



Advocacy in mental health nursing: an integrative review of the literature

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The term ‘advocacy’ has taken on a meaning beyond its legal origins and is now of importance as a concept in health and social care. Within nursing, the role of advocate has been accepted as an important one, although there are arguments against nurses taking on such a role. The majority of papers on this topic relate to nursing generically rather than being specifically mental health oriented. Nurses need to be made aware of the legal framework within which they practice, in terms of duty of care within their role of nurse advocate, maintaining standards of advocacy acceptable to their professional body, accountability relating to action and omission of actions, guidance on guarding against stepping beyond the boundaries of their professional practice of advocacy, and to have adequate knowledge of the law. This paper offers a critique of nursing advocacy models, raising a number of mental health nursing issues and identifying some areas for further research.

Keywords: advocacy, mental health nursing

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Introduction

Advocacy, a legal term meaning to plead on behalf of another (Wheeler 2000), now has an importance in the context of health and social care, having relevance to issues of minority status, poverty, disability and mental ill health (Bateman 1995, McNally 1995). It is notable that outside social and health services other non-legal groups have defined themselves as advocates, including those who advocate for general human, children’s, minority and animal rights (Davis *et al.* 2003).

In recent years, client advocacy, along with empowerment and rights, has become a fundamental concept within healthcare reforms and policies across many countries (Segesten 1993). As a core value in international nursing dominated by western nursing concepts and theories (Davis *et al.* 2003), advocacy has gained prominence in the Asia-Pacific region, Europe and North America (Leong & Euller-Ziegler 2004), with clients’ rights being given promi-

nence in both healthcare reform policies and legislation (Davis *et al.* 2003). Such reforms reflect a transformation of clients’ rights in the light of contemporary moves towards empowerment and consumer pre-eminence (Breeding & de Sales 2002, Hellwig *et al.* 2003). With international healthcare reforms emphasizing human rights, the salience of advocacy in nursing has increased. This paper, largely derived from a PhD study on advocacy in mental health nursing (Jugessur 2001), but since updated, explores the concept of advocacy in nursing and analyses a number of nursing advocacy models. A critique is offered in respect of the generalizability of such models to mental health nursing and areas for further research are identified.

Definition of advocacy

The root of the word advocacy can be traced to the 14th century French ‘Advocacie’ meaning ‘pleading for or

supporting' (Oxford English Dictionary 1989). The term advocate originated from the Latin 'Vocare' meaning 'to call' or Latin 'Advocatus' meaning 'one who is summoned to give evidence' (Breeding & de Sales 2002). The role of advocacy originated in the legal system where lawyers spoke on behalf of their clients in court, and this can be seen as involving verbal acts of persuasion and justified arguments (Dunning 1995, Grace 2001), further, defining advocacy as stating a case to influence decisions, getting better services, being treated equally, being included, being protected from abuse, redressing the balance of power and becoming more aware of and exercising rights. This definition is applicable to courtroom situations as well as those that exist when people are vulnerable, young, disabled, homeless, or are otherwise not able to defend themselves. The review indicated that advocacy can also be interpreted as a skill that ordinary people and professionals use to help others and is utilized by many non-legal professionals such as nurses, teachers, probation officers, social workers, doctors and indeed ordinary members of society. In this sense, the aim of advocacy is to empower the powerless and give people a voice to challenge injustice (Bateman 1995).

Types of advocacy

A literature review highlighted several forms of advocacy but these were not always clearly differentiated. Butler *et al.* (1988) and Sang & O'Brien (1984) defined the different forms as: professional advocacy, citizen advocacy, self-advocacy and collective or class advocacy. MIND (1992), however, identified only three main forms of advocacy: citizen, self and legal. In recent years, public health and media advocacy have been emerging in a very prominent fashion. In this new domain, professionals such as doctors work closely with the media to improve public health in events such as national non-smoking days and mental illness awareness days (Bateman 1995). In the following sections, self and citizen advocacy will be discussed followed by a more detailed exploration of professional advocacy.

Citizen advocacy

Citizen advocacy, sometimes called lay advocacy and occasionally independent advocacy or volunteer advocacy, is a process through which concerned citizens enter into relationships with, and advocate for, other citizens who are experiencing difficulties or who are otherwise disadvantaged (Sang & O'Brien 1984). Bateman (1995) argued that despite its inception in 1966 in the USA, citizen advocacy is relatively underdeveloped in the UK, and therefore, there are various definitions of it. For example, Williams &

Schoultz (1982) described citizen advocacy as a movement which endeavours to establish systems which will represent and safeguard the rights and interests of individuals who are disadvantaged and have difficulty in representing their own interests effectively in society. Others such as Butler & Forrest (1990) state that one-to-one relationship is central to citizen advocacy and that this enables advocates to use their time and energy in improving the lives of a particular individual whether on a formal or informal basis. Wolfensberger (1983) promotes citizen advocacy by calling for advocacy to be available to people who are devalued and disadvantaged. Many schemes based on this model of advocacy have been developed and exist to support vulnerable patient groups (Sang & O'Brien 1984). These models are independent of healthcare institutions and employ independent advocacy workers to facilitate and support the scheme (Mallik 1997a), with advocacy workers offering their services on a voluntary basis. Similarly, patient representatives have been introduced into the healthcare systems in both the USA and the UK as paid professionals. In the UK, the National Health Service (NHS) gives authority to the patient representatives to investigate patient/client concerns and complaints in hospitals, independently from the ward staff. This reflects the growing demands of the public for rights within the healthcare system (Starr 1982, Mallik 1997a).

Sang & O'Brien (1987) propose that the purpose of citizen advocacy is to identify and meet the instrumental and expressive needs of vulnerable citizens through befriending individuals. Fulfilment of instrumental needs ensures that people receive the services and entitlements (accommodation, welfare benefits, voting rights and access to shops and special care) which should enable them to lead a reasonable life and achieve full citizenship. Fulfilling expressive needs such as friendship, companionship, warmth, affection, attention, love, communication and identity is achieved through relationship with others. Williams & Schoultz (1982) stated that those who live in custodial care and institutional care are often starved of friendship. Therefore, citizen advocacy means not only building relationship with isolated persons but also engaging in a diverse range of activities together with clients and working towards constructive change towards independence, a strategy used in many rehabilitation wards and units today. Williams & Schoultz (1982) further argue that the citizen advocate role entails not only befriending individual residents within the context of a hospital but also opening up possibilities for the wide range of expressive relationships which most people experience in the community. Bateman (1995) confirmed that in the UK the Disabled Persons Act (1986) gives disabled people a legal right to have a representative, thus giving a boost to citizen advo-

cacy. However, Philpot (1993) argued that there are concerns about the costs of advocates, which can have the effect of increasing pressure on spending. This is clearly an issue for health and social welfare services whether public or independently provided.

Self-advocacy

The literature on self-advocacy concentrates on the learning of self-advocacy skills by people who are perceived as not being proficient in them. Self-advocacy involves people asserting their own rights, expressing their needs and assuming their duties of citizenships to the extent of their capabilities. To this extent, self-advocacy can be regarded as potentially providing a context for empowerment to be acted out (Goodley 1997). Sang & O'Brien (1987) state that the aim of self-advocacy is to counteract the deadening effect of other people always making decisions on one's behalf, in particular for those who are disadvantaged. For example, trade unions were influential in formulating proposals for a comprehensive UK health system in the 1940s, which led to the Beveridge Report in 1942 (Bateman 1995). Another example has its origin in the women's movements in 1960s and 1970s in the USA and the UK where the aim was to remove the effects of discrimination and oppression caused by sexism in society (Sang & O'Brien 1987). Such actions have much in common with the actions of the civil rights movements in the USA in the 1960s in which self-advocacy was seen as a means through which disadvantaged people obtained their rights. Butler *et al.* (1988) state that self-advocacy requires people to value themselves and to take positive action to challenge their devalued status in the eyes of the wider society. Williams & Schoultz (1982) argued that self-advocacy achieves this through the development of skills and knowledge and using them to achieve many choices as one can. Sang & O'Brien (1984) highlighted situations where people using mental health and learning disability services have carried out collective self-advocacy successfully. The first conference of the Campaign for Mentally Handicapped People, Our Life took place in 1972 in Oxford. A number of hospitals, local authorities and voluntary organizations sent delegates who had intellectual disability, either alone or accompanied by staff. Since then, yearly conferences have been organized, with titles including 'Participation with Mentally Handicapped People' (1974) and 'Working Out' (1975). Further examples of collective advocacy include the Nottingham-based 'Advocacy in Action' (Small 1991) which challenged practices that restrict the lifestyle of people with intellectual disability and MIND which became the main voluntary organization campaigning to promote the rights and best interests of people with mental

health problems. There are now 200 local MIND Groups in the UK. Williams & Schoultz (1982) argued that specific developments that have provided the foundation for the rapid growth of self-advocacy by people with intellectual disability and those with mental health problems have been deinstitutionalization, the articulation and the application of the philosophy of normalization (Bank-Mikkelsen 1969, Nirje 1969) and social role valorization (Wolfensberger 1983, 1991, 2000) and the growth of the concept of advocacy in general. This became a key concept at the heart of the UK NHS and Community Care Act (Department of Health 1990). The user and consumer groups now form part of NHS policy drive towards better services for the public. Both citizen and self-advocacy involve members of the general public practising advocacy.

Professional and legal advocacy

While the two forms of advocacy described above involve members of the general public, professional advocacy has clear distinguishing features. It emerges in varying forms in the legal, social work, medical and nursing professions. The most widely recognized professional advocacy is legal advocacy which has been practised since the days of Graeco-Roman scholars and is still claimed to be the forte of lawyers. It is based on the principle that lawyers have a principal responsibility and duty to act for the best interest of their clients (Grace 2001). Legal advocacy is the act of putting one's case in a most persuasive manner, involving presentation of relevant facts and principles of law so arranged as to have maximum impact on the mind of the audience, designed to attract a favourable decision (Wilson 1979). This form of advocacy is concerned with establishing peoples' rights by defending their conduct. It is unlike the two forms of advocacy discussed above, which is described by the UK organization Age Concern England (1991) as being the process of empowerment. Provisions of legal representation exist in all areas of law, including criminal, civil, human rights, employment, immigration, consumer and mental health law.

Advocacy in nursing

During the past two decades, the concept of advocacy has gained more prominence in practice (O'Connor & Kelly 2005). The International Council of Nurses calls on nursing to promote advocacy as a key role (International Council of Nurses 2000). This has been taken up by nursing regulatory bodies internationally (UK, USA, Canada, Australia and many European countries) and incorporated into their codes of conduct (Kubsch *et al.* 2004).

Following the publication of the *United Nations Declaration on the Rights of Disabled People* (United Nations 1971), many authors have identified advocacy as part of the role of the nurse (Kohnke 1978, 1980, 1982, Gadow 1980, 1990, Becker 1986, Copp 1986, Curtin 1988). It was accepted in the UK [United Kingdom Central Council (UKCC), now the Nursing Midwifery Council] in 1996 and similarly adopted in the USA, Canada and Australia (Breirer-Mackie 2001).

Nursing advocacy has a number of differences from legal, citizen and self-advocacy. Legal representatives have responsibilities to their clients above all else; citizen advocates speak up for other persons and self-advocates for themselves. The nurse must have due regard to all those persons within their care (Grace 2001, MacDonald 2006), and when advocating on behalf of another, must take account of the wider implications this may have.

In health care, advocacy seems to be mainly linked to vulnerable clients, who due to ill health are unable to make their concerns known to the healthcare professionals. However, the most significant demand for advocacy in the USA has been a combination of the failure of hospital care system to meet patients' needs and a strong emphasis on human rights. Similar views were expressed in the UK stating that advocacy was needed because of serious errors and mistakes arising from judgement made by professionals, resulting in a lack of confidence in the healthcare system (Patient Safety Agency 2004).

Nursing involves contact with people who are often unable to exercise their autonomy due to vulnerability arising from age, illness and disability, including intellectual disability and mental ill health (Kraft & Wilson 1988, Gadow 1989). Nurses can be seen as vital links between vulnerable patients and their families and the decision-making process by acting as advocates to optimize the patients' autonomy (Mallik 1997b, Wheeler 2000). Autonomy in this context can be taken to mean patients being given information regarding options and choices relating to care and treatment (Hewitt 2002) and being able to make rational decisions (Mappes & Zembaty 1986). As patients' advocates, nurses can be expected to take appropriate action regarding incompetent, unethical or illegal practice by any member of a healthcare team or the healthcare system and any action on the part of relatives that places the rights or best interests of clients in jeopardy. This suggests that as the concept of advocacy has developed, nurses' loyalty has shifted from the institution and the doctor/physician to the patient or client (Blackmore 2001). However, full implementation of advocacy still meets various barriers, particularly the perception that nurses owe greater loyalty to physicians (MacDonald 2006) and their employers (Morgan 1994) than to patients.

Although the recognition of such barriers has been examined in the literature (Hewitt 2002, Hyland 2002, Rodney *et al.* 2002), no concrete guidance or solutions are offered in dealing with these.

Mallik (1998) and Hewitt (2002) suggest nurse advocacy roles have increased over the past 20 years. Advocacy has been regarded as a nursing role for some time, and is seen as implicit within many nursing codes of practice (American Nurses Association 2001, Canadian Nurses Association 2002, Nursing & Midwifery Council 2002, International Council of Nurses 2006), although UK guidance for nurses working with people with intellectual disability (UKCC 1998) suggests clients could be supported more objectively by independent advocates. It could be argued that this should apply equally to clients' of mental health services.

Cahill (1994) suggests that when practising advocacy, nurses generally enter into therapeutic relationships with vulnerable patients/clients and advocate on their behalf to meet their needs, especially where the clients are unable to express concerns themselves. In such situations, nurses act as a communication bridge within the healthcare team (Jezewski 1993). Similarly, through therapeutic relationships, nurses offer clients support, friendship and attention and occupy a key position among healthcare professionals because of their close involvement with clients (Albarran 1992). There are, however, arguments and debates regarding ownership of the advocate role whether it is a unique role of the nurse or whether it applies to all healthcare professionals (Schroeter 2000).

There are arguments against nurses as advocates. For example, Bernal (1992) accuses nurses of using advocacy as a means of promoting professionalization rather than serving the best interest of the patient. Bernal's main argument is that nurses are not sufficiently free to advocate because they are constrained by the system that employs them, echoing a point made by a number of other authors (see Jenny 1979, Miller *et al.* 1983, Robinson 1985, Walsh 1985, Pullen 1995) that nurses have a duty to their employers as well as to clients. Chadwick & Todd (1992) argue that patients do not choose their nurse advocate, and as Melia (1994) suggests, nurses will always be in more powerful positions than patients, introducing a potentially paternalistic advocacy role (Woodrow 1997). Further, Gates (1994, 1995), Mallik (1997a) and Martin (1998) point out that nurses take considerable personal and professional risks when taking on this role. Martin (1998) suggests that these risks can include: (1) loss of respect and being made a scapegoat by colleagues and other members of the healthcare team; (2) stress, moral distress and frustration leading to sickness, especially when attempts at advocacy are unsuccessful; (3) being labelled 'trouble-

maker' and being relocated to other wards or departments; and (4) loss of jobs if they are regarded as whistle-blowing.

As Dimond (2005) notes, acting as advocates can bring nurses into conflict with patients, relatives, their employer, the profession and the public. Mardell (1996) argues that over the years nursing has been littered with casualties of advocacy conflict, and the case of Graham Pink, a 'whistle-blower' over poor standards of elderly care in Britain suitably, illustrates this (Turner 1993). Given such potentially negative implications for nurse advocacy, it is perhaps important that the nurse advocate works within the context of a supportive organization and with good relationships with management and the multidisciplinary team.

In Britain, informed choices and informed treatment have been enhanced and strengthened by various policies and legislations over the last 20 years, such as Mental Health Act (Department of Health 1983), NHS and Community Care Act (Department of Health 1990), The Patient's Charter (Department of Health 1991), the Data Protection Act (1998) and the Human Rights Act (1998). In the UK since January 2005, members of the public have been able to access details held by public bodies including the NHS, under the Freedom of Information Act (2000). Other recent changes in healthcare policy have led to the introduction of clinical governance, a framework through which UK health services are accountable for improving the quality of services. Under such a policy, NHS Trusts must provide patients with opportunities for involvement in decision-making about their care and clear channels through which to voice their concerns and complaints. Nurses need to be aware of their legal obligations and be ready to change practice accordingly.

Models of client advocacy in nursing

Curtin (1979) supports advocacy as a philosophical foundation for nursing. Her argument is based on the belief that every human being is entitled to certain human rights because they are born as humans and that the end purpose of nursing is to assist with the welfare of other individuals, i.e. 'human advocacy'. This philosophy, which is deeply rooted in *European Convention on Human Rights and Its Five Protocols* (Council of Europe 1950), is echoed in the UK Human Rights Act (1998) and firmly supported by the British nursing professional body (UKCC 1992, Nursing & Midwifery Council 2002), and advocacy is one of the core competencies required of a registered nurse in Australia (Australian Nursing Council 2002). As a foundation for the nurse-patient relationship, nurses should develop one-to-one relationships with clients with advocacy thus taking a more individualistic perspective. Curtin (1979) depicts nursing as a 'moral art', which emphasizes the common

interests of nurses and patients/clients in attaining freedom for the patients to achieve their own desired goals. Nurses undertaking the advocacy role should create an atmosphere that is open to and supportive of the individual patient's decision-making.

Gadow (1980) proposes a theory of 'existential advocacy', a philosophical model of nurse advocacy based on a humanistic theory of nursing. This is seen as an integrated part of the nursing role (Hewitt 2002) involving the nurse working in partnership with the patient as a means of enhancing the patient's autonomy. The nurse's role is to explain information, help analyse and interpret alternatives and choices and assist in clarifying the patient's beliefs and values and developing understandings. Patients are thus enabled to become more self-determining and are given the freedom to make more informed decisions about their care.

Kohnke (1982) offers a model based on the patient's rights to self-determination, with a view of individuals having a right to self-determination and the nurse advocate role being to inform and support the patient so that the latter is able to make informed choices about care and treatment, risks and possible consequences. This model, which shows respect for the patient's ability to make decisions based on informed choices, is geared towards patient empowerment and independence, moving away from paternalistic care and bureaucracy that restricts the self-determination of service users.

Advocacy models analysis

Patient advocacy models put forward by Curtin (1979), Gadow (1980) and Kohnke (1982) primarily address issues of nursing of physically ill persons and therefore not necessarily wholly appropriate to mental health. The arguments for promoting nurse advocacy come from two perspectives, one of moral and ethical concerns (UKCC 1989, 1992, 1996) and the other to avoid and redress professional errors (Morgan 1994). However, the future of nurse advocacy may change in Britain, particularly in relation to nurses' legal duty of care under the UK Human Rights Act (1998). Nurses have to consider the clients' best interests in all aspects of care including, representing them, speaking for them if capacity is lacking and either making or helping in decision-making about care. However, Gaylord & Grace (1995) indicate that not all nurses possess the characteristics necessary for the defence of client's rights, which requires an understanding of what those rights are and the capacity to address the system that infringes such rights.

Curtin (1979) sees the nurse's role as one of providing support for the client's decision-making, while Gadow (1980) argues that only the client can decide on what is in

his/her best interests. However, in mental health nursing, many patients experienced confusion and delusions may have little insight into their illness, and can become violent and aggressive. The decisions that they make may not only be dangerous to them but also dangerous to the wider public. In such cases a conflict of interest arises between clients' rights to autonomy and the nurse's legal and professional duty of care. The nurse may decide that it will be in the clients' best interests to use persuasion and negotiation to obtain cooperation and prevent harm to the client or others. This could lead to accusations of paternalistic behaviour (Hyland 2002); however, applying Kohnke's model of advocacy and accepting the client's dangerous or irrational decisions could lead to a charge of negligence due to a failure of duty of care. Logically, a seemingly paternalistic practice might be the best option, albeit one could be argued as against the principle of advocacy.

Both Gadow's (1980) and Kohnke's (1982) arguments that advocacy can be practised effectively are only fully justifiable where clients have the capacity to make a decision. However, they do not present nurses with answers to how to deal with difficult situations such as advocating for a silent client suffering from dementia or severe depression. Clients suffering from mental illness are not always able to communicate effectively or make rational decisions. Nurses, in these situations, practice a form of citizen advocacy where they represent and safeguard the client's best interests. In such circumstance nurses can become quite subjective in providing what they believe is in the client's best interests. In certain circumstances this may be addressed by use of psychiatric advance directives (Srebnik *et al.* 2003).

Conclusion

Little research has been undertaken on the role of nurse advocates in mental health. Between 1980 and 1997, a number of research studies explored directly the advocacy role of US and UK nurses (Sandroff 1981, Aroba 1990, Romaniuk 1990, Cole 1991, Fetsch 1991, Snowball 1996, Mallik 1997b, 1998). The introduction of advocacy as part of the nurse's role appeared in the nursing literature in the 1970s and was defined by many theorists (e.g. Curtin, Gadow and Kohnke) as the art of nursing, and was connected to humanistic and ethical approaches to empowerment. According to these models, client choice was seen as paramount and it was the nurse's role to aid the exercising of autonomy. It could be argued, however, that nurses' adoption of the advocate role has been as much to do with enhancing their own professional standing (Bernal 1992) as with empowerment and safeguarding clients' rights (Mallik 1997a, Wheeler 2000). Further, that claiming advocacy as

part of the 'unique role of the nurse' could be seen as an attempt to hijack the concept for their own benefit. It is questionable whether nurses really are in the best position to act as clients' advocates.

Although nurses regulating bodies internationally have requested nurses to act as clients' advocates, there is a lack of legal protection for this role (Martin 1998). Furthermore, the concept of advocacy is littered with dilemmas, conflicts, confusion and risks, but very few articles have analysed the legal implications and repercussions of the role for nurses. There would appear to be considerable scope for studies addressing the implications of these problems. Nurses need to be made aware of the legal framework within which they practice, in terms of duty of care within their role of nurse advocate, maintaining standards of advocacy acceptable to their professional body, accountability relating to action and omission of actions, guidance on guarding against stepping beyond the boundaries of their professional practice of advocacy, and to have adequate knowledge of the law. Effective dissemination of the above information to nurses is paramount if the level of risks associated with the advocacy role is to be reduced.

In light of the above, one could argue that the nurse establishment has failed to define advocacy explicitly as part of the role of the nurse and has failed to give nurses a clear framework of accountability within which to practice (Pullen 1995). This failure to create a universal definition and understanding has led nurses to practice advocacy based on their own individual interpretations with little recognition of the skills, knowledge and support required to perform the role effectively (Bennett 1999). In so doing, nurses risk finding themselves in conflict with managers and other professionals, due to institutional paternalism and medical dominance. The nurse is likely to be torn between a loyalty to the employer and a loyalty to the client, and pursuing the advocacy role to a point of potential conflict with the employer could lead to disciplinary action. One could strongly argue that nursing and midwifery organizations owe a duty of care to nurses, to provide them with an established definition of advocacy within which to work and to provide them with a legal framework of accountability within which to practice advocacy 'safely'. One question that comes to mind is whether or not it is morally, and more important, legally right for nurses to be exposed to and experience considerable personal and professional risks in advocating on behalf of patients. That regulating bodies offer little more than vague professional guidance regarding advocacy should be of concern to nurses.

Much of the advocacy literature (including this paper) does not offer practical guidance on the practice of nurse advocacy nor recommendations about organizational

changes that would support this practice. Empirical work that exists targets specialist groups like children's nursing, medical and surgical nursing but very few in the field of mental health nursing. This is an interesting point to note because although nurses started to claim the role of patient advocate as part of their expertise during the 1970s (Gadow 1980), the role of advocacy was first brought into the field of mental health and intellectual disability nursing during the 1960s.

Leaving aside the study by Cole (1991), a major omission from the published literature is accounts of patients' experiences of nurse advocacy. This suggests some considerable scope for future research. While outside the scope of this paper, it is worth noting that there is a considerable body of literature on the topic of self-advocacy for people with intellectual disability, including those where self-advocates are writing of their experiences (see Drage & McNally 1995), yet this does not seem to exist for those receiving services from other branches of nursing, including that of mental health. While there are clearly a number of issues relating to people with mental health problems advocating for themselves within the context of people with intellectual disability, it is generally accepted that collective advocacy is for themselves, but also on behalf of others with intellectual disability (Simons 1995), and still constitutes a practice of self-advocacy. Such concepts seem not to have arisen in mental health nursing to date.

It would be appropriate for future studies to help determine a clearly relevant model of nurse advocacy in mental health nursing and for the voice of those people who have used or are using mental health services to offer some insight into their experiences.

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