



Early Nursing and Social Work Interventions for Patients with Psychosocial Vulnerabilities in Acute Care Settings

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Abstract:

Early nursing and social work interventions for patients with psychosocial vulnerabilities in acute care settings are essential for equitable and effective healthcare. These interventions, grounded in biopsychosocial, trauma-informed, and social determinants of health frameworks, involve systematic screening, therapeutic communication, crisis de-escalation, family support, and proactive resource linkage. Implemented through collaborative models like embedded social work and interdisciplinary rounds, they aim to stabilize crises, engage patients in care, and facilitate safe transitions. Despite facing systemic barriers such as understaffing and reimbursement challenges, advancing these practices through policy reform, interprofessional education, and technology integration promises to transform acute care into a more humane, holistic, and cost-effective system that addresses the full spectrum of patient needs.

1. Introduction

The contemporary acute care setting, encompassing emergency departments, medical-surgical units, and intensive care wards, represents a crucible of high-intensity biomedical intervention. Its primary mandate is the rapid diagnosis, stabilization, and treatment of acute physiological pathologies. However, this environment, often characterized by noise, urgency, and technological complexity, is increasingly recognized as a critical frontier for addressing the profound psychosocial vulnerabilities that patients bring with them upon admission and which are often exacerbated by the experience of acute illness and hospitalization itself. Psychosocial vulnerabilities refer to a spectrum of conditions, states, and social circumstances that significantly impair an individual's capacity to cope with stress, navigate healthcare systems, manage illness, and achieve optimal health outcomes. This includes, but is not limited to, mental health disorders (e.g., depression, anxiety, psychosis, substance use disorders), cognitive impairments, developmental disabilities, homelessness, poverty, social isolation, low health literacy, experiences of trauma or violence, and frail family support systems [1].

The presence of these vulnerabilities is not a peripheral concern but a central determinant of the clinical trajectory. Patients with significant psychosocial needs experience longer lengths of stay, higher rates of hospital readmission, increased complications, poorer adherence to treatment plans, and greater dissatisfaction with care [2]. This creates a costly cycle for healthcare systems and devastating outcomes for individuals. The traditional, purely biomedical model of acute care is ill-equipped to identify or address these dimensions. Nurses and social workers, by virtue of their professional orientation, proximity to the patient, and role at the interface of the patient, family, and system, are uniquely positioned to lead a paradigm shift. Early intervention—defined as the

systematic identification and initiation of supportive, therapeutic, and coordinative actions from the point of entry or soon after—is paramount. Early action can mitigate crisis, prevent escalation of distress, facilitate smoother transitions, and lay the groundwork for post-discharge recovery [3].

The imperative for integrated psychosocial care is grounded in a biopsychosocial understanding of health, which posits that biological, psychological, and social factors are inextricably linked in the genesis and progression of disease. Ignoring the psychological and social components during an acute admission is tantamount to providing incomplete care. For instance, a patient admitted with diabetic ketoacidosis may have an underlying psychosocial vulnerability such as depression, which impedes their ability to manage their insulin regimen. Treating only the acidosis without addressing the depression ensures a likely return to the emergency department. Similarly, an elderly patient with a hip fracture may be medically cleared for discharge but have no safe home environment or caregiver support, leading to a preventable readmission due to a fall or infection [4]. The synthesis of nursing's holistic, bedside expertise with social work's systemic, resource-oriented advocacy creates a powerful synergy capable of transforming the acute care experience for the most vulnerable patients, ultimately bridging the gap between hospital care and sustainable health in the community [5].

The historical evolution of this role is significant. Nursing, since the time of Florence Nightingale, has embraced principles of holistic care, attending to the patient's environment and emotional state. Modern nursing theory continues to emphasize the therapeutic relationship and the response of the individual to actual or potential health problems. Social work, with its foundational commitment to social justice, person-in-environment perspective, and strengths-based approach, brings a critical lens to the systemic inequities that manifest as poor health. In the fragmented, fast-paced world of acute

care, these professions provide the essential thread of continuity, advocacy, and human connection [6]. However, operationalizing this ideal requires moving beyond admirable philosophy to structured, resourced, and validated practice protocols.

The consequences of failing to intervene early are severe. Psychosocially vulnerable patients are more likely to be perceived as "difficult" or "non-compliant," leading to stigmatization, tension with staff, and potentially substandard care. They may "fall through the cracks" of discharge planning, leading to unsafe discharges or homelessness. The stress of an unaddressed mental health crisis can worsen physical symptoms, and unmanaged substance withdrawal can complicate medical treatment. Therefore, the integration of psychosocial care is not an "add-on" luxury but a fundamental component of patient safety, clinical effectiveness, and ethical practice [7, 8].

2. Theoretical Foundations for Integrated Psychosocial Care

The move towards integrating psychosocial interventions in acute care is not merely pragmatic; it is deeply rooted in established theoretical frameworks that challenge the reductionist biomedical model. Three core paradigms provide the intellectual scaffolding for early nursing and social work practice: the Biopsychosocial Model, Trauma-Informed Care, and the Social Determinants of Health framework. Understanding these theories is crucial for developing interventions that are coherent, principled, and effective.

The Biopsychosocial Model, first articulated by George Engel, provides the most direct critique of traditional biomedicine. It posits that health and illness are the product of a complex interaction between biological factors (genetics, pathophysiology), psychological factors (mood, personality, behavior, coping styles), and social factors (culture, family, socioeconomic status, environment) [9]. In an acute care setting, this model compels professionals to look beyond the presenting lab values or imaging results. For example, a patient with recurrent heart failure admissions must be understood not only in terms of cardiac function (biological) but also their potential depression affecting self-care (psychological) and their ability to afford medications or access healthy food (social). Early interventions based on this model involve simultaneous attention to all three domains. Nursing care that educates about sodium restriction (biological) while assessing for depressive symptoms (psychological) and social work involvement to apply for medication

assistance programs (social) exemplifies a biopsychosocial approach from admission.

Closely aligned is the framework of Trauma-Informed Care (TIC). TIC is not a specific therapy but a fundamental shift in organizational culture and clinical practice that recognizes the widespread impact of trauma, understands potential paths for recovery, and responds by fully integrating knowledge about trauma into policies, procedures, and interactions [10]. For many patients with psychosocial vulnerabilities—including those with mental illness, substance use disorders, homelessness, or histories of abuse—the acute care environment can be re-traumatizing. Procedures, loss of autonomy, physical restraint, and authoritative staff behaviors can echo past traumatic experiences. Early TIC interventions by nurses and social workers involve creating physical and emotional safety, maximizing patient choice and control, employing a collaborative and non-coercive approach, and recognizing signs of trauma arousal (withdrawal, aggression, dissociation). A nurse using a calm, explanatory approach before a painful dressing change, or a social worker conducting a screening interview in a private, quiet space while ensuring the patient knows they can pause at any time, are practicing trauma-informed principles that can prevent escalation and build therapeutic alliance from the outset.

Finally, the Social Determinants of Health (SDOH) framework, championed by the World Health Organization, explicitly links social and economic conditions to health inequities. It identifies factors such as income and social protection, education, unemployment, housing, and social inclusion as powerful drivers of health outcomes [11]. In acute care, patients from disadvantaged social backgrounds often present with more advanced disease and have fewer resources for recovery. Early social work intervention is inherently focused on the SDOH. By conducting a swift assessment of housing stability, food security, income, and social support, social workers can identify the non-medical barriers to healing. An early referral to a social worker for a patient who is homeless, for instance, is an intervention directly targeting the SDOH of "housing," which is as critical to recovery from pneumonia as the antibiotic prescription. Nursing advocacy for a patient with low health literacy, ensuring comprehension of discharge instructions through teach-back methods, addresses the SDOH of "education."

Together, these theoretical foundations mandate early, proactive engagement. They shift the question from "What is the matter with you?" to "What matters to you, and how do your life circumstances affect this illness?" [12]. They

provide a common language and rationale for nurses and social workers to justify their interventions, collaborate effectively, and advocate for systemic changes that support holistic care. Interventions devoid of this theoretical grounding risk being ad hoc and superficial, whereas those informed by these models are systematic, deep, and aimed at root causes rather than just symptoms.

3. Early Screening and Identification: The Critical First Step

Effective intervention is predicated on timely and accurate identification. In the chaotic flow of acute care, psychosocial vulnerabilities can remain invisible to a system focused on triaging immediate physiological threats. Therefore, the implementation of systematic, sensitive, and efficient screening protocols upon admission is the indispensable first step in the pathway of care. Nurses, as the first and most consistent point of contact, are optimally positioned to initiate this process, with social workers providing more in-depth assessment for those who screen positive.

Screening must be brief, non-stigmatizing, and integrated into routine admission workflows. Common tools and domains include mental health screens (e.g., the PHQ-2/9 for depression, GAD-2/7 for anxiety), substance use screens (e.g., the SBIRT framework—Screening, Brief Intervention, and Referral to Treatment), cognition screens (e.g., the Mini-Cog for delirium or dementia), and assessments of functional status and social support [13]. Crucially, screening also involves inquiring about practical social needs. Standardized tools like the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) or the Institute for Healthcare Improvement's SDOH screening questions can systematically capture data on housing, food security, transportation, and utility needs [14]. The nursing admission assessment must evolve to include these key psychosocial domains as standard of care, not an optional add-on.

The process of screening itself is an intervention. Conducted with empathy and respect, it communicates to the patient that their whole person is of concern. A nurse asking, "Many people feel down or anxious when they are in the hospital. Over the last two weeks, have you been bothered by little interest or pleasure in doing things?" normalizes the experience and opens a dialogue. However, screening carries ethical responsibilities. It requires informed consent, confidentiality, and, most importantly, the capacity to act on positive screens. "Screen and abandon" practices are harmful and erode trust [15]. Therefore, a clear

referral pathway to social work or psychiatric consultation services must be activated immediately upon identification of a need.

Social workers then conduct a comprehensive psychosocial assessment, building on the nursing screen. This assessment is diagnostic, functional, and strategic. It explores the patient's personal and family history, coping mechanisms, strengths and resiliencies, cultural beliefs about illness, detailed social support network, financial and insurance status, and legal issues. The social worker's goal is to understand the patient's narrative—how their life context has contributed to their current crisis and what resources they possess or need to navigate recovery [16]. This deep assessment informs the development of a tailored, realistic care plan. For a patient with schizophrenia admitted for cellulitis, the social worker assesses not only their housing situation and outpatient psychiatric follow-up but also the patient's understanding of their infection, potential barriers to adhering to IV antibiotics, and the stability of their support system to assist them.

Technology is increasingly playing a role in early identification. Integrated electronic health records can prompt nurses with screening questions and automatically flag high-risk scores for social work review. However, technology cannot replace the nuanced clinical judgment and therapeutic rapport built by a skilled nurse or social worker who notices a patient's flat affect, a family's distress, or the clues of an unsafe home environment mentioned in passing [17]. The ideal model combines standardized digital tools with the irreplaceable human element of observation and engagement, ensuring that vulnerabilities are caught early, accurately, and compassionately.

4. Models of Interdisciplinary Collaboration: Nursing and Social Work Synergy

The complexity of psychosocial vulnerabilities demands a team-based response. While nursing and social work have distinct professional scopes, their collaboration is not merely additive but synergistic. Effective models of collaboration move beyond parallel practice or simple referral towards integrated, co-produced care. This synergy maximizes the unique strengths of each profession: nursing's 24/7 presence, expertise in physiological-psychological interplay, and management of the immediate care environment; and social work's systemic perspective, expertise in complex systems navigation, crisis intervention, and resource mobilization [18].

Several collaborative models have proven effective in acute settings. The **Embedded Social Work Model** involves assigning master's-prepared

clinical social workers directly to specific high-acuity units like the emergency department, oncology, or trauma services. In this model, the social worker is a core member of the unit team, participating in rounds, huddles, and family conferences from day one. The nurse and social worker develop a shared language and routine communication, allowing for real-time consultation. A nurse noticing a family conflict can immediately pull the embedded social worker for a joint family meeting, addressing relational stress before it impedes care [19].

The **Consultation-Liaison (C-L) Model**, often used for psychiatric needs but applicable to broader psychosocial care, involves a specialized team (which may include psychiatric nurses, social workers, and psychiatrists) available for consultation. In this model, the primary nurse or physician identifies a need and requests a formal consult. The C-L team then assesses and makes recommendations. While this model provides expert input, its effectiveness relies on the primary team's ability to recognize the need and the C-L team's timely response. Early intervention is best supported when the threshold for consultation is low and the process is swift [20].

The most advanced model is **Interdisciplinary Rounds (IDR)** with a specific psychosocial focus. In these structured meetings, the core team—including the bedside nurse, charge nurse, social worker, case manager, physician, and often pharmacists or physical therapists—discusses each patient with a focus on barriers to discharge and recovery. This forum allows the nurse to report behavioral observations and the social worker to report on family dynamics or resource acquisition, creating a unified plan. For a patient with dementia resisting care, the team can collaboratively devise non-pharmacological strategies (nursing), engage a family caregiver for reassurance (social work), and adjust medication schedules (pharmacy/medicine) [21].

Key to all successful models are clear role definition and mutual respect. Role blurring can lead to tension and missed tasks. Generally, nursing leads in continuous assessment, management of behavioral symptoms in context, patient education, and coordination of bedside care. Social work leads in complex family systems intervention, advanced counseling, legal and ethical issues, and securing concrete resources for discharge (e.g., housing, durable medical equipment, insurance approvals) [22]. Regular, structured communication channels—such as shared documentation in the EHR, brief daily huddles, and joint care planning sessions—are the glue that binds the collaboration.

A critical component of this synergy is **shared advocacy**. Nurses and social workers often must collectively advocate for the patient within the medical system. This may involve advocating for adequate pain management for a patient with a substance use history (combating stigma), for additional hospital days to secure a safe discharge plan, or for a care conference to align the medical team with a family's cultural or spiritual values. Their united voice carries significant weight in ensuring that the care plan is both clinically appropriate and humanely responsive to the patient's psychosocial reality [23].

5. Core Intervention Strategies in the Acute Care Phase

Once vulnerabilities are identified and a collaborative framework is established, specific evidence-based interventions can be deployed at the bedside. These strategies aim to stabilize the immediate crisis, engage the patient in their care, mitigate distress, and begin planning for the future. They are delivered by nurses and social workers in concert, often overlapping in their implementation.

Therapeutic Communication and Relationship-Based Care: This is the bedrock of all other interventions. For a psychosocially vulnerable patient, a trusting relationship with a nurse or social worker can be the single most stabilizing factor in the alien hospital environment. Nurses employ techniques of active listening, validation, and presence. A simple intervention like sitting at the bedside, making eye contact, and asking, "This must be very frightening for you," can de-escalate anxiety more effectively than a PRN medication for some patients. Social workers utilize motivational interviewing—a collaborative, goal-oriented style of communication that respects patient autonomy—to explore ambivalence about treatment or discharge plans. For a patient with alcohol use disorder reluctant to accept referral to rehab, a social worker using motivational interviewing would explore the pros and cons of their drinking and of change, building the patient's own intrinsic motivation rather than imposing an external directive [24].

Crisis Intervention and De-escalation: Acute care settings are rife with potential crises: a patient with psychosis becoming agitated, a suicidal patient in the ED, a family erupting in conflict. Nurses and social workers are frontline crisis responders. Structured models like the **CPI (Crisis Prevention Institute) Nonviolent Crisis Intervention** provide staff with skills to recognize the stages of escalating behavior (anxiety, defensiveness, acting out, tension reduction) and to intervene with verbal and

non-verbal strategies to defuse the situation early [25]. This includes using a calm tone, offering choices, reducing environmental stimuli (e.g., moving to a quieter room), and never confronting or cornering a patient. The social worker's role is often to engage with the family or support system during the crisis, providing support and information, which indirectly helps calm the patient. The goal is to resolve the crisis without resorting to seclusion or restraint, which are re-traumatizing and should be measures of last resort.

Behavioral and Environmental Modification: For patients with cognitive impairments (dementia, delirium), behavioral issues are a manifestation of unmet needs or environmental mismatch. Nursing-led interventions focus on modifying the environment and approach. This includes ensuring adequate lighting to reduce sundowning, maintaining consistent routines and caregivers to promote orientation, using clear and simple communication, and identifying and addressing triggers for agitation (pain, hunger, full bladder, boredom) [26]. Social workers contribute by obtaining a detailed history from family about the patient's lifelong routines, preferences, and effective calming techniques, and integrating this into the care plan. Creating a "behavioral care plan" that is communicated to all staff is a key collaborative intervention.

Family Systems Intervention and Support: The patient's illness profoundly affects the family, and a distressed family can impede care. Social workers are experts in family systems theory. Early intervention involves assessing family dynamics, level of functioning, and coping strategies. They facilitate family meetings to ensure clear, consistent communication from the medical team, address conflicts, align expectations, and identify a primary caregiver. For families in crisis or those facing a poor prognosis, social workers provide supportive counseling and grief intervention. Nurses support the family by providing regular updates, teaching them how to participate in care (e.g., feeding, positioning), and acknowledging their emotional strain. Engaging the family as partners, not visitors, is a powerful intervention that improves patient morale and prepares for discharge [27].

Brief Supportive Counseling and Psychoeducation: While long-term therapy is not the role of acute care, brief, focused counseling is essential. A social worker may provide several sessions of supportive therapy to a newly diagnosed cancer patient struggling with anxiety, helping them process the news and develop initial coping strategies. Nurses provide constant psychoeducation—explaining diagnoses, procedures, and medications in understandable

terms. For a patient with a psychosocial vulnerability, this education must be adapted. A nurse might use picture charts to educate a patient with intellectual disabilities about their diabetes care or collaborate with a social worker to create a simplified, pictorial discharge instruction sheet for a patient with low literacy [28]. Educating the patient and family reduces fear, increases a sense of control, and promotes adherence.

Initiation of Concrete Service Linkages: Perhaps the most definitive social work intervention is the active connection to resources. This begins during the acute stay, not as an afterthought at discharge. For a patient who is homeless, the social worker initiates contact with shelter systems or housing-first programs immediately upon admission. For a patient with substance use disorder, they facilitate a "warm handoff" to an addiction counselor or begin paperwork for rehabilitation placement. For an elderly patient going to a skilled nursing facility, they coordinate assessments and authorizations. This proactive work ensures that the discharge plan is not a fragile arrangement made at the last minute but a secure pathway that has been constructed throughout the hospitalization [29].

6. Addressing Systemic and Professional Barriers to Implementation

Despite the compelling evidence and ethical imperative, the consistent implementation of early, integrated psychosocial interventions faces significant barriers at systemic, professional, and cultural levels. Recognizing and strategizing to overcome these obstacles is critical for advancing practice.

Systemic Barriers: The foremost challenge is the **reimbursement and financing structure** of acute care, which historically rewards procedural volume and short lengths of stay over the time-intensive, cognitive work of psychosocial care. Nursing and social work services are often bundled into a hospital's per-diem rate, creating a financial disincentive to invest in robust psychosocial teams [30]. **Understaffing and high acuity** render nurses "task-saturated," with little time for the in-depth therapeutic communication required. Social work departments are frequently stretched thin, with caseloads covering multiple units, forcing them into a reactive, triage mode rather than proactive, early engagement. The **physical environment** of many acute care units—lacking privacy, being noisy and brightly lit—is inherently antagonistic to addressing psychological distress or conducting sensitive conversations [31].

Professional and Cultural Barriers: The **persistent dominance of the**

biomedical model in hospital culture can marginalize psychosocial expertise. Nurses and social workers may struggle to have their assessments and recommendations valued equally with laboratory data. There can be **interprofessional tension and role ambiguity** between nursing, social work, and case management, leading to duplication of effort or gaps in care. **Stigma** towards patients with mental illness or substance use disorders among some healthcare staff remains a profound barrier to compassionate, effective care. This can manifest as pejorative labeling ("frequent flyer," "drug-seeker") and therapeutic nihilism [32]. Furthermore, **burnout and compassion fatigue** among nurses and social workers, stemming from chronic exposure to suffering and systemic frustration, can erode the empathy and resilience required for this challenging work.

Strategies for Overcoming Barriers: Addressing these challenges requires multi-level action. **Advocacy for policy and payment reform** is essential, arguing for value-based payment models that reward holistic outcomes and reduced readmissions, justifying investment in psychosocial staff. **Workforce development** involves ensuring adequate staffing ratios, creating clinical ladders for expert psychosocial nurses, and funding dedicated social work positions in high-need areas like the ED [33]. **Environmental redesign**, where possible, to include quiet rooms, family consultation spaces, and calming décor can support therapeutic interventions.

On a professional level, **interprofessional education (IPE)** is crucial. Training nursing and social work students together, and providing joint in-service trainings for staff on topics like trauma-informed care, de-escalation, and SDOH, builds mutual understanding and respect [34]. Implementing **structured communication tools** (e.g., SBAR for psychosocial concerns) and **integrating standardized screening tools into the EHR** with automatic alerts can systematize and legitimize the process. **Leadership commitment** from hospital administration and unit managers to champion a culture of holistic care, to address stigmatizing language, and to support staff wellness through debriefing sessions and resilience training is foundational [35]. Ultimately, demonstrating the **return on investment (ROI)** through rigorous evaluation—showing reduced length of stay, lower readmission rates, improved patient satisfaction, and decreased use of restraint/seclusion—is one of the most powerful arguments for dismantling these barriers.

7. Future Directions and Conclusion

The integration of early nursing and social work interventions for psychosocially vulnerable patients represents a vital evolution towards more equitable, effective, and humanistic acute care. The future of this field lies in innovation, research, and deeper system integration.

Several promising directions are emerging. **Technology-Enhanced Interventions** offer new tools. Telepsychiatry consultations can bring psychiatric expertise to the bedside immediately. Mobile health apps can provide patients with anxiety or cognitive deficits with orientation tools, relaxation exercises, and medication reminders during their stay. Predictive analytics, using EHR data to flag patients at high risk for psychosocial complications or poor discharge outcomes, can enable even earlier, pre-emptive intervention [36]. **Specialized Clinical Roles** are developing, such as the Psychiatric Clinical Nurse Specialist (CNS) who consults on units for patients with complex behavioral needs, or the ED-based social worker specializing in crisis intervention and homelessness. **Expanded Models of Care**, like **Hospital at Home** programs, while not acute inpatient care per se, challenge the notion that acute illness must be treated in a hospital. For select psychosocially vulnerable patients (e.g., elderly with dementia), being treated in their familiar home environment with intensive nursing and social work support can prevent the disorientation and trauma of hospitalization altogether [37].

Community Health Integration is the ultimate goal. The most successful interventions will be those that seamlessly bridge the hospital and the community. This involves formal partnerships with community-based organizations (CBOs), peer support specialists, mental health clinics, and housing agencies. Social workers acting as true "system navigators" can facilitate warm handoffs, sharing of care plans, and even accompanying patients to critical first appointments post-discharge [38]. The **Patient-Centered Medical Home (PCMH)** model for primary care, when robustly linked to the hospital, provides a community anchor for ongoing psychosocial support.

Research Imperatives remain substantial. More randomized controlled trials are needed to isolate the specific impact of early psychosocial interventions on hard outcomes like mortality, readmission, and cost. Qualitative research is essential to capture the patient and family experience of these interventions. Implementation science studies can identify the most effective strategies for embedding these practices into

diverse hospital cultures and workflows [39]. Furthermore, research must focus on **health equity**, explicitly designing and testing interventions for historically marginalized populations who bear a disproportionate burden of both medical and psychosocial vulnerability.

8. Conclusion:

In conclusion, acute care settings are at a crossroads. They can continue to function as biomedical repair shops, inadvertently exacerbating health inequities by ignoring the psychosocial dimensions of illness. Or, they can transform into truly healing environments that recognize and respond to the whole human being in crisis. This transformation is led by the skilled, collaborative work of nursing and social work professionals. By implementing early, systematic screening, grounded in biopsychosocial and trauma-informed theories, and by deploying a repertoire of therapeutic, supportive, and pragmatic interventions, they can stabilize the immediate crisis, engage the most marginalized patients, and construct pathways to sustainable health.

The interventions detailed—from therapeutic communication and crisis de-escalation to family support and concrete resource linkage—are not ancillary services. They are fundamental components of quality, safe, and ethical medical care. Overcoming the entrenched systemic and cultural barriers requires persistent advocacy, interdisciplinary solidarity, and a commitment to valuing the time and expertise required for this work. The future of acute care depends on its ability to heal not just bodies, but minds and social circumstances. Investing in and empowering nursing and social work to provide early, integrated psychosocial interventions is one of the most strategic and morally imperative investments the healthcare system can make.

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