

Attitudes and practices of professionals who working in the Family Health Strategy regarding the approach to drug users in the municipality of Campina Grande, Paraíba, Brazil

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Abstract *The aim of this study was to evaluate the attitudes and practices of professionals of the Family Health Strategy regarding the approach to drug users in the municipality of Campina Grande, Paraíba. The cross-sectional and exploratory study carried out with 126 doctors, nurses and dentists of Primary Health Care (PHC). Variables investigated were related to sociodemographic data, professional profile, attitudes and practices about the approach to drug users according to the Integrated Plan to Confront Crack and Other Drugs. Descriptive and multivariate statistics were performed through Multiple Correspondence Analysis (MCA). Most professionals were female (88.9%) and reported questioning only sometimes about the use of drugs during the anamnesis (53.2%). Based on MCA results, variables with the greatest discriminatory power for dimension 1 were: training time (0.776), working time in the PHC (0.688), age group (0.656); while for dimension 2 were: professional category (0.383) and knowledge of drug users in their coverage area (0.166). There are important differences in attitudes and practices about the approach of drug users among professionals.*

Key words *Drugs. Primary health care. Public health. Human resources*

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Introduction

Crack, alcohol and other drugs abuse and dependence are a complex issue affecting the health of individuals, their families and the community they live in¹⁻⁴. This situation is highlighted by increased drug consumption and, as such, it is relevant within the scope of public health, both in Brazil and worldwide, demanding from the various fields of scientific knowledge studies that question this intricate issue, taking into account its impact on the current psychosocial context^{5,6}.

In this perspective, drug addiction-related care guidelines and public policies have been drafted and discussed in several countries, which is a challenging theme for health systems⁷⁻⁹. Analyzing Brazilian health policies and principles of the Unified Health System (SUS), focusing on universality, drug users have the right to access health services at all levels of care⁸⁻¹⁰.

The inclusion of Primary Health Care (PHC) in the services to these users increases the quality of care provided, and it is recommended that they actively and fully participate with other specialized services^{6,11}. This level of care relies on the work of multiprofessional teams that, in turn, must be able to recognize drug users, address and monitor actions relevant to their needs and those of their families⁶.

In recent years, the Ministry of Health (MS) has gathered efforts to coordinate strategic actions for the treatment and prevention of drug abuse. In 2003, the National Policy for the Comprehensive Care to Alcohol and Other Drugs Users¹² highlighted the importance of decentralized health actions in this context. More recently, in 2010, the Brazilian government established the Integrated Plan for Coping with Crack and Other Drugs, which, among other objectives, aims to promote the training of professionals and rehabilitation and social reintegration of drug addicts, including families and risk groups^{6,7,13,14}.

After a critical review of literature, we found that there are few studies that aimed to investigate the practices and attitudes of Family Health Strategy (ESF) professionals regarding addressing drug users^{1,3,6}. Studies of this nature may provide subsidies for the training of professionals, as well as for the elaboration of preventive and therapeutic approaches, with emphasis on harm reduction strategies, which will possibly allow a better prognosis for users.

In this context, this study aimed to evaluate the practices and attitudes of ESF professionals regarding their approach vis-à-vis drug users.

Methods

Study characterization

This is a cross-sectional and exploratory study developed through field research, involving ESF professionals in Campina Grande (PB), a municipality in northeastern Brazil with an estimated population of approximately 405,000 inhabitants¹⁵, according to the Brazilian Institute of Geography and Statistics (IBGE, 2010). Its network of SUS PHC services is territorially distributed over six Health Districts, with 74 Primary Health Care Facilities (UBS), covering all its territorial extension and that of its two municipal districts: São José da Mata and Galante. Health districts are geographic areas that comprise a population group with their socioeconomic and epidemiological characteristics, needs and health resources to attend them. The municipal districts refer to municipal administrative subdivisions that do not enjoy political autonomy, with significant population density, but which are far from the main urban area.

The field collection took place in the second quarter of 2015 with prior authorization by the Municipal Health Secretariat, through the Institutional Authorization Term (TAI) to conduct the research in the UBS. Following the norms of the National Research Ethics Committee (CONEP) provided for in Resolution CNS 466/12 and Chapter IV of Resolution 251/97, the research project was submitted to the Research Ethics Committee, State University of Paraíba, and was approved without qualifications. All participants who accepted to participate in the study signed the Informed Consent Form.

The study consisted of a census, and the target population were all upper-level health professionals members of the minimum teams working in the city's ESF, thus covering the professional categories of doctors, nurses and dentists. Losses were health professionals on vacation, maternity leave or sick leave and those who were not at the health service after three attempted visits scheduled at different times. The Municipal Health Department of Campina Grande provided the list of professionals in each Health District, arrived at 219 individuals in total. During search, we found that only 189 were working. Of these, 126 professionals (66.6%) accepted to participate and completed the questionnaire.

Regarding losses by professional category, the survey found 81 nurses working at their stations, and of these, 54 participated (66.7%). Regard-

ing physicians. 65 individuals worked and 43 (66.2%) participated in the study. As for dentists, 43 professionals were calculated, and of these, 29 participated (67.4%). Therefore, there were no differential losses, that is, there was no differentiated profile in the non-adherence to the research.

Theoretically, in epidemiological studies, for statistical reasons, it is recommended to carry out a census when the reference population is less than or equal to 250 individuals¹⁶. Ideally, adherence of all professionals to the study would generate greater results' consistency in these situations. However, this is not always possible in practice, and current literature does not provide much information on the percentage of expected and acceptable loss after conducting a census in these borderline situations.

Choosing to perform a finite population sample calculation using Epidat software version 4.1, considering that the reference population consisted of 189 professionals and setting an accuracy level of 5%, confidence level of 95% and expected proportion of 50% could consider a representative sample of 126 professionals. Therefore, while the percentage of losses has been high, it appears that it is acceptable for a study of this nature, without compromising the internal and external validity of the investigation.

Investigated variables

A two-part structured questionnaire was used as research tool. The first part included sociodemographic variables and related to the professional performance of participants, while the second included questions related to the attitudes and practices regarding the approach to drug users in the UBS, built by researchers and based on the Integrated Plan for Coping with Crack and Other Drugs (Decree N° 7.179, of May 20, 2010)⁷. Conceptually, attitude is characterized by the usual behavior of participants in different circumstances; practice refers to the act or effect of accomplishing something; perception can be understood as a way of individuals seeing, judging, conceptualizing or qualifying something^{3,17,18}.

Depending on how the question is constructed, attitude, practice and perception are commonly interpreted in interrelated fashion. The investigation of attitudes and practices may reflect professionals' view vis-à-vis feelings, opinions and perceptions about the studied subjects^{3,18}.

The survey started in March 2015 and covered all UBS; its conclusion was given in July of that

same year. The variables were categorized as follows: (i) sociodemographic data and professional performance: age range (≤ 25 years / 26-35 years / 36-45 years / 46-55 years / 56-65 years); gender (female/male); marital status (single/separated or widower/married or common-law marriage); professional category (dentist/nurse/doctor); overall working time in the ESF (<1 year / 1-5 years / 6-10 years); formation time (1-10 years / 11-20 years / > 20 years); workplace (health districts – 1 to 6); (ii) attitudes and practices about addressing drug users in the UBS: “do you know (licit and illicit) drug users in your own area of coverage?” (all / some / none); “in the anamnesis, do you ask a question about the use of (licit and illicit) drugs?” (always / sometimes / never); “in cases of urgency, such as overdose and intoxication with suspected chemical dependence, would you know how to clinically address the situation?” (Yes / No); “in cases of urgency, would you know how and where to refer care? (Yes / No).

Data analysis

Initially, the descriptive analysis was carried out with the sociodemographic variables of the participants, as well as those related to the professional performance and perceptions about addressing drug users in order to characterize the population under study. Subsequently, the Multiple Correspondence Analysis (MCA), a multivariate analysis method was used to define data structure and to explore joint relationships between professional categories and the other variables investigated. This is a statistical exploratory technique that is appropriate for situations in which one wishes to analyze categorical data with a large number of variables, besides positioning response categories in the same system of axes/dimensions¹⁹.

In the MCA, dimensions 1 and 2 refer to the characteristics of the objects studied that will serve as a comparison parameter, and they can be explored in theoretical and conceptual terms. They are established by estimating the eigenvalues and inertia of each variable. Depending on the study, dimensions are classified as objective (when referring to tangible or physical characteristics) or subjective (when they indicate intangible or perceived characteristics)¹⁹.

The starting point for performing the MCA was the structuring of a data matrix, in which rows contain ESF health professionals and columns contain the variables of interest (sociodemographic data and characteristics related

to professional performance and attitudes and practices on addressing crack, alcohol and other drugs users). Cross-referencing rows and columns provides a defined dataset “profile”¹⁹. In the generated perceptual map are two axes, called dimension 1 and 2, respectively, and all categories of variables located within the graph. When individuals have similar characteristics, one can perceive a greater geometric proximity between categories investigated and, therefore, the setting of groups¹⁹.

Discrimination measures (DM) indicate the variables most relevant to the formation of each axis/dimension and the coordinates of centroids (CC) help the reader locate each category on the perceptual map^{19,20}. The greater the value of the discrimination measure of a variable, the greater will be the difference of the categories of the variable between the groups established and its relevance to the setting of each dimension. However, variables with a low discriminatory value in a given dimension can be taken into account in view of their practical relevance²⁰.

The analysis also calculates the inertia and eigenvalues for each dimension, as well as the Cronbach’s alpha coefficient to verify the internal reliability of the set dimensions and to generate an appropriate estimate of the variance explained by inertia^{21,22}. Only recently has this type of analysis been gaining popularity in public health research and has been shown to be a valuable tool to support strategic planning²²⁻²⁷. All analyses were performed using IBM SPSS Statistics version 20.0 software (IBM Corp., Armonk, NY, USA).

Results

Table 1 shows the distribution of professionals according to sociodemographic variables and related to professional performance and attitudes and practices about addressing drug users. Most were female (88.9%), aged 26-45 years (65.0%), with ESF length of service ≥ 10 years (46.0%), and the most participative category was that of nurses (42.9%).

Almost all participants reported knowing only some of drug users in their area of coverage (86.5%), as well as asking a question only sometimes about drug use during the anamnesis (53.2%). In addition, in response to urgent situations, 37.3% answered that they would not be able to clinically address the situation and 22.2% stressed that they would not know how or where to refer care.

In the MCA, the first and second dimension showed respective eigenvalues of 3.180 and 2.029, inertia of 0.289 and 0.184 and Cronbach’s alpha of 0.754 and 0.558. These estimates indicate that the dimensions set have acceptable internal consistency, enabling us to draw reliable conclusions from the results generated by the MCA.

Table 2 shows the distribution of discrimination measures of the investigated variables and the coordinates of the centroids of each category resulting from the MCA for the first two dimensions. Hierarchically, the variables with the greatest discriminatory power for dimension 1 were formation time (0.776), ESF length of service (0.688), age group (0.656), and whether they could clinically address urgent situations (0.271). For dimension 2, they were professional category (0.383) and drug users were known in their coverage area (0.166). The variables age, ESF length of service and formation time were shown to be relevant for the setting of both dimensions. These associations are best represented graphically.

Figure 1 shows the perceptual map resulting from the MCA. We observed the formation of three groups of professionals with different profiles. Chart 1 illustrates the main differences between groups of professionals resulting from the MCA for the first two dimensions.

Group 1 (G1) consisted mainly of single male doctors aged 26-35 years of age, with shorter formation time (1-10 years) and ESF length of service of 1-5 years, stationed in health districts 3 and 5. Members of this group generally reported knowing all crack, alcohol and other drugs users in their area of coverage and always asked a question about drug use during the anamnesis. In addition, they answered that, in case of urgency, they would be able to clinically address the situation and knew how and where to refer care.

Group 2 (G2) consisted essentially of female nurses who were married/in common-law marriage, separated/widowed, between 36 and 45 years of age, with intermediate formation time (11-20 years) and ESF length of service of 6 years and over stationed in Health Districts 1, 4 and 6. Members of this group generally reported knowing only some of crack, alcohol and other drugs users in their area of coverage and only sometimes asking a question about the use of drugs during anamnesis. In addition, they responded that they would not be able to clinically address urgent situations.

Group 3 (G3) consisted mainly of dentists, 46 years of age or older, with a longer formation period (> 20 years), who reported never asking

Table 1. Distribution of Family Health Strategy professionals according to sociodemographic variables and related to professional performance and attitudes and practices about addressing drug users.

Variables	n	%
Sociodemographic characteristics		
Age range		
≤ 25 years	5	4.0
26–35 years	41	32.5
36–45 years	41	32.5
46–55 years	27	21.4
56–65 years	12	9.5
Sex		
Female	112	88.9
Male	14	11.1
Marital status		
Single	34	27.0
Separated or widower	20	15.9
Married or common-law marriage	72	57.1
Characteristics related to professional performance		
Professional category		
Dentist	29	23.0
Nurse	54	42.9
Doctor	43	34.1
Overall working time in the Family Health Strategy		
< 1 year	10	7.9
1–5 years	30	23.8
6–10 years	28	22.2
> 10 years	58	46.0
Formation time		
1–10 years	46	36.5
11–20 years	41	32.5
> 20 years	39	31.0
Workplace		
Health district 1	33	26.2
Health district 2	25	19.8
Health district 3	19	15.1
Health district 4	25	19.8
Health district 5	11	8.7
Health district 6	13	10.3

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a question about the use of drugs during the anamnesis and not knowing how and where to refer care in urgent situations.

Table 1. Distribution of Family Health Strategy professionals according to sociodemographic variables and related to professional performance and attitudes and practices about addressing drug users.

Variables	n	%
Attitudes and practices about addressing drug users		
Do you know drug users in your own area of coverage?		
All	4	3.2
Some	109	86.5
None	13	10.3
In the anamnesis, do you ask a question about the use of drugs?		
Always	50	39.7
Sometimes	67	53.2
Never	9	7.1
In cases of urgency, would you know how to clinically address the situation?		
Yes	79	62.7
No	47	37.3
In cases of urgency, would you know how and where to refer care?		
Yes	98	77.8
No	28	22.2
Total	126	100.0

Discussion

In the last two decades, the National Policy to Combat Drug Use has changed, shifting from a user-reprimand policy to a strategy concerned with comprehensive multiprofessional actions and with adequate planning for the prevention and treatment of addicts⁷. The deliberate and harmful use of alcohol and other drugs was established as a serious public health issue. Thus, knowing the attitudes and practices of ESF professionals is essential for the evaluation of health services actions and the effective orientation of public policies on the subject studied.

Data showed that most professionals knew only a few drug users in their coverage area, which is not in line with MS⁷ standards. Ensuring the right to receive adequate treatment for any person with drug abuse problems is one of the priority goals. There is a need for professionals to track and identify most drug users residing in each coverage area to make this goal operational.

Table 2. Distribution of discrimination measures of the investigated variables and the coordinates of the centroids of each category resulting from the MCA for the first two dimensions.

Variables*	DM		CC	
	Dimension		Dimension	
	1	2	1	2
Age range	0.656	0.651		
≤ 25 years			-1.855	-2.521
26–35 years			-0.937	0.381
36–45 years			0.488	0.655
46–55 years			0.700	-0.558
56–65 years			0.732	-1.234
Sex	0.075	0.003		
Female			0.097	0.020
Male			-0.777	-0.162
Marital status	0.252	0.033		
Single			-0.826	-0.298
Separated or widower			0.294	0.111
Married or common-law marriage			0.308	0.110
Professional category	0.194	0.383		
Dentist			0.631	-0.705
Nurse			0.090	0.703
Doctor			-0.539	-0.407
Overall working time in the Family Health Strategy	0.688	0.294		
< 1 year			-1.614	-1.677
1–5 years			-0.974	0.263
6–10 years			0.083	0.482
> 10 years			0.742	-0.080
Formation time	0.776	0.277		
1–10 years			-1.161	0.181
11–20 years			0.630	0.517
> 20 years			0.707	-0.758
Workplace	0.139	0.102		
Health district 1			0.122	-0.143
Health district 2			-0.013	-0.280
Health district 3			-0.504	0.488
Health district 4			0.411	-0.194
Health district 5			-0.777	0.657

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A previous study aimed to investigate the attitudes of PHC professionals towards people with alcohol-related disorders in a municipality of Minas Gerais, and the results showed that they were positive¹⁸. According to Ordinance No. 2.488 of October 21, 2011, which approved the National Primary Health Care Policy, participation in the mapping of own area of activity, identifying groups, households and individuals exposed to risks and vulnerabilities by making them their own responsibility refers to a common duty of ESF teams¹¹. Therefore, it is relevant that pro-

professionals know the whole community in which they work so that they can intervene effectively in health issues.

MCA's proposed method facilitated the establishment of participants' profiles based on the sociodemographic characteristics related to the professional work and attitudes and practices about addressing drug users. This study evidences the setting of three groups of professionals with different characteristics.

Formation time, ESF length of service and age group showed a high discriminatory power.

Table 2. Distribution of discrimination measures of the investigated variables and the coordinates of the centroids of each category resulting from the MCA for the first two dimensions.

Variables*	DM		CC	
	Dimension		Dimension	
	1	2	1	2
Health district 6			0.319	0.005
Do you know drug users in your own area of coverage?	0.014	0.166		
All			-0.254	0.061
Some			0.047	0.141
None			-0.318	-1.200
In the anamnesis, do you ask a question about the use of drugs?	0.046	0.074		
Always			-0.154	0.037
Sometimes			0.019	0.104
Never			0.712	-0.977
In cases of urgency, would you know how to clinically address the situation?	0.271	0.009		
Yes			-0.401	-0.074
No			0.675	0.124
In cases of urgency, would you know how and where to refer care?	0.069	0.037		
Yes			-0.140	0.103
No			0.491	-0.362

Note. DM: discrimination measures; CC: coordinates of centroids. Values in bold refer to the variables whose discrimination measures were close to or higher than the values of dimension inertia.

signaling the importance of these variables during the process of evaluation of professionals' attitudes and practices vis-à-vis the approach to drug users. Not knowing drug users in one's own area of coverage has been shown to be more associated with professionals with lower age range and with less ESF length of service. These findings reinforce the need to involve the professionals with a shorter working period at the UBS in the activities of prevention, care and social reintegration of users and drug addicts as well.

Another result that caused a stir was that dentists, with a more advanced age and with a longer formation period pointed out not knowing how and where to refer the care of a drug user in urgent situations. This is understandable, because knowing how to approach users and refer them to specialized services has become a point of reference in the National Curriculum Guidelines (DCN) only recently, with ongoing implementation in most training courses²⁸. All professional categories should be able to know how to approach, provide the initial care and refer the user to the service that best suits urgent situations.

Failure to address important themes in the training of health professionals, such as the harmful use of drugs, a current subject in society and science is noted from the answers of the professionals to the questionnaire. This shortcoming begins at graduation, which is the first space of knowledge construction. There is a clear gap in the knowledge acquired during the training for the different groups of professions, with emphasis on the formation time, considering that the most current curricula of health courses rely on the introduction of this topic, following recommendations of the DCN. Universities should change and include in their educational proposal public health issues that stand out over time in order to qualify professionals in their capacity to diagnose and intervene in these health problems^{28,29}.

Regarding drug use, results showed that most of the participants only do this survey sometimes and we found that the G3 group, consisting mostly of dentists, never does so, showing the great gap of knowledge on the importance of this initial interrogation for the diagnosis and treatment

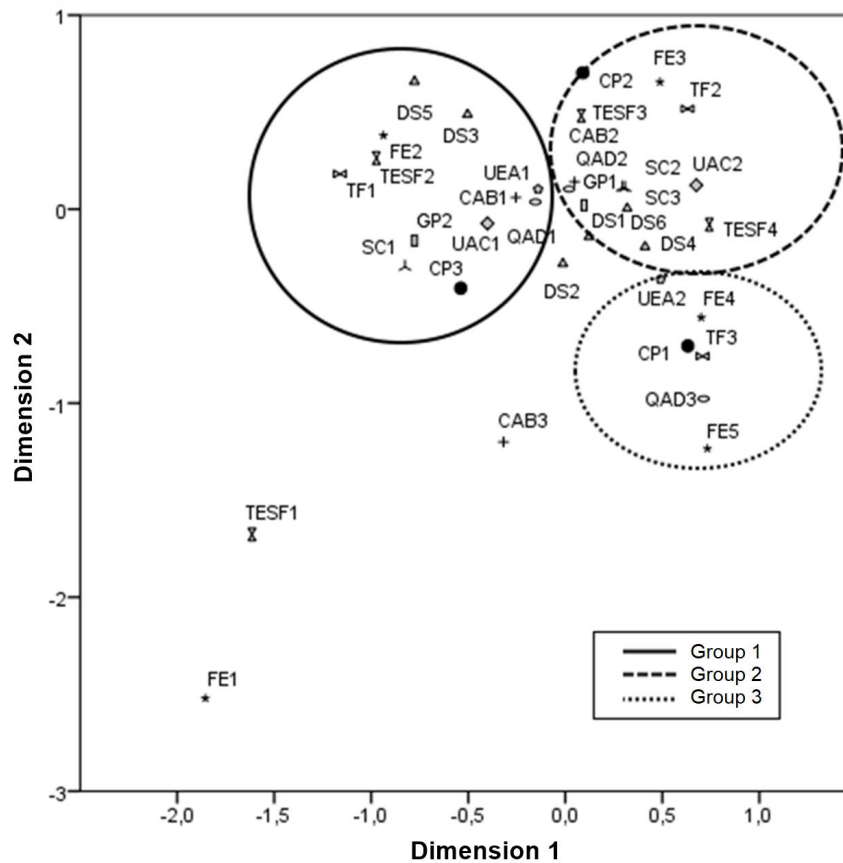


Figure 1. Perceptual map of the categories of variables investigated (sociodemographic data and characteristics related to professional performance and attitudes and practices about addressing drug users. Age range (FE1: ≤ 25 years / FE2: 26–35 years / FE3: 36–45 years / FE4: 46–55 years / FE5: 56–65 years); Sex (GP1: female / GP2: male); Marital status (SC1: single / SC2: separated or widower / SC3: married or common-law marriage); Professional category (CP1: dentist / CP2: nurse / CP3: doctor); Overall working time in the Family Health Strategy (TESF1: < 1 year / TESH2: 1–5 years / TESH3: 6–10 years); Formation time (TF1: 1–10 years / TF2: 11–20 years / TF3: > 20 years); Workplace (DS1: health district 1 / DS2: health district 2 / DS3: health district 3 / DS4: health district 4 / DS5: health district 5 / DS6: health district 6); Do you know drug users in your own area of coverage? (CAB1: all / CAB2: some / CAB3: none); In the anamnesis, do you ask a question about the use of drugs? (QAD1: always / QAD2: sometimes / QAD3: never); In cases of urgency, would you know how to clinically address the situation? (UAC1: yes / UAC2: no); In cases of urgency, would you know how and where to refer care? (UEA1: yes / UEA2: no).

of users. According to a study developed to determine the importance of proper professional-user verbal communication during consultation, the value of detailed anamnesis is often underestimated, evidencing the need for a systematic study that seeks to evaluate in detail the health conditions of the population, since anamnesis plays an increasingly relevant role in the description of users' health status³⁰.

A bond of trust begins to be built from this initial contact, through anamnesis, professional knowledge of users' social context, of drug abuse risk factors to which they are exposed, among other important points for the establishment of a treatment geared to the situation of deteriorating health of each individual in particular, seeking greater effectiveness in harm reduction and rehabilitation.

Chart 1. Main differences between groups of professionals resulting from the MCA for the first two dimensions.

Group	Characteristics
G1	<ul style="list-style-type: none"> - Male, single doctors; - Aged 26-35 years, with shorter formation time (1-10 years) and 1-5 years length of service in the ESF, stationed in Health Districts 3 and 5; - Reported knowing all crack, alcohol and other drugs users in their coverage area, and always asking a question about drug use during anamnesis; - Responded that they would know how to clinically address situations of urgency and how and where to refer care.
G2	<ul style="list-style-type: none"> - Female nurses that were either married/ in common-law marriage or separated/ widowed; - Aged 36-45 years, with intermediate formation time (11-20 years), and 6 years and over length of service in the ESF, stationed in Health Districts 1, 4 and 6; - Reported knowing only some of the crack, alcohol and other drugs users in their coverage area, and only sometimes asking a question about drug use during anamnesis; - Responded that they would not know how to clinically address situations of urgency.
G3	<ul style="list-style-type: none"> - Dentists aged 46 years and over, with higher formation time (> 20 years); - Reported never asking a question about drug use during anamnesis and that they would not know how and where to refer care.

In addition to anamnesis, other tools can be used in PHC to assist in the elaboration of a more effective drug treatment plan for each user in a particular way. An example is the application of model questionnaires to detect the consumption pattern of psychoactive substances, such as the alcohol-related Alcohol Use Disorders Identification Test (AUDIT), which guides the appropriate intervention from the users' level of use^{12,31}.

One training method currently available is the SUPERA course (System for the Detection of Abuse and Dependence on Psychoactive Substances: Referral, Brief Intervention, Social Reintegration and Monitoring), promoted by the SENAD (National Secretariat for Drug Policy) in

conjunction with the MH and Brazilian universities, which aims to enable health professionals to produce and use tools to detect the pattern of use of alcohol and other psychoactive substances¹³. This course has gained more visibility with the Integrated Plan for Coping with Crack and Other Drugs (2010)⁷, which includes training of health professionals, community leaders, municipal councilors and religious leaders in one of its axes.

In addition to health professionals, each household, education professional and community representatives play an important role in guiding users, providing them with the opportunity to acquire information and cooperating so that they are empowered to make choices to live with quality. A study on adolescent alcohol and tobacco use refers to the need to involve the family and the community in the implementation of programs aimed at preventing the use of tobacco, alcohol and other drugs³². In the field of drug user healthcare, paths must be followed to make comprehensive, fair and humanized care a reality³³.

Results point to the need to train ESF health professionals to intervene in an appropriate and interdisciplinary way in alcohol and other drugs abuse, and comprehensive actions for all users should be implemented, providing comprehensive care and including households, the social support network and the community.

This study has some limitations. One of them refers to the level of losses found and failure to use a validated questionnaire. However, the construction of research tools such as this, even for exploratory purposes is the first step towards the further elaboration of a validated tool to investigate professionals' attitudes and practices vis-à-vis addressing drug users.

This study contributed to the advancement of knowledge about the attitudes and practices of ESF professionals towards addressing alcohol and other drugs users for two main reasons. First, this is the first study on this subject in the region studied and, while restricted to a medium-sized Brazilian municipality, it paves the way for discussion of several issues on this subject of extreme relevance for the improvement of health care practices in ESF nationwide. Second, this is one of the very first studies that sought to explore relationships between sociodemographic data, characteristics related to professional performance and the attitudes and practices to address crack, alcohol and other drugs users based on the main items considered under the Integrated Plan for Coping with Crack and Other Drugs. The results are expected to draw the attention of managers

and professionals to the issue of drug abuse and to the lack of scientific and technical knowledge to deal with this problem.

Conclusion

Results suggest that there are important differences in knowledge and attitudes among ESF professionals about addressing drug users within PHC. This fact implies, therefore, difficulties in the planning and execution of multiprofessional

actions aimed at the care of this population at risk in the UBS, reducing the effectiveness of the service provided and increasing user vulnerability.

Managers and health professionals must always be updated on this issue. This knowledge must be acquired through incentives to professional training, permanent education strategies and updated curricula of undergraduate health courses, which requires reflective approaches on the service available to alcohol and other drugs users within an expected early prevention and harm reduction intervention.

Collaborations

L Farias and IM Bernardino participated in the acquisition and interpretation of data, writing and critical revision of the manuscript. RCR Madruga, S d'Avila and RSCC Lucas supervised the study, participating in the conception and design of the method and critical review of the manuscript for final approval.

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