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REVIEW ARTICLE

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Service users' experiences of restrictive practices in adult inpatient mental health services. A systematic review and meta-ethnography of qualitative studies

Bethany Griffin[a,b], John Baker[c], Katharina Sophie Vogt[a,b,d], Jessica Rich[a,b] and Judith Johnson[a,e,f,g]

[a]School of Psychology, University of Leeds, Leeds, UK; [b]Bradford Institute for Health Research, Bradford Royal Infirmary, Bradford, UK; [c]School of Healthcare, University of Leeds, Leeds, UK; [d]Department of Primary Care & Mental Health, University of Liverpool, Liverpool, UK; [e]Division of Nursing, Midwifery and Social Work, School of Health Sciences, University of Manchester, Manchester, UK; [f]Manchester University NHS Foundation Trust, Manchester, UK; [g]School of Public Health and Community Medicine, University of New South Wales, Sydney, Australia

ABSTRACT

Background: There is a focus globally on reducing restrictive practices in mental healthcare. However, we know little about how service users experience restrictive practices generally.

Aim: To explore and synthesise experiences of restrictive practices in adult inpatients mental health settings and to report on the depth and breadth of the literature. Methods. CINAHL, PsycINFO, Scopus, MEDLINE and Embase were searched. Qualitative studies exploring the service user experience of restrictive practices were included and analysed using meta-ethnographic synthesis.

Results: Twenty-seven papers were included. Restrictive practices are experienced negatively by service users, who feel punished and powerless when the therapeutic relationship is weak, and communication is lacking. The third-order constructs were: (1) anti-therapeutic and dehumanising, (2) a vicious cycle, (3) an abuse of power and (4) the critical role of support and communication (subthemes: (i) the impact of communication and (ii) how support and communication can minimise negative impacts).

Conclusions: Participants suggest that increasing supportive communication and detailing the decision making for using restrictive practices, would reduce feelings of coercion and increase trust in staff. Future research into the experience of restrictive practice should aim to capture the experience of informal restrictive practices such as locked doors and coercive language.

PRSIMA/PROSPERO statement: The review has been conducted and reported in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; see Supplemental Materials Table S1) and the Meta-Ethnography Reporting Guidelines (eMERGE; see Supplemental Materials Table S2). The protocol was registered on PROSPERO (registration number: CRD42023399272; URL: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42023399272).

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Introduction

Restrictive practices are defined as deliberate acts to restrict a service user's movement, liberty and/or freedom, to take control of a potentially dangerous or harmful situation in inpatient services (Department of Health, 2015; National Institute for Health and Care Excellence [NICE], 2015). Such practices include formal measures such as restraint, seclusion, and rapid tranquilisation, but also informal measures such as ward rules, such as locked doors, restrictions on movements around the ward and even coercive language (NICE, 2015). These interventions should only be used as a last resort after implementing de-escalation techniques and should not be put in place for longer than is necessary (Allikmets et al., 2020; Department of Health, 2014). Restrictive practices continue to be used in inpatient mental health settings globally, despite considerable debate about their use and the potential implications for patient's human rights (Amara, 2023; Hallett & McLaughlin, 2022; Maker & McSherry, 2019; World Health Organization, 2023).

Healthcare staff have reported feeling reliant on these measures to be able to protect themselves and other inpatients on wards (Moghadam et al., 2014), expressing concerns that the elimination of restrictive practices would negatively impact both patient and staff physical safety (Gerace & Muir-Cochrane, 2019; Snipe & Searby, 2023). Similarly, service users have stated some interventions are necessary to keep themselves and others physically safe (Butterworth et al., 2022; Cusack et al., 2018; Muir-Cochrane & Oster, 2021). Although staff and service users understand the physical safety aspect of restrictive practices, these measures can also create trauma and anxiety, and negatively impact therapeutic relationships (Chieze et al., 2019; Martin, 2023; Mellow et al., 2017; Wynn, 2004).

Globally, there is a focus on reducing restrictive practices in mental healthcare (World Health Organization, 2021). It

CONTACT Bethany Griffin psblg@leeds.ac.uk University of Leeds, School of Psychology, Leeds, UK

could be argued that restrictive practices vary widely. More intrusive measures, such as seclusion and restraint, are typically experienced by an individual patient on the ward, whereas less intrusive measures are applied across a whole ward (Paradis-Gagné et al., 2021). Here, we argue that all measures that have the intent to limit a person's movement are restrictive in nature and impact on the autonomy of individuals, thus should be viewed collectively. Similarly, previous research has demonstrated that wards that have high rates of using one restrictive measure, are more likely to have higher rates of other restrictive practices (Bowers et al., 2015). This is also the case for individual patients.

We know little about how service users experience both formal and informal measures of restrictive practices as a collective experience. This could mean that the priorities of reduction efforts and developed interventions may not be best suited to the needs of inpatients. For example, focusing on reducing formal measures such as seclusion and restraint, rather than focusing on the interaction between formal and informal measures. Synthesising the existing literature on a range of interventions could be the first step to exploring and reporting a thematic account of the wider experience. Similarly, without considering the wider context of restrictive practices (for example, times when restrictive practices may have been used effectively) and how this is experienced by service users, we cannot identify times where restrictive practices are used effectively and in the least harmful way.

Previous systematic and scoping reviews have focused on the experience of specific interventions under the restrictive practice umbrella, for example focusing on seclusion alone (Askew et al., 2019; Mellow et al., 2017), restraint alone (Evans & FitzGerald, 2002) or seclusion and restraint (Chieze et al., 2019). Only two published reviews have used the term "restrictive practice", limiting themselves to specific inpatient settings (acute settings; Butterworth et al., 2022); secure settings (Lawrence et al., 2022), with specialist wards (i.e. PICU and eating disorder wards) being excluded. Lawrence et al. (2022) also combined service user and staff perspectives together, preventing conclusions relating to the service user perspective specifically. Search terms in these reviews referred to restraint, seclusion, segregation, sedation and "blanket bans" (referring to restrictions given to all patients which can vary between wards) in Butterworth et al. (2022) and coercion, physical restraint and seclusion in Lawrence et al. (2022). Based on these search terms, previous reviews could have excluded certain measures that are restrictive in nature such as segregation (in the case of Lawrence et al., 2022) and restrictions on a person's ability to act independently, for example locked doors, constant observations and coercion and compulsion related to treatment (Department of Health & Social Care, 2021).

While the complexity of the subject matter is considerable, a review synthesising the available literature and service user experiences across all interventions, both formal and informal, and all adult inpatient mental health settings should be carried out to understand how best to move forward in both practice and research, as it is likely that inpatients will experience various forms of restrictive practice. Thus, the aim of the current systematic review was to explore and synthesise service users' experiences of restrictive practices in adult inpatient mental health settings, and to report on the depth and breadth of the literature. The current review addressed this by including additional interventions and measures (long- and short-term sedation, coercion and compulsion in relation to treatment, and constant observations) that were not considered in previous reviews, and across a wider range of adult inpatient mental health settings (e.g. including PICU and specialist treatment wards). An extensive list of what constitutes restrictive practice in the context of this paper is outlined in the eligibility criteria. This work builds on previous reviews by using a meta-ethnographic synthesis approach to answer, "What are service users' experiences of restrictive practice while in adult inpatient mental health services?".

Materials and methods

The review was conducted and reported in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; see Supplemental Materials Table S1) and the Meta-Ethnography Reporting Guidelines (eMERGE; see Supplemental Materials Table S2). The protocol was registered on PROSPERO (registration number: CRD42023399272; URL: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42023399272).

Ethical considerations

Quotes used in the meta-ethnographic synthesis were extracted from published peer-reviewed journal articles in the public domain. No new data or access to participants was involved in this review. As such, no ethical review was required.

Eligibility criteria

English language empirical qualitative research, conducted in adult (18–65 years) inpatient mental health settings (specialist wards such as eating disorder wards were included), reporting services users' experiences of restrictive practices were eligible for inclusion. For the purpose of this review, restrictive practices refer to any of the following interventions or measures: locked doors, preventing a person from entering certain areas of the living space and segregation, seclusion, manual and mechanical restraint, rapid tranquilisation (also referred to as chemical restraint) and long-term sedations, coercion and compulsion related to treatment (also referred to as coercive language and treatment pressures) and constant observations. Interventions and measures were included based on the National Institute for Health and Care Excellence (NICE) guidance (NICE, 2015) and under guidance from experts in the field supervising the project (JB and JJ).

Quantitative and mixed methods research that did not adequately separate quantitative and qualitative findings was not eligible for the purpose of meta-ethnographic synthesis. Similarly, studies solely reporting experiences of perceived coercion, involuntary admission and "blanket bans" put in

place due to organisational policy or as part of an individualised care plan, as well as studies that solely focused on staff accounts or did not adequately separate staff and service user accounts were not eligible for inclusion. Books, reviews, government policy, conference abstracts and grey literature were not eligible. Studies carried out with adolescents or children or solely focused on older adults (aged over 65) were not included, as well as research carried out in forensic units due to the additional legal proceedings which may impact their treatment.

Search strategy

Across the literature and in practice, the following are used interchangeably: restrictive interventions, restrictive measures, coercion and coercive intervention. Similarly, individual measures are referred to differently across the literature, thus the search needed to consider and address this. Search terms (example available in the Supplemental Material S1) were therefore developed using the SPIDER framework (Cooke et al., 2012): Sample (service users), Phenomenon of Interest (restrictive practice and inpatient mental health), Design (interviews/focus groups), Evaluation (experience) and Research Type (qualitative), using search terms used in previous reviews of a similar scope (Baker et al., 2021; Butterworth et al., 2022) and under supervision from an expert in the research area (JB) and expert in the methodology of systematic reviews and meta-ethnography (JJ). CINAHL, PsycINFO, Scopus, MEDLINE and Embase were searched by the primary author (BG) from inception to 24 February 2023, and updated to 20 September 2023 with no limitations on publication date. Reference lists of eligible studies and relevant previous reviews were also scanned.

Study selection

Eligible papers were extracted to the systematic review software Rayyan, where duplicate entries were removed. Rayyan is an online platform designed to aid screening and organisation of references for systematic reviews. The platform supports collaboration between reviewers to allow for blind screening. Here ineligible sources, for example book chapters and conference abstracts, were also identified by Rayyan, then checked and removed. Study selection consisted of two stages. First, full double screening of titles and abstracts was carried out independently by two reviewers (BG, JR), who then met to resolve any disagreements. Full-text screening was carried out by one reviewer, who then met with the research team (JJ, JB and KV) to discuss and confirm eligible papers. See Figure 1 for PRISMA flow diagram.

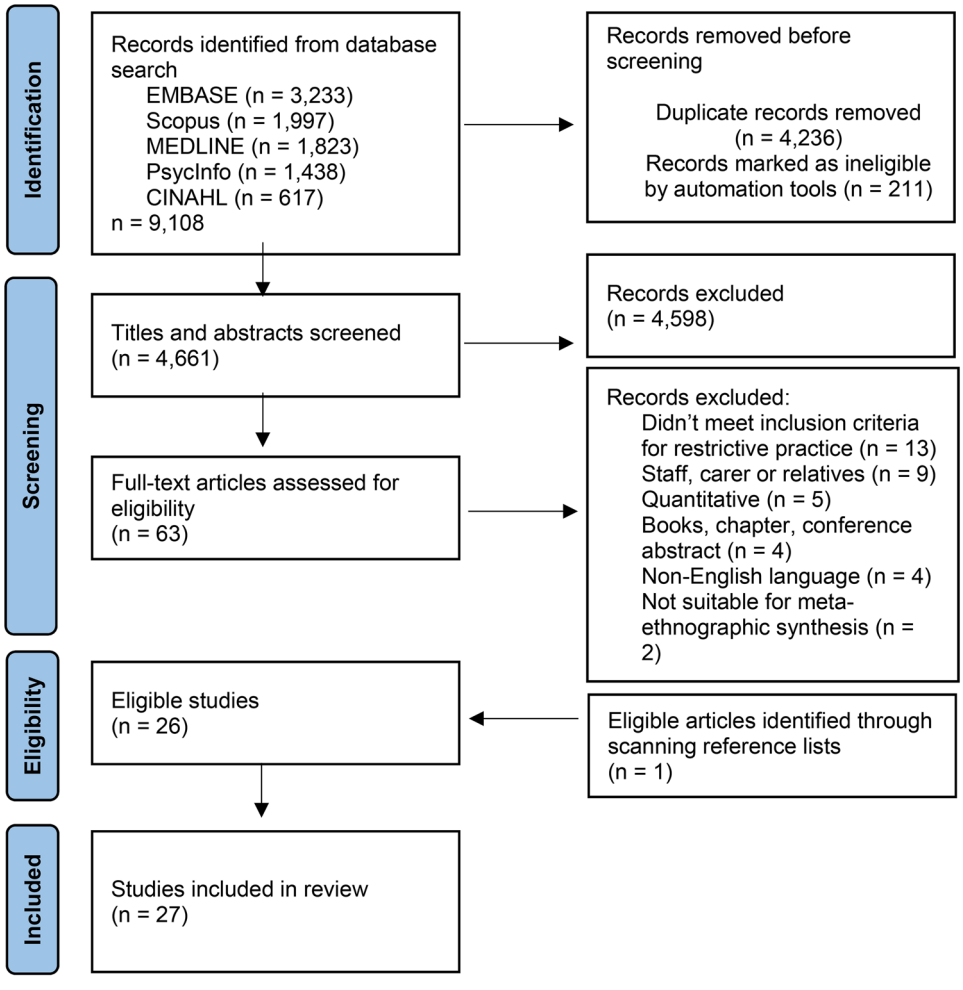

Figure 1. PRISMA flow diagram.

Data extraction

Single author (BG) extraction was carried out and recorded in a Microsoft Excel worksheet: sampling profile (population, characteristics, size), country of origin, study aims, restrictive practice reported, methodology and key findings. Qualitative data, including quotations from participants (first-order constructs) and key concepts reported by the original authors (second-author constructs) were extracted into a second Microsoft Word document.

Method of quality assessment

The Critical Appraisal Skills Programme (CASP) qualitative research checklist was used to assess the eligible studies. The first author (BG) appraised all papers independently, with 20% checked with a member of the research team (JR) to enhance rigour. This tool has been used previously in qualitative reviews, where a numerical value out of 10 is given with a higher score indicating greater quality (Sattar et al., 2020). While a limitation of the CASP is the subjective nature of the questions, focusing on methodology rather than conceptual strengths (Sattar et al., 2021), the tool was used to allow for "higher quality papers" to be used as index papers for the meta-ethnographic synthesis. No papers were rejected because of their quality appraisal scores. However, higher quality papers were analysed first, and lower quality papers were analysed last and were thus less likely to significantly influence the number of created categories and constructs than higher quality papers.

Data synthesis

A meta-ethnographic approach was used to analyse and synthesise the findings from across the eligible studies to enable new insights into service users' experiences and perspectives, whilst considering the context. Meta-ethnography is a sophisticated method of synthesis of empirical qualitative papers that allows for greater higher-order interpretations (themes derived from empirical studies) in context, when compared to commonly used methods of narrative synthesis (Sattar et al., 2021). The use of this method allows for a greater understanding of service users' experiences of several interventions and practices, that is applicable to policy makers, staff and researchers in inpatient mental health. The approach relies on the process of reciprocal translation to develop new interpretations, known as "third-order" constructs to understand a chosen phenomenon (Sattar et al., 2021). The first stage involved the lead researcher (BG) reading the extracted first-order (quotes including in the original papers) and second-order (the original authors themes and/or interpretations) constructs, before moving to the second stage; grouping similar concepts from the second-order constructs from each paper, whilst considering the primary interpretation. The third stage comprised of the researcher carrying out reciprocal translation; synthesising concepts within categories to allow for rich and interpretative themes to be developed, while considering how the papers related or opposed the previous paper (for full details of this process see Supplemental File S3). This hierarchical process is based on the quality appraisal ratings from the CASP research checklist. This process continues through all the papers within that category. Alongside this, a translations table was created which included the first- and second-order constructs for each category, which was cross referenced to develop the third-order constructs (see Supplemental File Table S3).

The first author (BG) is a PhD student, with no prior experience working in, or being a patient of, inpatient mental health services. Her work was supervised by clinicians in the area, including a mental health nurse (JB), a clinical psychologist (JJ) and a trainee clinical psychologist (KV), all of whom have experience conducting research in this area. JR is also a PhD student with no prior experience working in, or being a patient of, inpatient mental health services, but is currently researching transitions in mental healthcare. Throughout this process, BG reflected on their interpretation of the categories, ensuring that the original author's interpretations and participants quotes were accurately considered and reported. All authors reviewed the developed third-order constructs.

Results

A total of 27 papers were included in the review (see Table 1 for the study characteristics table), published from 1998 (Johnson, 1998) to 2023 (Cusack et al., 2023; Li et al., 2023; Lynge et al., 2023; Mac Donald et al., 2023). Fifteen studies were conducted in Europe (Allikmets et al., 2020; Bendall et al., 2022; Cusack et al., 2023; Haglund & Von Essen, 2005; Hoekstra et al., 2004; Kontio et al., 2012; Kuosmanen et al., 2007; Lanthén et al., 2015; Lynge et al., 2023; Mac Donald et al., 2023; Nyttingnes et al., 2016; Scholes et al., 2022; Tully et al., 2023; Verbeke et al., 2019; Wynn, 2004), four in North America (Ezeobele et al., 2014; Faschingbauer et al., 2013; Holmes et al., 2004; Johnson, 1998), three in Africa (Aluh et al., 2022; Mayers et al., 2010; Ntsaba & Havenga, 2007), three in Asia (Achir Yani Syuhaimie Hamid & Catharina Daulima, 2018; Chien et al., 2005; Li et al., 2023) and two in Australia (Meehan et al., 2000; Sambrano & Cox, 2013). Studies mainly recruited current inpatients (n = 18), however seven included former service users (Cusack et al., 2023; Hoekstra et al., 2004; Lanthén et al., 2015; Lynge et al., 2023; Mayers et al., 2010; Sambrano & Cox, 2013; Verbeke et al., 2019) and two used a combination of both (Bendall et al., 2022; Nyttingnes et al., 2016). Twenty-four studies included patients from non-specialised settings (i.e. acute and general psychiatric hospitals), one study recruited from a PICU (Allikmets et al., 2020), one study from specialised eating disorder units (Mac Donald et al., 2023) and one from an unspecified specialised care unit (Holmes et al., 2004). Twenty-three of the 27 studies reported gender, while only eight reported the ethnicity of participants (see Table 1 for full reported ethnicity and gender for each paper). The most common method of data collection was one-to-one interviews (n = 24), with two studies using focus groups (Aluh

Table 1. Study characteristics table.

Author (year)	Country of origin	Research aims	Participant group and sample size	Sample profile		Recruitment method	Research setting	Restrictive practice reported	Methodology	Analysis method
				Male Sex Proportion (%)	*Ethnicity Proportion (%)*					
Allikmets et al. (2020)	UK	To appraise the current care of acutely unwell and violent patients with the intervention of seclusion from a patient perspective	10 male PICU inpatients, detained under section 2 or 3 of the Mental Health Act	100%	Not reported	Not reported	Carried out by senior psychiatrists who did not work on the unit	Seclusion	A qualitative approach using a structured questionnaire in a face-to-face interview	Miles & Huberman (1994) method
Achir Yani Syuhaimie Hamid & Catharina Daulima (2018)	Indonesia - Central Java Province	To examine the experience of restraint use among individuals with violent behaviour in mental health hospital	Eight psychiatric inpatients diagnosed with a mental disorder and being or had experienced restraint	Not reported	Not reported	Purposive sampling	Conducted in three districts in Central Java Province	Restraint	In-depth interviews using a phenomenological approach	Colazzi's (1978) data analysis steps
Aluh et al. (2022)	Nigeria	1) To explore service users' perceptions and experiences of coercion is psychiatric hospitals in Nigeria 2) To explore suggestions on strategies to reduce the use of coercion in mental health care	30 service users who have previously been admitted to one of two major psychiatric hospitals	63%	Not reported	Attending nurses disseminated information about the study to eligible, interested service users	In two major neuropsychiatric hospitals, outside of the wards in the halls	Formal coercion (compulsory admission, seclusion, physical restraint, mechanical restraint and chemical restraint)	Focus groups guided by semi-structured discussion guide	Thematic analysis
Bendall et al. (2022)	UK	1) Explore how patients and staff members experience and make sense of restrictive practice 2) Explore how patients and staff members respond to restrictive practices?	Nine service users (eight current inpatients, one discharged)	56%	Asian British Pakistani 11% Black British 11% Black British African 22% Mixed White and Black African 11% White British 22% White Irish 22%	Inpatient participants were recruited by staff members known to them	Research took place on two adult acute wards, one male and one female, within a large city mental health hospital	A range of restrictive practice (coercion, restriction of movement, forced medication, restraint)	Qualitative semi-structured interviews	Thematic analysis
Chien et al. (2005)	Hong Kong	Explore the perspectives of Chinese psychiatrics inpatients with violent behaviours concerning the effects of the use of restraint on them	30 psychiatric inpatients, with violent behaviours from two acute admission wards	60%	American Asian 12% American Chinese 12% Chinese 77%	Convenience sample from two acute admission wards in 1400-bed mental hospital	Conducted in in an interview room attached to the admission wards within 1-2 days of the removal of restraint	Restraint (bilateral limb holders, safety vests and triangular bandages)	In-depth semi-structured interviews and examination of clinical records	Miles & Huberman (1994) method

(*Continued*)

Table 1. Continued.

Author (year)	Country of origin	Research aims	Participant group and sample size	Sample profile		Recruitment method	Research setting	Restrictive practice reported	Methodology	Analysis method
				Male Sex Proportion (%)	*Ethnicity Proportion (%)*					
Cusack et al. (2023)	UK	To explore the service user perspectives of their personal experiences of restraint	11 participants recruited based on having experienced physical restraint within acute mental health inpatient settings	Not reported	Not reported	Recruited via posters, blogs and social media through Rethink and National Service User Network (NSUN)	Four interviews in person (environment chosen by participants) and seven via telephone	Physical restraint	Dialogical narrative approach, using unstructured narrative interviews	Frank (2010) guiding questions "What is at stake and for whom? How does the story define or redefine those stakes? How does the story change people's sense of what is permitted, possible, responsible or irresponsible?"
Ezeobele et al. (2014)	United States of America	To explore and describe the psychiatric patients' lived seclusion experience	20 inpatient service users on acute wards, with a high risk for violent acts	60%	Not reported	Purposive voluntary sampling	Conducted in a 250-bed free-standing psychiatric acute care hospital where 85% of patients are involuntarily admitted	Seclusion	Semi-structured interviews utilising a phenomenological approach	Colazzi's (1978) data analysis steps
Faschingbauer et al. (2013)	United States of America	What is the lived experience of inpatient psychiatric patients who are placed in seclusion?	12 inpatient psychiatric patients upon completion of a seclusion episode	50%	Caucasian 67% Native American 17% African American 17%	Purposive sampling	Carried out at least 24 hours after the seclusion episode, but before 7 days, taking place in a closed conference room off the mental health unit	Seclusion	In-depth unstructured interviews utilising a phenomenological approach	Van Manen's (1990) phenomenological approach for text analysis
Haglund & Von Essen (2005)	Sweden	1) To describe voluntarily admitted patients' perceptions of advantages and disadvantages about being cared for on a psychiatric ward with a locked entrance door. 2) To study whether voluntarily admitted patients perceive any coercion connected to being cared for on such wards	20 voluntarily admitted psychiatric patients to a locked psychiatric ward	50%	Not reported	In collaboration with ward managers, a maximum variation sampling was used	Data collected on seven Swedish psychiatric inpatient wards	Locked doors	In-person interviews	Content analysis

(*Continued*)

Table 1. Continued.

Author (year)	Country of origin	Research aims	Participant group and sample size	Sample profile		Recruitment method	Research setting	Restrictive practice reported	Methodology	Analysis method
				Male Sex Proportion (%)	*Ethnicity Proportion (%)*					
Hoekstra et al. (2004)	Netherlands	Gain a better understanding of the seclusion room experience of chronic psychiatric patients, the way in which they cope with their seclusion room experience, and the effect of seclusion on the subsequent relations with care provider	Seven previous inpatient service users whose seclusion room experiences had taken place some time ago and were currently undergoing treatment at the VLMT Transmural Team of Mediant.	43%	Not reported	Not reported	Five out seven interviews were held in patients home, and two in the treatment environment	Seclusion	Qualitative research design, in line with Grounded Theory utilising interviews	Grounded theory
Holmes et al. (2004)	Canada	To describe the experience of patients with a severe and persistent psychiatric disorder regarding their stay in the seclusion room	6 patients of a specialised care unit	Not reported	Not reported	Not reported	Took place in a specialised care unit located in a psychiatric hospital in Eastern Canada, in a private room	Seclusion	Non-directive interviews, utilising the Heideggerian phenomenological research framework	Colazzi's (1978) data analysis steps
Johnson (1998)	United States of America	To understand the meaning of the experience of being restrained	10 participants	50%	African American 20% Caucasian 80%	Participants were initially referred by staff of two inpatient psychiatric units	Not reported	Leather restraints	Unstructured interviews	Analysed using a modification of Diekelmann et al. (1989) and Diekelmann(1995)
Kontio et al. (2012)	Finland	Explored 1) psychiatric inpatients experiences of seclusion/restraint, 2) their suggestions for improvements in seclusion/restraint, 3) alternatives to seclusion/restraint in psychiatry	30 inpatients from acute wards	63%	Not reported	Utilising nurses and physicians	Six acute closed wards in two psychiatric hospitals	Seclusion and restraint	Interviews	Inductive qualitative content analysis

(*Continued*)

Table 1. Continued.

Author (year)	Country of origin	Research aims	Participant group and sample size	Sample profile		Recruitment method	Research setting	Restrictive practice reported	Methodology	Analysis method
				Male Sex Proportion (%)	*Ethnicity Proportion (%)*					
Kuosmanen et al. (2007)	Finland	To find out whether patients had experienced deprivation of their liberty during psychiatric hospitalisation and to explore their views about this	51 patients admitted to an acute ward, who were in the process of being discharged during the study period	49%	Not reported	Utilising psychiatric nurses who were trained to conduct study interviews	Two closed acute psychiatric hospital wards	Deprivation of liberty (leaving the ward, locked wards, restrictions on communication, confiscation of property, coercive measures [seclusion, mechanical restraint and forced medication])	Semi-structured interviews	Inductive content analysis
Lanthén et al. (2015)	Sweden	To examine psychiatric patients' experience of mechanical restraints and to describe the care the patients received	10 former psychiatric patients	50%	Not reported	Utilising outpatient units as well as patient organisations	Location decided by the participants	Mechanical restraint	Interviews	Content analysis
Li et al. (2023)	China	To identify perspectives on physical restraint among patients with mental health conditions and to seek effective interventions targeting the psychological trauma which is caused by physical restraint	26 service users who had undergone or witnessed physical restraint in the last 6 months during psychiatric hospitalisation (15 experienced restraint, 11 witnessed)	46%	Not reported	Not reported	In a quiet room, public psychiatric hospital	Physical restraint	Semi-structured interviews	Thematic analysis
Lynge et al. (2023)	Denmark	To explore 1) how patients experience and possibly prefer these two types of coercion and 2) what could be done to avoid coercion according to patients	Nine participants that had been admitted to a psychiatric facility	67%	Not reported	One participant through outpatient clinics. Utilised a user-driven workshop for people with psychiatric disorders	Unclear	Physical holding and mechanical restraint	Semi-structured interviews	Thematic analysis

(*Continued*)

Table 1. Continued.

Author (year)	Country of origin	Research aims	Participant group and sample size	Sample profile		Recruitment method	Research setting	Restrictive practice reported	Methodology	Analysis method
				Male Sex Proportion (%)	*Ethnicity Proportion (%)*					
Mac Donald et al. (2023)	Denmark	To explore experiences and perspectives on involuntary treatment in patients with anorexia nervosa who had experienced multiple involuntary treatment events	Seven adult female participants that had multiple past involuntary treatment events related to anorexia nervosa over a period of at least one month within the past 5 years	0%	Not reported	Recruited purposively through flyers, homepage posts and Facebook posts, selected specialised residential units, Danish patients organisation and Danish society for eating disorders	Either in-person or telephone. In-person carried out in place of residence or Aarhus University Hospital	Involuntary treatment including involuntary admission, detention mechanical restraint, physical restraint, nasogastric tube feeding and constant observations	Semi-structured interviews	Thematic analysis using an inductive approach
Mayers et al. (2010)	Western Cape Province, Cape Town	1) To describe the perceptions and experiences of service users of the use of sedation, seclusion and restraint during a psychiatric emergency, 2) to identify the preferred choices of service users should they be placed in a situation that requires the use of sedations, seclusion or restraint	43 participants from psychiatric hospitals with experience of restrictive interventions	49%	Not reported	Convenience sampling from 17 established service user support groups	Not reported	Sedation, seclusion and restraint	Interviews using semi-structured questionnaire	Content analysis
Meehan et al. (2000)	Australia	Explore how patients receiving acute inpatient treatment in a mental health facility describe and construct meanings about their seclusion experience	12 patients	58%	Not reported	Convenience sampling	Two open acute care units on the campus of a large tertiary mental health facility	Seclusion	Semi-structured, thematically organised interview schedule	Meaning categorisation (Kvale, 1996)

(*Continued*)

Table 1. Continued.

Author (year)	Country of origin	Research aims	Participant group and sample size	Sample profile		Recruitment method	Research setting	Restrictive practice reported	Methodology	Analysis method
				Male Sex Proportion (%)	*Ethnicity Proportion (%)*					
Ntsaba & Havenga (2007)	Lesotho	To explore and describe the psychiatric in-patients' experience of being secluded in a specific hospital in Lesotho	11 local inpatients	36%	Not reported	Purposive sampling	A specific psychiatric hospital in Lesotho	Seclusion	Semi-structured phenomenological interviews	Tesch's method of open coding
Nyttingnes et al. (2016)	Norway	To increase knowledge of the effects of coercion	Approximately 35 patients and ex-patients	Not reported	Not reported	Not clear	15 full-day dialogue seminars on coercion and voluntariness	Coercion (restraint, seclusion, forced medication, CTO's, "minor coercive incidents")	Verbatim notes taken from the seminars	Thematic analysis
Sambrano & Cox (2013)	Australia	To understand how some Indigenous clients' experienced seclusion in acute mental health settings in Australia	Three outpatient participants with experience of being in seclusion within an acute mental health facility	67%	Aboriginal 67% Aboriginal and Torres Strait Islander 33%	Recruited current outpatients from a metropolitan mental health service	Metropolitan mental health service	Seclusion	Interviews	Qualitative analysis utilising the hermeneutic circle
Scholes et al. (2022)	England	To investigate women's experiences of restrictive interventions within inpatients mental health services	20 participants recruited across acute services and rehabilitation services	0%	Black African or Black Caribbean 10% White-British 90%	Recruited from three NHS Trusts in the North of England, participants self-referred from posters on the wards or by information leaflets distributed at community meetings	Not clear	Restrictive interventions (physical restraint, seclusion, and rapid tranquilisation)	Semi-structured interviews	Thematic analysis
Tully et al. (2023)	England	To explore experiences of restrictive practices as inpatients	22 current mental health inpatients (combination of acute, PICU and rehabilitation services)	0%	Asian 4.5% Black African 4.5% Black British 4.5% Black Caribbean 4.5% Mixed White and Black Caribbean 4.5% White British 77%	Recruited from hospitals across the North-west of England, through referral from ward staff or through self-referral	Not clear	Restrictive practice (restraint, seclusion, rapid tranquilisation, locked doors, routines on the ward forcing everyone to get out of bed at the same time or "blanket rules")	Semi-structured interviews	Thematic analysis

(*Continued*)

Table 1. Continued.

Author (year)	Country of origin	Research aims	Participant group and sample size	Sample profile		Recruitment method	Research setting	Restrictive practice reported	Methodology	Analysis method
				Male Sex Proportion (%)	*Ethnicity Proportion (%)*					
Verbeke et al. (2019)	Belgium	To propose an interactional model of the relational aspects of coercion that enhances theoretical understanding, based on the assumptions of patients	12 previous service users who had been hospitalised in a Belgian psychiatric institution	33%	Caucasian 100%	First five through a community-based organisation, following seven through snowball sampling	Interviews carried out in person, location unclear	Coercion (seclusion, restraint and involuntary treatment, diagnostic labelling, involuntary medication, pressure to take medication, house rules and being forced to do activities or have a daily routine)	In-depth interviews utilising open-ended questions	Interpretive Phenomenological Analysis (IPA)
Wynn (2004)	Norway	For patients to share their experiences regarding restraint	12 inpatients	75%	Not reported	Purposive sampling, selected on the basis of having recently been subjected to restraint which was reported to researchers by staff	Carried out at the psychiatric Departments at a University Hospital	Restraint (physical and pharmacological)	Interviews	Grounded theory

Table 2. Studies represented within each theme.

	Third-order constructs				
	1. Anti-therapeutic and dehumanising	2. A vicious cycle	3. An abuse of power	4.The critical role of support and communication	
Authors				4a.The impact of communication	4b.How support and communication can minimise negative impact
Allikmets et al. (2020)	✓			✓	✓
Achir Yani Syuhaimie Hamid & Catharina Daulima (2018)	✓	✓			✓
Aluh et al. (2022)	✓	✓	✓	✓	
Bendall et al. (2022)	✓	✓	✓	✓	
Chien et al. (2005)	✓			✓	✓
Cusack et al. (2023)	✓			✓	
Ezeobele et al. (2014)	✓		✓	✓	
Faschingbauer et al. (2013)	✓	✓		✓	✓
Haglund & Von Essen (2005)	✓	✓	✓		
Hoekstra et al. (2004)		✓	✓		
Holmes et al. (2004)	✓	✓	✓		
Johnson (1998)			✓		
Kontio et al. (2012)	✓			✓	✓
Kuosmanen et al. (2007)			✓		
Lanthén et al. (2015)		✓		✓	✓
Li et al. (2023)	✓			✓	
Lynge et al. (2023)	✓				
Mac Donald et al. (2023)	✓	✓		✓	
Mayers et al. (2010)	✓	✓	✓	✓	
Meehan et al. (2000)	✓	✓	✓	✓	
Ntsaba & Havenga (2007)	✓	✓	✓	✓	
Nyttingnes et al. (2016)	✓		✓		
Sambrano & Cox (2013)	✓		✓		
Scholes et al. (2022)	✓	✓			✓
Tully et al. (2023)		✓		✓	
Verbeke et al. (2019)	✓			✓	
Wynn (2004)		✓		✓	✓

et al., 2022; Nyttingnes et al., 2016) and one using a combination of interviews and examining clinical records (Chien et al., 2005). Two of the 27 studies explicitly reported the inclusion of lived experience researchers (Lynge et al., 2023; Mayers et al., 2010). Studies focused on a range of restrictive practices including: seclusion-only (n = 8), restraint-only (including physical holding, mechanical restraint and chemical restraint; n = 8), restrictive practice (n = 2), sedation, seclusion and restraint (n = 2), coercion (n = 2), locked doors only (n = 1), formal coercion and restraint (n = 1), seclusion and restraint (n = 1), deprivation of liberty (n = 1) and involuntary treatment (n = 1).

The full list of restrictive practices reported for each paper can be found in Table 1 and the way in which restrictive practices were represented in each third-order construct is presented in Online Supplementary Table S4. The CASP scores for the papers, following the scoring system used in previous research (Sattar et al., 2020), were as follows: two studies were considered low (scores less than or equal to 5), nine studies were considered moderate (scores of 6 or 7), 14 were considered high quality (scores of 8 or 9) and two studies were considered "higher" quality (scores of ten) (see Online Supplementary Material Appendix S2).

Reciprocal translations

The analysis resulted in four main third-order constructs, which demonstrate the mainly negative experience of restrictive practice, from the perspective of service users. The third-order constructs were: (1) anti-therapeutic and dehumanising, (2) a vicious cycle, (3) an abuse of power and (4) the critical role of support and communication (which includes the subthemes: (i) the impact of communication and (ii) how support and communication can minimise negative impacts). Table 2 shows the studies represented within each theme.

Anti-therapeutic and dehumanising

Service users reported their experiences of restrictive practices to be contradictory to what is expected of healthcare. Service users described feeling that the staff on the wards used unjustifiable force when implementing restrictive interventions (Aluh et al., 2022; Chien et al., 2005; Lynge et al., 2023; Mayers et al., 2010; Meehan et al., 2000; Sambrano & Cox, 2013), which led participants to then experiencerestrictive practice as a punishment (Achir Yani Syuhaimie Hamid & Catharina Daulima, 2018; Chien et al., 2005; Holmes et al., 2004; Li et al., 2023; Mac Donald et al., 2023; Ntsaba & Havenga, 2007; Nyttingnes et al., 2016; Sambrano & Cox, 2013). Studies also reported that service users felt dehumanised due to restrictive practices, describing being treated like a prisoner (Bendall et al., 2022; Ezeobele et al., 2014; Haglund & Von Essen, 2005; Ntsaba & Havenga, 2007; Sambrano & Cox, 2013; Scholes et al., 2022) or like an animal (Allikmets et al., 2020; Chien et al., 2005; Mayers et al., 2010; Scholes et al., 2022). Treatment by the staff during seclusion or restraint (including physical, mechanical and chemical) events created feelings of humiliation and embarrassment (Allikmets et al., 2020; Aluh et al., 2022; Chien et al., 2005; Faschingbauer et al., 2013; Lynge et al., 2023; Ntsaba & Havenga, 2007; Nyttingnes et al., 2016; Sambrano

& Cox, 2013). This was particularly exacerbated when service users' physical and personal needs (i.e. toileting, feeding and basic hygiene) were not met or cared for by staff during these events (Chien et al., 2005; Kontio et al., 2012; Ntsaba & Havenga, 2007). These experiences were linked with seclusion, restraint and rapid tranquilisation in studies which looked only at these forms of restrictive practices.

Service users also described the physical side effects of restrictive practices (e.g. sleeping for consecutive days, being unable to walk and talk and involuntary movements) which they experienced because of restrictive practices relating to forced medication (Aluh et al., 2022; Sambrano & Cox, 2013) or being physically handled (e.g. physical restraint) (Achir Yani Syuhaimie Hamid & Catharina Daulima, 2018; Lynge et al., 2023). Other service users described restrictive practice as being an extension of stigma and discrimination against them due to their mental health (Aluh et al., 2022; Nyttingnes et al., 2016; Verbeke et al., 2019), often being treated as a symptom rather than a person (Mayers et al., 2010), which were not linked to specific restrictive practices but could be experienced in relation to a range of restrictive practices.

A vicious cycle

Experiencing restrictive practice at the hands of ward staff left service users questioning whether the measures resolved aggression, as they are intended to, or exacerbate feelings of anger and distress (Aluh et al., 2022; Bendall et al., 2022; Faschingbauer et al., 2013; Mac Donald et al., 2023; Scholes et al., 2022). Service users detailed how restrictive practices (particularly restrictions on leave, locked doors, and physical, mechanical and chemical restraint) were used to prevent aggression towards themselves and others (i.e. ward staff and other service users). They made participants feel frustrated, angry and more likely to partake in self-harm and risk behaviours, which participants reported led to further and stricter restrictive practice measures, such as seclusion and rapid tranquilisation (Aluh et al., 2022; Bendall et al., 2022; Haglund & Von Essen, 2005; Mac Donald et al., 2023; Scholes et al., 2022; Tully et al., 2023). Participants felt that the use of restrictive practice led to negative emotions in service users such as anxiety (Faschingbauer et al., 2013; Wynn, 2004) and fear (Achir Yani Syuhaimie Hamid & Catharina Daulima, 2018; Haglund & Von Essen, 2005; Holmes et al., 2004; Lanthén et al., 2015; Meehan et al., 2000; Ntsaba & Havenga, 2007; Wynn, 2004), which was reported to manifest itself as anger (Holmes et al., 2004; Lanthén et al., 2015; Meehan et al., 2000; Wynn, 2004). Some studies reported service users feeling traumatised about receiving care from the same staff that can use restrictive practice (Aluh et al., 2022; Cusack et al., 2023; Scholes et al., 2022), particularly so for service users with a history of sexual abuse (Scholes et al., 2022), and the impact this could have on behaviour and emotions after restrictive practices had been used. An additional negative impact, especially for seclusion events, was the feeling of prolonged isolation infringing on service users' feelings of reality, trust, and implications for mental function (Hoekstra et al., 2004; Meehan et al., 2000), describing it as difficult to readjust to the ward environment after the event if no debriefing or re-orientation had been offered (Mayers et al., 2010).

An abuse of power

Service users expressed that restrictive practice was experienced as a method of giving power to staff (Bendall et al., 2022; Ezeobele et al., 2014; Johnson, 1998; Kuosmanen et al., 2007; Mayers et al., 2010), using these methods as a way of controlling service users when decisions were questioned or resisted (Aluh et al., 2022; Nyttingnes et al., 2016; Sambrano & Cox, 2013) or taunting service users through "games that cannot be won" (as described by service users; Bendall et al., 2022). This abuse of power left service users feeling powerless in return (Ezeobele et al., 2014; Haglund & Von Essen, 2005; Ntsaba & Havenga, 2007), leading them to implement their own coping strategies to regain feelings of control over their care (Hoekstra et al., 2004; Meehan et al., 2000). Service users expressed that they often felt it was easier to conform to staffs' restrictive practice methods (Bendall et al., 2022; Holmes et al., 2004; Meehan et al., 2000) than question or resist.

The critical role of support and communication

The impact of communication. The experience of poor communication on the wards was demonstrated through: not being involved in decisions around the use of restrictive practice or being allowed to suggest alternatives (Mayers et al., 2010; Meehan et al., 2000; Tully et al., 2023; Verbeke et al., 2019), the lack of information provided about what led to the restrictive interventions being implemented (Chien et al., 2005; Ezeobele et al., 2014; Kontio et al., 2012; Mayers et al., 2010) and not being told how and when the intervention will end (Allikmets et al., 2020; Ntsaba & Havenga, 2007). Some studies reported service users trying to elicit a response or gain answers from staff but eventually "giving up" seeing it as a futile attempt (Ntsaba & Havenga, 2007; Tully et al., 2023).

Service users acknowledged that restrictive practices are often necessary in providing physical safety for critically ill patients (Aluh et al., 2022; Bendall et al., 2022; Chien et al., 2005; Cusack et al., 2023; Lanthén et al., 2015; Li et al., 2023; Mac Donald et al., 2023; Tully et al., 2023), and that when staff expressed the reason for using restrictive practice, service users felt no need to defend themselves (Chien et al., 2005; Faschingbauer et al., 2013; Lanthén et al., 2015; Wynn, 2004) but when there was no explanation, feelings of coercion were exacerbated (Verbeke et al., 2019).

How support and communication can minimise negative impacts. Service users reported open communication between service users and staff and therapeutic support as suggestions for better ways to manage aggression (Achir Yani Syuhaimie Hamid & Catharina Daulima, 2018; Allikmets et al., 2020; Faschingbauer et al., 2013; Kontio et al., 2012; Wynn, 2004), both before the restrictive events as a method of de-escalation (Faschingbauer et al., 2013;

Kontio et al., 2012; Lanthén et al., 2015; Scholes et al., 2022; Wynn, 2004) and after the event as a method of debriefing (Faschingbauer et al., 2013). Caring and empathetic staff that treated service users as human, contributed to the therapeutic effects of restrictive practice (Chien et al., 2005; Faschingbauer et al., 2013; Kontio et al., 2012; Lanthén et al., 2015), such as enhancing feelings of physical safety (Lanthén et al., 2015).

Discussion

Restrictive practices experienced during inpatient mental healthcare appear to be perceived as a negative experience for service users, who feel punished and powerless when the staff-service user relationship is weak, and communication is lacking. Despite this, service users acknowledged that restrictive practices are often necessary in providing physical safety in times of crisis but the ways in which this is communicated could be improved. This experience seems to have impacted the trust that participants had in their treatment and the staff responsible to their care, which resulted in anxiety, fear and long-lasting psychological effects.

The current review advances on previous reviews by including a variety of inpatient settings (including PICU and eating disorder wards) and a wide range of interventions under the restrictive practice umbrella, to provide an account of the collective experience of restrictive practices, primarily the addition of locked doors and constant observation. However, patients from non-specialist wards (including acute and general psychiatric settings) comprised the majority of the participants included in studies in the review and seclusion and restraint (physical and chemical) were still the most frequently mentioned interventions. Despite this, all developed third-order constructs included a range of restrictive practices (see Supplementary Material Table S4), with third-order construct (2) a vicious cycle, being developed primarily based on the experience of informal interventions such as locked doors, "house rules" and coercive language related to treatment primarily. The review also highlights the discrepancies with the terminology used in this area, with different names used to describe the same interventions, for example coercion (Verbeke et al., 2019), deprivation of liberty (Kuosmanen et al., 2007) and restrictive practice (Tully et al., 2023) were all used to refer to seclusion, restraint, involuntary treatment (related to medication), locked doors and blanket bans. There were also examples of one phrase being used to describe different interventions, such as coercion being used to describe seclusion, restraint and forced medication (Aluh et al., 2022; Nyttingnes et al., 2016; Verbeke et al., 2019), as well as psychological and verbal pressures to take medication (Bendall et al., 2022). This work updates previous reviews (Butterworth et al., 2022); search concluding in 2021) by including eight additional papers published after 2022.

A key novel finding of this review, was the idea of restrictive practices creating a vicious cycle, in which service users questioned whether restrictive practice was supposed to de-escalate anger and aggression (towards self and/or others) or cause it. The negative feelings of anger, fear and anxiety as experienced by service users, have been mentioned in previous reviews (Butterworth et al., 2022; Chieze et al., 2019), however the cyclical nature of restrictive practice whereby these emotions, and the ways in which they are expressed, are met with further restrictions has not yet been explored. Previous work by Bowers (Bowers, 2014), developed a model of conflict (adverse events, including aggression and self-harm) and containment (referred as restrictive practices in the current review) in inpatient mental healthcare, identifies flashpoints from which conflict arises and staff react with containment. This work formed the basis for the Safewards intervention which has been shown to successfully reduce conflict and containment on wards (Bowers et al., 2015). While the model considers a variety of flashpoints, ranging from patient characteristics to the ward environment (including locked doors and rules), it does not explicitly consider containment as a flashpoint. Considering the cyclical nature of restrictive practices in this context could extend the scope of the Safewards model and intervention, to also considering how restrictive practices used with lack of communication and explanation can lead to further, more explicit restrictions being used.

The experience of restrictive practices as a whole being anti-therapeutic and dehumanising, was found in previous reviews on the experience of restraint and seclusion resulting in re-traumatisation and negative physical and psychological impacts (Butterworth et al., 2022; Chieze et al., 2019). Similarly, the importance of communication has been shown in previous reviews (Butterworth et al., 2022; Cusack et al., 2018). However, a key finding from the current review is that supportive communication, that emphasises the role of physical safety in making decisions to use restrictive practice and involves the service user in these decisions, could reduce feelings of coercion and add a therapeutic element to restrictive practice. It is important to note that the studies included in this review had participants that were current patients, as well as participants who had been discharged and were reflecting on previous inpatient stays. Therefore, the acknowledgement of physical safety could come from reflections of the care they received and not necessarily their thoughts during crisis or when restrictive practices were being used.

Strengths and limitations

The use of meta-ethnographic synthesis is a strength of the current review as it preserves the properties of the original papers' primary data, while allowing new emerging insights from the current authors interpretation of service users' experience of restrictive practice (Atkins et al., 2008; Sattar et al., 2021). There were several limitations of the current review to note. Firstly, the subjective nature of the CASP could have impacted the development of the third-order constructs; meaning objectively high-quality papers might have been subjectively rated lower and thus have less impact on the constructs than is needed. Secondly, the current review could not report on the experience of different ethnicities as only eight papers reported ethnicity. Third, the approach chosen for the current review, ordering based on higher quality scores,

prioritises higher quality papers and allows them to influence the results section more strongly. However, this process prevents a sense of change over time being developed, meaning how these experiences change overtime cannot be commented on fully in this review. Fourth, as mentioned above, there are discrepancies as to what specific interventions constitute restrictive practices and the variations with the language used for individual practices. It is important to note the differences in the ways in which healthcare providers actually carry out the practices also. Therefore, while caution was taken to include all variations in terminology, it is possible that certain interventions and thus papers using these terms, have been missed. Fifth, grey literature was omitted from the current review. It is possible that important service user perspectives are missed as a result of this.

Practical and research recommendations

While service users acknowledge the need for restrictive practice in circumstances of crisis or when a service user is critically ill, practitioners should use the least restrictive practice they can in a situation, including the review of when locked doors and blanket restrictions are being used. Ensuring that patients feel psychologically safe, as well as physically safe should be a priority. Supportive and effective communication can help to achieve this, as it can allow service users to be involved in decision making around their care and in turn build trust after an incident (Chien et al., 2005; Faschingbauer et al., 2013; Lanthén et al., 2015; Wynn, 2004). Methods of de-escalation should utilise a reciprocal process, involving both service users and staff, allowing space for self-regulation of both parties (Price et al., 2024). Staff should prioritise empathetic communication to aid trust and rapport during conflict (Gerace et al., 2018). While the cyclical nature of restrictive practice needs to be explored further, it demonstrates the need for debriefing and discussion (for both service users and staff) after the event, to ensure incidents are not happening repeatedly or to work through anger caused by restrictive practices. Staff should be supported in this, through effective training and evaluation of organisational policy and priorities.

Incorporating service users' voices, including in the conceptualisation of research, should be a priority for researchers in mental health. As highlighted in this review, decisions are often made without involving service users, thus ensuring the research that informs policy and practice is carried out collaboratively could help mitigate the feeling that research is being "done to service users" rather than being done with and for service users. The review identified that most of the research in this area has explored experiences of seclusion and/or restraint, therefore it is suggested that future research should further consider service users' experiences of locked doors and constant observations, particularly service users' perspectives on the use of cameras and artificial intelligence to monitor activity in bedrooms for constant observations or during seclusion and restraint (Appenzeller et al., 2020). It is also suggested that researchers consistently report on the ethnicities and gender of participants and be transparent about the generalisability of their findings. A previous review has demonstrated that ethnic minorities could be more likely to receive restrictive practices in inpatient mental health, however disparities in reporting and definitions (relating to both ethnicities and restrictive practices) makes it difficult for conclusions to be drawn from published literature (Pedersen et al., 2023).

Conclusions

Service users experience restrictive practice as an anti-therapeutic and dehumanising method of containment, that can create a vicious cycle. Service users suggest that increasing supportive communication and detailing the decision making behind the choice to use restrictive practices, would reduce feelings of coercion and increase the trust in the staff responsible for their care. Future research into the experience of restrictive practice should aim to capture the service user voice, particularly around the experience of locked doors and constant observations, to aid improvements in policy and practice.

Author contributions

The authors confirm contribution to the papers as follows: Conceptualisation and Design: BG, JJ, JB and KV; Data Collection and Screening: BG and JR; Analysis and Interpretation of Results: BG; Draft Manuscript Preparation: BG. All authors reviewed the results and approved the final version of the manuscript.

Transparency declaration

The author(s) confirm that the manuscript is an honest, accurate, and transparent account of the study being reported. Edits to the original protocol have been registered on PROSPERO (https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42023399272).

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Research material availability

Additional research material that supports the analysis of this study are available from the corresponding author upon reasonable request.

ORCID

Bethany Griffin http://orcid.org/0000-0002-2563-1509

Data availability statement

Data availability is not applicable to this article as no new data were created or analysed in this study.

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