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Prevalence of depressive symptoms in the elderly people assisted at the family health units and associated factors

Prevalência de sintomas depressivos em idosos atendidos em unidades de saúde da família e fatores associados

Prevalencia de síntomas depresivos em adultos mayores atendidos en unidades de salud de la familia y factores asociados

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Abstract: **Objective**: to analyze the prevalence of depressive symptoms in elderly people assisted at Family Health Units and associated factors. **Method**: This is a cross-sectional study carried out with a clipping of research in 2015 with a proportional stratified probabilistic sample of 557 elderly people assisted at Family Health Units in Tangará da Serra. The independent variables are sociodemographic and health conditions. The dependent variable is depressive symptoms and it was assessed using the depression scale. Poisson regression verified the associated factors. **Results**: the prevalence of depressive symptoms was 22.8%. The associated variables were: regular/bad/terrible health perception (PR = 6.69; CI: 3.78-11.82); functional dependence (PR = 2.99; CI: 1.85-4.83) and not having a job (PR = 3.96; CI: 1.02-15.38). **Conclusion**: the prevalence of depressive symptoms was higher than in other studies. Social factors and related to the health conditions of the elderly person are associated with depressive symptoms, and it is important to develop actions to promote active and healthy aging.
Descriptors: Aged; Prevalence; Depression; Mental Health; Geriatrics

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Resumo: Objetivo: analisar a prevalência de sintomas depressivos em idosos atendidos nas Unidades de Saúde da Família e fatores associados. **Método:** estudo transversal, realizado como recorte de uma pesquisa executada em 2015 com amostra probabilística estratificada proporcional de 557 idosos, atendidos em Unidades de Saúde da Família em Tangará da Serra. As variáveis independentes são sociodemográficas e condições de saúde. A dependente é sintomas depressivos e foi avaliada por meio da escala de depressão. Para verificar os fatores associados foi realizado regressão de Poisson. **Resultados:** a prevalência de sintomas depressivos foi 22,8%. As variáveis associadas foram: percepção regular/ruim/péssima de saúde (RP=6,69; IC: 3,78-11,82); dependência funcional (RP=2,99; IC: 1,85-4,83) e não ter trabalho (RP = 3,96; IC: 1,02-15,38). **Conclusão:** a prevalência de sintomas depressivos foi maior que em outras pesquisas. Fatores sociais e relacionados às condições de saúde dos idosos associam-se com sintomas depressivos, sendo importante desenvolver ações para promover o envelhecimento ativo e saudável.
Descritores: Idoso; Prevalência; Depressão; Saúde Mental; Geriatria

Resumen: Objetivo: analizar la prevalencia de síntomas depresivos en adultos mayores atendidos en las Unidades de Salud de la Familia y factores asociados. **Método:** estudio transversal, realizado como recorte de una investigación ejecutada en 2015 con una muestra probabilística estratificada proporcional de 557 adultos mayores, atendidos en Unidades de Salud de la Familia en Tangará da Serra. Las variables independentes son sociodemográficas y condiciones de salud. La variable dependiente es síntomas depresivos y fue evaluada por medio de la escala de depresión. Para verificar los factores asociados fue realizado regresión de Poisson. **Resultados: l**a prevalencia de síntomas depresivos fue 22,8%. Las variables asociadas fueron: percepción regular/mala/pésima de salud (RP=6,69; IC: 3,78-11,82); dependencia funcional (RP=2,99; IC: 1,85-4,83) y no tener trabajo (RP = 3,96; IC: 1,02-15,38). **Conclusión: l**a prevalencia de síntomas depresivos fue mayor que en otras investigaciones. Factores sociales y relacionados a las condiciones de salud de los adultos mayores se asocian con síntomas depresivos, siendo importante desarrollar acciones para promover el envejecimiento activo y saludable.
Descriptores: Anciano; Prevalencia; Depresión; Salud Mental; Geriatría

Introduction

Population aging is evident in the world, changing the countries' demographic and epidemiological profiles. During the aging process, the elderly person has biological and psychosocial changes,[1] and a progressive decrease in the functional reserve,[2] causing health problems that contribute to the development of depression.

Depression is a mental disorder with multiple causes, which significantly interferes with the social, professional, and health of elderly people. As it is related to the affective or mood area and causes low situational self-esteem, it is confused with other diseases, even with sadness.[3] This condition has serious consequences in the elderly's life, such as psychological distress, impairments in activities of daily living (ADL), increased health spending, impaired

interpersonal relationships, and the disability caused by the disease.[4-7] It is also considered a mental disorder, showing a high rate in the elderly population,[3,8] with a higher prevalence in women,[9-13] people with other comorbidities or institutionalized people, demonstrating the need for early identification and treatment of this pathology due to medical and neurological disorders that also compromise the quality of life of the elderly population.[12]

Research carried out in Brazil reveals that the prevalence of depressive symptoms in the elderly can vary. Studies developed in Rio Grande do Sul found a prevalence between 15.2%[14] and 18.0%.[15] In Minas Gerais, the prevalence found was 22.0%[16] and in Bahia was 52.6% of the elderly participating in a Community Center presented these symptoms.[17] These differences may be due to several factors or characteristics of the studied populations, showing the importance of investigating this phenomenon in different locations so that health actions can be planned according to local needs.

Thus, the literature highlights that some sociodemographic characteristics and health conditions are associated with a higher prevalence of depressive symptoms in this population. For example, females, low economic status, without a job, physical inactivity, negative self-rated health, functional disability,[14-15] retired, history of heart problems, dissatisfied with life,[15] and age between 60 to 70 years old.[16]

Although it is a very prevalent disease in this population, the literature shows that it is underreported and often not treated by health professionals, especially those in primary care. Many health professionals are unaware of the screening methods, they are unprepared to identify the symptoms, and they associate it with aging.[17] In this sense, because it is a disease with high prevalence and physical and psychological consequences, it is considered a health problem public. With the exponential increase in population aging and changes in the epidemiological profile, we need investigations that can assist in the knowledge about

prevalence, factors involved, methods of screening, detection, and preventive measures on depression in the elderly population.

Also, a systematic review study found that there are several investigations in Brazil to assess the prevalence of this event in the elderly population; however, they are concentrated in the southeastern and southern regions,[18] demonstrating the need to carry out further investigations on this phenomenon in the central west, mainly in the interior of the state of Mato Grosso (MT) as they are incipient. Thus, knowing the characteristics and factors associated with depression in elderly people can assist in the planning of effective interventions for the rehabilitation of these people or the prevention of this problem, especially in primary health care.

Thus, the following question emerged: What is the prevalence of depressive symptoms in the elderly population assisted at the family health units (FHU) in a municipality in the mid-north of the state of Mato Grosso? What sociodemographic and health characteristics are associated with this event? We believe that the prevalence of depressive symptoms in elderly people is high and this event will be associated with some sociodemographic factors and health conditions. In this sense, this study aims to analyze the prevalence of depressive symptoms in elderly people assisted at the FHU and the associated factors.

Method

This is a cross-sectional study carried out as a clipping from a database of a primary research[19] of 2015 with a proportional stratified probabilistic sample of 557 elderly people assisted at the FHU in Tangará da Serra, MT. The population consisted of 5096 elderly people identified by surveying the registration of families in the micro areas in ten basic health units in the municipality.

The finite population formula calculated the sample with a 95% confidence interval, a significance level of 5%, a maximum allowed error of 4%, a percentage of the phenomenon 50%.

We selected the elderly participants at random and we replaced those who did not meet the inclusion criteria with a new drawing until we could reach the necessary sample size.

The study included people aged 60 years old or over, assisted at the FHU, living in an urban area, and those who presented cognitive deficits evidenced by the application of the Mini-Mental State Examination, adopting the cutoff point according to education level.[20]

The research data collection was carried out in 2015, at the residence of the elderly participant, with an interview applying a questionnaire about sociodemographic characteristics, health conditions, and validated scales, such as Geriatric Depression Scale (GDS-15) to identify the depressive symptoms and Barthel's Index to assess the functional capacity of the elderly person.[19] We entered the data collected twice to correct discrepancies and we created a database with several variables related to the health conditions and characteristics of the participants with the help of the Excel® (Office 2019). In 2017, for the construction of this clipping, we accessed the primary research database, extracting the variables of interest for this study to later perform the data analysis.

The dependent variable in this study is the depressive symptoms. For its classification, we used the score recorded in the database obtained through the application of the GDS of each participant, considering positive those who had a value higher than 5 points.[20] This scale is an instrument to identify or confirm the suspicion of depression symptoms in the elderly population. A study indicates that it has good reliability in detecting cases of depression in elderly people.[21]

It is a quick assessment composed of a questionnaire with 15 questions of objective answers (yes/no) regarding how the elderly person has been feeling during the last week. Any health professional can use it. For each negative answer of the elderly person to the interviewer, there is a sum of 1 point, resulting in a score of 0 to 15 points. Scores between 0 to 5 are considered normal mood, from 6 to 10 points mild depressive symptoms, and scores greater than 10 points are considered severe depressive symptoms.[21]

The independent variables are sociodemographic (gender, age group, marital status; years of education; income of the elderly person; occupational situation and family arrangement) and health conditions (health perception; self-reported health problem; the number of health problems; use of medication; use of tobacco; use of alcoholic beverages; diabetes; neoplasia; cardiovascular and musculoskeletal problems; hypertension; fall in the last 12 months and functional capacity).

We analyzed the data with the Stata® version 11.1 statistical program. We carried out the descriptive data analysis with relative and absolute frequencies and bivariate analysis, using Pearson's chi-square test to identify the variables associated with the dependent variable, considering the statistical significance of 5% ($p < 0.05$). For this analysis, we categorized some variables to become dichotomous: age group, health perception, and depressive symptoms.

To determine the factors associated with depressive symptoms, we performed Poisson regression analysis with the stepwise forward method and we included the variables with $p < 0.20$ in the regression model. We estimated the gross and adjusted prevalence and prevalence ratio (PR) of the depressive symptoms variable and its 95% confidence interval (CI). Only variables associated with the dependent variable remained in the final model ($p < 0.05$).

The research was following the required ethical standards, meeting the guidelines and regulatory standards for research involving human beings. The primary research that built the database used in this study was approved by the Ethics and Research Committee of Hospital Júlio Muller under Opinion 921.129, on December 18, 2014.

Results

We evaluated 557 elderly people aged ≥ 60 years old, most were 60 to 69 years old (50.8%), female (61.8%), widowed, single or separated (54.2%), and with an income of up to one minimum wage (70.3%). Regarding their education level, most (42.2%) are illiterate. Most of the elderly

participants were retired (71.3%), received up to one minimum wage (70.3%), and lived with someone (84.9%) (Table 01).

Table 01 - Distribution of elderly people assisted at the Family Health Units according to sociodemographic characteristics. Tangará da Serra, Mato Grosso, 2015.

Variables	Frequency (n)	Percentage (%)
Gender		
Female	344	061.8
Male	213	038.2
Age group		
60 – 69 years old	283	050.8
70 – 79 years old	224	040.2
80 years old or more	50	009.0
Marital status		
Married/common-law marriage	255	045.8
Widowed/Single/Separated	302	054.2
Years of study		
None	235	042.2
One to three years	175	031.4
4 years or more	147	026.4
Income of the elderly participant in MW*		
Up to one minimum wage	392	070.3
More than one minimum wage	165	029.7
Occupational situation		
Retired	397	071.3
Working	39	007.0
Retired/Working	26	004.7
Not working	95	017.0
Family arrangement		
Living alone	84	015.1
Living with someone	473	084.9
Total	557	100.0

* The minimum wage (MW) at the moment was R$ 788,00.

Source: Database[19]

Regarding their health conditions, 43.9% of the elderly participants self-rated their health as regular, 54.6% reported having one to 4 health problems, and most of them (98.7%) reported having some health problem. Most of them use medication (83.3%), do not use alcohol and

tobacco (78.3% and 90.5%, respectively), and have preserved functional capacity (75.6%). Cardiovascular and musculoskeletal diseases were the most prevalent (72.4% and 69.7%, respectively) and the prevalence of depressive symptoms was 22.8% (Table 02).

Table 02 - Distribution of elderly people assisted at the Family Health Units according to health conditions. Tangará da Serra, Mato Grosso, 2015.

Variables	Frequency (n)	Percentage (%)
Perception of health		
Great	54	09.7
Good	192	34.5
Regular	245	43.9
Bad	36	06.5
Terrible	30	05.4
Self-reported health problem		
Yes	550	98.7
No	7	01.3
Number of health problems		
None	6	01.1
Une to four problems	304	54.6
Five or more problems	247	44.3
Use of medications		
Yes	464	83.3
No	93	16.7
Use of tobacco		
Yes	53	09.5
No	504	90.5
Use of alcoholic beverage		
Yes	121	21.7
No	436	78.3
Diabetes		
Yes	116	20.8
No	441	79.2
Neoplasm		
Yes	15	02.7
No	542	97.3
Cardiovascular Problem		
Yes	403	72.4
No	154	27.6
Musculoskeletal Problem		
Yes	388	69.7
No	169	30.3

Hypertension		
Yes	374	67.2
No	183	32.8
Fall in the last 12 months		
Yes	220	39.5
No	337	60.5
Functional capacity		
Dependent	136	24.4
Independent	421	75.6
Depressive symptoms		
Absent	430	77.2
Mild	110	19.7
Severe	17	03.1
Total	557	100.0

Source: Database [19]

The bivariate analysis between depressive symptoms and sociodemographic characteristics showed a statistically significant association with occupational status (p = 0.037) (Table 03). The prevalence of depressive symptoms in elderly people who do not work was 3.96 times higher than the prevalence of elderly people who work. In the retired elderly participants and retired elderly people who work, the prevalence was 2.94 and 2.49 times higher, respectively, than the elderly people who work.

Table 03 - Prevalence of depressive symptoms in the elderly participants assisted at the Family Health Units according to sociodemographic variables (n = 127). Tangará da Serra, Mato Grosso, 2015.

Variables	n	Prevalence (%)	Gross PR (CI95%)*	p-value†
Gender				
Female	85	24.7	1.25(0.90-1.73)	0.172
Male	42	19.7	1.0	
Age group				
60-69 years old	69	24.4	1.15(0.84-1.56)	0.366
70 years old and more	58	21.2	1.0	
Marital status				
Widowed/Single/Separated	62	24.3	1.12(0.83-1.53)	0.434
Married/common-law marriage	65	21.5	1.0	
Years of study				
None	64	27.2	1.48(0.99-2.21)	0.093
One to three years	36	20.6	1.12(0.71-1.75)	

Four years or more	27	18.4	1.0	
Income of the elderly participant in MW				
Up to one MW	8	25.0	0.90(0.48-1.68)	0.760
More than one MW	119	22.7	1.0	
Occupational situation				
Retired	90	22.7	2.94(0.97-8.88)	**0.037**
Working	3	07.7	1.0	
Retired and working	5	19.2	2.49(0.65-9.58)	
Not working	29	30.5	3.96(1.28-12.28)	
Family arrangement				
Living alone	19	22.6	1.00	0.966
Living with someone	108	22.8	1.00(0.65-1.55)	

* Prevalence ratio (PR) and 95% confidence interval (CI). † Chi-square association test
Source: Database [19]

As for the association between depressive symptoms and health conditions, there was statistical significance for the following variables: perception of regular/bad/very terrible health (p <0.001) (PR = 2.25; 95% CI 1.57-3, 22), five or more numbers of health problems (p <0.001) (PR = 2.06; 95% CI 1.50-2.83), musculoskeletal problems (p = 0.001) (PR = 0.53; CI 95% 0.35-0.80) and cardiovascular problems (p = 0.004) (PR = 1.56; 95% CI 1.15-2.11), falls in the last 12 months (p = 0.002) (PR = 1 , 60; 95% CI 1.18-2.17) and dependence for functional capacity (p <0.001) (PR = 2.36; 95% CI 1.76-3.17 (Table 04).

The prevalence of depressive symptoms among the elderly participants with the perception of regular/bad/terrible health was 25% higher than those who rated their health as great/good. Those with five or more health problems had a prevalence of depressive symptoms of 2.06 times higher than those with none to four health problems. Among those who had cardiovascular and musculoskeletal problems, the prevalence of depressive symptoms was 56% and 53%, respectively, compared to those who did not have such clinical conditions. In the elderly participants who fell in the last 12 months, the prevalence was 60% than those who did not fall, and the dependents had 2.36 times more prevalence of depressive symptoms than the independents.

Table 04 - Prevalence of depressive symptoms in the elderly participants assisted at the Family Health Units according to variable health conditions in the elderly (n = 127) Tangará da Serra, Mato Grosso, 2015.

Variables	n	Prevalence (%)	Gross PR (CI95%)*	p-value†
Perception of health				
Great/Good/Regular	86	17.5	1.0	**<0.001**
Bad/terrible	41	621	3.55(2.70-4.64)	
Health problem				
Yes	126	22.9	1.60(0.25-9.92)	0.589
No	1	14.3	1.0	
Number of health problems				
None to four problems	48	15.8	1.0	**<0.001**
Five or more problems	79	31.98	2.06(1.50-2.83)	
Use de medications				
Yes	112	24.1	1.49(0.91-2.44)	0.093
No	115	16.1	1.0	
Use of tobacco				
Yes	11	20.8	1.0	0.709
No	116	23.0	1.10(0.63-1.92)	
Use of alcoholic beverages				
Yes	28	23.1	1.01(0.70-1.47)	0.920
No	99	22.7	1.0	
Diabetes				
Yes	29	25.0	1.12(0.78-1.61)	0.526
No	98	22.2	1.0	
Neoplasm				
Yes	2	13.3	1.0	0.376
No	125	23.0	1.72(0.47-6.35)	
Cardiovascular problem				
Yes	53	30.3	1.56(1.15-2.11)	**0.004**
No	74	19.4	1.0	
Musculoskeletal problem				
Yes	103	26.6	0.53(0.35-0.80)	**0.001**
No	24	14.2	1.0	
Hypertension				
Yes	93	24.9	1.33(0.94-1.90)	0.097
No	34	18.6	1.0	
Fall in the last 12 months				
Yes	65	29.6	1.60(1.18-2.17)	**0.002**
No	62	18.4	1.0	
Functional capacity				
Independent	72	17.1	1.0	**<0.001**
Dependent	55	40.4	2.36(1.76-3.17)	

* Prevalence ratio (PR) and 95% confidence interval (CI). † Chi-square association test. Source: Database [19]

For Poisson regression analysis, all variables with p≤0.20 were included in the following order: health perception, number of health problems, functional capacity, musculoskeletal problem, fall in the last 12 months, cardiovascular problem, occupational situation, education level, use of medications, hypertension, gender and age group.

Through the association of depressive symptoms with sociodemographic and health variables, the following variables remained statistically significant in the final model: health perception, functional capacity, occupational situation, adjusted for gender and age group (Table 05).

The highest prevalence of depressive symptoms found was among the elderly participants with bad/terrible health, functionally dependent and who do not work. A goodness-of-fit test was performed, showing that the model is adequate (p = 0.4386).

Table 05 - Multiple Poisson Regression Model: variables associated with depressive symptoms in the elderly treated at Family Health Units. Tangará da Serra, Mato Grosso, 2015.

Variables and categories	Gross PR (CI95%)	Adjusted PR (IC95%)*	p-value[†]
Perception of health			
Great/Good/Regular	1.0	1.0	**<0.001**
Bad/terrible	3.55(2.70-4.64)	6.69(3.78-11.82)	
Functional capacity			
Dependent	2.36(1.76-3.17)	2.99(1.85-4.83)	**<0.001**
Independent	1.0	1.0	
Occupational situation			
Retired	2.94(0.97-8.88)	3.28(0.90-11.95)	0.071
Working	1.0	1.0	
Retired and Working	2.49(0.65-9.58)	3.41(0.66-17.49)	0.141
Not working	3.96(1.28-12.28)	3.96(1.02-15.38)	**0.047**
Gender [‡]			
Female	1.25(0.90-1.73)	0.89(0.55-1.45)	0.665
Male	1.0	1.00	
Age group[‡]			
60 to 69 years old	1.15(0.84-1.56)	1.44(0.92-2.26)	0.105
70 years old or more	1.0	1.0	

* Prevalence ratio (PR) and 95% confidence interval (CI). [†] Chi-square association test. [‡] Adjustment variables of the Poisson regression model.

Regardless of gender and age group, the elderly people with bad/terrible health perception have a prevalence of depressive symptoms 6.69 times higher than the prevalence of depressive symptoms in elderly people with a perception of great/good/regular health. The prevalence of depressive symptoms in functionally dependent elderly people was 99% higher than the prevalence of depressive symptoms in independent elderly people.

The prevalence of depressive symptoms in the elderly people who do not work was 3.96 times higher than the elderly people who work regardless of gender and age group.

Discussion

The prevalence of depressive symptoms found in this study was 22.8%, higher than in other studies in the southern region of the country.[14-15] However, it was similar to other studies in the literature such as one carried out in Minas Gerais[16] and another in Paraíba,[22] with a prevalence of 22% and 28.1%, respectively. In a population-based survey carried out in Rio Grande do Sul with 1593 elderly people belonging to the coverage area of the Family Health Strategies, the prevalence of the event was 18%.[15]

Studies developed in Minas Gerais found a different prevalence of depression in the elderly population. One of them evaluated elderly residents in the rural area and found that 22% of them had these symptoms.[16] The other was performed with participants hospitalized in clinical and surgical units and identified that 39% of them had mild to moderate depressive symptoms and 8% had severe symptoms.[23]

The disparity between the results found in the studies analyzed may be due to the difference between the populations studied such as their characteristics and the location of the country. Rio Grande do Sul is one of the states with the highest human development index, highest life expectancy due to better living, sanitary, scientific, and technological conditions,

and, maybe because of this, the prevalence of depressive symptoms in the elderly population in this region of the country is smaller than others.[24]

Elderly people who live in rural areas have different characteristics from those who live in the urban area, especially those who are assisted by the FHU, hospitalized, institutionalized, or who attend elderly community centers. Researches that identified a high prevalence of depressive symptoms in the elderly people assisted by the FHU,[15,22] and this study reinforce the importance of actions to identify this problem in this population, rehabilitation of mental health through multi-professional treatment, and actions for prevention and health promotion in primary care.

The literature shows that depression is often neglected by health professionals, little investigated in primary care, and also by family members, considered difficult to diagnose or classified as something natural in the aging process.[17] Thus, it is important to develop permanent education with health professionals to enable them to identify the elderly people who have depressive symptoms and to offer comprehensive assistance to promote their mental health.

The negative perception of health associated with depressive symptoms is also a result observed in other studies.[1,15,25-26] Elderly people with bad or very bad health perception have a higher incidence in the development of depression than the elderly people who reported having a good assessment of their health.[1] The literature also points out that bad or very bad perception of health can also be considered as a depressive symptom,[25] being associated with the presence of chronic diseases that are common pathologies in the elderly population.[27]

The perception of health is a subjective data of the self-observation of the individual in his general condition, which includes biological, psychological, and social dimensions associated with elements of the person's life (disability, cognitive loss, work, and sexual, among others).[28] Thus, because most of the elderly participants in this study have health problems, low education, and income, they may have contributed to self-rated their health as negative and consequently have depressive symptoms.

We also found a higher prevalence in elderly people with functional dependence, also found in other studies.[4,9,12,14-16,25] The impairment of functional capacity is closely related to depressive symptoms, because, as the individuals are dependent on their ADL, they are more emotionally affected, triggering depression.[4] When the elderly person decreases the desire to perform basic activities of life, we observe an indicative of these symptoms, hindering to carry out such activities. Thus, it causes this elderly person a greater degree of functional dependence.[14]

The association of functional dependence and the prevalence of depressive symptoms makes elderly people have a pessimistic view of their life, causing impairment in their daily experience. Needing help from another person to carry out their daily activities becomes uncomfortable for the elderly person and often makes them feel worthless, contributing to the development of depressive symptoms.

Research in the municipality of Campina Grande, Paraíba, found an association of depression and functional dependence for performing instrumental activities of daily living (IADL) and ADL and concluded that individuals without depression were more active.[4] Thus, functional disabilities, the institutionalization of the elderly person, and the appearance of geriatric syndromes become strong indicators of depression.[29] When they face limitations in performing activities that require greater physical and cognitive capacity, the elderly people may suffer mood changes and low self-esteem, contributing to the development of depression. We need to identify the factors that can cause such limitations, or the possible psychological changes to prevent the onset of the disease.

In this context, the family of the elderly person plays an important role in the functional, emotional reestablishment of this elderly person and for the treatment of depressive symptoms. However, the nurse must insert in this process, contributing not only to the functional independence of the elderly people but also to the reestablishment of their family bond through the therapeutic process.[10]

This study and the literature showed the association with depressive symptoms with the occupational situation of not working. Elderly residents in an urban area who do not work have a greater association with this event than the elderly people who have a paid work activity.[14] On the other hand, other studies pointed to an association of depressive symptoms with retired elderly people.[10,15,30]

Institutionalized elderly people who do not perform work activities have greater life dissatisfaction because they do not have financial autonomy, corroborating the appearance of depressive symptoms.[30] Retired elderly people have a higher level of depressive conditions because they are socially devalued since staying active in the work area helps them to feel useful in providing service to society.[10]

In this context, elderly people who do not work are idler since with inactivity in the labor market there is a decrease in income and aspects related to financial autonomy. That is, this elderly person is no longer the financial provider, previously considered as productive becomes financially dependent, favoring the onset of depressive symptoms.

In this study, elderly people with terrible self-rated health, functional dependents, and who do not work have a higher prevalence of depressive symptoms. In this sense, we need interventions in health services to reduce the prevalence of this event through policies to assist the elderly population and to establish appropriate therapy for the rehabilitation of mental and physical health in the FHU municipalities across Brazil, working to reinsert this population into society.

Our results show that the elderly people assisted at the FHU also have depression, so they must be investigated and followed up. In this sense, the Ministry of Health recommends the global assessment of the elderly person in primary care, including the assessment of depressive symptoms through the GDS.[20] Depression is one of the most prevalent psychiatric disorders in the elderly population and needs to be investigated. Thus, it is up to the FHU team

to promote embracement, identify the risks and the presence of the disease, and develop actions for the rehabilitation of the elderly's health.

Thus, there is an alert for public policy services, especially the primary care network, in the search for investments in health promotion actions and training of FHU professionals for the identification and early diagnosis of the disease. Therefore, measures that aim at an effective therapeutic plan to stimulate the elderly people for their independence and autonomy are important to give them a dignified life and to improve their functional and mental capacity.

The cross-sectional design is a limitation of this study, in which it is not allowed to assess causality and effect. However, the study sample is representative of the municipality and allows the results to be extrapolated to the population as a whole.

Conclusion

In this study, the prevalence of depressive symptoms in the elderly participants was 22.8%, considered high compared to other studies in the literature. We conclude that the associated factors were regular/bad/ terrible perception of health perception, functional dependence, and not working. Thus, regardless of gender and age group, the elderly people with bad/terrible health perception, functional dependents, and who do not work have a higher prevalence of depressive symptoms.

These results are important since the knowledge of these factors can help health professionals who work in the FHU in planning actions for the prevention and diagnosis of the disease, subsidizing the creation of public policies for the promotion of active and healthy aging.

We need to invest in future research with the design of cohort studies to identify the risk factors that lead to developing depression, aiming at a better understanding of the associated factors. Also, we need to develop studies that evaluate preventive measures to reduce the incidence or progress of the disease.

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