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Research Paper

Choreographing, tailoring and dialoguing care in residential rehabilitation

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ABSTRACT

Alcohol and other drug residential rehabilitation is an abstinence-based modality for assisting people with long-standing concerns associated with their substance use. While ubiquitous, models of care in residential rehabilitation services vary widely and the impacts of the care delivered within them remain contentious. Critically, therapeutic processes in residential rehabilitation remain under-theorised with little attention given to the characteristics of "good care" within these settings. To examine this, an extended period of ethnographic fieldwork was conducted at one residential rehabilitation service in Eastern Australia, involving forty-one in-depth interviews with residents and staff, observations and documentary analysis. Drawing on critical accounts of care derived from science and technology studies, our analysis details how caring well in residential rehabilitation was enacted through repertoires of: *tailoring care* to the needs and preferences of individuals; *choreographing care* to attend to the multiple and diverse needs that circulate in residential rehabilitation; and *dialoguing care* to attune to the needs of those enmeshed in care relations. These repertoires also facilitated care by mitigating the totalising tendencies of institutional care, and enhancing meaningful engagement across the residential community, improving access to therapeutic resources that accrue in the program over time. This analysis emphasises the programmatic flexibility and complex, resource intensive relations necessary for the expression of "as-well-as-possible care". It also alerts stakeholders to how systems of care both condition needs and enact vulnerabilities, challenging us to envisage new systems and relations to enable people to live better lives in accordance with their needs and preferences.

Introduction

Residential alcohol and other drug rehabilitation is an abstinence-based modality, commonly understood as a treatment of last resort for people with long-standing concerns associated with their substance use (de Andrade et al., 2019; Staiger et al., 2014). Across the world, models of care in residential rehabilitation services vary widely from high-cost private programs to publicly-funded services and involuntary residential facilities for criminalised people (de Andrade et al., 2019; Miles et al., 2022; Reif et al., 2014; Werb et al., 2016). As residential institutions, these programs purport to enact around-the-clock care to address people's substance use and related concerns by providing treatment, respite and support to assist people to improve wellbeing and affect change in their lives (de Andrade et al., 2019; Mutschler et al., 2022). Some residential rehabilitation modalities are shorter in duration and focus more on substance use and maintenance of abstinence, while others such as Therapeutic Communities can run for one to two years or longer and seek to fundamentally re-order peoples' identities, social relations and lifestyles (De Leon, 2000; Kaye, 2020).

While ubiquitous in Australia and many other parts of the world (De Leon & Unterrainer, 2020; Gómez Restrepo et al., 2018; Vanderplasschen et al., 2014), the effectiveness and impacts of the care delivered within residential rehabilitation remain contentious. A substantial body of research depicts voluntary residential rehabilitation as an effective intervention, particularly for those retained in programs long-term (e.g. see de Andrade et al., 2019; Staiger et al., 2020; Vanderplasschen et al., 2013). However, much of this research is hampered by methodological and conceptual challenges undermining quality of evidence and the conclusions that might be drawn from it (Miles et al., 2022). For instance, identification of "active ingredients" of residential rehabilitation remains elusive and a lack of high-quality longitudinal studies disentangling the effect of residential rehabilitation from other factors

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driving outcomes is an enduring challenge (de Andrade et al., 2019; Scottish Government, 2022). Several studies have questioned the long-term cost effectiveness of residential rehabilitation (e.g. see Malivert et al., 2012; Mojtabai & Graff Zivin, 2003; Smith et al., 2006), while critical scholars have problematised care in residential rehabilitation institutions, particularly in the United States, as punitive and carceral and for responsibilising vulnerable residents (Kaye, 2020; McKim, 2017; Whetstone & Gowan, 2017). Critically, the therapeutic process in residential rehabilitation remains under-theorised – commonly referred to as a "black box" (Broekaert et al., 2006; Debaere et al., 2014; McKim, 2017) – and as a result little is known about the characteristics of "good care" within these settings.

Studies examining treatment and care practices in alcohol and other drug settings, and across healthcare more broadly, often emphasise the ways individuals are positioned as the near exclusive focus of care (Bjerge et al., 2014; Caluzzi et al., 2024; Ekendahl et al., 2020; Mol, 2008). Indeed, tailoring care to individuals' needs and preferences has been promoted as a fundamental principle in drug treatment and residential rehabilitation in Australia and more broadly (Australian Government, 2019; Madden et al., 2021; Marchand et al., 2019). Yet as we detail below, care practices in residential rehabilitation typically exceed this individual focus to encompass the needs of multiple people and groups, including residents, treatment peer groups, residents' friends and families and the broader rehabilitation community (De Leon & Unterrainer, 2020). To date, little attention has been given to the way these multiple care imperatives are attended to in these institutional settings. Moreover, how the needs of diverse groups are identified in these settings, and the ways care is organised in accordance with these assessments, remain unexplored. Equally uncertain are the kinds of care practices and relations that constitute "good care" in residential rehabilitation. These are significant omissions given conceptual and empirical work stressing that care is neither neutral nor self-evidently good (de la Bellacasa, 2017; Martin et al., 2015; Mol & Hardon, 2021). Indeed, this is particularly critical given the long-standing concerns about the ways substance use treatment programs can control and regulate the lives of people receiving care, generating harms (whether inadvertent or otherwise), despite widespread adoption of the language and rationale of care (Campbell, 2020; Farrugia et al., 2021; Kaye, 2020; McCorkel, 2017).

In Australia, residential rehabilitation is understood as a key mechanism for reducing the purported negative impacts of substance use (Commonwealth of Australia, 2017). Despite its prominent status in the imaginaries of drug treatment and recovery, rehabilitation accounts for about seven per cent of drug treatment episodes in Australia (Australian Institute of Health and Welfare, 2025), although these services often report long-wait lists and a shortage of rehabilitation beds, often attributed to underfunding (Douglas, 2024; Francia et al., 2023; Victorian Alcohol and Drug Association, 2022). In seeking to better understand how care is organised and delivered within residential rehabilitation, it is vitally important, therefore, to consider what care looks like when it works well within these settings. Moving to investigate these diverse aspects of care, the analysis presented in this article is derived from an extended period of ethnographic fieldwork at *Open Roads Therapeutic Community,* a large residential rehabilitation service located in Eastern Australia.

Approach

Our analysis draws on and extends the work of Annmarie Mol (2008) and John Law (2010) to examine the situated, emergent and heterogenous dimensions of care in residential rehabilitation. Mol, Law and other science and technology studies scholars, have demonstrated that what constitutes "good care" depends not only on the specific contexts and objects of care, but also how care is practised as a particular ensemble of affective, practical and ethico-political commitments (see also de la Bellacasa, 2017; Dennis, 2019; Duff & Hill, 2022; Tronto, 1993). Foregrounding this logic of care focuses attention on questions concerning what kinds of caring practices are useful, under what circumstances, and for whom (Duncan et al., 2021; Farrugia et al., 2019; Mol, 2008). This is complex because what works in one setting or situation may not work in another (Mol & Hardon, 2021). The relational understanding of care promoted by science and technology scholars like Mol and Law reveals how practices of care unfold in response to particular local needs and typically involve, as a result, a speculative or experimental dimension and "messy" processes of trial and error (de la Bellacasa, 2017; Mol, 2008). In this kind of situated, relational care ethics, notions of "good" and "bad" care are never settled, rather, care is negotiated, contested, practised and adapted according to the activities, needs and capabilities of those involved in caring relations (Mol, 2008). This suggests the value of replacing notions like "good care" with a practical focus on the labour involved in caring as well as possible (de la Bellacasa, 2017). This sociomaterial understanding of care, considers how networks of human and non-human actors, such as knowledges, technologies, bodies, assessment tools, categories, practices, affects, and spaces, co-constitute the subjects and objects of care through caring relations. Instead of care being administered to people in prefigured and linear ways, caring involves mutual adjustment and tinkering, whereby care and its participants are dynamically attuned to each other by attending to the evolving and local needs of the moment (Mol & Hardon, 2021). Thus necessarily, there are multiple effects, actors and objects of care, both individual and collective.

Building on Mol's theorising on care, and drawing on Charis Thompson's (formerly Cussins) conception of "ontological choreographyof " (Cussins, 1996; Thompson, 2005), Law's (2010) analysis of veterinary care practices provides important insights into the complexities of care. Law's work points to how care involves the choreography of various individual and collective realities of care in space and time. Law emphasises the multiplicity of care, describing the ways care practices typically come to involve multiple objects of care, whose diverse imperatives often generate tensions. Law (2010, p. 69) observes that these care practices might productively be conceived as an improvised and experimental choreography involving an elaborate organisation and arrangement of care actors and their separations in space and time, and that caring can be understood as "the art of holding all those versions of care in the air without letting them collapse into collision." Law's work on choreographing multiple care imperatives is particularly generative here for understanding residential care contexts. Examining techniques of choreography highlights processes that extend beyond the more nuanced micro-practices, subtle moves and adjustments that have featured in much recent analyses of heath care practices, particularly work invoking the kinds of 'tinkering' with care described by Mol and others (Gibson et al., 2020; Lancaster et al., 2024; Molterer et al., 2020). This serves also to reveal a wider cast of care actors within residential rehabilitation programs and the multiple kinds of care that circulate simultaneously in these spaces.

Following science and technology studies (STS) scholars like Mol, Law and de la Bellacasa, critical drug scholars have in recent years pursued care as a key matter of concern (Barnett et al., 2024; Bjerge et al., 2014; Caluzzi et al., 2024; Dennis et al., 2020; Duff & Hill, 2022; Duncan et al., 2021; Farrugia et al., 2019; Lancaster et al., 2024; Savic et al., 2023; Theodoropoulou, 2023). These studies advance understandings of care in drug treatment settings as an emergent, situated, experimental and ethico-political practice coproduced by human and non-human actors in diverse care relations. Two notable studies consider aspects relating to "good care" in alcohol and other drug residential rehabilitation. Theodoropoulou's work on recovery practices, based in part on data gathered from a residential rehabilitation service in Greece, proposes that "good practices of care" (2023, pp. 36-37) are those that enhance people's capacities to act in accordance with their desires. Theodoropoulou argues that organising care around these situated and emergent dimensions of recovery, resists responsibilising neoliberal modes of care that are commonly embedded in drug

treatment systems and implicated in stifling agency and wellbeing. Caluzzi and colleagues' (2024) examination of young people's understandings of care in residential rehabilitation in Australia, highlights tensions between individual, collective and institutional imperatives in the provision of care, and how relational, participatory modes of caring that respected young people's autonomy were implicated in caring well. However, the techniques and repertoires through which care unfolds when it works well for its participants in residential rehabilitation remains largely unexplored. Explicit attention to these contingent aspects of care, and particularly how diverse care imperatives are weighed, balanced and contribute to (or mitigate) the constitution of care in residential rehabilitation, may help address some of the enduring methodological and empirical challenges notable within the existing literature regarding the mechanisms of good care. Drawing from these recent STS-inspired critical drug studies of care, we aim to examine what constitutes care when it works well at *Open Roads Therapeutic Community*. Our analysis details how caring well in this setting was enacted through repertoires that enabled people to attend to, choreograph and balance multiple imperatives and tensions in care.

Methods

Field site

Ethnographic fieldwork was conducted at *Open Roads Therapeutic Community*[1] a residential rehabilitation service located in Eastern Australia. *Open Roads* is "modified therapeutic community" (De Leon & Unterrainer, 2020), a long-form residential rehabilitation modality that incorporates "evidence-based" practices alongside traditional legacy therapeutic community practices, which seek to address substance use-related "problems" by instilling new modes of social and self-care and reconfiguring peoples' identities, social relations and lifestyles (De Leon, 2000; Kaye, 2020). *Open Roads* thus utilises a peer-driven approach where residents are intimately involved in decision-making and day-to-day management of the program. The program is hierarchical and residents earn greater freedoms, responsibility and privileges as they progress through the program phases from orientation, to senior resident and transition back to the community, typically taking at least 12 months to complete in full. *Open Roads* employs a large professional staff including peer workers, counsellors, psychologists, psychiatrists, doctors, nurses and social workers. About half of staff were *Open Roads* graduates. Concomitant with recent trends involving the increasing adoption of therapeutic jurisprudence in Australia (Freiberg, 2023), a large proportion of residents were subject to criminal legal orders mandating treatment. Daily life is communal and highly regimented consisting primarily of work responsibilities and chores, numerous meetings and opportunity to participate in various kinds of recreation including art therapy, sports, movie nights and occasional off-site trips. Therapeutic groups are run multiple times per week depending on program phase. Residents undertake education relating primarily to scaffolding motivation to change, and building self-care skills and knowledge. Formal individual supports are given as required and one-on-one counselling is employed occasionally depending on individual need. A culture of "care and concern" is widely promoted, seeking support via one-on-one and group-based discussions is encouraged, and embedded informally within everyday practices and social interaction.

Data collection

Ethnographic data were generated through forty-one in-depth interviews with residents and staff, fieldnotes collected during observations conducted over an 18 -month period between 2021 and 2023, and documents, including resident and staff manuals detailing care practices, program models, policies, rules, values and aims. The first author undertook both non-participatory and participatory observations of staff meetings, group and individual therapy, education and training, recreation and social life. Particpatory observations (Schubotz, 2020) involved adopting an "observer as participant" role through engagement in these activities including some therapeutic work, and a collaborative approach to data generation through sharing and discussing emerging data with staff and residents, utilising "participants as observers" to contextualise and enrich data, and iteratively shape the object study. Open-ended semi-structured interviews ranged from 50 minutes to 2 hours. Participants were asked about their experiences and insights into the program, key events and practices relating to care and their treatment journey, and the extent to which these activities were useful and attended to their needs. Ten follow-up interviews were conducted with residents and staff to tap the temporal dimensions of care and to contextualise and garner participant input on emergent findings. Ethics approval was received from Monash University Human Research Ethics Committee (Project ID: 25966) and participants who were not employed staff were reimbursed AUD50 per interview.

Participants

Interviews were conducted with 20 residents and 9 staff, 5 of whom were ex-residents and graduates of *Open Roads* (see Table 1). Prospective participants were typically identified by the researcher through opportunistic encounters at the service, aided by regular presence of the researcher on site and at staff and resident meetings. People expressing interest were given an explanation about the study and formally invited to participate following consultation with *Open Roads* staff. While recruitment was initially an opportunistic process to begin, purposive sampling was employed as recruitment unfolded. This ensured residents were recruited from a diversity of backgrounds and program stages. Follow-up interview recruitment was also made on this basis.

Analysis

Interviews were recorded and then transcribed using Amazon Transcribe automatic speech to text system (Amazon Web Services, 2025), which demonstrated adequate efficiency and accuracy in

Table 1
Participant demographic characteristics.

Characteristics	
Age (range), years	24 – 63
Open Roads Participants n (%)	
Residents	20 (69)
Professional staff (past residents)	5 (17)
Professional staff (other)	4 (14)
Gender, n (%)	
Non-binary	2 (7)
Woman	9 (31)
Man	18 (62)
Sexuality n (%)	
Lesbian, Gay, Bisexual, Pansexual, "not straight"	9 (31)
Heterosexual	20 (69)
Admission type n (%)	
Custody	11 (44)
Community	14 (56)
Program stage at interview n (%)*	
Level 0 (orientation)	0 (0)
Level 1	10 (33)
Level 2	4 (13)
Level 3 (senior resident)	6 (20)
Level 4 (transition to community)	2 (7)
Post exit (program not completed)	6 (7)
Post graduation	6 (20)

* includes follow-up interviews (n = 10) and interviews with staff who were past residents (n = 5).

[1] The name of the service has been changed to protect the privacy of research stakeholders.

transcription piloting. All audio data were encrypted and no data were shared with Amazon. Transcripts were manually de-identified and cross-checked for accuracy. NVivo 14 (Lumivero, 2025) was used to organise and store the data. Participants are referred to using pseudonyms.

A recursive inductive-deductive process was used to analyse and code interview, observational and documentary data. Themes were inductively generated from the data and deductively grounded and framed with reference to concepts and ideas noted in earlier sections. This involved iterative attunement to and sensitisation with the data, open iterative coding and cross-checking between data sources, literature and theory. In coding and theorising we focused primarily on care practices and repertoires, but in accordance with our sociomaterial orientation, we also explored how these were co-constituted with conditions, knowledges and technologies of care. Given the contingent, emergent and local dimensions of care, our analysis of "as-well-as-possible care", was guided by what conditions, practices and knowledges people reported were useful and worked well to scaffold wellbeing in accordance with their needs and preferences (de la Bellacasa, 2017; Mol, 2008).

Our analysis outlines three repertoires of care and the practices, knowledges and ideals that typify them. Repertoires are specific arrangements or techniques that bring together practices, knowledges and ideals, and this notion has been widely utilised by science and technology scholars in the analysis of care (Driessen & Ibáñez Martín, 2020; Pols, 2006). John Law (2010, p. 67) observes that "care depends not so much on a formula as a repertoire that allows situated action." Hence, the repertoires we present in our analysis are not routines formulaically enacted in care, but rather should be regarded as means of co-constituting care and care's participants through unique local manifestations of care.

A key consideration in our theoretical orientation and research approach is a concern with the "analysis of the conditions of the possibility of care, what can be made to matter, what for and by whom?" (Dennis & Farrugia, 2017, p. 87). As such, this article does not seek to overlook the disciplining and subjugating effects of residential rehabilitation, which have been well documented (see Kaye, 2020; McCorkel, 2013, 2017; McKim, 2008, 2017; Whetstone & Gowan, 2017). Instead, we focus on the mechanisms and repertoires that contribute to care working well so that we as researchers too can enact care by striving to "maintain, continue, and repair the world so that all can live in it as well as possible" (de la Bellacasa, 2017, p. 161; adapted from Tronto, 1993).

Findings

Below, we present three care repertoires generated in our analysis of the conditions and mechanisms of "care working well" at *Open Roads: Tailoring care* to the needs and preferences of individuals; *choreographing care* to attend to diverse care needs of multiple people and groups; and *dialoguing care* to facilitate the exchange of information when assessing and attuning to needs and preferences.

As we will show, tailoring, choreographing and dialoguing care are not distinct repertoires, they are often enacted in concert to synergistically co-constitute care and its participants. Below, we detail how the push and pull between tailoring care to individual needs and choreographing the care needs of various people is enacted through repertoires of dialoguing care. Opportunities to practice and scaffold techniques, repertoires and skills bound up with tailoring, choreographing and dialoguing care are also considered alongside practices of staging care as well as possible amid the constrains of institutional residential settings.

Tailoring care

> *Kylee, a recent arrival to Open Roads, stands in the main hallway atrium sobbing quietly on their own, tears trickling down their face … Renata, a senior clinician walks up and gently puts her arm around their shoulders. "What's wrong? Are you ok?" Choking back the tears, Kylee tries to speak but cannot, although seems to appreciate the warmth and gentle touch. "How can I help?" Renata adds, "Is there anything you need?"* [Fieldnotes, March 2021]

One key aspect that characterised the ways care worked well for its participants at *Open Roads,* involved repertoires of *tailoring care*. As highlighted in this fieldnote observation, tailoring repertoires were ways of attuning to the material and affective needs, capacities and preferences of individuals. This involved practices, knowledges and values of sensitising, optimising, and attending to the needs of individuals, their bodies, their preferences and desires. In this way, care repertoires are individualised, attending to people's uniqueness and autonomy. For instance, in the encounter between Kylee and Renata described above, Renata utilises a combination of gentle touch and vocal tone to tailor care to Kylee's specific affective and embodied needs. These are not widely employed practices at the service and may even go against norms at *Open Roads* governing physical contact between staff and residents. But in this particular moment, care is attuned to Kylee's singular needs.

Attending to the unique and specific needs of individuals is consistent with policy documents guiding therapeutic practices at *Open Roads* that emphasise the importance of tailoring care to individual circumstances and need. For instance, these policies stipulated that treatment duration at *Open Roads* should be tailored to "individual requirements", that program responsibilities, privileges and progress be guided by "individual circumstances" and "individual goals", and the "mix of group and one to one counselling [be] based on individual need" (Australasian Therapeutic Communities Association, 2024, pp. 3-4).

Repertoires of tailoring care to the unique needs of individuals at *Open Roads* involved attending to residents' self-care needs as well as tailoring care to the needs of others concomitantly[2]. Much of the therapeutic model hinged on people doing "productive work" in assigned job roles. This typically involved working closely with people, offering opportunities to practice skills, techniques and repertoires bound up in self-care and care of others through social interaction. It should however be noted that many found it difficult to balance the demands of both of these aspects of care, as indicated below by Hana a senior staff member and program graduate reflecting on their time in the program:

> "It's difficult … on one hand, you're supposed to be working on boundaries and self-care when, on the other hand, you're [working] within an inch of your life [and] have absolutely nothing to give and then be asked to give support to somebody".

Several techniques of embodied relaxation, breathing, mediation and yoga were taught at *Open Roads* to assist residents to address these demands according to individual need. Taking time out to balance the affective and embodied labour demands of the program including for recreation, art, exercise and for respite and reflection, was highly valued by residents and clinicians alike. Self-care practices that attended to people's unique needs and preferences were reported to enable the exercise of individual autonomy, as Jamie, a resident nearing graduation stressed: "*That's a cornerstone of my recovery … self-care … exercising regularly, eating better*".

Below, River, a senior resident who had been through the program multiple times, describes how they'd recently developed more understanding of the program through learning the importance and value of attending to their own affective self-care needs:

[2] Circumstances of tailoring care to the self, highlight conceptual intersections between repertoires of tailoring care and practices self-care, however we conceive these as two distinct concepts. "Tailoring care" refers to repertoires of care working well, and are thus modes of ordering constituted through particular practices, ideals and knowledges as outlined in the "Analysis" section above. "Self-care" refers to practices that attend to care of one's self as an object of care, that can be independent of collective coordination of care and circumstances of care working well.

> I've been doing a lot of work on trying to identify my emotions and triggers, that's mostly what I've been focusing on this program and that was from the feedback that I got from the psychologist very early on … I realized that I needed to do lots and lots of what they call "self-care" … probably more than the regular person because my [emotional] cup overflows very easily …

River here describes how practices (i.e. psychological assessment, feedback and support, intrapsychic reflexivity), knowledges (i.e. about unique individual affective realities, trauma and triggers) and ideals (i.e. valuing one's uniqueness, valuing the importance of monitoring individual affective states) combine to constitute distinctive repertoires of tailoring care. Respite was particularly valued by River, as an opportunity to take some time away from the demands of the program:

> … Like today I'm going to go and probably like get changed in my unit and get ready and I'll put on some music and I'll do that for the graduation and then I'm on the keys [an assigned work role] tomorrow morning and I've got a driving lesson … But tomorrow night I'm having an early night and I'm going to do something for myself. Like do a face mask or watch a movie with my room mates or something and go to bed early and get a quality night's sleep. And then on Sunday I'm going to go down to the art shed and do something and probably go for a walk off property and I have to plan those things in advance.

River's account highlights that for their residential rehabilitation to work well, it requires a sensitisation to and optimisation of care relations to their unique, situated needs and preferences. In this instance, a process of tailoring care involves acknowledging River's individuality, that they have "strong emotions", perhaps stronger than most, and that taking time out to do self-care practices will be beneficial.

A two-track process of tailoring is involved here. First staff and residents tailor care to meet River's needs. In parallel, River tailors self-care to meet their own individual affective and material needs. A fundamental aspect of this tailoring process is the ideals and knowledges that permit the program itself to be tailored, adjusted, tinkered with and choreographed to suit River's specific needs and preferences. This is contingent on valuing River's uniqueness and autonomy despite tensions with critical institutional and therapeutic imperatives. For example, River had to formally "seek support" from a senior resident or staff member and discuss their need to have an early night. This had to be weighed and assessed, necessitating discussions between staff and residents about whether changes could be made to the program to attend to River's needs and desires. In order for River to take an early night, changes needed to be made to the program, and allowances made for River to "isolate off the floor". These "isolating behaviours" were typically discouraged at *Open Roads*, and senior residents like River were in high demand and critical to ensure the community could function well, making it more difficult to find time for respite. Another resident also needed to be found to fill-in for River and space made in the program schedule to tailor care to River's unique needs. Thus, facilitating time for rest and respite for River, tailoring care to River's individual needs, particularly in an institutional, residential environment that is bound by significant resource restrictions, was an important way to demonstrate care and genuine value for River and their uniqueness and autonomy.

Choreographing care

> *An important staff meeting is taking place. Discussions concern the result of a long-term, resident-driven reform process. A change in a "cardinal rule" is proposed. And a shift in the way house rules are viewed and enacted more broadly. Past residents share their experience of living with strict rules. And enactments of simplistic heteronormative realities. Senior staff Alex and Sam advocate "a new narrative … a shift from protectionism to empowerment" from a "black and white view of the rules" that can inadvertently instil fear to "purposive boundaries to empower people." Some staff raise concerns these changes will require significant reconfigurations in practices, attitudes, be complex to manage, may have unintended consequences and fundamentally change living conditions and the community as a whole. "Lets give it a try and see how it goes" Sam suggests. "We can adjust as we go."* [Fieldnotes, July 2021].

At *Open Roads*, repertoires of choreographing care often involved improvisational practices of co-ordinating and reconfiguring arrangements amongst care actors when attending to the multiple and often distinct care imperatives of individuals and groups. As indicated in the fieldnotes above, these repertoires were often bound up in values and knowledges of inclusivity and diversity, and in practices of caring with social categories, identities and collectives. These repertoires attended to the push and pull between individual and collective needs and imperatives. As Samuel a senior staff member notes, the needs of individuals were viewed as interconnected with that of the rehabilitation service and community of residents; *"adjusting to the care needs of the individual, that's what [Open Roads] does all the way from [treatment entry] … and meeting the needs of the individual in that process as well as the needs of the [therapeutic] community."* An added complexity is that by facilitating and coordinating these multiple and at times divergent forms of care, these choreographies had to account for the way "individuals and collectives require different kinds of care" (Mol, 2008, p. 12). Caring for individuals, while simultaneously attempting to care for collectives to "try to improve the collectively shaped conditions under which [people] live" (Mol, 2008, p. 69) sometimes led to tensions at *Open Roads,* as detailed in the fieldnotes above.

Repertoires of choreographing care were especially well demonstrated through a period of program reforms that took place during ethnographic fieldwork at *Open Roads* relating to gender and sexuality. Tao a senior staff member and support coordinator for Lesbian, Gay, Bisexual, Transgender and Gender Diverse, Intersex, Queer (LGBTIQ) residents describes the process:

> We did a big feedback and complaint process with all the LGBTIQ residents, and that indicated a lot of areas that we could improve … We're reviewing the so called "one-on-one" rule, which very much is framed in a heterosexual system [where a] man and a woman can't be interacting together alone ... developing a therapeutic group for LGBTIQ residents … with the dedicated [LGBTIQ staff support] role.

Tao here describes a long-term review process undertaken at *Open Roads* to improve resident and staff safety and inclusivity, examining the extent to which rules and practices were seen to be meeting the collective needs of sexual and gender diverse people. These efforts attended to the collective and individual needs of LGBTIQ residents, who identified that a range of changes to the program were required. This review required significant investment of energy, time and space, to coordinate, evaluate, adjust and reconfigure a range of care actors (i.e. people, resources, practices, knowledges, cultures, values, spaces, atmospheres) to facilitate program reforms in such a way as to best attend to the multiple needs and preferences bound up in changing long-standing rules and practices at *Open Roads.* Various kinds of dialoguing were employed, including a considerable number of staff and resident meetings, deliberations, and one-on-one discussions. Community days were held, education initiatives run, rainbow flags, posters, stickers, and pronoun badges were used and distributed widely. Funds, time and resources needed to be reorganised and re-apportioned to support the LGBTIQ staff role and make space in the tight program schedule for an LGBTIQ group, and to facilitate the numerous meetings and discussions required, for community days to be held and for reconfigurations of the space.

As Tao reflects, these changes also attended to the needs of a diverse range of people and groups at *Open Roads*:

> I think this is a broader change. there is now an expectation for clinicians … to use an intersectional lens, to use a domestic violence lens, an LGBTIQ lens to use an … indigenous, intergenerational

> trauma lens, to see the nuance [in care] … Erasing those legacies of structural violence has created a general increase of cultural safety.

This highlights how the labour of choreographing care to ensure that it worked well in this instance at *Open Roads,* involved valuing principles of inclusivity and diversity (of needs) as a means of facilitating multiple and diverse kinds of care to coexist. This also underscores the importance of pluralism in care involving a greater diversity of needs in care deliberations, affording greater agency for more people to participate meaningfully in care. A number of participants reported positive effects stemming from this reform initiative including Jamie who described the significant impact this had on their experience of and trajectory through *Open Roads*:

> I didn't openly "come out" until [late in the program] when I felt comfortable in my relationships and sort of true to bring that to the space. I was ready [earlier in the program], but I didn't feel safe ... I'm still learning who I am, my sexuality and stuff like that, and I think the pace that honestly is going on at the moment is cool … They had the Wear it Purple days and they're doing … "rainbow days" and stuff like that. That awareness is there, therapists are really good as well, with holding that boundary if there's anything [derogatory] brought up about someone's sexuality, race, identity, they really come down tough on it … like we're here and we're all together and we support each other and they really drove that message home, so sort of changed the culture almost and I think that helped me work through my stuff as well.

Jamie was among a number of study participants who reported that these changes in culture and conditions at *Open Roads* helped to foster atmospheres of safety, inclusion and care where they felt more comfortable to explore their own identity and how it may have shaped their experiences in life, particularly their relationships to various substances. As Jamie recounts above, these inclusive conditions worked well because multiple and diverse needs bound up with membership of various collectives (e.g. therapeutic peer groups, and those relating to ethnicity, sexuality etc.) were able to be recognised and attended to. Choreographing care in this way meant Jamie and others could feel more comfortable about themselves, and feel safer about their living conditions. Indeed, Jamie felt that these changes were one of the reasons they elected to stay at *Open Roads* affording access to therapeutic resources that accrue in the program with time.

Reflecting on these changes in service approach, Tao highlights how attending to collective needs in this case, involved enacting living conditions that fostered both pluralism and solidarity in care:

> Erasing those legacies of structural violence has created a general increase of cultural safety ... whether that's through our [policies and] processes or whether it's through events, days of significance, for instance … organizing a community day for Wear it Purple day, to sort of give it some, some significance and education and some fun … just sort of ways that [residents] can start to feel more comfortable in their own home … and now moving more towards an educational space… for the non- LGBTIQ residents as well and bringing them along on the journey. So that creates a lot more empathy and cultural safety … and also realizing as a group, they can …develop a sense of solidarity with each other and support each other.

Tao highlights that choreographing multiple and disparate care imperatives at *Open Roads* often hinged on allowing time and space for building collective rapport and identity. This was often enacted during recreation, where people could enjoy time together as a counterbalance to the serious work that accounted for the majority of people's time at *Open Roads*.

Dialoguing care

> *Testing the small cactus' hydration requirements, Dylan places their index finger in its soil. The soil appears cracked and dry but further dialogue with the plant is required. The soil seemingly feels dry beneath the surface too as Dylan slowly gives it some water, taking care not to over-fill its small pot.* [Fieldnotes, July 2022]

A key dimension of care working well at *Open Roads* were repertoires of dialoguing care. As evidenced in this observation, repertoires of dialoguing care involved practices and processes of transmission and exchange of information, feedback, and mutual adjustment of actors in caring relations when assessing and attuning to needs and preferences. Dialoguing repertoires were underpinned by ideals of empathetic concern, what was termed "concern for other", and valuing affective realities and reflective listening as critical to shaping and understanding needs.

Below Angelo, a resident, recounts an event that led to a key turning point in his journey through the program, one in which repertoires of dialoguing revealed his needs to himself, and those bound up in his care. Angelo had been in the program for some six months, but hadn't seen his parents for close to a year as he'd been in custody prior to coming into residential rehabilitation. Angelo's relationship with his family had fallen apart, so tensions were high:

> I asked mum and dad to come in here to the [rehab] and the whole thing went pear shaped … As soon as I saw mum and I got triggered and things fell apart, I went into high emotion [got angry and emotional] and they had to leave.

This incident was viewed as a serious transgression of program rules and values by the *Open Roads* community. This required the organisation of a series of recursive dialoguing, feedback and reflective arrangements and practices between Angelo and those participating in Angelo's care. As Angelo describes, through these dialoguing repertoires, both formal and informal, care could be better negotiated, adjusted, tailored and choreographed to better attend and attune care participants to the needs of each other:

> I got grouped … with four or five of my peers … and then I realised I got more work to do ... [Open Roads] offered me, in a group, for me to go back to level two and do [emotional regulation training] again … I was lucky enough that [the senior therapist] … who had a background in family counselling … said [in group] like, "His mother has been triggered and he's been triggered and maybe some real therapy can start here."

A range of dialoguing practices were necessary in order to attune people to Angelo's needs following this incident with his parents. But these dialoguing practices also considered the needs of Angelo's family and the *Open Roads* community. Through communication and feedback with Angelo's parents, staff and residents at *Open Roads* about his situation and needs, Angelo was afforded an opportunity to parse his situation, the incident and its effects. As Angelo recounts below, these repertoires of dialoguing about needs, were underpinned by ideals valuing empathetic concern and reflective listening as critical to understanding needs and care:

> "A big part of what has happened is being supported in here ... I got vulnerable … through talking and being honest … telling people how you really feel, asking for help when you need it.. and try and to like attentively listen and absorb as much as you can ... it's how you look after your house, how you look after yourself and how you care for other people."

Several groups were run, residents and staff had discussions both with and without Angelo about what might be best, and Angelo's parents were called to discuss some options. An array of dialoguing practices were enacted in order to tailor care to Angelo, his mother and

father individually. Dialoguing also enabled care to be choreographed to best attune, attend to and balance care with respect to the needs of others at *Open Roads*. As Angelo describes, this enabled the tailoring and choreographing of care to both his and his family's needs:

> The outcome of that intervention is that my mother and father came in here yesterday for a family counselling session … Which this place doesn't normally do.

Indeed, as Mol (2008, p. 76) notes "good communication is a crucial precondition for good care. It also is care in and of itself. It improves people's daily lives." These needs-focused repertoires of communication and feedback enabled Angelo to attune himself to his own needs just as he became more attuned to the needs of others and as others were to him. Through these repertoires of dialoguing care, it was recognised that an approach was required that accommodated the importance Angelo places on his family; that in the long-term Angelo's wellbeing is likely tied up with the wellbeing of his parents, and thus the strength and quality of their relationship:

> What's really important to me is my family, my children … like if I hadn't stayed that day [described above] there will be no journey of mending with my family with my parents. My son wouldn't have given me his mobile number, which he's now saying he'll call me, [he said] "now I trust you because you've been getting assistance for the last four or 5 months." (Angelo)

Repertoires of dialoguing care were vaired and multiple. They included formal needs assessments that occured at entry to *Open Roads* and during the program. As demonstrated above, they were at times organised around a specific case or incident. Verbal dialoguing was commonplace, while on other occasions a less direct kind of dialoguing, one that was unstructured, non-verbal, affective and embodied was observed. These were revealed in everyday micropractices of care, such as an exchange of looks, a warm smile, or an arm around the shoulder. As described below by Samuel as senior staff member, dialoguing repertoires involved values and knowledges bound up in empathy and open exchange, making an affective connection, sensitising *with* people, to their needs, preferences and desires:

> I think what works in that is the genuineness of the interaction … you've got to build that rapport. But I think even that, I think diminishes what it really means to have those connections with people. And that real sense of "I care" … It's about how we interact with each other and that's so important to the work we do.

The examples above have shown how tailoring, choreographing and dialoguing care are not distinct repertoires, rather they are often enacted synergistically to co-constitute care and its participants. These excerpts demonstrate that when care worked well, it was often contingent on the tension, a push and pull, between tailoring care to individual needs and choreographing the needs of various people, mediated through repertoires of dialoguing care.

Discussion

This ethnography contributes to understandings of institutional care by illuminating mechanisms of care at work in one residential rehabilitation service in Australia. Our analysis details the intricate, complex and relational dimensions of the labour of care, and the dedication of residents and staff involved in crafting organisational arrangements amenable to caring as well as possible with and for people in these settings. Despite being described in the literature as a relatively homogenous, uniform and stable treatment modality, this ethnography depicts residential rehabilitation as a fundamentally experimental, heterogenous, dynamic, and relationally emergent technology of care. Our analysis indicates therefore that residential rehabilitation might be most productively understood as an assemblage of multiple actors and forces (e.g. individuals, collectives, interventions, repertoires, events, cultures, knowledges, technologies, spaces) that require and are bound up in multiple kinds of care. This suggests that contests surrounding residential rehabilitation knowledges and practices, including those around effectiveness (Smith et al., 2006; Vanderplasschen et al., 2013), care practices (Kaye, 2020; McKim, 2017) and cost (Mojtabai & Graff Zivin, 2003), may be based in part on unhelpful oversimplifications of residential rehabilitation as singular, stable interventions, on narrow ideas as to what constitutes healthcare, and on scalar slippages whereby population-level knowledges and realities are conflated with local ones.

The scholarship cited in earlier sections has detailed how caring is often bound up in complex choreographies by which multiple care imperatives are identified and arranged (Cussins, 1996; Lewis et al., 2024), according to the tensions that arise between them (Heerings et al., 2022; Lancaster et al., 2024), and in efforts to variously hold together and hold apart disparate and sometime incompatible forms of care (Law, 2010; Mol, 2008). Building on this work, the present study has detailed how repertoires of choreographing care at *Open Roads Therapeutic Community* were central to instances of caring well, and enacted synergistically with repertoires of tailoring to individual needs, and mediated by repertoires of dialoguing care. In describing these repertoires, this ethnography contributes to understandings of how practices, knowledges and values attend to and shape the care needs of a range of actors, both collective and individual (cf. Cussins, 1996), revealing in turn the ways different realities and imperatives of care come to matter in service design and delivery.

Tailoring to individuals (as entangled with others)

Our analysis highlights how repertoires of tailoring care to individuals tends to emphasise people's uniqueness and autonomy. This was useful for people at *Open Roads* in that it contributed to countering the potentially totalising nature of institutional care where individual needs and preferences can be overwhelmed by institutional and collective imperatives (Barragan et al., 2022; Davis et al., 2023). Driessen and Ibáñez Martín (2020, p. 257) argue that "tailoring care is not necessarily about how differences can be attended to but also what kinds of differences are attended to." Our analysis highlights that these valuations in care, when they worked well for people at *Open Roads,* succeeded by attending to their differences relationally and collectively. For instance, in the example of tailoring care for River detailed above, care worked well because it attended to River's individual need for rest and respite from the program *and* by attending to River's energy, capacity and desire to care for and with others at *Open Roads.* River's unique needs and preferences only made sense when parsed in relation to the networks of caring relations within which they were entangled. Repertoires of tailoring care thus often worked well at *Open Roads* by enacting and valuing people as fundamentally entangled with others, as opposed to the dominant enactment of a responsible, autonomous and atomised subject of substance use treatment (Ekendahl et al., 2020; McKim, 2008). Thus, repertoires of tailoring care are not only implicated with care working well, but by tying care of the self with care of others, they do so by attending to the collectivity of care, enacting a "social-self care" (Letak, 2025). Accordingly, this mode of care counters responsibilising notions of self-management often bound up in substance use treatment (Theodoropoulou, 2023) and more broadly across the care economy (Moser, 2024).

Whose needs?

A large body of care scholarship frames care as a practice organised around the work of attending to people's needs and preferences. However, much less attention has been given to how needs are shaped by care practices. This is an important consideration in institutional settings where vulnerability, dependence and harm can be enacted through care and where institutional needs can be privileged over the needs, welfare and wellbeing of residents (Barragan et al., 2022; Dillard-Wright

& Jenkins, 2024). Indeed, Homanen (2019, p. 76) stresses how "care often both exceeds and collides with the logics of governance and valuation" in institutional settings. This highlights potential limitations of taking an overly localised or pragmatic view of care practices. Formulations of "good care" in the literature commonly describe an experimental practice of doing one's best to attend to people's needs, bound by the limitations of the moment, of caring as well as possible (de la Bellacasa, 2017). If applied routinely, or selectively, this view can obscure the role of higher-order actors like institutional logics, rules, values, policy, and cultures in shaping care. This in turn, risks undervaluing or overlooking the importance of practices that can enact change in living conditions as critical to care working well. This has important implications for residential rehabilitation, a modality that seeks to both provide care and instil techniques of (self)care.

Our findings demonstrate how participation in care is vital to tempering the totalising tendencies of institutional care, particularly where opportunities for participation are meaningful and involve tangible agency to adjust living conditions. The corollary here is that notionally inclusive processes of collective decision making and collective care delivery can have totalising tendencies that put the needs of collectives ahead of individuals. For instance, Heerings and colleagues (2022) describe how clients were often excluded from "collective tinkering" practices in care in a Dutch community housing service, highlighting how collective care practices can in fact exacerbate asymmetries in care. These issues have particular resonance in our findings with respect to the involvement of sexual and gender diverse people in shaping conditions of living at *Open Roads.* This example highlights how enabling meaningful participation in care, necessitates enacting processes to actively ensure institutional and collective imperatives don't subsume, silence or marginalise people's needs in residential care settings. This is a revealing illustration of caring well in residential rehabilitation services, particularly given the history of institutional marginalisation, subjugation and oppression reported by sexual and gender diverse people (Stanley & Smith, 2015), including in residential rehabilitation (Lyons et al., 2015; Robinson-Griffith et al., 2025). We therefore suggest that caring well with collectives and individuals in residential rehabilitation, requires paying close attention to how needs are conditioned through care and whose needs are being privileged, when and how. The inherently assymetric nature of institutional care, underscores the importance of conducting regular needs assessments in residential rehabilitation, both formally and informally. On the basis of our findings, needs assessments should involve sensitivity to the conditions within which they occur, attending to capacities and preferences of those involved in assessments, and close attention to who and/or what is being cared for, whose needs are *not* being met, and why and how inequities may emerge in this work.

Flexibility, time and space for caring multiply

Our analysis highlights the importance of programmatic flexibility, and the adequate time and space upon which it depends, in enabling repertoires of care to attend to the broad diversity and multiplicity of needs that emerge in residential rehabilitation. Programmatic flexibility has increasingly been identified as important for caring well across a range of contexts (Bartels et al., 2021; Funk et al., 2022). This represents a conundrum for residential rehabilitation modalities, which are often characterised by strict rules, but where responsiveness to changes in everyday needs and circumstances is a fundamental aspect of care (Caluzzi et al., 2024). Programmatic flexibility is a necessary requirement to allow space for "tinkering practices" in care, which by definition are dynamic and experimental, and implicated in practices of caring well with people across a range of settings. For instance recent work by Jackson-Taylor and Atkin (2025) highlights the importance of making space for tinkering and creative calibration in care when attending to a diversity of needs and the facilitation of caring environments for gender diverse people. This is echoed in our findings where repertoires of care at *Open Roads*, when they worked well for people, were found to hinge on practices and ideals valuing self-governance and participation in care, and sufficient program flexibility to enable changes in care practices. These repertoires of care hinged on caring with social categories and identities as helpful differentiations, rather than as fixed and mutually exclusive divisions. The needs of sexual and gender diverse residents, while framed and attended to as intrinsically important, were enacted as part of broader valuations in care relating to the importance of diversity and inclusion. Thus, repertoires of care worked well when they were enacted synergistically with ideals valuing the inclusivity of diverse groups, including matters of substance use, ethnicity, religion, sexuality, gender, criminal legal involvement and socioeconomic background.

Scholarship on tinkering has often detailed the importance of micropractices of care, or small, subtle experimental movements and adjustments (Gibson et al., 2020; Lancaster et al., 2024; Molterer et al., 2020). Our analysis illustrates that sometimes more radical, large-scale efforts to manage, arrange and distribute practices, variously holding together and holding apart actors and events in space and time, are equally important in caring well with people. This was exemplified in how extensive and sweeping changes to rules and living conditions relating to gender and sexuality played out at *Open Roads*. Caring well at *Open Roads* involved moves both small and large to facilitate holding together and holding apart multiple individual and collective care imperatives, sometimes in tension, to create inclusive conditions where people from a range of diverse backgrounds could collaborate to care as well as possible for and with each other. This is a challenge for residential rehabilitation services. Holding together and holding apart diverse and even incongruent versions of care is a resource intensive endeavour. It requires sufficient allowances, mechanisms, processes, time and space for tensions in care to be choreographed and adapted to attend to people's diverse and situated needs. For instance, a cross-cutting element of our analysis highlights that care worked well at *Open Roads* when there was sufficient time and space for people to participate in recreation and group and community activities, and to take rest and respite for recuperation from daily demands and for reflection. Adequate resourcing and programmatic flexibility underpin each of these elements, as do people's skills, capacity and agency to engage in tailoring, choreographing and dialoguing care.

Dialoguing, capacity and agency

Caring at *Open Roads* often involved a dialogue between care imperatives across different temporalities and scales; a tension between practices of tailoring to individual needs and preferences, and those relating to choreographing the best outcomes for various collectives; between what might be best in the moment and what might best in the future. As demonstrated in the examples of both Angelo and River, this dialogue and feedback afforded new perspectives and insights about caring for others and caring for oneself. In this way dialoguing repertoires were critical in that they mediated repertoires of choreographing and tailoring care. Our findings thus demonstrate that caring well was in large part contingent on capacities and agencies to engage in communication, feedback, and exchange of information when assessing and attuning to people's (self)care needs and preferences. After all, participating meaningfully in care is contingent on people's capacity and agency (Davis et al., 2023). Yet not everyone may equally be able to mentalise, communicate or understand their own needs or the needs of others. Some people may find the social, group-based, public communication required to care well in residential rehabilitation difficult. Caring well with people equitably is therefore contingent on provision of adequate opportunities for learning about and practicing care. Indeed, a range of care scholarship has shown how "learning about and calibrating between diverse local "goods" is part of the activity of caring" (Mol & Hardon, 2021, p. 185). Our findings thus highlight the importance of providing opportunities for scaffolding dialoguing skills and repertoires

in facilitating as well as possible care. This highlights the therapeutic potential of peer-driven interventions like residential rehabilitation that seek to meaningfully involve residents in all decision making, and scaffold and instil repertoires of care amongst and between residents. Yet choreographing repertoires often operated at higher-order scales, involving arrangements between multiple people and collectives, such as between staff, residents, families and external treatment providers. Implementing these kinds of changes was partially contingent on social capital and institutional authority and agency. Notably, the examples of changing program rules and living conditions at *Open Roads* highlight how care worked well when capacities to affect program change and choreograph care were distributed between a range of residents and staff, including those outside senior staff and resident groups. These examples highlight that caring well with people in these settings requires attending to people's diverse capacities, a direct accounting of people's agency, and putting processes in place to instil, scaffold and empower skills and capacities necessary for tailoring, choreographing and dialoguing care.

Conclusion

This article describes varied mechanisms of caring well with and for people in residential rehabilitation. Our analysis highlights how "as-well-as-possible" care is enacted through repertoires of tailoring care to the needs and preferences of individuals, choreographing multiple and diverse care imperatives as they are enacted and mediated through practices of dialoguing care to attune to the needs of those bound up in care relations. Our analysis also reveals the significant material and affective labours and resources involved in these care repertoires, derived from diverse caring networks. Moreover, we detail how care worked well at *Open Roads* in instances where care practices were underpinned by sufficient flexibility to allow for multiple and diverse kinds of care to coexist, reflecting peoples' diverse, evolving needs and practiced in ongoing collaborative attempts to choreograph and attune knowledge and technologies and practices, to these needs. This study contributes to understandings of residential rehabilitation as a technology of care, highlighting that caring well in these settings may require attending to institutional tendencies to totalise care and people's needs by meaningfully involving people in decision making about living conditions and care.

Public residential rehabilitation services in Australia are embedded within treatment and legal frameworks governed by significant resource restrictions (Ritter & O'Reilly, 2025) consistent with neoliberal and carceral imperatives and practices (Pereira et al., 2020). Examining residential rehabilitation practices via the imperatives of care however, shifts the focus to the importance of striving to better understand whose needs are being privileged in residential rehabilitation and examining what is being valued in care. Such a move foregrounds the complex and resource intensive relations and labours upon which care depends. It also attunes stakeholders to those treatment and care practices focused on people's needs and preferences, and ways to foster collective and self-care relations to enable people to live better lives, while being alert to how systems of care condition needs and enact vulnerabilities. Importantly, this logic of care also challenges us imagine new ways of enacting systems of continuing care for people in residential treatment and beyond.

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Availability of data and materials

The data generated and analysed during the current study are not publicly available. The qualitative data collected in this study could be used to identify participants; as such, it is only available to the research team and protected by Australian privacy law.

Ethics approval

The authors declare that they have obtained ethics approval from an appropriately constituted ethics committee/institutional review board where the research entailed animal or human participation.

The research received ethics approval from Monash University Human Research Ethics Committee (MUHREC Project ID: 25966)

CRediT authorship contribution statement

Ramez Bathish: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Cameron Duff:** Writing – review & editing, Supervision, Methodology, Conceptualization. **Michael Savic:** Writing – review & editing, Supervision, Methodology, Conceptualization.

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