Harmful Practices Pilot

Final Evaluation Report

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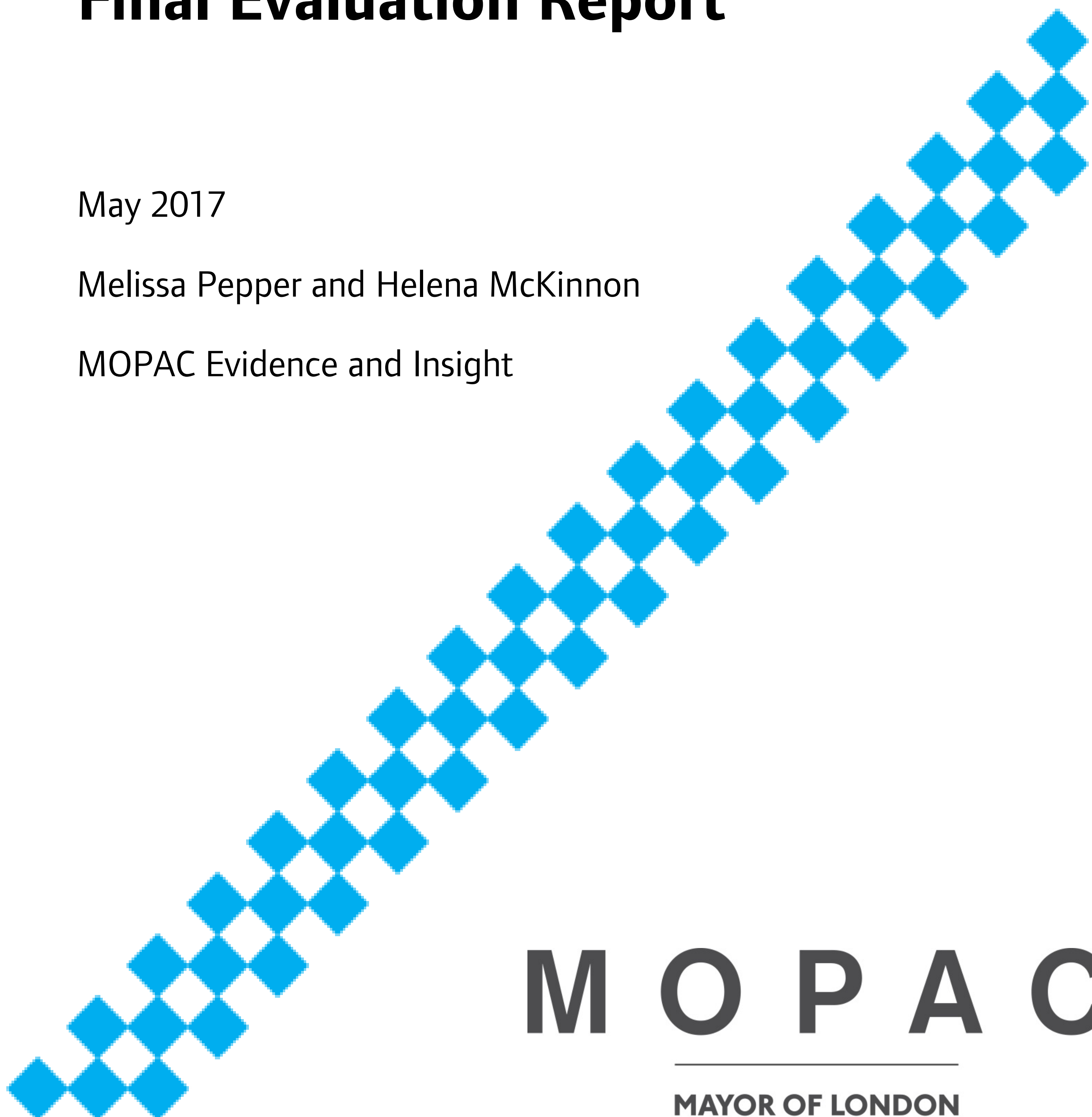
MOPAC Evidence and Insight



Executive Summary **3**
Introduction **4**
Background 4
The MOPAC Harmful Practices Pilot 5
Final Evaluation Report: Building on a Year One Interim Report 6
Methodology **6**
Results: Reflections on the Two Year Pilot **7**
Implementation 7
Early Identification and Prevention: Training Professionals 8
Safeguarding and Support: Advising and Guiding Professionals through the Educator Advocate Service/Surgeries 12
Community Engagement: Empowering Women and Girls 16
A 'Partnership' Pilot: Working Together to Tackle Harmful Practices 18
Discussion **19**
References **21**
Appendices **22**

Executive Summary

The MOPAC Harmful Practices Pilot aimed to improve the way agencies identify and respond to Female Genital Mutilation (FGM), 'Honour' Based Violence (HBV), Forced Marriage (FM), and Faith Based Abuse (FBA), with a focus on early identification and prevention, safeguarding and support, and community engagement. The two year pilot, delivered by the Partnership to End Harmful Practices (PEHP, a consortium of seven women's organisations) in Westminster, Kensington and Chelsea, Hammersmith and Fulham, Tower Hamlets and Waltham Forest, began in April 2015. It involved three key areas of work: training for professionals; an Educator Advocate (EA) service delivered by a member of staff from one of the PEHP organisations to provide advice and support to practitioners (via two half-day surgeries per borough per week located in statutory agencies); and community engagement activity. This report reflects on learning from the pilot, during which a number of positive messages emerged:

- Training has been widely recognised as a key success with the **74 courses** delivered received well by attendees in terms of quality, content, and improving practitioner knowledge around harmful practices. Respondents felt the training had improved their ability to identify and respond to harmful practices, and often highlighted examples or plans to share learning with colleagues back in the workplace.
- EAs facilitated **591 surgery sessions** providing advice and support in relation to **218 harmful practice and Violence Against Women and Girls (VAWG) cases**. Project leads and practitioners recognised the wealth of knowledge that EAs brought around harmful practices and beyond (e.g., immigration advice, language skills), and shared examples of cases where EAs and practitioners worked together to support clients.
- EAs arranged or took part in **51 community engagement events** with the majority of feedback received indicating that attendees understood more about harmful practices and where to access support after events. Practitioner attendees spoke positively about opportunities to find out more about services in their area, which would help them better support clients.
- A **strong partnership approach** underpinned the pilot, with statutory and voluntary services learning from each other around how to support those experiencing, or at risk of experiencing, harmful practices.

However, the pilot has also presented challenges, particularly around the EA role/surgeries, where referrals have at times been slow, access to resources (e.g., internet, computers, and case files) limited, and EAs have been required to continually build relationships, promote the project, and 'carve out' their role within fast-paced, often changing surgery host organisations. While community engagement efforts were welcomed, pilot staff interviewees felt that some events could have achieved more with additional coordination and planning, including specific community engagement materials. The pilot highlights learning around the importance of comprehensive early project planning, and clear operating models, both at strategic and operational 'on the ground' level – challenges not unique to the Harmful Practices Pilot.

The Harmful Practices Pilot has started conversations, encouraged 'professional curiosity' in practitioners, and highlighted new ways of thinking amongst statutory and voluntary agencies about under-researched and often misunderstood violent and abusive practices affecting thousands of individuals throughout the UK and millions across the globe. Practitioners and professionals who took part in fieldwork often commented that the pilot training package could be developed for wider rollout, together with refresher workshops to ensure that learning continues. The training 'offer' should be embedded within an organisational commitment to review policies to ensure that trained staff can put learning into practice back in the workplace. The pilot contributes to a limited yet developing evidence base around harmful practices. The challenge now is to continue to raise awareness and further develop partnerships amongst statutory and voluntary agencies, and communities themselves, in order to build on learning to more effectively identify and support individuals experiencing, or at risk of experiencing, harmful practices.

Introduction

Background

The limited (although developing) research around harmful practices – including Female Genital Mutilation (FGM), 'Honour' Based Violence (HBV), Forced Marriage (FM), and Faith Based Abuse (FBA)[1] – clearly highlights the serious and long-lasting physical, emotional and psychological effects on those who experience them. The context in which harmful practices take place is complex, set against a backdrop of power, control and constructs of gender, where (actual or perceived) family love can mask abuse by multiple perpetrators and 'normalise' violent practices. Studies consistently point to a lack of professional awareness of harmful practices, compounded by inadequate training provision. Practitioners often have low confidence when engaging with affected individuals or communities, and are reluctant to intervene due to fear of being perceived as culturally insensitive. Furthermore, the response to harmful practices and the support available for those experiencing them is piecemeal, with limited strategic coordination and integration into wider safeguarding and Violence Against Women and Girls (VAWG) services. Specialist Black, Asian and Minority Ethnic (BAME) women's organisations have been identified as an important factor both for immediate safety and a wider sense of empowerment; however, with few services available (and those that are, under pressure), responses are often inconsistent and opportunities to support women and girls are being missed (Bahunga, 2012; Dickson, 2014; Larasi et al., 2014; Norman et al., 2009; Payton, 2015; Roy et al., 2011; Tedam, 2014).

Available data on the prevalence of harmful practices presents a patchy and incomplete picture due to issues such as under-reporting, a lack of uniform and systematic recording systems, and misunderstanding around definitions[2]. The World Health Organisation (2016) state that more than 200 million women and girls alive today have experienced FGM, while in England and Wales it is estimated that 137,000 women and girls are living with the consequences of FGM, with a considerable concentration in London (21 cases per 1,000 population compared to 4.8 for England and Wales as a whole) (Macfarlane and Dorkenoo, 2015). Indeed, around half (49%, n=620/1,268) of newly recorded cases and total FGM attendances (49%, n=1,140/2,332) captured by the Health and Social Care Information Centre - on behalf of the Department of Health and NHS England - in October to December 2016, relate to women and girls from the London NHS Commissioning Region (NHS Digital, 2017)[3].

From a policing perspective, the Metropolitan Police Service (MPS) recorded 233 FGM incidents (which included 22 offences) in 2016/17, an increase on the previous financial year (209 and 17)[4]. In terms of forced marriage, in 2016 the government's Forced Marriage Unit gave support in 1,428 cases, 11 per cent of which took place entirely within the UK. London made up the largest proportion – over a fifth (21%, n=307) – of all cases (Home Office/Foreign and Commonwealth Office, 2017). The MPS recorded 226 FM incidents which included 96 offences in the most recent

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[1] See appendix one of https://www.london.gov.uk/sites/default/files/vawg_strategy.pdf. for definitions

[2] This was recognised in the 2015 HMIC inspection *The Depths of Dishonour: Hidden Voices and Shameful Crimes* which recommends the development of a standardised approach to data collection. Caution is advised when interpreting harmful practices data included in this section due to low reporting levels and inconsistent recording practices.

[3] 'Newly recorded' women and girls are those who have had their FGM information collected in the FGM Enhanced Dataset for the first time. 'Total attendances' refers to all attendances in the reporting period where FGM was identified or a procedure for FGM was undertaken. Women and girls may have one or more attendances in the reporting period. This category includes both newly recorded and previously identified women and girls. From 31st October 2015 mandatory FGM reporting was introduced in England and Wales, which imposes a duty on healthcare professionals to report cases in girls aged under 18 years to the police.

[4] Incidents are a count of all crime records (all Notifiable Offences and Other Accepted crimes), including those which have been classified as 'No Crime' or a 'Crime Related Incident'. Offences are a count of confirmed classifications of crime records (all Notifiable Offences only). MPS data is based on the presence of a relevant harmful practice flag or offence code. It is difficult to ascertain how consistently flags/offence codes are used; however, it is likely that data does not present a complete picture of all cases.

financial year (2016/17), a slight increase on the previous year (200 and 79 respectively). Data around HBV and FBA is considerably more limited, compounded by a lack of clear legislative framework[5]. Figures obtained by the Iranian and Kurdish Women's Rights Organisation (IKWRO) indicate that across the UK in 2010 there were more than 2,800 incidents of HBV reported to police, again with the largest proportion in London (18%, n=495). The MPS recorded 349 HBV incidents which included 228 offences in the most recent financial year, slightly down on the previous year (412 incidents and 278 offences). In terms of FBA, research for the Department for Education and Skills identified 38 cases of child abuse linked to accusations of 'possession' or 'witchcraft' between 2000 and 2005, while a later study highlighted the deaths of at least six children in the UK between 2000 and 2010 following periods of abuse arising from being labelled 'witches' (Stobart, 2006; Tedam, 2014). According to MPS data there were 31 'ritual and ritualistic abuse' incidents which included 14 offences recorded in the financial year 2016/17, a decrease on the previous year (71 incidents and a further 49 offences). The scarcity of available data and research in this area makes it difficult to fully understand the scale, impact, and context of harmful practices.

The MOPAC Harmful Practices Pilot

The Mayor's Office for Policing And Crime (MOPAC) Mayoral Strategy on Violence Against Women and Girls 2013-17 developed plans to establish a multi (voluntary and statutory) agency taskforce to address harmful practices. Starting in April 2015 and running for two years, the MOPAC Harmful Practices Pilot aimed to improve the way agencies identify and respond to FGM, HBV, FM, and FBA. The initial overarching themes of the pilot were focused around:

- *Early identification and prevention:* Through the development and delivery of training to key agencies to enable them to identify and respond to harmful practices;
- *Safeguarding and support:* Through a specialist harmful practices Educator Advocate post to work with agencies to ensure women and girls who have experienced, or are at risk of, harmful practices are safeguarded and offered specialist support;
- *Enforcement and prosecutions*: Through a focus on the police response to harmful practices with the ambition of securing prosecutions and ensuring that other interventions are being used effectively and appropriately[6]; and
- *Community engagement*: With a focus on both empowering women and girls within affected communities, and challenging the acceptance of harmful practices by men, boys, and wider communities.

[5] FGM has been a specific criminal offence in the UK since 1985, with various acts of legislation – most recently the Serious Crime Act 2015 - adding to the legal framework. The Anti-Social Behaviour, Crime and Policing Act 2014 made it a criminal offence to force someone to marry. There is no specific legislation around HBV or FBA, which are covered under a range of violence, abuse, and child safeguarding laws.

[6] As learning developed throughout year one, the pilot amended in response. For example, previous research (e.g., see Larasi et al., 2014), together with pilot stakeholders and professionals, identified that enforcement may not be a positive outcome for all women and girls; therefore, an initial focus on enforcements and prosecutions was considerably scaled back with the pilot predominantly focusing on themes of early identification and prevention, safeguarding and support, and community engagement. Although not a key area of this specific pilot, MOPAC acknowledges that enforcement action is an important part of the response in some harmful practice cases, and hopes that learning will also inform these approaches going forward.

The programme of work was delivered by the Partnership to End Harmful Practices (PEHP)[7] in two locations - the tri-borough partnership (Westminster, Kensington and Chelsea, and Hammersmith and Fulham) and the east London partnership (Tower Hamlets and Waltham Forest). There were three key areas of work:

- Half-day multi-agency and two-day specialist training sessions for professionals[8];
- An Educator Advocate (EA) service/surgery – delivered by a member of staff from one of the PEHP specialist women's organisations with two half-day surgeries per borough per week located in (predominantly) statutory agencies and voluntary organisations – to provide advice and support to professionals and practitioners around harmful practices; and
- Community engagement activity.

The first 18 months of the pilot rolled out alongside a Department for Education (DfE) Innovation Fund project, focused on addressing FGM through work with health care professionals and borough-based social care teams. Although separate and distinct in terms of processes and evaluation methods, the two pilots were conducted under the umbrella of a single Mayor of London/MOPAC harmful practices model, in the same areas with borough based project managers responsible for the delivery of both. The pilots offer opportunities for MOPAC and wider statutory and voluntary sector agencies to both learn from a proactive approach to addressing FGM, HBV, FM and FBA, and contribute to a currently limited evidence base around understanding and responding to harmful practices across London and beyond[9].

Final Evaluation Report: Building on a Year One Interim Report

This final evaluation report builds on a year one interim report produced in June 2016, which focused primarily on implementation, views of those attending the first tranche of training sessions, and the early experiences of professionals and communities receiving services as part of pilot delivery. Year two fieldwork has developed this, while attempting to explore how training delegates have transferred learning into their day-to-day working, the influence of EA support on professionals' ability to identify and respond to harmful practices, and the experiences of women and affected communities involved in the pilot.

Methodology

The Evidence and Insight (E & I) Unit – a team of social scientists based within MOPAC – were commissioned to undertake an assessment of the Harmful Practices Pilot[10]. The challenges of evaluation research in complex and evolving pilot landscapes such as this have been well documented (Dawson and Williams, 2009; Patton, 2002). Given the nature of harmful practices and the likely small sample sizes the pilot would generate, the most feasible design was deemed to be a 'proof of concept' process assessment. The evaluation aims were to:

[7] The PEHP consists of seven organisations: Iranian and Kurdish Women's Rights Organisation (IKWRO); Foundation for Women's Health Research and Development (FORWARD); Latin American Women's Rights Organisation; Asian Women's Resource Centre; IMECE Women's Centre; ASHIANA Network; and the Women and Girls Network.

[8] The training 'offer' also included a series of specialist half-day follow-up training sessions focusing on the psychological impact of harmful practices, risk assessments, and safeguarding.

[9] This report comments on the evaluation of the MOPAC Harmful Practices Pilot only. The DfE FGM pilot was initially planned for one year but extended for an additional six months. A separate evaluation of the FGM pilot was conducted externally by Opcit Research with the University of Central Lancashire (UCLAN) Department of Social Work and is available at https://www.gov.uk/government/publications/female-genital-mutilation-early-intervention-model-evaluation.

[10] Thanks to Barry Charleton, Christina Soderberg, and Laura Duckworth for data inputting and analytical support. Thanks also to the peer reviewer for useful comments on both the interim and final report.

- *Critically review implementation*: Has the pilot been delivered effectively (e.g., in terms of the process, services delivered, and meeting professional and individual needs)?
- *Capture the views of practitioners:* Has the pilot improved the ability of practitioners and professionals to identify and respond to harmful practices? What are their views on the development and support they have received as part of the pilot? Have safeguarding processes been revised to ensure cases of harmful practices are responded to?
- *Capture the views of communities:* Are individuals who have experienced harmful practices better able to identify and understand what has happened to them, and communicate their needs and views? Has there been an increase in the number of cases coming to the attention of/being reported to professionals?

Adopting a pragmatic action research approach[11], the evaluation fieldwork incorporated a holistic range of methods to capture both 'the numbers and the stories' of those involved in the pilot (Patton, 2002). This included: two stakeholder surveys (113 responses); training feedback surveys (660 responses); community engagement surveys (78 responses); 48 semi-structured face-to-face or telephone interviews with stakeholders, pilot staff, practitioners, and clients; observations at four training sessions and five community engagement events; and performance data around both individual cases supported and overall pilot delivery. An evaluation timeline and full details of fieldwork conducted is included in Appendix one.

This report draws together findings across the range of evaluation methods under five headings which reflect both the overarching aims of the pilot (including each aspect of delivery – training, EA service/surgeries, and community engagement) and other emerging key themes: *implementation* (largely incorporating point one of the evaluation aims outlined above); *early identification and prevention* (point two of evaluation aims); *safeguarding and support* (points two and three of evaluation aims); *community engagement* (point three of evaluation aims); and *a partnership approach to tackling harmful practices* (point one of evaluation aims)[12]. Pilot learning outlined in this report contributes to a currently limited evidence base, and hopes to inform approaches of other organisations in their work to tackle harmful practices.

Results: Reflections on the Two Year Pilot

Implementation

Year one of the pilot highlighted a clear need for initiatives to tackle harmful practices with the majority (86%, n=36/42) of year one stakeholder survey respondents coming into contact with a person who had experienced, or was at risk of experiencing, a harmful practice. Concerns around professionals taking the wrong course of action, individuals' ability to identify, understand and disclose that they had experienced a harmful practice, engagement with services, and whether survivor needs were being met were also raised. Implementation proved difficult in year one, particularly in the early months, as pilot staff worked to clarify operating models, roles, and

[11] For example, researchers fed back immediately after observations at training and community engagement sessions, regularly attended and contributed to pilot steering groups, produced a short report in January 2016 reflecting on practical learning from fieldwork to date in order to allow adequate time to inform plans for year two of the pilot, and delivered an interim report at the end of year one. Given the size of the research cohort, some caution should be used when considering results. Fieldwork data set out in this report reflects the views of those who took part in surveys and interviews, and researcher observations.

[12] To reduce duplication, findings from all evaluation methods – including surveys, interviews, and observations – are structured within these thematic headings, rather than presenting each as a separate dataset.

responsibilities. This was at times compounded by the separate DfE funded FGM pilot which initially rolled out alongside the Harmful Practices Pilot. As the lifespan of the FGM pilot was shorter, there was a greater sense of urgency to 'get going', which perhaps impacted on the time available to carry out adequate groundwork for the Harmful Practices Pilot. Indeed, a year one interviewee raised concerns that in the early days of delivery perhaps the Harmful Practices Pilot *'hadn't been all it could have been as a result'*.

Challenges persisted at times throughout year two with interviews conducted with project leads (across MOPAC and the pilot boroughs) and EAs at the end of the pilot often highlighting a need for additional planning early on in the pilot. One interviewee felt that the *'vision was there'* but the pilot sometimes *'lost its direction'*. Implementation problems were most commonly noted in relation to the EA service/surgery component of the pilot with an early lack of clarity around how the role would work in practice, and responsibilities for identifying and setting up surgeries. Although a document outlining the role of EAs/surgeries was developed, it would be fair to suggest that an unclear 'offer' early on in the pilot contributed to implementation difficulties around this part of the work. These were compounded in the second year due to a number of pilot staff changes including four of the five EAs, two project leads, and the PEHP project manager – a role that was not substantively filled throughout year two. This was highlighted as problematic by a number of year two interviewees: as one commented: *'we needed a lynchpin who makes sure everything happens'*. Rigorous implementation and delivery are essential to successful programmes, and it would perhaps be fair to suggest that 'start up' of this pilot commenced too early in the project planning stages. Such challenges are by no means unique to the Harmful Practices Pilot (e.g., see Dawson and Stanko, 2013) and it is positive that year two interviewees reflected on significant learning around implementation, which they felt would inform planning and delivery going forward.

Early Identification and Prevention: Training Professionals

Over the two-year period a total of **74 courses** ran across the two pilot areas: 40 half-day multi-agency, 12 two-day specialist, and 22 half-day follow-up courses focusing on risk assessment (6), psychological impact of harmful practices (10), and safeguarding (6). It isn't possible to state how many *individuals* were trained as professionals often attended more than one course; however, attendance sheets received (these were missing for 20 sessions) indicated:

- 341 attendees at multi-agency courses (an average of 12, ranging from 2 to 19)
- 155 attendees at specialist courses (an average of 11, ranging from 4 to 22)
- 75 attendees at follow-up courses (an average of 5, ranging from 2 to 14)[13].

Attendees completed a feedback survey at the end of each training session (including both days of the two-day specialist course), with 660 feedback surveys received in total (surveys were missing for 15 sessions). Training session attendees came from a variety of professional backgrounds, predominantly health, social care, and the Voluntary and Community Sector (VCS) (see appendix two). There was a notably slower uptake of training in the tri-borough partnership in year two and

[13] Figures based on number of attendees 'signing in' on attendance sheets. It is likely that some attendees did not sign in. It was anticipated that there would be approximately 15 attendees at each multi-agency and specialist training session and six attendees at follow-up training sessions. Average attendee figures are based on: 341 attendees signing in across 29 multi-agency courses for which signing in sheets were provided; 255 attendees signing in across 23 days (day one and two) of the specialist courses for which signing in sheets were provided; and 75 attendees signing in across 15 follow-up courses. Feedback analysis is based on 660 returned feedback forms. Not all respondents answered all questions. 'N' numbers are stated throughout. See appendix three for a full breakdown of courses, attendee numbers, and feedback forms received, together with details of courses cancelled/rescheduled, and signing in sheets and feedback forms not received.

a number of courses were rescheduled or cancelled (see appendix three). Issues were discussed regularly in steering group meetings and partners actively sought to understand drivers. Low take-up was linked to capacity issues (the tri-borough training team were understaffed and unable to promote courses as widely as they had in year one), wider mandatory training demands on professionals, and the possibility of reaching saturation point. The PEHP allocated some unused sessions to deliver bespoke 'in-house' training, and boroughs explored possibilities around offering training to neighbouring areas.

Positive Views on Training

Training was widely recognised by interviewees and survey respondents as a key success of the pilot, with frequent praise for the sessions' focus on concepts of power and control, and their potential to encourage 'professional curiosity' and empower practitioners to recognise and respond to harmful practices. Training sessions were well received by attendees in terms of quality, content, and feeling that the pilot would improve practitioners' ability to address harmful practices (see table one). Themes were generally the same across areas and training course types, albeit with slightly more positive responses from east specialist courses compared to tri-borough specialist courses – however some analyses were based on small numbers.

Table 1: Training session survey feedback

Statement[14]	Agree	Neither agree nor disagree	Disagree
The training met my expectations	85% (n=532/625)	9% (n=54/625)	6% (n=39/625)
The training achieved its stated objectives	86% (n=536/620)	7% (n=45/620)	6% (n=39/620)
The training materials were useful	86% (n=536/623)	6% (n=39/623)	8% (n=48/623)
The trainer was knowledgeable	89% (n=554/623)	4% (n=28/623)	7% (n=41/623)
There was a good level of participation and interaction	88% (n=547/625)	5% (n=34/625)	7% (n=44/625)
I was given enough time to ask questions	87% (n=545/625)	6% (n=35/625)	7% (n=45/625)
The training session was pitched at the right level	85% (n=530/624)	7% (n=41/624)	8% (n=53/624)
The environment was safe and supportive	88% (n=548/624)	4% (n=28/624)	8% (n=48/624)
There was an atmosphere of trust and confidentiality	89% (n=555/621)	4% (n=23/621)	7% (n=43/621)
Overall I was satisfied with the training session	87% (n=541/622)	6% (n=39/622)	7% (n=42/622)
I understand the aims and objectives of the Harmful Practices Pilot	87% (n=508/585)	6% (n=38/585)	7% (n=39/585)
I know where to get more information/support around the Harmful Practices Pilot	88% (n=514/586)	6% (n=35/586)	6% (n=37/586)
Overall, this training session has provided me with enough information to play my part in delivering the Harmful Practices Pilot	85% (n=506/596)	9% (n=54/596)	6% (n=36/596)

[14] Training attendees were asked to indicate their level of agreement with a series of statements with '1' being strongly agree and '5' strongly disagree. Figures used to indicate agreement to some extent are those responding '1' and '2'. Figures used to indicate disagreement to some extent are those responding '4' and '5'. Responses given as '3' are considered to be 'neither agree nor disagree'.

I think that the Harmful Practices Pilot will improve practitioners/agencies ability to address harmful practices	88% (n=531/602)	5% (n=32/602)	6% (n=39/602)
I would recommend this training course to other colleagues	88% (n=531/603)	6% (n=34/603)	6% (n=38/603)

In freetext fields on the training feedback survey, attendees often commented positively on the quality and content of sessions (in particular, group discussions, case studies, information on sign-posting, referrals and support services, and hearing victims' stories), trainer knowledge, and opportunities to share experiences with a range of different agencies. However, some respondents highlighted a need for additional in-depth information, and adequate time being allocated to sessions (particularly the half-day multi-agency course), together with some logistical issues (e.g., problems with the venue or technology), which affected a small number of sessions. In terms of how the training would impact their work, most respondents reported positive changes in terms of their confidence to identify and respond to warning signs and support survivors, and plans to share learning with colleagues.

'I am more informed and now know who to approach if I have concerns or if someone should approach me for help'

'I think I'm in a better position to look out for those critical signs'

'[The training has] *given me confidence to explore/start conversations with clients and colleagues when dealing with possible victims of harmful practices'*

'Albeit an uncomfortable subject, I found this training to be a great eye opener, very interactive and resourceful'

'No matter how deeply rooted a practice may be it is possible to take steps to make changes. Sessions like this will have a positive impact…education/awareness is the key to help make these changes'

Transferring Learning in to Practice

An updated version of the survey used from the latter part of year one included questions on the likelihood of implementing learning in the workplace, and levels of knowledge at the start and end of training sessions. Three-quarters of respondents (75%, n=272/363) thought there was a high likelihood of implementing learning in the workplace, with almost two-thirds (64%, n=222/348) stating this would be within a month. Responses varied by course type and area, with a smaller proportion of completed multi-agency responses (65%, n=93/143) and a larger proportion of completed specialist responses (83%, n=131/158) stating there was a 'high' likelihood of implementing learning. A smaller proportion of responses from tri-borough training sessions stated there was a high likelihood of implementing learning (67%, n=87/129), largely driven by multi-agency training session attendees. Self-reported assessments of learning highlighted a notable shift towards proportionately more attendees rating their level of understanding as 'excellent' at the end of training sessions (35% compared to 6% at the start overall: 23% vs. 1% in multi-agency sessions, 39% vs. 3% in specialist, and 41% vs. 18% in follow-up). There were also sizable increases in those rating their knowledge/understanding as 'good' (from 30% to 57% overall) and reductions in assessments of 'fair/just satisfactory' and 'poor' (from 44% to 7% and 20% to 1% respectively overall).

While the training surveys completed at the end of each session gave 'in the moment' feedback, the year two stakeholder survey attempted to explore the influence of training on practice back in the workplace. The majority of respondents (84%, n=58/69) had attended at least one type of training session. As table two below outlines, while most respondents agreed that the training had improved their ability to identify and respond to harmful practices, a lower proportion (just over three-quarters) felt they had been able to translate their training into practice, or that there was a clear 'fit' between what the training said they should do and what they could actually do in their role. A year two interviewee felt that training should go beyond standalone sessions and be embedded within a workplace commitment to review policies and practices: *'I don't think that it* [training] *should just be offered. I think it should be offered and then a commitment in some way of senior management of how it's going to be implemented…So it's not just the learner whom the onus is on. It's on whomever they work under'*.

Table 2: Year two stakeholder survey responses

Statement[15]	**Agree**	**Neither agree nor disagree**	**Disagree**
Since the training I have been able to translate learning into practice in my role	76% (n=34/45)	16% (n=7/45)	9% (n=4/45)
There is a clear 'fit' between what the training said I should do and what I can actually do in my role	78% (n=35/45)	11% (n=5/45)	11% (n=5/45)
Overall, the training has improved my ability to identify harmful practices	89% (n=40/45)	4% (n=2/45)	7% (n=3/45)
Overall, the training has improved my ability to respond to harmful practices	87% (n=39/45)	7% (n=3/45)	7% (n=3/45)

Reflecting on their training since being back in the workplace, year two stakeholder survey respondents often highlighted greater awareness around harmful practices and sharing learning with colleagues:

'[The training] *has given me a different perspective on how we manage risks and our approach to conversations we have with our service users'*

'I have been able to give practical advice and guidance to other practitioners around legislation and safeguarding issues'

'The training has made me more mindful of the circumstances that clients may have been through on their journey'

'I am more confident in my understanding of harmful practices…and am more at ease when I approach these topics… I have also been able to work and respond faster to these victims and get them help with other agencies'

[15] A number of questions in the survey were based on a Likert scale with respondents asked to indicate the extent of their agreement on a scale of 1 to 7 with '1' indicating 'strongly agree' and '7' indicating 'strongly disagree. Figures used to indicate agreement to some extent are those responding '1' to '3'. Figures indicating disagreement to some extent are those responding '5' to '7'. Responses given as '4' are considered to be 'neither agree nor disagree'.

Year two interviewees referred to the training as a 'legacy' of the pilot that could be developed flexibly (e.g., to incorporate specific referral pathways and local support services) for rollout beyond the pilot boroughs, in particular targeting professionals who can *'embed and cascade learning'*.

Safeguarding and Support: Advising and Guiding Professionals through the Educator Advocate Service/Surgeries

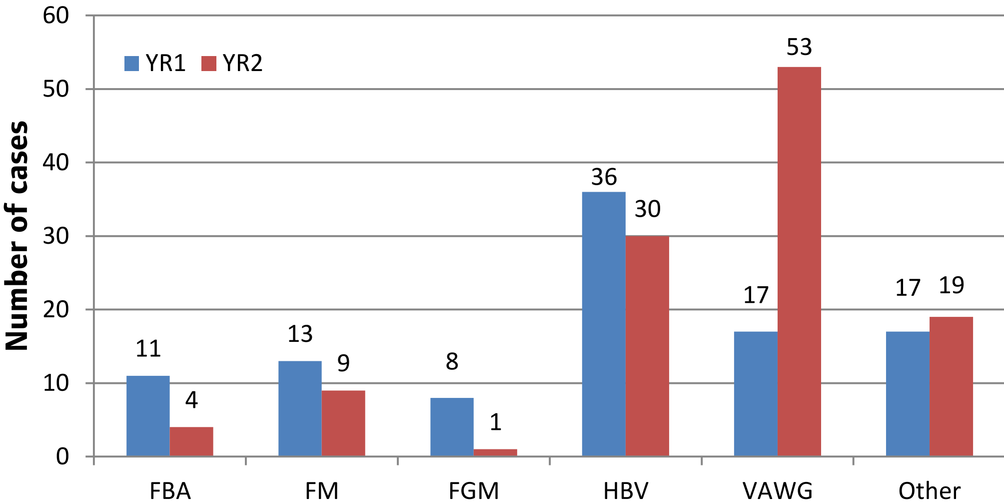
Performance framework data returns indicated that across the five boroughs over the course of the pilot:

- There were **591 surgery sessions** (approximately 81% of anticipated delivery)[16].

- Surgeries were held in **17 different locations**: social services (including children's, family, and adult services) (6); hospitals/medical centres (3); children's centres (2); One Stop Shops (2); a Multi-Agency Safeguarding Hub (1); a police community safety unit (1); a school (1); and a VCS organisation (1).

- EAs provided advice and support in relation to **218 cases** (102 in year one, 116 in year two), covering the four strands of harmful practices in the pilot, together with almost half (49%, n=106/218) defined more widely as VAWG, domestic abuse, or mental health related (see figure one)[17].

Figure 1: Cases supported by EAs by harmful practice type



[16] On the basis of six successive quarters from the third quarter of year one onwards (performance framework data returns for the first two quarters of year one were patchy and inconsistent). No surgery data was returned for two boroughs in quarter three of year two. Anticipated delivery is calculated on the basis of ten surgery sessions per week across five pilot boroughs for six quarters (approximately 78 weeks), excluding the two boroughs for which data was missing in quarter three of year two (n=728 surgeries in total). Reasons for surgeries not taking place included public holidays, annual leave, tube strikes, and training. Attempts have been made to make up for missed surgeries with additional surgeries or training events.

[17] As outlined in the pilot model, this service is predominantly offered to practitioners to enable them to better identify and respond to harmful practices; however, in some cases the EA may provide direct support to affected women and girls. This figure includes all cases returned in the performance framework (excluding obvious duplications). Performance framework returns were patchy in quarters one and two of year one. It is difficult to unpick reasons behind the high volume of VAWG and 'other' cases. This may point to the 'continuum' of VAWG issues of which harmful practices form a part, challenges identifying harmful practices, and/or that professionals welcomed support around both harmful practices *and* wider VAWG and other related issues.

The majority of individuals in these cases were female (8 cases involved males), ranging in age from children (aged one) to older adults (up to 75 years old) with over 30 self defined ethnic backgrounds[18]. The majority of cases were referred by services or agencies including social care, hospitals/health, police, education, VCS, and Independent Domestic Violence Advisors (IDVAs) (77%, n=159/206) or self referred (23%, n=47/206). Advice and support offered by EAs detailed in performance framework returns included accommodation/refuge, emotional support/counselling, welfare and benefits advice, language support, advice around appropriate action to take, risk assessment and safety planning, signposting to other services/professionals, no recourse to public funds, immigration, and legal matters, and outreach including visits alongside other practitioners. Referrals specified included to other professionals (e.g., IDVAs, domestic violence workers, FGM social workers), Multi-Agency Risk Assessment Conferences (MARACs), legal support, and third sector organisations.

Opportunities and Challenges of the EA Service/Surgeries

Year one analysis highlighted the potential value of the EA service/surgeries, in particular supporting professionals to see harmful practices through a 'different lens' giving them the confidence to make decisions, and EAs making useful contributions to areas beyond (but often intrinsically linked to) harmful practices (e.g., domestic abuse, immigration issues). Similar themes emerged throughout year two fieldwork with, as one stakeholder survey respondent commented, staff being supported to *'think outside of the box and ask more questions'*. Project leads and practitioners interviewed recognised the wealth of knowledge that EAs brought around harmful practices, wider VAWG issues, human rights, and available VCS support services, together with language skills and cultural understanding, which one reflected meant that statutory services could give *'over and above what we are normally able to offer'*. A practitioner interviewee from an organisation that hosted a surgery spoke about the support the EA provided to staff in raising their awareness of harmful practices and *'knowing what kind of gentle nudges to make, or how to make people feel safe enough to disclose'*, an approach they hoped would continue after the pilot finished.

However, there were some ongoing challenges around the EA service/surgeries throughout the pilot: clarity around the role and developing a clear 'offer' to potential hosts; being located in a consistent team that deals with appropriate referrals in which the EA can build relationships where, according to a year two interviewee, *'they can have more impact'*; logistical issues around arranging a staff/building pass, securing access to the internet, computers and case files within host organisations; and being able to effectively review and influence harmful practice policies within statutory organisations. A common theme throughout steering group discussions and interviews was that surgeries were often slow. Indeed, only around half of respondents to the year two stakeholder survey (albeit small numbers - between 49% and 53% of 41 respondents) knew who the EA was in their borough, how to contact them, and what services they offered/what they could do to help them, with a slightly lower proportion (39%, n=16/41) knowing when and where

[18] Demographic information was not provided in all cases. The level of information varied from case to case, with some including just one demographic field, and others full demographic information. Self-defined ethnicities stated included Afghanistani, Albanian, Algerian, American, Bangladeshi, British, Caribbean, Chinese, Dutch, Egyptian, Eritrean, Ethiopian, French, Indian, Iranian, Iraqi, Jamaican, Kurdish, Latin American, Mauritian, Moroccan, Nigerian, Pakistani, Portuguese, Punjab, Saudi Arabian, Serbian, Spanish, Sudanese, Turkish, and Uzbekistani.

surgeries were held in their borough. Only a fifth (20%, n=10/50) of respondents had attended an EA surgery or accessed support from an EA (with all who answered questions (n=7) commenting positively about the service received). Of those not accessing EA support, reasons given were not knowing who the EA was, what services they could offer or how to contact them, and having no relevant cases.

Building EA-Practitioner Relationships in a Busy Landscape

EAs often used surgery time to offer support in other ways: training and briefings for staff; advice/signposting around wider VAWG and immigration issues; and translation services. One project lead highlighted how useful this was; however, that it relied on the initiative and proactivity of the EA to build relationships with staff and seek out these opportunities. EAs interviewed often spoke about the challenges of building and sustaining relationships and needing to continually promote the pilot, particularly when they are present for only a half day a week and within host organisations undergoing staff and structural changes. One EA interviewee commented:

> *'If I had gone there three times a week or if I was even based there, I'm pretty sure I would have a different relationship altogether because I would be part of the team. Going there once a week for two or three hours doesn't really make a difference but if I was there on a very regular basis I would be like them…working together is important… it takes a lot of courage for a survivor to make that decision to call for help and that's a good opportunity to give them all their options'.*

Another likened their role to *'a helium balloon'* 'flying around' asking people if they can help, while an EA referred to the service in which they were located as *'…like a beehive. People are in and out for meetings…every day was a promotion of the project because you keep seeing new people then you don't see the person for the rest of the year'*.

This scenario was often compounded by a range of different professionals (e.g., IDVAs, Healthy Relationship advisors), as one interviewee stated *'parachuting in and out'* of services, which created confusion for practitioners. One practitioner commented on: *'lots of different projects floating around. There's agreements made at service level which we don't have much to do with so we just tend to get people turn up in the office and we get told who they are and what they can be helpful with'*, while another stated: *'It's difficult to know who's who and who to refer to and what the right service is…you just feel a bit overloaded as to who would be the best person and what is the difference'*. Indeed, EAs sometimes struggled to 'find their place' alongside other experts, and practitioners similarly found it challenging to recognise the difference between them.

Working Together to Support Clients

Despite an inconsistent flow of cases, with practitioners themselves often commenting in interview that they didn't always have enough of the 'right' type of cases for EAs to work on, examples shared by practitioners during year two interviews where an EA had supported them in their work indicated positive experiences:

'Early on they were very useful in facilitating and identifying refuges for people without public funds which was really helpful. More recently they did a visit with one of my social workers which was really good…we asked the right type of questions. Being very informed, very early on without us being involved in a family's life when it wasn't necessary'

'The EA came to a meeting…and did safety planning work for a young person going overseas at potential risk of arranged marriage. Useful practical advice offered, also information about use of Forced Marriage Orders'

'It's not often we have a case that falls within their remit. When we do it is superb to have them on board…they're our safety net'

EA interviewees commented on increased awareness and changes in attitudes that they observed amongst professionals they worked with. A project lead interviewee felt that the EA had supported practitioners to contextualise their understanding of harmful practice within a theoretical framework of power and control, which had the potential to change the way they viewed cases. In terms of survivors' experiences of the Harmful Practices Pilot, EAs highlighted perceptions of an improved service offered through increased professional awareness and knowledge, and providing a 'bridge' between statutory services and their own VCS organisation. A practitioner felt that the EA service/surgery '…b*eing based within statutory organisations might make services easier to access…for men as well as women. If clients were going to a specific women's centre they may feel some stigma attached to this'*. As part of year two fieldwork, EAs worked with the evaluation researchers to explore views of clients who had received support from the EA and other professionals during the pilot[19]. Clients shared a range of experiences: lack of awareness around their rights or help available, feeling disappointed and 'not believed' by professionals, and the support they had received from the EA or other service providers during the pilot including legal advice, referral to counselling and medical services, and access to safe accommodation.

'Once I spoke with the Educator Advocate and the other advisor I felt more comfortable about the situation…I felt that the Educator Advocate was listening to what I am saying, and they were knowledge[able] *about forced marriage'*

'This was the first time I got support for my FGM as I was not aware of this support available…I was able to speak about the complications that this has caused me throughout my life'

'I felt that the Educator Advocate had listened to what I was saying… The information I received was good as I was not aware that I was able to receive this support from services…I have been passing this information to other people and I will continue to do so'

'I was relieved when the help and support [from various professionals including EA] *came so fast'*

[19] Following advice from EAs and PEHP partners, evaluation researchers developed a detailed discussion guide (together with clear instructions and information in order to secure voluntary informed consent) for EAs to use with clients. Although not without limitations (e.g., selection bias, EAs essentially 'self-evaluating'), this was the most practical – and least intrusive - approach available for obtaining client views. It was also an interesting way to involve pilot staff in evaluation fieldwork. EAs spoke to four clients in total (two in the east and two in the tri-borough) including one case of forced marriage, one of FGM, and two of domestic abuse.

The EA role/surgeries have undoubtedly been one of the more challenging aspects of the pilot – particularly around volume of referrals, access to information, being able to influence policy, and EAs 'carving out' their role in busy and often changing organisational landscapes. However, there are positive findings around the volume of cases that EAs have offered advice and support around, that project leads and practitioners recognised the wealth of knowledge that EAs brought and valued the opportunity to work more closely with the VCS sector, and insightful examples of joint EA-practitioner working. Interviewees reflected on learning from the pilot commenting that more time planning and developing the EA role and location of surgeries, securing buy-in and commitment at strategic level, and building relationships from within organisations would improve delivery. Some thought that an 'as and when required' EA service, with support offered to practitioners via telephone, email and face-to-face when needed, would work well (rather than EAs being in the office when there weren't any relevant cases) and allow the service to be flexed across a broader range of organisations. However, initially getting to know individual experts face-to-face and establishing rapport is important. As one practitioner commented: *'It's good when you see the face, establishing some kind of working relationship. Because* [the EA is] *here we've already established some kind of rapport with her. I don't think she has to come in and sit with us every week. I can contact her. Having a face-to-face conversation makes a difference'*.

Community Engagement: Empowering Women and Girls

Providing opportunities for the community to come together to learn, discuss and be part of the response has been recognised as a crucial factor in challenging harmful practices. Furthermore, engaging and building trust is particularly important for women and girls who may be scared to come forward due to repercussions for their family and wider community (Tedam, 2014; Norman et al., 2009; Larasi et al., 2014). Performance framework data returns indicate there were **51 community engagement events** throughout the pilot (17 in year one, 34 in year two) attracting over 1,000 attendees[20].

Events included awareness raising sessions, workshops, support groups, conferences, 'community conversations', youth groups, and social events (coffee mornings, a summer BBQ, a festival, and a fair). Attendees included young people, professionals, those in temporary accommodation, and a range of individuals from different ethnic backgrounds. Events often took place as part of existing forums, rather than specifically arranged for the pilot, and sometimes incorporated a 'social side' including food, music, and wider health, wellbeing, and personal support, in addition to advice and education around harmful practices. Fieldwork observations picked up a positive, welcoming 'vibe' with events held in accessible community spaces (e.g., schools, colleges, community centres, and places of worship). A year two interviewee highlighted the importance of *'focusing on safe spaces where people go….where communities are likely to build their own network'*.

[20] Approximate attendance was provided for 13 events in year one (194 attendees) and 31 events in year two (825 attendees).

Engaging and Informing Communities

The majority of respondents to feedback surveys (between 92% and 96%, n=78) collected across seven events[21] agreed that after the event they understood more about harmful practices, knew more about where to get support/advice, and would feel confident asking for support/advice if they/somebody else needed it. In freetext feedback comments, attendees spoke positively about the range of speakers, some of whom presented powerful, personal accounts of harmful practices, and engaging in conversations around power and control. Professionals often commented that they valued the opportunity to find out more about the pilot and other services in the area, which would help them better support clients.

> *'Forced marriage – not legal, against women rights. It is a choice. Nobody has* [the] *right to force anyone'*

> *'Forced marriage - today I know that it became illegal. That is very good news!! This must stop'*

> *'FGM is absolutely not acceptable and it is not a cultural issue, it is about humanity'*

> *'An engaging and uplifting session. Extremely important for women's progression and development'*

Designing a Community Engagement Model

The community engagement element of the pilot developed organically, with no set model outlining target audience or materials. While this proved useful in terms of identifying and capitalising on opportunities as they arose and flexing them to fit the target audience, project lead and EA interviewees felt that the pilot could have benefitted from a more co-ordinated, planned approach at times, including developing specific community engagement materials, in order to best harness the opportunities that dialogue with potentially affected communities offered. A year two interviewee felt this could have helped the events go beyond awareness raising to asking communities about their experiences to inform practice. The fluid approach to community engagement also made it difficult to systematically capture feedback and draw out learning[22]. However, interviewees reiterated the importance of all community engagement efforts around harmful practices: bringing together communities, breaking down isolation, opening up dialogue, and offering support networks. The reach of community engagement events can go beyond those who attend. The spoken word is powerful. As one interviewee commented: *'even a small event can have a bigger reach than we think'*.

[21] Five in the east, two in the tri-borough including a mixture of professionals/practitioners/members of staff (35) and members of the community (21), with the remainder not stated.

[22] Despite early efforts to communicate dates (e.g., the PEHP set up a community engagement calendar in a shared Dropbox which evaluation researchers were given access to) and regular reminders to EAs via email and at steering group meetings, it proved difficult to systematically find out about community engagement events in advance, therefore researchers were unable to attend or disseminate feedback surveys for completion (these were also made available via the Dropbox). Researchers attended a small number of events (five – at three of which feedback was collected) and EAs collected feedback at a further four events on behalf of evaluation researchers.

A 'Partnership' Pilot: Working Together to Tackle Harmful Practices

A clear message about the importance of addressing harmful practices within a partnership approach, involving the statutory and voluntary sectors and communities themselves, underpinned all aspects of the pilot. The commitment of all delivery partners – both 'on the ground' and at strategic level – was often highlighted as a success of the pilot by interviewees. EAs spoke positively about being part of the PEHP partnership, in particular regular opportunities to meet and share experiences and ideas, while PEHP and borough project leads valued the focus that MOPAC placed on tackling harmful practices, which supported them in prioritising issues within their organisations.

The realities of negotiating partnership working across a range of agencies was tricky at times, for example, around communication, the speed at which 'business' operates, and being able to 'talk the language' of other sectors. The number of partners involved in the pilot required strong, clear leadership, which some interviewees felt was inconsistent at times. Despite this, the pilot offered an important opportunity for VCS and statutory partners to work together to address harmful practices. A number of stakeholder survey respondents and interviewees from both statutory and voluntary sectors felt that each could benefit from learning from the other. An interviewee from a statutory service commented:

'It gave us all an experience that we will draw on in the future - that you can work together more effectively to get better outcomes…it gave the voluntary sector a stronger foothold, voice… particularly the realisation of what they are already doing in the VAWG sector… I do think they are better placed to respond in a less stigmatised way and offer forms of help that people find more acceptable'

As an EA interviewee highlighted: '…*we don't only speak the language, we understand the culture, we understand…people from our community'*. Interviewees from both statutory and voluntary services stated that they hoped partnerships would be sustained after the pilot had ended, with practitioners continuing to refer, advise, and seek support from each other. As a year two pilot staff interviewee commented:

'We're here for the same thing – to save lives – so for us to be able to put their specialism and ours together is really important'

Discussion

Summary

This report has outlined some key learning from the MOPAC Harmful Practices Pilot, an initiative to improve the response to those who have experienced, or are at risk of experiencing, Female Genital Mutilation, 'Honour' Based Violence, Forced Marriage, and Faith Based Abuse, through training, support, and engagement with practitioners, professionals and communities.

A number of positive messages have emerged throughout the pilot:

- Training has been widely recognised as a key success with the **74 courses** delivered throughout the two years received well by attendees in terms of quality, content, and improving practitioner knowledge around harmful practices. Once back in the workplace, respondents felt the training had improved their ability to identify and respond to harmful practices, and often highlighted examples/plans to share learning with colleagues.
- EAs facilitated **591 surgery sessions** in a range of organisations throughout the pilot period, providing advice and support in relation to **218 harmful practice and VAWG cases**. Project leads and practitioners recognised the wealth of knowledge that EAs brought around harmful practices and beyond, and shared examples of cases where EAs and practitioners worked together to support clients.
- The **51 community engagement events** delivered were welcomed, with the majority of feedback received indicating that attendees understood more about harmful practices and where to access support after events. Practitioner attendees spoke positively about opportunities to find out more about services in their area, which would help them better support clients.
- A **strong partnership approach** underpinned the pilot, with statutory and VCS service providers learning from each other around how to support those experiencing, or at risk of experiencing, harmful practices.

However, the pilot has also presented challenges, particularly around the EA service/surgeries, where referrals have at times been slow, access to resources (e.g., internet, computers, and case files) limited, and EAs have been required to continually build relationships, promote the project, and 'carve out' their role within fast-paced, often changing surgery host organisations. While community engagement efforts were welcomed and positively received by those attending, pilot staff interviewees felt that some events could have achieved more with additional coordination and planning, including specific community engagement materials. The pilot highlights learning around the importance of comprehensive early project planning, and clear operating models, both at strategic and operational 'on the ground' level – challenges certainly not unique to the Harmful Practices Pilot.

Learning and Concluding Thoughts

Throughout year two fieldwork, survey respondents and interviewees reflected on the 'legacy' of the pilot and sustainability of learning going forward. Many thought that the training should be developed flexibly (e.g., to incorporate specific referral pathways, local support services, etc.) into a product for rollout beyond the pilot boroughs. Learning from the pilot highlights the importance of embedding training within a workplace commitment to review policies to ensure that trained staff can put learning into practice in a supportive environment.

Survey respondents and interviewees felt that refresher training or regular workshops were necessary to keep practitioner knowledge and awareness up-to-date, particularly for those who may encounter harmful practice cases less frequently. It is also vital to be alert to harmful practices beyond those included in this pilot, which may be changing or emerging, including breast flattening, 'corrective' rape, 'widowhood rituals' levied at older women, and other forms of violence and abuse which are defended on the basis of tradition, culture or religion (Action Aid, 2013).

The Harmful Practices Pilot has started conversations, encouraged 'professional curiosity', and highlighted new ways of thinking amongst statutory and VCS agencies about under-researched and often misunderstood violent and abusive practices affecting thousands of individuals throughout the UK and millions across the globe. Learning from the pilot contributes to a limited yet developing evidence base and hopes to inform the approaches of other organisations in their work to tackle harmful practices. The challenge now is to continue to raise awareness and further develop partnerships amongst statutory and VCS agencies, and communities themselves, in order to build on learning to more effectively identify and support individuals experiencing, or at risk of experiencing, harmful practices.

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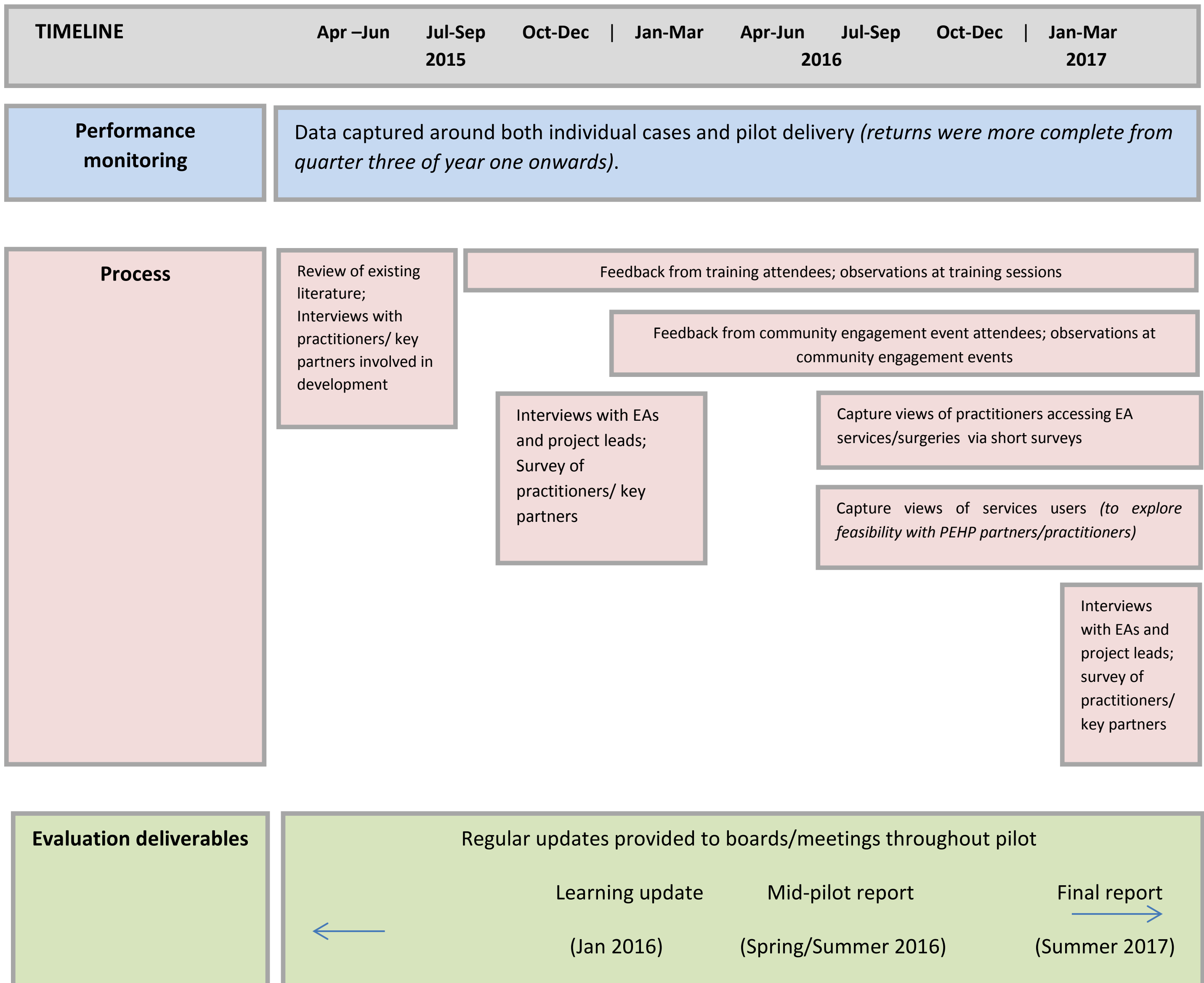
Appendices

Appendix 1: Methodology – evaluation timeline and fieldwork conducted



Method	Participants	Date
Performance framework and contract management data returns	Provided by the PEHP	From quarter 2 2015/16 onwards
Attendance at MOPAC and borough steering group meetings	29 meetings attended	April 2015 - May 2017
Theory of change interviews (face-to-face)	MOPAC and borough project leads x 5 interviews/6 interviewees	May – June 2015
Training feedback surveys	660 feedback surveys received	August 2015 – February 2017
Observation at multi-agency and specialist training sessions	Multi-agency session x 2 Specialist session x 2	September 2015 – January 2016
Year one key stakeholder interviews (face-to-face)	MOPAC, borough and PEHP project leads x 7 interviews/8 interviewees	October – November 2015
Year one online stakeholder survey	44 responses *Social services/social work (14), VCS (10), health (9), children's centre (4), housing (3), local authority (3), Community Rehabilitation Company (1).* *Waltham Forest (19), Tower Hamlets (8), Westminster (4), Kensington and Chelsea (3), Hammersmith and Fulham (7), Kensington and Chelsea and Westminster (1), across tri-boroughs (2). Five of these respondents worked across wider boroughs including Barnet, Brent, Croydon, Harrow, Merton, Newham, Redbridge, Richmond, Sutton and Wandsworth.*	November 2015
Observation at community engagement events	Events x 5	November 2015 – December 2016
Year one Educator Advocate interviews (face-to-face)	Educator Advocates x 5	November 2015
Community engagement feedback surveys	78 feedback surveys received from 7 community engagement events *Professionals/practitioners/members of staff (35); Members of the community (21); remainder not stated.*	January 2016 – March 2017
End of year one Educator Advocate 'catch up' interviews (telephone)	Educator Advocates x 5	April 2016
Year one surgery host/practitioner interviews (telephone)	Surgery hosts/practitioners x 5	March- April 2016

Online EA/surgery attendee feedback	*The evaluation research team designed an online feedback survey to capture views of practitioners after they accessed support from the EA and/or attended a surgery. Success of this method was dependent on EAs remembering, and being able to (e.g., having contact details and access to Wi-Fi/a computer), send the survey link on to practitioners, and practitioners themselves choosing to complete it. Regular reminders were emailed to EAs and raised in focus groups. The survey received only two responses. These were not included in analysis for this report.*	June 2016 – April 2017
Service user feedback (collected by Educator Advocates)	Clients x 4	November 2016 – January 2017
Year two online stakeholder survey	69 responses *Social services/social work (16); VCS (16); health (12); Police/CJS (6); local authority (5); housing (4); education (2); children's centre (1); remainder not stated.* *Waltham Forest (23); Tower Hamlets (11); Westminster (10); Hammersmith and Fulham (5); Kensington and Chelsea (9); Pan London/multiple boroughs (9); remainder non-pilot boroughs/not stated.*	March – April 2017
Year two key stakeholder interviews (face-to-face)	MOPAC, borough and PEHP project leads x 5 interviews/7 interviewees	March – April 2017
Year two Educator Advocate interviews (face-to-face)	Educator Advocates x 5	March – April 2017
Year two surgery host/practitioner interviews (face-to-face and telephone)	Surgery hosts/practitioners x 7 interviews/8 interviewees	March – April 2017

Appendix 2: Professional backgrounds/organisations of training attendees (who stated their job role/organisation on training feedback surveys)

Multi-agency course	Number	%
Voluntary Community Sector (VCS)	60	18
Health - Other	53	16
Social Care - Children	42	13
Police/Criminal Justice	37	11
Social Care - Social Worker	24	7
Education	23	7
Housing	20	6
Social Care - General	4	1
Health - Sexual Health	3	1
Social Care - Other	3	1
Health - Midwife/Gynaecological	2	1
Not stated/unclear	65	19
Total	336	100

Specialist course, day 1	Number	%
Health - Other	26	20
Social Care - Social Worker	17	13
Voluntary Community Sector (VCS)	13	10
Social Care - Children	9	7
Health - Midwife/Gynaecological	4	3
Police/Criminal Justice	3	2
Housing	2	2
Social Care - Other	2	2
Education	1	1
Not stated/unclear	54	41
Total	131	100

Specialist course, day 2	Number	%
Health - Other	23	19
Social Care - Social Worker	12	10
Social Care - Children	11	9
Voluntary Community Sector (VCS)	11	9
Police/Criminal Justice	4	3
Health - Midwife/Gynaecological	3	3
Housing	2	2
Health - Sexual Health	1	1
Not stated/unclear	51	43
Total	118	100

Follow-up course	Number	%
Voluntary Community Sector (VCS)	20	27
Health - Other	12	16
Social Care - Children	6	8
Social Care - Social Worker	6	8
Education	4	5
Health - Midwife/Gynaecological	2	3
Social Care - Other	1	1
Not stated/unclear	24	32
Total	75	100

Appendix 3: Training courses, attendees and feedback forms received; courses cancelled/rescheduled

Count	East (Tower Hamlets and Waltham Forest)		Tri-borough (Westminster, Kensington and Chelsea, and Hammersmith and Fulham)		Total		
	Year 1	Year 2	Year 1	Year 2	Year 1	Year 2	Total
Number of courses	Multi: 9 Specialist: 3 Follow: 4 *Risk: 0* *Psych: 3* *Safe: 1*	Multi: 8 Specialist: 3 Follow: 9 *Risk: 3* *Psych: 3* *Safe: 3*	Multi: 12 Specialist: 3 Follow: 6 *Risk: 2* *Psych: 2* *Safe:2*	Multi: 11 Specialist: 3 Follow: 3 *Risk: 1* *Psych: 2* *Safe: 0*	Multi: 21 Specialist: 6 Follow: 10 *Risk: 2* *Psych: 5* *Safe: 3*	Multi: 19 Specialist: 6 Follow: 12 *Risk: 4* *Psych: 5* *Safe: 3*	Multi: 40 Specialist: 12 Follow: 22 *Risk: 6* *Psych: 10* *Safe: 6*
Number of attendees **registered**	Multi: 126 SP1: 41 SP2: 26 Follow: 8 *Risk: 0* *Psych: 3* *Safe: 5*	Multi: 136 SP1: 65 SP2: 64 Follow: 60 *Risk: 20* *Psych: 29* *Safe: 11*	Multi: 114 SP1: 46 SP2: 46 Follow: 26 *Risk: 6* *Psych: 12* *Safe: 8*	Multi: 37 SP1: 34 SP2: 20 Follow: 8 *Risk: 0* *Psych: 8* *Safe: 0*	Multi: 240 SP1: 87 SP2: 72 Follow: 34 *Risk: 6* *Psych: 15* *Safe: 13*	Multi: 173 SP1: 99 SP2: 84 Follow: 68 *Risk: 20* *Psych: 37* *Safe: 11*	Multi: 413 SP1: 186 SP2: 156 Follow: 102 *Risk: 26* *Psych: 52* *Safe: 24*
Number of attendees **attended/signed in**	Multi: 99 SP1: 31 SP2: 18 *Individuals across SP days: 34* Follow: 4 *Risk: 0* *Psych: 0* *Safe: 4*	Multi: 113 SP1: 52 SP2: 48 *Individuals across SP days: 56* Follow: 46 *Risk: 16* *Psych: 22* *Safe: 8*	Multi: 93 SP1: 34 SP2: 31 *Individuals across SP days: 35* Follow: 17 *Risk: 0* *Psych: 9* *Safe: 8*	Multi: 36 SP1: 27 SP2: 14 *Individuals across SP days: 30* Follow: 8 *Risk: 0* *Psych: 8* *Safe: 0*	Multi: 192 SP1: 65 SP2: 49 *Individuals across SP days: 69* Follow: 21 *Risk: 0* *Psych: 9* *Safe: 12*	Multi: 149 SP1: 79 SP2: 62 *Individuals across SP days: 86* Follow: 54 *Risk: 16* *Psych: 30* *Safe: 8*	Multi: 341 SP1: 144 SP2: 111 *Individuals across SP days: 155* Follow: 75 *Risk: 16* *Psych: 39* *Safe: 20*
Number of feedback forms received	Multi: 90 SP1: 30 SP2: 27 Follow: 11 *Risk: 0* *Psych: 7* *Safe: 4*	Multi: 98 SP1: 44 SP2: 42 Follow: 34 *Risk: 13* *Psych: 16* *Safe: 5*	Multi: 115 SP1: 31 SP2: 28 Follow: 23 *Risk: 6* *Psych: 9* *Safe: 8*	Multi: 34 SP1: 25 SP2: 21 Follow: 7 *Risk: 0* *Psych: 7* *Safe: 0*	Multi: 205 SP1: 61 SP2: 55 Follow: 34 *Risk: 6* *Psych: 16* *Safe: 12*	Multi: 132 SP1: 69 SP2: 63 Follow: 41 *Risk: 13* *Psych: 23* *Safe: 5*	Multi: 337 SP1: 130 SP2: 118 Follow: 75 *Risk: 19* *Psych: 39* *Safe: 17*

Specialist day 1 (SP1); Specialist day 2 (SP2)

Area	Courses cancelled	Courses rescheduled (but went ahead)	Sign in sheets/feedback forms not received
East	2 x follow-up risk assessment (Y1)		1 x multi-agency (sign in sheet and feedback missing) (Y1) 1 x specialist day 2 (sign in sheet missing) (Y1) 2x follow-up psychological impact (sign in sheet and feedback missing; sign in sheet missing) (Y1) 1 x follow-up risk assessment (sign in sheet and feedback missing) (Y1) 1 x follow-up risk assessment (sign in sheet and feedback missing) (Y2) 1 x follow-up psychological impact (sign in sheet and feedback missing) (Y2) 1 x follow-up safeguarding (sign in sheet and feedback missing) (Y2)
Tri-borough	1 x follow-up risk assessment (Y1) 9 x multi-agency (Y2) 6 x follow-up risk assessment (Y2)	3 x multi-agency (Y2) 1 x specialist (Y2)	4 x multi-agency (sign in sheet and feedback missing) (Y1) 2 x multi-agency (sign in sheet missing) (Y1) 1 x multi-agency (sign in sheet missing) (Y2) 4x multi-agency (sign in sheet and feedback missing) (Y2) 1 x follow-up risk assessment (sign in sheet and feedback missing) (Y2)