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SOCIODEMOGRAPHIC AND HEALTH CHARACTERIZATION OF INSTITUTIONALIZED OLDER ADULTS AT RISK OF VIOLENCE

CARACTERIZAÇÃO SOCIODEMOGRÁFICA E DE SAÚDE DA PESSOA IDOSA INSTITUCIONALIZADA EM RISCO DE VIOLÊNCIA

CARACTERIZACIÓN SOCIODEMOGRÁFICA Y DE SALUD DE LA PERSONA MAYOR INSTITUCIONALIZADA EN RIESGO DE VIOLENCIA

Nathaly da Luz Andrade[1]; Francisco de Assis Moura Batista[1];
Bruna Caroline Cassiano da Silva[1]; Eulália Maria Chaves Maia[1];
Bruno Araújo da Silva Dantas[2]; Gilson de Vasconcelos Torres[1].

[1]Federal University of Rio Grande do Norte, Natal, Brazil.
[2]Federal University of Rio Grande do Norte, Santa Cruz, Brazil.

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ABSTRACT

Introduction: Violence or abuse perpetrated against elderly individuals is recognized as a multifaceted, heterogeneous, and multidimensional phenomenon, exerting detrimental effects on the aging process's quality.

Objective: The aim of this study is to investigate the relationship between the risk of violence and sociodemographic as well as health-related characteristics among institutionalized elderly individuals.

Method: This is a cross-sectional, quantitative, and observational analytical study involving elderly residents of Homes for the Aged conducted in 2023 in Brazil. Variable assessment utilized the Elderly Person's Health Booklet, institutional medical records, and the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) questionnaire. To test the study hypothesis, descriptive and multivariate analyses were conducted.

Results: Sample with n = 223, aged ≥ 60 years institutionalized. The multivariate association analysis showed statistical significance in the risk of falls ($p = 0.002$), self-reported diseases ($p = 0.010$), cognitive decline ($p < 0.001$), depression ($p < 0.001$), nutritional risk ($p = 0.029$), sarcopenia risk ($p = 0.042$), risk of functional decline ($p = 0.003$), and in situations of violence ($p < 0.001$).

Conclusion: The presence of risk of violence in institutionalized elderly individuals is observed, indicating a trend in the victims' profile, with impairments in physical, mental, and social health.

Keywords: Aged; Elder Abuse; Homes for the Aged.

RESUMO

Introdução: A violência ou abuso contra pessoas idosas se configura como um fenômeno complexo, heterogêneo e multidimensional, com prejuízos que interferem na qualidade do processo de envelhecimento.

Objetivo: Verificar a associação entre o risco de violência e características sociodemográficas e de saúde em pessoas idosas institucionalizadas.

Método: Estudo transversal, quantitativo, observacional e analítico com pessoas idosas residentes de Instituições de Longa Permanência, realizado em 2023 no Brasil. Para avaliar as variáveis, foram utilizados a Caderneta de Saúde da Pessoa Idosa, prontuários nas instituições e o questionário "Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)". Para testar a hipótese do estudo, foram realizadas análises descritivas e multivariadas.

Resultados: Amostra com n = 223, com idade ≥ 60 anos institucionalizados. A análise de associação multivariada mostrou uma significância estatística em risco de quedas (p = 0,002), doenças autorreferidas (p = 0,010), declínio cognitivo (p < 0,001), depressão (p < 0,001), risco nutricional (p = 0,029), risco de sarcopenia (p = 0,042), risco de declínio funcional (p = 0,003) e em situação de violência (p < 0,001).

Conclusão: Verifica-se a presença de risco de violência em pessoas idosas institucionalizadas indicando uma tendência no perfil das vítimas, apresentando prejuízos na saúde física, mental e social.

Palavras-chave: Abuso de Idosos; Idoso; Instituição de Longa Permanência para Idosos.

RESUMEN

Introducción: La violencia o abuso contra personas mayores se configura como un fenómeno complejo, heterogéneo y multidimensional, con prejuicios que interfieren en la calidad del proceso de envejecimiento.

Objetivo: Verificar la asociación entre el riesgo de violencia y las características sociodemográficas y de salud en personas mayores institucionalizadas.

Método: Estudio transversal, cuantitativo, observacional y analítico con personas mayores residentes de Instituciones de Larga Permanencia, realizado en 2023 en Brasil. Para evaluar las variables, se utilizaron la Libreta de Salud de la Persona Mayor, los expedientes en las instituciones y el cuestionario "Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)". Para probar la hipótesis del estudio, se realizaron análisis descriptivos y multivariados.

Resultados: Muestra con n = 223, con edad ≥ 60 años institucionalizados. El análisis de asociación multivariada mostró una significancia estadística en riesgo de caídas (p = 0,002), enfermedades autorreferidas (p = 0,010), declive cognitivo (p < 0,001), depresión (p < 0,001), riesgo nutricional (p = 0,029), riesgo de sarcopenia (p = 0,042), riesgo de declive funcional (p = 0,003) y en situación de violencia (p < 0,001).

Conclusión: Se verifica la presencia de riesgo de violencia en personas mayores institucionalizadas indicando una tendencia en el perfil de las víctimas, presentando perjuicios en la salud física, mental y social.

Descriptores: Abuso de Ancianos; Anciano; Hogares para Ancianos.

INTRODUCTION

The literature highlights concerns surrounding aging due to the significant global increase in the population of older adults, a process that has become of urgent social relevance. These demographic changes reflect a contemporary society that shifts its focus from collective/social causes to individual concerns, such as adopting better lifestyle habits and emphasizing the aesthetic attributes of the body to evoke youthfulness and virility[1].

Aging is a process that involves intrinsic/chronological factors of a natural and inevitable order, as well as extrinsic factors/photoaging, which are associated with the environment and daily behaviors that influence this process[2]. The way individuals use their coping mechanisms to adapt to this stage of life impacts their perception of aging, linking not only biological changes but also psychosocial ones[3].

From a Freudian psychodynamic perspective, each individual ages in their own way and subjectively handles this passage of time. This perspective underscores the diversity within the aging process and considers the uniqueness with which each older person faces challenges, such as maintaining active social connections, integrating into life contexts, and negotiating their relationship with their own body and identity[3].

Brazilian legislation addresses the complexity of the phenomena affecting older adults and guarantees fundamental rights. Law No. 8.842 of 1994 established the National Policy for Older Adults to ensure social rights for this population, creating conditions to promote their autonomy, integration, and effective participation in society[4]. However, the state's guarantee of these rights is not always respected, and cases that violate the integrity of older adults are underreported, highlighting the vulnerability to which they are routinely exposed[4].

Violent situations remain underreported. The Lancet Global Health published data indicating that approximately 1 in 6 older adults experiences some form of violence. The study also revealed that in the northeastern region of Brazil, physical violence is prevalent, accounting for 28% of cases, while neglect and abandonment constitute 17.3%[5]. The World Health Organization (WHO) defines violence as the intentional use of physical force or power, whether actual or threatened, against oneself, another person, a group, or a community, that results in, or is likely to result in, injury, death, psychological harm, developmental disability, or deprivation[6].

The World Report on Violence and Health further characterizes elder abuse as a single or repeated act, or a lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. Norwegian researchers explain that violations against older adults often involve a triangular relationship comprising a victim, a perpetrator, and others who directly or indirectly observe the situation[6].

Given the inequalities and vulnerabilities that older adults face in various life contexts—and recognizing the importance of clinical practices, evidence-based research, and public policy development—this study aims to investigate the association between the risk of violence and the sociodemographic, clinical, and health characteristics of institutionalized older adults. The study hypothesizes that the risk of violence is particularly present among participants with altered sociodemographic, clinical, and health aspects.

METHOD

This is an observational, analytical, cross-sectional study with a quantitative approach conducted among older adults residing in Long-Term Care Facilities for Older Adults (LTCFs) in the municipality of Natal, Rio Grande do Norte, Brazil. The study aimed to evaluate the sociodemographic and health characteristics of this institutionalized population at risk of violence.

This analysis represents a methodological subset of a multicenter study conducted through an International Research Network, which spans Brazil, Portugal, Spain, and France, as outlined in public call 01/2020 – Research Networks of the Federal University of Rio Grande do Norte. The broader study focuses on older adults in the settings of Primary Health Care (PHC) and LTCFs.

The study was conducted in LTCFs in the northeastern region of Brazil, specifically in the state of Rio Grande do Norte, which has an estimated population of 3.302.729 inhabitants, and in the city of Natal, as reported in the latest census published in 2022 by the Brazilian Institute of Geography and Statistics[7].

As part of the methodological framework of the multicenter study, a purposive sampling method was adopted. The sample size was calculated using the formula for finite populations, considering an estimated population of older adults residing in LTCFs in the Natal region. The process assumed a sample size of 125.630 older adults, with a confidence level of 95% (Z = 1.96), a sampling error of 5% (e = 0.05), an expected accuracy proportion (P) of 50%,

and an expected error (Q) of 50% among older adults receiving PHC or residing in LTCFs. This resulted in an estimated sample size of 200 older adults from the Natal region. An additional 10% was added to account for potential losses, and 223 participants completed the study.

Participants were selected according to eligibility criteria based on Brazilian regulations, specifically Law No. 10.741 of 2003, the Statute for Older Adults, which defines older adults as individuals aged 60 years or older[8]. Inclusion criteria were: (1) age 60 years or older; (2) residence in an LTCF.

Exclusion criteria was: the presence of clinical conditions preventing study participation, as determined by the researcher or reported by LTCF professionals.

Data collection occurred during the second half of 2023, from July to December, conducted by a research team comprising undergraduate and graduate students from health-related fields. All team members were previously trained in the use of research instruments.

The instrument used for sociodemographic and health characterization was the Older Adult Health Record Booklet[9], and the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) was employed to assess the risk of violence[10]. When additional information was deemed necessary, access to medical records was obtained with prior authorization from the institution and participants.

The variables analyzed included: sociodemographic characteristics such as gender (female/male), age group (60-79 years/80 years or older), race/skin color (white/non-white), education level (literate/illiterate); and clinical and health characteristics such as self-reported illnesses, cognitive decline, presence of depression, frailty, vulnerability, and nutritional risk.

The risk of violence was assessed using the H-S/EAST, a cross-cultural adaptation for Brazilian Portuguese originally developed in the United States to identify both direct signs (presence) and indirect signs (suspicion) of elder abuse[10]. This easy-to-administer tool consists of 15 complementary and opposing items, with a score of three or more points indicating a risk of violence[10]. For this study, a dichotomous variable (yes/no) was used to indicate the presence or absence of risk for violence.

For data processing and refinement, initial data were entered into Microsoft Excel® 2007, and after database correction and coding, the data were exported and analyzed using the Statistical Package for Social Science (SPSS) version 23.0 for Windows.

In SPSS 23, the chi-square test and Fisher's exact test were used to measure associations between sociodemographic and clinical variables and the risk of violence. Descriptive analyses of categorical variables were performed using absolute and relative frequencies, with a significance level of 5% and confidence intervals of 95% applied to all analyses. A p-value of < 0.05 was considered statistically significant.

Eligible participants who agreed to participate were informed about the study and invited to sign the Informed Consent Form (ICF). The multicenter project was approved by the Research Ethics Committee of the Onofre Lopes University Hospital at the Federal University of Rio Grande do Norte/Brazil (approval no. 4267762; CAAE: 36278120.0.1001.5292).

RESULTS

The sample consisted of 223 participants residing in LTCFs in the municipality of Natal, Rio Grande do Norte, Brazil. Table 1↗ presents the sociodemographic characterization of the sample, which revealed a predominance of females, individuals aged ≥80 years, and non-white participants.

The risk of violence was more prevalent in this same group, specifically among females (62.3%), individuals aged ≥80 years (63.2%), and non-white participants (48.4%), indicating a profile more susceptible to the risk of violence (Table 1↗).

Cross-analysis of education level and risk of violence revealed no statistically significant difference between literate and illiterate groups. The difference was minimal, at just 3.1%, with values of 44.4% and 41.3%, respectively, suggesting that education level was not strongly associated with the risk of violence (Table 1↗).

In Table 2↗, the association between the risk of violence and clinical and health variables demonstrated that the majority of participants exhibited a risk of violence, with statistical significance in the following items: fall risk ($p = 0.002$), self-reported illnesses ($p = 0.010$), cognitive decline ($p < 0.001$), depression ($p < 0.001$), nutritional risk ($p = 0.029$), sarcopenia risk ($p = 0.042$), functional decline risk ($p = 0.003$), and current experience of violence ($p < 0.001$).

In the statistical analysis, the observed percentages based on variable associations indicated a profile structure among participants at risk of violence. The results highlighted a higher probability of fall risk (74.9%), routine use of multiple medications (polypharmacy) (60.1%), cognitive decline (66.4%), depressive symptoms (63.2%), nutritional risk (66.4%), sarcopenia risk (63.2%), and functional decline risk (81.6%). Additionally, the majority of participants

not only demonstrated a risk but also reported experiences of violence (51.6%). It is worth noting the pronounced difference among participants at risk of violence who reported self-reported illnesses (85.2%) and those exhibiting functional decline and frailty, with rates of 81.6% and 83.9%, respectively (Table 2↗).

The fall variable, which was positively associated with the risk of violence, showed closely aligned results in its dichotomous categorization, with a minimal 3% difference between the "no" (42.2%) and "yes" (43.5%) groups.

Contrasting with the results in Table 2↗, the vulnerability score associated with the risk of violence, specifically for the group of older adults at risk of violence, revealed a finding that raises questions. The data show that individuals not in a situation of vulnerability presented a higher rate (46.2%) of violence risk compared to those identified as vulnerable, who showed a lower percentage (39.5%), despite also being at risk of violence.

DISCUSSION

The results of this study indicated that, when analyzing the association between the risk of violence and sociodemographic characteristics of institutionalized older adults, the findings align with evidence already reported in the literature[11]. There was a predominance of violence risk among non-white women and individuals aged 80 years or older.

A study conducted in 2022 found that the profile of women victims of lethal violence in Brazil revealed a relationship between race/ethnicity and violence, with 61.1% of victims being Black women, compared to 38.4% who were white women[11-12]. This association highlights the historical and social imprints of racism and gender inequality, underscoring the hierarchical structures shaped by ethical, aesthetic, and political paradigms that influence this phenomenon[13-14]. In this context, the data from the present study reflect the same trend for older women.

In the first semester of 2024, data accessed from the National Human Rights Ombudsman Panel in Brazil identified women aged 70 to 84 years as the group most affected by violence[15]. These findings coincide with the results of this research, emphasizing this group as particularly vulnerable to risk or violations. This situation reveals the fragility of public responsibilities and the democratic rule of law, contradicting Article 230 of Brazil's 1988 Federal Constitution[16], which guarantees older adults the principle of human dignity and the right to age with dignity[17], as well as the principle of absolute priority outlined in the Statute for Older Adults[8].

Analyzing the clinical and health variables associated with violence risk among institutionalized older adults, the results demonstrated statistical significance for fall risk, functional decline, nutritional risk, sarcopenia, cognitive decline, depression, and situations of violence. These findings align with previous studies[2,5-6], which suggest that increased longevity impacts body functionality, leading to significant social, health, legal, and familial adjustments. These adjustments have been particularly influenced by the increasing presence of women in the workforce, which has restructured family dynamics[1]. There is growing urgency to address the specific care needs arising from aging, particularly among those at risk of violence, as highlighted by this research.

Long-Term Care Facilities for Older Adults emerge as alternatives for this population, which often lacks active family ties or has families with insufficient resources to manage the complexities of aging[18-19]. Studies show that various factors contribute to institutionalization, including functional incapacity, chronic diseases, hospitalizations, and the older adult's own perception of their physical and/or mental frailty[19-20].

Depressive symptoms, as identified in this study, have been frequently observed during the transitional stage of old age[20], linked to both psychopathological conditions and experiences of grief[21]. This is compounded by the risk of violence[20]. From a psychoanalytic perspective, this transgenerational stage involves continuous psychic elaborations in response to the loss of significant objects of investment accumulated throughout life. Institutionalized older adults face intensified losses, including significant relationships, professional activities, and social or domestic roles[22]. The symbolic elaboration of grief brings awareness of finitude, and feelings of helplessness and isolation may emerge, associated with the experience of losing one's identity or sense of self[21], This process is amplified by prolonged institutionalization.

A study conducted in Minas Gerais, southeastern Brazil, with 178 older adults, demonstrated an association between depressive symptoms and violence risk, where the majority of those showing this association were female. This aligns with the profile identified in the present study. The same study also noted that male participants who reported no experience of violence showed lower levels of depressive symptoms[20]. These findings reflect a consistent pattern of victims across Brazil, despite geographic and regional differences.

Research conducted in São Paulo, Brazil, with institutionalized older adults, highlighted impairments in functional capacity, self-care, and vulnerability due to depressive states and the risk of violence experienced by this population[23]. The findings are consistent with the present study, as older adults who neglect their health or exhibit reduced self-care may be more prone to polypharmacy (continuous use of multiple medications) and report higher

rates of comorbidities (self-reported diseases). These variables were strongly associated with violence risk, demonstrating that as the number of illnesses and indiscriminate medication use increases, the risk of mistreatment also rises[24].

Older adults with compromised functional performance are 1.4 times more likely to be at risk of violence[25]. Living longer also implies prolonged exposure to the consequences of aging, as functional decline often leads to increased dependence on others for daily activities, placing older adults in a vulnerable position and increasing their risk of abuse[26-27].

In this study, older adults with greater cognitive decline were associated with violence risk. Similarly, a study conducted in Chicago, USA, involving 6,159 older adults found that cognitive function decline was related to increased mistreatment risk. The study also highlighted contributions from low perceptual speed and episodic memory[28]. It was noted that cognitive decline was more evident in clinical settings compared to community settings, where deficits may increase dependency and violence risk. Additionally, abusive behaviors may exacerbate or accelerate cognitive decline in older adults[28].

A noteworthy point concerns the variable of vulnerability. The results in this sample contradict existing literature, as older adults not in a situation of vulnerability demonstrated a higher violence risk (46.2%) compared to those identified as vulnerable (39.5%). Previous studies[29-30], highlight a greater risk of older adults experiencing violations when in situations of vulnerability, particularly when considering the combined analyses of factors associated with violence risk, as also observed in this study. These factors may predispose institutionalized older adults to a group of risk elements that make them more susceptible to violence. A study conducted in the Republic of China identified several risk factors compatible with our findings, placing older adults in vulnerable situations and making them prone to abuse[31].

Critically analyzing this variable and contributing to the scientific field, this finding offers a different perspective on the profile of institutionalized older adults not classified as vulnerable who are also at risk of experiencing violence, to a similar extent as those considered vulnerable. Additionally, another analysis emerges when examining the education variable, which revealed proximity between results, suggesting that whether an older adult is literate or not does not exempt them from abuse. It can be inferred that the situation of vulnerability influences how older adults perceive and report various forms of violence, with non-vulnerable older adults feeling more secure in reporting and exposing the violations they suffer, thus increasing statistical data.

It is important to emphasize that this study expands knowledge on the factors influencing institutionalized older adults' increased risk of violence. The findings reinforce the need for further research, particularly studies focused on interventions and strategies aimed at training professionals and society to address violence against older adults. This highlights the importance of mitigating inequalities and using scientific knowledge to better prepare legal protection mechanisms to support older adults who are victims of violence. Additionally, it emphasizes the need to avoid institutional violence and prevent the revictimization of older adults who suffer mistreatment.

Promoting strategies to support investments in public policies for institutionalized older adults and victims of violence, as well as strengthening health intervention and promotion initiatives, is essential. This can be achieved by fostering intersectoral discussions and strategically encouraging older adults' participation. Recognizing them as autonomous and independent individuals helps deconstruct the social representation that aging is associated with unproductivity. Instead, respect for ancestry, transgenerational knowledge, and the prominent role of older adults in historical, cultural, and social development should be prioritized.

The limitations of this study are primarily methodological, as the cross-sectional design captures a single temporal snapshot, which does not imply a causal relationship between variables over time. This highlights the importance of conducting longitudinal studies with larger sample sizes to increase the statistical precision of results, provide a deeper understanding of the population studied, and enable the detection of more precise differences between groups.

CONCLUSION

The risk of violence among institutionalized older adults was particularly associated with clinical and health characteristics. Violence risk was predominant among participants with fall risk, self-reported illnesses, cognitive decline, depression, nutritional risk, sarcopenia, functional decline, and those already experiencing violence. These findings support the study's hypothesis.

Consequently, older adults with lower violence risk demonstrated better-preserved cognitive functions, absence of depressive symptoms, greater functional and nutritional autonomy, and a more positive perception of health and self-care. These protective factors help mitigate violence risks and potential violations.

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Authors
Nathaly da Luz Andrade
https://orcid.org/0000-0002-5990-5766
Francisco de Assis Moura Batista
https://orcid.org/0000-0003-2403-4830
Bruna Caroline Cassiano da Silva
https://orcid.org/0000-0002-3192-8448
Eulália Maria Chaves Maia
https://orcid.org/0000-0002-0354-7074
Bruno Araújo da Silva Dantas
https://orcid.org/0000-0002-7442-0695
Gilson de Vasconcelos Torres
https://orcid.org/0000-0003-2265-5078

Corresponding Author/Autora Correspondente
Nathaly da Luz Andrade – Universidade Federal do Rio Grande do Norte, Natal, Brasil.
nathalylandrade@outlook.com

Authors' contributions/Contributos dos autores
NA: Conceptualization, writing – original draft.
FB: Writing – original draft.
CM: Supervisão, redação – revisão e edição.
BS: Methodology.
EM: Supervision, writing – review and editing.
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Ethical Considerations
Approved by the Research Ethics Committee of the Onofre Lopes University Hospital – UFRN/Brazil [CAAE: 36278120.0.1001.5292 – no. 4267762].

Considerações Éticas
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Table 1 – Sociodemographic characteristics of institutionalized older adults according to risk of violence. Brazil, 2024.[↖↖]

Sociodemographic variables		Risk of violence		Total n (%)	p-value*
		Yes n (%)	No n (%)		
Gender	Female	139 (62.3)	21 (9.4)	160 (71.7)	0.406
	Male	52 (23.3)	11 (4.9)	63 (28.3)	
Age Range	60-79 years	50 (22.4)	9 (4.0)	59 (26.5)	0.817
	80 years or older	141 (63.2)	23 (10.3)	164 (73.5)	
Race/Skin Color	White	83 (37.2)	16 (7.2)	99 (44.4)	0.490
	No white	108 (48.4)	16 (7.2)	124 (55.6)	
Education	Literate	99 (44.4)	21 (9.4)	120 (53.8)	0.148
	Not literate	92 (41.3)	11 (4.9)	109 (46.2)	

*Pearson's Chi-Square Test.

Table 2 – Clinical and health characterization of institutionalized older adults according to risk of violence. Brazil, 2024.[↖↖]

Clinical/health variables		Risk of violence		Total n (%)	p-value*
		Yes n (%)	No n (%)		
Falls	Yes	94 (42.2)	19 (8.5)	113 (50.7)	0.287
	No	97 (43.5)	13 (5.8)	110 (49.3)	
Fall risk	Yes	24 (10.8)	11 (4.9)	35 (15.7)	**0.002**
	No	167 (74.9)	21 (9.4)	188 (84.3)	
Polypharmacy	Yes	57 (25.6)	13 (5.8)	70 (31.4)	0.224
	No	134 (60.1)	19 (8.5)	153 (68.6)	
Self-reported diseases	Yes	1 (0.4)	3 (1.3)	4 (1.8)	**0.010****
	No	190 (85.2)	29 (13.0)	219 (98.2)	
Cognitive decline	Yes	43 (19.3)	19 (8.5)	62 (27.8)	**<0.001**
	No	148 (66.4)	13 (5.8)	161 (72.2)	
Depression	Yes	50 (22.4)	23 (10.3)	73 (32.7)	**<0.001**
	No	141 (63.2)	9 (4.0)	150 (67.3)	
Nutritional risk	Yes	43 (19.3)	13 (5.8)	56 (25.1)	**0.029**
	No	148 (66.4)	19 (8.5)	167 (74.9)	
Risk of sarcopenia	Yes	50 (22.4)	14 (6.3)	64 (28.7)	**0.042**
	No	141 (63.2)	18 (8.1)	159 (71.3)	
Risk of functional decline	Yes	9 (4.0)	6 (2.7)	15 (6.7)	**0.003**
	No	182 (81.6)	26 (11.7)	208 (93.3)	
Frailty	Yes	4 (1.8)	2 (0.9)	6 (2.7)	0.207**
	No	187 (83.9)	30 (13.5)	217 (97.3)	
Vulnerability	Yes	103 (46.2)	17 (7.6)	120 (53.8)	0.933
	No	88 (39.5)	15 (6.7)	103 (46.2)	
Situation of violence	Yes	76 (34.1)	27 (12.1)	103 (46.2)	**<0.001**
	No	115 (51.6)	5 (2.2)	120 (53.8)	

*Pearson's Chi-Square Test.
**Fisher's Exact Test.