

Former inpatients' narratives of substance use four years after substance use disorder treatment: A qualitative follow-up study

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Abstract

Aim: The aim of this study was to explore the narratives of former substance use disorder (SUD) inpatients about substance use after their discharge from long-term SUD treatment in 2017. **Method:** We conducted semi-structured in-depth interviews with 11 former inpatients of SUD treatment. The data were analysed using a qualitative, thematic analysis model. **Findings:** During the analysis, two main themes emerged pertaining to participant reflections on substance use – their experience of *non-problematic substance use* (that is, substance use without declining into pre-treatment levels of misuse behaviours) and *problematic substance use* (that is, substance use associated with destructive patterns). All participants except one had engaged in substance use after their discharge three to four years ago. The commonly used substance was alcohol, which also appeared to be the most common substance for which there was consensus among the informants regarding non-problematic use. **Conclusions:** Most of the participants continued to use substances in some way, and some reported that such use did not affect them negatively. Healthcare providers and therapists in SUD treatment should avoid defining a relapse or failed treatment outcome in concrete terms. What is perceived as an actual relapse or a failed treatment outcome is highly subjective. Furthermore, complete sobriety might not necessarily be the best or the

Submitted: 22 February 2021; accepted: 17 September 2021

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only way to measure the SUD treatment stay. An improvement in the quality of life and well-being, even when core symptoms are still present, may be considered a successful treatment outcome.

Keywords

follow-up study, qualitative method, relapse/lapse, substance use disorders, treatment outcomes

Substance use disorders (SUDs) were originally conceptualised as moral, spiritual, medical, psychological, and social problems, with a clear focus on the moral and spiritual components (Westermeyer, 2013). However, at present, SUD is widely regarded as a multifaceted health problem caused by biological, psychological, personal, cognitive, social, cultural, and environmental factors. The main difference is that professionals do not consider the moral and spiritual components as a variable for the disorder (Hole, 2014; Skewes & Gonzalez, 2013). This approach to studying SUDs based on the biopsychosocial model (Engel, 1977; World Health Organization, 2008) fosters a more holistic understanding of this condition and its treatment. The concrete symptoms of SUD include the following:

A desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals. (World Health Organization, 2021, pp. 60–70).

The primary objectives of long-term treatment for SUDs include a perceived improvement in the quality of life and the complete cessation of substance use during the treatment period and after discharge (Kelly & White, 2011; Laudet, 2007). Further, long-term treatment for SUDs aims to reinforce personal routines and structures and address challenges regarding mental, physical, and social health.

The provisions for the treatment of SUDs have been specified in the Norwegian Municipal Health Care Act (The Norwegian

Directorate of Health, 2015) within a specialised health service. The objective is to provide interdisciplinary treatment services, including social, psychological, and medical services. Because of the Act of Patient and User Rights (§ 2-1b) (Pasient- og brukerrettighetsloven, 1999), persons with SUDs have the same rights as other patients within the specialised health services system (The Norwegian Ministry of Health and Care Services, 2004). The treatment package includes 24-hour treatment in an emergency unit, short- and long-term inpatient treatment, and outpatient treatment.

Approximately 30–40% of inpatients who receive long-term SUD treatment drop out during the treatment period (Andersson et al., 2019; Lappan et al., 2020; Nordheim et al., 2018). A dropout is a patient who has not completed the planned treatment programme. Qualitative findings suggest that drug cravings, negative emotions, a lack of personal contact, and the absence of activity cause patients to drop out (Nordheim et al., 2018; Palmer et al., 2009). These findings underscore the complexity of SUDs and the struggles that people face when trying to stop using substances.

The relapse rate appears to be high among the former SUD patients. Researchers have distinguished between *relapses* and *lapses*. “Relapse” is defined as the recurrence of SUD symptoms after a period of reduced or total cessation of substance use (Dawson et al., 2007; Hendershot et al., 2011; Steckler et al., 2013). In contrast, a “lapse” is defined as an initial phase that can eventually lead to problematic behaviours associated with substance use or a single episode of substance use. In other words, during a lapse, an individual may have a drink or smoke a joint, but these events do not lead

to pre-quitting levels of problematic use behaviours (Gossop et al., 2002; Steckler et al., 2013).

Relapses are common indicators of SUD treatment outcomes. Some studies address differences in prevalence rates for relapse between concrete substances, whereas studies that are more general group substances into illicit drugs or alcohol or both. According to a three-month follow-up study conducted on former SUD inpatients in Norway, 37% ($N = 374$) had experienced a relapse (Andersson et al., 2019). A six-year follow-up study conducted on former SUD inpatients in Norway revealed that 70% ($N = 287$) had experienced drug- or alcohol-related problems during the year preceding the follow up (Landheim et al., 2006).

In Norway, SUD treatment has traditionally focused on the complete cessation of substance use among patients, and some treatments still do so to a certain extent. However, over the last two to three decades, the focus has gradually shifted toward harm reduction and improved quality of life during treatment and after discharge (Olsen, 2019; Skretting, 2014). Furthermore, this has generated discussions about what should be regarded as an indicator of successful treatment outcome. Is it possible to master a life situation with a substance use disorder? How do former SUD patients conceptualise relapse or problematic substance use?

Aim

The aim of this study was to explore the narratives of former SUD inpatients on substance use after discharge.

Method

This qualitative study was conducted as a part of a larger quantitative methods cohort project, the Tyrili cohort, which included 138 patients who received treatment for SUDs in seven different treatment facilities in the Tyrili Foundation (called Tyrili hereafter) in 2016 (Bergly & Sømhovd, 2018). Tyrili is a non-profit non-governmental organisation within a

specialised public-funded healthcare system. Tyrili provides long-term inpatient treatment for SUDs with a duration of 6–9 months. Tyrili has a humanistic, non-religious, and cross-disciplinary approach to its treatment. The treatment focuses on strengthening healthy social relations, mental and physical health, economy, housing, and it builds on values such as community, equality, solidarity, respect, and honesty (Wangensteen & Jansen, 2015).

When planning and starting our sub-project, we applied for approval to read and use some parts of the data from the Tyrili cohort project. This gave us information from structured short interviews with our informants when they entered their treatment stay (in 2016). Some of the information from these short interviews was presented in our findings. This mainly applies to questions about personal motivation to seek professional SUD treatment.

Participants

The participants were six women and five men aged 30–45 years, all of whom were recruited from the Tyrili cohort project. We aimed to recruit male and female participants who represented different treatment facilities within Tyrili. The gender distribution of our participants was inconsistent with that of the patient population in Tyrili (men: 75–80%). However, this did not appear to adversely affect our study or findings. Most of the participants had a story of substance use that started at the age of 12–15 years. All the informants had received treatment for SUDs related to the use of illicit drugs. They reported polysubstance use, defined as using more than one substance, either on separate occasions (sequential use) or at the same time (concurrent use) (Crummy et al., 2020). The most common substances used by the sample were amphetamine, illegally acquired pills (benzodiazepines and opiates), GHB (gamma-Hydroxybutyric acid), cannabis, and heroin. Only one of the informants had alcohol use considered to be as problematic as the use of illicit drugs.

All the participants had completed their treatment at Tyrili in 2016 and 2017. All of them had received professional support or treatment during the last four years. During the recruitment process, we contacted the participants via telephone, mail, and messenger. In addition, the therapists at Tyrili helped us get in touch with some of the participants.

Interviews

Semi-structured in-depth interviews were conducted in 2020. Four interviews were conducted over the telephone because of the coronavirus pandemic. Semi-structured interviews allow researchers to explore how individuals experience phenomena in their own “life worlds”, the world as perceived in daily life, and how situations are immediately experienced, independent of existing explanations (Kvale & Brinkmann, 2015). The participants were questioned about their treatment experiences, reflections on their treatment, their mental and physical health, critical phases after discharge, and substance use during the three or four years following treatment. By paying attention to the words they chose to use in their descriptions and reflections, we hoped to gain a deeper understanding of how each participant perceived substance use and its effect on their lives.

Data analysis

Following the deidentification of the interview transcripts, we were left with approximately 110 pages (54,150 words) of transcripts. We used a qualitative, thematic, analysis approach that makes it possible to analyse events, experiences, meanings, thoughts, and discourses (Guest et al., 2012; Silverman, 2011). We aimed to understand our informants’ stories through an inductive approach with a “bottom-up” perspective, placing the themes very close to the data themselves (Braun & Clarke, 2006; Patton, 2014). To create a system for further analysis of the data, we formed a thematic scheme of a six-step model

which consists of familiarising ourselves with the data material, generating initial codes, searching for themes, reviewing themes, defining and naming these themes, and, finally, reporting the material (Braun & Clarke, 2006; Braun et al., 2014).

Ethical considerations

This study was approved by the Norwegian Centre for Research Data (reference number: 800600). Ethical guidelines were upheld during the entire research process. We obtained written consent from all participants, except for the four individuals who were interviewed over the telephone. We read the relevant information aloud and offered to share the document by email. All the participants were anonymised. Fictitious names are used to refer to them in this article. The quotations were translated and anonymised without losing the content and meaning of the narratives.

Findings

During the analysis, two main themes emerged pertaining to participants’ narratives of substance use: their experience of *non-problematic substance use* and *problematic substance use*. Some of the participants could have been cited under both non-problematic and problematic use because of different reflections of substance use.

Non-problematic use

All the participants except one had engaged in substance use after their discharge about three to four years ago. In this section, we present participants’ descriptions of non-problematic substance use. The commonly used substance was alcohol, which also appeared to be the only substance for which there was consensus among the informants regarding non-problematic use.

In 2016, Erik (34) went for SUD treatment to control his illicit drug misuse behaviour. For several years, he constantly regulated his feelings by heavy use of illicit drugs. During this

follow-up interview, Erik reported that during the last few years, he had sometimes drunk two to three beers, often with colleagues. Drinking alcohol had never been a problem for him. Further, he reportedly possessed personal *tools* that helped him control his craving for other substances such as heroin and amphetamines, which were his preferred substances prior to SUD treatment.

I do have some personal tools and tactics ...
When I am under the influence of alcohol, I certainly avoid specific places, such as the open drug scenes in Oslo city. These places ... well ...

Erik told us that he had gained control of his economic situation, and that his life situations, including his job, his girlfriend, and three boys, were fundamental factors that helped him control his misuse behaviour that existed for 15 years.

Thomas (42) had entered SUD treatment in 2016, aiming to change his life situation and control the substance use that was causing him to spend too much money. Thomas shared the following thoughts about alcohol use:

I might drink a beer during the weekends. And, if there is a party, maybe a Christmas party with my colleagues, I drink the same way as the others.

He also shared his reflections on the possibility of using illegal substances in “controlled situations”:

I think I could have used other substances during the weekends, in controlled situations, for the rest of my life, without turning back to the life I lived before, I could have managed that ... However, this is a no-go while living with my girlfriend and our children.

Thomas described his job and his family as satisfactory and crucial for him to maintain control of his substance use.

Kristine (30) had experienced a couple of short periods of relapses when she used amphetamines and cannabis for a day or two. However, since then, she has refrained from using them for a long time. When we asked about alcohol consumption, she provided the following response:

I do not define drinking alcohol at a party as a relapse.

In 2016, she had gone for SUD treatment aiming for a life that is absent of any substances. However, she did not consider alcohol consumption in social settings a problem.

Some of the informants’ reflections were relevant to the themes of both non-problematic and problematic use. They talked about the distinctions of substances, where they problematised the use of some substances, in some situations, but considered others as non-problematic.

Helene (39) went to SUD treatment in 2016 because she feared that her lifestyle with a heavy use of substances might kill her, and she wanted to get in control of the misuse behaviour. During the interview in 2020, she did not perceive her consumption of alcohol as a problem or relapse. Her perceptions of *problematic use*, what she called relapse, first became a “reality” when she used other substances after drinking alcohol. Even though consuming alcohol caused her to use illicit substances, she did not intend to quit alcohol in social contexts. She underscored the difference between alcohol and other drugs and between non-problematic and problematic use (even within the same context).

I do drink some alcohol at the weekends, but I really never had a problem with alcohol; it’s all about having a good time with my friends. I do not drink for many days, just a party every now and then. However, there have been some episodes where the wrong people have arrived at after-parties ... And that led me into relapses, wherein I ended up using GHB.

Lars (38) described periods of what he experienced as non-problematic and problematic substance use. He was in a detoxification unit when the interview was conducted. He had completed almost two weeks of detoxification, following which he was going to move into a housing unit for individuals with SUDs. Since his discharge in 2017, he had been experiencing what he described as several relapses into heroin use, which obviously was experienced as a problematic use. Lars participated in an opiate maintenance treatment (OMT) programme and used methadone as a substitute. Because he had to frequently take urine tests as part of the OMT programme, which did not permit opioid use, his use of heroin caused periodic problems.

On the other hand, Lars reported relatively frequent cannabis use. He did not attempt to quit using cannabis because he believed that cannabis had a positive rather than a destructive effect on his life. He spoke about cannabis as a substance that was positive for him, a substance that gave him positive experiences. He referred to his use of cannabis as non-problematic, and one of his most fervent wishes for the future was the decriminalisation of cannabis use.

Cannabis is the only substance I won't quit. It is the only substance that I appreciate both the "high" and the medical effects ... I like the person I become when I smoke cannabis, unlike heroin ...

However, even though Lars was struggling with his misuse behaviour, he was optimistic about the future and believed that he would be able to quit using heroin because he perceived heroin use to be very destructive to him, that is "problematic".

Problematic use

We got to listen to participants sharing their reflections on destructive or problematic use, use that several defined as "relapse". There were different stages of relapse. Some spoke

about "a couple of days of use before stopping", whereas others reported longer durations (such as weeks or months) of heavy use before "cleaning up". Some participants reported frequent use, whereas others reported less frequent use, but all were categorised as problematic. Alcohol was also problematised in this theme.

At the time of the interview, Therese (45) had just completed her two-week stay in a detoxification unit and had moved into a stabilisation unit for a week-long stay. Therese described her post-discharge life situation as hopeless. She experienced what she described as several severe relapses, the first of which occurred immediately after discharge.

I have not managed to get rid of this misuse of substances. I am struggling with recurrent depression, feelings of hopelessness, and thoughts that life is not worth living anymore. Thoughts of just using drugs until the wallet is empty and then just dying ... for the moment, I look a bit brighter on my life, after just finishing two weeks of detoxification; that is positive.

She described relapses as follows: "going back and into the destructive patterns of heavy drinking and use of amphetamine". Consequently, she sought professional help. Even though she had managed to stay sober for a while, she reportedly faced formidable challenges because of substance use. Therese perceived alcohol consumption as a relapse. In contrast, most of the other participants considered alcohol use to be non-problematic. She believed that she must quit alcohol and amphetamines to gain control over her life and misuse behaviours. Therese hoped to build some healthy social relations during this ongoing treatment stay, and claimed this as a key factor for succeeding in getting sober.

Malin (31) had experienced what she described as several relapses into heavy alcohol and amphetamine use since discharge. Furthermore, although she had participated in different treatment programmes over the last

four years, she had not achieved sobriety until her last inpatient treatment programme, which had taken place two months before the interview. Since then, she had completely refrained from using substances.

I discharged myself from a treatment clinic a couple of months ago and have actually managed to stay away from any substance use since!

Malin had a job, was in a stable relationship, and wished to practice complete abstinence. She had no plans to use alcohol or other drugs. Malin's mother had died a year before the interview, and she was motivated to stay sober and clean for the sake of her mother's memory.

Lasse (37) had quit drinking alcohol because he felt that alcohol fuelled his craving for amphetamines, and he had completely abstained from using substances. Lasse reported that he had experienced two relapses.

It was a couple of days of using amphetamine and pills before I stopped by myself ... I thought it would be positive for me not to drink at all. I have fewer thoughts of getting high on amphetamine and pills after quitting drinking. Even though I never got drunk, I got those bad thoughts of getting high. And I do not want or need those thoughts. I do not think my brain separates between different substances, and therefore my problems with addiction were maintained.

In 2016, Thor (29) went for SUD treatment because of his many panic attacks due to heavy use of amphetamine and illegal pills such as strong benzodiazepines. After discharge, Thor experienced a couple of periods which he considered relapses, where he lost control and used amphetamines and pills.

Some time after discharge, I started to work for 12 hours a day at my new job, including four hours of traveling. It became way too

much, and suddenly, I was into heavy amphetamine use, and then pills – potent benzodiazepines.

Thor perceived this event as a relapse, and it motivated him to take significant steps toward the cessation of the use of these substances. However, Thor stated that he still enjoyed drinking alcohol.

I drink maybe four bottles of beer during the week, that's it. Sedative substances have never really been my thing, or, maybe, when I was 21–22, but not anymore. I do not consider my alcohol use now as a relapse.

Hege (30) had entered SUD treatment in 2016 with a personal motivation to start a new life absent of any substance, and to work through traumas from her childhood. At the time of the interview, Hege was still using heroin consistently. She described her use of heroin as low frequency.

I feel that I am living a "clean" life, even though I still use heroin every now and then. This is something that just happens. It is like small relapses, happens for a day or two, and then, I will stay clean for two or three weeks.

She started using heroin in her early twenties and had been participating in the OMT programme last year. She took methadone as a substitute for opiates. Her use of heroin and pills had largely decreased, but she still used them occasionally. She engaged in activities such as yoga, participated in self-help groups, and played soccer as a part of a street team. This was crucial for her to feel satisfied and build a positive self-image. According to Hege, having to test negative on urine tests to participate in the OMT programme was the biggest challenge posed by her heroin use. However, there was a sense of ambivalence in her approach to coping with substance use.

I hope that I, one day, will be without substances. However, maybe I will never just quit and stay without substances for the rest of my life, as others do. People walk different paths.

Discussion

The aim of this study was to explore the narratives of substance use among former SUD inpatients after discharge. All of the informants except one said they had continued substance use in some way after their treatment discharge in 2017. The stories of what they described as problematic substance use contained single episodes of substance use (illicit drugs), and damaging, long-lasting periods of heavy use, which led to overdoses for some. The stories of what was considered as non-problematic use contained moderate alcohol consumption, often in social settings. Some also talked about getting drunk at parties without experiencing this as problematic, and one did also define his cannabis use as completely non-problematic. A few participants decided to abstain from using any substances entirely, and they were working towards this goal at the time of the interview.

None of our informants had an alcohol disorder as a primary disorder when they applied for SUD treatment. However, some had consumed alcohol along with their preferred substances before starting the treatment, and most of them consumed alcohol after treatment discharge also. Some of these informants aimed for complete sobriety from all illicit substance use after treatment discharge, but still consumed alcohol and did not define this as problematic use, relapse, or failed treatment outcome. Even though alcohol was not their main preferred substance before entering treatment, alcohol still is one of the most common substances which is combined with illicit drugs among people with SUDs (Ives & Ghelani, 2006), and some researchers consider alcohol consumption as a risk factor for developing or

maintaining substance use disorders (Kazemi et al., 2012; Østergaard et al., 2016).

The narratives of non-problematic substance use can be understood in terms of lapse, where some researchers describe a lapse as an initial phase that can eventually lead to problematic behaviours associated with substance use or a single episode of substance use, without the need to return to pre-quitting levels of problematic use behaviours (Gossop et al., 2002; Steckler et al., 2013). On the other hand, the informants who consumed alcohol did not consider their alcohol consumption as an initial phase that may lead them into their earlier misuse behaviour, except for those who had taken a stand to not drink at all, claiming alcohol as a potential trigger factor.

Some incidents of substance use were perceived as problematic, while others were not. Most of the participants did not consider alcohol consumption to be a case of relapse, even when this led to use of illicit drugs. The informants perceived using illicit substances as a case of relapse – a problematic use, and (potentially) a failed treatment outcome, except for one of the informants who claimed that his cannabis use was non-problematic.

Most participants described their life situations as satisfactory. Common factors among descriptions included stable job, partners, children, and a perceived improvement in their ability to cope with their life circumstances, which they found meaningful. Even though most of them continued to use substances in one way or another, their substance use patterns had morphed into what they described as controlled use.

In this section, we discuss how these narratives can be interpreted and understood within a field that witnesses constant development because of cultural changes, research, and political changes in relation to SUDs and SUD treatment.

In Norway, important political and professional discussions on substance use emerged during the 1980s and 1990s. Until then, the general understanding was that the primary

objective of successful treatment was total abstinence from substance use (Hallgrímsson, 1980; Skretting, 2018). Even at present, some treatment centres provide services based on the conceptualisation of SUDs as a chronic disorder from which one can never recover. One only needs to alleviate the symptoms of SUDs because this would facilitate total abstinence from substance use for the rest of one's life (e.g., the 12-steps programmes/philosophy) (Laudet, 2008; Nash, 2020). However, this is not necessarily an incorrect approach, according to studies showing that treatment outcomes measured in the absence of substances are about the same as other treatment methods such as cognitive/behavioural therapy (Kelly et al., 2017; Ouimette et al., 1997). Nevertheless, changes in the conceptualisation and treatment of SUDs in many areas in this field have been facilitated by the harm reduction model. This model posits that the most important objective of the SUD treatment is to mitigate the consequences of substance use with the foreknowledge that a patient may continue to engage in substance use (to some extent). The overall objective is to improve quality of life and health rather than to work toward total abstinence (Bagot & Kaminer, 2018; Marlatt et al., 2011; Westermeyer, 2013).

Furthermore, perceived improvement in quality of life and other personally meaningful outcomes have emerged as important indicators of treatment outcomes. This may be attributable to legislation, which, to a great extent, will be based on patient perceptions and a broader focus on understanding SUDs as complex conditions. However, this underscores the need for a more holistic analysis of what should be regarded as a successful treatment outcome. This has been highlighted and addressed by past researchers (Donovan, 2004; Kiluk et al., 2019; Laudet et al., 2009; Tiffany et al., 2012). On the other hand, total abstinence is not excluded as a possible treatment outcome among SUD patients. One should not ignore the fact that several studies indicate that longer duration of abstaining periods may

increase the chances for avoiding relapses (Hser, 2007; Kirshenbaum et al., 2009; Worley, 2017). The total abstinence of former SUD patients is associated with reduced mental distress symptoms in six- and ten-year follow-up studies (Bakken et al., 2007; Burdzovic Andreas et al., 2015).

However, measuring treatment outcomes using indicators other than those based on total abstinence of substances can also be viewed as a means to understand the broader meaning of a recovery concept, where patients' perceptions and what they consider to be important in their lives are acknowledged. Listening to people's stories makes their understanding of the relevant relational, social, political, and cultural factors more apparent. This entails a critical voice against conceptualisations of recovery that are primarily based on the illness model, according to which individual responsibility is the primary determinant. Instead, recovery should be conceptualised as involving an interplay between individual and social, political, and cultural factors (Pettersen et al., 2019; Topor et al., 2011).

The SUD treatment policy has changed over the past few decades. There has been a change in focus from total abstinence to harm reduction and self-perceived improvement in quality of life. Under this approach, an SUD is regarded less as a moral problem and more as an outcome attributable to multiple factors. Muller et al. (2019) found that after one year of SUD treatment, a lack of social support, contact, and relations had stronger effects on (reduced) quality of life than changes in specific substance use patterns. Accordingly, they underscored the need for a greater focus on these factors during and after treatment. This finding is consistent with our participants' emphasis on the important aspects of their lives rather than the total abstinence from substance use.

Conclusion

Most of the participants continued to use substances, mainly alcohol, in some way, and

some reported that such use did not affect them negatively. Different forms, patterns, and consequences of substance use were also observed.

In accordance with the participants' narratives, healthcare providers and therapists in SUD treatment centres should discuss the possibility of relapse in patients who receive SUD treatment. They should avoid defining a relapse or a failed treatment outcome in concrete terms. What is perceived as an actual relapse or a failed treatment outcome is highly subjective. Furthermore, complete sobriety might not necessarily be the best or the only way to measure the outcome of SUD treatment, and should not be the main goal for SUD treatment providers. One should focus on stable social relations, family relations, job situations, and mental/physical health, which leads to perceived improvement in patients' ability to cope with their life circumstances.

Acknowledgments

We would like to thank the former inpatients who consented to participate in this study and acknowledge the treatment staff at the Tyrili facilities who helped us connect with the informants.


Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship and/or publication of this article.

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