Alcohol in primary health care: attitude of health professionals regarding the consumption and harmful use of alcohol and alcoholism

O álcool na atenção primária à saúde: atitude dos profissionais de saúde quanto ao consumo e uso prejudicial de álcool e o alcoolismo

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Abstract

Factors associated with the attitudes of Primary Health Care (PHC) professionals regarding the consumption and harmful use of alcohol and the users' alcoholism were evaluated, in addition to their perceptions about possible changes in alcohol consumption during the COVID-19 pandemic. This is an evaluative study conducted in the interior of São Paulo in 2020. Sociodemographic characteristics regarding alcohol consumption and attitude towards users were analyzed. A total of 65 of the 94 professionals in the municipality participated, with 67.7% of them having experience in the subject. Most (80%) did not change their consumption during the pandemic, but 50.8% noticed an increase in consumption by users. Positive attitudes towards being male (p=0.014) and having white skin color (p=0.020), living alone (p=0.047) and higher consumption by professionals (p=0.037) were identified. Acting in the Family Health Strategy (Estratégia Saúde da Família - ESF) was associated with more positive attitudes (p=0.029). In conclusion, personal characteristics influence the attitude, as well as the type of service. There is much to be done regarding the attitudes of health professionals to offer adequate care to users who consume alcohol. However, disseminating specific knowledge about the disease and the alcohol user seems to be one of the main coping strategies for this important health problem.

Keyword: Alcohol Drinking; Alcoholism; Primary Health Care; Attitude of Health Personnel; Health Evaluation.

Resumo

Avaliaram-se fatores associados às atitudes de profissionais da Atenção Primária à Saúde (APS) quanto ao consumo e uso prejudicial de álcool e o alcoolismo dos usuários, além de suas percepções sobre possíveis mudanças no consumo de álcool durante a pandemia de covid-19. Trata-se de pesquisa avaliativa feita no interior de São Paulo em 2020. Analisaram-se características sociodemográficas sobre o consumo de álcool e a atitude com os usuários. Dos 94 profissionais do município, 65 participaram, sendo 67,7% deles com experiência no tema. A maioria (80%) não modificou seu consumo durante a pandemia, mas 50,8% deles perceberam aumento no consumo pelos usuários. Identificaram-se atitudes positivas em relação a ser do sexo masculino (p=0,014) e ter cor da pele branca (p=0,020), residir sozinho (p=0,047) e maior consumo pelos profissionais (p=0,037). Atuar na Estratégia Saúde da Família (ESF) associou-se com atitudes mais positivas (p=0,029). Concluiu-se que características pessoais influenciam na atitude, assim como o tipo de serviço. Há muito o que avançar em relação às atitudes dos profissionais de saúde para que ofereçam assistência adequada aos usuários que consomem álcool. Porém, a disseminação de conhecimento específico sobre a doença e a pessoa que faz uso de álcool parece ser uma das principais estratégias de enfrentamento deste importante agravo à saúde.

Palavras-chave: Consumo de Bebidas Alcoólicas; Alcoolismo; Atenção Primária à Saúde; Atitude do Pessoal de Saúde; Avaliação em Saúde.

Introduction

Mental health problems are estimated to correspond to around 12% of the global disease burden, being responsible for 1/3 of all disabilities in the Americas region. Alcohol use correspond to the ninth most frequent cause of those disabilities, leading to more than 3 million deaths in 2016 (PAHO, 2018). In addition to acute intoxication and dependence syndrome, the harm caused by harmful alcohol consumption is reflected in mental and behavioral disorders, digestive disorders, traffic accidents, situations of interpersonal violence, cardiovascular diseases, and several other health conditions (Brasil, 2018). In Brazil, estimates show that 50% of Brazilians consume alcohol on a regular basis, and in 24% of the cases the use is frequent and heavy, which demonstrates a pattern of high risk to health (Laranjeira, 2012; Brasil, 2018).

Primary Health Care (PHC) services – especially those operationalized in the Family Health Strategy (ESF) model due to their attributes of first contact, cross-sectionality, care coordination, and family- and community-centered approach –, are understood as spaces that present better conditions to adopt an early and resolute approach to alcohol consumption as a risk factor for these numerous health problems (Brasil, 2003; Flôr et al., 2017; Macinko; Mendonça, 2018).

However, despite this potential, the early identification of risky consumers has still gone unnoticed by health professionals, especially in relation to consumption patterns that do not characterize dependence (Brasil, 2003; Fontanella et al., 2011).

This scenario worsens due to the growing increase in alcohol consumption during the COVID-19 pandemic when compared to previous years, which may turn into harmful use and also be responsible for the increase in complications associated with alcohol use, signaling an important long-term public health problem (Clay; Paker, 2020; Rubin, 2021).

People's attitudes are established by the interrelationship between cognitive, affective, and behavioral components, and can be modified by experiences in relation to the object (Aronson; Wilson; Akert, 2018). Similarly, health practices are social constructions and, therefore, influenced by

the different conceptions, values, and social norms experienced by the professionals who carry them out (Aronson et al., 2018; Oliveira et al., 2019; Souza; Menandro; Menandro, 2015). Thus, one questions which factors are linked to the positive or negative attitudes of these professionals towards issues related to user alcohol consumption. Additionally, the doubt is whether there were changes in professionals' personal consumption habits and the way they spoke to service users about the topic of alcohol throughout the COVID-19 pandemic.

It is expected that such responses can contribute to the identification of improvements in the PHC health teams' work process, as well as subsidizing reformulations towards more inclusive public policies. Thus, considering the potential of the interrelationship between knowledge production and management of health practices addressed in the evaluations (Novaes, 2000), this work aimed to evaluate factors associated with PHC health professionals' attitudes regarding consumption and harmful alcohol use and user alcoholism, in addition to their perceptions of possible changes in consumption throughout the COVID-19 pandemic.

Materials and methods

This is an evaluative investigation (Novaes, 2000), based on the application of an electronic survey to 94 professionals (doctors and nurses) who composed the 42 teams of 34 PHC services in a municipality in the interior of the state of São Paulo, in the year 2020.

The collection instrument, structured on Google® Form, contained 64 closed-end and single-answer questions about the interviewees' sociodemographic characteristics (sex, age, self-declared skin color, and level of education), professional's consumption profile (three questions from Alcohol Use Disorders Identification Test-Concise/AUDIT-C, and one about changes in their drinking habit during the pandemic), professional experiences (length of experience, experience in caring for alcoholics, perception of change in user alcohol consumption during the pandemic), organizational service model (ESF or traditional model - UBS), and their attitudes towards the topic (Scale of Attitudes towards Alcohol, Alcoholism and Alcoholics/ EAFAAA) (Vargas, 2014; Meneses-Gaya et al., 2009). Understanding the inductive power of evaluative investigations (Champagne; Contandriopoulos; Tanon, 2011), an open-ended question was added to the end of the form to identify whether the experience of answering the instrument caused any change in the way the professional thought of the use of alcohol, alcoholism, and the person who uses alcohol.

The invitation and form were sent by the municipal administration and the data was collected anonymously only after participants read and accepted the Informed Consent Form (ICF). The database was validated by checking response duplicity and/or absence and analysis of response behavior, and no response had to be excluded.

The analysis had two stages: (1) descriptive analysis, where the results were expressed through absolute numbers and respective percentages of the interviewees' sociodemographic and professional profile, as well as their alcohol consumption level. Considering that the EAFAAA is a Likert-type scale to measure the professionals' attitude, the concepts were first converted into scores (Strongly disagree = 1; Partially disagree = 2; Not sure = 3 ; Partially agree = 4; Strongly agree = 5) and, in this way, the average scores were calculated for each of the four Factors and for the total (Soares; Vargas; Formigoni, 2013). For this calculation, the items of each participant were added by Factor, divided by their respective number of items. Therefore, this score varied between 1 and 5. Next, a general attitude score was calculated for all Factors, that is, by adding up all the participants' responses and dividing them by the total number of scale items (n=50). In this manner, the mean of the scores of each Factor and the general mean represent the trend in attitudes of each Factor and the general attitude. To interpret this result, values between 1.0 and 2.5 were considered as indicative of a negative attitude; values between 2.6 and 3.5 of an intermediate attitude, and values between 3.6 and 5.0 of a positive attitude. (2) inferential statistical analysis, where the professionals' attitudes were taken as the outcome variable (mean score in each of the four Factors and the total EAFAAA score). Student's t test for independent samples was used to compare the mean scores on the EAFAAA scale, considering the binary variables (sex, living condition – alone or with someone, graduate training, type of health unit – UBS or ESF, and

experience in working with alcoholics). To correlate the Factors and general mean of attitudes with self-declared skin color, length of service, alcohol use frequency, number of doses per consumption, and binge drinking (large amounts in a short period of time) frequency, the analysis of variance technique for a one-factor model was applied, complemented by Tukey's multiple comparison test. Pearson's correlation coefficient was used to analyze the association between the participant's age, in years, and attitude scores. A 5% significance level ($p<0.05$) was considered in all statistical analyses. The contents referring to the open-ended question were grouped according to their correspondence with the attitudes addressed in the respective EAFAAA Factors and analyzed in relation to their distribution among them.

Resultados

With regard to the 94 doctors and nurses from the municipal PHC, 69.14% responded to the questionnaire, and the majority of professionals were white (81.5%), female (70.8%), aged between 30 and 49 years (72 .3%), with less than 15 years of professional experience (63.1%), different graduate levels, and with experience in working with alcoholics (67.7%). Regarding alcohol consumption, 21.5% declared to be teetotalers, and among those who consumed alcohol, the use frequency was two to four times a month (38.5%), followed by once a month or less (27.7%), with one to two doses in each use episode (47.7%), and weekly binge drinking as reported by 10% of participants. Most interviewees (76.9%) worked in services organized according to the ESF model (Table 1).

Table 1 – Frequency distribution of the personal characterization variables of health professionals (doctors and nurses) in PHC and the operational model in the service they work in, in 2020

Variables	N=65 (100%)
Sex	
Female	46 (70.8)
Male	19 (29.2)
Age (years)	
20-29	12 (18.4)
30-39	21 (32.3)
40-49	26 (40.0)
50-59	5 (7.6)
60	1 (1.5)
Self-declared skin color	
White	53 (81.5)
Black	2 (3.1)
Brown	8 (12.3)
Yellow	2 (3.1)
Living conditions	
Alone	12 (18.5)
With someone	53 (81.5)

continues...

Table 1 – Continuation.

Variables	N=65 (100%)
Length of experience (years)	
" 5	15 (23.1)
5 to 15	26 (40.0)
"15	24 (36.9)
Additional training (Graduation)	
Yes	62 (95.2)
Specialization	30 (46.1)
Medical Residency	23 (35.3)
Master's degree	9 (13.8)
Doctoral degree	0 (0.0)
No	3 (4.8)
Experience with alcoholics	
Yes	44 (67.7)
No	21 (32.3)
Alcohol intake frequency (in time)	
Teetotaler	15 (23.0)
Monthly or less	18 (27.7)
2 to 4x/month	25 (38.5)
2 to 4x/week	5 (7.7)
4 or more times a week	2 (3.1)
Amount of alcohol consumption on drinking occasions (in number of standard doses1)	
Teetotaler	13 (20.0)
1or 2	31 (47.7)
3 or 4	15 (23.1)
5 or more	6 (9.2)
Binge drinking frequency2	
Teetotaler	38 (58.5)
Less than once a month	14 (21.5)
Monthly	6 (9.2)
Weekly	7 (10.8)
Every day or almost every day	0 (0.0)
Organizational model of the PHC service	

continues...

Table 1 – Continuation

Variables	N=65 (100%)
ESF (Family Health Strategy)	52 (80.0)
Traditional UBS (Basic Health Unit)	13 (20.0)

Legend: PHC = Primary Health Care. [1]Standard dose: 40 ml of distillate; 85 ml of liqueurs; 140 ml of wine; 340 ml of beer). [2]Binge drinking: pattern of consumption in large quantities in a short period of time

Most participating professionals did not change their alcohol consumption during the pandemic (80%), and 7.7% stated having reduced it. Around half of the professionals (50.8%) reported the perception of an increase in user alcohol consumption during the COVID-19 pandemic. It is noteworthy that 15.4% of participants reported not asking about alcohol consumption routinely when attending users (Table 2).

In relation to the professionals' attitude towards alcohol, alcoholism and alcoholics, it is possible to notice an intermediate general attitude regarding doubts and uncertainties compared to the attitudes questioned (general mean = 3.43). More positive attitudes were observed regarding the understanding of the alcohol user as a human being who has a pathology and that many of their behaviors do not define them as people (Factor 2 = 4.02). The other Factors analyzed indicated a tendency towards intermediate attitudes - caring for people who use alcohol, including difficulty relating to these individuals and the feelings generated in the healthcare team, in addition to need of training for this process to be carried out (Factor 1 = 3.51); legitimize the act of drinking as acceptable behavior (Factor 4=3.46), and those focused on the etiology of alcoholism in relation to biopsychosocial issues (Factor 3=3.06).

Table 2 – Frequency distribution of variables on the change in personal alcohol consumption by PHC health professionals (doctors and nurses) and their perception of users served during the COVID-19 pandemic, in 2020

Variables	N=65 (100%)
Personal consumption since the beginning of the pandemic	
Increased consumption	8 (12.0)
Decreased consumption	5 (7.7)
There was no change	52 (80.0)
User consumption since the beginning of the pandemic	
Increased consumption	33 (50.8)
Decreased consumption	1.0 (1.5)
There was no change	21 (32.3)
No questioning about consumption	10 (15.4)

Table 3 – Distribution of mean attitude scores of health professionals (doctors and nurses) in PHC services according to the EAFAAA Factors (1, 2, 3, 4 and general), in 2020

EAFAAA Factors		Mean
Factor 1	Work and interpersonal relationships with users with alcohol-related disorders	3.51
Factor 2	Person with alcohol use disorders	4.02
Factor 3	Alcoholism (etiology)	3.06
Factor 4	Alcoholic beverages and their use	3.04
General	General attitudes: consumption, abuse and alcoholism	3.43

Legend: EAFAAA= Scale of Attitudes towards Alcohol, Alcoholism and Alcoholics

An association was identified between the general attitudes of professionals who worked in the ESF (p=0.029), as well as of those who declared themselves to be male (p=0.014). A difference was also found between people self-declared white and yellow in relation to the general mean (p=0.020), but also in attitudes regarding working with alcoholics and having the skills to do so (Factor 1 p=0.007). It is also noteworthy that self-declared yellow professionals obtained lower scores in these attitudes, as well as in general, when compared to white professionals (Factor 1 p=0.007). Still regarding the professionals' personal characteristics, those who lived alone presented higher scores in all Factors, showing an association only with attitudes related to opinions towards alcoholic beverages and the right to drink (Factor 4 p=0.047), and they also presented association with these attitudes regarding the amount of alcohol consumption; those who reported being teetotaler had significantly lower scores (p=0.037).

Table 4 – Distribution of means (M) and standard deviation (SD) of the attitudes of health professionals (doctors and nurses) in PHC services according to personal characterization variables and the operational model in the service they work in, in 2020

Variables	EAFAAA Factors				
	Factor 1 M(DP)	Factor 2 M(DP)	Factor 3 M(DP)	Factor 4 M(DP)	General M(DP)
Sex					
Female	3.47 (0.52)	3.94 (0.64)	3.02 (0.38)	2.98 (0.46)	3.38 (0.30)
Male	3.65 (0.36)	4.23 (0.66)	3.19 (0.40)	3.20 (0.48)	3.58 (0.30)
p-value*	0.179	0.110	0.107	0.090	0.014
Age	-0.099	-0.065	0.059	-0.075	-0.093
p-value**	0.140	0.178	0.288	0.155	0.155
Self-declared skin color					
White	3.61 (0.45)b	4.09 (0.60)	3.12 (0.40)	3.00 (0.46)	3.49 (0.28)b
Black	3.08 (0.53) ab	4.45 (0.07)	2.82 (0.13)	2.72 (0.40)	3.23 (0.16) ab
Brown	3.14 (0.44) ab	3.61 (0.89)	2.89 (0.23)	3.28 (0.39)	3.21(0,37) ab
Yellow	2.93 (0.39) a	3.40 (0.14)	2.73 (0.26)	3.56 (0.79)	3.09 (0.38) a
p-value***	0.007	0.088	0.170	0.127	0.020
Living conditions					
Alone	3.53 (0.41)	4.27 (0.48)	3.13 (0.40)	3.29 (0.47)	3.55 (0.26)
With someone	3.52 (0.50)	3.97 (0.68)	3.06 (0.39)	2.99 (0.46)	3.41 (0.32)
p-value*	0.907	0.157	0.567	0.047	0.173
Length of experience (years)					
" 5	3.69 (0.52)	4.28 (0.44)	3.04 (0.34)	3.11 (0.39)	3.56 (0.29)

continues...

Table 4 – Continuation

Variables	EAFAAA Factors				
	Factor 1 M(DP)	Factor 2 M(DP)	Factor 3 M(DP)	Factor 4 M(DP)	General M(DP)
5 to 15	3.36 (0.42)	4.00 (0.59)	3.08 (0.40)	2.95 (0.52)	3.35 (0.24)
”15	3.52 (0.49)	3.92 (0.74)	3.08 (0.42)	3.06 (0.49)	3.42 (0.34)
p-value***	1.878	1.603	0.070	0.529	1.884
Additional training (Graduation)					
Yes	3.53 (0.49)	4.02 (0.66)	3.07 (0.39)	3.04 (0.48)	3.44 (0.31)
No	3.27 (0.25)	4.07 (0.55)	3.09 (0.35)	3.15 (0.45)	3.37 (0.36)
p-value*	0.361	0.910	0.925	0.700	0.697
Experience with alcoholics					
Yes	3.58 (0.46)	4.07 (0.68)	3.08 (0.39)	3.08 (0.48)	3.48 (0.29)
No	3.38 (0.52)	3.93 (0.61)	3.05 (0.39)	2.97 (0.47)	3.34 (0.34)
p-value*	0.115	0.417	0.800	0.372	0.100
Alcohol intake frequency (in time)					
Teetotaler	3.51 (0.49)	3.88 (0.78)	3.09 (0.43)	2.79 (0.48)	3.36 (0.34)
Monthly or ”	3.56 (0.49)	3.99 (0.52)	2.99 (0.28)	3.05 (0.44)	3.43 (0.23)
2 to 4x/month	3.53 (0.49)	4.10 (0.64)	3.14 (0.43)	3.11 (0.39)	3.48 (0.33)
2 to 4x/week	3.33 (0.35)	4.12 (0.48)	2.89 (0.34)	3.35 (0.54)	3.40 (0.46)
4 or more times a week	3.45 (0.35)	4.25 (1.06)	3.37 (0.64)	3.34 (1.10)	3.57 (0.30)
p-value***	0.936	0.384	0.759	0.067	0.404
Amount of alcohol consumption on drinking occasions (in number of standard doses1)					
Teetotaler	3.51 (0.46)	3.87 (0.71)	3.05 (0.45)	2.72 (0.43) a	3.34 (0.30)
1 or 2	3.50 (0.51)	3.48 (0.70)	3.04 (0.38)	3.06 (0.51) ab	3.42 (0.31)
3 or 4	3.59 (0.43)	4.08 (0.54)	3.09 (0.36)	3.18 (0.31) ab	3.50 (0.30)
5 or more	3.46 (0.62)	4.42 (0.52)	3.23 (0.44)	3.26 (0.42) b	3.56 (0.35)
p-value***	0.936	0.384	0.759	0.037	0.404
Binge Drinking2					
Teetotaler	3.51 (0.49)	3.88 (0.78)	3.09 (0.43)	2.79 (0.48)	3.36 (0.34)
" once a month	3.56 (0.49)	3.99 (0.52)	2.99 (0.28)	3.05 (0.44)	3.43 (0.23)

continues...

Table 4 – Continuation

Variables	EAFAAA Factors				
	Factor 1 M(DP)	Factor 2 M(DP)	Factor 3 M(DP)	Factor 4 M(DP)	General M(DP)
Monthly	3.53 (0.49)	4.10 (0.64)	3.14 (0.43)	3.11 (0.39)	3.48 (0.33)
Weekly	3.33 (0.35)	4.12 (0.48)	2.89 (0.34)	3.35 (0.54)	3.40 (0.46)
Every day or almost every day	3.45 (0.35)	4.25 (1.06)	3.37 (0.64)	3.34 (1.10)	3.57 (0.30)
p-value***	0.918	0.850	0.451	0.101	0.772
Organizational model of the PHC service					
ESF (Family Health Strategy)	3.58 (0.46)	4.10 (0.62)	3.09 (0.40)	3.05 (0.43)	3.48 (0.29)
UBS	3.31 (0.51)	3.78 (0.72)	3.00 (0.35)	3.02 (0.60)	3.28 (0.35)
p-value*	0.057	0.098	0.394	0.837	0.029

Legend: EAFAAA= Scale of Attitudes towards Alcohol, Alcoholism and Alcoholics; M=Average; SD=Standard Deviation; APS=Primary Health Care; Factor 1 - Work and interpersonal relationships with users with alcohol-related disorders; Factor 2 - Person with disorders related to alcohol use; Factor 3 - Alcoholism (etiology); Factor 4- Alcoholic beverages and their use. [1]Standard dose: 40 ml of distillate; 85 ml of liqueurs; 140 ml of wine; 340 ml of beer). [2]Binge drinking: pattern of consumption in large quantities in a short period of time, *Student's t test. **Pearson's correlation coefficient. ***Variance analysis technique for a one-factor model complemented with Tukey's multiple comparison test. No statistical differences between identical letters.

It was found that the professionals' experience in answering the questionnaire provoked reflections in almost all participants (n=64), but only 21.6% commented on the subject, highlighting reflections related to the process of working with the person who consumes alcohol (Factor 1) for the majority. At the same time, the lack of reference to other content is noteworthy, in particular the legitimacy of drinking (Factor 4), which did not emerge in any of the comments (Chart 1)

Chart 1 – Distribution of comments from health professionals (doctors and nurses) from PHC services on reflections triggered by the experience of answering the questionnaire, classified according to the attitudes contained in the EAFAAA Factors (1,2,3 and 4), 2020

Factor 1 (ten related comments)
"Yes, however, some patients don't tell us the truth for fear of saying whether they drink or not, so it's difficult to know who really drinks and even more so how much, as most say 'once in a while' 'only on the weekends' 'not a lot.' And if wanting to drink is not part of them, it becomes more complicated for you to introduce this subject and this 'need,' as many say it makes them feel calmer."
"Yes. Because it's a topic that still brings difficulties to the team."
"Yes. I understand that there is still a lack of training and skills to deal with chronic alcohol users."
"That we need to have alcoholism approach groups in our family health units."
"Yes, although alcohol and drug users, once treated in basic health units, are referred to CAPSÁLCOOL/DROGAS."
"Yes, and that better preparation of the entire team is necessary, for qualifications in listening and meeting the drug addicts' demands. More effective actions are better structured when the entire team understands the dependency process."
"Yes, no doubt. In everyday life, we do things automatically on many occasions. This is due to the high demand, mental fatigue and perhaps not wanting to get involved with the patient, knowing that this profile requires a little more work and the time between consultations should be shorter to establish a bond."

continues...

Chart 1 – Continuation.

Factor 1 (ten related comments)
"Yes. Care for alcohol users is quite complex, and it is a part of the population that is at serious risk of being kept away from health services because they do not feel welcomed."
"Yes! Primary Care is the gateway and reception for these individuals, we need to be well trained to deal with this biopsychosocial problem."
"Yes, very much. Many times, when an alcoholic patient arrives, we treat them with disdain or respond with delay to see if they go away. Inevitably, alcohol affects or worsens health as a whole (physical, mental and social health)."
Factor 2 (one related comment)
"Yes, in my reality, alcoholics rarely seek care. "
Factor 3 (two related comments)
"The pandemic will produce more addicts."
"Yes, because we don't address why they drink, but the symptoms that the person presents as a result of drinking"
Factor 4 (no related comment)

Legend: EAFAAA= Scale of Attitudes towards Alcohol, Alcoholism and Alcoholics

Discussion

The results signaled perceptions of changes in user alcohol consumption during the COVID-19 pandemic, but there were no changes on the part of health professionals. They also allowed us to verify that factors related to the professionals' personal characteristics, including the quantity of doses and frequency of personal consumption, as well as the type of organizational model of PHC services, are factors associated with professionals' attitudes regarding consumption and harmful alcohol use and alcoholism

Such results corroborate the literature that points to sex (Bezerra, Freitas; Amendola, 2020; Pinho et al., 2018; Ramírez; Vargas; Luis, 2019) and level of training (Vargas; Bittencourt, 2013; Soares; Vargas; Formigoni, 2013; Vargas, 2014) as some of the factors that influence the way health professionals address alcohol use.

Considering that men drink more than women, regarding both quantity of doses and frequency (Laranjeira, 2012), it can be thought that the fact that they have more positive attitudes is related to permissiveness in relation to alcohol users (Vargas; Luis, 2008). This assumption is justified by the fact that professionals who consume alcohol tend to have their own consumption as a parameter of normality, and are more permissive compared to those who use it moderately (Vargas; Luis, 2008). In addition to having generally favorable attitudes towards alcohol, alcoholism and alcoholics, these professionals also came closer to the threshold of statistical significance regarding alcoholic beverages and the right to drink. These results reinforce the hypothesis of a relationship between self-consumption and more positive attitudes towards users.

This same reasoning can be used when observing that professionals with self-declared yellow skin color have more negative attitudes, both in general and in issues related to working with alcohol users, when compared to white professionals. This result may reflect the fact that people of Asian origin present lower rates of harmful alcohol use than other ethnic groups (Chartier; Caetano, 2010), suggesting that they reproduce this cultural influence in their attitudes.

Similarly, the fact that professionals who live alone have more positive attitudes towards alcoholic beverages and the right to drink leads us to think whether one of the reasons for this result would be the fact that those who live alone drink more (Franco; Baldin; Paiva , 2011), reflecting on the way this professional understands the act of drinking and, consequently, on their attitude towards the alcohol user.

All these results corroborate the association identified between the personal alcohol use by professionals with more positive attitudes regarding opinions about alcoholic beverages and the right to drink.

Despite the number of professionals below the average of the Brazilian population who declared to be teetotalers (Laranjeira, 2012), as well as those who stated a pattern of binge drinking (Carlos; Herval; Gontijo, 2018) and the majority denying the increase in their own consumption during the pandemic (Clay; Paker, 2020; Rubin, 2021), it is necessary to consider that professionals who use alcohol have greater difficulty revealing the real amount they consume (Soares; Vargas; Oliveira, 2011). Perhaps, for this reason, even though they did not recognize the increase in their own consumption, they declared the perception of an increase in alcohol intake by users served during the pandemic.

This apparent contradiction between the perception of their consumption and that of the user may be reflected in the attitudes identified as intermediate by professionals, especially in the face of moral conflicts, when professionals and users consume alcohol (Bezerra; Freitas; Amendola, 2020; Soares; Vargas; Oliveira, 2011). This ambivalence in professionals' attitudes is reported in the literature (Caixeta; Pedrosa; Hass, 2016; Ramírez; Vargas; Luis, 2019) and detected in the fact that they do not feel comfortable in taking a position in their responses on the topic (Bezerra; Freitas; Amendola, 2020; Soares; Vargas; Formigoni, 2013; Vargas; Bittencourt, 2013).

Nonetheless, despite the difficulties faced by these professionals in caring for this public (Vargas; Luis, 2008), when observing the attitudes of each Factor separately, a tendency towards positive attitudes regarding the person who presents complications related to alcohol use and their personal characteristics was evident, in addition to the professionals' expectations when working with these individuals. These results corroborate what is found in the literature that reports this association, regardless of whether they have specific training to address alcohol use (Caixeta; Pedrosa; Hass, 2016; Vargas, 2014).

At the same time, it diverges from other studies that point to a predominance of negative attitudes (Bezerra; Freitas; Amendola, 2020; Ramírez; Vargas; Luis, 2019; Vargas, 2014). This difference can be justified by the specialized professional profile, as the literature shows that the more specialized and prepared professionals are to work with people who make harmful alcohol use, the better their attitudes, while the longer they have worked in the service, the worse such attitudes (Vargas; Bittencourt, 2013; Soares; Vargas; Formigoni, 2013).

The limitation in professional training is demonstrated in several studies, leading to the assumption that professionals does not have the habit of approaching the topic in a preventive manner (Romero-Rodríguez et al., 2019; Soares; Vargas; Formigoni, 2013; Vargas; Oliveira; Luís, 2010). In the same way, this better professional preparation on the subject may be linked to attitudes related to the influence of biopsychosocial determinants of alcoholism, covering psychological, biological, and moral factors (Vargas, 2014). The attitudes of participating professionals tended to be intermediate in this Factor and not negative as in other studies (Bezerra; Freitas; Amendola, 2020).

Professionals' tendency to accept the alcoholic as a person (by looking at the person who drinks – Factor 2), but not accepting their disease in the same way (by not positioning themselves regarding its etiology - Factor 3), suggests influences permeated by the stigma of harmful alcohol use – idealized as deviating from good customs (Ramírez; Vargas; Luis, 2019; Pinho et al., 2018; Oliveira et al., 2019; Soares; Vargas; Formigoni, 2013).

In this moral view, the alcoholic is not seen as a person to be treated, but as a chronic case of repetition, which disrupts the health service functioning. This concept, which still persists and brings stigmatizing and stereotypical perceptions, favors the professionals' demotivation to deal with these individuals (Oliveira et al., 2019; Vargas; Luis, 2008). Therefore, all this stigma and lack of knowledge, which generates professionals' discomfort in addressing alcohol consumption (Pinho et al., 2018; Vargas; Bittencourt, 2013), can also be observed in relation to service users, as signaled in these professionals' perception and reported in the literature, that the alcoholics does not recognize themselves as needing to be taken care of or, even, do not feel comfortable in the health service to reveal

this need (Brazil, 2003; Fontanella et al., 2011; Soares; Vargas; Oliveira, 2011).

Thus, recognizing that this vision is influenced by the social environment in the knowledge constructed by health professionals, as well as of the society in general, and that health practices are also social, the reproduction of this vision ends up being incorporated into professionals' actions beyond technical-scientific knowledge (Oliveira et al., 2019; Souza; Menandro; Menandro, 2015), reflected in work routines such as, for example, waiting for spontaneous user demand. However, it is also influenced by the biomedical model of care – still hegemonic in the country – which emphasizes a moral approach to the etiology of alcoholism (Malvezzi; Nascimento, 2018; Soares; Vargas; Formigoni, 2013; Souza; Menandro; Menandro, 2015; Vargas; Luis, 2008) and intervention only when symptoms are already present in cases of dependence, instead of investigating the user consumption pattern during routine care (Fontanella et al., 2011).

The literature also points out other typical characteristics of this care model, such as the expectation that the user, when seeking the service, believes that total abstinence is the best solution, when it is already proven that the harm reduction approach would be the most appropriate (Malvezzi; Nascimento, 2018). Or, even, that the user causes health professionals to have feelings of impotence, anger and rejection when faced with situations that seem to disorganize their work routine, such as the arrival of a drunk person, whose behavior may seem inappropriate and outside the standards of "civility" (Malvezzi; Nascimento, 2018; Vargas; Oliveira; Luís, 2010), which ends up keeping these people even further away from services.

Thus, by recognizing that all these characteristics are reflected in professional attitudes and practices, it can also be considered that they influence the care model operationalized in the different PHC services, as in the fact that professionals working in services organized according to the ESF model have demonstrated, in general, more positive attitudes towards alcohol, alcoholism and alcoholics when compared to those working at traditional UBSs. Furthermore, they came closer to the threshold of significance in relation to attitudes towards working with alcoholics and the alcoholic as a person, reinforcing the hypotheses that this arrangement has a broader view of health (biopsychosocial model) and a work process more focused on the needs of community health, in addition to the benefit of being located closer to the population (Fertonani et al., 2015).

Nevertheless, despite the greater resolution attributed to services organized according to the ESF model (Flôr et al., 2017; Macinko, Medonça, 2018), a series of deficiencies are highlighted in the literature, with emphasis on the difficulty in implementing the expanded health care model for this public through interdisciplinary care and matrix support actions (Sanine; Silva, 2021), less focused on the biological body and medicalization (Fertonani et al., 2015).

Some limitations deserve to be highlighted, especially in relation to the low number of participants and the fact that the majority work in the ESF, suggesting that those who agreed to participate could be people previously more sensitive to the topic due to the work process itself, implemented in the routine of services organized according to the ESF model. Although the lack of differentiation between health professionals (whether doctor or nurse) favored the participants' anonymity, this fact made it impossible to stress important differences between their attitudes and consumption patterns. It is also recognized that there are other characteristics that can influence such attitudes, as the level of knowledge and use of screening tools for harmful alcohol use, brief intervention and treatment of alcohol dependence, professionals' religiosity, as well as the history of alcoholism in the family, which were not analyzed in this study. However, even so, its results allowed the identification of important factors associated with the attitudes of PHC professionals regarding the consumption and harmful alcohol use and the alcoholism of PHC users, as well as their perceptions of possible changes in users' consumption during the COVID-19 pandemic, favoring in-depth future studies.

Final considerations

In general, professionals presented intermediate attitudes, which denote ambivalence towards a certain object, or even difficulty in positioning

themselves. Although they demonstrated positive attitudes towards the alcoholic, the attitudes were intermediate in relation to working with an alcoholic, the etiology of alcoholism and alcoholic beverages and the right to drink, suggesting a lack of knowledge of the subject, as well as reflections of the disease stigmatization and its moral issues. At the same time, the association of these attitudes with personal characteristics, such as sex, skin color and living or not with someone, as well as personal alcohol consumption, reinforces the conception of the sociohistorical construction of such attitudes, alerting to the need for interventions with society, as well as with professional training.

The association of positive attitudes towards alcohol, alcoholism and alcoholic with PHC services organized according to the ESF model, despite not allowing establishment of causal relationships, suggests that a greater proximity to the population and the organization of a care model centered on biopsychosocial integration, according to the person's, family's and community's health needs, may have influenced this result, reaffirming the potential of this organizational model, also for the topic of alcohol.

Finally, it is recognized that there is much room for progress in relation to the health professionals' attitudes so that they can offer qualified care to alcohol users. However, the dissemination of specific knowledge of the disease and the person who uses alcohol seems to be one of the main strategies for coping with this important health issue.

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