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Title: Using Foucault to (re)think localisation in chronic disease care: Insights for nursing practice

Abstract

Ageing populations and rising rates of chronic disease globally have shifted key elements of disease management to ideas of integrated care and self-management. The associated policies and programs often focus on intervention and support beyond the sites of the hospital and clinic. These shifts have significantly impacted the delivery and practice of nursing for both nurses and the clients with whom they work. This article argues that Foucault's comments on space, place and heterotopia (1986) are useful in exploring these changes from a philosophical perspective, to draw out the complexity of these programs and add texture to discussions on the ways these shifts to localisation and the dominant discourses of self-management and responsibility have reconfigured nursing practices. The theoretical discussion is augmented with illustrations from an Australian integrated health care program.

Introduction

Alongside global increases in the incidence and prevalence of chronic diseases and longer life expectancy , have been significant developments in care programs for people with long term conditions. There has been a discernible shift in focus from curative treatment for some clients with chronic diseases, to investment in long-term disease management (Callaghan & Wistow 2006; Dennis et al. 2009; El Enany, Currie & Lockett 2013; Hallinan & Hegarty 2016; McNab et al. 2016; Wood, Hocking & Temple-Smith 2016). As services have diversified, nursing and care practices have also changed and become embedded within dispersed programs that have increasingly focused on the promotion of self-management and adaptation to health needs (Greaney & Flaherty 2020). These types of programs and terms such as integrated care, comprehensive and shared care and self-management have been prominent within government health policy in Australia, Canada, New Zealand and the UK over the last three decades (Liddy *et al.*, 2015; Kendall *et al.*, 2011; Oliver-Baxter, Bywood and Brown, 2013). Although definitions of these care approaches differ, they are unified by a shared premise that the greatest efficiency and effectiveness of care for many people with long term chronic diseases can be realised when intervention and management are joined together through health promotion,

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population-based care and localised, individualised interventions (Grone and Garcia-Barbero, 2001; World Health Organization, 2008; Van Hees *et al.*, 2018), with nurses taking up key roles in these new arrangements.

Research into these new configurations of nursing have identified that nursing work increasingly involves support and liaison roles that relate to the development of an individual's self-management (Audulv, Asplund & Norbergh 2012; Greaney & Flaherty 2020; Kendall *et al*. 2011). The associated nursing practices often aim to develop people's abilities to integrate multiple aspects of their own health and care into their daily life in physical sites outside hospitals such as homes and community settings (Goodwin *et al*. 2014). In addition to changes in how and where nursing care is delivered, this pivot towards the integration of self-care has other potential implications which warrant careful consideration from the perspectives of both nurses and service users. As recently noted in this journal by Greaney and Flaherty (2020), "the rhetoric of self-care may advance a neo-liberal agenda which legitimizes victim blaming, and further alienates individuals with pre-existing vulnerabilities and health inequalities" (p. 5). The manifestation of this rhetoric is not necessarily an objective of these care programs but rather an unintended side effect of nurses "acting from a humanist, empowerment perspective" (Paradis-Gagne & Holmes 2021, p.8).

The development of these types of care programs are often directed by policy documents which set out overarching objectives that are then interpreted locally to address specific population health needs. Such programs are mobilised through what has been described as translation (Rose 1996, 1998) and assemblage (Murray Li 2007) as policy moves out from a source and into the lives, homes and communities of a population (Author & Author 2018). Whilst the significance of these changes have been acknowledged, there remains a lack of focus on the spatial aspects of these policy-driven shifts across sites of care that have reshaped nursing practice and care work in terms of "space and place" (Andrews 2016, p. 272).

This article contributes to this work by drawing on Michel Foucault's observations on place and space and, specifically, his brief comments on heterotopia (Foucault, 1986).We use these analytical tools to consider how these shifts in care have (re)shaped some aspects of nursing practices. We argue that utilising these analytical tools can contribute to a philosophical

exploration of contemporary nursing care that unfolds beyond the physical sites of the hospital and clinic. We begin the article with a discussion of Foucault's approaches to space and place and heterotopia and how this work adds useful analytical tools to the analysis of nursing programs. We then illustrate how such a perspective can be used through the spatial analyis of policy documents which directed an integrated care program in New South Wales (NSW), Australia (Turnbull & Reich ????). We argue that using this approach foregrounds the unexpected complexities and side effects of these approaches to care that unfold across spaces and places.

Adding to an analytical tool-box: Foucault, space and place

Foucault's ideas and analystical frameworks have been taken up in the analysis of nursing practices and development of nursing theory (for example Clinton & Springer 2016; Holmes, Perron & Savoie 2005; McIntyre, Burton & Holmes, 2020; Poland, Lehoux, Holmes & Andrews 2005; Springer & Clinton 2015). The following discussion contributes a complementary analysis of nursing care by using Foucault's comments on space, place and heterotopia to explore the translation of an integrated care policy into local practices. Unlike the "coercive community care" associated with some mental health interventions that work thorugh intense surveillance (Paradis-Gagne & Holmes 2021), programs of integrated care aim to help the individual with chronic disease incorporate self-management into their everyday life. These approaches enact a type of coaching or training to help teach the individual how to self-manage their own care. Over time this shift decreases the need for surveillance and intervention as the individual becomes an expert practitioner in their own care and disease management. This coaching and the associated nursing practices unfold and are enacted across multiple and transient spaces of intervention. .

Foucault often referred to space and place in his extensive body of work but he did not develop a theory of space as such. Rather, he used spatial considerations as part of his analytical *tool-box* (Foucault 1994a) as he considered how attempts to govern intersected with power, knowledge, the self, truth, place and space across different historical periods (Elden & Crampton, 2007; Mitchell, 2003; Pykett, 2012). For example, in the preface to the English version of *Birth of the Clinic* (Foucault 1994), first published in French in 1963, Foucault stated that "this book is about space, about language, and about death; it is about the act of seeing, the gaze" (p. ix). The

spatialisation he explored within this work related to the emergence of the 'medical gaze' in eighteenth century France and associated spaces of Western medicine. His threefold spatialisation referred to (i) how diseases were classified, (ii) the conceptualisation of diseases as *within* and *of* the body, and (iii) the assembling of local and regional hospitals and care facilities for treating patients diagnosed with a disease. Philo (2000) summarised the primary spatialization of this classification of diseases as *fixing* the named disease within "the abstract, two-dimensional spaces of the table" (p. 12). Secondary spatialisation then referred to the emergence of a way of thinking about the body as the embodiment or container of disease. As the body became the "concrete space of perception" (Foucault 1994, p. 10) of disease interventions to look *at* and *in* the body itself developed further. The third level of spatialization was concerned with the distribution of the sick or diseased body and how these bodies with diseases were "divided up into closed, privileged regions, or distributed through cure centres" (Foucault 1994, p. 16) in local and regional networks of clinics, hospitals and other care facilities.

In his later work, *Discipline and Punish* (Foucault 1995) (first published in French in 1975), Foucault explored the spatial effects of this distribution and partitioning of bodies within certain physical and architectural spaces. Foucault's (1995) analysis of Bentham's Panopticon in *Discipline and Punish* is the frequently cited architectural representation of what he called disciplinary power. This power worked not just in an architectural structure but through the distribution and arrangements of "bodies, surfaces, lights, gazes" (Foucault, 1995, p. 202). Foucault's later work on biopower and governmentality (Foucault, 2007) moved the analytical focus away from institutional spaces and to the increasingly decentralised spaces associated with self-governing (Barnett, 1999).

Foucault's comments on heterotopia can be positioned chronologically between these major works which are associated with his archaeological and genealogical periods (*Birth of the Clinic* and *Discipline and Punish* respectively). Foucault first used the term heterotopia in 1966, in the preface of *Les Mots et al Choses*, which was translated into English as *The Order of Things* (Foucault, 1970). He referred again to the concept in a radio broadcast addressing the themes of utopia and literature and, finally, in his lecture to the *Cercle d'etudes Architectuales* (Circle of Architectural Studies) in 1967. This lecture was first published in French a number of years later

(1984) and then in English as ‘Of other spaces’ in the journal *Diacritics*[1] (1986). The lecture was re-translated into English and entitled ‘Different spaces’ in 1994 (Foucault, 2000). Although Foucault’s comments on heteroptopia were brief and their publication was slow (Johnson, 2006), we argue in the following section that considering heterotopia within the broader *oeuvre* of Foucault’s work on space and place can provide a useful ‘tool’ for the analysis of the spatiality of contemporary healthcare programs and nursing practices.

Heterotopia

Foucault began his lecture to the *Cercle d’etudes Architectuales* by tracing how conceptualisations of time and space developed during the medieval ages, then touched on modern space as predominantly relational:

> The space in which we live, which draws us out of ourselves, in which the erosion of our lives, our times and our history occurs, the space that claws and gnaws at us, is also, in itself, a heterogeneous space…we live inside a set of relations that delineates sites which are irreducible to one another and absolutely not superimposable on one another (Foucault 1986, p. 23).

Foucault listed various sites that can be described as bundles or webs of relations, such as spaces of transit or movement like streets and trains, before turning to his particular interest in the lecture:

> But among all these sites, I am interested in certain ones that have the curious property of being in relation with all the other sites, but in such a way as to suspect, neutralize, or invert the set of relations that they happen to designate, mirror, or reflect. These spaces, as it were, which are linked with all the others, which however contradict all the other sites, are of two main types (Foucault 1986, p. 24).

The first of these two types was the heterotopia of crisis. Foucault described these as “privileged or sacred or forbidden places, reserved for individuals who are, in relation to society and to the human environment in which they live, in a state of crisis: adolescents, menstruating women,

[1] It is this 1986 version which is referred to in this paper.

pregnant women, the elderly, etc" (Foucault 1986, p. 24). These are less common in contemporary society. The second type were heterotopias of deviation for individuals

> individuals whose behavior is deviant in relation to the required mean or norm … Cases of this are rest homes and psychiatric hospitals, and of course prisons; and one should perhaps add retirement homes that are, as it were, on the borderline between the heterotopia of crisis and the heterotopia of deviation since, after all, old age is a crisis, but is also a deviation since, in our society where leisure is the rule, idleness is a sort of deviation. (Foucault 1986, p. 25).

Foucault explained the notion of a heterotopia by contrasting it with a utopia which he described as "fundamentally unreal" (Foucault 1986, p. 24). Heterotopias, in contrast, were a "simultaneously mythic and real contestation of the space in which we live" (Foucault 1986, p. 24). Such spaces come together in *relation* to but *apart* from other spaces of 'normal' life. Sandberg et al (2016) argued that the notion of heterotopia could be used to consider how and when certain spaces in contemporary life are assembled and function in relation to contemporary understandings of citizenship. Sandberg *et al* (2016) used heterotopia to frame a discussion of the 'spaces' constructed in policy and discourse for "the production of desirable and ideal citizens as part of a neoliberal governmentality (p. 117). Elm-Larsen (2006) argued that heterotopia takes on analytical power in the context of post-institutional care and foregrounded it's utility by contrasting it with the *function* of Foucault's more widely used concept of panoptical spaces:

> The concept of heterotopia is especially well suited to describe marginal spaces, because this concept does not operate with the traditional centre-periphery orientation and because heterotopia is not related to unambiguous functions of discipline and surveillance. (Elm-Larsen 2006, p. 78).

Scholars from the fields of health (Carter 2019; Hutton 2010; McGrath & Reavey 2013; Street & Coleman 2012; Street, Coleman & Brown 2012), geography (Elden 2007; Elden & Crampton 2007; Huxley 2007; Johnson 2006; Thompson 2011) and adult education (Sandberg et al. 2016) have used Foucault's work on space and comments on heterotopia to (re)think contemporary, decentralised approaches of governing. Rather than the disciplinary spaces associated with the

hospital or prison that work through division and separation, this research across fields has explored how configurations of "decentralised, localised self-surveillance, self-control and self-punishment" (Elm-Larsen 2006, p. 78) unfold beyond institutional boundaries (Andrews 2003; Andrews & Shaw 2008; Johnsen, Cloke & May 2004; Patton 2010). Within such spaces, discourses, practices and material objects assemble subjectivities that are directed by the logic and rationales of particular programs. As demonstrated through a study of emergent approaches to citizenship education (Sandberg et al 2016), such programmatic logic offers the potential for the individual to take up the subjectivity offered and move to a position of legitimacy within a broader population of responsible clients or citizens. This way of governing through ideas and discourses of responsibility also position individuals of who do not take up offers of self-improvement as responsible for any outcomes.These dispersed approaches rely heavily on the circulation and reinforcement of discourses and ways of thinking and talking that establish a shared understanding of what these programs seek to do and how people can be mobilised to work towards these objectives.

Heterotopia and spatial analysis of an integrated care program

In the following sections we utilise these conceptual 'tools' in a spatial analysis that explores how policies and program documents work to deploy nursing practices across spaces and places of care for people living with chronic diseases. In particular we use heterotopia, following Elm-Laresen (2006) and Sandberg et al (2016), to move away from over-simplified divisions between the sites of hospital and home or community based care. Instead we use heterotopia to consider how these other, different spaces of care opened up through practices which facilitated "decentralised, localised self-surveillance, self-control and self-punishment" (Elm-Larsen 2006, p. 78). The spaces are beyond and across boundaries as they drawn on a programmatic logic that offers *patients* an opporunity to become *clients* and learn how to take on a subjectivity of 'legitimacy 'within a broader population of responsible clients or citizens.

To do this we highlight the importance of organisational documents in such dispersed programs of care. These dispersed programs unfold through processes of translation (Rose 1996, 1998) and assemblage (Murray Li 2007) as they take shape in localities far away from policy sources. The policy documents which guide localised implementation act as conduits and connectors to new and different spaces in which nursing care is enacted. Murray Li (2007) described such

documents as “framing the arena of intervention” (p. 270) and creating the conditions in which certain interventions appear logical. However, Murray Li (2007) cautioned that such texts can contain “simplified narratives that gloss over tensions” (p. 270) and make local configurations or assemblages seem far more coherent than they actually are. We will argue that using Foucault’s work on space and heterotopia draws out some of these misalignments and draws attention to the risks inherent within such dispersed approaches to the management of chronic disease.

The following analysis draws in detail on documentary data which was gathered as part of a larger study of a state-wide, government funded primary health care program in a metropolitcan area of New South Wales (NSW), Australia. In this article we refer to the program as *Integrated Care NSW*. Documents were collected from publicly available sources including government websites and analysed using a Foucauldian approach to discourse analysis (Bacchi, 2009; Waitt, 2010). Ethics approval for the broader study was granted by the relevant University ethics committee[2].

The following sections of the analysis illustrate how Foucault’s work on space and heterotopia can be used to explore a dispersed program like *Integrated Care NSW*. The documents analysed outline the “arena of intervention” (Murray Li 2007, p. 270) by setting out the problem as well as the programs’ objectives. Importantly, the documents also describe ‘solutions’ to these problems. These solutions include detailed guidance and advice for the local lead practitioners referred to as General Practice (GP) Liaison Nurses (defined by the program as a specialist Registered Nurse[3]) on how they can fulfil these objectives by working in the homes and communities of patients and clients. It is this guidance and advice that opens up multiple and transient spaces of care for targeted individuals and (re)shapes everyday nursing practices. Case studies feature heavily in the policy documents as illustrations to local nurses of what to do in different situations. These influential case studies assemble an ideal space of care that glosses over “the tensions” (Murray Li 2007, p. 270) inherent within everyday life. The case studies create spaces in which the troublesome patient is reassembled as the good client of the program and thus is able to take their place as a legitimate and responsible citizen within the broader

[2] The University of Technology, Sydney, Human Research Ethics Committee - reference code UTS HREC Approval 2011-029 R) was received on 02/07/2013 (reference code 2013000025).
[3] Registered Nurse status requires completion of a three-year Bachelor’s could plus registration with the Australian Health Practitioner Regulation Agency https://www.ahpra.gov.au/

society. Rather than using Foucault's comments on heterotopias of crisis and deviation, we argue that the notion can be used to show how the program assembled spaces that were unreal and "perfect…meticulous…well-arranged" (Foucault 1994, p. 184). These spaces in which nursing care practices were enacted dislocated from the everyday life of the individual and thus can be viewed heterotopically as decentralised and localised spaces in which self-governing was facilitated. In the following sections we use heterotopia and spatial analysis to firstly examine how the rethinking of care for chronic diseases was translated into a heterotopia space where nursing care came together in relation to but apart from other spaces of normal life (Foucault 1986). Secondly, we focus on one of the case studies to explore how at the ideal 'space of care' was assembled to promote the subjectivity of the good, self-governing client.

Rethinking care for chronic disease: Integrated care as heterotopias

Integrated Care NSW's policy and programmatic texts reflected the gradual and significant diversion of resources from hospital-based care into primary care and community programs for people with chronic diseases in Australia (Australian Institute of Health and Welfare, 2013). In addition to the shift in funding the program also illustrated the rethinking of the roles and responsibilities of health care providers and patients who were reassembled as 'clients' with chronic diseases. The stated objectives of the program were to "reduce the risk and impact of disease and disability…reduce avoidable admissions (and unnecessary demand for hospital care) build a sustainable model of health care delivery" (NSW Government, n.d.).

These stated objectives emphasised the problems associated with chronic disease in terms of risk, disability, costs of hospital care and sustainability of services. The program was focused not on developing or extending hospital or clinic services, but rather on implementing change through the localisation of care delivery and setting up community level partnerships across physical sites. The program itself was led by a Registered Nurse who was referred to as the General Practice Liaison Nurse (GP Liaison Nurse). The flexibility and unstructured nature of the program was apparent in the texts - "There is no single model of integrated care that is suited to all settings; Local Health Districts should be guided by their community needs about the configuration that is best suited to each locality" (NSW Government, 2012, p. 3). Local programs, led by the GP Liaison Nurse were asked to develop their own practices to "reduce the

increasing burden of chronic disease and to focus on those people in the community who need a greater level of coordinated care" (NSW Government 2012, p. 6) – a significant change for nursing practice.

The care that was to be delivered by the program was described as *client centred* and based on "communication…including explanation of health issues and exploration of feelings, beliefs and expectations…partnerships…so that they have the autonomy within the client-clinician relationship to be involved in decision making… beyond specific conditions, on health promotion and healthy lifestyles" (NSW Government 2012, pp. 12–13). These spaces in which this care was delivered through nursing practices were not linked to physical sites as such the hospital but rather webs of relations (Foucault 1986) set up to educate and help the client to become responsible for their own self-care according to the terms of the program. The focus of the care practices of the GP Liaison Nurse was not the chronic disease itself but the education of client as they were helped to become responsible for their own self-care within the new ordered boundaries of program. These spaces were transitory as once the client demonstrated compliance and self-governing they were discharged from the program.

Referral to the program, and entry to its space of care, was governed through practices and connections within the networks of experts that detected inadequacies, failures and *potential* within particular *patients* to become a client of the program in a more orderly and structured heterotopia. Referral was not initiated by the patient or client but was an outcome of meetings and networking amongst professionals, such as the monthly meeting of GP Liaison Nurses and other community-based healthcare staff, or in response to a request from a nurse or local doctor. Access to the program and its assembled programmatic boundaries were dependent upon assessment by an expert that, like the referral itself, was done before the patient was even made aware of the program. The extract below from the local information brochure provided to 'patients' and potential clients of the program highlights these processes:

> Referrals to [Integrated Care NSW] are generally made by GPs, Community Health workers and hospital staff.
> Once a referral is received, an assessment will be completed by a Community Health worker.

> [Integrated Care NSW] will be explained to you and your consent obtained to be enrolled as a […] client.
> Your GP will be contacted and their consent obtained for their participation. At this point you become a […] client (NSW Government, n.d.-a).

Although the program did not confine patients or draw them together in physical sites or places, its processes of access and inclusion had an *effect* of including some people and thereby excluding others. For example, the program texts identified the target population in the following terms:

> People with complex health needs or chronic illnesses who are living at home
>
> People who are frail and elderly and living at home
>
> Refugees…Disadvantaged communities (NSW Government, n.d.-a).

It was through practices such as referral, assessment and enrolment, that the boundaries of new spaces of care were continually (re)negotiated in the networks and webs of relations across these different local services.

Through these practices of referral, assessment and enrolment some of the local area *patient*s were encouraged and helped to become an active and engaged *clients.* Networks of experts, led by the GP Liaison Nurse were connected in these new spaces of care, across various places, to identify patients who had the need and 'potential' to take up the subjectivity of the *client*. These 'other' spaces of care opened up as transient heterotopias of opportunity and reform. The spaces were structured by processes and practices of inclusion, exclusion and, once self-governing was demonstrated, discharge and movement out of the space of care.

The spaces of care, discussed above, were assembled through practices such as assessment, referral and enrolment that allowed an individual to move from a patient to a client of the program. In the policy texts, this shift highlighted the intention of the program and the associated policies which sought to mobilise individuals in accordance with ideas of responsibility and self-management. Two distinctive subjectivities emerged through this analysis – firstly, the *patient* was assembled as chaotic and irresponsible in their use of health care resources. They were represented as lacking in self-knowledge and the skills required for responsible self-

management. This was in contrast to the subjectivity of the *client* who was responsible, self-managing and successful in terms of the optimisation of their own health and the minimisation of their use of health care resources.

These contrasting subjectivities are illustrated in a case study included in the a key policy text. The case study of 'Joan' illustrates how the program unfolded through multiple spaces of care that encouraged self-surveillance and compliance. This case study is discussed in detail in the following section.

Introducing 'Joan': Moving from patient to client

The case study in the Integrated Care NSW text introduced Joan, a 'typical' 'successful' local patient with chronic disease to illustrate the priorities of the integrated care program and its practices. The following introduction to Joan highlighted the issues with her health as well as her suggested history of non-compliance:

> Case Study: Integrated Care NSW – improving outcomes for individual clients
>
> Joan* is a 40 year old partial quadriplegic who weighs 115kg and has a history of refusing to go to the hospital for necessary care. Any care required in hospital needs to be negotiated with Work Cover NSW[4]. On admission Joan must be turned every hour and there had previously been conflict about whose role it was to provide this level of care. Prior to Integrated Care NSW communication with the insurer was not initiated until after hospital admission, which often meant a delay to her necessary care and a longer hospital stay from resulting pressure sores.

In this case study, Joan is initially assembled as a *patient* with a concerning history of refusing hospital admissions. Joan's refusals to go to hospital, and the complexity of the involvement of multiple agencies in her care, have led to a deterioration in her physical condition. Consequently, Joan has needed longer and more expensive hospital admissions. The following extract from the program text then describes how the new care practices provided unfolded around and through

[4] WorkCover NSW was a government agency (established in 1989) to promote safety in the workplace.

Joan as she was reassembled as a ‘client’ of Integrated Care NSW and took up a position of legiticmacy in (Sandberg et al., 2016):

> Enrolment to the Integrated Care NSW program has facilitated better care through a discussion with all stakeholders and an agreed management plan for who does what when. In partnership with Joan an agreed process was developed for an emerging need for hospitalisation. This has resulted in early intervention by the Integrated Care NSW GP Liaison Nurse who is able to negotiate post admission care with the hospital, reducing the delay to appropriate care and ultimately resulting in a reduced length of stay. After 8 months, Joan has had 30% less hospitalisations. (*name and age have been changed) (NSW Government 2012, p. 13).

The outcome of better care as a result of her enrolment with Integrated Care NSW is constructed in terms of reduced hospital stays. The care that allowed this outcome to be achieved did not relate to practices and processes associated with Joan’s body. In contrast, this integrated care involved Joan becoming a partner in her own care and management. Within this space of integrated care, the lead practitioner, the GP Liaison Nurse, functioned as a mediator (Holmes, Perron & Savoie 2006) between the objectives of the program and the life and body of Joan. Joan was drawn into a space that was orderly and structured and that was in contrast to the disorder of her previous situation. Within this transient and well-ordered space (heterotopia) Joan was able to learn how to manage her own health and care responsibly. The program’s care was deemed to be successful yet the care practices did not involve intervention in a medical sense but rather focused on helping Joan to engage with her own self-management and demonstrate her ability to be a “responsible, self-governing citizen” (Street & Coleman 2012, p. 13). Similarly, the GP Liaison Nurse was no longer treating her chronic diseases but was rather a partner with Joan who was training her as she negotiated her way to become a successful self-governing client of the program.

Insights for nursing practice: Using heterotopia and spatial analysis

The illustration of the analysis of the program texts of Integrated Care NSW from this spatial perspective and drawing on Foucault’s notion of heterotopia, provides an illustration of an alternative way of thinking about place and space in contemporary health care programs. Importantly, this perspective highlights the ways in which nursing care practices are woven

through the webs of relations that make up these approaches to the self-management of chronic diseases. The site of the hospital or clinic represented a crystallisation of discourses of health, illness and expertise (Foucault, 1991). These physical sites have been dis-assembled as care has moved out and into communities and homes. There remains, however, a distinct architecture and ordering of these new spaces of care that has an effect of shaping and (re)configuring the practices that connect the nurses in these roles with newly assembled individual clients of Integrated Care NSW.

In arguing that the space of Integrated Care NSW's integrated care can be viewed as a heterotopia assembled through neoliberal political and economic rationalities (White, Hillman & Latimer 2012), a particular order can be discerned. Within these spaces of integrated care, the client was reassembled and integrated into the provision of their own care as a partner and expert. The space of this integrated care settled across the physical body of the client as well as the various domains of their life and health as Joan was assembled and "co-opted" (Street & Coleman 2012, p. 13) into its programmatic logic. The relations of the heterotopia and the way in which care unfolded was in keeping with the rationalities discussed by Foucault in relation to heterotopias. Poland et al (2005, p. 174) noted the complex ways in which clients and citizens are governed through power relations and techniques associated with such "focus on the cultivations of new subjectivities of personal empowerment, participation, self-actualisation, risk management, and health and safety". Such techniques work by aligning the desires of the subject with the rationalities that assemble the program and its practices within diverse webs of relations.

In these localised spaces, interventions not only shifted from physical sites such as the hospital or clinic but the *work* that constituted nursing practice also changed significantly. The patient became the 'client' in these spaces and the GP Liaison Nurse worked to engage them in being active and responsible in managing their own care. This linking of space and subjectivity resonates with other studies that have utilised heterotopia for analysis and found that such spaces offer the newly formed citizen a "temporary stability, enabling their shaping and moulding into desirable subjects" (Sandberg *et al.*, 2016, p. 105). Within the context of contemporary nursing care for clients of integrated care programs this is increasingly focused on the management of health and disease through ideas of self-management, education and partnership. While advocates have highlighted the importance of an individual playing an active role in managing

their own health and care, it is vital that questions are asked about how this is done through the (re)shaping of care practices and the increasing pivot towards communication, networking and information sharing. This is important in terms of understanding the changing nature of the nursing profession (McIntyre, Burton & Holmes 2020) as well as the potential impact of structural inequalities (Greaney & Flaherty 2020) on responses to care. Using heterotopia within a spatial analysis opens up the analysis to foreground these questions and highlight the complexities of integrated care programs for the nurses and those living with chronic disease.

Conclusion and implications for nursing practice

Dispersed programs, like Integrated Care NSW, are mobilised through the translation of policy out from a source and into local communities. Nurses are key in the implementation of such care programs and often manage the processes of identification, referral and discharge that direct individuals through. The implementation of localised and community or home-based care for people with chronic diseases has led to some fundamental changes in nursing roles and practices. Of key significance in the context of this article is the shifting of these practices out from the hospital or clinic and into the community through dispersed and transient spaces of care and intervention. Considering these spaces as heterotopias that exist temporarily and function to reform and legitimise the behaviour of individauls highlights how policies seek to teach a certain form of self-management. Rather than using tools of ongoing surveillance, the individual is coached and taught how to be a ‘good’ citizen with chronic disease. Once the associated skills have been demonstrated, the client was deemed fit to be discharged from the care program. The nursing practices described in the policy documents created a space of care which can be considered as heterotopic – that is, the space was not a physical site but rather a transitory set or web of relations that were shaped and directed by the logic of the program.

Foucault’s work on space and comments on heterotopia are useful analytic tools for the analysis of such programs. Such theoretically grounded perspectives are important tools in the investigation of how changes in approaches to nursing care in programs like Integrated Care NSW conform to certain logic and rationales. As noted by Paradis-Gagne and Holmes (2021) theoretical perspectives facilitate the important interrogation of programs and practice innovations that claim to offer greater freedom and choice yet do so at a high potential cost to

both the service user and the nursing practitioner. It is this potential cost that makes such studies of relevance to the nursing profession. Although increased community and home-based care may be of benefit to service users, the policy documents that direct these programs construct spaces of care in a linear ways that gloss over the tentions and challenges of living with chronic diseases. This analysis highlights the importance of constructing such programs with empathy and awareness of the tension between what ‘happens’ in policy documents and everyday ‘life’. For nurses it also highlights the ongoing shifts in care practices that emphasise education and coaching within the narrowly defined parameters of the programs and their policies.

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