Bioethics in the reception of psychoactive drug dependents in therapeutic communities

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Abstract

The abuse of psychoactive substances is an extremely difficult problem in all its aspects and of worldwide importance, requiring the provision of services to large number of dependents, not always provided by the responsible public sectors. This requires the complementary participation of private non-profit institutions, such as that offered by therapeutic communities. These communities are institutions of different origins, adopt different methodologies and receive hypervulnerable people. This requires that volunteers and health professionals receive an ethical reception during transient residential care, which makes this area a field for the contribution of Bioethics to solve ethical conflicts during admissions. By poor ethical approach there is in literature, especially in Brazil, this article highlights some principles and bioethical references, such as autonomy, secret and confidentiality, alterity, spirituality, solidarity and respectful care and encourages the academic community to contribute to the enrichment of bioethical reflection on care in these institutions.
Keywords: Bioethics. Ethics. Therapeutic community. Substance-related disorders. Drug users.

Resumo

Bioética no acolhimento a dependentes de drogas psicoativas em comunidades terapêuticas

O abuso de substâncias psicoativas é problema mundial e extremamente difícil em todos os seus aspectos, requerendo a oferta de serviços para grandes contingentes de dependentes, nem sempre atendidos pelos setores públicos responsáveis. Isso exige a participação complementar de instituições privadas sem fins lucrativos, como as comunidades terapêuticas. Essas comunidades são instituições de diferentes origens, adotam metodologias distintas e recebem pessoas hipervulneráveis, o que exige dos voluntários e profissionais de saúde acolhimento ético e torna essa área campo em que a bioética pode contribuir para solucionar conflitos durante a atenção residencial transitória. Pela escassa abordagem ética de comunidades terapêuticas na literatura mundial, em especial na brasileira, este artigo enfatiza alguns princípios e referenciais bioéticos, como autonomia, sigilo e confidencialidade, alteridade, espiritualidade, solidariedade e cuidado respeitoso. Por fim, estimula a comunidade acadêmica a contribuir para enriquecer a reflexão bioética sobre o cuidado às pessoas nessas instituições.
Palavras-chave: Bioética. Ética. Comunidade terapêutica. Transtornos relacionados ao uso de substâncias. Usuários de drogas.

Resumen

Bioética en el amparo de personas dependientes de drogas psicoactivas en comunidades terapéuticas

El abuso de sustancias psicoactivas es un problema mundial extremadamente difícil en todos sus aspectos, por lo que requiere la prestación de servicios a un gran número de personas dependientes, quienes no siempre son atendidas por los sectores públicos responsables. Esto requiere la participación adicional de instituciones privadas sin fines de lucro, como las comunidades terapéuticas. Dichas comunidades son instituciones de diferentes orígenes, adoptan diferentes metodologías y acogen a personas altamente vulnerables, lo cual les exige a los voluntarios y a los profesionales de la salud un amparo ético y convierte esta área en un campo en que la bioética puede contribuir para solucionar conflictos durante la atención residencial transitoria. Por el escaso abordaje ético de comunidades en la literatura mundial, especialmente en Brasil, este artículo enfatiza algunos principios y referenciales bioéticos, como autonomía, sigilo y confidencialidad, alteridad, espiritualidad, solidaridad y cuidado respetuoso. Finalmente, invita a la comunidad académica a contribuir en el enriquecimiento de la reflexión bioética sobre el cuidado de las personas en estas instituciones.
Palabras clave: Bioética. Ética. Comunidad Terapéutica. Trastornos relacionados con sustancias. Consumidores de drogas.

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Declara não haver conflito de interesse.

This article extends from the one published in the previous issue of Revista Bioética [1], in which, in addition to recommendations for Sanitary Surveillance, the different characteristics of the therapeutic communities (TC) were portrayed, especially their participation in mental health care in Brazil.

This paper discusses chemical dependence, considered a worldwide problem that has a great negative and permanent impact on the lives of people, families and in the communities themselves. Since its recent introduction in Brazil, the use of crack has been increasingly spreading and growing, rapidly leading to dependence and reaching very high levels - for example, 70% among cocaine addicts who sought treatment [2].

The World Health Organization (WHO) [3] identifies that, in colloquial language, the term "drug" generally refers specifically to psychoactive substances and often to illegal drugs. The so-called psychoactive drugs are those that have an active principle capable of stimulating, depressing or disturbing the human mind, disorganizing the central nervous system and causing disorientation of brain functions. Thus, in this article, the use of the term "drug" has the meaning of any substance which, introduced into the body by any route of administration, alters the central nervous system in some way and may create physical or psychological dependence, or both [4].

In turn, the concept of dependence (dependence or addiction disorder) is confused and often criticized both within and outside the specialized environment of mental illness [5]. Based on diagnostic criteria, Goodman [5] refers briefly to the fact that dependence is the process in which a behavior that can produce pleasure and provide relief from internal discomfort is used in a pattern characterized by 1) recurrent failure to control behavior (lack of power) and 2) continuation of behavior despite significant negative consequences (ungovernability) due to social, financial, psychological or physical problems.

The definitions of dependence mention loss of control, lack of power, and ungovernability [6]. According to the WHO guidelines, dependence is defined as a set of cognitive, physiological and behavioral symptoms that indicate that a person has difficulty controlling the consumption of psychoactive substance, and continues to use despite adverse consequences. This term replaced the designation of addiction (addiction) and habituation. Therefore, addiction is a complex disease that can be treated and affects brain function and behavior causing changes that persist after cessation of the drug [3].

Because of this and the few opportunities of the public sector to meet the demand for long-term treatment, the therapeutic communities (TC) have been considered important support in the attention to the user, [7,8], as occurs in Brazil [9,10] and in several countries [11]. In this sense, a UN document [12] describes that the most common model of long-term residential rehabilitation is the TC.

In the world literature and especially in Brazilian literature, there is little production on a bioethical approach to the TC [13]. Thus, this article aims to contribute to the ethical debate about the experience of psychoactive drug addicts in these units, selecting some relevant principles and bioethical references in the community life of TC, such as autonomy, privacy and confidentiality, otherness, spirituality, solidarity and respectful care. It is also intended to stimulate the academic community as to the enrichment of this bioethical reflection so necessary to solve daily conflicts in institutions with characteristics as different as the TCs.

Importance of bioethics for admissions in therapeutic communities

The ethical issues involved in the reception of psychoactive substance dependents in the TCs are present in the context of admission, whether in the individual, in the family or in the activities of those responsible for that service. The bioethical references can act as a support to reflect on the search for ethical solutions, reason why they can be very useful in the debate of the conflicts that arise in the daily life of the TC.

It is an open system that can contribute to the development of bioethics in a more productive way, including inter, multi and transdisciplinary approaches to dealing with complex situations [14], such as those experienced in CT. Bioethics does not come only from the reflection of scientists, philosophers or theologians, but also from the world view of the society. To think that only specialists can discuss bioethics is a big mistake because it is a field of practical application that can guide the decision that each one makes about moral problems.

It is recommended that TCs have ethical devices capable of guiding personal relationships, guiding the action and reflection of people towards the social reality in which they are inserted [8], especially because of the fragility and vulnerability of the guests/patients. Gomes [8] concludes that a TC is a micro-society in which the daily routine is

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the cause of conflicts and contradictions, which requires a collective ethical standard of living based on the principles of sharing, honesty, and horizontal relations between support staff, residents and spirituality goal of overcoming drug use.

Therefore, it is fundamental for those responsible for the TC to have values and attitudes that are dignified with the ethical point of view of the relations between the ones who receive and the ones who are being received, and to be able to understand the fragility of the addict and give the protection and have the necessary respect for their human condition. A study conducted with leaders of a TC in Santa Catarina (in southern Brazil) spontaneously revealed a set of 18 values with absolute predominance of the words respect, ethics, human valorization and spirituality, which have surpassed the values of transparency, social commitment, sustainability, integrity, respect for individuality, professionalism, responsibility and solidarity, among others [15].

A recent survey revealed that approximately 50% of Brazilian TC managers have a higher education level, 36.6% have high school level education, and 7.7% have only elementary school level education [10]. In order to overcome possible ethical deficiencies in the training of health service technicians, as those are the ones in direct contact with patients and their families, it is recommended that they should be qualified for this activity [14] and, to this end, the proposal to create inter-municipal committees of bioethics is rescued [16].

Bioethics: some principles and references

The autonomy of the patient

Autonomy, one of the four fundamental principles of the anglo-saxon current of bioethics, can be understood as the individual's ability to make decisions that affect one's own life, self-determination and self-government. That is, it is the power to decide what is good, to have freedom of expression, to make choices facing the dilemmas of one's life. In other words, respect for autonomy translates into respect for the dignity of the human being, which, in turn, is directly connected with free consent, since he must always be informed. Respect for people includes at least two ethical convictions: all people must be treated as autonomous agents, and if there is, for some reason, reduced autonomy, everyone has the right to be protected. These theoretical statements find their practical application in informed consent [17], which represents the materialized expression of autonomy [18].

The use of the term "consent" is questioned for not adequately reflecting the issue, preferring more appropriate expressions such as "informed decision-making" or "informed choice" [19]. It should be remembered that contemporary bioethics and the informed consent were born at the same time, because postwar bioethics emerged as a discipline that contemplated the patient's autonomy and one's right to choose or reject interventions in one's body [20].

However, there is autonomy only if the individual has the right to more than one option, so that one can exercise one's right to choose. In addition to the freedom to choose, autonomy also presupposes freedom of action, that is, that the person is able to act according to the decision made, regardless of one's degree of knowledge.

Thus, in order for the patient to adequately exercise his or her autonomy, a more solid basis is needed, enshrined in the notion of free, informed, renewable and revocable consent. Consent does not presuppose practices of physical, psychological or moral coercion, simulations or deceptions, and is only morally accepted when it contains the following elements: information, competence, understanding and willingness [21].

Regarding the exercise of autonomy, at least two important ethical situations can be added in TCs: 1) those who are able to deliberate on their personal goals and act under the guidance of this deliberation; 2) those who have their autonomy diminished or are unable to decide for themselves (hypervulnerable) and who should have their protection increased.

On these limit situations, Caplan [6] states that dependents are not, in principle, incompetent as long as they are able to reason, remember complex information, set goals and be guided in time, place and personal identity. However, if a drug is able to block one's ability to restore or reestablish one's autonomy, leading to loss of control, lack of power and ungovernability, then mandatory treatments may be ethically justifiable to remove people from such situations.

The author states that the restoration of autonomy is the end of any moral argument for compulsory treatment, concluding that *the mandatory treatment that alleviates the coercive effects of addiction and allows the return or reemergence of a true autonomy of the patient may be the right thing to do* [6]. Finally, to infringe

autonomy to recreate autonomy is an ethical attitude, provided that, after coercive treatment, the autonomous capacity of the addict is restored *so that, in the short term, they can regain autonomy to decide for themselves.* [22].

For others, however, compulsory treatment is a serious ethical restriction [23]. Childress [24] places the protection of persons with reduced autonomy within the principles of beneficence and justice, and Beauchamp and Childress [25] emphasize that: 1) if there is no understanding of the situation, there will be no autonomy; 2) mental incapacity limits the autonomy of the disabled; 3) coercive institutionalization restricts the autonomy of internees.

Complementing, Durand [26] refers the rights to be informed, to decide and to choose as essential elements to the exercise of autonomy, but requiring the individual's ability to exercise: 1) the ability to understand the explanations provided and the implications of the act; 2) the ability to deliberate on possible choices according to their values and goals pursued; 3) the ability to clearly express one's choice. The ethical foundation of informed consent, beyond autonomy and beneficence, is also based on the values of loyalty, truthfulness and respect [19].

Thus, considering that admissions in TCs are not coercive, but related to the will of the patients themselves and, therefore, considering that they are capable of being aware and of exercising governability about their decisions, respect is expected for the their autonomy in the perspective of the aforementioned ethical conduct. Here, it is worth mentioning the value of "respect" as the most cited by the leaders of TCs in Santa Catarina [15], because it is in accordance with the moral responsibility of these institutions to preserve dignity, autonomy and respect for the values of the internee. Given this value in the daily practice of the TC, it will be possible to gain the confidence of the internee to establish the necessary care.

Privacy and confidentiality

The guarantee of the preservation of information related to diagnosis, complementary examination or treatment is a *prima facie* duty (an obligation that must be fulfilled) of all professionals and also of the institutions [27]. In turn, this aspect can be approached both by the question confidentiality.

Privacy is the limitation of access to a person's information and to very person, his or her privacy, and ensures the preservation of his or her anonymity. This is particularly important because in TCs this view of respect for privacy is more complex, since they live collectively and daily in limited space for a few months. Therefore, information on addicts should be limited to the functions of each individual and governed by the principle of ethical responsibility for the consequences of each action [27], even for those whose professions are not subordinated to codes of ethics [28].

At the same time, confidentiality, as an ethical pillar of the relationship between host and internee, is the guarantee of the safeguarding of personal information given in confidence and the protection against its unauthorized disclosure. Patients or dependents are the owners of their own information, while professionals and institutions are only their faithful custodians - all who come in contact with information by professional necessity are only allowed to access it, but not the right to use it freely [26].

Francisconi and Goldim [27] they also point out that this relationship of trust is established between the professional or caregiver of the institution and the internee, and must extend, necessarily, to all others who have any information about the patient. Much of the bond between host and internee can be credited to this guarantee. But above all, as Gracia points out, our personal values emphasize our identity, which is why when we are they are not respected we feel outraged and mistreated [29].

The bioethical reference of otherness

Lévinas [30] proposes the inclusion of otherness in the ethical reflection, identifying it as the face of the Other, the importance of the Other, and that each of us has the task of being responsible for the Other, especially those who are socially more vulnerable. The author [30] adds that this movement towards the Other demands radical generosity that must be offered without any reward or gratitude being expected, for this action must be regarded as a one-way altruistic act [31]. If the altruist is the one who thinks of others before thinking about oneself, the exercise of meeting or relating to otherness would be *the most complete representation of one's own ethics* [32]. In the same sense, Cortella asserts that *the view of otherness is the ability to see the other not as different, and not as a stranger* [33]. That is, otherness is the Other, the one who is not me.

By the perfect adaptation to the environment of the TC and its application in the relations between the host (I) and the internee (Other), the words of Hossne and Segre are reproduced here: *the Other, as it has been said, must be known, recognized and understood. Therefore, the Other has every right to*

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speak and demand to be heard and listened to, and I, You, or We, have the duty to hear and to listen to the Other. In the same way, the Other has every right to be seen, to be seen in totality and I, You or We have the duty to look and see, to see and to see the Other. There is also the need to ensure sufficient "focus of light" on the Other - in other words, a minimum of "clarity" must be ensured in order to look and see the Other [34]. It is expected that the health professionals contemplate the other, not as a patient, (a passive and suffering being, incapable), but as a similar in a symmetrical relation (or as close as it can be). That is why Hossne and Segre conclude:

Knowing the Other involves taking their "biography" comprehensively into account, including their spirituality and their vulnerability (as another reference). Respecting the Other, that is, otherness, implies respecting self-determination, that is, the reference of autonomy. (...) *In knowing the face of the Other, with the bioethical objective of the best option of values for the Other,* phronesis *and* sophrosynê *come into play, that is, the reference to prudence comes into play* [34].

In this vision of acting in the interaction with the Other, we recover the pioneering institution of support to the chemically dependent people in Florianópolis, the Center for Interaction and Human Integration (Centro de Interação e Integração Humana), better known as Open Door Movement (Movimento Porta Aberta) [35]. This project seeks to value the patient as a human being and aims to integrate them into the recovery environment and their return to society. As disclosed by the institution itself, it is taken into account that *the human person is seen and constitutes the fundamental value of human coexistence and where the most needy find our help, shelter and affection* [36].

This humanitarian sentiment, which is clearly expressed in the actions of the Open Door, is in keeping with what the internees want and hoped for the most: the opportunity to freely express their feelings and emotions, and to receive affection, courtesy, attention and respect as human beings [37]. In other words, alterity encourages personal reflection to make people aware of ethical issues [13].

In this sense, from the thought of Lévinas, it is shown that the "sensitivity" of face to face initiates starts an eminently ethical way of humanizing the thought and action of the health professional due to the care of the vulnerable Other [38]. Being together is not only to be by the Other's side, it is necessary to see and feel the Other, with the necessary identification of Self and the Other, which means that otherness is more than friendship, it goes beyond the concept of solidarity and is closer to empathy, or the ability to *feel along* with the Other [39].

What we now call empathy is still confused with sympathy, a confusion that dates back to the middle of the last century [38]. Thus, it is important to emphasize the importance of empathy in the context of human relations in TC, since it represents an experienced emotional experience between an observer (host) and an individual (internee). The first, based on visual and auditory perceptions, identifies and understands the feelings of the second, so that to be perceived as empathic, the observer must convey this understanding to the patient [40].

Empathy is also an important element in a person's ability to understand other people, which is why patients treated by empathic professionals report greater satisfaction with treatment and are more likely to follow the guidelines than those treated by less empathic professionals [41,42]. That is, the benefits of improved empathic communication are tangible both to the observer and to the observed [42]. This understanding can be understood as the exchange of sensibility between host and internee, and is fundamental for the quality of care [40,41], especially in the continuous stays for a few months, as observed in TCs. Ten Have and Gordjin [43] synthesize that the relationship between professional and patient should be based on empathy, which is why it is considered a central concept in health ethics.

Regarding the models of the physician-patient relationship, Emanuel and Emanuel [44] identified four types, classified as paternalistic, informative, interpretative and deliberative, the latter being considered ideal. The deliberative method further preserves the patient's autonomy so that they can develop critical attitudes about their values, and the health professional seeks to dialogue more with them, promoting other principles related to the health situation experienced. This model can also be applied to relationships with other health professionals [40].

Under the particular circumstances of TCs, each team member ends up being complementary to the other in this "magical" human relationship, in which active participation of the host is essential to the desired success [45]. Thus, solving the moral problems that patients presenting or proposing should result from a shared process between the host and the internee, the first being the use of their knowledge to suggest alternatives of therapeutic approaches

and the second, exposing their legitimate values and needs to ensure a safe and prudent decision [46].

It is understood, therefore, that in the TC, the deliberative process is present every day, since there are group meetings, seminars, house meetings and, when necessary, general meetings, always with the participation of the internees and those responsible who discuss and decide jointly [47]. In addition, the daily organization of clinical, educational and encounter groups are fundamental parts of the process of awakening each other's awareness of the Other to behavioral attitudes and patterns that must be modified. In these groups the patients directly help each other, in the difficult process of deliberation for personal change [47].

Spirituality as a bioethical reference

The growing interest in the knowledge of the relationship between spirituality and health, both by researchers and health professionals, and by the population in general, is acknowledged. Hossne and Pessini [48] consider spirituality as a new frame of reference for bioethics. Souza [49] clarifies that, as with ethics and morality, spirituality and religiosity are not synonyms, being the first implicit form of dealing with deep dimensions of subjectivity without necessarily including beliefs.

Boff [50], in turn, emphasizes the importance of spirituality in the transformation and preparation of the human being for the confrontations of our century. The American philosopher Sam Harris admits that spirituality must be disconnected from religion [51]. In the same vein, Souza [49] mentions that the quest for the inner dimension of the human being, in essence, is spirituality which, when it seeks the well- being of the other in its otherness, reflects ethics.

Souza, Pessini and Hossne [52] conclude that this responsibility for the Other (the welcome) is the spiritual challenge of bioethics, and it is in this context, in the TC environment, that spirituality should emerge as an important reference for bioethics, as mentioned by the TC leaders in Santa Catarina [15]. In TC treatment programs, it is admitted that spirituality is a fundamental element to recover the addict [47], being present in more than 90% of the units surveyed by the Institute of Applied Economic Research (Instituto de Pesquisa Econômica Aplicada - IPEA) as one of the "basic methods" of treatment [10].

Thus, spirituality constitutes a force for the transformation of addicts, since it can lead them to recognize and give meaning to their lives. As observed in one of the TCs studied: *spirituality enters not exactly as "treatment," but part of it: something that will provide a kind of ethical support for people to recover both within the TC and in their later life* [53]. It is clear, therefore, that the dimension of spirituality is a factor of well-being, comfort, hope and health, and health institutions must organize themselves to include this aspect of human need [54].

Regarding the mental health of chemically dependent people, spirituality has been increasingly worked out in clinical situations, as highlighted in international documents that value this dimension in health care and assistance (*Universal Declaration on Bioethics and Human Rights*, *Declaration on Rights of Patients* of the World Medical Association [55]) and the *Charter of the Rights of Health Users in Brazil*, which recognize the importance of spiritual care the right to religious assistance of the user [54].

A review of the literature [56] concludes that health professionals already have scientific indications about the benefit of a spiritual approach to the therapy of any potential disease, which is why they hope that in the near future the importance of this type of support in health institutions will be recognized.

Panzini *et al*. [57] emphasize that there are consistent indications of the association between quality of life and religiosity, based on studies of reasonable methodological rigor and several variables to evaluate this aspect. Another review study provides practical guidance for spiritual assessment and its integration into mental health treatment, as well as suggestions for research on the topic [58]. In the same sense, Lucchetti *et al*. [59] recognize the importance of this association and make recommendations on what the clinician should know about the patient's spiritual issues to provide more humane and comprehensive care, including pediatric patients [60].

The scientific literature makes clear the importance of spirituality in mental health, since the evidences have shown the generally positive relation between both, which, per se, justifies being this important reference instrument of bioethical reflection in the scope of TC [13]. Another study on the topic indicates that approximately 80% of studies on religion/spirituality and health are on mental health and that most of them show significant relationships between these spheres and health improvement [61]. In emphasizing the role of spiritual education, it was found that 100 of the 141 medical colleges in the USA and Canada have courses on this subject and the in 70% of them, these are part of the curriculum [61].

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A bibliographical survey performed by Leite and Seminotti [62] also suggests positive relationships between spirituality and mental health, although negative aspects regarding health recovery have been found. Similar results were found in studies of outpatients with schizophrenia or schizoaffective disorder [63]. In a study of psychiatric morbidity in England, it was found that people who had spiritual understanding of life had worse mental health than those with no such understanding [64].

Gomes [8] states that spirituality in TCs is essentially practical and available to residents, regardless of previous religious conceptions or even their absence, and Boff points out that *it is not the religions that are decisive but the spirituality underlying them. It is spirituality that unites, binds and re-links and integrates. It, and not religion, helps to compose the alternatives of a new civilizing paradigm* [65].

In turn, as De Leon [47] emphasizes addicts are not only treating their illness or changing their behavior and attitudes but being forged to change themselves. The TC, in addition to contemplating the resident in its entirety of spirit, soul and body, is by its nature a (re) educational model for preparing the resident for a return to social life [8]. Thus, it must be concluded that to *scientifically studying spirituality is a very exciting and dangerous undertaking. This is an area full of prejudices, for and against spirituality* (...) *we need to explore the relationship between spirituality and health to improve our knowledge about the human being and our therapeutic approaches* [66].

Solidarity as a bioethical reference

From the human point of view, solidarity assumes social value that unites us to each other, forming a community that must defend the same interests, and its inclusion as a referent of bioethics aims to use it in the deliberations about values [67]. Hossne and Silva [67] explain that solidarity could subsidize bioethical resolutions, since its main objective is to allow the characterization of the referential in view of more appropriate ethical actions.

The concept of solidarity can be seen as a set of bonds that unite individuals in the constitution of a social group [68], whose primary function is to maintain group cohesion and conserve life [68], expressions that allow us to understand its adequacy to the experiences in CT. Solidarity was ignored until the beginning of this century before the predominance of the individualist and autonomic vision. However, with the emergence of social and political approaches, it became more valued in the bioethical perspective [68].

Solidarity conveys, among others, the following message: *you are not alone, move away from loneliness, we are with you* [70]. Thus, it is not only a notion or concept, but mainly a practice or way of life, which allows that goes from the ethical mark of human relations in the universal sense to the level of individual conduct, in the various aspects of existence [67].

Due to the growing interest and applications, the universal sense of solidarity focuses on the interests of the communities as a whole, since in recent times its concept has been linked to four new areas of bioethics reflection: 1) the scope of public health; 2) the context of justice and equity in health systems; 3) the global health paradigm (global bioethics); 4) the link with processes that lead to the well-being of society [68]. The authors emphasize that, in the field of bioethics, solidarity has a special relevance in health care, such as in long-term care and in issues related to social assistance [68], situations experienced in the TCs.

Volunteers understand solidarity as a process based on social responsibility, and are aware that their actions are important for society [71]. De Leon [47] explains that living and working in TC helps to promote solidarity with partners and to aggregate people through of the interpersonal relationship, indispensable in the day to day. These volunteers are the primary agents of change as they are responsible for themselves and for helping their fellows.

Likewise, Selli and Garrafa [72] evaluate that, among the new principles and values linked to contemporary sociability, the one that best represents interpersonal relations is solidarity. In turn, Junges [18] emphasizes that it should be used as a way of diminishing the enormous class inequality and ethically which lead to asymmetric social relations.

Taking this into account, solidarity must be understood as the agent's ability to discern the social and political dimensions that are inseparably present in solidary action [72]. Selli and Garrafa call this *critical solidarity*, suggesting their inclusion as a value to be incorporated in the agenda of bioethics for the 21st century to guide people in voluntary practice [72]. In addition, they introduce the expression *organic voluntaryness*, a concept defined as a politicized, committed, active and beneficent participation of people who develop voluntary service in search of conditions necessary for effective democratization of the State and not only as a dedication to a particular

cause or to someone through the sense of personal solidarity. In this way, critical solidarity focuses on the commitment of the subject to his interventions and actions, and organic volunteering becomes a space for the exercise of individual and collective freedom [72].

Finally, it is emphasized that, in a TC, solidarity induces mutual obligations, reason for it to be incorporated in the method of treatment, because all people are partners and depend on each other. It should be emphasized, therefore, that helping others is something deeply rooted in the natural duty of solidarity existing in the human collective, as it happens in TCs, where internees stay together for a few months. In addition, it is also present in the actions of many who have concluded the recovery program at TC and who have voluntarily become "sponsors" of newcomers [47]. In Brazil, 32.6% of TC leaders declared themselves to be beneficiaries of TC treatments [10].

Respectful care – the new bioethical reference

Dictionaries define "care" as attention, zeal, dedication, affection and, above all, gratuitous and pleasurable empathy. Phenomenologically, "care" is a way of being, a way of being of the people that generates permanent behaviors and attitudes, which becomes the basis of a new general ethics, the ethics of special attention to the weak (vulnerable) [73]. Concluding this conceptualization and relying on Heidegger, Pegoraro defines *the entity that we are as a careful-being* [74].

Dall'Agnol [75], considering the foundations of bioethics, introduces a new and important concept in this discussion, respectful care: it is a new look at care, which refers to an attitude considered fundamental to current bioethics. For many contemporary moral ethicists and philosophers, both *caring* and *respecting* are attitudes that express ways of valuing vulnerable individuals, as for example in TC.

Care, in general, is understood as a means of preserving or enhancing the well-being of the vulnerable individual. However, it can turn into paternalism when the caregiver wishes to impose values, some specific procedure or certain conception of good that is not shared by the vulnerable individual [75], something that should be avoided in this relationship.

According to Dall'Agnol [75], due respect can limit care and prevent it from degenerating into paternalistic actions. However, according to the author, respect itself can become a negative attitude if it is not adequately dosed, which leads to the conclusion that respect without care can lead to indifference and individualism, that is, reinforcing the theory of *respectful care*.

In this aspect, sympathy would be a fundamental ingredient, understood as the capacity to share the joys or sorrows, pains and sufferings of others. It should also be said that care ethics are based on a single, individual relationship between the caregiver and the vulnerable individual and thus the former should preserve or enhance the well-being of the vulnerable individual by expanding the situation to a wider and collective relationship as in TC, for example.

In short, care is understood as a way to care for and increase the well-being of vulnerable individuals. In this sense, a fundamental bioethical principle should be that of respect for the person and not simply respect for the autonomy of the conscious person, bearing in mind that respect is one of the most important values of the human being and very relevant in social relations. It should be remembered that, in the same line, respect was the human value spontaneously referred to by the managers and technicians of TC of Santa Catarina at the 1st State Seminar of the Projeto Reviver, in 2014 [15].

It can be understood that this form of care is fully realized when a bond of trust and respect between the parties is established. To gain this confidence, the caregiver must demonstrate responsibility, competence, respect and sensitivity, expressed in personal relationships. It should be remembered that the internees, due to their clinical condition, are always vulnerable, but nonetheless, must be respected in their dignity as human beings and as holders of fundamental rights.

Therefore, attention should be paid to the need to rethink and re-examine care and respect in the broader context of general bioethics, in a dignified, ethical, and humane way (the importance of listening in relationships), since they are fundamental rights of the vulnerable. Finally, it is emphasized that respectful care is a new bioethical concept and its ethical application in the interpersonal relationships of TC is very significant, reason to conclude that *only respectful care constitutes a truly moral attitude and, therefore, it is fundamental for current bioethics* [76].

Final considerations

Those who care about the future of bioethics emphasize the need for this field to leave the academic space and gain wide diffusion in society to be active, through its principles and references, in the

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search for the best solutions in the concrete conflicts of reality. Sánchez González and Moreno suggest that in the future bioethics should be *an instrument of moral education for a new deliberative and participatory democracy,* (...) *constitute the nucleus of the civil ethics that societies need*[77]. Thus, based on this view, bioethical considerations that were little analyzed in the TC care process, such as autonomy, privacy, confidentiality, otherness, spirituality, solidarity and respectful care were incorporated.

Although TCs engage in activities that are deeply divergent and criticized for receiving public resources, and due to their discussed efficacy and treatment methods that restrict some fundamental rights of patients, it is imperative to understand that denying their existence or turning our back on them is incoherent, it is an escape from the social reality experienced by thousands of chemically dependent.

The importance of discussing the future perspectives of TCs, to make them more effective and compatible with contemporary bioethical standards is therefore understood. For this reason, the challenges for TCs in the country should be an approximation to scientific research, ongoing evaluation, and the creation of educational processes based on bioethical principles and benchmarks to enhance TC teams. Therefore, it is suggested that Inter-Municipal Bioethics Committees be established as compatible mechanisms to meet these needs.

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