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Shaping Priority Services for UK Victims of Honour-based Violence/Abuse, Forced Marriage, and Female Genital Mutilation

Victims of honour-based violence/abuse (HBV/A), forced marriage (FM), and female genital mutilation (FGM) are now defined as ‘priority groups’ in the UK’s Code of Practice for Victims of Crime (commonly known as the Victims’ Code of Practice or VCOP). These groups encompass: those who are affected by the most serious forms of crime; those persistently targeted by crime; those vulnerable by age or physical or mental health; and, those classified as intimidated victims. The Code recommends that these victims receive a ‘priority service’ that includes rapid needs assessment and enhanced support. This article draws upon research commissioned by a county police force in southern England which wanted to develop its provision for ‘priority service’ victims. It analyses data gathered from interviews with victims and multi-agency practitioners and explores four dimensions of victim and practitioner experience: recording and locating victims; initiating a case; modes of protecting victims; and, closing a case. It also discusses future directions and challenges for priority victim work in England and elsewhere, and identifies the many challenges experienced by practitioners working to support the victims of HBV/A, FM, and FGM. This article argues that the voices of both victims and practitioners must be considered in the co-creation of future priority services in this field.

Introduction

UK responses to honour-based violence/abuse (HBV/A)¹ and the related offences of forced marriage (FM), and female genital mutilation (FGM) are changing rapidly (HMIC, 2015).

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The Victims' Code of Practice (VCOP) was amended in 2015 to better meet the needs of 'priority victims,' i.e., those defined as affected by the most serious crimes; those persistently targeted by crime; those vulnerable by age or physical or mental health; and, those classified as intimidated victims (CPS, 2017a). These groups can expect to receive a priority service that includes rapid needs assessment and enhanced support. They now include those who have experienced alleged and proven HBV/A, FM, and FGM. In a further and related development, the National Police Chiefs' Council (NPCC), the body with overall responsibility for investigating alleged criminal activity across police forces, recently published a revised strategy on HBV/A, FM, and FGM (NPCC, 2015) that particularly emphasises developing appropriate multi-agency responses to meet the needs of those affected by these offences. This article analyses data gathered from interviews with priority victims and the multi-agency practitioners working with them. It explores four areas of victim and practitioner experience: recording and locating victims; initiating a case; ways to protect victims; and, closing a case. It also discusses future directions and challenges for priority victim work in England and more widely.

The new approaches to victims of HBV/A, FM and FGM outlined above are rooted in earlier (inter)national initiatives, some dating back decades. At the international level, United Nations (UN)-backed programmes now aim to prevent violence against women and girls (VAWG) and to frame it as human rights abuse. Many states now require local authorities and police forces to have clear strategies for reducing VAWG (MOPAC, 2017; for the UK's National Statement of Expectations, see Gov.uk, 2016). In Europe, significant developments have included resolutions on VAWG from all EU member states and the Council of Europe. The most substantial of these is the Convention on Preventing and Combating Violence

¹ We use the combined term HBV/A to reflect the fact that the terms HBV and HBA are still both used by practitioners and academics in these fields.

against Women and Domestic Violence (CETS No. 210, Istanbul Convention) which came into force in August 2014. It recognises violence against women as a human rights violation and outlines measures designed to prevent such violence, to prosecute its perpetrators, and to protect its victims. The EU signed the convention in June 2017 and it has since been ratified by 27 Council of Europe member states. A further 17 states have signed but not yet ratified the convention.²

The UK's broader VCOP has been informed by these global and European developments but also by longstanding international campaigns to recognise the rights and needs of all crime victims more generally (Spencer and Walklate, 2017). Some scholars and practitioners argue that this new level of (inter)national recognition of gender-based violence affecting women and girls across class, communities and cultures raises questions about the 'distinctiveness' of HBV/A, FM, and FGM (see, for example, Anthias, 2014; Gharaibeh, 2016; Strif and Walby, 2013). This article considers - and challenges - that viewpoint. One source of that challenge rests on the activities of grassroots activists and community-based support groups that have played a leading role in driving the development of new and specific legal provisions for victims of HBV/A, FM, and FGM (for an overview, see, Gangoli et al., 2018; Graca, 2017; Mulivill et al., 2018; Sanders-McDonagh and Neville, 2017), in particular. Indeed, it was a freedom of information request made by one of these activist groups - the London-based Iranian and Kurdish Women's Rights Organisation (IKWRO) - that prompted publication of the first set of national HBV/A statistics, which revealed that more than 11,000 HBV/A incidents had been reported to the UK police between 2010 and 2014 (IKWRO, 2015). While HBV/A is clearly a form of broader gender-based violence, it involves specificities that require a specific response.

² Source: https://eeas.europa.eu/delegations/council-europe/28130/eu-signs-istanbul-convention-13-june-2017_en

Efforts to counter these offences are becoming increasingly visible in UK criminal justice strategies. The Forced Marriage (Civil Protection) Act 2007 enables courts to issue new Forced Marriage Protection Orders (FMPO), a form of injunction that prohibits persons from committing acts that might lead to a named individual being forced into marriage. From June 2014, FM became a specific offence in England and Wales under the Anti-Social Behaviour, Crime and Policing Act. Prior to the introduction of this act, prosecutors would have dealt with FM cases using existing legislation, such as that covering false imprisonment, kidnapping, and violence. Now, forcing someone to marry carries a maximum penalty of seven years' imprisonment in the UK, and breaching the terms of a civil law FMPO is a criminal offence carrying a maximum five-year sentence (CPS, 2017b). For the year ending 2017, 278 applications to prevent a forced marriage were made and 247 FMPOs were issued (Fisher, 2017; Ministry of Justice, 2018). Broader FM trends are tracked nationally by the Forced Marriage Unit (FMU), which, in 2017, recorded 1,196 FM incidences involving British nationals and those with dual nationality in the UK and overseas (FMU, 2018).

As a result of this new legislation, two successful convictions for FM have recently been secured in the UK courts. In the first of these cases, which came before Birmingham Crown Court on 30 April 2018, the mother of a teenage girl (who cannot be named for legal reasons) was prosecuted under key elements of the FM law under s121 of the Anti-Social Behaviour, Crime and Policing Act 2014. It was alleged that the girl's mother had taken her to Pakistan when she was 17, telling her that the trip was a holiday; however, while there she was forced to marry a relative almost twice her age. Throughout the trial, the girl's mother denied claims that she had forced her daughter into the marriage, asserting that her daughter had 'agreed' and was 'ready' for marriage. However, on 22 May 2018 the girl's mother was found guilty

on two counts of forced marriage and one of perjury. She was sentenced to three-and-a-half years for forced marriage and to one additional year for perjury.³

The second conviction for FM was secured at Leeds Crown Court on 29 May 2018. In that case, the young woman involved, who was 19 at the time and studying for her A-levels, was taken out of college during term time for what she thought was a six-week holiday to Bangladesh to visit family and celebrate Eid. However, while there her parents revealed that she was to marry her first cousin. The girl's father told her that the groom had been chosen for her, that he was suitable, and talked of having planned the marriage for some time. When she refused the proposed marriage, she sought the support of her mother, who made it clear that this was a shared parental plan for her future. Her mother swore at her, reminded her that 'no' was not an option and that, if necessary, violence would be used against her; her father also threatened his daughter when she refused to co-operate. In court it was stated that '[Her father] would ask her ...if she'd changed her mind yet and threatened to slit her throat if she didn't comply' and that he 'told her that he'd brought her up for 18 years with love, but that he'd chop her up in 18 seconds if she disrespected him.' The situation changed when the British High Commission in Bangladesh, alerted by young woman's sister just days before the planned wedding, worked with the UK government's Forced Marriage Unit, and the Bangladeshi police to protect the young woman and bring her back to the UK.⁴ The parents were found guilty of using violence and coercion to force their daughter to marry against her will, and were sentenced at Leeds Crown Court on 18 June 2018.

Forced marriage is not the only offence against young women and girls which the UK has legislated against in an attempt to protect them and their human rights. The Female Genital

³ Source: <https://www.theguardian.com/uk-news/2018/may/23/birmingham-woman-jailed-duping-daughter-forced-marriage>.

⁴ Source: <https://www.theguardian.com/uk-news/2018/may/29/couple-found-guilty-attempted-forced-marriage-daughter>

Mutilation Act 2003 made it an offence for anyone to perform or assist in carrying out FGM in the UK, to assist or coerce a girl to carry out FGM on herself, or to take someone out of the country to subject her to FGM. It is also an offence for UK nationals/permanent UK residents to perform FGM on any person overseas, even in countries where it is not a criminal offence. Since October 2015, all professionals have been required to report to the police if a girl under 18 discloses that she is (or if she is suspected to be) a victim of FGM. In July 2015, new FGM Protection Orders (FGMPO) were introduced as a means of imposing the prohibitions, requirements or restrictions deemed necessary to protect an individual. Between their introduction and December 2016, 121 applications and 94 orders for FGMPOs were made (Family Court Statistics Quarterly, 2016, Ministry of Justice, 2018).

Unlike FM and FGM, HBV/A is not a specific statutory offence but rather, a collective term that encompasses 'a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour' (CPS, 2017b). These practices can include FM, FGM, harassment, assault, false imprisonment, threats to kill, rape, and murder. HBV/A is prosecuted according to the laws that regulate the specific offence committed. HBV/A can be distinguished from domestic abuse and other forms of violence because it is often committed with some degree of approval and/or collusion from family and/or community members in response to perceived immoral/shameful behaviour on the part of the victim. HBV/A is found across a range of male-dominated cultures, including South Asian, African, Middle Eastern, South and Eastern European, Turkish, Kurdish, Afghani, and traveller communities. Victims can include men, but the majority are women and girls. The scale of HBV/A in the UK is unknown, but high levels of under-reporting mean that it is likely to far exceed the number of cases revealed by IKWRO in 2015 (Authors, 2017). A further aim of this article is to outline the challenges of revealing, reaching out to, and respecting this hidden population of victims.

Over the past decade, HBV/A has become a growing policy challenge in the UK (see Bacchi, 2009; Brandon, 2008; Brandon and Hafez, 2008; Thiara, 2010; and Chantler, Gangoli and Hester, 2009). Together, these and other studies have explored aspects of victims' experiences (Hague, 2013; Gangoli et al., 2018; Mulvihill et al., 2018), the emergence of new professional practice in response to HBV/A (Local Government Association, 2015; Payton, 2014; Safe Lives, 2014), and the key issues of racism, discrimination, and cultural misunderstanding in this field (Korteweg, 2014; Mirza, 2016; Razack, 2004). However, to date, few studies have asked how these approaches might be coalesced in wider efforts to develop, or reduce barriers to accessing, services for a group now formally included among VCOP's 'priority victims'. In terms of specific policy and practice developments, Korteweg (2014) explores the implications of HBV/A understandings in an immigration context for the legal profession. However, she cautions against the use of culture in public, policy, and legal approaches to honour killing. She argues that, by reifying culture, debates regarding honour killings and HBV/A unfairly racialise immigrant communities within which this form of violence occurs. While that argument is valid, culture is nevertheless an important element in expressions of (and responses to) violence, **as the two 2018 UK FM prosecutions show**. Addressing the role of culture as part of a meaning-making process can facilitate culturally sensitive and appropriate understandings of, and responses to, HBV/A. Supporting this view, Payton (2014: 2863) argues that while HBV/A 'is increasingly recognized as a form of violence against women and girls,' it is 'neither fully conceptualized nor integrated into risk management strategies ... used to address gender-based violence in Europe and Anglophone states.' This article intends to address this gap and respond to recent calls for UK service commissioners to 'identify practical steps' to ensure that local learning 'on the detection/prosecution' of HBV/A is 'maximised and put into practice' (Gov.uk, 2016: 7).

That said, this article also looks beyond the detection/prosecution nexus to identify other key ways in which victims of HBV/A in all its forms can be best supported.

This research was undertaken to inform the development of such services for victims of HBV/A, FM, and FGM in Hertfordshire, a large county in southern England that borders London and has a significant black and ethnic minority (BME) population residing in its urban centres.⁵ The 2011 census records 12% of the usual resident population as being drawn from BME groups, with most of those in turn having South Asian heritage. Contextual and quantitative data were gathered from a wide range of national and local sources. The research team also created its own unique local geographic information system mapping data (Weir and Crawley, 2014). Police recorded HBV/A and FM incident and crime data were plotted in ArcGIS and a hotspot map was created using the smoothing algorithm, kernel density estimation, which is considered the most accurate hotspotting technique (Johnson, 2017; Chainey, 2013). Qualitative data were gathered from 24 victims and practitioners. Ten female victims of British Pakistani, British Bangladeshi or broader South Asian heritage agreed to participate, and were recruited through local practitioner networks. Interviews were conducted in person or by telephone in settings selected by the respondents, typically their own home, a social space or the premises of a trusted local service. The interviews were conducted in four different languages: Urdu, Punjabi, Hindi, and English. All the women had experienced some form of HBV/A, and in four cases, this had involved actual or attempted FM. All had engaged on some level with Hertfordshire services in recent years. They ranged in age from 18 to 50; seven were mothers and had a total of 13 children between them. We argue that these children should be regarded as secondary victims and suggest that further research is required to address their particular needs.

⁵ It was supported by the office of the Hertfordshire Police and Crime Commissioner as the local agency responsible for commissioning services for all victims.

Additional interviews and focus groups were completed with 14 multi-agency practitioners working with this client group in Hertfordshire and beyond. They represented a range of statutory services, including schools, child protection, police, and health, as well as non-statutory services, notably voluntary-sector refuge and specialist support agencies. The majority of these participants were women of white British heritage. Two of the interviews were conducted with medical professionals who had dealt with a small number of local FGM cases. Despite many attempts, the team was unable to identify or interview any women or girls currently living in Hertfordshire who had directly experienced FGM.

This article explores four dimensions of victim and practitioner experience: recording and locating victims; initiating a case; modes of protecting victims; and, closing a case. It then discusses the future directions and challenges for priority victim work.

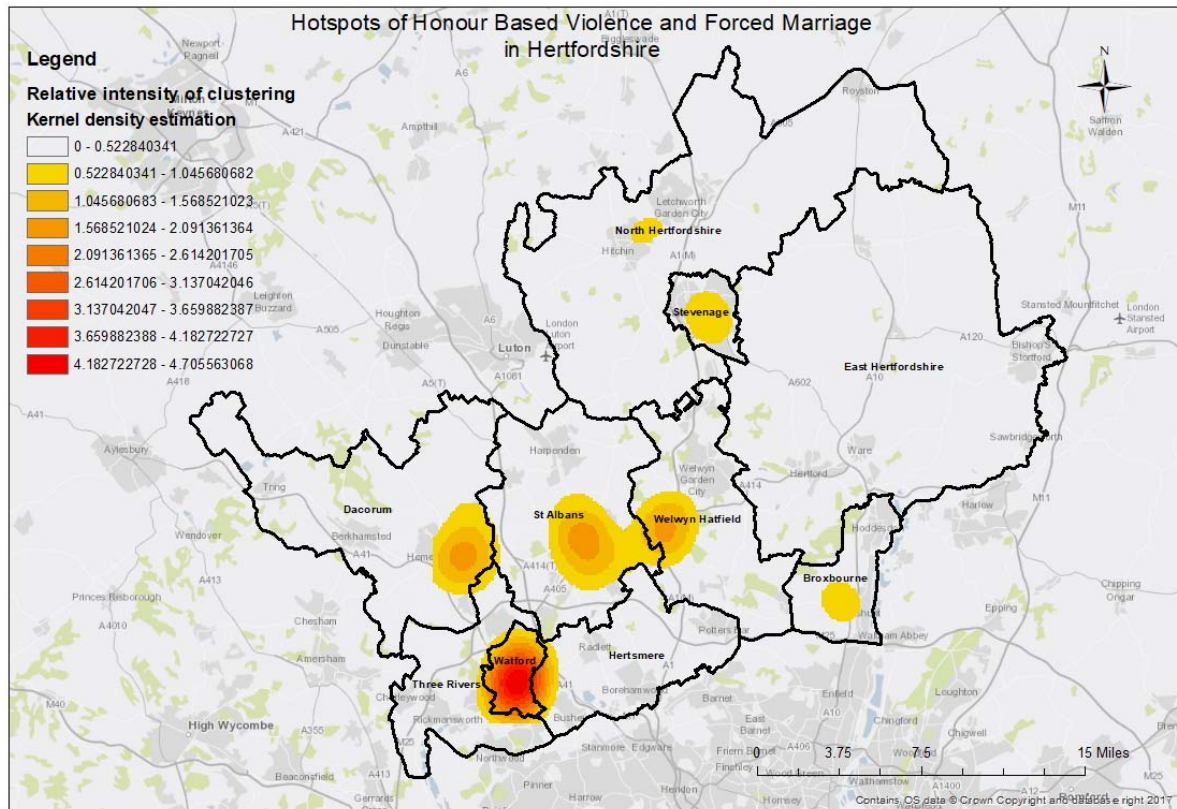
Recording and locating victims

One of this initial aims of this project was to document the scale of HBV/A, FM, and FGM in Hertfordshire and to map its distribution. County police data showed 270 recorded HBV/A incidents or crimes occurring between April 2013 and February 2017. The data offers valuable insight into the nature of these cases: 77% were flagged by the police as linked to domestic abuse, and just 4% were flagged as FM; 43% involved alleged perpetrators described as being of Pakistani heritage; 21% involved victims described as Asian/British Bangladeshi; and, over one-third were concentrated in a ‘hotspot’ in and around Watford, the county’s most ethnically diverse town (see Figure 1). However, this headline summary also highlights immediate challenges in the local recording of HBV/A. It became clear during the research process that not all incidences of HBV/A had been recorded as such, with an unknown proportion being noted as more general domestic abuse cases. At the same time, some incidences of HBV/A had not been additionally flagged as domestic abuse when they

perhaps ought to have been. This discrepancy is significant, because it meant that only a proportion of recorded HBV/A cases were routinely referred to local multi-agency risk assessment conferences (MARACs); a vital first move towards early intervention may, therefore, have been missed. Further, the ethnicity of alleged perpetrators and victims was unevenly and often inaccurately recorded. All these factors make it difficult for the police and other practitioners to identify and locate potential priority victims - the first step towards meeting their wider needs. Notably, local data support the need to separate the specific incidence of HBV/A from the wider incidence of domestic abuse. The county's domestic abuse joint strategy identifies Stevenage as its highest risk area and Watford as a medium risk area.⁶ The local police data discussed above, however, shows that Watford is the county's HBV/A hotspot - a fact that would remain hidden without specific flagging and mapping.

Figure 1: Hotspots of HBV/A and FM in Hertfordshire (crimes and incidents combined) Hertfordshire Police, 2017. N = 270

⁶ Source: <https://www.hertfordshire.gov.uk/media-library/documents/herts-sunflower/domestic-abuse-joint-strategy-needs-assessment.pdf>, section 7.9.



To date, Hertfordshire has had only a small number of reported FGM cases. Local health service professionals, now legally obliged to report on it, recorded 35 cases between April 2015 and March 2016 and local police have recorded 20 cases since 2011. However, it is not clear how many, if any, of these 20 cases were also among those raised by health professionals, or how these cases were progressed, beyond the fact that just one resulted in an interim FGMPO being issued. As with broader categories of HBV/A, the number of cases is likely to be much higher, given that 12,000 female residents of Hertfordshire were born in countries with high FGM rates, notably Somalia. Research on FGM rates across local authorities in England and Wales, undertaken by combining prevalence data with census and birth registration data, estimates that 1,295 women in Hertfordshire have experienced FGM (Macfarlane and Dorkenoo, 2015a). Additional data indicates that around 400 women from high-prevalence FGM countries gave birth in Hertfordshire in the year 2013-14, which means that approximately 200 girls who are likely to be subject to FGM in the future were born

there (Macfarlane and Dorkenoo, 2015b). Thus, similar challenges to those around victims of HBV/A surround the local identification and location of FGM victims, although these challenges are faced most directly by health practitioners - midwives, health visitors, and general practitioners (GPs) - rather than by the police.

Initiating a case

Victims' experiences of disclosing their abuse are very varied, but our participants' narratives can be divided into two broad groups: those who disclosed at a point of crisis, and those who disclosed at an earlier juncture. The first group was more likely to approach the police, often in direct and immediate fear for their own physical safety or that of their children, and the second group was more likely to approach a friend, relative or representative of other services, particularly teachers or health professionals.

Fatima and Tabassum both disclosed at a point of crisis. Fatima, 40, grew up in Pakistan and married a man 14 years her senior when she was 24. The couple lived and worked in Saudi Arabia for a time before moving to the UK with their two young daughters. A trained nurse, Fatima was able to find work quickly, first in the Midlands and then in Hertfordshire.

However, her husband found it harder to gain employment, and she reported that this was a contributing factor to his increasing emotional, financial and physical control. Fatima's first (and highly problematic) contact with local agencies occurred when she called the police after her husband assaulted her because she had refused to give him her bank card.

Shockingly, the police attending the incident believed Fatima's husband's claim that she had instigated the assault, and took no action. Thereafter, his abuse escalated to the point where he would regularly threaten Fatima with a knife. **Here, she describes her experience:**

I was knowing that I'm at risk and my children are at risk but I was not able to do anything because police weren't there for support ... I felt down. At that point, they

didn't help at all. No, not at all and if, you know, if that time, they could catch that point instead of threatening me, they could, you know, speak to him, you know, so he might...become a better person if he wanted to. Because it would have given him more courage to abuse me when I was threat[en]ed that I will lose my job and I will lose everything. You know, it made me so...vulnerable to that situation that I was thinking that there is no support around... But when I, you know, met Jess and that domestic violence advisor, she was the one who then spoke to Paul and spoke to, you know, whatever places, MARAC [Multi-Agency Risk Assessment Conference].

Fatima's second contact with local agencies was more proactive and supportive. She approached her GP suffering from severe stress and, during the appointment, felt able to disclose the abuse she was experiencing. The GP put her in touch with a domestic violence helpline, and the staff there referred Fatima to a local victim support service that assigned her to an independent domestic violence advisor (IDVA). Her subsequent dealings with the local police were much more effective as a result of IDVA support - with their assistance, she was able to secure restraining and other orders against her husband.

Tabassum, 34, was born in the UK but moved to Pakistan with her family at the age of 10. As a young adult, she married a man she had met at work in Lahore. He soon became violent and coercive, and continued to assault her when she was pregnant:

Basically, there had been a series of domestic violence [incidents] by my husband. It all started off ... as soon as I got married, and ... [when] he got to know that I was expecting, so he thought that's it. He's got married to me, now she's expecting and I'm sort of his property. He can do whatever he wants to, and it started right off, like literally six/seven weeks, after one-and-a-half months or something after I conceived and all of that. The domestic violence, the most important thing is that you need to

realise that once it starts, it's never going to finish. The person is never going to stop. He's going to blame everything on you. They've got this way of manipulating and controlling your mind that makes you think that you do something that [provokes] them, which makes them come to the point where they start all of that, all the violence.

Fearing for her safety, Tabassum left her husband, moved in with relatives, and applied for a British passport for her new baby daughter. Having secured the passport, she then applied to the British High Commission for an 'emergency travel document.' She was refused, but was nonetheless able to leave Pakistan for the UK soon afterwards:

It took about nine months to get my daughter's passport, and during that time, just to make him think that I might return to him, because people like this they need to have the comfort that, okay, maybe she's going to come back to me. If I ever gave him the feeling that I'm leaving him for good, then that's the time they react and they get mad and all that.

After arriving in the UK, Tabassum and her daughter stayed in Hertfordshire with relatives, who put her in contact with the local police because of her concerns that her husband or his UK-based extended family might try to abduct her daughter. Tabassum spent a short period in a local women's refuge and later moved back to Pakistan to prepare for divorce and custody proceedings.

Both Tabassum's and Fatima's stories reveal much about the diverse circumstances under which 'crisis disclosure' can occur; they also illustrate how 'local' services for these groups of priority victims must now respond to the complex international dimensions of many HBV/A cases.

One further case demonstrates the difficulties with disclosure women faced in the recent past—difficulties many women continue to encounter today. Naheed, now 50, experienced child sexual abuse, FM, and domestic violence, but never felt able to approach the police. She recalled that when she was 13 her mother told her that she had agreed to a marriage between Naheed and an older first cousin from Pakistan—a man who according to Naheed had ‘sexually abused me when I was a child.’ The marriage was ‘considered a way of making things alright again.’ Naheed recounted, [I] ‘married [in the UK] at 16; as soon as I finished school, so, in school I had my engagement ring.’ Her school took no action, and her husband subjected her to continual violence, but she felt unable to disclose this to other family members or outside agencies—she felt that her mother, in particular, would not support her. She gave birth to her first child when she was 17. During this period, her husband spent long periods back in Pakistan, but was frequently violent on his return visits. When their daughter was two years old, Naheed contacted UK immigration authorities and disclosed her abuse and her belief that her husband ‘had two British passports’ in an effort to prevent him from returning. Her husband stayed away, affording Naheed ‘three years of peace,’ but then returned. At this point, Naheed said, ‘I was about a month with him and then I took my daughter and we just ran away ... we just left because I thought, “I can’t do this anymore”.’ She moved in with a close family friend some distance away and, with her support, enrolled in a degree course and later became a teacher. Reflecting on why she felt unable to disclose her experiences more widely, Naheed revealed:

It felt disloyal to the community ... I was scared of being ostracised because I was still very young and [I felt] the shame of it all ... You’ve been told since you were a child that it was your fault, so you think it is.

Schools and safeguarding teams can, however, play an earlier and much more prominent, albeit sometimes turbulent, role when it comes to protecting younger victims, as the case of now 18-year-old Zara exemplifies.

From the age of 14, Zara's parents had pressured her into first agreeing to a future marriage to a man who was 10 years her senior, and then to marrying a younger second cousin (the son of her grandmother's brother). Both men were resident in Pakistan at the time. At the age of 15, Zara disclosed her fears about what was happening, first to friends at school and then to a teacher who subsequently informed Hertfordshire police. The police then contacted, and later visited, Zara's parents. After that visit, Zara's parents forced her to leave the family home, despite the fact that she was in the midst of her GCSE exams. She spent the first night away from home with her boyfriend's family. Social services then arranged a local foster care placement, and sought to move her to a London refuge. Zara reports having a difficult relationship with her social workers after leaving home, as she felt that they did not believe her or put her needs above those of her family. She was very reluctant to move to the refuge; her foster care arrangement was subsequently extended and remains in place today.

Zara recalled her deep reluctance to involve the police or her parents and how she overcame it:

Yeah, well, obviously, my teacher was concerned, so she got the police involved, but when I saw the police there, because I didn't know what was happening, then I was, like, 'Why have you called the police? What's going on? I didn't want all of this to happen, it's just going to go right out of hand;' but she said to me, 'We're only doing what's best for you.'

After agreeing to a series of appointments in school with the police, she remembered:

[The police] said ‘We need to speak to your parents about it.’ I was just like, ‘No, it’s not going to happen. I’ll sort it.’ I just didn’t want things to get worse ... but in the end, we had to go and tell my parents. It was a bit scary but I think, yeah, they listened, my parents.

In this case, Zara’s status as a minor meant that the key processes driving the instigation of her case were determined by statutory child protection and safeguarding procedures. That said, it is notable that both her teachers and the police allowed Zara to set the pace, to a degree, in terms of how they timed the implementations of those processes. They also interceded on Zara’s behalf to support her case to remain in local foster care rather than being moved to a more distant women’s refuge. Importantly, it was her parents’ decision to make her leave the family home that triggered her referral into foster care and her designation as a ‘looked-after child.’ Significantly, Zara opted not to proceed with an FMPO against her parents:

I refused to get one ... because I just didn’t want my family to be taken, like, down to court. I just didn’t want to make things worse than what they already were. Then once I left home, I got asked again if I wanted to, and I refused then because I knew I wasn’t going to go back, so I thought, what’s the point, if I’m not even going to go back and get [an FMPO].

Although the experiences of the victims and practitioners explored in these brief examples indicate that more still needs to be done to improve the efficacy of targeted initiatives designed to protect those at risk of FM, to prosecute those who perpetrate FM, and to raise awareness of this issue as one that gravely affects the human rights of females in specific communities, the positive experiences of the victims discussed here were characterised by timely, personal updates on the progress of their case in the days and weeks following their

contact with services and, where appropriate, provision of additional security measures such as a phone. The women appreciated not only having a dedicated police officer who knew the case, which meant each time they had contact with services they did not have to repeat their story, but also having a second officer who was similarly well briefed. Those victims who were contacted by the force HBV specialist were particularly happy with the support they received. **These specialist contacts were therefore very central to the ability of police and other agencies to identify, and begin to meet, the needs of these particular ‘priority victims’.** The next section addresses the wider importance of acknowledging and respecting victims’ preferences within priority services.

Protecting victims

According to the VCOP, services for priority victims should include rapid assessment and enhanced support. That support can take many different forms, as our interviewees testify. Four interviewees, including the youngest and oldest, had spent time in a women’s refuge, and all found the support offered there invaluable. The provision of refuge accommodation must, therefore, remain a central element in commissioning or enhancing services for priority victims of HBV/A. However, in this article we focus on four other kinds of support offered to or sought by the victims featured in our study: prosecution of perpetrators, protection orders, safeguarding, and open-ended support.

The current VCOP does not include specific guidance or support for victims wishing to bring charges against perpetrators, but it does require victims to be kept informed if a charge is brought and to be advised of their right to submit a Victim Personal Statement. A very small proportion of domestic abuse and HBV/A perpetrators face criminal charges: just 8% of all UK domestic abuse incidents in 2016, for example, although 72% of those prosecutions did

result in a conviction (ONS, 2017). There are many reasons for the low number of prosecutions, but a key one is the huge struggle faced by victims seeking to follow this route.

Only one of the 10 victims we interviewed attempted to press charges, but, having done so, she then felt unable to proceed. Aliya, a British Indian woman now in her late thirties, pressed charges against her abusive estranged husband on two occasions, but could not pursue them, recalling, 'I had threats from him and his family to say they were waiting outside my house to watch to see if I was going to go to court or not.' She asked local IDVAs to attend court with her, but said that they were unable or unwilling to do so. Her husband now lives apart from Aliya (and her children, one of whom is still a minor), but continues to threaten her. She expressed her fear that further reports to the police might result in her younger child being removed from her care:

I just feel every time I call the police they have a duty to call social services because I've got a [nine-year-old child] and when social services get involved they [do it] so heavily that it makes you look like you're a bad parent, that you're the issue ... and the whole concentration then goes to social services and [not] the police.

However, other interviewees reported that they had taken out various protective orders against perpetrators and worked with a range of agencies to enforce them. In addition to new specialist orders such as FMPOs and FGMPOs, protective mechanisms include more established options such as restraining, non-molestation, and harassment orders.

For instance, Fatima, whose case was discussed above, applied for and gained a two-year restraining order against her husband after suffering a sustained period of HBV/A, including physical assault and coercive control. He subsequently left their house and went to stay with his extended family in Pakistan. On receiving tip-offs from relatives that he was planning to return to the UK to remove their daughter to Pakistan, Fatima informed the local police, and

they alerted the Border Agency of the potential risk to Fatima's child; Fatima's husband was arrested at a UK airport on his return from Pakistan. Since then, the couple have divorced and Fatima and her children have retained the family home. Her husband has been granted indirect access to the children by the family court, and lives in the same neighbourhood with a new partner.

Available national data cited earlier indicate that only a small proportion of FM victims have taken out FMPOs against alleged perpetrators. In many cases, doing so would require victims not only to challenge (or break ties with) their closest relatives—mothers, fathers, aunts, uncles, sisters, brothers—but to initiate formal proceedings against them. The fact that these are civil rather than criminal proceedings seems to have little effect on that understandable reluctance.

Malika, now 23, sought help at the age of 20 after enduring repeated sexual assault and harassment from her brother-in-law and the threat of a forced marriage to his brother. She was living with her parents and extended family, so contacted the police from her workplace. She made the decision to disclose when her parents took possession of her mobile phone and passport and appeared to be making marriage plans behind her back. The police came to meet Malika at work, arranged for her to stay in local refuge accommodation, and informed her of her right to take out a FMPO. She opted not to do so, commenting in her interview, 'I chose not to take it out, and it's only because I felt at the time there was just so much going on that I didn't want to take it out.' The police have continued supporting Malika by making regular contact with her over the three years since she disclosed, and, in turn, she has assisted them with local HBV/A awareness campaigns.

As outlined above, just one of Hertfordshire's reported FGM cases resulted in the issuance of an interim FGMPO. It was not possible to establish further detail on that particular case, but

our interviews with health professionals in Hertfordshire yielded valuable insights into the challenges of supporting FGM victims. One GP described her encounter with a 26-year-old woman of Sudanese descent: the woman had been ‘cut’ as a child, but, as she was about to be married, she wanted to be ‘uncut’ and was, therefore, seeking surgery. She also spoke about her ‘distress’ at this ‘awful’ prospect, and her concerns about how her partner would react to her physical appearance after treatment. The GP referred her to a north London hospital, but was unable to follow up beyond this, as the woman moved away from the area soon afterwards. However, the GP did take the opportunity to advise the woman that if she were to give birth to a girl in the future, she should not have this child cut. In this scenario, issuing a retrospective FGMPO to protect the woman, or a prospective FGMPO to protect a future daughter, was neither possible nor desirable.

Safeguarding is the final protective strategy now widely used to protect (potential) victims of HBV/A and related offences. It is a broad term encompassing a range of activities that can be initiated and undertaken by a range of agencies. Since the concept of safeguarding first emerged within child protection, it has over the last decade been much more widely adopted and extended to include adults. The Care Act 2014 requires all UK local authorities to have safeguarding systems in place to protect any person’s right to live in safety, free from abuse and neglect (NHS England, 2017). Safeguarding now plays a central role for all professionals working across HBV/A, but, as our interviews suggest, the practice raises complex questions of professional ownership, discretion, and consistency.

As indicated in the earlier discussion of how HBV/A cases are first initiated, safeguarding strategies seem to be most effective when directed at reducing risk to direct or primary victims who are children or young people. In Zara’s case, her teachers were quick to act when they heard about her FM fears. Another interviewee, Zareen, 22, was assisted by safeguarding teams when she chose to pursue higher education against her family’s wishes:

My dad didn't want me to continue with my education ... He thought that the woman's place was at home, to get married and have children. To be a wife basically. I thought if I took another year at [sixth-form] college they might come round, but then when they didn't, I made the decision to leave and put in an order [FMPO] to continue my education.

In both these examples, frontline professionals who first encountered the women's cases were very familiar with safeguarding aims and objectives.

However, safeguarding strategies may be less effective where frontline professionals are not as familiar with safeguarding, or, more importantly, when they perceive safeguarding as an 'addition' to their already heavy workloads. One GP referred to the challenges she faces when incorporating safeguarding into her routine work:

Certainly, for us it's a very difficult job just to, kind of, cover everything. So, general practice has got a lot of tick boxes, a lot of processes and, predominantly, we're looking at health. When it comes to health prevention we always struggle with it a bit ... because we're not funded for a lot of the outside questions like safeguarding.

According to many health professionals, and the GP interviewee, routine 'six-week check' appointments for new-born babies and their mothers represent an ideal opportunity to identify potential abuse of the mother, the child or both. However, they thought that these appointments are often too short to allow for adequate coverage of more complex issues. This GP described the problem thus:

We ask whether the child or the sibling is on the child protection register [and] if there's any domestic violence in the family and we now have a specific question, which the doctor can choose which person they ask, which is, 'do you belong to a

community that practices FGM?’ [And] on top of that you need to ask, ‘Are you breastfeeding? Are you feeling depressed? Is the baby smiling?’ There are a lot of questions to ask and then suddenly there’s this extra bit, which comes very much out of context. You’re talking about a physical assessment of a baby and then suddenly you go into this very sensitive discussion—all in 10 minutes.’

Although this doctor’s comments were offered in relation to her experience of dealing with FGM, they also hold wider relevance for GPs’ experiences of attempting to play their multi-agency part in safeguarding adults, children, and infants - among them, (potential) HBV/A and domestic abuse victims - in such limited timeframes. Yet, as Fatima’s case has already indicated, a brief but effective and sensitive encounter with a GP can be a key trigger for a victim’s disclosure and life-changing (and indeed, life-saving) intervention.

Police officers also reported challenges in adapting to more expansive and open-ended safeguarding practices. One officer remarked:

I think the problem with safeguarding [is that it] is unusual for the police in the sense that it’s not a question of, you have done your prosecution and you more or less move on to the next job. The safeguarding remains there for the future, doesn’t it, however long that is and that could be months, years, and I don’t think, in all honesty, we have really got the structure to allow for that long-term safeguarding. We are very much focused on, like, what do we need to do now, right, we need to do this, we need to do that, but in long-term monitoring, I don’t think we manage that sufficiently at the moment.

He also felt that more open-ended safeguarding activity could be compromised by tightly scheduled and time-restricted police activities, particularly procedures governed by the Police

and Criminal Evidence Act [PACE] (which, for example, sets strict timetables for interviewing, charging or releasing suspects):

I'm limited by time, by custody time limits, by PACE clocks. I'm limited by so many different things as to when I can do stuff; I have to go to court on a certain day, I don't have any option, so if I have an appointment to see a victim of honour-based violence on that day and I get called to court because it's a bail application, I have to go, so I let that person down. I find it really, really difficult now, and I find it quite uncomfortable to try and manage a safeguarding case to the degree that I used to.

Maintaining a commitment to open-ended, discretion-driven work with HBV/A victims would seem to play a vital role in shaping future priority services for these victims. Indeed, a number of our interviewees indicated that they had benefitted from patient support offered at their own pace. Such support was vital in enabling these women to disclose their abusive situations and feel empowered to take steps to change their circumstances. It also facilitated enhanced support to victims such as those featured here, who often become very isolated from family, friends, and community at the point of disclosure.

Malika elaborated on the importance of the daily phone calls she received from the non-government organisation supporting her when she was first admitted to a refuge, but also highlighted the harm caused when that particular form of support broke down:

The organisation that was helping me out, they were really, really good. They used to ring me up every single day ... and I used to think, 'Why are they calling me?' I was with one specific lady who used to ring me every day, 'Hi, how are you, what are you doing today, what's your plans?' I used to think - nothing, I've got no money, I've got no family, I don't know anybody, I'm in a refuge. But ... because of her, having phone calls every single day, I got

through. When I was in my second refuge, the police officers around that area didn't even have a clue that I was there, or about my protection, or even the protection in general of other ladies I'd come across. It was only when I got in touch with my original police officer to say, 'I don't feel protected' [that things improved]. I felt I had to go through him to get all the other support, otherwise I couldn't have got through it.

Importantly, while this open-ended, discretion-driven support is central to priority services for HBV/A victims, it is not always clear how or when it should be withdrawn. The final section of this article addresses the challenges involved in closing a case.

Closing a case

Much research on HBV/A, and domestic abuse more generally, focuses on the need to encourage victims to disclose their experiences, and on the subsequent need to keep those victims safe from immediate harm (Mulvihill, et al., 2018; Gangoli, et al., 2018). However, there is much less focus on the point at which support can or should be withdrawn. A striking finding from our interviews concerned the long-term nature of priority victims' need for support, particularly for mothers who must negotiate their ex-partner's rights to ongoing contact with their children. Many HBV/A perpetrators are fathers who often seek, and are entitled to, such contact. As Rozina's case highlights, this parental right can greatly expand both the temporal and spatial dimensions of victim support.

Rozina, now 26, left school at 16 and gained work as a traffic warden in Birmingham. She was sent to Bangladesh for an 'arranged marriage' at the age of 17. She has since come to view this as an FM, as her passport was 'taken away,' and she divulged that 'the only way I could come back to [the UK] was if I got married.' She soon became pregnant and was sent back to the UK to give birth. Her family forced her to return to work when her baby was just

six weeks old so that she could provide payslips as evidence that she would be able to support her husband's migration application. Soon afterwards, he duly moved from Bangladesh to the UK and became abusive towards Rozina. Having 'taken a year of it,' and in the midst of a particularly violent incident, she 'called 999,' saying, 'I've never spoken about this before but please come and help me—I think he's going to kill me.'

Rozina was given assistance from the police to leave the family home with her young son. She first moved to a women's refuge in the Midlands, and later relocated to the South West, forming a new relationship with a white British man and having a second child with him. The couple then moved with the two children to another county on local MARAC advice after receiving death threats from Rozina's father and other family members. Despite this threat, Rozina is obliged to maintain (in)direct communication with her ex-husband, as he continues to seek contact with his son through the family court. In Rozina's case, safeguarding and protection measures are still in place nearly 10 years after the initial FM and over five years after she left her husband for the refuge. Rozina describes her ongoing fear for her own safety and that of her current partner and children, even though her ex-husband has completed a court-ordered domestic violence perpetrator programme. Her need for safeguarding persisted not only because he continued to behave in a directly threatening manner during contact handovers, but also because, in Rozina's view, his extended family 'would never give up their war' against her.

Rozina's case demonstrates how the safeguarding agenda can create competing and contradictory priorities, particularly where children are secondary, rather than primary, HBV/A victims. A female victim may need to be safeguarded from her violent partner, yet that same partner may lawfully exert his rights to maintain long-term contact with his children unless he is also deemed to pose a threat to them. Four of the seven mothers we interviewed had encountered persistent problems linked to ongoing custody or contact

agreements. Rozina, in particular, felt that she had lacked guidance when agreeing to family court contact arrangements, an issue which must be considered in future service development for priority victims.

The definition of case closure depends, to a large extent, on the nature of the victim's disclosure and the support she is offered and/or accepts (Mulvihill, et al., 2018). In the most positive instances of victim - police contact identified in our sample, the victim received exceptional aftercare, maintaining long-term occasional contact with, and at the professional discretion of, her dedicated officers. This might best be described as 'open-ended safeguarding' and would seem to have a key part to play in service development for these priority victims.

Conclusion

In 2016, the UK published a National Statement of Expectations that sets out a framework for local authorities and police forces designed to guide their efforts to tackle VAWG (Gov.uk, 2016). The document calls for service commissioners to 'identify practical steps' to ensure that local learning 'on the detection/prosecution' of 'honour based violence' is 'maximised and put into practice' (Gov.uk, 2016: 7). Responding to that call, this article has sought to contribute much-needed evidence-based local learning that can inform local practice in this field. Drawing on the experiences of victims and practitioners in a large southern English county, it argues that HBV/A - and the linked issues of FM and FGM - is a distinctive policy challenge requiring a specific yet flexible response. It acknowledges the intersectionality of HBV/A and accepts that it is a product of both gender-based and culturally inflected violence; policy and practice responses to HBV/A have been, and continue to be, shaped by racism and cultural misunderstanding. However, this article seeks to move these debates forward by

channelling victim and practitioner insights into pragmatic programmes for change that, ultimately, help reduce harm.

Overall, this article argues in favour of protecting and developing distinctive services for victims of HBV/A, FM, and FGM on the grounds that their victims share distinctive needs, despite having different cultural and/or class backgrounds. It supports the view expressed in more detail elsewhere (Gangoli et al, 2018; Mulvihill et al, 2018) that this distinctiveness is attributable to the fact that such victims face unique challenges in disclosing their abuse, challenges which may often have complex intra-national or international dimensions. Further, victims of HBV/A are likely to require a range of support options that stretch beyond the detection/prosecution and refuge nexus and to include protection orders, safeguarding, and ongoing discretion-driven care, most especially when children are or may be involved as secondary victims. As the above discussion of protection orders shows, adult women victims may choose not to pursue all these options, in which case that choice should be respected. To that extent, this article aligns with Payton's (2014) analysis of the ways in which concepts of honour can shape service responses and, in particular, that 'risk assessment thus needs to commence from a client's apprehensions of harm and from the histories and capacities of potential perpetrators rather than her own cultural identity or actions' (Payton, 2014: 2879). The question of whether HBV/A, FM, and FGM are 'distinct' forms of gender-based violence continues to divide scholars and practitioners in this field. This article argues that these practices have been framed, *de facto*, as distinct through the enacting of distinct legislation to outlaw them; by extension, victims of these practices are framed as distinct and this is a further reason why they currently require distinct responses. However, it is argued here that those responses can, and should, be multilinear rather than unilinear.

Finally, this article argues that identifying and responding to priority victims, according to the VCOP's definition, depends on consistent recording, mapping, and sensitive sharing of core

case data, including victims' ethnic heritage where appropriate, and the clear flagging of HBV/A as a distinct form of broader domestic or gender-based abuse. Without such information and information-sharing, the local scale and distribution of HBV/A will remain concealed; its victims will remain hidden; and, their needs will remain unmet. To argue that these victims should be a local priority, and that they deserve priority services, is to acknowledge and seek to remedy past policy and practice failings.

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