

The family planning of women with mental disorders: what CAPS professionals have to say

PLANEJAMENTO FAMILIAR DE MULHERES COM TRANSTORNO MENTAL: O QUE PROFISSIONAIS DO CAPS TÊM A DIZER

PLANEAMIENTO FAMILIAR DE MUJERES CON TRANSTORNO MENTAL: LA OPINIÓN DE PROFESIONALES DE LOS CAPS

Escolástica Rejane Ferreira Moura¹, Tatiane Gomes Guedes², Suellen Alves Freire³, Adriana Teofilo Bessa⁴, Violante Augusta Braga⁵, Raimunda Magalhães da Silva⁶

ABSTRACT

The objective of this study was to explore the family planning demands that occur at the Psychosocial Care Center (Centro de Atendimento Psicossocial - CAPS) and investigate the contributions of this service to women with mental disorders. This qualitative study was performed with eight workers from a CAPS located in Fortaleza-CE. Data collection was performed through interviews, and the data were submitted to content analysis. The following demands were identified: relatives' request for information on how to cope with a sexually active patient; patients susceptible to sexual violence and pregnancy; and women with depression taking lithium carbonate. Contributions identified were: the need for an integrated network (primary healthcare/CAPS) with professionals who understand the complexities regarding these women's family planning; supportive care should be provided in the primary healthcare setting, emphasizing matrix organization as a strategy to make both centers co-responsible, thus avoiding unnecessary patient referrals to the CAPS by strengthening the ability to deal with these cases in the primary healthcare setting

DESCRIPTORS

Women
Mental disorders
Family planning
Mental Health Services

RESUMO

O objetivo deste estudo foi verificar demandas de planejamento familiar que chegam ao Centro de Atendimento Psicossocial (CAPS) e investigar contribuições desse serviço para as mulheres portadoras de transtorno mental. Trata-se de estudo qualitativo, realizado com oito profissionais de um CAPS de Fortaleza-CE. A coleta de dados ocorreu por meio de entrevista, sendo utilizada para análise a técnica de conteúdo. As demandas detectadas foram: solicitação de informações pelos familiares para lidar com paciente sexualmente ativo; pacientes suscetíveis à violência sexual e gravidez; mulheres com depressão, em uso de carbonato de lítio. As contribuições: necessidade de rede integrada (atenção básica/CAPS), com profissionais conhecedores das particularidades do planejamento familiar dessas mulheres – parte defende atendimento na atenção básica, parte, atendimento no CAPS, destacando-se o matriciamento como estratégia a responsabilizar os dois polos, evitando encaminhamentos desnecessários aos CAPS, pelo fortalecimento da resolubilidade dos casos na atenção básica.

DESCRIPTORIOS

Mulheres
Transtornos mentais
Planejamento familiar
Serviços de Saúde Mental

RESUMEN

El objetivo del estudio fue verificar demandas de planeamiento familiar que llegan al Centro de Atención Psicossocial (CAPS) e investigar contribuciones de tal servicio hacia las mujeres afectadas por transtorno mental. Estudio cualitativo, realizado con ocho profesionales de un CAPS de Fortaleza-CE. Datos recolectados mediante entrevista, utilizándose técnica de análisis de contenido. Las solicitudes fueron: pedido de informaciones a los familiares para hacerse cargo del paciente sexualmente activo; pacientes susceptibles a violencia sexual y gravidez; mujeres con depresión, medicadas con carbonato de litio. Contribuciones: necesidad de red integrada de atención primaria/CAPS, con profesionales conocedores de las particularidades del planeamiento familiar de tales mujeres: una parte apoya su atención en la atención primaria; y otra, atención en el CAPS, destacándose la participación como estrategia para corresponsabilizar a ambos polos, evitando derivaciones innecesarias a los CAPS, por la facilitación de la resolución de casos en la atención básica.

DESCRIPTORIOS

Mujeres
Trastornos mentales
Planificación familiar
Servicios de Salud Mental

¹RN. Professor, Federal University of Ceará, Nursing Department. CNPq Research Fellow. Fortaleza, CE, Brazil. escolpaz@yahoo.com.br ²RN. Nursing Professor, Faculdade Nordeste. Fortaleza, CE, Brazil. tguedes@fanor.edu.br ³RN, Federal University of Ceará. Fortaleza, CE, Brazil. suellen_a_f@hotmail.com ⁴RN, Federal University of Ceará. Fortaleza, CE, Brazil. dridribessa@hotmail.com ⁵RN. Professor, Federal University of Ceará, Nursing Department. Fortaleza, CE, Brazil. vivi@ufc.br ⁶RN. Professor, Federal University of Ceará, Nursing Department. Coordinator of the Master's Program in Collective Health. Fortaleza, CE, Brazil. rmsilva@unifor.br

INTRODUCTION

Current mental health policy is designed to encourage the re-socialization of patients by progressively replacing the hospital-centered and asylum-based model, which has an exclusionary, oppressive and reductive nature, with a care model guided by the principles of the Brazilian Unified Health System (SUS): universality, equity and integrality added to a proposal to deinstitutionalize the mental health care system⁽¹⁾. Therefore, it is expected to change the paradigm of disease to the individual's suffering in existence in his/her social body with the construction of new knowledge and practice concerning madness.

Psychosocial Care Centers (CAPS^(a)) were created to respond to this proposition. CAPS are devices designed to care for patients with mental disorders, encourage social and family integration, support patients in their efforts toward autonomy, and integrate them in a concrete social and cultural environment, designated as their territory. CAPS are the main strategy in the process of psychiatric reform⁽²⁾. Additionally, these services have to offer specialized technical support concerning mental health care to the Primary Health Care (PHC) service through a matrix system. Within this system, we highlight family planning care directed to women with mental disorders as the object of this study.

The matrix system or matrix support is a tool used in the field of mental health care to change the organizational structure of the health care system network, in order to avoid unnecessary referrals to CAPS, by strengthening the solution of cases within the primary health care service. Matrix support is designed to provide both care support and technical-pedagogical support to the team of the Family Health Strategy (ESF). The referral team or professionals, in this case, CAPS, is the one responsible to provide care for an individual, family or community case, increasing the possibility of establishing bonds between professionals and users⁽³⁾. The link between mental health practices and ESF practices is based on bonding, shared responsibility, and the involvement and knowledge of the family, in which a community- and territory-based model is imperative at this level of care⁽⁴⁾.

The current Brazilian Policy on Women's Integral Health Care corroborates the relevance of this study because it proposes to include actions directed to social actors excluded from the health care system in the public health care network, especially women with mental disorders. This is the reason these women were chosen to be the subjects of this study. According to this policy's guidelines, women's integral health care should be guided

by respect for differences, without discrimination of any kind and without the imposition of one's personal values or beliefs. It includes the qualification of mental health care to women of 26 capitals, in the Federal District and cities where there are CAPS, therapeutic residence services, and other modalities of mental health care services aimed to replace the previous model. The proposed health actions emphasize: improved obstetric care; family planning; care in the event of abortion; combat against domestic and sexual violence; and care provided to adolescents and women during menopause. This policy also includes prevention and treatment of women with HIV/AIDS and those with non-transmissible chronic diseases, such as mental disorders⁽⁵⁾.

Based on the previous discussion, we observe that women with mental disorders have the right to access family planning care services, which is provided by ESF teams, responsible for providing primary health care service in Brazil. Reinforcing this statement, a study conducted by the Health Care System in Fortaleza, CE, Brazil of 255 women with mental disorders and cared for in one unit of CAPS, verified that these women require care in terms of family planning, as well as a gynecological-obstetrical profile similar to that of most women in fertile age but without a diagnosis of having a mental disorder. Such findings indicate the need for actions focused on this population⁽⁶⁾.

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Even though family planning is a responsibility of the ESF teams (PHC), such care is not very effective and does not cover all women with mental disorders. The reason is that the healthcare system is fragmented, that is, PHC workers seem to be poorly informed about the specificities of family planning provided to women with mental disorders and workers at CAPS seem to be poorly informed about the actions that should be accessed by this population⁽⁶⁾. Consequently, these women become vulnerable to unplanned pregnancies and to issues involving the pregnancy-maternity relationship and mental disorders such as the teratogenicity of some psychotropic drugs, which when not used may cause psychiatric breakdowns in addition to harming autonomy and leading to potential psychiatric hospitalizations, that may harm care provided to children.

Therefore, the following questions emerged: do the professionals working at CAPS receive demand for family planning? How do they provide such care? How can they contribute to promoting family planning to these patients? To answer these questions, the following objectives were established: to verify the needs concerning family planning for women with mental disorders cared for at CAPS units and to identify the contributions of this service's workers to this field of care.

METHOD

This field study with a qualitative approach was conducted in a CAPS II, which belongs to the Regional Executive Secretary II in the city of Fortaleza, CE, Brazil. A total of eight professionals participated in the study, including a nurse, a nursing auxiliary, a nursing technician, a psychiatrist, a social worker, an occupational therapist, a psychologist, and an educator. These professionals were chosen because they are in direct contact with patients and for this reason can perceive their needs concerning the object of this study, making the gathering of ideas from an interdisciplinary perspective more likely. Workers with less than one year in the field of mental health were not included, considering the need for a minimum time to adapt and establish rapport in the field. Four professionals did not participate due to lack of time and two refused to participate.

Data were collected in December 2009 through semi-structured interviews addressing subjective and objective questions. The subjective questions were tape-recorded and the objective questions were completed on the form by the researcher herself, which enabled a greater interaction between the interviewer and the participants.

Transcribed data were organized according to content analysis. Such an analysis is a technique of investigation that consists of discovering core meanings that compose communication, the presence of which, or frequency with which they appear, may mean something for the chosen analytical object⁽⁷⁾. The forms were coded by the letter P and numbered according to the order of interview.

Guidelines from Resolution 196/1996, Brazilian National Council of Health, concerning research involving human subjects were complied with. The study was submitted to and approved by the Ethics Research Committee at the Federal University of Ceará (COMEPE-protocol nº 227/09). After being informed of the study's objectives, the participants provided written and informed consent. Participation was voluntary and confidentiality was ensured.

RESULTS AND DISCUSSION

Characterization of the participants

The age of the participants ranged from 29 to 55 years old; six were women. Four professionals worked in the mental health field for two years and the remaining for one year, four, five, and 15 years. All reported some kind of specialization in the mental health field.

Six professionals reported having cared for patients with mental disorders who required family planning. The remaining did not report such demand, though all reported that no action focused on family planning had been developed within CAPS. This result is coherent with the organization of the SUS, since family planning is a responsibility of the ESF staff, who should send patients to more

complex levels only when these require surgical contraceptive methods or present complex infertility conditions. However, the ESF teams should receive technical support from specialized teams in the event of chronic diseases, or patients with complications and special conditions, or in the case of women with mental disorders, such support should be provided by CAPS teams⁽⁸⁾. Despite the negative answer of all the respondents concerning the development of actions in the sphere of family planning within CAPS, these professionals reported some demand, which are presented and discussed in the following item.

CAPS is responsible for providing mental health care to patients in this facility and one of the challenges faced by the service is to go beyond and become not only a place that provides technical care to mental suffering *per se*, but also a place that promotes social and inter-sector cooperation, especially in relation to the ESF, providing support concerning mental health care, including mental disorder *versus* family planning as a field of matrix support⁽⁹⁾.

Needs concerning family planning presented to the CAPS staff from women with mental disorders

The needs of these women were synthesized in the following categories: family members ask for information to deal with sexually active patients, patients that are vulnerable to sexual violence and pregnancy (no fixed partner, the partner does not participate in family planning), and patients with depression using a teratogenic drug (lithium carbonate).

The real need to understand these women's sexuality and their need for family planning care is evident. Specific situations are reported, situations for which the EFS teams could provide care, with the technical support of experts in the mental field – CAPS.

The sexuality of women with mental disorders is a controversial subject because on the one hand, there is this belief that individuals with mental disorders are exhibitionists and exacerbate their sexuality. On the other hand, there is a belief that these are asexual individuals. It is important to acknowledge that the sexuality of individuals with mental disorders is similar to that of individuals considered to be "normal". These individuals feel and love as anyone else and have the need to express themselves sexually.

A bibliographic review was conducted in the BIREME database and the production from 1990 to 2003 addressing the sexuality of adolescents with mental disorders was analyzed. It revealed that parents are faced with new challenges when their children with mental disorders reach adolescence and need to be re-integrated into society. This is especially true when these adolescents awaken to genital sexuality, since there is still a lot of prejudice in this field. The difficulty of parents in dealing with the sexual manifestations of these adolescents, such as masturbation, became apparent, which led to the conclusion that discussions with parents and adolescents with men-

tal disorders need to be expanded with a view to enable them to experience sexuality with less stigma and be less exposed to risks⁽¹⁰⁾.

The primary health care services and CAPS need to form an integrated network with professionals qualified to deal with the sexuality of this population, to include family members and turn them into caregivers. A study conducted with 17 nurses of psychiatric hospitals in Ribeirão Preto, SP, Brazil aimed to identify the social representations of these professionals concerning the sexuality of patients with mental disorders and verified that nurses denied the sexuality of mental patients, defining the manifestations of sexuality witnessed in the psychiatric units as deviation, transgression or disease⁽¹¹⁾.

When family members ask for information on how to deal with a sexually active patient, as reported by P2, it is important to inform the general particularities of family planning concerning this group, but each situation needs to be analyzed individually. Among these particularities, the ones considered to be the most relevant include: heritability of mental disorders such as bipolar disorder, which has a genetic factor and inheritance is characterized by complex mechanisms of transmission, involving multiple genes that are under the influence of environmental factors; psychiatric hospitalizations and/or episodes of psychological suffering, which can interfere in contraceptive practice, care provided to children, or in prenatal care; the use of contraceptives that require a woman's self-control, which may be compromised by a patient's altered behavior, loss of autonomy or lack of discernment; the need of a partner and/or family members to be involved in the reproductive and contraceptive choices of certain patients and in certain times of their lives (periods of crises); the use of psychotropics since some (anticonvulsants) present drug-interaction with oral hormonal contraceptives and others may cause teratogenic effects when used during pregnancy (lithium carbonate)⁽⁶⁾.

(...) family members become concerned that an unwanted pregnancy might occur; so they seek information, also because a pregnancy with a disorder would be unfeasible (...). Family members are the first to report that the patient has a partner (P2).

When P2 states that *because a pregnancy with a disorder would be unfeasible*, he sets a counterpoint because the message seems judgmental and generalizing, hurting the sexual and reproductive rights of people with mental disorders. In this context, it is important to make a differentiated clinical judgment between episodic disorders with better prognosis and the possibility to be controlled therapeutically and chronic disorders, with a more complex prognosis and therapeutic control; the experience of maternity may improve certain psychological disorders.

A study conducted in Ribeirão Preto, SP, Brazil with ten women with mental disorders, all with at least one child aged from 7 to 12 years old, spoke about being affected by a mental disorder and stated it may negatively affect the

quality of affective and family relationships. Nonetheless, despite all the difficulties they face to perform the role of being a mother, these women stated that maternity was a *normalizing* event in their adult lives. The interviewees had in common the fact of having experienced at least one unplanned pregnancy, as an experience associated with the urgent need to face maternity. The study also revealed that these women had the need to recognize themselves in the maternal function so they managed to keep fighting the limitations imposed by their mental disorders⁽¹²⁾.

A demand highlighted by P3 and P4 was the vulnerability of these patients in relation to sexual violence and pregnancy due to a relationship with a casual partner and the non-involvement of this individual in family planning. For P3,

(...) contrary to what it is believed, patients with more severe mental disorders also have active sexual lives (...) while women are more vulnerable to sexual violence (...) We see a lot of people with severe mental retardation who were raped and became pregnant, this is relatively frequent.

P4 mentioned a user with five children who suffered from sexual violence and faced hardships.

Violence against these women is an important social and public health problem. In addition to the pressure imposed on them due to their responsibilities as women and mothers, they are also victims of sexual discrimination, concomitantly with experiencing poverty, hunger, malnutrition, excess of work, and domestic and sexual violence⁽¹³⁾.

The factors that contribute to greater sexual violence against mental patients include: increased dependency on others for long-term care; denial of human rights, which results in a perception of a lack of power, both from the view of the victim and the aggressor; the perception of the aggressor that there is a lower risk of being caught; difficulties the victim has making others believe her story; the victim's poor knowledge concerning what is appropriate and not appropriate in terms of sexuality; social isolation, increased risk of being manipulated by others; potential of being abandoned or being vulnerability in public places; a lack of economic independence on the part of most individuals with mental disorders⁽¹⁴⁾.

Hence, it is important to warn women with mental disorders and their family members about the risks of sexual violence, instructing them concerning the importance of being vigilant and the prevention of being exposed to suspicious or risk situations, and informing them that sexual violence is a crime and should be reported so the aggressor is punished.

Given the vulnerability of this population to sexual violence, which is often associated with impaired autonomy, and consequently, with unplanned pregnancies, contraceptive methods that are independent of personal control such as IUDs, injectable contraceptives, and tubal ligation,

would be the first indication of actions to take. Although, the risk of sexually transmitted diseases remains⁽⁶⁾.

This is not about awakening or encouraging women with mental disorders to practice sex, because contrary to what is believed, most of these patients are already sexually active, but to provide them with information about what happens to their bodies that causes them to feel desire, inform them as to what masturbation is, and the possibilities of becoming pregnant and acquiring sexually transmitted diseases, thus, ensuring them their rights and dignity⁽¹⁵⁾.

In addition to being exposed to a pregnancy due to sexual violence, some of these women do not have a fixed partner, and when there is a fixed partner, he does not share responsibility for family planning. Such a behavior is common among the male population in general, and should be addressed as a priority when there is a mental disorder, in which one of the spouses should become more substantially responsible for family planning⁽⁵⁾. P5 highlighted the following in relation to this aspect:

There is this case of a patient who already had an unplanned child and then became pregnant again when she began receiving care in CAPS and has an unstable relationship (...)

P8 reinforces:

We've worked with many women who already had children, with no fixed partners or a partner who does not participate [in the family planning].

Women with depression arising from bipolar disorder or postpartum depression refer to another demand reported by the CAPS team. P4 noted that

most patients already have grown children and don't want to get pregnant anymore, and many are sterilized (...) the users who are of a fertile age and cannot get pregnant because of the heavy medication they take [referring to bipolar disorder], would have to stop taking lithium if they became pregnant, and if they stop taking the mood stabilizer, their condition will definitely be compromised.

In this report are included demands for contraception for women who are satisfied with their offspring and no longer want to conceive; women who are already sterilized, but paying attention to safe sex it is still relevant; and the particular aspect related to patients taking lithium carbonate, a teratogenic medication, which, when used during pregnancy or if suspended, may lead to psychiatric breakdowns. Hence the risks and benefits need to be evaluated and in this case, a joint evolution between the physician and/or nurse from the primary health care service with the specialist at CAPS is required.

Contributions of CAPS workers to the family planning care of patients with mental disorders

As previously mentioned, none of the interviewed professionals reported actions focused on family plan-

ning for women with mental disorders. However, P1 reported:

Here, the one who addresses this subject is the doctor or the nurse;

P4 and P6 reinforced this report:

the nursing staff provides guidance;

and P4 proceeds:

(...) but there's some effort involved for the EFS staff to provide such care. The CAPS is specialized and family planning is the responsibility of the ESF staff [...] we provide the appropriate guidance when we are faced with such a demand and refer the patient to the primary health care service.

The statements of P1, P4 and P6 were confirmed by the report of P3, who stated:

(...) when we see it is simple family planning, and the person feels anxious or depressed, then we just need to prescribe a pill, or something like that, and we provide guidance. When it's the case of people vulnerable to suffer sexual violence or women with understanding problems, we refer to the nursing staff (...) to get guidance here at CAPS, because unfortunately sending patients to the PHC service is not a two-way road, we always receive people who should be cared for in the PHC service but they don't cooperate.

Concerning this aspect, P8 also mentioned:

(...) what we do is to provide guidance within the groups concerning the importance of family planning, but it's not a specific family planning intervention. We work for them to bring their husbands and send them to the unit.

We observe in these testimonies that the team's actions are unsystematic and sporadic, and they recognize these are actions to be implemented in the PHC service, and it is probably the reason they all reported not providing family planning care within CAPS or not becoming committed to another field of care, which is not the main focus of mental health care. The professionals mentioned contributions appropriate to these demands but the need to define responsibilities, flows, and the roles of the health teams in both ends of care delivery became apparent.

Therefore, the production of health care undergoes structural reforms to achieve greater problem-solving capacity. Within the matrix system, the teams from the referral units (is this case, CAPS) provide specialized support to the primary care teams. In this respect, the referral teams are responsible for extending clinical care, performing therapeutic projects in the medium and long terms, promoting bonding and responsibility, reducing unnecessary referrals. The professionals in Fortaleza, CE, Brazil, are internalizing this strategy and the services are still occasional, but the first initiatives are in the process of being implemented. The idea is innovating and should be enlarged as interaction among professionals is established⁽¹⁶⁾.

In the context of contributions, the CAPS team listed difficulties and facilities dealing with the needs of patients concerning family planning, characterized as support to the organization and management of health services.

The list of difficulties included the patients' deficit of attention and cognition, which hinders the professionals' approach; the lack of a partner or family members during consultations; the need to provide technical qualification to both the team at CAPS and at the PHC service; insufficient time to provide care; lack of family planning directed to this population within the PHC service; and the lack of contraceptive methods within CAPS. We observe that this set of responses shows a lack of definition concerning who is responsible to provide care to this population. The reports show family planning is a responsibility of the PHC service, but there is also a concern as to whether the CAPS team is qualified (which is essential for them to provide technical support within matrix support) and has contraceptive methods available.

This context is shown in the following testimonies:

(...) The greatest difficulty is the disorder itself, because sometimes the patient comes without a companion and doesn't know what to report about her sexual life, doesn't talk about the subject, doesn't maintain such a dialog. I come from the medical clinic, so I already have an advantage with patients in this field, but I believe that it's not the same for other professionals who just arrived and don't have experience with the medical clinic, they miss it more than I do.(P2).

(...) I have 15 minutes to care for a patient. I have to see the medication, the symptoms, which are our main responsibility, only that care is not restricted to symptoms, there are family issues, social and family planning issues. So, given the time available, it is not feasible to do this and we know that family planning is a responsibility of the PHC service (...) it requires qualifications, but we always receive people who should receive care there. Not having the right methods in the CAPS is a problem, we should have condoms in the CAPS (P3).

(...) The PHC's professionals are not prepared, because they send everyone here [CAPS]. Professionals should be prepared but most have no interest (P6).

(...) I cared for a patient who was in her third pregnancy and she has severe postpartum depression and the doctor didn't want to give her medication [referring to technical insecurity], even though she was in the seventh month of pregnancy (P8).

Depending on the type of mental disorder, women may have some attention and cognition deficit; consequently, they have difficulty learning information necessary for decision-making and/or the autonomy to use a contraceptive method appropriately. Therefore, establishing a relationship of trust with the patient is crucial to promoting family planning care. Considering that these women have

disorders that may compromise their autonomy, individualized care is essential, along with the involvement of the partner and other significant family members in decision-making, treating the relationship between pregnancy and mental disorder, even though it is a delicate subject, as a sexual and reproductive right of this population⁽⁶⁾. Three interviewees reported the importance of the family context in this approach, noting the participation of the family and partner during consultations, which is an opportunity for them to prepare to support the patient.

The need for qualification is apparent in both services. In this context, the participants themselves noted matrix support as a significant instrument to minimize this gap, identifying specific situations that can be considered in the purview of PHC service and, in other cases, in the specialized mental health care services (CAPS). This strategy is widely accepted by the interviewed professionals and they highlight the importance of integrating CAPS and the PHC service in order to share cases and gather knowledge to better care for this population. P7 emphasizes this condition when he states:

I guess qualification should be provided to professionals, because care within the units is very fragmented. Within matrix support, it's a team having various perspectives (P7).

And P2 complements this view:

(...) matrix support is working to open discussion of this type of care. Investing in professional qualification is the most appropriate path to being recognized by the other units composing the network.

With regard to insufficient time to provide care, it is known that CAPS should provide clinical follow-up and promote the patients' social reinsertion, encourage family reconstruction, aid reinsertion in the job market, and promote leisure, as a social sphere that promotes quality of life, access to civil rights and strengthens family and community ties, in addition to supporting mental health care in the PHC unit. There are many actions to be developed and for that it is necessary to organize human resources, define roles and the quantity of patients cared for within CAPS⁽⁹⁾.

The PHC service should be the entrance door for patients with mental disorders, however, it is apparent these patients are underserved. This is a difficulty experienced by the CAPS workers, which, as a secondary service, should receive only the most severe cases of mental disorders. There is a certain disbelief in the referral of patients to the PHC service because there is no counter-referral. Patients end up lost within the healthcare network, when the network should ensure the implementation of integral actions⁽⁶⁾. Reinserting mental health patients into the community is a significant challenge for health workers in the ESF. Professional qualification during the undergraduate program and a lack of qualification programs available during professional practice are obstacles that hinder the implementation of care for these users⁽⁴⁾.

The facilities listed by the CAPS professionals include: acknowledgement concerning the importance of patient interest in sexuality-related information, which is facilitated by group activities. The presence of a family member during consultations is mentioned as both a difficulty and a facilitator.

The reports exemplify these contributions:

(...) when there's a family member present during consultation, and a lot of the patients do have one present, you can intermediately clarify doubts, you have a better access to the patient (P2).

The facilitating factor is that the patient has an open dialog with us (P3).

Testimonies within the groups become more common, because they open up and talk with other professionals (P5).

Therapeutic groups are important in the treatment of mental health patients because they are a privileged opportunity for patients to exchange experiences in which they help each other to overcome problems, that is, the socialization established within the groups enables personal transformation. When the participants establish solidarity ties with the professionals, the group becomes a community that relates through the lens of culture through which people see the world. Hence, patients feel comfortable to discuss about subjects of interest and interact, which facilitate the care provided by the workers and the workers' better understand the patients' dimensions of life⁽¹⁷⁾.

Other reports from the CAPS professionals directly referred to the family planning care provided to this population. They emphasized guidance concerning: the use of combined oral contraceptives for patients with milder disorders and the referral of patients with more severe disorders and a high risk of becoming pregnant to obtain tubal ligation; ongoing medication treatment for their disorder, and in the case of lithium carbonate, to pay attention to the teratogenic risks because patients become more vulnerable to crises when this medication is suspended; the importance of the family role; encouraging the partner and family during family groups and home visits.

P3, P4, P6 and P7 added the role of the nursing team to provide guidance concerning family planning. For that, the nursing team needs to know and understand this context to offer appropriate support and the information required by each patient and to help the patient to become an active participant in their therapeutic process, including her nuclear family. Hence, it is necessary to encourage the patient and her family members to understand the disease and the remaining aspects of her life, including the sexual and reproductive aspects and family planning⁽¹⁶⁾. We should note that each health worker has specific functions and these should be performed the best possible way, however, each professional is also responsible for the integrality of health actions. Therefore, each health worker should support other workers and follow-up on cases, contributing with knowledge and actions.

Depending on each case, we refer to and talk with other professionals. I particularly refer to the nursing staff. The difficulty is that the team has a high rate of turnover and there is no way to follow a case with a specific professional (P6).

The opinions of the CAPS team concerning family planning care provided to women with mental health disorders are polarized. Part of the professionals argue that these patients should be cared for in the PHC service, but such a service is not provided and the professionals are not prepared to care for this specific population. Part of the group argues these patients should remain within CAPS, but CAPS does not provide contraceptive methods and when there are male condoms available, people question whether these should be distributed considering the work overload of these professionals.

Amidst these different points, we perceive these women are not supported in terms of family planning and the various spheres of their health, as manifested by P4:

(...) A person is not only mental disorder, is not like a stone in the gallbladder, not only a headache, she is a whole (...) if you look from the biomedical model perspective, you look for a disease, and unfortunately it happens a lot, you don't see someone with happiness, with a life history, who dates, kisses, goes shopping, goes out, goes to the beach. We have matrix support, otherwise we'll try to take care for a lot of things and won't be able to cover everything (...).

This discussion only reinforces the relevance of this study. It encourages responsibility concerning care provided to people with mental disorders and the needs to be shared by the PHC service and CAPS in the field of family planning. P4 and P5 also highlighted that they prefer to refer the cases to matrix support to obtain a better resolution, while P1, P2 and P3 stated they prefer to refer cases to the PHC units. A consensus was not reached among the interviewees. However, we highlight matrix support as a strategy to share responsibility between the CAPS and PHC units, joining forces and opinions toward multidisciplinary care, sharing cases, and increasing the EFS problem-solving capacity as recommended by matrix support.

Family planning can be included in the therapeutic plan. Sometimes, we refer patients to the PHC unit and they send them back. The patient goes back and forth so many times that we end up caring for patients who should actually be cared for in the unit. After all, here they are listened to, establish bonds and participate in groups." (P5).

When we perceive there is a need for family planning, we provide appropriate guidance but then refer patients to the PHC unit (P4).

CONCLUSION

Six of the eight professionals reported they cared for women with mental disorders who require family planning care and agree that such needs should be considered in addition to those in the psychiatric field. Hence, this study provides evidence that women with mental disor-

ders show demand for family planning care, which reinforces the need for a care network to care for this public.

The contributions provided by the Psychosocial Care Center to deal with the family planning needs of patients with mental disorders motivated a discussion concerning the appropriate place to care for this population within this field. On the one hand, current law stipulates that PHC provide such care and, consequently, it should be technically prepared to provide it. On the other hand, CAPS provides specialized mental health care and should be technically prepared to deal with the psychiatric needs of these women. However, the law also provides that the PHC unit is the health service's entrance door for women with mental disorders and special cases should be referred to CAPS, though both services should be responsible for and give continuity to basic actions implemented for the patients.

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