

The Autonomy of Choice and the Role of the Nearest Relative under the Mental Health Act 1983

Abstract

The role of the 'nearest relative' as defined in section 26 of the Mental Health Act 1983 (MHA1983) has unrestricted implications in influencing the chances of a mentally challenged family member to receive treatment. The role was introduced by the 1959 Act but was devoid of governing principles or clearly defined purpose. However, it has become formally recognised as a patient safeguard to limit the extremes of professional discretion and protect patients from unjustified compulsory admission in the 1983 Act which has further been amended by the MHA 2007. The role of 'nearest relative' survived two earlier attempts to eradicate it in the draft Mental Health Bills of 2002 and 2004. However, since its introduction, the role has generated debates because of grave concerns about the relative's powers to manipulate admissions and the vagaries of family relationships.

Studies have shown that relatives have always had a role to play, one way or another, in the hospitalisation of mental patients. The only exemption is where the patient has no relative(s), in such circumstance, the role may be played by a friend or carer. The view has been expressed that the idea of the 'nearest relative' in the Mental Health Act 1983 was intended as another safeguard to protect the rights of a service user who is being involuntarily detained and treated against their will. This means that the relative or carer will receive necessary information and be involved in decisions regarding the patient. The Nearest Relative is an essential but controversial role, with some supposed flaws in the way they are selected.

The principal focus on this study is to determine the degree to which patients can choose or an Approved Mental Health Professional (AMHP) will be able to identify persons who can take up the role to act as the 'Nearest Relative' (NR). This will be achieved by looking at the outmoded hierarchical list of relatives suitable to act as such under the MHA 1983 and the knotty issues surrounding wrong persons taking up on the role of a NR.

Furthermore, this work will provide a background insight into the role of the 'nearest relative' under the Mental Health Act and identify the issues/problems surrounding it. Attempt will be made to proffer recommendations for reform as well as the justifications for the recommendations

Keyword: Medicines and healthcare products regulatory agency • Electronic nicotine delivery system • Action for smoking on health • Flavours

Received: 22-Aug-2024, Manuscript No. FMCI-24-146455; **Editor assigned:** 26-Aug-2024, PreQC No. FMCI-24-146455; (PQ); **Reviewed:** 09-Sep-2024, QC No. FMCI-24-146455; **Revised:** 11-Jan-2025, Manuscript No. FMCI-24-146455; (R); **Published:** 18-Jan-2025, DOI: 10.37532/2041-6792.2025.15(1).617-625

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Introduction

The powers/rights, functions, and problems pertaining to the role of the nearest relative under the MHA

This section will highlight and consider in some detail, vital aspects of the NR role under the MHA. The nearest relative is usually a family member and not a qualified professional or expert, as listed in the pecking order set out in section 26 MHA. The powers/rights which are exercisable by the NR by virtue of the MHA are as follows;

The right to demand for an assessment: Section 13(4) of the Mental Health Act 1983 (as amended) (MHA 1983) empowers a NR to involve a local authority to request an Approved Mental Health Professional (AMHP) to assess a case, with a view to making an application for a person to be admitted to hospital. The NR is entitled to a written explanation from the AMHP if admission is unsuccessful [1].

The right to apply for compulsory admission or guardianship: By virtue of sections 2, 3 and 4 of the MHA 1983, the NR can apply for a patient to be admitted to hospital or for guardianship under section 7 of the MHA. However, in reality, this hardly ever takes place, and the code of practice advises that in the majority of cases, an AMHP will be the more appropriate applicant.

The right to be consulted or informed: Section 11(4) of the MHA 1983 states that, before making an application for detention under section 3 or for guardianship under section 7, an AMHP must consult the person acting as the NR, save such consultation is not reasonably practicable or would involve unreasonable delay [2]. A similar qualified right is contained under section 11(3), for the person appearing to be the NR to be informed of (although not consulted about) a patient's detention.

The right to order discharge of the patient: In sections 23 and 25 of the MHA 1983, the NR possesses the ability to order the discharge of a patient who is detained in hospital under sections 2 or 3, or is subject to supervised community treatment, through giving the hospital managers at least 72 hours' notice in writing. Unless, within 72 hours of the giving of notice, the responsible clinician certifies that in his or her opinion the patient, if discharged, would be likely to present a danger to themselves or others, the patient must be discharged. Where such a 'barring certificate' is issued, the NR may apply to the mental health tribunal, unless the patient is detained under section of the MHA 1983 [3]. As far as guardianship is concerned, the NR can direct discharge of guardianship without delay, since there is no provision for barring by the responsible clinician. Thus, a discharge order of guardianship by a NR will be effective immediately it is given.

The right to object to section admission to hospital or guardianship: An application for admission to hospital under section or for guardianship under section cannot proceed if the person consulted as NR objects. The application can only be filed in such circumstances if the NR has been displaced by the county court and/or the new NR has not objected. However, the displacement can be successful only if the objection is deemed by the court to be unreasonable. In this scenario, the power to object could be regarded as an essentially procedural safeguard, as it can be circumvented in such circumstances.

Literature Review

It follows that from the powers/rights of the NR, the MHA positions the NR, in any circumstance, very central in the decision-making process, except the AMHP believes that doing so would be detrimental to the person they are assessing. It is safe to say therefore, that the role of NR is a powerful one, however, it can only be efficient when the holder is fully informed or aware of the functions, powers and rights and also knows how to use them. The role of the NR is usually misconceived with that of the next of kin, however, this is not the case as the role of the NR differs from that of the next of kin, because the next of kin has no legal backing within the MHA.

It is the duty of the AMHP to reasonably identify who the NR appears to be when the patient lacks capacity to choose for himself. However, this duty can be challenging and complex, considering that there are chances for mistakes, particularly occurring from the intricacies of human relationships. The duty of the AMHP to identify the NR involves settling the complexity of sections and of the MHA. This situation which has been likened to "walking a tightrope", comes to play when the AMHP is in the process of commencing a MHA assessment [4,5].

Section of the MHA 1983 highlights the list of family members who can fulfil the role of an NR. The section defines 'relative' to mean anyone in the following hierarchical list:

- Husband, wife, or civil partner
- Son or daughter
- Father or mother
- Brother or sister
- Grandparent
- Grandchild
- Uncle or aunt
- Niece or nephew²²

Under the MHA 1983, the AMHP will proceed through this list from using a top-down approach until a suitable NR, who meets the criteria required to take up the position, has been identified. A relationship of half-blood will be treated as if it is of full blood (e.g.

half-siblings are treated as if they were full siblings). An illegitimate person is treated as if he/she were the legitimate child of the mother, and the father, only if he has parental responsibility within the meaning of section 3 of the Children Act 1989, a cohabitant who lives with the patient 'as husband/wife/civil partner, and has done so for six months or more, is treated as being the husband/wife/civil partner. A person who is not a relative at all (not on the list) can become a relative if the patient ordinarily resides with him and has done so for five years or more. However, this person is added to the bottom of the hierarchy (below nephew or niece). An adopted child (even when an adult) will be identified as the child of an adoptive parent and not of a natural parent [6]. In a situation where more than one relative exists within a group on the list (such as brother or sister, half-blood and full blood) relatives of full blood will take priority over those of the same description of the half-blood, also the elder/eldest is favoured; and the sex of the relative is immaterial. Stepchildren or stepparents and cousins are not reflected in the list of relatives (although they could become relatives via the 'five year' rule). A person must be above the age of 18 years of age, residing in the UK (if this is the service user's country of residence) to be eligible to be identified as an NR. It can be seen that the list is used in a scale of preference model whereby priority is given to enable the AMHP to determine which relative that will come before the other.

The list of family members who are eligible to take up the role of a NR seems capricious. The view is held that the list is reflective of the parliament's view on whom relatives are or should be. The list does not take cognisance of the complexities that might exist in family relationships and that persons who are not mentioned on the list as relatives can be way closer to a patient and knows more about the patient than a family member who is prioritized on the list, as such robbing the patient of his/her autonomy of choice. A case in point is the omission of cousins on the list of relatives and the inclusion of other persons who are not relatives but must have lived with the patient for more than 5 years [7-10]. The parliament failed to consider the fact that situations surrounding various patients may vary such as a situation where a person who is in a better standing with the patient is not reflected on the list or is the least in priority for example; the identification rules will typically eliminate a long-term friend of the patient irrespective of how well they know the patient or whether they are best placed to act in the patient's best interests (unless the two have ordinarily resided with each other for at least five years).

Prior to the 2007 amendment, only certain persons (relative, someone living with the patient or an approved social worker (the predecessor to the AMHP), but not the patient could apply to a court for an order displacing the nearest relative. This is not the case anymore as section of the MHA allows patients themselves to apply to a County Court for the displacement of their NR. This might be an

improvement but still falls short of giving the patient full discretion to choose a NR from the outset. It is apt to state that it is the duty of the AMHP to identify a NR when the patient lacks capacity, and in doing so, should act in the best interest of the patient. The AMPHs can be classified as best interest assessors. The role of the AMHP as a best interest assessor is to look at the circumstances surrounding the provision of care or treatment and determine whether those circumstances deprive the relevant person of their basic human rights as guaranteed by the European Convention on Human Rights (ECHR). Looking at the priority process of identification on the list of relatives, there is a rebuttable presumption that the NR will act in the patient's best interests under the MHA. A study has stated that the mode of identification of nearest relative is outdated because of its restrictive and hierarchical approach and considering that family relationship can be complicated. Another study has also described section 26 as prescriptive instead of intuitive for the same reasons as the former [11].

As Angela Browning MP poignantly observed during the committee stage of the Mental Health Bill 2006, she stated:

The list set out in section 26 of the 1983 Act is now somewhat anachronistic. It reads like an inheritance tax situation in which the bloodline goes down through the family and people find that they have been left a lot of money by a nearest relative whom they have never met. The idea when talking about someone's mental health that a person, simply because of a blood relation, is suddenly responsible for or is even interested in them, is not how society works now. Many years on from the 1983 Act, families tend to be more disparate, and other relationships come into play.

Undeniably, the NR role is an important and powerful role to occupy. Also, the key role of carers and family members as a safeguard to protect patients in the compulsory admission process cannot be underestimated. According to a study, the axiom 'we all need somebody to lean on', is valid when a person is physically or mentally challenged [12]. That somebody to lean on may possibly be a relative, friend or carer who will act in the patient's best interest such as objecting when a wrong compulsory admission process is being done which amounts to the deprivation of liberty as guaranteed under the ECHR.

A clear example that demonstrates the importance of the role of a NR as a safeguard is the case of *TTM v London Borough of Hackney*. In that case, the patient was initially detained under section 2 MHA and then, with his Nearest Relative's approval, under section 3. However, the nearest relative, concerned with the lack of progress, had decided to exercise his right to discharge the appellant, which took effect. Subsequently, a new application for detention under section 3 was made by an approved mental health professional on behalf of the London Borough of Hackney. The nearest relative exercised its power

of objection and challenged the lawfulness of his detention on the basis that there had been a breach of section 11(4) of the MHA as the NR had objected to the application. The claimant at first instance was unsuccessful, but on appeal the court allowed the appeal based on the facts of the case. It held that the patient's right to liberty guaranteed by Article 5 of the ECHR had been infringed thus, the patient had been illegally detained and was entitled to compensation. In this case we can see that the NR provided adequate protection of the patient's rights due to the ability given by the MHA to object.

Admittedly, the role of a NR is an important and significant safeguard, but when such a role is given to or possessed by the wrong person, the best interest of the patient will be difficult to realise and thus, basic human rights infringed. The role of the NR can occasionally be prone to abuse, considering that some relatives are not best placed to support the patient in this capacity. Emphasis have been laid on the promotion of the patients right to a private and family life as guaranteed by Article 8 of the ECHR, that the patient should be at the epicentre of deciding who should take up the role of a NR. The safeguard on the role of a NR is still fragile looking at the selection process in sections 26 (definition of 'relative' and 'nearest relative') and (appointment by court of the acting nearest relative) of the Mental Health Act 1983 which limits the patient in choosing whom to act as a NR and thus, incompatible with Article 8 of the ECHR [13-15].

A case that clearly conveys this idea is *R(E) v Bristol City Council* in this case, the patient suffered from mental health problems for many years and had been detained under the MHA severally. The nearest relative of the patient was her sister, with whom she did not get on well and whom she had not seen for a long while. As a result, she did not want her sister involved with her care at all, and her psychiatrist thought that it would be unhelpful to her mental health for her sister to act as her nearest relative. In correspondence, E's sister decided to delegate her responsibilities as nearest relative to the local authority. Yet, the local authority was of the view that it was not discharged of its obligation unders. 11(3) of the MHA to inform the sister as statutory nearest relative of any intention to apply for admission for assessment. The patient (E) applied for judicial review, for a declaration that it was unlawful for the authority, or any approved social worker employed by it, to notify or consult E's nearest relative unders. 11 of the MHA without her consent, and for an order prohibiting the authority, or any approved social worker, from notifying or consulting with E's nearest relative without her consent [16]. It was resolved by the court that the sister (Mrs. S) is not a suitable person to carry out the many powers and responsibilities given to her as the claimant's nearest relative under the Mental Health Act 1983. On the ratio that (a) the claimant does not want her as her nearest relative, (b) it might be positively harmful to

the claimant's mental and emotional well-being for Mrs. S so to act, and (c) Mrs. S, it seems, does not wish so to act.

Also, the court in *TW v Enfield Borough Council* has recognised that a careful balance must be struck between the patient's rights under Articles 5 and 8 of the ECHR. It is noteworthy to mention that the case of *JT v UK* was the first to make a declaration of incompatibility with the ECHR under the Human Rights Act 1998 made by the domestic court regarding the NR provisions. The case was about a patient whose stepfather was alleged to have sexually abused her and as a result did not wish her NR (her mother, who was still with the stepfather) to be involved in decisions pertaining to her care. A unanimous conclusion was held by The Commission that there had been an infringement of Article 8 of the ECHR and the UK Government at the time took necessary steps to amend the law to remedy the incompatibility and empower patients to exercise some control over the choice of NR. This has been reflected in the extant legislation and patients can now apply to the court to displace an 'unsuitable' NR. Nevertheless, this fails to meet with the desired expectation of giving the patient absolute control to nominate or appoint their desired person (relative, friend or carer) to act as the NR in the first instance. The criticisms on dilatory processes regarding the NR displacement procedure has been recognised by court in some cases. Loopholes surrounding the role of a NR as an effective safeguard must be re-evaluated to be in conformity with the United Nations Convention on the Rights of Persons with Disabilities (CRPD), an international instrument that specifically guarantees rights of persons with disabilities [17]. The next section will suggest possible proposals for reform that will help ameliorate the problem of limitation of the autonomy of choice of a suitable NR.

Discussion

Proposals for reform

The previous section has looked at the problems surrounding the limitation/restriction of autonomy of choice of patients in selecting a nearest relative. The identity of the NR is currently recognized by the AMHP through a hierarchical list which affords patients no choice. This method of identification is susceptible to identifying a NR who has little/no knowledge or involvement with the patient, or whose involvement may be detrimental to the patient. In order to address the problems highlighted, legislative amendment is essential to restate the importance of the wishes and feelings of patients in having absolute discretion in selecting their NR. Drawing from the recommendations of the Independent Review (known as the Wessely Review), the amendment of the MHA is hereby proposed to include the following;

- For the prescriptive 'definition and hierarchical list' of nearest relatives in section 26 of the MHA to be deleted and amended to allow

any individual who is desired or preferred by the patient to assume such role provided that the person nominated or chosen is willing and capable of performing such role.

- For the term 'nearest relative' to be substituted with 'nominated person' to affirm the empowerment of patient autonomy.
- For the Nominated Person (NP) to undergo some basic training to irradiate such a person of their responsibilities and powers and how it should be used in the best interest of the patient.

A descriptive idea of how the section could be drafted is: A nominated person is a person who a patient has chosen and has been identified by the AMHP to represent the patient in its day-to-day decisions. Provided that the nominated person who has been chosen and identified is willing and capable of performing such role on behalf of the patient [18].

Such persons who have been chosen and identified shall undergo a mandatory training on the duties and functions of a nominated person for a period and through a medium that may be determined by the AMHP. The functions and powers of the NP would largely be based on those presently exercised by the NR. They include inter alia the ability to hinder detention (for treatment but not for assessment), to discharge a patient and to appeal to the Tribunal where the discharge of a patient has been prevented by the responsible clinician. The need to strengthen the choice and autonomy of patients in respect of Appointing the right individual as NP will mean fewer cases of unsuitable people being automatically selected for the role. In turn, this will oust the tedious processes which could most times be challenging in the appointment of NPs in the extant law, particularly when two or more people qualify within a certain class or group of relatives (such as brother and sister). It is strongly believed that the amendment of the extant MHA to reflect the changes as highlighted above will draw us closer within the spirit and intendment of Article 8 of the ECHR and the support decision-making model of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Justification for the amendment

Over the decade, the rights of persons with mental health challenges have been significantly improved and reinforced internationally by treaties such as the CRPD. The CRPD is an international treaty passed by the United Nations General Assembly in December 2006 and subsequently came into effect in May 2008. The UK went ahead and ratified this treaty in 2009. The intendment of the convention is to promote equality for all people living with disabilities. These include guarantee of human rights, promoting autonomy, ensure equal treatment, and counteract discrimination against persons with disabilities. The CRPD in its general principles make provisions on respect for inherent dignity, individual autonomy

including the freedom to make one's own choices, and independence of persons. This treaty can be seen as a zenith with respect to the rights of persons with disabilities. The focus of the CRPD on individual autonomy indicates that the government will be progressively more required to count and respect a patient's own view of their relationships.

The capability to exercise individual choice regarding the appointment of a NR must be a vital element in any form of re-assessment of the NR role. According to a study "relationships are constitutive of who people are and become does not, of course, mean that all relationships are good." The study also highlighted that 'relational autonomy' is very necessary because it is part of what enables people to detach themselves from relationships that are unhealthy. In emphasizing the support mechanisms for persons with mental disabilities under the CRPD, it is noteworthy to state that the CRPD places a positive duty on governments to provide a range of community supports to live independently and be included in the community. This comprises the rights to choose both place of residence and their particular living arrangements [19,20]. Drawing from that, it empowers persons with disabilities to decide how and with whom they would like to live. This places a duty on the governments to engage with families and the community more broadly in order to protect and promote this right. This is certainly applicable to the feature of the NR function and their direct involvement in care/treatment decisions.

The ECHR could be described as providing a ground for rudimentary protection of rights. But other human rights instruments have significantly extended such protection of rights, beyond the ECHR in several areas. It can also be said that the CRPD comes with it the promise to further strengthen the rights of persons with mental disabilities in the UK, on the condition that the government is ready to take appropriate steps to implement it.

Indeed, the importance of good relationship cannot be overemphasized as it relates to a person's health. However, when such relationship tends to be bad or goes sour, the effect could be detrimental to one's health especially as it pertains to mental health. Research has measured the value and effects of relationships in a study of 9,000 men and women in the British Civil Service. The volunteers were evaluated on their relationships and the various negative aspects that exist in their close relationships. They were also closely monitored for health problems. Those who mentioned that their relationships were bad had a 34% increase in the risk of developing heart problems, especially after taking their weight, social support, and other factors into consideration.

One of the objectives of admitting patients into mental health hospitals is to get adequate treatment.⁸⁰ Amongst the core principles of the Independent Review in their final report, is the principle of

therapeutic benefit. This involves ensuring patients are supported to get better, so they can be discharged from the Act. The principle of therapeutic benefit will be counterproductive in a situation where there is bad blood or enmity between a person who has been chosen as a nearest relative from the hierarchical list in the MHA by a patient. Therefore, the need to strengthen the autonomy of patients in exercising their discretion in choosing a person who will act as a nearest relative is sacrosanct and germane to enable patients to realise their rights as guaranteed by the ECHR and CRPD. It is unjustifiable that patients are denied the opportunity to choose their nearest relative at first instance (the person with certain statutory rights relating to their admission to hospital, treatment in hospital and discharge). This is because a patient who has the ability of making a choice must be handed the right to do so.

Conclusion

This study has carefully examined the roles and powers of the nearest relative and has identified problems regarding the identification process on who should take on the NR role which is restrictive and suppresses patients' autonomy of choice. This work concludes that section 26 of the MHA 1983 is not in total conformity with the intentment of the ECHR and UNCRPD. Case analyses have been used to portray the shortfalls concerning the list of relatives as outlined in section 26. This work has acknowledged as a fact that the

role of the nearest relative is an important safeguard towards the protection of patients' rights. However, this safeguard is not short of loopholes, taking into cognisance how uncertain family relationships could be. It has been stated that the role of the nearest relative should not be assumed by anyone who does not have the best interest of the patient at hand. This is because the extant legislation is drafted in a way that a relative who is not in good terms with the patient can assume the role of a NR, hence putting a patient's human rights at the risk of being infringed (such as unwanted compulsory admission which amounts to deprivation of liberty).

Proposals for reform have out rightly been suggested to help ameliorate the shortcomings surrounding the role of the nearest relative. The suggestions for reform support an eradication on the definition and list of relatives in section 26 of the MHA. As well as the replacement of the term 'nearest relative' with a proposed term 'nominated person' to empower the autonomy of choice of patients. It is believed that the eradication of the prescriptive hierarchy and preference for patient choice gives the AMHP greater flexibility in determining the most suitable nominated person.

Justification for the proposals suggested has shown that amendment of the law to reflect the proposals will provide a therapeutic benefit on patients as study has shown that bad relationships can exacerbate health problems.

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