WRITTEN EVIDENCE TO THE DEPARTMENT OF HEALTH AND SOCIAL CARE IN RESPECT OF ITS CONSULTATION INTO REFORMING THE MENTAL HEALTH ACT

April 2021

Introduction

1. Muslim Women's Network UK (MWNUK) is an award-winning, national Muslim women's organisation (www.mwnuk.co.uk) that has been advancing equality, promoting women's empowerment and connecting voices for change for over 18 years. We are a small charity (reg. no. 1155092) that works to improve social justice and equality for Muslim women and girls. We find out about the experiences of Muslim women and girls through research and our helpline enquiries. We identify policy and practice gaps and use this information to inform decision makers in government as well as informing our community campaigns at a grassroots level.

2. We also develop resources and train women so they are better aware of their rights. We have a separate website for our national helpline (www.mwnhelpline.co.uk) that provides advice and support on a range of issues including mental health, domestic abuse, forced marriage, honour based violence, sexual exploitation and abuse, female genital mutilation, discrimination etc. We also run an online platform, the MWN Hub, by which Muslim women and supporters are able to interact with one another and share their views and opinions on relevant issues (www.mwnhub.com)

3. The impact of our work is particularly felt in reducing the vulnerability of Muslim women and girls, reducing the prejudice they face, and giving them greater access to rights and services – all of which allow them to contribute to society like any other citizen. We are also creating a critical mass of voices to influence change with more women being confident to challenge discriminatory practices within their communities and in society, and to influence policy makers.

4. Although we work predominantly with Muslim/BAME women and girls and will primarily focus on the experiences of Muslim/BAME women within our submission, the points we raise may equally apply to women of other ethnicities and faiths (or those of no faith at all) as well as to men. Where we make recommendations or ask for change, we therefore do so on behalf of those who may be affected by or may benefit from the same.

Evidence

5. As the only national charity working with and providing a frontline service to Muslim women and girls in the UK, we provide support and advice on a range of issues. This includes mental health issues, domestic abuse, sexual abuse, forced marriage and honour based abuse. Our MWN Helpline statistics relating to all 44 issues that we deal

with can be found at our MWN Helpline Data Dashboard: http://www.mwnuk.co.uk/muslim-women-helpline-dashboard.php

6. The support we provide to our beneficiaries ranges from providing practical and emotional support, liaising with police officers, refuges, social workers and other key stakeholders, providing case work support, providing counselling services, and providing assistance through emergency funds. Informed by our service users' experiences, we also raise awareness of the issues so that victims and potential victims are better aware of their rights and the support available to them (such as through resource production, workshops and outreach activities) and we also campaign for change.

7. Our knowledge and experience is therefore derived from the very real, lived experiences of our service users and through our other activities. MWNUK take a holistic approach to the provision of support and advice and understand the many factors which may affect those experiencing mental health issues and which need to be taken into account.

8. We now make the following points for your consideration to the following questions:

Question 1: We propose embedding the principles in the MHA and the MHA code of practice. Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?

9. MWNUK welcome the overdue reforms of the Mental Health Act, which proposes a strengthened holistic model of care.

10. Historically, too many have experienced further trauma and disempowerment, particularly when detained; conditions which no doubt further exacerbated their mental health issues. And the effects of which would not only have been felt by the individual, but by their families and loved ones, and their communities.

11. The inequalities faced by black men are well documented, and Black, Asian and Minority Ethnic communities will no doubt be looking to this Act's reform for a demonstrable commitment to tackling institutional racism and inequalities.

12. It is our view that the principles could also be embedded wherever there is an overlap with supporting those with mental health needs; in the police, criminal justice system, third sector and the private sector. For example, with more workplaces recognising they should offer mental health support, employers could use the principles when considering what support an employee may need. Each sector would need support to understand how to best embed the principles and produce useable guidelines and training for its workforces.

13. Also, the principles could be embedded in community settings, such as clinic appointments at hospital psychiatry services, and IAPT services. While the principle of 'Least Restriction' may not apply, treating 'the Person as an Individual' would go some way to ensuring that a 'one size fits all' approach becomes more redundant, and instead individual needs are considered and supported.

14. For example, the year-on-year increase of calls to the MWN Helpline since 2015, clearly demonstrate the need for faith and culturally sensitive services. By offering our professional service as a safe space to share all parts of the individual's experience, more people are not only using our service, but feel comfortable sharing the breadth of the issues they are facing, and are more likely to feel supported and consider the information and advice we provide as ultimately they feel heard. As a charity strengthened by our adherence to policies i.e. safeguarding, we too would welcome embedding these principles into our approach.

15. In the last year in response to the pandemic we have also seen many other local mental health 'services' set up. While intentions may be good, MWNUK is concerned that such services and individuals are unregulated, and we do not even know the policies they abide by. With long waiting lists for NHS mental health services, those with mental health issues are turning to private solutions like these. And due to lockdown measures, the remoteness of operation has meant even less oversight of potential harms caused. The mode of operation has largely been digital, for example, online counselling, and there is no real way of knowing where an individual is based should something go wrong. The risk to mental health and safety is real.

16. MWNUK are in favour of regulation of such services to ensure more people are not exploited and isolated, particularly when they may already be vulnerable. We would also welcome more research into these harms.

Question 2: We want to change the detention criteria so that detention must provide a therapeutic benefit to the individual. Do you agree or disagree with this proposal?

17. MWNUK strongly agree. We are mindful however that reform of the Act alone is insufficient, as for those not qualifying for the threshold of detention, we run the risk of leaving them in need of support without any assistance.

18. Following this unprecedented year it is fully expected that demand for mental health support will continue to increase. For the first time since 2015, the MWN Helpline too found 'mental health/feelings' as its top issue (40% of all cases received), and the number of counselling sessions provided by our service more than doubled when compared to 2019. If this was the impact on our service, nationally, the picture is much bleaker.

19. In order to ensure every individual is given the care they deserve, we believe the following is needed:

a. significant capital investment by the government to the NHS to be able to modernise the mental health estate
b. sustainable funding for NHS and Local Authorities current mental health services and its expansion to meet increased demand
c. embedding a co-production approach whenever designing and implementing services
d. ongoing investment in a well-resourced valued mental health workforce which is diverse at all levels

e. ongoing implementation and improvement of all Equality competency frameworks within healthcare services
f. meaningful training for all mental health professionals in the aforementioned principles, equality and diversity principles, and more awareness of diverse communities from a range of delivery partners
g. sustainable investment in and funding for public health, social care and community-based specialist mental health care to ensure more people with mental health issues are treated well, and treated early
h. a national awareness raising campaign, including available resources and training on the changes to the Act

20. It is also important that from the outset, service users co-design services, and inpatient environments so that they are conducive to healing and recovery. The Independent Review of the Mental Health Act 1983 published in December 2018 states that *"ward environments and ward cultures alike should support independence, social interaction and activity"*.

21. For many Muslim women, this is likely to include places to interact with family and practice their faith, dietary needs and female only spaces. Ultimately, a ward should help prepare you for life in the community once you are discharged.

22. "Whilst on a Psychiatric ward, I expressed that I only wanted a female member of staff to check in on me whilst I was in the shower. However, this was disregarded and a male member of staff knocked and walked in. I had turned when he knocked, and when I saw him I just froze. He did say 'just checking in on you' and left promptly, but it left me feeling traumatised. I don't even think I finished washing my hair- I just got dressed and left."

23. Please note, treating 'the person as an individual' is crucial here, and to reiterate that Muslims are not a homogenous group, and what is needed for one Muslim, may not be required for another.

Question 3: We also want to change the detention criteria so that an individual is only detained if there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. Do you agree or disagree with this change?

24. MWNUK agree with this statement, as for too long 'risk of significant harm' has meant traumatic unnecessary detentions for longer than is often required. In agreeing, we would also strongly support the Independent Review of the Mental Health Act 1983 published in December 2018, which states on page 111:

25. "We want to reverse this trend; to use new detention criteria to give professionals the backing they need to take more risks with risk. We believe the Act needs to be more explicit about how serious the harm has to be to justify detention and/or treatment, or how likely it is that the harm will occur. We are recommending that there must be a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. But our recommendations will not work if they are seen as 'stand-alone'. If the Government agrees, tackling the problem of risk aversion must happen across the board. There is little point in mental health professionals

deciding to accept a greater perceived risk if the courts, regulators, media and others do the opposite."

26. MWNUK again urges that all changes to the Act are well communicated to all sectors and the public. We believe that amendments to the Act present a real opportunity to acknowledge the failures of the past, commend the developments we have made de-stigmatising mental health societally, and action the changes that are now necessary. With any change national awareness raising campaigns should include accessible information, resources and training.

27. We do caution that the detention criteria must be clearly outlined, and followable by all those making decisions on detention. Too often have we seen individuals not detained, when in fact detention is the best option for them, even temporarily.

Question 8: Advance choice documents will follow a standard format and approach, and should include the following information about an individual's preferences, including on treatment and non-medical therapeutic approaches, as well as any other information deemed relevant by the individual:

a. **any treatments the person does not wish to consent to as well as their preferred clinically appropriate treatments**
b. **preferences and refusals on how treatments are administered (for example refusal of suppositories, and preference for care staff of a particular gender, to avoid retraumatising them, given the relationship between gender-based violence and trauma)**
c. **name of their chosen nominated person**
d. **names of anyone who should be informed of their detention, care and treatment (including specific instructions on which individual should get what information)**
e. **communication preferences**
f. **behaviours to be aware of which may indicate early signs of relapse**
g. **circumstances which may indicate that the person has lost the relevant capacity to make relevant decisions**
h. **religious or cultural requirements**
i. **crisis planning arrangements, including information about care of children/other dependents, pets, employment, housing etc**
j. **other health needs and/or reasonable adjustments that might be required for individuals with a disability or learning disability and for autistic people**

Do you have any other suggestions on what should be included in a person's advance choice document?

28. MWNUK believe that ACDs are an important tool in treating the person as an individual. This should be a 'living' document; reviewed and updated regularly premised on making **no assumptions** and being completely non-judgemental. Muslims are diverse, and while awareness training of different minority groups is encouraged to broaden the perspective of healthcare professionals, such training should never result in an individual being stereotyped. E.g. while some Muslims may require a space to pray, others may not. Religious/ cultural beliefs may also be the

reason why someone refuses treatment, for example, they may belief they are spirit possessed and therefore not willing to accept/engage in treatment.

29. The documents must be available in plain-speak, be accessible and interpreters must be used where required.

30. Culturally, for many Muslims in the UK, family play a significant active role in an individual's life. This is an important point to note, and while of course it could be of detriment to an individual, can also be an important tool to their recovery. Such 'supporters' too will need support, and it is vital to educate and resource them with the tools to help their loved one in a mental health crisis.

31. *"For my brother, treating his mental health illness in isolation without involving family members would not have worked as well. Our parents needed educating about how to handle him, what to do, what to say etc. Thankfully, as I'm a doctor I could do this. At the time my brother lived with extended family and they also needed education on how to support my brother but they refused to engage and I think the mental health service should have pushed this more. The mental health service did offer family therapy to enable a dialogue but again when it was refused I think it could have been pushed more. For my parents using interpreters from the same community was a big no-no as they were likely to know the interpreter or have contacts in common."*

32. *"I remember being settled in inpatient Psychiatric Ward, and asked for a prayer mat, qur'an and mug (for wudhu)… and the HCP asked in response 'what's that- where would I get it from?'. I asked 3 times, and by the time I was provided one it was also time for me to leave. This was only after I was allocated an 'Equality and Diversity' person as I feel there was recognition that they were not meeting my cultural and faith needs. This person was amazing, she first spoke to my mum in Punjabi and explained my mental health condition and what it means practically. And then arranged for an Imam to speak to my dad. This was pivotal in my parents' understanding of my mental health condition, and that it wasn't a bad thing. Their previous understanding of mental health had come from movies stereotyped as someone in Psychosis. The chaplain spoke to me first to ensure he knew what I wanted shared with my dad, which I really appreciated."*

Question 9: Do you agree or disagree that the validity of an advance choice document should depend on whether the statements made in the document were made with capacity and apply to the treatment in question, as is the case under the Mental Capacity Act?

33. MWNUK strongly agree to this statement. The Advance Choice Document should be made with capacity and be quite specific.

Question 10: We think that a care and treatment plan should include the following information:

a. **the full range of treatment and support available to the patient (which may be provided by a range of health and care organisations)**
b. **for patients who have the relevant capacity and are able to consent, any care which could be delivered without compulsory treatment**
c. **why the compulsory elements of treatment are needed**
d. **what is the least restrictive way in which the care could be delivered**
e. **any areas of unmet need (medical and social) for example where the patient's preferred treatment is unavailable at the hospital**
f. **planning for discharge and estimated discharge dates (with a link to s117 aftercare)**
g. **how advance choice documents and the current and past wishes of the patient (and family and/or carers, where appropriate) have informed the plan, including any reasons why these should not be followed**
h. **for people with a learning disability, or autistic people, how Care (Education) and Treatment Reviews, where available, have informed the plan, including any reasons why these should not be followed**
i. **an acknowledgement of any protected characteristics, for example any known cultural needs, and how the plan will take account of these**
j. **a plan for readmittance after discharge for example informal admission, use of civil sections, or recall by the Justice Secretary**

Do you have any other suggestions for what should be included in a person's care and treatment plan?

34. MWNUK believe that a comprehensive Care and Treatment Plan is vital for ensuring a holistic package of care. All of the bulleted points in this question are necessary to give individuals the wrap-around support needed. We acknowledge that across the country many healthcare professionals already take this approach. However, it is our experience that others do not- largely not for lack of will, but due to their under-resourced services. We implore the government again to invest sustainably in mental health services; not just one aspect of it, but all aspects an individual may encounter on their treatment journey. Getting better holistic support will significantly improve recovery rates and will be less burdensome and costly on the system long-term.

35. As said previously, whenever considering implementing such systems we must also consider accessibility and who is likely to inadvertently be marginalised. From the Muslim women we have supported, it is astounding that interpreters are not available (particularly in diverse areas with large minority populations) when needed. Likewise, faith and culturally sensitive services should no longer be considered a luxury or a 'nice to have'. We fully support calls to add a fourth dimension; the spiritual, to the biological, psychological and social model of care. As outlined in the Handbook of Spiritual Care in Mental Illness (2015) report by Jo Barber and Carol Wilson of Birmingham and Solihull Mental Health Trust:

36. *"A fourth dimension, the spiritual, has recently been recognised, and research suggests we need to take it seriously as a significant factor in resilience and recovery."*

37. For example, last year a woman contacted the MWN Helpline to talk about the sexual, physical and verbal abuse from her husband of 16 years. She had received NHS counselling but felt she needed a service that would understand her faith and be more culturally aware of her situation. The caller was still married to her husband; who had

acknowledged his abuse and wanted to make amends. She felt it was too late, but felt trapped in the marriage because they had three children. She was very angry and needed to explore the complexities of her feelings. Our faith and culturally sensitive service gave her that space to process her thoughts and emotions fully and decide her next steps.

38. It has also been our experience on the MWN Helpline, that an overlap of vulnerabilities and therefore involvement of different agencies, sometimes complicates providing support. The role of a 'coordinator' in such instances is vital, and ensures resources are not duplicated.

39. Also, it is often difficult for professionals to know the full breadth of available services. We strongly recommend that as part of the investment in the NHS digital strategy, that there is scope to further strengthen the NHS service website/app, by asking services, including charities to self-enrol on this central system, which is then available publicly. This would go some way to improving the support available to everyone.

Question 11: Do you agree or disagree that patients with capacity who are refusing treatment should have the right to have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering?

Please give reasons for your answer

40. MWNUK assert that each case must be assessed individually, but we do agree that patients with capacity who are refusing treatment should have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering. There would need to be a high level of harm to override a patient's wishes.

41. The analogies we consider is someone with cancer refusing invasive treatment, or the domestic abuse victim who wants to stay in the relationship. As hard as it may be for professionals supporting such individuals, ultimately it must be the individual's decision.

42. Also, while we have advanced somewhat in recent years in regards to the stigma surrounding mental health issues, more must be done to ensure individuals do not refuse treatment because they are fearful about the societal impact of naming their condition and receiving treatment.

Question 12: Do you agree or disagree that, in addition to the power to require the responsible clinician to reconsider treatment decisions, the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given?

43. MWNUK generally agree that in addition to the power to require the responsible clinician to reconsider treatment decisions, the Mental Health Tribunal judge should be able to order that a specific treatment is not given. In our view, the Tribunal judge acts as an additional safeguard for individuals. Such oversight we feel is necessary as it may bring to light particular patterns of treatments prescribed by clinicians, or oversights, or wider institutional issues which may need to be addressed either with training or guidance.

44. Equally, we are wary of situations where the stopping of treatments could be detrimental and so all treatments and evidence must be taken into account. It is our preference that more than one judge sits at tribunals so as to allow further balance, but as a minimum if a patient is from a minority group it is critical that their cultural needs form a part of the assessment.

45. We also stress that in order to tackle inequalities, tribunals must be diverse and reflect the communities they serve.

Question 13: The new nominated person will have the same rights and powers to act in the best interests of the patient as nearest relatives have now. These include rights to:

a. **object to the patient being made subject to the act**
b. **apply for the patient's discharge**
c. **appeal to the tribunal if this application for discharge is denied**
d. **apply for the patient to be detained under the act**
e. **receive information from the hospital about the patient's care, detention or community treatment order (CTO), unless the patient objects to this**

46. In addition to the powers currently held by the nearest relative, we propose that the nominated person should also:

a. **have the right to be consulted on statutory care and treatment plans, to ensure they can provide information on the patient's wishes and preferences**
b. **be consulted, rather than just notified, as is the case now, when it comes to transfers between hospitals, and renewals and extensions to the patient's detention or CTO**
c. **be able to appeal clinical treatment decisions at the tribunal, if the patient lacks the relevant capacity to do so themselves and the appeal criteria are met**
d. **have the power to object to the use of a CTO if it is in the best interests of the patient**
e. **To support nominated persons to access and exercise these enhanced powers we will provide clear, detailed guidance on the powers of the nominated person role.**

Do you agree or disagree with the proposed additional powers of the nominated person? Please give reasons for your answer

47. MWNUK support the expansion of this role beyond nearest relatives to give people more choice and autonomy when subject to the act. We agree that the new Nominated Person (NP) should have the aforementioned rights.

48. Our concern with nearest relatives or a NP is whether the person does in fact have the individual’s best interests in mind when making decisions and can demonstrate this. We also question whether any NPs themselves understand what is being asked of them:

49. *"My mum was automatically my next of kin. However, she did not fully understand what the role entailed. Her natural inclination was to agree with a doctor's viewpoint, because culturally doctors are deemed of higher status that should be listened to. She would not have challenged the decisions made, treatments provided or not provided, even if she knew I wanted something different."*

50. Our concerns extend to those in unhealthy abusive relationships; e.g. those who are groomed, trafficked, forced into marriage, or are in domestically abusive relationships. In these examples it is likely that the person nominated is in fact the perpetrator of these crimes and may further exert power and control over the individual. Having details of the individual's care, being consulted about the individual's movements, and having the power to appeal clinical treatment decisions may all be tools used to further abuse the individual.

51. In the following case study*, it is likely that Laila's (not her real name) NP would have been her partner:

52. *"Laila was in an abusive relationship and the forms of abuse she suffered included sexual, emotional, physical and psychological abuse. Laila had a longstanding history of abuse and mental health issues. During one argument, her partner called the police and kicked her out of his property making her homeless. When the police arrived, Laila had severe visible bruising on her face and body. However, because her partner had called the police she was the one arrested and kept in custody overnight. As Laila had a criminal record e.g. for theft, she was viewed by police as a 'troublemaker' and not questioned about how she had sustained her bruises.*

53. *Upon her arrest the police also confiscated Laila's medication for her mental health condition. When she was released the next morning, the police told her they could not find her medication and said that there was nothing they could do about it. Laila was unable to get a new prescription immediately, which led to her mental health deteriorating over the next week or so. Laila contacted the MWN Helpline because she was sleeping in her car and had nowhere to go."*

54. Therefore, we strongly urge for better safeguards to be put in place and suggest that the process of nomination is further formalised with greater checks and balances. If healthcare professionals, or others (e.g. family members) have concerns about the NP, these should be logged, and we would support the option of an Interim Nominated Person, appointed by an AMHP, to receive information about the individual against their wishes.

Question 14: Do you agree or disagree that someone under the age of 16 should be able to choose a nominated person (including someone who does not have parental responsibility for them), where they have the ability to understand the decision (known as 'Gillick competence')?

55. MWNUK agree that someone under the age of 16 should be able to choose a nominated person where they have the ability to understand the decision, as young people too should have choice and autonomy.

56. While each case should be assessed individually and this may not be relevant to all, we would suggest that before someone under the age of 16 chooses an alternate nominated person to those who have parental responsibility for them, that professionals involved ensure they have worked with the family to educate them about the individual's mental health condition and contributing factors. These relationships

are often crucial to recovery, although we acknowledge that this may not be true for everyone.

57. Again, our concerns about this extend particularly for those in unhealthy abusive relationships; including those who are groomed and trafficked. We know that perpetrators often isolate individuals from their families as a method of further control.

Question 15: Independent mental health advocates (IMHAs) are trained specifically to work within the framework of the act and to enable patients to participate in decision-making. They are currently responsible for supporting patients to understand:

a. **their legal rights under the act and those of the people who are able to act on their behalf**
b. **the particular parts of the act which apply to them**
c. **any conditions or restrictions to which they are subject**
d. **any proposed or received medical treatment, and the reasons for that treatment**
e. **the legal authority for providing that treatment**
f. **the safeguards and other requirements of the act which would apply to that treatment**

To ensure patients are able to benefit from the reforms to the act proposed in earlier chapters, we propose to expand the role of IMHAs to include the following additional safeguards:

a. **supporting patients to taking part in care planning**
b. **supporting individuals in preparing advance choice documents**
c. **power to challenge a particular treatment where they have reason to believe that it is not in the patient's best interests**
d. **power to appeal to the tribunal on the patient's behalf**

Do you agree or disagree with the proposed additional powers of independent mental health advocates? Please gives reasons for your answer

58. MWNUK strongly agree with statement above. IMHAs are vitally important and we urge the government to invest more and sustainably into a diverse workforce. The difference that diversity makes is well documented, and IMHAs too need to be culturally appropriate. Again, each person must be treated as an individual, and no assumptions must be made. For example, rather than assume an Asian patient would want an Asian IMHA, the patient should be asked their preference. It could be that the patient believes someone from the same community would judge them or would share with their community their condition details. While neither may be true, the patient would be less likely to engage with this IMHA.
59. On the contrary, an IMHA from the same community may be seen by other patients as comforting and they would assume greater understanding of their cultural/religious needs.

60. We would also support the option of being able to change IMHAs if patient wishes.

Question 16: Do you agree or disagree that advocacy services could be improved by:

Please give reasons for your answer

61. MWNUK are in favour of enhanced rights to advocacy for every individual. As with IMHAs in the previous question, we urge the government to invest more and sustainably into a diverse workforce, in order to reduce the bias and inequalities faced by patients. Also, it is our belief that this will ensure faith and cultural needs are accounted for when embedding the principle of treating the patient as an individual.

Question 20: We want to ensure that health professionals are able to temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, but are trying to leave A&E. Do you think that the amendments to section 4B of the Mental Capacity Act achieve this objective, or should we also extend section 5 of the MHA?

62. MWNUK believe in principle that health professionals should be able to temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, but are trying to leave A&E. However, in our experience A&Es are not the best environments for supporting an individual in crisis. The lights, strangers, feeling overwhelmed, lack of access to stress relievers such as music or TV, as well as other factors may all contribute to wanting to leave.

63. We strongly recommend the government invests in specialised Mental Health A&Es. Such successful models of practice already exist, for example the Lotus Assessment Suite in South West London.

64. Until then, better ways to create safe, stable, and calming environments within existing A&E departments must be found, which see medical and psychiatry teams better able to coordinate care. For example, dedicated liaison psychiatric teams.

Final Comments

65. As a point of clarification, we must explain that where our comments and examples have been limited to Muslim and BAME girls, this is due to the nature of our organisation and its work. As a national Muslim women's charity our work predominantly deals with Muslim and BAME women and girls albeit we also work with individuals of other faiths and are therefore also aware of issues of relevance to other faith and non-faith communities. We are also aware that some of the issues experienced by Muslim and BAME women and girls can also be experienced by non-Muslim, non-BAME women and girls, as well as men and boys. In turn we wish to clarify that where we make any recommendations, we do so on behalf of all those within wider society who may be affected.

66. We hope our comments prove to be useful in your considerations.

On behalf of Muslim Women's Network UK,
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21 April 2021

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