of FM	
	Karma Nirvana	The FMU[18]
Gender	N	N
Female	1,250	1,400
Male	950	225
Total	2,200	1,625

Given the widely different gender profile of cases encountered by local and national organisations discussed in Section 3.1 it was apparent that some FM cases are likely to be known only to national organisations. Thus, in seeking to generate an estimate of the cases known to both local and national agencies, it is not plausible to assume that the national cases are all counted within local estimates. Instead, the national cases need to be added to the local cases, at least to some degree.

Estimating a maximum

To estimate the maximum number of reported FM cases from the data presented above, we make the most generous possible assumption that all the cases reported to us by local and national organisations are completely independent of each other (that is, every case is known to just one organisation). This scenario is unlikely, but if it were true, the number of FM cases would be the sum of all the cases reported locally and nationally, as presented in Table 3.8. Thus, the maximum number of FM cases reported in 2008 was in the region of 8,000.

Table 3.8 Maximum number of cases

	Cases of FM			
	Local estimate	Karma Nirvana	The FMU	Total
Gender	N	N	N	
Female	3,775	1,250	1,400	6,425
Male	150	950	225	1,325
Total	3,925	2,200	1,625	7,750

[18] For the FMU data, the gender is only known for 1,470 cases, but the gender breakdown has been scaled up here to the total number of enquiries received by the FMU.

Estimating a minimum

To estimate the minimum number of reported FM cases from the data above, we would need to assume that the cases reported by these organisations are not all independent and that there is some degree of double-counting. Some information on the extent of double-counting was available from the data collection questionnaires returned by local organisations, who were asked to estimate the number of their cases they thought were known to other organisations. On aggregate, they reported that this applied to 26% of cases. This information is not available for cases reported by Karma Nirvana or by the FMU.

The most cautious, but unlikely, assumption would be that the extent of double-counting is extremely high. Firstly, all the cases that local organisations indicated were known to other organisations could be excluded (assuming that these are known either to other local organisations or to national organisations); excluding these cases would leave just the cases that were only known to a single local organisation. Secondly, with regard to the national organisations, complete overlap between Karma Nirvana and the FMU could be assumed, and the highest number of *women* reported by either organisation (which was reported by the FMU) could be added to the highest number of *men* reported by either organisation (which was reported by Karma Nirvana). Table 3.9 presents the numbers associated with these assumptions, and the total[19]. Based on these assumptions, the minimum number of FM cases reported in 2008 was in the region of 5,000.

Table 3.9 Minimum number of cases

	Cases of FM			
	Local estimate	Karma Nirvana	The FMU	Total
Gender	N	N	N	
Female	2,800	-	1,400	4,200
Male	125	950	-	1,075
Total	2,925	950	1,400	5,275

3.3 Summary

This chapter describes an estimate of the profile and prevalence of reported cases of FM in England. Whilst FM is not exclusively an issue for Asian communities, 97% of those seeking advice or help relating to FM from organisations were identified as Asian. The majority of victims that seek advice or support from local and national agencies are:

- Women
- Aged 18-23
- UK citizens
- Seeking advice or support regarding the *threat* of FM.

[19] The rationale for adding the highest number of women and men reported by each organisation is that this represents the minimum number of female and male cases known to national organisations. For instance, since Karma Nirvana know about 950 male cases of FM, there must be at least 950 known at the national level. The assumption of complete overlap between Karma Nirvana and the FMU would assume that the 225 male cases known to the FMU are already included within the 950 known to Karma Nirvana, which is why they have not been added separately to the total.

In terms of national prevalence across England, as reported at the start of this section, our estimate is that between 5,000 and 8,000 cases (of either actual FM or the threat of FM) were reported in 2008. It is unlikely that the actual number falls at one extreme or the other, as the extent of double-counting is unlikely to be so high that the minimum estimate applies, and the extent of double-counting is unlikely to be so low that the maximum estimate applies.

However, it is important to bear in mind that this analysis is based only on FM cases that were known to voluntary or statutory organisations, and within this study we have no means of estimating the number or profile of cases of FM that do not come to the attention of any organisation. Such cases *may* represent a substantial proportion of the total number of FM cases in England, and their profile may potentially be very different. Studying this problem would need a very different research approach, probably involving a very large-scale general population survey with sufficient sample numbers from minority ethnic groups for robust prevalence estimation. The sensitivity of the issue would generate particular challenges for data collection, the accepted best method in most similar surveys being face-to-face interviews with respondent self-completion for the most sensitive questions.

4 The service response

Chapters 4 to 7 provide the findings of the qualitative element of the project, focusing first in this chapter on the co-ordination of the response to FM, in Chapter 5 on the detection of cases, followed by case response in Chapter 6, and finally preventative, awareness-raising activities in Chapter 7.

4.1 Co-ordination of service response

Across all four LAs, responsibility for co-ordinating local response to FM was formally situated within DV structures and processes, rather than, for example, CP or LSCB processes. Most respondents indicated this was appropriate on the basis that FM is a specific manifestation of domestic and familial abuse. Some respondents indicated that situating FM within DV was the most practical and realistic option in terms of utilising existing resources and capacity.

DV co-ordination was commonly situated within the local strategic partnerships related to Crime and Disorder Reduction, and was supported through multi-agency DV Forums and associated sub-groups and working parties. DV Co-ordinators tended to have a strategic role focused on the development and implementation of the LA-wide DV strategy but they also took on a range of other responsibilities that included planning and review of local commissioning of DV services, capacity-building activities with the voluntary sector, and acting as a resource for advice and guidance for stakeholders.

Placed within DV co-ordination, the quality of FM co-ordination was significantly affected by the existing levels of DV resources and within each LA. Those LAs that were comparatively better-resourced had an infrastructure that allowed for FM co-ordination responsibilities and activities to be more readily absorbed. In contrast, LAs where DV co-ordination was under-resourced tended to struggle with co-ordinating a multi-agency response to FM.

For example, LAs A and B had DV teams that co-ordinated not only strategy development and implementation but also case response, targeted staff training, and promotion of local DV services. These teams included designated staff members with FM co-ordination responsibilities. In contrast, both LAs C and D co-ordinated FM response through one DV Co-ordinator. These latter DV Co-ordinators voiced general concerns around a lack of DV / FM operational and case management evidence feeding back into strategic development. They also struggled with strategic planning around capacity-building issues such as identifying targeted DV / FM training. It is important to note that the level of DV resources and capacity in a particular LA did not seem related to whether the LA was large or small in terms of population.

The under-resourced LAs also tended to rely more heavily on the local voluntary sector and particularly the BME voluntary sector, not only for FM case response but also to co-ordinate a multi-agency FM strategy. FM co-ordination in under-resourced LAs tended to be in the earlier stages, with activities being undertaken to identify key professionals for FM-specific working parties and gathering information from agencies for strategic decision-making. Better-resourced LA DV teams, on the other hand, were engaging in better-co-ordinated FM activities, for example LA A aimed to present regular updates on FM data and activities to the DV Forum. These LAs also seemed to have stronger relationships with Children's Services (CS), and tended to have dedicated staff carrying out prevention work in schools or BME community development work.

In under-resourced LAs, respondents articulated gaps in FM co-ordination as being a reflection of the local gaps in DV co-ordination. For example, although DV strategies were reported to mention FM, concerns were expressed about the limited ownership of the DV strategy across statutory and voluntary agencies.

Across the LAs, concerns were voiced about the level of disengagement with the DV agenda from certain agencies, especially those perceived to be central to addressing FM. Most commonly Education was identified as sometimes missing from DV Forum membership, and Housing was also mentioned. One DV Co-ordinator was unable to identify an LA staff member with overall responsibility for schools, which halted plans to co-ordinate DV work in schools. Another DV Co-ordinator commented that Education had failed to respond to repeated requests for information on children missing from education or invitations to attend DV Forum meetings.

Some respondents also identified a lack of BME voluntary sector representation on DV Forums, commenting that for many BME organisations, limited resources and capacity were significant barriers to regular attendance at meetings. Others indicated a gap in terms of wider BME community representation such as local BME councillors, religious leaders, and generally a wider cross-section of BME voluntary and community organisations (VCOs).

On the whole, DV Forums were reported to be well-attended and useful for developing inter-agency dialogue and learning. However, several respondents commented on experiencing periods of instability when the 'right' people were not involved. Many also voiced concerns about the widely varying levels of FM understanding and awareness among representatives, particularly as agency representatives changed. As one respondent commented, one minute she could be working with an enthusiastic and informed professional and the next minute they could be replaced by someone with little interest or understanding of FM.

Main drivers of FM co-ordination

In each LA, FM co-ordination appeared to be driven by a small group of individuals, often BME professionals working in the voluntary sector. This was perceived as both a strength, in terms of driving the agenda forward, but also a weakness in terms of the void they left behind when they decided to leave. In one LA, when the Lead for the FM working group left there were no attempts to find a replacement and the FM working group disbanded. The impact of FM co-ordination being driven by a small group of individuals is that levels of activity, particularly when work is done on a voluntary basis, are difficult to sustain over time, and when individuals leave the momentum achieved is disrupted, resulting in lengthy periods of inaction. In one area, a voluntary-led BME FM Forum had disbanded when the Chair left and it had taken the LA over 12 months to reform an LA-led FM working group.

LAs seemed to have found it difficult to address the void that individuals active in regard to FM left behind. Partly, LA inaction was a genuine reflection of under-resourced DV coordination. However, the inaction also seemed to be a reflection of statutory agencies' fears around cultural and political insensitivity. In some LAs, there was heightened awareness of the need for the statutory sector to be culturally sensitive, probably due to a relatively recent local history of racial unrest. Several LA respondents indicated that statutory agencies were reluctant to address FM for fear of cultural insensitivity and BME community backlash (indicating a lack of awareness of BME voluntary sector activity against FM). Police respondents in some areas indicated a lack of understanding of FM, and a lack of confidence in terms of their ability to detect and respond to FM cases. They tended to identify a need to develop closer working links with BME communities, including recruiting more BME Police Officers, in order to help develop their understanding of the local nature and scale of FM.

The BME voluntary sector was generally perceived as performing a central role in addressing the gaps in statutory FM co-ordination, which included a wide range of activities such as capacity-building and staff training, FM prevention work with young people, supporting victims and community development work. It was common to find such activities being undertaken without LA funding or being carried out with very limited resources and capacity. One respondent working in the BME voluntary sector indicated frustration that whilst demand for their FM work in schools was increasing, along with FM referrals, they were unable to increase their level of activity without further funding. Having developed within a grant funding environment, they were also finding it difficult to understand the LA's new tendering process without investing more of their time into attending meetings with the LA.

BME organisations and individuals active in FM co-ordination in the LA areas were not necessarily always working from a DV or CP perspective. Rather, some BME organisations were focused on youth empowerment and supporting young people to make their own decisions. As part of their work, ways of communicating young people's concerns to their parents were sometimes explored (unless avenues for resolving conflict with their parents had already been exhausted by the time they were referred, or they were in a crisis situation). Given the risks associated with involving family in responding to FM, this raises concerns around the need for accurate risk-assessments by such professionals (discussed further in Section 6.1).

In LA D, the local police emerged as a driver of FM co-ordination. This police force had recently recruited a BME Police Officer with a specific remit to deal with FM, who had been actively increasing the force's capacity to detect and respond to FM. As a result they had been experiencing rising numbers of FM reports. They indicated that they had dealt with more than 75 cases of FM over a nine month period and had taken out six Forced Marriage Protection Orders (FMPOs). It was their experience that the LA agencies they worked with lacked understanding of their roles in relation to FM, and were particularly unaware of FMPOs. This police force had taken a lead role in emphasising the need for an integrated multi-agency response, and had initiated several policy and practice discussions with different statutory and voluntary agencies.

FM policies

In one LA, the DV Forum had produced an FM protocol and were in the process of updating practice guidance for frontline staff. In two other areas, those responsible for DV co-ordination had not produced FM-specific guidelines or protocols but were waiting for FM-specific working groups to meet and take on responsibilities for reviewing policy and practice. A key aspect of these planned working groups involved the DV Co-ordinators and LSCBs working in parallel in the review and planning of FM co-ordination. This joint working relationship was seen as crucial in terms of achieving a level of consistency in the approach to FM between DV and CP perspectives.

In one LA, the LSCB's DV sub-group had produced an FM protocol covering child protection issues, but there were doubts expressed about the extent of ownership and use of this beyond Social Care. This LSCB had not gathered feedback from Social Care about its use of the FM Protocol so were unable to comment on its use and impact.

DV Co-ordinators were not necessarily aware of the extent to which other agencies had made progress in relation to FM policies and practices, as operational remits lay with individual agencies. However, BME and DV voluntary sector respondents indicated that they had been involved in developing DV / FM policies and guidance with specific local statutory organisations. For example, in one LA, they had worked closely with Housing, and in another, they had worked with worked with a wide range of agencies to raise awareness of FMU guidelines and to develop agency-specific guidelines.

Statutory respondents also indicated that some agencies had produced agency-specific FM guidelines. For example, a PCT had produced guidelines for GPs and primary care professionals, and in one area the police were in the process of translating Association of Chief of Police Officers (ACPO) and FMU guidelines into policies and procedures tailored for local police forces.

Interestingly, the police in LA D had chosen not to develop an FM policy within a DV policy framework. They felt that a separate FM policy would be more useful as this would enable them to link it more clearly into the several policies informing the work of the Public Protection Unit (PPU), which included not only DV but also CP and Vulnerable Adults.

Many of the respondents interviewed were familiar with FMU guidelines and their comments were generally very positive, with many respondents finding them very useful and indicating that they were widely distributed. However, several respondents felt that awareness of these guidelines was lacking among some professionals. Inconsistent levels of awareness of FMU guidelines across agencies and among professionals within the same agency were commonly reported.

Some comments indicated that the guidelines needed a clearer distinction between FM and arranged marriage as many professionals still lacked confidence about being able to recognise FM. Several respondents commented that there was a lack of confidence among professionals in using FMPOs. It was suggested that the guidelines could include more technical information about the law as professionals (in both the statutory and voluntary sectors) seemed to lack understanding of the legal powers and processes.

One police respondent commented that the forthcoming guidance from the FMU on different agencies' roles was greatly anticipated, as it could prove to be very useful in promoting a shared understanding of what each agency does and is supposed to do in relation to FM.

Recording FM and sharing data

Many respondents, across all the LAs, indicated a lack of valid and reliable local statistical data on FM. Those in statutory strategic management roles tended to highlight the need to understand the local nature and scale of the problem of FM and viewed statistical FM data as an important element in strategic review and planning processes. There was a general lack of co-ordination of multi-agency sharing of statistical FM data, although some agencies across all the LAs indicated they had begun to take steps to address this gap (as described in Section 4.2).

Although the majority of agencies recorded FM details in client case notes or personal confidential files, they did not typically collate this information or share it in a statistical format. They tended to report that this was due to funders and other stakeholders not requesting FM information from them, inadequate IT systems, and a lack of resources and capacity for database development and data management. In one area, an FM flag had been added to the LA's DV referral form, a copy of which was supposed to be passed on to the LA's DV Co-ordinator by all professionals dealing with DV victims. However, forms were not consistently completed, with only ad-hoc chasing by the DV Co-ordinator, and FM cases which did not lead to a referral were not covered by this system.

Some agencies, such as DV agencies and the police, reported introducing an FM flag on their databases but they also suggested that this marker was under-used. Some respondents pointed out that accurate recording of FM was also hampered by some professionals' lack of confidence in identifying FM (due to lack of training). However, several respondents perceived the introduction of FM flags as a step towards building a shared understanding of the local scale of FM.

4.2 Capacity-building

Statutory and voluntary agencies were involved in a range of capacity-building activities including:

- Multi-agency seminars and conferences
- Targeted staff training
- Developing BME representation and involvement
- Information-gathering for review and planning
- Developing multi-agency case response.

Multi-agency seminars and conferences

Across all four LAs, most respondents reported having attended local and regional DV / FM seminars or conferences. These included sessions delivered by the FMU, speakers from other relevant national organisations, and presentations by local agencies. Some respondents were enthusiastic about the learning they had taken from these events. One VCO respondent reported how cascading this learning to Personal Advisors working in schools had resulted in increased staff confidence to identify and respond to FM cases. This respondent had carried out staff training sessions using FMU materials, posted FMU written guidance for staff to access through the intranet, and acted as an internal resource for FM-related advice and guidance. However, other respondents reported that they needed refresher training, or that they needed to further develop their understanding of FM in relation to their specific roles and the local area, and in relation to understanding the causes of FM and how it differs from arranged marriages.

Staff training

Across all the LAs, some FM training was being offered to some staff. Staff training was targeted at frontline staff. Respondents reported FM training being delivered to a range of staff including physical and mental health professionals, Substance Misuse Workers, Social Workers, EWOs, CP practitioners, and designated CP Officers in schools and colleges.

Across the four LAs, FM training was most commonly reported to be included in DV or CP courses. Some respondents indicated that insufficient time was allocated to FM and that it was 'squeezed' into the training programme. They also indicated that limited resources and capacity were significant barriers to developing and delivering a one-day FM course.

FM training did not appear to be core or mandatory training for any group of professionals apart from the police (who in one area were developing a mandatory FM training package for all local Police Officers). One respondent suggested that even within the DV service sector FM was not considered core training for DV workers, and that FM was not being incorporated into DV modules used in the sector.

Developing BME community representation and involvement

In some areas, respondents referred to the central role of BME community representation and involvement in FM-related work. Given that FM was reported to be a culturally and politically sensitive issue, developing BME community representation, participation and involvement was seen as an appropriate way not only to progress FM-related work but also to improve an organisation's own cultural expertise. The range of ways in which this was done included the following:

- One LA had advertised for two DV Advisor posts, with experience of FM and a spoken Asian language as desirable criteria.
- A police force had recruited a BME Police Officer with an FM remit.
- A PCT had contracted a local BME Training Consultant to deliver FM training to health professionals.
- A police force had planned to develop closer links with BME communities through Neighbourhood Police Teams.
- A DV Co-ordinator was re-examining commissioning plans to better support the local BME FM-related work.
- A DV Co-ordinator planned to widen membership of DV / FM Forums to include BME councillors, a wider range of BME community groups, and possibly religious leaders.

Information-gathering for review and planning

Statutory agencies in particular reported that they had started an information-gathering and information-sharing process to improve inter-agency understanding of the nature and scale of FM locally. They intended to use this improved understanding to inform strategic decision-making.

Across all four LAs, several respondents had introduced or were planning to introduce an FM flag on their case records and databases in order to identify numbers of FM cases. One voluntary sector DV organisation had formed a Quality Team with data management and reporting responsibilities. One LA reported having purchased a new case management system and were planning to introduce the system through staff training.

One LSCB was developing a questionnaire for key staff, for example Social Workers, asking for details of experience of FM referrals and knowledge of FMPOs, in order to identify training needs and prioritise staff roles for FM training.

One DV Co-ordinator was in the process of contacting several agencies to find out what data they collected on FM and to assess how it could be used for FM co-ordination activities. Additionally, commissioning contracts were being examined to identify how to build in data requests.

The police in LA D were planning a series of policy and practice group meetings with key statutory and voluntary organisations to share their own experience of FM and to encourage inter-agency information-sharing and learning.

Developing multi-agency case response

Two LAs in particular were planning a move towards a more integrated multi-agency response to FM.

One LA indicated plans to place senior practitioners from three key agencies at the police station, to improve risk-assessment at the point of referral from the police. They also indicated plans to link the social work case management system to the police system. In response to local evidence from the police that Social Care professionals were not informed about FMPOs, this LA had placed information on FMPOs on their Safeguarding website.

Statutory agencies in this LA were also in the process of developing policy and practice. The police were translating relevant national guidelines into local area and local police force-specific guidance. The LA were updating their Safeguarding procedure to reflect new guidance from the FMU. The police were also planning FM policy and practice steering groups to develop better practice around multi-agency case response.

The voluntary-led FM Forum in another area reported having worked with several statutory agencies to develop policies and practice guidelines including Education, Social Care and Health.

4.3 Barriers to FM co-ordination

Barriers reported by respondents included:

- Lack of resources and capacity for DV co-ordination and BME voluntary sector;
- FM work viewed as an 'add-on', particularly in the absence of additional funding sources;
- Lack of support from senior management staff;
- FM considered as a culturally and politically sensitive issue, leading to professional inaction;
- General lack of understanding among agencies of their roles in relation to FM, and specifically around FMPOs;
- Limited or no understanding, interest or commitment in regard to FM among professionals;
- Lack of clarity on the difference between arranged marriage and FM;
- Lack of valid and reliable sources of local data on FM, a lack of resources and capacity in agencies to collate their own FM monitoring data, and a lack of strategic co-ordination of multi-agency sharing of statistical FM data;
- DV and CP services not working in parallel on the issue of FM.

5 Detection

5.1 FM referrals

Direct reporting of FM by the young person or via a concerned friend was a typical way in which schools, colleges, youth agencies and the BME DV / FM voluntary sector identified cases.

In some areas, pockets of work had been carried out in schools by the BME and DV voluntary sector to raise students' awareness of FM (discussed further in Chapter 7) and alert teachers and Personal Advisors to the warning signs. Several respondents indicated this had led to increases in young people confiding in teachers or the local Connexions service, and in young people directly reporting FM to voluntary agencies.

Direct reporting to the police was much less common across the LAs with the exception of the area where the police had experienced steady increases in direct reporting from young people as a result of actively increasing their own capacity to detect and respond to FM. This police force had carried out some work in schools. They had also chosen to emphasise their role in relation to safeguarding and protection, and as an access point to other services. Finally, they reported an increase in anonymous calls to police stations requesting contact details of local support services and the FMU.

Interestingly, a few respondents, including some working for refuges, indicated they had experienced situations where concerns about FM had arisen in relation to the child of a DV victim they were supporting. One refuge reported that they dealt with the situation by finding the daughter alternative accommodation away from the mother they were supporting.

For statutory agencies and voluntary sector DV agencies, it was relatively uncommon for FM to be mentioned at the point of referral or first contact with the victim. Several respondents indicated that FM usually transpired to be an issue later on, during the course of the agency's work with the victim. FM tended to be hidden behind other more obvious presenting problems in relation to DV such as physical abuse. Health and mental health services also reportedly had cases where the presenting issue was eating disorders or self-harm and FM transpired later.

Being missing from education was generally considered as a useful indicator of FM risk, although the LAs tended to identify only a few cases per year, either through direct reporting from a concerned teacher or through follow-up investigation. There was some indication that in some areas there was a lack of knowledge among EWOs of the protocols to follow in cases where a pupil had gone abroad. Some respondents were concerned that it was too easy for parents to home-school their children and anticipated the (then forthcoming) national review of home-schooling with interest (Badman, 2009).

In one area the local college monitored the electronic registers daily and texts were sent to absent students to enquire of their whereabouts. The college also reported a good information-sharing agreement with the local Connexions service, so if they had any concerns about particular students they could request relevant information.

5.2 Factors preventing detection

Varying perceptions of FM prevalence

In the absence of reliable FM data among agencies, respondents' perceptions of local prevalence varied widely. Statutory agencies tended to indicate they had identified relatively few cases of FM, whereas VCOs tended to have experience of considerably larger numbers of FM cases, with some DV agencies estimating that FM represented around a fifth of their total BME domestic violence caseload. A few BME DV VCOs that targeted young people estimated they had dealt with over 50 cases during a one-year period. In these agencies this work was carried out by one or two workers and they indicated that they were struggling with increases in caseload due a lack of resources and capacity.

Some statutory respondents indicated that many professionals perceived FM as a relatively small issue that is given a disproportionately high profile by the national Government and the media. However, many respondents suspected the number of reported cases of FM were the 'tip of the iceberg', and a few respondents estimated that reported cases represented around 10-25% of the true number of local cases of FM.

Some respondents pointed to a lack of national and local Government strategic focus on and firm commitment to tackling FM in terms of adequate resourcing and capacity-building, including IT 'solutions' for improving agencies' data collection and reporting of FM.

Affected communities 'hard to reach'

Respondents indicated that the known FM cases were predominantly from established South Asian communities, mainly local Muslim communities, with a few reported cases from other communities including Polish, Yemeni, Somali and Irish travellers.

FM was often articulated as the result of cultural traditions and internalised community pressures, male-dominated societies, disempowered young people and isolated women with limited freedoms outside the home. Several respondents referred to affected communities as being 'hard to reach', inward-looking, heavily reliant on community-based services operating through local mosques, and generally mistrusting of statutory agencies such as Social Care and the police.

One VCO children's DV counselling service, which took referrals from a number of different statutory agencies, commented that Asian families tended to represent around 20% of their referrals, but that with many Asian families they could not get through the initial stage of assessment for counselling. This agency could only carry out interventions with children with the full consent of their parents, and faced difficulties in getting young women to come to their offices to attend appointments. They also experienced difficulties in gaining access into the family home, unless workers colluded with the victim's or another professional's suggestions of pretending they were visiting to read the gas meter or were representing the local Housing Department. This pretence was viewed as unusual, somewhat excessive, uneasy and highly stressful for workers and victims, and somewhat questionable in terms of codes of professional practice. BME VCO respondents tended to perceive potential young FM victims as having limited freedoms outside the home and as being generally disempowered. However, these VCOs tended to use schools and colleges as the main arena for making initial contact with their clients and mobile phone calls and texts as the main means of communication with the young people.

FM detection not a priority

Several respondents suggested that FM was not recognised as a strategic priority within LAs because of other competing priorities. Some respondents talked of LAs as being ‘swamped’ with DV referrals and of CP services being ‘stretched’ with higher volumes of high-risk cases. The VCO operating a fairly new children’s DV counselling service commented that they had intended the service to be a preventative intervention for low-risk cases but had found themselves typically dealing with complex and acute DV referrals that required more intensive and longer-term counselling interventions. Detection of FM within DV and CP cases therefore paled as a priority in comparison with other issues.

FM as a politically and culturally sensitive issue

Several respondents indicated a fear of FM as a political and cultural sensitive issue, due to its association with specific communities. This fear tended to be more pronounced among statutory agencies than VCOs. A few agencies warned against presenting FM as a problem that disproportionately affects Muslim communities, indicating such views could potentially fuel racism, attract negative local media attention and damage local community cohesion efforts. In the context of a generalised fear of cultural insensitivity, some statutory respondents argued for FM to be more clearly defined as a specific criminal act, suggesting that this would give many professionals increased confidence to detect and respond to it (although there are counter-arguments around criminalisation further deterring victims from coming forward, discussed further in Section 6.4).

Lack of professional understanding of FM

There was some indication of a lack of professional understanding of FM preventing agencies’ abilities to detect it. Respondents identified a need among professionals for greater knowledge and understanding of FM, its causes and functions, how it differs from the cultural practice of arranged marriage (particularly as young people may also have concerns about arranged marriages, as even where a young person has chosen to marry their spouse, they may still clash with their parents over, for example, the type of wedding it is going to be), how to recognise FM, and culturally-informed pathways of responding to FM effectively.

Some respondents expressed concern that some FMs were not recognised as such by victims, impeding detection. For example, there were cases where the young person experienced intense emotional pressure to marry and felt they had no choice but go along with family wishes, but still saw the marriage as arranged rather than forced. The importance of raising awareness among potential victims of the difference between arranged marriage and FM is discussed further in Chapter 7.

A lack of understanding of FM could also impede professionals in identifying and responding to excessive parental control. That is, when parents start to see FM as an antidote to their child’s perceived ‘bad behaviour’ (for example, drug-taking).

Language barrier and lack of access to interpretation services

Some agencies indicated that language barriers were also a factor impeding the detection of FM, particularly in cases where young people had come to the UK via spousal visas, and occasionally when their regional dialects were unfamiliar to BME workers. Several agencies indicated a general lack of access to appropriate community interpreters.

Lack of reporting sites and lack of local 24 hour contact points

Some respondents indicated there was a general lack of reporting sites for young people to go to with concerns about FM. These respondents pointed out that most young people are reluctant to approach statutory agencies for fear of agencies getting involved and carrying out interventions with their families. Also, they indicated that young people often want to talk about their concerns confidentially without their parents' knowledge. There were few local agencies, particularly for those with limited freedom, where young people could seek appropriate advice, support and protection. Furthermore, some respondents indicated a lack of local 24hour contact points for young people. One respondent stressed the importance of a local 24hour service and indicated that evenings and weekends were the most likely times of the week that a young person would be flown out of the country for an FM abroad. This respondent had dealt with numerous cases of FM out of working hours, and some of those cases were high-risk calls from young people that required contacting the appropriate agencies for assistance.

5.3 Factors facilitating detection

Perception of FM as a clear abuse of young people's right to choose who they marry

Government guidance is clear on the lack of choice or consent being central to the distinction between arranged marriage and FM, but some professionals on the frontline still felt unsure of the distinction between the two. BME voluntary sector respondents tended to be clearer on this than professionals in the statutory sector, placing the absence of choice at the centre of their distinctions. Useful ways of articulating the distinction were as follows:

- if the young person does not want to marry the partner the family has presented to them then it is an FM;
- young people may not identify themselves as having gone through an FM but will tell workers that they did not say 'no' because they had no other choice but to go along with family wishes;
- communities most likely to be affected by FM are those communities where the practice of arranged marriages is a norm but has been abused through taking away the young person's right to choose their partner.

Working from such definitions of FM, BME VCOs tended to report identifying comparatively higher numbers of FM cases than statutory sector agencies.

Empowerment of young people through information about their rights

Several BME VCO respondents indicated that many young people were disempowered and allowed limited independence from their families. However, other BME respondents indicated that young people are taking more interest in exploring their own religions, and are becoming more aware of their rights under British law and rights under their inherited religions. They were also becoming more aware of the existence of FM support services and consequently were more likely to report FM now than previously.

FM awareness work in schools and colleges was seen by most agencies, statutory and voluntary, as crucial in terms of increasing detection and reporting of FM (discussed further in Chapter 7). As indicated earlier, BME VCOs tended to get most of their FM referrals from young people attending schools and colleges where they had previously carried out FM awareness work. Developing access to FM services through schools and colleges was generally viewed as an important factor in increasing detection and response to FM.

Raising awareness of FM among teachers, Learning Mentors and Personal Advisors

Although many of the BME voluntary sector agencies focused their awareness-raising work in schools on working directly with young people, some agencies had worked with teachers and teaching support staff to raise their awareness of FM warning signs and how to respond. A few agencies indicated that although this was crucial work, they had faced specific difficulties in adequately resourcing this work to avoid extra training costs for the schools. However, where work had been carried out there was recognition that it was effective in terms of more teachers, Personal Advisors and Learning Mentors being able to detect FM and respond to FM concerns raised by young people.

Multi-agency FM training for professionals

Several respondents indicated they valued multi-agency FM training, such as the FMU sessions. Those respondents who worked directly with young people tended to find such multi-agency FM training particularly useful. Several respondents indicated they had widely distributed the FMU training materials. One Personal Advisor had cascaded his learning from FMU seminars and distributed materials to other Personal Advisors, offering himself as a source of advice and guidance. He reported that this had led to an increase in Personal Advisors' confidence in detecting FM and an increase in young people coming forward with FM-related concerns.

A focus on listening, signposting, and protection services

Many of the agencies working with young people recognised that young people do not necessarily want formal statutory interventions with their families, and that in some cases support, advice, guidance and safety can be achieved without such intervention. Although most of the police respondents suggested the police role in terms of protection and signposting needed developing, one police force had been particularly proactive in developing this aspect of the police role. As a result they were experiencing increasing numbers of young people approaching them for FM support, signposting and protection. Similarly, a college-based respondent indicated that the college tended to call in Social Care to speak with young people within the context of giving advice and guidance rather than more formal interventions.

Information-sharing protocols between agencies

Agencies' effective use of information-sharing protocols was also identified as an important facilitating factor in detecting FM. For example, in one LA the police would contact the DV Team for information on a known family, and in another LA, the local college would contact Connexions for information about particular students. Information-sharing protocols tended to be perceived as working better in situations where the agencies were located in close physical proximity to each other. The Connexions service in particular reported little difficulty in terms of multi-agency working since several statutory agencies had a base in the same building. One respondent commented that face-to-face informal discussions between agencies facilitated clearer communication and a quicker response.

Using direct methods of communication with young people

Some BME VCO respondents indicated that they tended to use direct methods of communicating with young people concerned about FM. Rather than visit their homes or approach their parents, they tended to rely on arranging face-to-face contact with these young people in schools and colleges, communicating with them by mobile phone and using texts, and arranging one-to-one private conversations with statutory professionals. One respondent talked of dealing with a high-risk case entirely by text and mobile phone

conversations, without any face-to-face contact, arranging for the victim to flee her home and get to a refuge without her family noticing. Another respondent talked of victims who were always accompanied by family members outside the home. She warned their GP that the victim and family had an appointment, and requested that the victim be taken to a separate room for a private conversation to confirm FM and arrange for police support and protection.

6 Case response and management

6.1 Case response

Although all four LA areas had similar co-ordination mechanisms and a similar range of agencies involved in case response and management, the nature and quality of this response varied between areas. Moreover, within all four areas there were differences in understanding of what might constitute a case of FM and differences of opinion and perspective on what, in turn, an appropriate case response should be.

As discussed in Section 4.1, the existence, awareness and use of locally-developed case response protocols varied. However, agencies in all areas appeared to be using / referring to the FMU's guidelines and finding them useful.

Co-ordinated case responses differed depending on whether the victim was an adult (and therefore considered as a DV case) or a child (and therefore considered as a CP case). However, as FM was primarily seen to be a constituent element of DV in all four areas, descriptions of response and case management tended to be articulated by respondents in terms of DV. The Multi-Agency Risk Assessment Conference (MARAC), a multi-agency meeting with the aim of reducing the risk of serious harm for the victim, was a key stage of the DV response. The purpose of this meeting in relation to FM was to both identify and discuss cases of FM risk in the area, and to create a risk management plan involving all agencies for those seen to be at risk or those experiencing or having experienced FM.

A case of FM framed in terms of DV mobilised a typical response involving a partnership of the police (Community Safety Unit), and DV caseworkers (either from the voluntary sector or from the LA), the aim of which was to remove the victim from risk of harm. This involved finding alternative accommodation for the victim (usually within a local refuge) and potentially following up with rehabilitation services (for example, ongoing counselling for the victim and/or financial support). For the most part, the latter services were delivered by the voluntary sector. Depending on the circumstances of the case, the police would prepare their case for prosecution (fact-finding and suspect interviews) and refer the case to the Crown Prosecution Service (CPS). Where the victim had been taken abroad, the DV caseworker or police referred the case to the FMU.

The typical CP response was less clearly articulated. In cases where the victim was under 18, schools, colleges or voluntary sector organisations who suspected a risk of FM liaised with Children's Services. Children Missing from Education (CME) played a key role here: after 21 days' absence from school, and after several checks (such as chasing up emergency contacts for the family, writing letters to family, and checking with the child's friends), the school is obliged to inform the LA Education and Welfare team who in turn may carry out a range of checks including those with Housing, CS (to find out if the child is on the Child Protection Register), and benefits agencies, and may finally conduct a home visit. After this, the child will go on the Missing Children Register. The stage at which CS got involved depended on whether there had been previous concerns about the family. If the child was already abroad, and FM was suspected, then CS would contact the FMU. Where a child was not missing, but was nevertheless considered to be at risk of FM, CS was responsible for dealing with the case. As with the MARAC process, suspected child protection issues would be brought to a multi-agency meeting.

As cases where the victim had been taken abroad tended to be associated with a high risk of significant harm, and these are referred to the FMU, DV and CS caseworkers at the local level tended to deal with a wider range of risk than those reported to the FMU. In addition, the cases dealt with by our respondents consisted largely of female victims, in contrast to the caseload of the national organisation Karma Nirvana.

The quality and character of both of the DV and CP processes depended on the factors described in the remainder of this section.

Capacity of partner agencies

Both statutory and voluntary agencies cited a lack of capacity as limiting their response to individual cases. In two LA areas, DV co-ordinators felt limited in their capacity to co-ordinate case responses. One LA was making additional investments in the form of further independent DV Advisor posts, to take on FM casework alongside MARACs. In addition, the lack of integrated reporting and case management information systems in some areas further limited the potential for co-ordinated responses. Other statutory authorities also mentioned capacity. For example, police informants expressed some concerns about how lack of resources meant that they had to rely on interpretation services supplied locally as in close-knit communities a victim might find that the interpreter knew their family. This could compromise full disclosure from the victim or lead to details of allegations being relayed back to the family. However, capacity was of most concern to the voluntary sector, who often did not have funding for interpreters or signers, and had difficulties staffing their services and providing sufficient social support for victims (such as emergency accommodation, counselling or financial help). In two areas, voluntary sector agencies (who were more likely than statutory agencies to be directly approached by victims) reported not being able to attend case management meetings. A final capacity issue concerned the high turnover of staff in statutory children's services and schools. This was seen to be particularly detrimental to establishing norms and practices around ensuring that FM was taken seriously and appropriately dealt with.

Taking FM seriously

In all areas, we noted variation among key partners in the importance they attached to responding to FM. In one area, both schools and LA EWOs were perceived as not being proactive enough in identifying, investigating and reporting cases of FM to partner agencies (such as the police or CS). In another area, it was the LA's CS that was seen to be non-responsive to other agencies' concerns about specific cases of FM. Moreover, there were seen to be weaknesses in the chain of communication between key players (for example, in one area police worked well with CS but had little or no contact with schools or Education Services). As FM is a complex, largely hidden phenomenon requiring the co-ordinated intervention of a broad range of agencies, such variability in response was seen as highly problematic.

Cultural sensitivity

Reflecting the barriers to detection discussed in Chapter 5, certain statutory agencies were seen to be reluctant to intervene in cases because of a perception of FM as a 'cultural issue', and therefore beyond their remits as statutory agencies. In one area, this was seen as a problem mainly with the LA's CS and Education Services, who were described as having a tendency to 'make positive noises' around responding, but to leave actual responses to the voluntary sector and police. In another area, schools themselves were seen to be shy in responding or reporting their suspicions. For example one respondent talked about how it was precisely those cases of CME that showed signs of FM that were less likely to be followed up in schools, as this was seen as an issue specific to the culture of the child. Therefore, although there was consensus that statutory services had made significant improvements in the treatment of DV cases, there was concern that FM was still sometimes dismissed as a private family matter, either as a cultural practice (sometimes linked to a reluctance to damage relationships with a particular community), or as a legitimate response to a young person's 'bad behaviour'.

Compartmentalisation / culture of referral

Other respondents talked about an eagerness to refer 'difficult' cases of FM on, which undermined follow-up and partnership working. For example, in one area EWOs seemed unaware of CS procedures on FM while in another, police talked about an unwillingness of the LA to support them on taking action on specific cases. This attitude was especially pernicious where there were service gaps (as in the case of 16- and 17-year-olds, discussed further in Section 6.3). An example of this is the case of a 17-year-old 'runaway' from an FM situation who was deemed not to be a CP case by the LA because the victim was able-bodied and mentally stable. In this case, another statutory agency had to lead the response and persuade CS to become involved.

Related to the tendency to refer on difficult cases of FM, respondents also talked about practices of downplaying some cases of FM in relation to other abuse. Where professionals had to prioritise FM cases against other DV cases, such as in Housing Departments in areas of high demand for housing, cases of threat of FM without associated physical abuse (and where the victim did not have children) tended to be seen as lower priority than other DV cases.

Attitudes / perceptions of the victim

Some respondents reported having to work with victims to help them properly recognise the nature and severity of the risk they were under. For cases where the risk was not considered to be immediate, this involved showing them that the risk was not likely to go away and that they could take action to reduce it. For those perceived to be at more immediate risk (where, for example, parents had taken actions such as making travel arrangements), respondents had to work with victims to persuade them to seek help immediately, because things were unlikely to change and their parents were unlikely to change their minds. These situations were perceived to be especially difficult as some young people saw seeking help as a radical step (often perceived to be a direct assault on their parents).

Differences in partners' expertise

Despite the introduction of guidance, some respondents described cases where clear warning signs (for example one-way tickets) had not been picked up by the professional in contact with the family. There was also some lack of awareness among statutory agencies of the voluntary services available, such as specialist refuges. The quality of response to children missing from education (by schools and LAs) was seen as varying depending on the LA.

In general, agencies appeared to be developing expertise around responding to FM at different rates. For example, in one area it was the police who took the lead on individual cases while working with the LA to increase their expertise and confidence, whereas in other areas, either the LA or the voluntary sector had taken the lead.

Differences in professional practices and norms

Differences in professional practices and norms emerged as a key mediating factor in the quality of response. The greatest such difference emerged between voluntary and statutory agencies. Although these differences are not insurmountable, they do speak to fundamental differences in the framing of FM risk and hence FM case management, and therefore require careful attention.

The first difference emerged in the way that cases came to the attention of voluntary organisations. Voluntary sector respondents talked about being approached by the victim directly or by their friend, whilst statutory agencies depended on inter-agency referrals or on picking FM up in a community safety context[20]. Voluntary agencies may often be more open to victims because they are usually part of the victim's own community. As a result, voluntary agencies did also tend to see a wider range of cases in terms of severity, and in terms of proximity to crisis, while statutory agencies were more likely to see cases which had already reached a crisis.

Secondly, reflecting their wider range of cases, voluntary agencies did not always see the possibility of FM as an imminent crisis, but variously as part of a process, as a threat or as a way for parents to voice discontent with the behaviour of their children. For cases where crisis was not deemed imminent (and were deemed less serious, e.g. the young person had not reported physical abuse), these agencies placed more emphasis on empowering the young person to deal with their parents' unreasonable threats or demands through understanding the meanings and motivations behind them. This was combined with very practical strategies should the situation escalate (such as establishing contact networks, hiding passports, etc.). Community counselling services also placed emphasis on discussing with the victim whether leaving home was the best solution for them, depending on the level of risk the victim was facing and how easily that risk could be managed by professionals. In one LA, a Further Education (FE) college had approached parents in cases where a young person had voiced concern about being taken abroad to marry, but about the importance of education rather than the threat of FM. With the permission of the young person, a tutor had called parents, or visited them at home, to stress the importance of attendance and education increasing the young person's life chances. This was reported to have 'bought time' for the young person to continue their education with less immediate pressure of FM.

In addition to dealing with young people, voluntary organisations sometimes reported working with parents or other adults. Some were approached by parents (for example in cases where their child had run away from home) who professed to be unaware of their child's fears, and were felt by professionals to be amenable to thinking about the situation differently.

With this approach, averting the threat of FM while maintaining the family structure was reported to have been achieved in some cases. This approach did not necessarily entail family mediation, and voluntary agencies showed similar awareness to statutory agencies of the risks associated with mediation. Nevertheless, this approach potentially raises some concerns; statutory guidance issued by the FMU (which also reflects the view of some voluntary organisations), clearly advises against contacting the family or undertaking mediation in any circumstances, as mediation has been found to escalate risk, including sometimes leading to the murder of the victim. The approach is also heavily dependent on well-informed, accurate risk-assessment, which, given the lack of awareness and expertise described above, is not guaranteed. In addition, prioritising discussing the best course of action with the young person may also conflict with CP guidance (e.g. in some cases, even if the young person does not want to leave the family home, it may not be appropriate to take their wishes into account if they are under 18).

Nevertheless, the 'solutions' that some voluntary agencies offered to the victim's problems, which sometimes involved mediation, were often described as more acceptable to the victim, as they did not always involve the intervention of the state, nor did they necessarily seek to implicate the victim's family as perpetrators. There may therefore be value in a more 'victim-centred' approach. Arranging for the victim to leave home combined with police intervention (the response which has dominated guidance relating to FM) may not be the best route in

[20] The FMU deals with a mixture of direct approaches by victims and referrals.

every case, although this should be assessed in conjunction with wider CP responsibilities, and with a full understanding of the risks associated with honour-based violence. A balance needs to be reached between the potentially very high (and sometimes life-threatening) risks associated with family mediation and with the victim staying at home, and a recognition of the full range of FM cases, which, in turn, may require a range of appropriate case management approaches.

6.2 Pitching the level of response

Even once an FM case had been identified and appropriately risk-assessed, professionals perceived several barriers to being able to take action. These centred around the reluctance of the victim to challenge their family, or to let anyone else do so (so a professional might be wary of using statutory powers) and the difficulty of achieving successful legal action, especially where the case had involved the threat of FM rather than actual FM, and physical abuse had not been reported, hence evidence of criminal behaviour was harder to secure.

Professionals reported that FM often came up in a wider context of other reasons for referral, such as other forms of DV. Sometimes professionals identified an FM risk in relation to the child of a DV victim. Professionals also identified child abuse, sexual exploitation, and parent-adolescent conflict as possible contexts for FM. There was also a great deal of emphasis on reviewing each case on its own merits and responding appropriately. Respondents saw FM victims as having a wide range of needs (emotional, legal, housing, financial, educational) requiring a wide range of responses.

Pitching the level of response however emerged as a challenge for agencies. There was a tendency, especially among statutory services, to interpret 'taking a case seriously' as taking out a care order or FMPO (as opposed to a careful risk-assessment of the FM threat, which might not involve an order but might nevertheless require a whole range of service responses, such as counselling). Some professionals were anxious that being seen not to have taken a case seriously enough could be detrimental both to their own agency and to partnership working as a whole should FM or some other harm occur. This sometimes explained why they had opted for statutory interventions, even if their risk-assessment suggested that these might be too 'heavy-handed'.

6.3 Case co-ordination

In view of all the factors described above, proper case co-ordination emerges as central to crafting an appropriate and timely multi-agency response to FM. However, the quality of such co-ordination was variable. In one LA, co-ordination of response was seen to be largely absent with no joint referral procedures or information-sharing agreements in place, each agency following their own organisational practice / policy.

There was a clear need to dovetail the range of responses on offer. For example, whereas voluntary sector agencies may work with a client around managing an ongoing or growing threat of FM within the family, the police are geared towards dealing proactively with an immediate threat. While the former is a minimal incremental intervention, the latter is immediate and radical. Managing this process of matching the response to the needs of the case was seen as key. This related to the need for professionals to maintain awareness of the range of responses and professional approaches available for managing FM, and to ensure the input of key players into specific cases (for example ensuring that voluntary youth services were up to speed on what the local CS were willing and able to offer in relation to a case).

There is also a need to ensure that victims do not slip through gaps in services. This was specifically mentioned with regard to the gap in effective case response for 16- to 18-year-olds. Some flexibility is necessary, given that young people of this age can vary in their maturity and in their response to services. Nevertheless, respondents voiced concern over a lack of clarity regarding who should take responsibility for responding to this age group, particularly in Social Services and the police (with CP teams catering more for victims aged under 16, and Adult Services / CSUs catering more for victims over 18). Moreover, some services required by 16- to 17-year-olds had been found to be provided only for those 18 and over (such as some refuges or Homeless Persons Units). In addition, where a victim of FM did not want action to be taken, both statutory and voluntary agencies were reluctant to intervene if the victim was over 15, as they were considered competent and able to decide for themselves, even if other professionals involved considered that statutory action was required.

These findings echo previous reports of difficulties experienced by schools in making child protection referrals for 16- to 17-year-olds (Whitehead, 2007). These suggested that there is a reluctance among Social Workers to apply to 16- and 17-year-olds Section 47 of the Children Act 1989, which relates to child protection, and a tendency to favour Section 17, which relates to children in need. Section 47 gives Children's Social Care Departments legal powers to make statutory interventions, whilst under Section 17, the offer of a service is subject to the parents' agreement, which is inappropriate for FM cases. The Children's Society has also reported evidence of a high threshold for teenagers accessing CP services (Evans et al., 2007), and Shelter has identified confusion among some housing providers who wrongly believe they cannot offer tenancies to 16- and 17-year-olds (Shelter, 2007). A tendency to assume that older children have in some way brought abuse upon themselves has also been reported as having a negative impact on the CP response, in contrast to perceptions and treatment of younger children experiencing the same treatment (Rose and Barnes, 2008).

6.4 Attitudes towards the use of FMPOs

Respondents reported a range of attitudes towards the use of FMPOs. In three out of the four LAs, little usage had been made of FMPOs, for a range of reasons. The first related to concerns about being perceived to be using legislation 'against' particular minority communities. However, those voicing such concerns believed that these perceptions would be short-lived as the use of FMPOs became normalised. Others (especially those from the voluntary sector) expressed uncertainty about their powers to use FMPOs, what their legal role would be and which statutory agencies they would need to involve in taking one out.

Concerns were also voiced about the message that the use of FMPOs, rather than the use of criminal law, sent out to communities, reflecting the view that FM needs to be countered as a criminal infringement of liberty and rights, and clearly portrayed as a crime. However, others took the view that framing FM within criminal law might serve to stigmatise those communities most affected by it, and further discourage victims to come forward (as discussed in the Home Affairs Select Committee report).

Nevertheless, in one LA, the police had been using FMPOs quite extensively. In this area FMPOs were considered an effective tool to prevent victims being taken abroad for FM. Respondents in this area also reported the use of other Protection Orders (such as Police Protection Orders or Emergency Protection Orders) where the victim was under 18, followed by an FMPO when appropriate. FMPOs were also reported to have a preventative function in that parents and communities were perceived to have taken notice of their use. Finally a respondent in this area reported that (contrary to perceptions) FMPOs were being granted on circumstantial evidence and hence did not need to be a burden for agencies to prepare.

6.5 Barriers to effective case response and management

The barriers to effective case management discussed above can be summarised as follows:

- Lack of sufficient resources, especially in the voluntary sector
- High staff turnover in the statutory sector, making it difficult to embed understanding and practice norms
- Variability in levels of professional commitment to respond to FM
- Reticence to challenge practices perceived as cultural norms
- Tendency to refer out of service with lack of follow-up
- Limited understanding of FM
- Limited understanding of the range of approaches that can be taken in response to FM, which are reliant on careful and informed risk-assessment
- Lack of badly-needed case co-ordination
- Gaps in service provision (specifically that for 16- to 18-year-olds)
- Lack of knowledge about FMPOs
- Lack of experience of working with FM leading to uncertainty around appropriate level of response and practices (causing delay in high-risk cases).

6.6 Facilitators to effective case response and management

Good case- and risk-assessment is central to effective case response and management. Assessment requires a capacity to work with agencies to determine the level and severity of risk based on the understanding that FM does not always emerge 'out of the blue' as a one-off singular event, but can be the result of a range of circumstances that can be managed through early appropriate interventions.

There is also a need for a variety of responses depending on the needs of the case. These include counselling, and support and empowerment for the young person / victim, but may also, where the case demands, require care plans, removal, FMPOs and prosecution. It is also vital that all partners understand and respect the variety of case management responses available.

Effective case response requires all partners to take FM seriously. This involves:

- All partners feeling able to challenge damaging practices without being seen to challenge the cultures with which these practices are associated.
- All partners taking an 'end-to-end' interest in a case rather than either holding on to a case for too long or referring it on too quickly because it is difficult.
- All partners having sufficient training and practice guidelines about detecting and responding to FM, both from their own perspective and from the perspective of other partner agencies.

Good case management and co-ordination is essential in order to ensure (a) that the most appropriate response is delivered to the victim throughout the course of the case, and (b) that victims do not slip through the existing gaps in service provision.

Sufficient resources across the board are also required. The lack of proper resourcing seems to be most acute in the voluntary sector. VCO respondents described resource limitations impacting on the majority of their services, including providing ongoing support and empowerment for young people at risk of FM, and support for those who have been the victims of FM. However, there is also a need for statutory sector resourcing and this is particularly strong with regard to co-ordinating case management responses.

Central Government interventions (such as FMU guidelines and FMPOs) were seen to be key in creating capacity to respond to cases. Guidance was used and promoted by many respondents. However, there is likely to be some way to go in ensuring that all key players are behind it. Moreover, the development of local variations to guidance and ways of applying guidance was still in the early stages. Overall, FMU guidance was perceived to be useful in case responses, in terms of focusing on the voices of victims who were affected. However, opinions on the use of FMPOs in case response were mixed, with much confusion as to how they should be applied and some concern that their application might be seen, in the short term, as the disproportionate use of legal powers against a minority (rather than a legal remedy to a case need).

6.7 Key features of good response

The following emerged as key features of a good response to a potential FM case (applicable to both statutory and voluntary agencies):

- Individual assessment and support plan to identify services required, including employment and financial needs;
- Where required, reassurance for the victim that going against FM is not going against their religion or culture ;
- Encouragement and help with continuing education;
- Where required, referral for counselling;
- Providing information on services available, including leaflets.

Where the case was deemed to be high-risk

- Advice on warning signs (especially in relation to impending trips abroad);
- Advice on where to hide their passport;
- Taking a photograph of the young person;
- Obtaining copies of passports or passport details;
- Provision of a mobile phone;
- The use of code words during telephone or other conversations to indicate immediate danger;

- Establishing a contact able to confirm that the victim is safe should they go missing;

- Establishing and agreeing measures of maintaining contact should the victim be taken out of the country;

- Safety measures for trips abroad (named guarantor other than parents, contacts in the host country to check on the young person);

- Flexibility in location for meetings (for example police statements and interviews taking place in a refuge if the victim is uncomfortable going to the police station);

- Establishing a 'contract' with the young person stating what authority they grant the agency to intervene or enquire should they leave the country.

Where the young person had left home

- Housing support

- Support to encourage independence, including training on life skills

- Legal advice.

Other key aspects

- Following up referrals (e.g. following up a faxed form with a phonecall, especially in urgent cases)

- Recruiting male and female workers from the local community

- Seeking advice of other agencies (e.g. the FMU, specialist young person or women's group) where appropriate, which doesn't have to involve referral of case if appropriate to maintain confidentiality

- Different LA departments working closely together (e.g. Social Work team attached to Homelessness Unit)

- Provision of bilingual workers;

- Training alongside guidelines (including on FMPOs), so professionals engage with them

- Provision of drop-in advice sessions

- Provision of formal 24 hour facility for reporting FM or seeking help (as some respondents reported having to give out their own mobile numbers to young people to call in the event of an emergency)

7 Prevention & awareness-raising

Responding adequately to FM entails paying attention to the prevention of FM as well as case response. The prevention of FM relates to both detecting the threat of FM in time for services to respond, and preventing the threat of FM in the first place. Raising awareness of FM among the communities vulnerable to it was widely recognised by respondents as being the key to prevention.

There were some good examples of prevention activities in all four LA areas, but a clear need for more activity was also expressed, with statutory agencies wanting to work more closely with local communities, and voluntary organisations wanting more funding for preventative work.

7.1 Prevention activities undertaken

Activities with young people

Schools and colleges were the main locations for prevention activities with young people. For young women with limited freedom and at risk of FM, schools and colleges were seen as potentially the only location for accessing help. School-based activities also provided the opportunity to reach the friends of victims, who - as discussed in Chapter 4 - could have a significant role in alerting others to FM, and in one area students had been trained to help other students as peer counsellors. Another aim of these activities was to educate young men, to prevent them becoming perpetrators of FM.

Some activities concentrated on FM only, while others included FM as one topic in a wider context, which could make it easier to broach, as discussed below. The context could be DV, honour-based violence (HBV), sexual exploitation / child protection, or healthy and respectful relationships. Activities concentrated on raising awareness of the risks of FM, educating young people on their rights, providing others' testimonies and providing information on the support available.

The main types of activities undertaken were as follows:

- Use of written materials (predominantly FMU and DCSF materials): posters were displayed, and leaflets and information cards distributed;

- Web-based information: this included an electronic poster system on college computers with information on FM and who to approach within the college, and a DV website including information and contacts relating to FM;

- Training sessions: talks and/or group sessions, sometimes including showing a film about FM, were used to provide information and raise awareness - in one area, school pupils attended the area's annual conference on DV (which one year had a focus on FM);

- Using drama to explore FM: in one college students had put on a play followed by a talk;

- Interactive work: in one school, pupils had worked together on producing an information leaflet on FM, aimed at other pupils.

Although plans were being made in one area for an LSCB-led FM working group to co-ordinate prevention activities, there tended to be little overall co-ordination of activities in schools generally. The development of activities was relatively ad-hoc, and in some cases dependent on existing referral relationships between schools and external agencies. Voluntary groups tended to be more active in developing and undertaking activities (some of which were LA-funded), though activities were sometimes carried out in partnership with LA departments. Both local and regional police forces had been involved in some areas, either in delivering talks, or in encouraging the LSCB to plan activities. The FMU had also been directly involved in some activities. Some sessions were led by external professionals, while others were delivered by teachers or Personal, Social, Health and Economic Education (PSHE) co-ordinators who had received training and/or materials from external agencies.

A wide range of voluntary groups had been involved in school-based prevention, including BME counselling groups, youth organisations, DV refuge and outreach services, and Victim Support. The focus of the group (BME, Youth, DV) inevitably had an influence on the context of the FM training. Hence, a youth organisation might be more likely to cover FM in the context of other issues faced by school pupils such as sexual exploitation, while a DV organisation might be more likely to cover FM within a general DV training session. FM activities were also sometimes undertaken as part of PSHE. In one area, a DV prevention worker led on DV activities that covered FM across several schools.

The benefits of prevention activities were clear. The feedback from students who had taken part in a training session (as reported by a professional) was that they felt more aware of the distinction between arranged marriage and FM, what their rights were, and what to do if they became at risk. Prevention activities could also provide an indirect route to responding to particular cases. In one school, where a student was suspected to be at risk but the teacher felt a direct approach to that individual would not have been welcome, a training session had been done with a whole group of students instead.

Although less common, some community-based work outside schools had been undertaken, led by the BME voluntary sector, and aimed at adult victims as well as young people. This included raising awareness among women's groups; running DV drop-in advice surgeries in community venues such as GP health centres, community centres, and children's centres; and holding information stalls at Asian festivals. One BME voluntary organisation who had organised events involving FM speakers with other key local services had found that not many young women were attending, and had hence turned their attention back to schools.

7.2 Activities with parents and the wider community

Although it is potentially easier to reach young people, as this can be done through schools, prevention activities also need to reach parents, in order to prevent the threat of FM in the first place. As discussed in Chapter 2, community pressure can be a factor leading to FM, hence activities targeted at the wider community are also important.

Both statutory and voluntary agencies however tended to shy away from tackling such prevention activities, though there were some good practice examples: in the area where good relationships had been developed between the LA and the local Muslim centre, community-based prevention activities were more common. The main initiative consisted of seminars jointly organised by the LA and the local Muslim centre, including one on FM. These seminars were well-attended by an audience which included parents' groups. The LA's CP team reported that following liaison on how to prevent FM, some imams had also included the topic of FM in their Friday sermons, focusing on FM not being Islamic practice. Friday prayers potentially had very large congregations, including some (mainly women) listening to the sermon on the radio at home.

The main example of reaching parents through schools was in relation to CME initiatives, which involved communicating to parents the importance of education and the school's disapproval of students missing classes or going on extended holidays abroad. This could have an indirect impact on the risk of FM, as such messages could persuade parents to postpone marriage plans in order for their children to complete their education. In one area, a school had also reached parents through a session about obtaining consent for DV training for their children, which allowed the facilitator to raise the *parents'* awareness of FM as a by-product.

As the main aspect of raising awareness is to explain that coercing someone to marry against their will is wrong, and FM is often justified on religious or cultural grounds (see Chapter 2), emphasising that FM is not condoned in any religion was seen as one of the important messages to convey to parents. Another important message to convey was the negative impact of FM on young people. Involving young people who had experienced FM in talking about their experiences was seen as a good way to make older generations understand the implications of FM. Emotional pressure 'counting' as duress was also a key message - it was felt that headway had been made in terms of reducing the acceptability of physical violence, but that there was further to go in terms of persuading people that emotional pressure to marry is also unacceptable.

7.3 Barriers to undertaking successful prevention activities

Lack of resources

The main limitation identified by professionals as restricting the extent of prevention activities was a lack of resources. Some LA outreach services such as DV were seen as under-funded, while some voluntary groups described being overstretched and having to prioritise case response. Voluntary groups with a BME and/or DV focus, for example, who were well-placed and willing to carry out school activities, were restricted in the number of schools with which they could work. The limited resources of some voluntary organisations were considerably stretched by dealing with NRPF cases to which statutory services were not able to respond. A move towards funding more generic services among LAs, widely criticised by the BME voluntary sector, had also led to the closing down or downsizing of specialist services focusing on specific ethnic groups, making prevention activities even less of a possibility.

This highlights the classic resources dilemma of immediate concerns (responding to FM cases) taking priority over investment in long-term needs (prevention activities) which could in time reduce the volume of cases.

Unclear responsibilities

As discussed in Chapter 4, FM did not have a clear 'home' in terms of which LA department(s) should take the policy and/or practice lead. This resulted in a lack of overall co-ordination of prevention activities.

A lack of co-ordination at a higher level could also limit the success of prevention initiatives. In one area, for example, the police-based DV co-ordinator had developed a DV education pack which covered FM, but taking it out to schools was proving difficult due to a lack of co-ordination between the LA and schools, and in particular the fact that there was no clear LA contact in the Education Department with overall responsibility for schools.

Cultural sensitivity

Although professionals reported that fears around cultural sensitivity had lessened, some had still encountered reluctance from schools to take part in prevention activities, with FM still being seen as 'taboo'. Reflecting barriers to detection and case response, there was some remaining fear that undertaking FM prevention activities would mean targeting, and hence offending, one or more particular BME communities. In one of the areas where little dialogue had developed between the LA and local communities affected by FM, and despite a few local BME organisations taking a strong stance against FM, some defensiveness by some individuals or groups within local communities was also reported as a barrier to agencies taking on prevention activities. This fear of potentially damaging relationships with certain individuals (such as community leaders) or groups within local communities has hence discouraged prevention activity, even though these individuals or groups may not actually be representative of communities' views. The potentially sensitive and divisive nature of FM clearly needs to be acknowledged in any planning of prevention activities, but should be seen as an argument for more action rather than less.

Lack of knowledge and confidence

The complexity of FM was another barrier to preventative work. Some respondents reported a lack of confidence among colleagues (including school teachers) in their ability to tackle the issue. Where FM could have been incorporated into another initiative, for example in a Housing Department's leaflet on DV, FM was not seen as an easy 'add-on', as the Housing Department did not feel sufficiently knowledgeable about an FM victim's needs or rights in relation to public housing. This lack of confidence and unwillingness to engage seems however to be out of proportion with the complexity of FM, as for example a leaflet would not need much information added to it to be relevant to FM victims, who come under well-established public housing rules covering the rights of vulnerable children or young adults at risk and in need of re-housing away from their families.

Community and gender barriers

Concerns also included fears that prevention activities led by white professionals (especially without the relevant language skills) could be seen as inappropriate, and that these professionals might find it difficult to gain recipients' trust. Hence activities could be limited by difficulties recruiting someone from the right community (or a lack of funding to take on extra staff to satisfy this requirement).

In one area, the attempts of the DV outreach service to work with religious bodies were felt to have been hampered by the religious bodies being male-dominated and the workers being female (as well as white). It was felt that a man from one of the local communities affected by FM would get a much better reception. Female-dominated, voluntary women's groups expressed similar concerns about approaching male religious leaders to work together.

On the other hand, a male BME youth worker who had given talks to community organisations had picked up some unease among the members of BME women's groups that he had talked to about education and FM.

Lack of trust in agencies

Lack of trust had been encountered by both statutory and voluntary agencies. A DV outreach service based with the police had undertaken training activities that had not been well-received. A voluntary BME DV organisation had also encountered resistance from parents and governors to school-based prevention activities, based on suspicions that the organisation would corrupt female students and encourage them to leave home.

7.4 Facilitators to undertaking successful prevention activities

Increasing dialogue

It is difficult to overcome barriers between organisations and communities in relation to a single issue such as working together on the prevention of FM without a wider concerted effort to bring these different organisations and communities together. In the area where a seminar programme had been set up (jointly organised by the LA, voluntary groups and the local Muslim centre), the seminars (as well as the presence of imams on various steering groups) seemed to have led to stronger relationships on a range of issues, including FM. Relationships between the LA and local imams, between the voluntary sector and imams, and between different organisations within the voluntary sector, had all been strengthened.

Making the most of established relationships

Despite the reservations noted above associated with religious leaders being overwhelmingly male, 'grassroots level' members of the community (including certain religious leaders) were seen by some as good vehicles for awareness-raising among parents, as opposed to potentially less trusted 'external' agencies or professionals. Using existing links, such as parent advice centres already working with families, or women's groups based in religious institutions, was also seen as important. Specialist community organisations tended to have a particularly good understanding and knowledge of FM (as a result of their greater contact with victims), and are hence well-placed to take a lead in prevention activities (as long as there is financial support).

Learning from and sharing good experiences

Sharing good experiences and learning from previous experiences could also help with breaking down barriers and reducing possibly unfounded fears related to tackling FM. One religious leader reported that a women's group he had worked with had been pleasantly surprised by his engagement with DV issues. In another area, community events around race crime and extremism had been run successfully despite potential cultural sensitivity. The improved relationships between the LA and community groups that resulted from this could potentially increase professionals' confidence with tackling FM.

Sensitive contextualising

A greater recognition of the wide range of ways in which FM manifests itself, and the potential links between FM and wider issues, is essential not only in order to provide a comprehensive picture of the risks of FM, but also to help remove some of the sensitivities. For example, acknowledging the links with other types of DV leads to addressing FM under the DV umbrella and / or PSHE, which has the advantage of moving the focus away from it being an 'ethnic minority issue'. It is also likely to be easier to engage parents in activities presented as related to the more low-risk scenarios of parent-adolescent conflict (but the higher-risk DV scenarios could still be covered).

Explaining the difference between arranged marriage and FM accurately is also key, as discussed earlier, so that it is clear that it is not 'a whole way of life' that is being challenged but a form of DV (that happens to occur within specific communities).

8 Conclusions and recommendations

8.1 Framing and responding to FM

We can see from this research that FM is framed in three ways corresponding to three professional discourses or approaches. Each of these framings leads to different responses.

- First, FM is framed within DV discourses, practices and responses, where it is seen as a type of abuse or violence within families. A DV framing points towards a legal response involving a perpetrator and a victim. The victim is to be removed from the situation and legal remedy sought.

- Second, FM is framed as a CP issue, where it is understood in terms of the need to protect vulnerable children from the impact of familial dysfunction. This framing also involves the intervention of the state, often to remove the victim but with the ultimate aim, if possible, of rehabilitating the family unit.

- Third, FM is framed as a human rights issue where it is understood in terms of negative cultural practices that limit the freedom, rights and welfare of the individual. This framing calls for interventions that empower the individual to resist these forms of abuse, and work with communities to ensure that negative cultural practices which lead to abuses of human rights are made unacceptable.

In our four LA areas, the DV framing predominated, mobilising a response involving police and DV voluntary / statutory sector services. The CP framing appeared to be less clearly articulated. Where there was a CP response to FM, it involved both CS and schools and appeared to be less co-ordinated and less effective than the DV response. Our report also describes a human rights response to FM that was predominantly carried out by BME voluntary sector agencies.

The potential for individual cases of FM to fall through the gaps between these three different approaches is great, and the task of co-ordinating these approaches to deliver an integrated response in terms of prevention, detection, case management and response, is a highly challenging one.

We conclude from this research that all three framings and responses are necessary, all must be properly resourced, and effective co-ordination of all three is key to improving the quality of the overall response.

8.2 Better co-ordination and capacity-building

It has already been stated that effective co-ordination is key to delivering an integrated response to FM in terms of prevention, detection and case management. The location of FM co-ordination within a DV co-ordinating framework has pros and cons. The main pro is that FM is incorporated as an aspect of DV and therefore has a structured response. The cons are that it is often understood solely in terms of DV practice and that classic disjunctures in services apply, the most damaging of which is the disjuncture between DV services, schools / colleges and LA CS. This leads to incomplete responses and gaps in service provision.

The challenge for co-ordination lies in bringing together these services in ways that transcend their differences of focus around the problem of FM. This implies developing co-ordination, prevention and case management protocols which spell out the roles and accountability of partner agencies.

Training is also key to developing capacity within agencies. Across the four LAs, FM training was most commonly reported to be included in DV or CP courses. However, it was also felt that FM was not prioritised enough in these courses and insufficient time was given to exploring its complexity. Limited resources precluded the development and delivery of designated courses on FM. Moreover, FM is not core or mandatory training (in its own right, rather than as part of a DV or CP course) for any group of professionals.

Co-ordinators in all four LA areas stressed the need for FM operational and case management evidence to feed into local co-ordination and capacity-building. However, again, a lack of resources precluded this. Finally, respondents felt that a lack of data on a local and a national level could lead to assumptions that FM is less common than it is. The need for better data collection and sharing was stressed.

Our conclusions in regard to co-ordination and capacity-building are as follows.

- Local co-ordination of FM response and prevention is lacking in strategic direction. There is a need for a national FM strategy framework to focus and develop local co-ordination in relation to FM. We would recommend that it is developed specifically to inform the strategic co-ordination of FM activities at a local level.

- FM is one of those issues that cuts across numerous policy areas, covering a wide range of statutory structures. Moreover, there is a need to integrate FM further into broader policy on violence against women. We therefore support the Government's initiative to develop a cross-departmental strategy on violence against women and girls, and its proposal to include FM within this (Home Office, 2009).

- There is much that could be done on a national level to support co-ordination and capacity-building. Specific national activities might include:

    - Developing national training protocols[21] and 'training the trainer' interventions around FM. This should be carried out in partnership with BME voluntary sector organisations.

    - Amending and developing current national guidelines to address the question of prevention; to state the value of community responses to FM more clearly; to give clearer guidance on co-ordinating disparate responses to FM; and to tackle the question of lack of confidence or reticence among workers.

    - Developing data collection protocols for LAs (to inform their FM response) - these could require the addition of an FM flag on case records and the regular collection of these data by an LA-based FM co-ordinator.

    - Developing a national database of good practice around preventing FM, and responding to it in an effective and co-ordinated way;

    - Considering the potential role of national capacity-building organisations (such as the Improvement and Development Agency for Local Government - IdeA - and the Centre for Excellence & Outcomes in Children's and Young People's Services) in identifying, co-ordinating and improving national, regional and local knowledge about FM.

[21] This is part of the FMU's 2009/10 action plan.

8.3 Better resourcing of BME VCOs

A lack of resources and capacity was viewed by all agencies as a key limiting factor in addressing FM. However, BME VCOs were often at the forefront of local area response, demonstrating a level of expertise in addressing FM that was frequently lacking among other agencies.

There is a clear need to resource BME VCOs adequately to increase their capacity to deliver front-line prevention and case-response services in collaboration with statutory sector partners.

There is also a need to increase BME VCOs' resources and capacity to work in partnership with a range of statutory sector agencies. This would enable them to share their expertise more formally and assist local statutory sector agencies in improving their understanding of FM and how to respond to it. Thus we make the following recommendation:

- Additional resources should be made available to support the development of FM partnerships between local statutory agencies and local BME VCOs with a strong track record of tackling FM.

8.4 Better engagement and understanding

In all four LA areas, despite a relatively high prevalence of FM, key agencies were perceived to be disengaged from the FM agenda. Although this was not always the case, schools, LA Education Departments, and to a lesser extent LA Children's Services and Housing Departments, were seen to constitute a vital missing link in responses to FM. This disengagement has many causes (including lack of resourcing), but a simple lack of understanding was also frequently cited. Moreover, respondents frequently talked about a reticence to engage in FM work or intervene in FM cases because of fears over cultural sensitivity and misunderstandings about the nature of FM and how it related to cultural norms and values (such as arranged marriage). Respondents also identified a hesitance about working on FM for fear of alienating a community or of provoking a 'community backlash'.

Fears concerning cultural sensitivities speak to a profound misunderstanding and over-simplification of the nature of minority ethnic communities. First, they rely on an essentialist notion of minority ethnic communities as monolithic, unchanging and existing outside of the dominant social and democratic structures pertaining locally and nationally. However, all minority ethnic communities, like all communities, are riven with differences of opinion on matters, are in a process of perpetual social and cultural change, and have constant interaction with the dominant social structures and norms. Interventions around sensitive matters such as FM (from within or without communities) are certain to cause debate and antagonism, but negative reactions are not going to be 'by' a united minority ethnic community 'against' a state authority. Rather these interventions are likely to reverberate within and around that community and will involve a range of individuals and organisations within and without it. Moreover, alliances built up within and around communities are likely to come under strain. If these alliances are central to community cohesion and good relationships *between* communities (especially in areas with a history of racial or ethnic unrest), then sensitive issues such as FM, may serve to reignite old enmities. In these cases, it may be important to take an active approach to managing relationships with (and within) communities and their representatives.

A second factor inhibiting response was a simple failure to conceptualise FM properly. Many respondents talked about a reticence among colleagues to intervene in cases of FM because they would be going against an accepted community practice. This speaks to a failure to distinguish between the use of a cultural practice (such as arranged marriage) to support individuals, families and communities in a functional way and the use of the same practice in a dysfunctional way that undermines individual rights and well being (FM). By challenging and intervening in FM, one is not attacking the cultural practice (marriage or arranged marriage) but rather the *misuse* of the cultural practice. Not to do so is akin to not challenging rape or violence within a marriage for the reason that to do so might undermine the institution of marriage.

The distinction between arranged marriage & FM is critical. Many individuals from affected communities will have had an arranged marriage or, if not yet married, will be expecting or negotiating such a match. Arranged marriages must be carried out with the full ongoing consent of all parties. It is common for children to refuse many partners before agreeing to marry, and some may never agree. This process will carry with it tension, antagonism and dissent (which are all normal in family life) and it is entirely appropriate for children to question and resist their parents' wishes. A marriage becomes forced when, for whatever reason, the child feels they cannot question their parents' wishes and the parents abuse their power over the child. It is likely that this scenario would be entirely unacceptable to the vast majority of people in communities that practice arranged marriages and would be seen as a symptom of a family in crisis. It is vital that all those charged with responding to FM (from within or without the communities affected) understand and appreciate this distinction. Thus, to respond appropriately to FM, an appreciation of the value of arranged marriage as a cultural practice is essential. Thus we make the following recommendation:

- National training protocols on FM should be accompanied by enhanced resources for the provision of such training, and should counter inappropriate reticence, fear and cultural over-sensitivity among workers. Awareness-raising interventions should also be undertaken within the key services. Such training and awareness-raising must provide spaces for workers to speculate on their own assumptions and fears without being judged or proscribed.

8.5 Better prevention

Although there are many pockets of good practice around the prevention of FM, prevention activities were not prioritised nor systematic in any of the four LA areas. Moreover, the more immediate need for case response took priority over a longer-term preventative strategy. There is a need for a longer view to be taken around prevention, and a focus on work with communities and families with the aim of creating the conditions under which FM will come to be viewed by everyone as unacceptable.

The main agencies involved in carrying out prevention work were those from the DV and BME VCO sector. This work would appear to be pitifully under-resourced, and even where it does exist, the capacity of statutory sector partners (such as schools, LAs and police) to make use of it is not sufficient.

The development of prevention capacity must take the communitarian approaches suggested by the BME and DV VCO sector as its starting point (for example engaging with community / faith leaders, empowering individuals within their communities and families, raising awareness within communities). Although this sector is perhaps best-placed to lead on preventative activities, preventative responses must not only focus on changing communities from within. There is much that can be done to exert pressure on community leaders through the political and economic structures they are involved in. For example, LAs with high numbers of elected members from affected communities could make a point of

condemning FM and very publicly engaging in preventative activities. Other examples of interventions from outside of communities include the cultivation of allies or champions within communities. For example, a mosque committee is unlikely to be won over by an LA officer, but cultivating links with a sympathetic individual on or close to a mosque committee might be a more effective way of influencing them.

Supporting communities to develop responses has pros and cons. Care is needed in terms of prevention and doubly so in terms of case response. The involvement of pre-existing mechanisms to deal with the issue of FM, and supportive or well-briefed community and religious leaders / elders or community mediators, may be beneficial in some instances, but community mechanisms that impinge on the rights and freedoms of individuals cannot be supported. Some of our respondents emphasised that women and young people can be rendered voiceless or disempowered by some of these mechanisms, or pressurised unduly into solutions that are not really acceptable. It is therefore key to identify community leaders whose views reflect an approach grounded in CP and women's rights (which may involve training).

Another under-used mechanism as part of community development is parenting interventions. FM could be incorporated into parenting and family interventions that relate to parenting within diasporic or minority ethnic communities. These could look at parental expectations of female or youth behaviour, and how to avoid situations where the young person hides their behaviour and its discovery by parents leads to potential crises such as FM. The BME VCO sector again would be well-placed to lead on such initiatives, perhaps in the context of Children's Centres or Extended Schools, as well as community centres and groups.

We recommend that prevention work is prioritised at LA level through:

- Development and implementation of LA FM prevention strategies detailing key aims and objectives, roles and responsibilities of partners, co-ordinating mechanisms, prevention protocols, methods, approaches and outcomes.

- Central support for local FM prevention work in the form of national prevention co-ordination activities (LA FM prevention strategy template and guidance, conferences, websites, forums, identification and sharing of good practice models etc).

- Increased resources for prevention activities within communities.

8.6 Better detection

This research has identified a range of factors likely to influence capacity to detect or identify cases of FM in local communities. To improve this capacity we make the following recommendations:

- This research indicates that better detection and identification of FM lies in young people's capacity to report it. Potential victims are often severely restricted in their movement, with educational settings the only places where they are free from the surveillance of family. We therefore recommend increasing access to reporting facilities for young people (for example, within schools and colleges, providing a 24hour facility, etc.).

- BME VCO organisations are likely to receive more reports of FM because the types of intervention they offer are often more acceptable to (potential) victims of FM. Although there should be as many routes to help as possible, we recommend increasing resources for the BME VCO sector to respond to reporting more effectively.

- CME plays a huge potential role in detection. We therefore recommend support for schools, EWOs and LA CS and Education Departments to monitor the extent to which CME guidance relating to FM is being followed.

- Although both DV and CP have their own processes in place for detection, there is little evidence either of integration of these processes, or of joint working with the BME VCO sector. We therefore recommend a focus on improving FM co-ordination and joint working between all key agencies and services in relation to any FM / DV forums or protocols (schools, EWOs, LA CS and Education Departments, police and the voluntary sector).

- Communities that are more aware of the issue of FM and more alive to the damage it causes are more likely to recognise FM within their own families and neighbourhoods. It is also important that someone who does notice FM knows how to respond and has access to a range of ways of reporting it. We therefore recommend more awareness-raising work around FM, focusing on warning signs, in schools, colleges, youth settings and within local communities.

8.7 Better case management and response

Lack of resources (especially in the BME VCO sector), lack of engagement, lack of knowledge and expertise, and lack of co-ordination have all been identified as key barriers to an effective case management response. It is likely that all of the recommendations made elsewhere in this chapter would help to improve this response dramatically.

We identified case response mechanisms and methods appropriate to the three ‘framings’ of FM identified above (DV, CP and human rights perspectives). Each of these mobilises different responses involving different stakeholders. All are appropriate depending on the level of risk and nature of the case. However, there is little evidence that they are currently co-ordinated. Moreover, national and local response protocols attend overwhelmingly to the DV and CP response at the expense of that offered by the BME and DV VCO sector. There is a need to redress this imbalance and stress the proper co-ordination of this range of responses at a local level to ensure effective case management. To support this we make the following recommendations specific to improving case response.

- Increase resources (both financial and infrastructural) to BME and DV VCO sector to improve their capacity to respond to cases of FM appropriately.

- Improve national response protocols to take more account of models used by BME and DV VCO.

- Promote informed, careful risk-assessment, which needs to go beyond standard CP risk-assessment approaches, to take into account the particular risks associated with FM.

- Promote more 'victim-centred' approaches to case management, where the wishes and needs of the victim are prioritised and (risk levels allowing) the victim is given more opportunity at an earlier stage to recognise and determine their own best response to the risks they perceive (this may or may not include leaving the family).

- Improve capacity for case co-ordination at an LA level.

- Improve protocols for joint working to address gaps in service provision (specifically that for 16- to 18-year olds), acknowledging that how to address the gap will need to vary according to local capacity, but that responsibilities nevertheless need to be clear.

- Improve guidance for the most appropriate use of FMPOs (in relation to the range of responses available).

- Provide training and awareness-raising for professionals in order to enable them to:

    - challenge damaging practices without being seen to challenge the culture itself;

    - take an 'end-to-end' interest in a case rather than either holding on to a case for too long or referring it on too quickly because it is difficult;

    - understand the range of appropriate ways of responding to FM.

8.8 Achieving an adequate response to FM

The estimate of 5,000 to 8,000 reported cases in England in 2008, provided in Chapter 3, shows that FM is a serious problem which requires an effective national response. Any moves to improve the national response to FM nevertheless need to recognise the varying levels of prevalence of FM across the UK. All the above recommendations could be tailored to identify requirements for low, medium, and high levels of response based on prevalence thresholds in different LAs (e.g. school-based prevention activities focusing solely on FM rather than as part of wider DV training might be more appropriate in a high prevalence area). In the absence of more rigorous data collection, police data where available (in relation to population) could be used as a proxy for FM prevalence. Where police data is not being collated, thresholds could be based on the proportion of communities considered 'at risk' in the population (informed by the findings discussed in Chapter 3).

It is worth stressing again that the barriers to good practice discussed in this report were identified in areas of relatively high prevalence of FM. Hence where prevalence is low, and ethnic and cultural diversity is also likely to be limited, investing in the development of an adequate response can be justified through a recognition that barriers such as fears around cultural sensitivity are likely to be even higher. The need to raise awareness and understanding of FM, as well as to improve co-ordination and capacity to respond to FM among services, schools and communities, hence remains important in all areas for a case to be successfully detected and receive a good and effective response.

References

Asian Women's Resource Centre (2005) *Forced Marriage: Service User Consultation Report*, London: AWRC.

Badman, G. (2009) *Report to the Secretary of State on the Review of Elective Home Education in England*, London: DCSF.

Brandon, J. and Hafez, S. (2008) *Crimes of the Community - Honour-Based Violence in the UK*, London: Centre for Social Cohesion.

Deveaux, M. (2007) 'Personal Autonomy and cultural tradition: The arranged marriage debate in Britain' in B. Arneil, M. Deveaux, R. Dhamoon and A. Eisenberg *Sexual Justice/Cultural Justice: critical perspectives in political theory and practice*, Abingdon: Routledge.

Evans, K., Houghton-Brown, M., and Rees, G. (2007) *Stepping up: the future of runaways' services - a review of services in England, proposing a 'national safety net for runaways'.* London:The Children's Society.

Forced Marriage Unit (2005) *Forced Marriage: A Wrong Not A Right. Consultation paper on whether or not to make FM a specific criminal offence*, London: Home Office.

Forced Marriage Unit (2008) *The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage*, London: FMU.

Gangoli, G., Razak, A.and McCarry, M. (2006) *Forced Marriage and Domestic Violence among South Asian Communities in North East England*, Bristol: University of Bristol and Northern Rock Foundation.

Gill, A. (2005) 'Governing violence: gender, community and state interventions' in *Community Safety Journal* 4 (2): 37-45.

Home Affairs Select Committee (2008) 'Domestic Violence, Forced Marriage and "Honour"-Based Violence', London: House of Commons.

Home Office (2000) *A choice by right: the report of the working group on forced marriage*, London: Home Office.

Home Office (2009), *Together we can end violence against women and girls. Consultation Paper*, London: Home Office.

Homicide Prevention Unit SCD (2005) *A Strategic Scope of Forced Marriage and related issues, reported to the MPS, between 01/04/2003 - 31/03/2005*, London: Homicide Prevention Unit SCD.

Khanum, N. (2008) *Forced Marriage, family cohesion and community engagement*, Luton: Equality in Diversity.

Magill, C. and Lee, V. (2008) *CPS pilot on forced marriage and so-called 'honour' crime – findings*, London: CPS.

Muslim Arbitration Tribunal (2008) *Liberation from Forced Marriages,* London: MAT.

Ofsted (2008) *Children who go missing from education - briefing paper*, London: Ofsted.

Rose, W. and Barnes, J. (2008) *Improving safeguarding practice. Study of serious case reviews 2001-2003*, Research report RR022, London: Department for Children, Schools and Families.

Scottish Women's Convention (2007) *Comment on the Forced Marriage - A Wrong Not a Right consultation paper*, Glasgow: SWC.

Siddiqui, H. (2003) ''It was written in her kismet'' in R. Gupta, *From Homebreakers to Jailbreakers: Southall Black Sisters*, London: Zed Books.

Shelter (2007) *Good practice briefing. Tenancies for minors. An overview of the law on, and good practice in, lettings to 16- and 17-year-olds,* London: Shelter

Uddin, P. and Ahmed, N. (2000) *A Choice by Right: The Report of the Working Group on Forced Marriages*, London: Home Office.

Wilson, A. (2007) 'The forced marriage debate and the British state' in *Race and Class* 49 (1): 25-38.

Whitehead, J. (2007) 'Do 16-year-olds qualify for protection?' in *Primary Headship* June 2007 (http://www.teachingexpertise.com/articles/do-16-year-olds-qualify-for-protection-2258).

Ref: DCSF-RR128

ISBN: 978 1 84775 467 7

© National Centre for Social Research 2009

www.dcsf.gov.uk/research

Published by the Department for
Children, Schools and Families

department for
children, schools and families