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Abstract

This paper makes an original contribution through the revitalisation, refinement and exemplification of the idea of the ‘critical juncture’. In the health and illness context a critical juncture is a temporally bounded sequence of events and interactions which alters, significantly and in a lasting way, both the experience of the person most directly affected and the caring work which is done. It is a punctuating moment initiating or embedded within a longer trajectory and is characterised by uncertainty. As contingencies come to the fore individual actions have a higher-than-usual chance of affecting future, enduring, arrangements. These ideas we illustrate with detailed qualitative data relating to one individual’s journey through an interconnected system of mental health care. We then draw on observations made in a second study, concerned with the improvement of mental health services, to show how micro-level critical junctures can be purposefully used to introduce instability at the meso-level in the pursuit of larger organisational change. In addition to demonstrating why scholars and practitioners should pay closer attention to understanding and responding to critical junctures we are, therefore, also able to demonstrate how their emergence and impact can be examined vertically, as well as horizontally.

Keywords

child and adolescent mental health services; crisis resolution and home treatment services; critical junctures; mental health; systems; trajectory.

Introduction

Across the social sciences the idea of significant turning points, or what we refer to in this paper as ‘critical junctures’, is a familiar and recurring one (Abbott, 1997). It features prominently in the contemporary, macro-level, study of political and institutional history (Capoccia and Kelemen, 2007). From within sociology, Hughes (1971) writes of turning points in the micro-level context of the individual life course. Critical junctures also feature in the small-scale study of health and illness experiences (Glaser and Strauss, 1968). Although the levels of analysis in these examples differ, in all cases the ‘critical juncture’ references a pivotal moment when actions have enduring consequences which are hard to reverse. Typically the examination of these proceeds in horizontal fashion, so that the significance of a critical juncture for a large-scale polity (such as a nation state) is analysed for that same polity, and a small-scale critical juncture is analysed for its effect on the individual and those immediately surrounding.

Our original contribution in this paper begins with the revitalisation, refinement and exemplification of the idea of the critical juncture in the context of health and illness. We achieve this by carefully laying out what we understand a ‘critical juncture’ to be, and by then illustrating our thinking with detailed qualitative data derived from a case study of one individual’s journey through an interconnected system of mental health care. In the second part of the paper we show how critical junctures arising at the micro-level have potential to trigger, or can be used to lever, lasting change at macro or intermediate meso levels. We do this with reference to observations made in a second study, concerned with the improvement of child and adolescent mental health services (CAMHS). In addition to demonstrating why health and social care scholars and practitioners should pay closer attention to understanding

and responding to critical junctures we are, therefore, also able to demonstrate how their impact can be examined vertically.

Understanding critical junctures

Writing primarily for a political history readership Capoccia and Kelemen (2007) take issue with casual usages of the ‘critical juncture’ idea, and set out to define it with precision.

Referencing Pierson (2004) they identify junctures in history as ‘critical’ because they set in train institutional forms which, via processes of path dependence, are hard to alter. Compared to the periods of relative stability which precede and follow them, critical junctures are always short-lived. Arising at periods of instability they are windows during which agents’ actions have significantly higher-than-usual chances of shaping future arrangements. As they unfold, contextual influences (or contingencies) come to the fore as people in positions of relative power make choices, selected from a range of plausible possibilities, which in turn prove particularly consequential.

In Capoccia and Kelemen’s view critical junctures can occur at different levels (for example, within segments of a political system or across whole nations), but specificity is necessary in defining units of analysis. We suggest that the unit can be scaled down to the level of the individual, with Capoccia and Kelemen’s honed idea of the critical juncture capable of being used to improve understanding of the health and illness experience and the micro-level organisation of work and services. Critical junctures in this context can be thought of as defining moments which happen both to previously healthy people and to people already living with long-term illness. They are temporally bounded sequences of events and

interactions which alter, in lasting ways, both the personal health and illness experience and the caring work which is done. As contingencies come to the fore and as choices are faced, for the individual with ill-health and those surrounding the critical juncture stands out from the day-to-day as a punctuation, initiating or taking place within a longer trajectory of care (Strauss *et al*, 1985; Allen *et al*, 2004; Hannigan and Allen, forthcoming). To the person already living with ill-health it may appear as a singular perturbation, contributing to the biographical disruption (Bury, 1982; Williams, 2000) associated with chronic illness. Its appearance also has implications for work, in that it may require involved staff to begin additional sequences of activity and may draw new staff in.

Whilst, in the context of this paper, these observations are largely data-driven we also acknowledge the earlier use of the ‘critical juncture’ term in Glaser and Strauss’ (1968) *Time for Dying*, their monograph on caring work for people at the end of life. Subsequent work in this tradition is helpful in understanding how critical junctures originate, to which we add new insights on their internal dynamics. Each may begin with a health event (or, as Strauss *et al* (1985) term it, an individual-level illness-related contingency), and thus be a turning point with physiological or psychological origins. In our thinking it is this type of critical juncture which Glaser and Strauss in *Time for Dying* are primarily interested in. Informed by Strauss *et al*’s (1985) later idea of system-level, as well as individual-level, contingencies we additionally suggest that a critical juncture may have roots entirely outwith the health experience *per se*, and instead be triggered by organisational forces.

Whatever its origins, a critical juncture is always likely to be felt, and influenced, by others. This interactional, negotiated, quality in which individual agency is prominent is particularly

significant for critical junctures unfolding in developed health systems. These have intricate divisions of labour, meaning that a critical juncture may come to be worked on and moulded by a true multitude of purposefully acting staff, family members and others. These people, in turn, may themselves be shaped by their involvement. Noting the idea from complexity science that small happenings can trigger large effects (see for example: Urry, 2005), we observe that a modest initial event may sometimes culminate in a critical juncture with unforeseen magnitude. Thus, although some junctures may recognisably be ‘critical’ from their outset (for example, a juncture triggered by a sudden, catastrophic and life-threatening illness), others evolve over time. Junctures of this second type become ‘critical’ only as the trajectories which they initiate (or within which they occur) unfold and emerge. As we show below, under certain conditions small-scale critical junctures can also be purposefully used to destabilise larger systems in the pursuit of institutional change.

Illustrating the critical juncture: a study of community crisis resolution and home treatment care

Aim, design and methods

To illustrate the critical juncture idea we deploy data from a study centring on the work, impact and user experience of community crisis resolution and home treatment services. Information on this study’s aims, design and methods has been published previously (Hannigan, forthcoming), but is summarised here for completeness.

Crisis resolution and home treatment services have become widespread throughout the UK (see for example: National Audit Office, 2007), reflecting fast-moving national mental health

policies (Hannigan and Coffey, 2011) favouring community alternatives to hospital admission for people in acute distress (see for example: Department of Health, 2001; Welsh Assembly Government, 2005). Relevant National Health Service (NHS) research ethics and local research governance approvals were secured for a project using an embedded case study design (Scholz and Tietje, 2002; Yin, 2009), where ‘the case’ examined was an exemplar interprofessional crisis team in Wales set in its local system context. Each of the smaller, embedded, units of analysis (or, alternatively put, the cases within the case study) was an individual with past experience of using this team’s services. Ethnographic data (Hammersley and Atkinson, 2007) were generated, at two interconnected ‘levels’ of organisation, over an 18 month period from the middle of 2007. Meso-level data relating to the setting up of the case study team and its impact within the local system of services of which it had become a part were generated through interviews, observations and document review. An analysis of these data has been previously reported (Hannigan, forthcoming). Of greater direct interest in the context of this paper are the data generated to meet the study’s aims of investigating the micro-level organisation and experience of care as people passed into, through and back out of crisis services.

Four individuals with personal experience of using the case study team’s services gave their informed consent to take part in the project. Interview and documentary data were gathered after each user participant’s acute phase of ill-health had resolved, and after each had been discharged from intensive, home-based, crisis support. Interviews were conducted with service users, and with practitioners located in the crisis team and in other parts of the local system through which each user moved as his or her trajectory of care unfolded. Participants were invited to talk about the journey through the system, the negotiation of roles and responsibilities and factors helping and hindering care delivery. Research access was also

secured to the NHS case records for each service user, as these related to the time period covering the provision of crisis care. These written practitioner notes were both used as data in their own right and as a means of identifying workers to whom interview invitations should be extended.

All but two of the interviews conducted were audiorecorded. Detailed handwritten notes were instead taken in both cases. Summaries were made immediately following the completion of all interviews, and were included in the project's dataset. Audiorecordings were fully transcribed and anonymised, and contemporaneous notes taken in place of direct recording were wordprocessed. Observational field notes were written up in full without identifiers. Handwritten notes, made without the inclusion of identifying information, were made from the NHS records relating to the provision of crisis care to each of the four service user participants, and were then wordprocessed. Wordprocessed copies of local policy documents relating to crisis services were obtained. All anonymised individual interview transcripts, the records of the two unrecorded interviews, case note records, field notes and policy documents were entered as separate 'primary documents' into a single 'hermeneutic unit' in version 5.5 of the software package Atlas.ti (Scientific Software Development, 2009). Each was read in close detail, with notes added using Atlas.ti's memo facility as an initial step in opening up the data for more intensive analysis (Dey, 1993). This was followed by systematic coding (Coffey and Atkinson, 1996). Distinguishing codes were attached, for example, to all data segments relating to the provision of crisis care to each of the four service user participants, and to all data relating to points in each service user's evolving trajectory. In this paper only data relating to the trajectory of one of four participating service users are drawn on, with the express purpose of illuminating our critical juncture idea.

Findings: a critical juncture beginning with a health contingency which initiates a trajectory of care

Living with her husband, Chloe was an active and engaged member of her community whose depression propelled her into mental health care, and into a hitherto unforeseen trajectory which over time pulled in an array of professionals and support workers. Her trajectory included an early, transformative, event illustrative of the critical juncture idea. Chloe's narration of this moment is detailed and vivid, and here she first sets it in its wider context:

Chloe: I suppose it begins summer of last year when I started to become ill, something was going on, I wasn't too sure what was happening. I came up to, I suppose, we'd just had the August bank holiday and I was at work and I suddenly became really quite ill and this eventually transpired to be the onset of the rheumatoid arthritis that I have, but also at the same time I think the depression was starting, and a lot of people said it was reactive perhaps to the illness and whatever. [...] I spoke to my GP [general medical practitioner] about feeling weird and what was going on and she said it was depression, I needed to get onto tablets whatever, whatever, so that happened. So I was taking tablets for the depression, trying to find out what on earth was going wrong physically with me and really just getting more and more dragged down. It was a great pressure on my husband, I wasn't getting anywhere, I didn't feel, didn't feel as though the tablets were working, I just felt ill, I was losing weight, it was horrendous, all of that going on.

Unfolding trajectories are characterised by phases with associated 'arcs of work' (Strauss *et al.*, 1985), and here Chloe's was taking shape with a growing awareness on her part ('feeling weird', and 'getting more and more dragged down') of a general deterioration in her well-being. At this initial (in our formulation, non-critical) phase Chloe's network of involved carers remained modest. However, she continues:

Chloe: Yeah, yeah, but the event, it's umm, beginning of February it was, this sounds terrible but I think the pressures in this household were so great, there was one evening where we had a sort of, my husband said that he'd got to get away, got to go out for a while and so on, so

there was a bit of to-ing and fro-ing going on that night, there was absolutely nothing to do with violence or whatever like that but my neighbour, I swear it was my neighbour, I don't know, called the police, he heard door-banging or whatever, he was maintaining I think that there was probably a potential violent situation going on, which was not the case. It was just absolute exploding stress I think, that's how I would say. Anyway, the police arrived that night [...] that was an awful feeling, I've never felt quite like that before because suddenly the police officer said, 'I am in control now'.

[...]

He [the police officer] then decided, kept my husband down here, I was upstairs, I wasn't allowed to move from where I was at all, not to sit down, not to get a pair of slippers, nothing, and this was late at night, very late at night. Then there was some discussion about, because they decided that I, from what they discovered here whilst speaking to both of us, they decided that I needed to go for an assessment. Ambulance was called, and there was some discussion about me going to the General Hospital for an assessment there, and was I willing or whatever. They were also trying to get hold of a sort of an out-of-hours doctor.

Here Chloe is referring to a significant and singular perturbation. For her, her husband and the members of a newly enlisted team of workers there is uncertainty as options are weighed.

Chloe adds:

Chloe: [...] I forget exactly how late it was but it was quite late because I had actually gone upstairs to go to bed you see when the knock came to the door, and I wasn't sure what I preferred really, I said I kind of preferred, I did have that sort of choice, to wait for the doctor but the doctor seemed to be delayed somewhere and it was getting to a point, well, 'are you going to come with us to the General or what?', and the doctor arrived anyway.

Researcher: The on-call GP?

Chloe: Yeah, and it was a lady, she spoke to me about the situation, agreed that I should go for an assessment but it was then sorted out that I would go by ambulance to the psychiatric hospital which eventually happened. [...]

I arrived at the hospital late at night, starting to snow, I think I was in pyjamas and a dressing gown and slippers, and there was a fair bit of waiting there, I was waiting in the entrance hall. Then I had an interview, I suppose you would call it the assessment with two people in the room, a doctor and a nurse [...]

It was getting very late and eventually the doctor arrived in the doorway and she said because of your physical condition as well as what seems to be your mental condition, we are going to admit you.

Chloe's detailed narration reproduced in these extended data extracts captures the temporal sequencing of events and actions which denote her entrance into the local mental health system, this proving a pivotal turning point in her journey. Individual-level contingencies embedded within this critical juncture include Chloe's subjective sense of diminished well-being and her fraught relationship at home. System-level contingencies include the latitude of relatively powerful decision-makers, in conditions of uncertainty, to interpret events as evidence of illness and to mobilise the system accordingly. Implicit categorisation takes place (Griffiths, 2001). Whilst organisational features (such as the local availability of different types of service) constrain the range of possibilities open to staff, beginning with the decision of the police officer to call an ambulance Chloe becomes categorised as someone with a mental health problem. This step is an important one, for as Moncrieff (2010) suggests the interpretation of behaviour as evidence of illness legitimates health care workers' decisions, including their commitment of resources. An arc of work (Strauss *et al*, 1985) is then in evidence, involving increasingly specialised assessments and negotiations across system boundaries ending in Chloe's admission to hospital.

From Chloe's longer trajectory of care, which took off in an entirely new direction following the events described above, comes a second critical juncture exemplar which differs from the first in two important ways. First, it was not obviously 'critical' from the outset, and second, its origins lie more completely in features of the system rather than in Chloe as an individual. In their study of the trajectories of people recovering from stroke, Allen *et al* (2004) show how these are shaped by the relative availability of resources. The resources which are open to people with health and social care needs, and the preparedness of workers to access and use these, are organisational contingencies (Strauss *et al*, 1985) likely to have a bearing on

the direction a trajectory will take. In Chloe's case, crisis team members were required to conduct assessments and produce favourable interpretations of eligibility in order for newly referred people to access their service. This was a necessary step because of the scarcity of dedicated crisis care within the local system. Viewed retrospectively, a critical juncture in Chloe's journey to recovery was initiated at the point of her transition to the care of the case study team. This hospital-to-community referral was generated six days after her inpatient admission, with the written case record summarising Chloe's suitability for home-based care referencing a 'significant deterioration in [her] mental state' along with her being 'willing to have CRHTT [crisis resolution and home treatment team] input as an alternative to hospital admission'.

Crisis team members who subsequently worked with Chloe validated their categorisation of her as a suitable candidate for access to scarce resources by referencing the unexpected, disruptive, character of her mental ill-health. One worker said:

Crisis team worker: I spent quite a lot of time with Chloe and she was referred for quite severe depression [...] So this lady was living with her husband in a nice family home and everything seemed to be really good, grown up sons, she'd led a very active life, she'd worked part-time because her part-time hobbies and interests meant a lot to her so she was financially comfortable enough to dedicate as much time to her hobbies as to her work after the family. She was a very devoted grandmother, had lots of contact with her grandchildren and seemed to have suddenly fallen apart [...]

The ways in which mental health teams organise themselves during deliberations held to consider potential new clients have direct implications for the provision (and withholding) of services to individuals (Griffiths, 1997), with newly referred people's suitability for care being discursively constructed by practitioners (Griffiths, 2001). Workers' assessments, and the decisions they subsequently take, open up future potential trajectory directions and

simultaneously close out others. In the extract above Chloe is described in a morally favourable way, and it is in this context that new lines of work opened up in this phase of her trajectory as multiple members of the crisis team responded to her having ‘fallen apart’ through involving themselves, both practically and in formal therapeutic ways, in her care.

For Chloe herself, her referral for home treatment and her subsequent engagement with workers proved pivotal, positive and health promoting:

Chloe: [...] you get a daily contact by telephone, saying about when they’re coming out and to see you and so on. So you’ve got daily contact, you know you can ring them any time day or night, whenever it is. They started a programme of, I think at first they do a lot of listening which is very nice, if other people don’t want to listen to you they will so that is something that you cling on to because you know that they will listen to you. And then it started from that, ‘Right, what about you getting your coat on, shall we go out for a ride in the car, just a ride and if you can’t do it we’ll come back?’ [...] we’d go out on sort of an outing as I get a little bit more able to do that. So I, as I said I found that that was nice, they were like people who were coming to me, you know, they wanted to be in my company and they were going to listen to me and they would perhaps take me out and all of that.

In Chloe’s case, then, this second critical juncture which propelled her towards the crisis team initiated a new phase in her trajectory in the course of which she was supported and made to feel valued as she took steps towards recovery. Reviewing Chloe’s trajectory as a whole, and using the kind of counterfactual thinking favoured by Capoccia and Kelemen (2007), it is possible to trace plausible alternative sequences of decisions and actions at both junctures.

For example, in the first the police officer might have categorised Chloe’s behaviour as evidence of something other than a possible mental health problem. In the second, crisis team staff may have rejected Chloe as ineligible for access to their service, or their colleagues working elsewhere in the system may not have referred her for crisis care at all. Each of these

alternatives would have set Chloe's trajectory down a different, and potentially enduring, path.

Thus far in this paper, through an analysis of aspects of one person's unfolding trajectory we have introduced the idea of critical junctures and illustrated how these can have both individual and system (or organisational) origins. We have shown the importance of interactions, and the decisions which are made by powerful actors, for the shaping of future trajectories. We have also shown how relatively small events (like making and accepting referrals) can trigger larger effects, which in the case example we have given meant helping a person on a road to recovery. Drawing on observations from a second study (unrelated to the first, but also in the field of mental health) we now extend our analysis from the horizontal to the vertical, to show how critical junctures emerging at one 'level' can effect or be used to lever change at another.

Illustrating the larger impact of critical junctures: a study addressing demand on a child and adolescent mental health service (CAMHS)

Aim, design and methods

In this second study a dedicated triage clinic was introduced into a single community child and adolescent mental health service (CAMHS) in Wales as a way of better managing demand. Using action research methods, the project involved collaborative working to solve the real-life health service problem of excessive waiting times for secondary care. The work was led by a researcher who was also a CAMHS nurse, who facilitated a series of activities through which the service's established assessment processes and its approach to prioritising referred cases were changed over time.

Underpinning the project were commitments to democratic decision-making and the idea of the action researcher as ‘reformer’ rather than ‘revolutionary’ (Greenwood and Levin, 2007). Across the life of the study different types of data were generated, using ethnographic methods, surveys and through reuse of routinely collected service-level records. Observations from participation in the field were captured and recorded as field notes, included in which were notes made at team meetings during which the development of the new triage approach was discussed. Data were also generated at multi-disciplinary meetings held during the triage clinics where clinical decisions were reviewed, and at team events where ideas were presented and service changes discussed. Later team meetings were audiorecorded once ethical approval for this had been granted and consent from participants secured. Observations also took place, and field notes were made, during actual triage interventions. In the construction of field notes care was taken to distinguish and declare researcher perceptions and pre-understandings from the observations being made (Emerson *et al*, 1995). Entries over time came to increasingly concentrate on team dynamics and on how people were approaching the process of change. Interviews were held with nine workers to further explore practitioners’ change experiences, of whom five were interviewed both pre and post the triage intervention. A reflexive diary was used as a space to keep an audit trail of actions and processes, as a chronology of the research journey and as a place to have reflective conversations (Hart and Bond, 1995). All qualitative data were managed using version 5.2 of Atlas.ti (Scientific Software Development, 2009), and two ‘hermeneutic units’ were created: one to manage the data relating to the service change, the other to manage data evaluating the intervention. In the analysis of the change process an inductive style was used, an approach useful in the generation and testing of hypotheses which simultaneously enables the researcher to remain grounded in the data (Silverman, 2011).

Findings: a micro-level critical juncture used in the service of leveraging larger change

Capoccia and Kelemen (2007) distinguish longitudinal from cross-sectional critical junctures, observing that a pivotal moment at one institutional level may be inconsequential in another.

Here we show how, under certain conditions, a juncture which is critical at a small scale can set arrangements on a new and different path at a scale which is significantly greater.

Following Capoccia and Kelemen (2007: 357) our focus at the larger of the two levels is on the ‘main actors, their goals, preferences, decisions, and the events that directly influenced them’, and we trace the process through which the narrative deployment of a micro-level critical juncture can purposefully trigger uncertainty in the service of organisational change.

In the CAMHS team, prior to the introduction of the dedicated triage clinic a child’s suitability for the secondary mental health service began with a referrer’s assessment and his or her articulation of the young person’s needs. Referrers came from a range of professional backgrounds, and included GPs, school nurses, teachers, social workers and care workers from the voluntary sector. All had different experiences and understanding of mental health in the context of child development, local services, and perceptions of the risks posed to children. They also had different ideas about which children they thought required routine or emergency appointments from CAMHS. From the perspective of the receiving team, the quality of information provided in letters was variable, and was often insufficient as a way of making decisions about the appropriateness of the child’s referral or the urgency with which a response should be made (Potter *et al*, 2005).

Unlike in the crisis services study no small-scale, trajectory-level, data were directly generated. However, in their day-to-day encounters with young people and their families,

members of the CAMHS team were intimately involved in the shaping of trajectories and in the making of decisions at pivotal moments. In the initial stages of developing the triage clinic within the service, narrative case stories were used as levers for organisational change. These were real-life examples of initial assessments with young people referred to the team. One in particular stood out as a critical juncture with profound significance for those most directly involved, centring (as we describe in detail below) on the case of a young girl. In the context of promoting change in meso-level organisational structures and processes this was a micro-level exemplar which served to demonstrate, in a concrete way, the inefficiency in the service as it operated at that time.

The exemplar critical juncture case story focused on a 14 year old girl who had waited, pre-triage, for approximately ten months for an initial assessment in CAMHS. She had been referred because she was experiencing bullying at school. During her assessment she had displayed symptoms of psychosis, a serious mental health problem particularly in a young person. The sequence of events and interactions beginning with this (much-delayed) meeting had proven pivotal. The girl's trajectory had taken off in a new direction as CAMHS staff had set about their work having collectively realised the magnitude of her needs. She had required an immediate CAMHS intervention because of the severity of her difficulties, but because of the way the service had operated had inappropriately remained on the waiting list until her name had reached the top.

Beyond these immediately traceable horizontal reverberations which will have been felt by those most directly involved, in the context of this paper the narrative deployment of the case story additionally illuminates the capacity critical junctures have to exert influence beyond the micro-level within which they arise. Particularly exemplified are the two ideas of

‘compatibility’ and ‘relative advantage’, which feature both in Rogers’ (2003) text on the diffusion of innovations and in Greenhalgh *et al*’s (2005) systematic review in this same area. ‘Compatibility’ includes the idea of emotional resonance, and the extent to which a suggested new way of working reflects the values of local actors. Previous studies have shown this to be an important factor in the uptake of innovation in health services (see for example: Denis *et al*, 2002), and in this CAMHS team the purposeful presentation of this girl’s critical juncture helped the larger, planned, effort of promoting system change by connecting with practitioners’ beliefs. In terms of actors and their goals (Capoccia and Kelemen, 2007), the elevation of the girl’s case into the meso-level was a purposeful act on the part of those concerned to introduce uncertainty in the service of organisational development. As a ‘nonformal narrative account’ (Capoccia and Kelemen, 2007) the case had dramatic appeal. When presented to the CAMHS team it invited members to consider, using counterfactual reasoning, how a different way of processing referrals might plausibly have led to a swifter service being offered. Once told, the narrative could not be ‘unheard’. Whilst an extreme example, the case story had hinted at the possibility of other young people sitting inappropriately on the waiting list with no real gauge of how serious their health needs and risks might be. Tracing the process shows that the girl’s critical juncture functioned at the meso-level by suggesting that it might not be an isolated case, and drew attention to the relative advantages of the proposed triage change. Taken out of its immediate micro-level context, it connected sufficiently, at both emotional and organisational levels, for staff to risk a fundamental shift in their assessment practices.

In drawing on this second study we have been able to show how a critical juncture can be deployed as a narrative to create ripples throughout a larger system. In pulling the threads of this paper together in the following, closing, section we are also able to identify (if not from

our respective datasets) clear examples of critical junctures influencing wider systems without these being embedded within action research or other deliberative change management programmes. These ideas we develop before examining the implications of our ideas and observations, in their totality, for services, day-to-day practice and theory.

Discussion and conclusions

We have shown the importance of critical junctures for directly involved individuals (service users, family members and practitioners), with the events and actions constituting them capable of setting trajectories along new and enduring paths and shaping the future work which is done. Chloe's first critical juncture illustrates this property. The categorisation of her behaviour as evidence of mental ill-health, the mobilisation of workers and the collective decision to admit Chloe to hospital were committing events. These opened up a trajectory possessing momentum, and having associated lines of work, from which retreat (had it been sought) would have been difficult. Here we do not suggest that a critical juncture prescribes the exact course a future trajectory will take. What we *do* suggest is that the kind of impact a critical juncture exerts means that any previous state of relative stability cannot be readily regained. Things change, and will be different thereafter. We also think that the sequencing of events and interactions in a critical juncture is important. In this context we reiterate how an entirely different path might have been followed had Chloe's neighbour not called the police in the way Chloe describes, or had decisions been taken differently over the course of that first, key, evening. From the viewpoint of the practitioner the act of referring a service user for additional services is a relatively simple one, but as Chloe's case also shows it can trigger far larger change. Had no referral to crisis services been made, or had less favourable assessments of Chloe's eligibility been discursively determined (or indeed, if no crisis team

had been in operation) then a very different, subsequent, trajectory would have evolved. Modest, everyday, actions can trigger consequences stretching far forwards into time.

Observations of this type reinforce our depiction of critical junctures as essentially complex and dynamic. In any given case the range of possibilities arising is limited by aspects of the setting (for example, the local availability of human and material resources). As Strauss (1978) describes in his work on ‘negotiated orders’, organisational features serve to frame, but not determine, the interactions which take place (which, in this context, means the interactions which shape critical junctures and the longer trajectories within which they become incorporated). In their work on trajectories, with a view to better understanding what happens in the interactional ‘black box’ through which these are created Allen *et al* (2004) draw on game theory, looking to the numbers of people interrelating and their characteristics. Our primary concerns in this paper have been of a different order, centring primarily on introducing and illustrating the idea of critical junctures *qua* critical junctures rather than on why the trajectories within which they occur follow the directions that they do. However, what our data also clearly point to is the negotiated, contingent, character that critical junctures have and the significance of situated interactions taking place between constellations of people in shaping what happens.

Having (re)introduced our critical juncture idea we have, in the second part of this paper, shown their capacity when actively deployed in narrative form to exert impact in vertical, as well as horizontal, ways. Reflecting the purpose of the study from which it arose the example we have given to illustrate this feature is of an individual critical juncture (initiating a longer trajectory) being used, in a deliberate way, to destabilise institutional arrangements as part of

a wider programme of promoting change. Taken together our observations illuminate the relationships which bind together whole systems of health and social care at the biggest scale, the meso-level systems found in localities, and the multitude of small-scale, trajectory-level, systems embedded within these. What Strauss (1978) calls the ‘lines of impact’ between these different scales of organisation run in both directions, although most analyses proceed from the larger to the smaller to reveal how (for example) national policy influences local services which, in turn, creates an immediate context for what happens at the face-to-face level. In this paper we have been able to reverse the direction of analysis, examining how lines of impact can run from the micro to the meso. By moving beyond the confines of the two studies drawn on here it is possible to push this kind of upwards-facing vertical analysis further, by drawing attention to other instances of small-scale happenings triggering larger change. We acknowledge that most of what happens at the micro-level stays at the micro-level, but cases can be found of the reverberations from events, which might be either strikingly positive or negative, taking place within individual trajectories breaking through to effect change across whole systems of services. As Hannigan and Allen (2006) point out, cases exist of mental health services at the individual micro-level falling down, sometimes with tragic consequences, which in turn have served as prompts for large-scale system change (see for example: Ritchie *et al*, 1994). More positive examples, also from the mental health field, come from research in single meso-level sites where new ways of helping people at the micro-level filter upwards to change policy and services for the better at the macro-level (see for example: Stein and Test, 1980).

In addition to our contribution to theory we think our paper has implications for practitioners. Not all junctures are critical, and distinguishing those which are from those which are not may require the type of hindsight perspective which street-level workers (Lipsky, 1980)

making decisions in the moment do not have the luxury of possessing. Nonetheless, our focus on turning points and path dependencies may at least sensitise workers to the possible larger consequences of their actions, and alert them to the existence of plausible alternatives at any given moment linked to an awareness of the different types of trajectory that may then unfold. For workers involved in the task of improving services our paper also points to the value of using small-scale critical junctures in creative, narrative, ways with the purpose of promoting larger change. As we have shown, invoking naturally occurring critical junctures can create powerful opportunities to try things which are new and untested in the pursuit of system development. Finally, having introduced the idea of critical junctures into the health care arena we call for further work into understanding them. For example, this could include examinations of the interactions between influencing institutional features and the discursive, purposeful, practices of workers.

Acknowledgments

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About the authors

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