

## REVIEW ARTICLE

# Mental health patients' preferences regarding restrictive interventions: An integrative review

Camilla Rosendal Lindekilde<sup>1,2,3</sup>  | Martin Loch Pedersen<sup>2,3</sup>  |  
 Søren Fryd Birkeland<sup>1,2,3</sup>  | Jacob Hvidhjelm<sup>4,5</sup>  | John Baker<sup>6</sup>  |  
 Frederik Alkier Gildberg<sup>2,3,4</sup> 

<sup>1</sup>Open Patient Data Exploratory Network (OPEN), Department of Clinical Research, University of Southern Denmark (SDU), Odense, Denmark

<sup>2</sup>Psychiatric Department Middelfart, Mental Health Services in the Region of Southern, Middelfart, Denmark

<sup>3</sup>Forensic Mental Health Research Unit Middelfart, Department of Regional Health Research, Faculty of Health Science, University of Southern Denmark (SDU), Middelfart, Denmark

<sup>4</sup>Center for Psychiatric Nursing and Health Research (CPS), Mental Health Services in the Region of Southern Denmark, Esbjerg, Denmark

<sup>5</sup>Mental Health Center Sct. Hans, Mental Health Services in the Capital Region of Denmark, Roskilde, Denmark

<sup>6</sup>School of Healthcare, University of Leeds, Leeds, UK

## Correspondence

Camilla Rosendal Lindekilde, Open Patient Data Exploratory Network (OPEN), Department of Clinical Research, University of Southern Denmark (SDU), Odense, Denmark.  
 Email: [camilla.rosendal.lindekilde@rsyd.dk](mailto:camilla.rosendal.lindekilde@rsyd.dk)

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## Accessible summary

### What is known on the subject?

- The use of restrictive interventions is described as a violation of patients' rights and autonomy. It must only be used as a last resort to manage dangerous behaviour, to prevent or reduce the risk of mental health patients harming themselves or others.
- International mental health policy and legislation agree that when restrictive interventions are applied, the least restrictive alternative should be chosen.

### What the paper adds to existing knowledge?

- The results are ambiguous, as to which restrictive intervention is preferred over others, but there are tendencies towards the majority preferring observation, with mechanical restraint being the least preferred.
- To make the experience less intrusive and restrictive, certain factors are preferred, such as a more pleasant and humane seclusion room environment, staff communicating during the application and staff of same gender applying the intervention.

### What are the implications for practice?

- When applying restrictive interventions, mental health professionals should consider environment, communication and duration factors that influence patient preferences, such as the opportunity to keep some personal items in the seclusion room, or, when using restraint, to communicate the reason and explain what is going to happen.
- More research is needed to clarify patients' preferences regarding restrictive interventions and their views on which are the least restrictive. Preferably, agreement is needed on standard measures, and global use of the same definition of restrictive interventions.

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## Abstract

**Introduction:** The use of restrictive interventions is a violation of patients' rights that causes physical and psychological harm and which is a well-known challenge globally. Mental health law and legislative principles and experts agree that when restrictive interventions are applied, the least restrictive alternative should be used. However, there is no consensus on what is the least restrictive alternative, especially from the patient perspective.

**Aim:** To investigate the literature on mental health patients' preferences regarding restrictive interventions applied during admission to a psychiatric hospital.

**Method:** An integrative review informed by the PRISMA statement and thematic analysis were undertaken.

**Results:** There were tendencies towards patients preferring observation and, for the majority, mechanical restraint was the least preferred restrictive intervention. Factors such as environment, communication and duration were found to influence patients' preferences.

**Discussion:** There is a lack of agreement on how best to measure patients' preferences and this complicates the choice of the least restrictive alternative. Nonetheless, our findings show that staff should consider environment, communication and duration when applying restrictive interventions.

**Implications for Practice:** More research on restrictive interventions and the least restrictive alternative is warranted, but agreement is needed on standard measures, and a standard global definition of restrictive interventions.

## KEYWORDS

coercive measures, mental health, patient preferences, psychiatry, restrictive practices, service users, systematic review

## 1 | INTRODUCTION

The use of restrictive interventions (RI) remains very controversial and is a well-known problem in mental health settings internationally, both within general mental health (Steinert, 2016) and forensic mental health (Hui et al., 2016). The use of RI is described throughout literature as a violation of patients' rights and autonomy (Beauchamp & Childress, 2019; Birkeland & Gildberg, 2016; Chieze et al., 2021; Gildberg, Fristed, et al., 2015), that causes physical and psychological harm to staff (Goulet et al., 2017; Paradis-Gagné et al., 2021) and, especially, to patients (Abderhalden et al., 2006; Aguilera-Serrano et al., 2018; Cusack et al., 2018; Hui, 2017; Kersting et al., 2019). Furthermore, there are significant differences in the types of RI that are legal in different countries (Aggerdæs et al., 2009; Bak & Aggerdæs, 2012). However, international mental health policy and legislation agree that, when RI are applied, the least restrictive alternative (LRA) should be chosen (Johnston & Sherman, 1993; NICE, 2015; WHO, 2008).

Currently, there seems to be no consensus on what is considered the LRA regarding RI (Chieze et al., 2021). In particular, knowledge on patients' RI preferences are limited. Previous studies investigated

patients' perceptions of RI outside hospitals (Corring et al., 2017; Pridham et al., 2016). Therefore, this study reviews the existing research literature on mental health patients' preferences regarding RI during admission to a psychiatric hospital.

### 1.1 | Background

RI are defined as interventions '[...] that may infringe a persons' human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid tranquilisation' (NICE, 2015). Such interventions should only be used as a last resort to manage dangerous behaviour, to prevent or reduce the risk of mental health patients harming themselves or others (Curtis et al., 2016; Duxbury et al., 2019; Steinert, 2016). International research points out that the prevalence of RI use is too high (Goulet et al., 2017; McLaughlin et al., 2016). The prevalence varies greatly across countries. For example, from 1.7% of mental health patients admitted to acute psychiatric wards in Middle Norway (Reitan et al., 2018) to 12.0% in the Netherlands (Noorthoorn et al., 2015). Noorthoorn et al. (2015) also compared data from 15 countries

and reported a previous mean percentage of coercive measures of 7%. Recently, Danish data have shown that 22.4% of all admitted adult mental health patients were exposed to RI in 2021 (Sundhedsstyrelsen, 2021). The use of RI varies across countries, related to differences in culture and policies (Bak & Aggernæs, 2012; Hui et al., 2016; Raboch et al., 2010).

Existing research has reported several adverse effects of the use of RI (Goulet et al., 2017; Hui, 2017; Kersting et al., 2019), and that it has a negative impact on patient experience (Aguilera-Serrano et al., 2018; Van Der Merwe et al., 2013). Patients suffer physical injuries, pain, (Aguilera-Serrano et al., 2018; Cusack et al., 2018; Goulet et al., 2017) and cardiac arrest, which has caused death in a few severe cases (Kersting et al., 2019). Patients also experience psychological distress, such as fear, anxiety and humiliation (Aguilera-Serrano et al., 2018; Cusack et al., 2018; Goulet et al., 2017). In some cases, the use of RI can manifest in post-traumatic stress disorders or re-traumatisation (Aguilera-Serrano et al., 2018; Cusack et al., 2018; Goulet et al., 2017) and can also impact on the therapeutic relationship (Goulet et al., 2017; Jaeger & Rossler, 2010). However, a minority of patients experience RI positively, in the sense that they report feeling calm when staff take control of their behaviour (Cusack et al., 2018).

A systematic review by Glerup et al. (2019) investigated quantitative international research on patients' preferences between mechanical restraint (MR) and seclusion, concluding that there were no statistical significant differences between patients' preference for MR or seclusion (Glerup et al., 2019). At the same time, we know that the use of RI conflicts with human rights and patient autonomy principles (Niveau, 2004; Steinert, 2016; UN, 1991; WHO, 2008). Therefore, the LRA principle has been applied in mental health legislation and guidelines in several countries (Freeman & Pathare, 2005; WHO, 2008).

The LRA principle states that whenever RI are needed, mental health patients should receive the least restrictive treatment appropriate to their health needs and which allows for the maintenance of the highest level of autonomy and personal freedom (Johnston & Sherman, 1993). However, legislation and guidelines on the use of the LRA are heterogeneous and do not offer specific guidance on how and when proper efforts are exercised in deciding which RI is the least restrictive (Bak & Aggernæs, 2012; Chieze et al., 2021; WHO, 2008). Furthermore, the lack of guidance combined with the lack of knowledge of patients' perceptions of restrictiveness makes it difficult for psychiatric staff to implement the LRA (Huckshorn, 2006). Consequently, the application of the LRA is based on culture, and on individual, and inconsistent, staff decisions (Bak & Aggernæs, 2012; Bowers et al., 2004; Jacobsen, 2012; Laiho et al., 2016; Wynaden et al., 2002). In recent years, consensus on patient involvement in care seems to be both called for and best practice (Haw et al., 2011), but little research has been carried out that includes patients' perspectives on the matter of the LRA (Cusack et al., 2018) and, especially, that uncovers what patients find least restrictive and which RI is preferred over others, including which factors influence patients' preferences.

## 1.2 | Aim

The aim was to systematically review the existing international research literature on mental health patients' preferences regarding RI, including MR, seclusion, manual restraint, rapid tranquillisation and observation, applied during admission to a psychiatric hospital.

## 2 | METHODS

An integrative review was undertaken to systematically review the literature on mental health patients' preferences regarding RI in order to achieve a comprehensive understanding of the subject. This method allows inclusion of diverse types of research and synthesis of heterogeneous study results (Remington & Toronto, 2020; Whittemore & Knafl, 2005). This review was informed by the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) statement (Page et al., 2021), and the protocol was registered in PROSPERO (CRD42022284117).

### 2.1 | Literature search and study selection

Studies were identified from a systematic search of the databases: Embase Ovid, PsycINFO Ovid, CINAHL EBSCO, ProQuest Dissertations and Theses Global, Scopus Elsevier and MEDLINE(R) ALL Ovid, on 11 May 2022. The search was built of three blocks using the Boolean operators 'AND' and 'OR', as presented in Appendix S1 (De Brún et al., 2014; Remington & Toronto, 2020). The subject headings and free text words used in the search were drawn from the research questions (see Table 2), and literature within the topic of mental health and coercive measures (De Brún et al., 2014).

The search was run with the assistance of an information specialist. In addition, an ancestry search as described by Remington and Toronto (2020) was used. The search blocks and database search strings are presented in Appendix S1. The search was re-run 17 August 2023.

The first and second authors independently selected relevant studies in the phases of title and abstract screening, and full-text screening in Covidence (2023). In the case of disagreement, all other authors were involved in the discussion. Figure 1 shows the selection process in a PRISMA flow diagram (Page et al., 2021).

### 2.2 | Eligibility criteria

Studies were included if they reported on mental health patients' preferences regarding RI used during admission to a psychiatric hospital (see Table 1). The overall definition of the term RI for the scope of this study was informed by the NICE guidelines. However, various

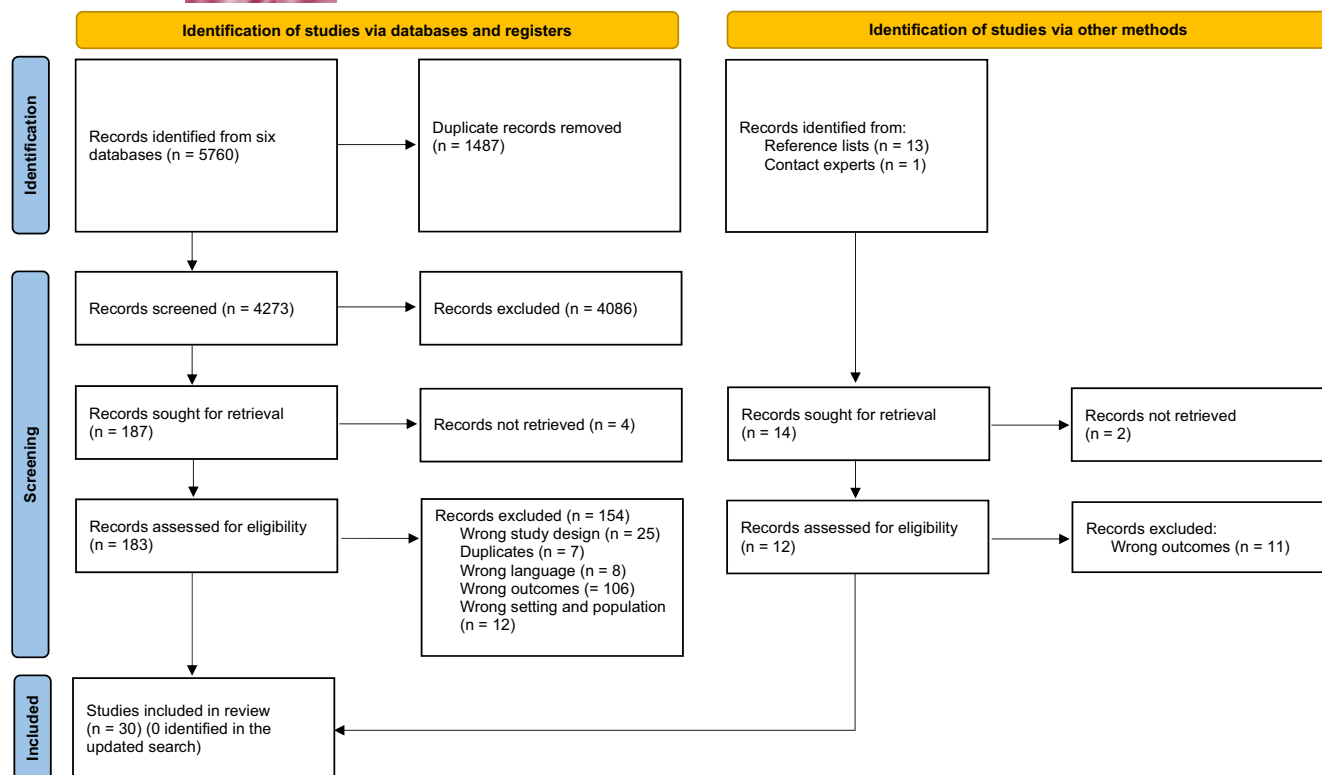


FIGURE 1 PRISMA flow diagram. The PRISMA flow diagram showing the study selection process.

TABLE 1 Concepts and definitions.

Concept	Definition
Restrictive interventions (RI)	Interventions that may infringe a persons' human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation (NICE 2015)
Mechanical restraint (MR)	The use of restraining straps, belts or other equipment to restrict movement (Bowers 2004)
Seclusion	Isolated in a locked room (Bowers 2004)
Manual restraint	The patient is manually held by at least one member of staff, to restrict movement (Völlm 2016)
Rapid tranquilisation	The coercive administration of medication, typically by intramuscular injection (Völlm 2016)
Observation	Intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with a service user, to ensure the service user's safety and the safety of others (NICE 2015)

Note: Concept and definition of restrictive interventions and the types of restrictive interventions included in the study.

references with more detailed definitions are used in the current study to define each RI. Research written in languages other than English and Scandinavian languages were excluded. Reviews were excluded, but were scanned for relevant references. Studies that did not explicitly define the RI were also excluded.

## 2.3 | Critical appraisal

The Mixed Methods Appraisal Tool (MMAT) (Hong, Pluye, et al., 2018) was used by the first author to assess the quality of the included studies. MMAT was initially developed to overcome challenges in the quality appraisal of reviews, including studies of various methods (Hong, Gonzalez-Reyes, & Pluye, 2018). It was used in this study because of the heterogeneity of the designs of the included studies.

TABLE 2 Analytical questions.

1. What characterises *the existing research literature* on patients' preferences regarding RI during admission to a psychiatric hospital, including the methods used to capture mental health patients' preferences?
2. What characterises *mental health patients' preferences* regarding RI and *which factors influence patients' preferences* regarding RI during admission to a psychiatric hospital?

Note: Analytical questions used in the thematic analyses.

## 2.4 | Data extraction and analysis

Data extraction and analysis were guided by the analytical questions (see Table 2) and included a combination of descriptive reporting

TABLE 3 Matrix of study characteristics.

Author, year Country	Data collection method	Sample size (n)	Response rate	Age (mean/range)	% Females	Previous experience of RI	Type of restrictive interventions studied				
							Obs.	RT	Secl.	Man. restr.	MR
Quantitative studies (n=21)											
Bergk, 2011 Germany	Questionnaire: CES, VAS	233	43.8%	39.5–42.0 <sup>a</sup>	51%	Yes			X		X
El-Badri, 2008 NZ	Questionnaire: Self-developed	111	N/A	18–65	54.1%	Mixed <sup>b</sup>			X		
Georgieva, 2012a Netherlands	Questionnaire: CES, VAS	125	60%	37	45%	Yes		X	X		X
Georgieva, 2012b Netherlands	Questionnaire: Self-developed	451	35.7%	37–40 <sup>a</sup>	54%	Mixed		X	X		
Guzman-Parra, 2018 Spain	Questionnaire: CES, VAS	128	89.1%	37.8	31.5%	Yes		X			X
Hottinen, 2012 Finland	Questionnaire: ACMQ	233	35%	16.3	N/A	Mixed	X	X	X	X	X
Hotzy, 2019 Switzerland	Questionnaire: ACMQ-D	418	N/A	N/A	N/A	Mixed	X	X	X	X	X
Hui, 2015 UK	Questionnaire: ACMQ	316	N/A	39.5	N/A	Mixed	X	X	X	X	X
Keski-Valkama, 2010 Finland	Structured Interview: Self-developed	154	68.8%	38	31.1%	Yes			X		
Krieger, 2018 Germany	Questionnaire: Self-developed	264	N/A	42.5	45.5%	Mixed	X	X	X	X	X
Larue, 2013 Canada	Questionnaire: Self-developed: 'Survey on Patients' Perceptions Regarding the Application of Control Measures'	50	N/A	N/A	38%	Yes			X		
Mielau, 2016 Germany	Questionnaire: Self-developed: Clinical case vignettes	90	N/A	38.1	34%	Mixed		X			X
Norris, 1992 USA	Questionnaire: Self-developed: 'Psychiatric Patients' Perception of Seclusion Sentence Completion Form', 'Profile of Psychiatric Patients Who Have Been Secluded'	20	100%	15–55	55%	None			X		
Reisch, 2018 Switzerland	Questionnaire: ACMQ	435	N/A	N/A	N/A	Mixed	X	X	X	X	X
Sheline, 1993 USA	Questionnaire: Self-developed	163	63%	33.6	N/A	None		X			
Soliday, 1985 USA	Questionnaire: Self-developed	146	59%	18–66	40%	Mixed			X		
Steinert, 2013 Germany	Questionnaire: CES, VAS	102	59%	39.6	45%	Yes			X		X
Veltkamp, 2008 Netherlands	Questionnaire: Self-developed	166	74%	36.5	36%	Yes		X	X		
Vishnivetsky, 2013 Israel	Questionnaire: Self-developed	50	N/A	16.8	52%	Yes			X		X

(Continues)

TABLE 3 (Continued)

Author, year Country	Data collection method	Sample size (n)	Response rate	Age (mean/range)	% Females	Previous experience of RI	Type of restrictive interventions studied				
							Obs.	RT	Secl.	Man. restr.	MR
Whittington, 2009 & Dack, 2012 UK <sup>a</sup>	Questionnaire: ACMQ	1361	N/A	N/A	48%	Mixed	X	X	X	X	X
Total sample		4966									
Qualitative studies (n=9)											
Faschingbauer, 2013 USA	Interview: (type not mentioned)	12	N/A	33	50%	Yes			X		
Gallop, 1999 Canada	Interview: Open-ended	10	N/A	39.8	100%	Yes		X		X	X
Haw, 2011 UK	Interview: Semi-structured	57	N/A	29	52.6%	Yes		X	X	X	
Johnson, 2013 UK	Interview: Semi-structured	12	N/A	33	N/A	Yes	X		X		
Jones, 2007 UK	Interview: Semi-structured	10	N/A	39.3	30%	Yes				X	
Lynge, 2022 Denmark	Interview: Semi-structured	9	N/A	43	33.3%	Yes				X	X
Mayers, 2010 South Africa	Interview: Semi-structured	43	N/A	38	51.2%	Mixed		X	X		
Meehan, 2000 Australia	Interview: Semi-structured	12	N/A	18–52	41.7%	Yes			X		
Naber, 1996 Germany	Interview: Semi-structured	124	49.6%	29	77.5%	Yes		X			X
Total sample		339									

Note: Study characteristics of the 30 studies included in the integrative review of patients' preferences regarding restrictive interventions (RI). Abbreviations: ACMQ, Attitudes to Containment Measure Questionnaire; CES, Coercion Experience Scale; man. restr., manual restraint; MR, mechanical restraint; N/A, not applicable; Obs., observation; RI, restrictive intervention; RT, rapid tranquilisation; secl., seclusion; VAS, visual analogue scale.

<sup>a</sup>Using data from same population/investigation.

<sup>b</sup>Mixed: participants included both with and without former experience with RI.

and thematic analysis informed by Gildberg, Bradley, et al. (2015); Gildberg and Wilson (2023), integrating all included studies of various methodologies. The thematic analysis was adapted to answer the two analytical questions individually. The descriptive reporting and stages of thematic analysis in relation to each analytical question are detailed below. The first author extracted data from each included study. The extracted data were discussed with and checked by the second author.

Regarding analytical question 1 (see Table 2), the thematic analysis was adapted to consist of Steps 1 to 4: First reading, analytical question, coding and condensation, as reported in Gildberg & Wilson (2023). These steps resulted in the descriptive part of the analysis presented in Table 3. The second part of analytical question 1 was answered by adding steps 5–7: categorisation, thematisation of categories and taxonomical relations. The categorisation is presented in Appendix S3, and the taxonomical relations are presented in Figure 2. Regarding the second analytical question, the thematic analysis was also adapted to consist of Steps 1 to 4, descriptively

presented in Table 4. In addition, to address the second part of research question 2, Steps 5 and 6 were added, resulting in the overall themes and sub-themes presented in section 3.1.2.

The iterative process continued through the analysis entailing constantly going back and forth between the categories, and text from the included studies, to empirically test the results (Gildberg, Bradley, et al., 2015; Gildberg & Wilson, 2023).

### 3 | FINDINGS

#### 3.1 | Characteristics of the included studies

As shown in Figure 1, 30 studies from six scientific databases were included in the review. The combined samples of participants in the studies totalled 5305 mental health patients. The studies came from 13 countries, primarily United Kingdom (UK) (n=6), Germany (n=5) and United States of America (USA)

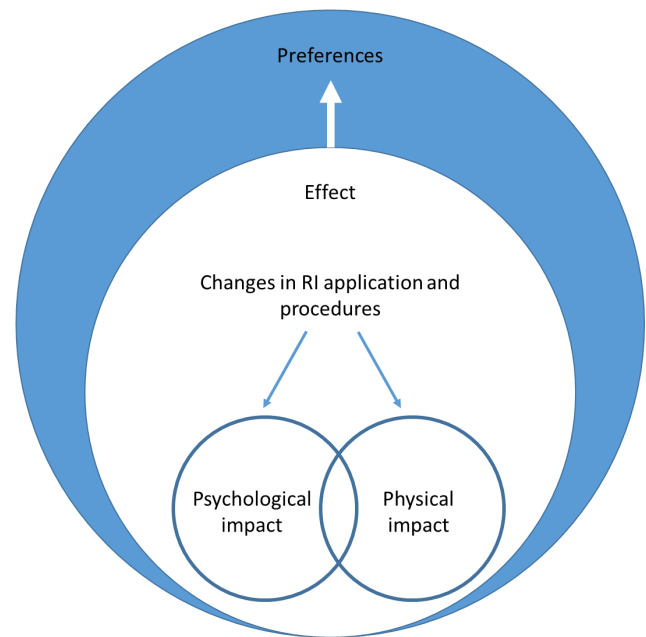
( $n=4$ ). Of the 30 studies, 21 collected data quantitatively. Eleven studies applied self-developed questionnaires, and 10 studies used pre-developed, validated questionnaires, either the Coercive Experience Scale (CES) or the Attitude to Containment Methods Questionnaire (ACMQ). The CES measures the psychological impact during psychiatric coercive interventions (Bergk et al., 2010), and the ACMQ rates RI for acceptability (Bowers et al., 2004). Nine studies collected data via interviews. Five of these studies accounted for the positioning of the researchers as part of the clinic, but only two addressed how this could influence the results. Seclusion was the most investigated RI ( $n=22$ ), followed by rapid tranquilisation ( $n=16$ ), MR ( $n=15$ ), manual restraint ( $n=10$ ) and observation ( $n=7$ ). Only three studies included data on adolescents (Hottinen et al., 2012; Norris & Kennedy, 1992; Vishnivetsky et al., 2013), and two of these studies investigated adolescent population only (Hottinen et al., 2012; Vishnivetsky et al., 2013). Further details on characteristics of the included studies are presented in Table 3, grouped in a quantitative matrix and a qualitative matrix and categorised in alphabetic order.

### 3.1.1 | Characteristics of the items used to measure patients' preferences

The thematic analysis identified 60 conceptual components used to investigate mental health patients' RI preferences (see Appendix S3). Only items that relate to answering the first research question were included. The 60 conceptual components were merged into five categories: Preferences, changes in RI application and procedures, psychological impact, physical impact and effect. Preferences cover concepts that generally examine which RI patients favour over others, for example, related to patients' overall attitude, preparedness to undergo or global strain. Changes in RI application and procedures cover changes surrounding the use of RI, and an examination of which changes that can influence which RI is preferred over others. Psychological impact is concepts related to RI impact on patients' mental and emotional experience, and physical impact is concepts related to the physical consequences of restrictions or physical force when exposed to RI. Effect includes concepts related to both positive and negative effect of applied RI as perceived by patients, for example, adverse effects or calming down.

The taxonomical relations between the five categories are shown in Figure 2 and elaborated on below.

The categories *effect*, *changes in RI application and procedures*, *psychological impact* and *physical impact* are all parts of the category *preferences*. This means that these components, whether individually or combined, influence patients' preferences among RI. *Changes in RI application and procedures*, as presented in the included studies, impact on the *psychological and physical impact* that in turn impacts patients' preferences: For example the studies report that when changing RI procedures and application this was reported to impact



**FIGURE 2** Taxonomical relations between themes. Connections between conceptual components. The connections between identified categories of conceptual components that were used to investigate mental health patients' preferences regarding RI.

on *psychological impact* and/or *physical impact*. The items *psychological impact* and *physical impact* are, in turn, reflected in the reporting of *preference*. Items within the categories *psychological impact* and *physical impact* at times overlap, for example, autonomy and dignity, and the included studies do not necessarily differentiate strictly between what could be categorised as a *psychological impact* and a *physical impact*, nor do they explicitly define items used.

### 3.1.2 | Results of critical appraisal

Only nine of the 30 studies were rated as high quality. Twenty-one studies were rated as lower quality. Five studies (Gallop et al., 1999; Jones & Kroese, 2007; Naber et al., 1996; Reisch et al., 2018; Sheline & Nelson, 1993) presented unclear research questions, which made it difficult to appraise questions related to the research question, for example: '*Is the sampling strategy relevant to address the research question? And do the collected data allow to address the research question?*' (Hong, Pluye, et al., 2018). Three studies (Georgieva, Mulder, & Whittington, 2012; Georgieva, Mulder, & Wierdsma, 2012; Vishnivetsky et al., 2013) did not give a sampling strategy. The risk of non-response bias in 13 studies was due to missing data on response rate (Dack et al., 2012; El-Badri & Mellso, 2008; Hotzy et al., 2019; Hui, 2015; Krieger et al., 2018; Mielau et al., 2016; Reisch et al., 2018; Vishnivetsky et al., 2013; Whittington et al., 2009) and missing reasons for non-response (Georgieva, Mulder, & Wierdsma, 2012; Hottinen et al., 2012; Sheline & Nelson, 1993; Veltkamp et al., 2008). Two studies did not state whether the measurement tool was validated

(El-Badri & Mellsop, 2008; Sheline & Nelson, 1993). Furthermore, two qualitative studies (Lynge et al., 2022; Naber et al., 1996) were rated as lower quality because the findings were not adequately derived from the data, and because there was a lack of coherence between qualitative data collection (Naber et al., 1996) and interpretation (Lynge et al., 2022). See Appendix S2 for the quality appraisal of all included studies.

### 3.1.3 | Results of reported patients' preferences

A sub-sample of 23 studies reported on patients' preferences for RI (see Table 4). The sub-sample consisted of seven qualitative and 16 quantitative studies. The RI investigated in each study were rated from 1 (preferred by most participants) to 2–5 (preferred by least participants), depending on the number and types of RIs investigated. The ranking was based on the RI that the majority of participants in the given study preferred or found most acceptable or least intrusive/restrictive. In two studies, investigating seclusion and MR (Bergk et al., 2011), and rapid tranquillisation and seclusion (Veltkamp et al., 2008) the interventions were equally preferred or

results were imprecisely reported. Eight studies reported findings on 'observation', and in seven studies, 'observation' was ranked as the preferred RI by most patients. Twelve studies investigated 'MR'. In all 12 studies, 'MR' was rated the least preferred intervention by the majority of participants. 'Seclusion' was preferred to 'MR' in 8/8 studies. When compared to seclusion or MR alone, 'rapid tranquillisation' was the preferred intervention; however, in measuring acceptability, 'rapid tranquillisation' was rated less acceptable than seclusion in 4/6 studies. The two studies focusing on adolescent populations concur that most prefer seclusion over MR (Hottinen et al., 2012; Vishnivetsky et al., 2013). Looking at the findings from a historical perspective, patients' preferences do not seem to change over time. See Table 4 for further results on patient preferences.

### 3.2 | Factors that influence mental health patients' RI preferences

The thematic analysis of factors that influence patients' preferences regarding RI resulted in two overall themes, *the application process of RI and patient characteristics*.

TABLE 4 Matrix of reported patients' preferences.

Author, year, country	Type of RI studied				
	Rapid tranquillisation	Observation	Seclusion	Manual restraint	Mechanical restraint
Mayers, 2010, South Africa	1st	N/A	2nd	N/A	N/A
Keski-Valkama, 2010, Finland	1st	N/A	2nd	N/A	N/A
Georgeiva, 2012a, Netherlands	1st	N/A	2nd	N/A	N/A
Haw, 2011, UK	1st	N/A	2nd	N/A	N/A
Sheline, 1993, USA	1st	N/A	2nd	N/A	N/A
Georgeiva, 2012b, Netherlands	1st	N/A	2nd	N/A	N/A
Naber, 1996, Germany	1st	N/A	N/A	2nd	N/A
Guzman-Parra, 2018, Spain	1st	N/A	N/A	N/A	2nd
Mielau, 2016, Germany	1st	N/A	N/A	N/A	2nd
Meehan, 2000, Australia	N/A	1st	2nd	N/A	N/A
Johnson, 2013, UK	N/A	1st	2nd	N/A	N/A
Krieger, 2018, Germany	3rd	1st	2nd	4th	5th
Hotzy, 2019, Switzerland	3rd	1st	4th	2nd	5th
Reisch, 2018, Germany	3rd	1st	4th	2nd	5th
Whittington, 2009 & Dack 2012, UK <sup>a</sup>	4th	1st	3rd	2nd	5th
Hottinen, 2012, Finland	4th	1st	3rd	2nd	4th
Vishnivetsky, 2013, Israel	N/A	N/A	1st	N/A	2nd
Steinert, 2013, Germany	N/A	N/A	1st	N/A	2nd
Hui, 2015, UK	3rd	2nd	1st	2nd	3rd
Lynge, 2022, Denmark	N/A	N/A	N/A	1st	2nd
Veltkamp, 2008 Netherlands	Equal	N/A	Equal	N/A	N/A
Bergk, 2011, Germany	N/A	N/A	Imprecise	N/A	Imprecise

Note: Reported patients' preferences for restrictive interventions from 23 studies.

Abbreviation: N/A, not applicable.

<sup>a</sup>Using data from same population.



### 3.2.1 | The application process of RI

The application process of RI comprises patients' perceptions of procedures in the application of RI that have a positive or negative impact on their preferences. Three sub-themes emerged: *environmental changes*, *communication* and *expectations for service experience*.

#### *Environmental changes*

The thematic analysis showed that eight studies suggested that environmental changes impact patients' experience and influence their preferences. Helpful environmental changes included providing physical items and decorations, for example, reading and writing materials, a bed instead of a mattress on the floor, bathroom facilities, soft walls or coloured walls and oversized clothes. The theme of environmental changes also covers patients wanting to have a higher degree of control of the environment, for example, the ability to self-regulate temperature in the room, get fresh air, smoke and not be stripped off. (El-Badri & Mellso, 2008; Haw et al., 2011; Keski-Valkama et al., 2010; Larue et al., 2013; Meehan et al., 2000; Norris & Kennedy, 1992; Soliday, 1985; Steinert et al., 2013). According to the patients, simple changes in the environment can make the RI experience more pleasant and humane.

#### *Communication*

Patients preferred better communication and easier and quicker access to talk with staff during seclusion were mentioned in seven studies (El-Badri & Mellso, 2008; Faschingbauer et al., 2013; Haw et al., 2011; Keski-Valkama et al., 2010; Meehan et al., 2000; Norris & Kennedy, 1992; Steinert et al., 2013). Examples of communications with staff included talking through the seclusion situation, or being allowed to negotiate its duration (Haw et al., 2011; Meehan et al., 2000). Patients also preferred having the opportunity to talk with family, friends or counsellors while in seclusion (El-Badri & Mellso, 2008). Better communication was perceived by patients as more humane and acceptable, and patients who experienced better communication expressed that they felt more respected (Faschingbauer et al., 2013; Keski-Valkama et al., 2010; Steinert et al., 2013). Communication preferences also included staff talking about reasons for manual restraint (Haw et al., 2011), and in general, patients would prefer to have more contact and communication with staff during MR (Steinert et al., 2013).

#### *Expectations for service experience*

Four studies reported on application procedures as factors that influenced preferences, in regard to MR and manual restraint (Gallop et al., 1999; Haw et al., 2011; Jones & Kroese, 2007; Lyngge et al., 2022). Gallop et al. (1999) found that women being restrained by male staff members added a further dimension of fear for women patients. When different staff chose different types of restraint, patients felt more anxious, because of the perceived lack of predictability in staff choice (Jones & Kroese, 2007). Two studies reported

that patients requested staff to be less violent when using restraint (Haw et al., 2011; Lyngge et al., 2022). Patients expressed preferences that staff be well trained in restraining techniques, for example, restraining patients in a way that made it easier to breathe (Haw et al., 2011) and that restraint duration be as short as possible (Lyngge et al., 2022).

Five studies described factors that influenced patients' preferences in regard to seclusion (Dack et al., 2012; Georgieva, Mulder, & Wierdsma, 2012; Haw et al., 2011; Keski-Valkama et al., 2010; Krieger et al., 2018). The more seclusion was used on the wards, the better were the patients' attitudes towards the intervention ( $r=+0.18$ ,  $p<.05$ ) (Dack et al., 2012). One study reported that patients preferred surveillance through a window to a surveillance camera (Krieger et al., 2018). Also, shorter duration of seclusion was considered preferable (Georgieva, Mulder, & Wierdsma, 2012; Keski-Valkama et al., 2010).

Five studies presented factors that influenced patients' preferences regarding rapid tranquilisation (Georgieva, Mulder, & Wierdsma, 2012; Haw et al., 2011; Jones & Kroese, 2007; Naber et al., 1996; Sheline & Nelson, 1993). The preferred types of medication were Ativan or Xanax ( $n=31$ ) over Haldol, Proxolin or Navane ( $n=26$ ) (Sheline & Nelson, 1993), and Lorazepam ( $n=19$ ) and haloperidol ( $n=13$ ) over olanzapine ( $n=5$ ) (Haw et al., 2011). Patients preferred doctors not to use antipsychotics that had side effects (Naber et al., 1996). In one study, patients were reported to choose seclusion over medication, because of the side effects of medication (Haw et al., 2011). According to Haw et al. (2011), male patients preferred medication to be administered by a staff member of the same gender, and that it be used over seclusion, because it worked more quickly than seclusion. Most patients preferred oral dispensation to injection (Haw et al., 2011; Jones & Kroese, 2007). Medication was preferred over seclusion, if time in seclusion was perceived as 'too long' (Georgieva, Mulder, & Wierdsma, 2012).

Two studies reported on the application of multiple RI (Gallop et al., 1999; Georgieva, Mulder, & Whittington, 2012). These studies reported that when RI were combined, for example, restraint or seclusion combined with rapid tranquilisation, it added to patients' feelings of loss of control, and physical and psychological distress. Combined RI were rated by patients as the least preferred in these studies.

### 3.2.2 | Patients' characteristics

The theme 'patients' characteristics' comprises patients' characteristics and how these characteristics influence patients' RI preferences. This theme included the sub-themes of *age*, *gender* and *previous experience of RI*.

#### *Age*

Four studies found no significant association between preferences and age (Guzmán-Parra et al., 2019; Krieger et al., 2018; Soliday, 1985; Vishnivetsky et al., 2013). However, one study found

that older patients expressed greater general approval of manual restraint ( $r = .123$ ,  $p < .001$ ), seclusion ( $r = .083$ ,  $p = .002$ ) and constant observation ( $r = .105$ ,  $p < .001$ ) (Whittington et al., 2009).

### Gender

Six studies found no significant association between RI preferences and gender (Georgieva, Mulder, & Wierdsma, 2012; Guzmán-Parra et al., 2019; Haw et al., 2011; Krieger et al., 2018; Soliday, 1985; Vishnivetsky et al., 2013). Three studies found associations between gender and RI preferences (Mayers et al., 2010; Veltkamp et al., 2008; Whittington et al., 2009). Veltkamp et al. (2008) found that 46% of the men preferred seclusion compared with 27% preferring rapid tranquilisation, while 60% of women preferred rapid tranquilisation compared with 23% preferring seclusion (Veltkamp et al., 2008). Mayers et al. (2010) also found that women were less approving of seclusion than were men (Mayers et al., 2010). Whittington et al. (2009) found that men had a higher approval of MR ( $t = 3.16$ ,  $df = 1318$ ,  $p = .002$ ), seclusion ( $t = 2.42$ ,  $df = 1330$ ,  $p = .016$ ) and manual restraint ( $t = 2.26$ ,  $df = 1339$ ,  $p = .024$ ) than had women (Whittington et al., 2009).

### Previous experience

Seven studies investigated whether previous experience of RI influenced patients' preferences. Two studies found no difference in preferences between patients with previous experience and patients with no experience (Hui, 2015; Veltkamp et al., 2008). In the five studies reporting that previous experience was an influence, the findings were ambiguous. In one of the included studies, patients exposed to any RI rated the measures less acceptable compared with patients who had no experience (Reisch et al., 2018). Three studies found exceptions to this: In Hottinen et al. (2012), patients who had been subjected to MR viewed it more positively than patients who had not been mechanically restrained. Whittington et al. (2009) reported that patients who had been subjected to observation approved more of it than non-'observed' patients. It was also suggested that patients who had experienced either MR or seclusion might prefer these interventions to rapid tranquilisation (Georgieva, Mulder, & Wierdsma, 2012). Also, patients who had been subjected to manual restraint, and rapid tranquilisation separately disapproved more strongly than those not subjected to these measures (Mielau et al., 2016; Whittington et al., 2009). Patients who had no restraint experience preferred rapid tranquilisation to seclusion (Georgieva, Mulder, & Wierdsma, 2012) and MR (Mielau et al., 2016).

## 4 | DISCUSSION

In this integrative review, including both qualitative and quantitative studies, we summarised the findings from 30 studies on patients' preferences and the factors likely to influence preferences regarding RI, comprising mechanical restraint (MR), seclusion, manual restraint, rapid tranquilisation and observation.

The use of 12 different instruments and 60 conceptual components across the included studies made it hard to compare results. One of the challenges in accurately measuring patients' perceptions of RI situations is the inconsistencies in how individual experiences of RI are defined and measured. For instance, experiences linked to a RI situation are complex, involving both physical and psychological impacts on the individual as well as external factors relating to changes in the RI procedures (Lawrence et al., 2022; Negroni, 2017). However, after conducting a thematic analysis, we identified five themes that could help inform future research into mental health patients' preferences regarding RI. The identified five themes suggest that when investigating patients' RI preferences, one should consider all aspects surrounding the RI experience and examine both the physical and psychological impact, changes in the RI procedure, and patients' perceived effect of the RI.

Patients' apparent preference for observation over the other four RI is consistent with previous findings, where health authorities ranked observation as the least intrusive (Bak & Aggernæs, 2012). An exception was found by Hui (2015), where seclusion was ranked above observation and manual restraint, and rapid tranquilisation and MR was ranked as the least preferred. Bak and Aggernæs (2012) also found MR as the most intrusive RI. Other findings continue to point towards an apparently higher acceptance of seclusion over other coercive measures (notably rapid tranquilisation) while restraint (both manual and mechanical) seems less tolerable, probably because seclusion is perceived as 'non-invasive' (Chieze et al., 2019).

Two former studies found that staff rated MR as the most aversive and least accepted intervention (Harris et al., 1989; Whittington et al., 2009). Several studies confirm our finding that MR is, overall, the least preferred RI. This indicates that while the literature occasionally groups together MR, seclusion, rapid tranquilisation, observation and manual restraint, it is important for psychiatric staff to consider the possibility of an unspoken hierarchy when it comes to RI. Still, we should bear in mind that this is the broad perspective favouring the majority and that every patient has an opinion that should be considered if the situation allows it. Also, advanced directives implemented in some countries in mental health law can improve patients' involvement in treatment (Braun et al., 2023).

Previous research was inconclusive as to whether seclusion or MR is superior, in terms of patients' perceptions of efficacy and safety (Gleerup et al., 2019). Our review findings, from both quantitative and qualitative studies, suggest that the majority found seclusion less restrictive, and more acceptable. It seems that some patients would rather prefer MR or seclusion, even though, objectively, they both seem more restrictive and intrusive than other RI, for example, observation. However, because such a wide range of methods to investigate patients' preferences were used in the included studies resulting in heterogeneous data, exact calculations of how many preferred which RI were not possible; nor could we make direct comparisons between preferences. Previous reviews relating to RI also reported that the literature was distinguished by a lack

of consistent terminology and wide range of measures (Aguilera-Serrano et al., 2018; Baker et al., 2022).

In some respects, the wide range of methods reported in this review may be explained by the lack of standard definitions of RI. For instance, observation can vary in intensity, or rapid tranquilisation, also referred to as chemical restraint, is bound up with factors like administration method (pill or injection) and is often used in combination with manual or MR (Negroni, 2017; Pedersen et al., 2023).

Inconsistency in RI definitions may have impacted the findings of the current review, potentially causing challenges during the process of selecting studies for inclusion, where some studies might have been excluded on the basis of an absence of clear RI definitions. Above all, this review shows that the issue of RI is a multidimensional and very complex phenomenon (Gildberg et al., 2021). In addition to the issues of diverse approaches to RI definitions, analysis within the current study did not take into account contextual complexities such as settings, regional definitions of RI or legislations specific to each country, all of which might represent additional factors that directly or indirectly have a bearing on patients' preferences (Steinert et al., 2005).

Another aspect of the variation in this review results of patients' ranking of preferences relates to factors associated with the application of RI and patient characteristics. It appears, from the thematic analysis in this review, that 'environmental changes' and 'communication' are important aspects that contribute to the basis for patients' preferences among RI. 'Environmental changes', such as access to personal items, being able to self-regulate room temperature, bathroom facilities and getting fresh air, were factors that influenced patients' preferences during seclusion. Similarly, a review by Aguilera-Serrano et al. (2018) states that the physical environment on the wards is an influential factor in the subjective experience of coercive measures, in general. Khatib et al. (2018) mentioned the role of staff in creating a safe environment is characterised by attending to the patients' wellbeing, making sure that the room temperature is suitable, and that the room is well ventilated. Former studies found that patients have experiences of being punished instead of treated with care, which influences the therapeutic relationship (Aguilera-Serrano et al., 2018), possibly leading to longer inpatient stays and maybe even more coercion. It seems obvious that fresh air and regulation of temperature are needs that should be fulfilled to uphold human rights, make seclusion less restrictive and intrusive, and for patients to feel safe and cared for, instead of punished, regardless of the fact that they are being deprived of their freedom. These environmental aspects, for example, poor ventilation, could perhaps explain why there are some patients who prefer MR to seclusion.

For seclusion, manual restraint and MR, communication with staff and family during the intervention was a factor preferred by patients, to make the experience of the intervention more acceptable and humane. This was also found by Aguilera-Serrano et al. (2018), who stated that patients' subjective experience of coercive measures was influenced by staff providing information and being present during the intervention (Aguilera-Serrano et al., 2018). Likewise, other studies have concluded that patients

express the need for face-to-face interaction in close proximity to the RI or as a means of de-escalating, to alleviate the negative experience and contribute to restoration of trust between patient and staff (Aguilera-Serrano et al., 2018; Ezeobele et al., 2014; Khatib et al., 2018; Van Der Merwe et al., 2013). Other factors that influence patients' RI preferences were for the intervention to be of short duration. Two recent studies also found that time is relevant, singling out duration to be a factor of importance in patients' attitudes towards RI (Gleerup et al., 2019; Khatib et al., 2018). Gleerup et al. (2019) stated that, because MR was of short duration, for some patients it was their preferred RI. Increased regularity of assessment is found to decrease the duration of MR episodes (Allen et al., 2020). Further research is needed regarding assessment tools and decreasing the duration of seclusion. If staff could integrate better communication and ensure the shortest duration of RI, patients will have a less intrusive and restrictive experience, as the environment would be more humane. This would dignify and improve treatment within mental health care when RI are deemed necessary. Preferences relating to duration, environment and communication only add further to the complexity of measuring patients' ranking preferences regarding RI.

Of the nine included studies that investigated age or gender as possible influential characteristics on patients' preferences, most did not find significant differences. This reinforces the suggestion that RI preferences do not relate to pre-defined patient characteristics, but seems to be a matter of individual preferences relating to the patients' needs and personal history. However, the small quantity of eligible literature reporting on this area warrants further research. For example, patients' gender and the gender of staff undertaking the RI could perhaps influence their ranking of RI, but it is unclear how or to what extent. To the best of our knowledge, the abovementioned findings have not been documented elsewhere.

We have reported ambiguities in the data regarding patients' RI preferences being influenced by patients' former RI experience or if patients had no RI experience. Two of the included studies found a general disapproval of all RI among patients with RI experience, which is in line with the findings of a previous study by Brady et al. (2017), but contrasts with Hui et al. (2016) who found that patients with RI experience were more approving of RI than were patients with no RI experience. Georgieva, Mulder, and Wierdsma (2012) explain the difference in preferences with regard to legislation, that is, that in countries where, seclusion is legal, this would be the preferred intervention. In some cases, this might help explain why some patients lean towards interventions like MR, which objectively are seen as more restrictive and intrusive. On the other hand, these findings also highlight the difficulties in comparing RI research across countries since there are considerable variations in legislation as well as variations in cultures and traditions within each country's health services, the clinical practice within individual hospitals and wards (Bak & Aggernaes, 2012; Bowers et al., 2004; Fernández-Costa et al., 2020; Jacobsen, 2012; Laiho et al., 2016; O'Donovan et al., 2023; Wynaden et al., 2002). The variability in clinical practice, coupled with differences in international legislation,



makes it complex to develop standardised guidelines for the use of RI (Fernández-Costa et al., 2020) as well as standardised ways to investigate preferences and development of a global hierarchy of patients' RI preferences.

The results of this review may offer more questions than answers. For instance, considering the tendency that the majority of patients prefer seclusion over MR, should MR then be abolished because it seems to be the least preferred by the majority of patients and therefore likely to be viewed as the most intrusive RI? If the majority of patients prefer seclusion to MR, countries such as Denmark, where seclusion is against the law, might consider reevaluating their policy on RI. An option could be to make seclusion legal as an RI alternative to MR. However, on the one hand, if we are talking about reducing or abolishing RI, it would not make sense to add even more types of RI. On the other hand, if a patient is seriously self-harming, then seclusion do not seem like a good solution; in that case, MR could be the preferred intervention. This discussion should, of course, be seen in the light of the guidance that RI should only be used as a last resort, to keep patients safe from harming themselves or others. Finally, even though RI is used within the law, exhaustive ethical consideration of the patient's right to self-determination and human rights should be evaluated in determining the extent to which these interventions should be used (O'Donovan et al., 2023).

## 5 | STRENGTHS AND LIMITATIONS

This review used the integrative review approach (Remington & Toronto, 2020; Whitemore & Knafl, 2005), allowing for the inclusion of diverse types of research. However, sources other than research articles, such as book chapters, conference abstracts and mental health authorities' reports, did not contain patients' perceptions, and were therefore excluded. It was a strength to include both qualitative and quantitative research, including three PhD theses, because this variety provided a broader perspective on the subject. However, this, combined with the complexity and varying quality of the included studies' results, makes it difficult to reach a uniform conclusion.

The inclusion of low-quality studies was also a limitation, and findings were not weighted with consideration to quality. One third of the studies had a risk of non-response bias, for example, missing response rates. This unfortunately led to the limited strength of the conclusion. However, including the studies of lower quality allowed us to show the complexity within the field and broaden the perspective of factors influencing patients' preferences.

Some studies directly asked patients for their preferences, while other studies asked about acceptance or the degree of restrictiveness. The RI that patients found least restrictive in this review were interpreted as the preferred RI. Since thematic analysis was used, the results were a human interpretations and construction of meaning (Gildberg, Bradley, et al., 2015; Gildberg & Wilson, 2023), yet it made it possible to rigorously and transparently account for themes and sub-themes.

Some of the factors that influenced patients' preferences were presented in only a few of the studies, rendering thin descriptions.

Others, such as environment and communication, are of broad representation across several studies. This means that it is evident that findings related to short duration, environmental changes and communication influence patients' preferences regarding RI.

## 6 | CONCLUSION AND IMPLICATIONS FOR PRACTICE

This integrative review underlines that patient RI preferences is a subjective matter that is complex and difficult to measure. The findings suggest that in very broad terms, patients tend to prefer observation rather than MR, seclusion, manual restraint and rapid tranquilisation. MR seems to be the least preferred intervention. However, the current state of evidence does not support an unambiguous conclusion as to patients' RI preferences. Factors such as the seclusion room environment and staff communicating during the application of the intervention appear to support more positive patient perception of RI, making the experience less intrusive and restrictive. We should bear in mind that the review results show only the preferences of the majority, and that there are patients who, for example, prefer MR over the other objectively less restrictive and intrusive interventions. However, in these findings there appears to be a hierarchy of preferences which clinicians and policy makers should be aware of.

One of the things that was not within the scope of this review are the circumstances leading to the use of RI. Further investigations could examine patients' preferences in relation to the patients' behaviour leading to the use of RI, looking into which RI are 'preferred' or appropriate for various aggressive or violent behaviour, such as violence against furniture, violence against staff and patients, breaking house rules or self-harm.

Another gap in the literature is user involvement, which was not mentioned in any of the 30 included studies. Some of the included studies were conducted before the service user involvement in research was put on the research agenda. Including service user involvement in future research regarding RI and patients' perceptions of what is least restrictive and intrusive is recommended.

In the future, governments, mental health authorities, researchers and mental health professionals should at least consider finding a way to make uniform and clear definitions of each RI, and to consider all aspects surrounding the RI experience when investigating patients' RI preferences, as well as looking further into the phenomenon of the LRA. This might make it easier for future researchers to investigate these subjects and phenomena.

## 7 | RELEVANCE STATEMENT

Several countries are subject to legislation regarding the least restrictive alternative principle. The principle implies using the least restrictive intervention but lacks specificity. The lack of specificity makes it difficult for mental health staff to adhere to and implement this principle into practice. Therefore, this review presents an

unspoken hierarchy of patients' preferences regarding restrictive interventions. The results show that factors such as improved communication and the environment surrounding restrictive interventions influence how restrictive patients perceive these interventions. The review's findings may help inform psychiatric staff about patients' preferences for less restrictive interventions.

## AUTHOR CONTRIBUTIONS

Camilla Rosendal Lindekilde, Martin Loch Pedersen, Søren Fryd Birkeland, Jacob Hvidhjelm, John Baker and Frederik Alkier Gildberg were all involved in conception and design, critical revision of the article content and final approval of the version to be published. Camilla Rosendal Lindekilde and Martin Loch Pedersen were involved in data collection. Camilla Rosendal Lindekilde and John Baker were involved in matrix development. Camilla Rosendal Lindekilde and Frederik Alkier Gildberg were involved in the analyses. Camilla Rosendal Lindekilde were lead on interpretation of results and writing the article.

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## DATA AVAILABILITY STATEMENT

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

## ETHICAL APPROVAL

The data used in this study are based on former empirical research, and therefore, no ethical approval is required.

## ORCID

Camilla Rosendal Lindekilde  <https://orcid.org/0000-0001-6165-7792>

Martin Loch Pedersen  <https://orcid.org/0000-0003-3620-3523>

Søren Fryd Birkeland  <https://orcid.org/0000-0001-7857-3181>

Jacob Hvidhjelm  <https://orcid.org/0000-0002-9495-9786>

John Baker  <https://orcid.org/0000-0001-9985-9875>

Frederik Alkier Gildberg  <https://orcid.org/0000-0001-9075-6108>

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