Intervention in a Loosely Organized System: An Encounter with Non-being

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Abstract

Historically, organizational theory and the theory of organizational change have been preoccupied with highly structured organizations, the bureaucracy being the archetype. But recently what may be called a loosely organized system has attracted the attention of some organizational theorists and change theorists. Loosely organized systems are well exemplified by relations between organizations, but they also occur within organizations, especially large ones like multinational corporations. If intervention is defined as a way of organizing to promote learning and change in social systems, then the question arises: How is this organizational task accomplished in a loosely organized system? This is the central question in this paper, which revolves around a case study of intervention in a network of community agencies: How does the interventionist shape an essentially integrative strategy to an essentially disintegrative social system?

Intervention in a Loosely Organized System:

An Encounter with Non-being

Most people think of a family as a husband, wife, and their children. This idea persists even though the "nuclear family" has become a minority in this country as new family forms produced chiefly by divorce and remarriage proliferate (Uzoka, 1979). One of these new forms is the pair of nuclear families linked by children of a previous marriage, what we might call a "dual family system."

The dual family system is an example of a loosely organized system (LOS), which is characterized by a weak, ill-defined, and often conflictful association among its component parts. In the world of organizations, the loosely organized system may be found readily in the relations among organizations. A classic interorganizational example is the collection of community agencies within a city that serve a common client population but achieve only a minimum of coordination. But loosely organized systems are also found within organizations; consider the corporate conglomerate, for example, with its collection of independent profit centers. In much the same way that families can be connected by the children or child-raising responsibilities of previous marriages, organizations or elements within organizations can be linked by shared personnel or by a strand or two of mutual purpose. Organizational theory, however, has neglected the LOS in favor of more tightly organized arrangements like the bureaucracy.

The nature of loosely organized systems makes intervening in them difficult. Imagine, for example, the problems of consulting to a pair of families with children in common. The two families have distinct identities, and this differentiation is likely to be far stronger than the notion of the families as an integral system. A theorist may see the families as a system, but the families see themselves as separate and unique. A consultant trying to help the families deal with mutual problems (for example, school for the children in common) would have to work with both families as if they were, in fact, a unit. Because the LOS exists only tenuously, it is an insubstantial social entity for an interventionist to embrace.

The Loosely Organized System

Of five dimensions of social organizations, Vickers (1965) identified one as the "strength or integrity of an organization." He remarked that "the tendency to preserve form may be marked or faint; it is a matter of convenience whether we regard some configuration of relations as stable enough to deserve the name of system" (p. 120). A loosely organized system is one whose integrity is underdeveloped, so much so that it may be a real question as to whether it can be said to exist. To describe the nature of relations within such a configuration, Weick (1976) has proposed the notion of "loose coupling," which he defined as an attachment that tends to be "circumscribed, infrequent, weak in its mutual effects, unimportant, and/or slow to respond" (p. 3). Alderfer (1976) has developed a typology that contrasts underbounded and overbounded systems; Brown (in press) has developed a similar dichotomy between underorganized and overorganized systems. Whether the social aggregate is typed as loosely coupled, underbounded, or underorganized, the idea is that it is lacking in internal organization.

Drawing on these sources, we offer the following six properties of a loosely organized system. An LOS tends to have unclear or competing goals, which make it difficult to mobilize energy for system purposes. In similar fashion, authority to direct the system tends to be either weak or split; the system may be characterized either by an absence of strong leadership or by the presence of competing leaders. Likewise, roles defining the relations among system elements are often ambiguous; as a result, coordination is low or conflict may be high. Membership in an LOS can be unstable with member defined as an individual or an aggregate of individuals: Members often turn over rapidly or participate fitfully in system activities. Communication can be irregular for a complex set of reasons. Members may not be aware of the existence of others in the system; they may not know who ought to communicate with whom; they may be unable to establish links among the parties identified as needing to communicate; or an assembled group may be sufficiently fragile and underdeveloped that effective communication is difficult. Finally, resources (especially in public sector organizations) are typically in short supply, either because the system is not adept at acquiring resources or makes inefficient use of the resources it has. If it is reduced to being constantly concerned with surviving, the LOS will also suffer from a short-term time perspective.

Although the foregoing description is cast somewhat negatively, loosely organized systems are neither inherently good nor bad. Indeed, they can have definite advantages, which Weick (1976) and Aldrich (1977) explore at length. An

LOS has the advantage, for example, of detaching the fates of system elements from one another so that, in the event that one element is buffetted by changes in the outside world, other elements are buffered against these disturbances (Pfeffer & Salancik, 1978).

Intervention in an LOS

The problem of intervening in a loosely organized system is the problem of adapting the intervention to the nature of the system. Intervention is conceived here broadly as a set of arrangements for promoting learning and change in the system. More than a set of discrete techniques, intervention is, then, a way of organizing to increase the system's understanding of itself and to thereby position it to make indicated changes. Like any other organizational activity, intervention has its own characteristic structures and processes. An example of a structure is the use of consultants as a communication link between levels in an organization: The consultants gather information from employees at each level and transmit perceptions of the various levels to one another. A characteristic process is the building of rapport during interviews to encourage the flow of valid information. Intervention, then, is organizing a social system--that is, elaborating the appropriate structure and processes--to facilitate learning and change in the system.

For each class of organizational phenomena, intervention needs to be organized somewhat differently. The field of planned change has grown up chiefly around tightly organized systems (Alderfer, 1977), in which the primary task of the intervention is to "de-organize" the system (Brown & Kaplan, 1978; Brown, in press). Rigid boundaries and strict role definitions are relaxed so that vital information can flow more freely. In an LOS, however, the need is not likely to be for greater flexibility. Structures and processes suitable for intervention in tightly organized systems need to be adapted, and perhaps new ones invented, for the LOS.

The Scope of this Paper

The purpose of this paper is to use a case study to build theory about intervention in a loosely organized system. In this paper the LOS case is an interorganizational system. We are interested in interorganizational analysis for the opportunity, as Litwak and Hylton (1962) put it, to "study social behavior under conditions of unstructured

authority" and general lack of organization. The question of intervention in an interorganizational setting is important but relatively untouched. In a recent paper, Trist (1979) argued that it is the space between traditional organizations and society as a whole where the so-called meta-problems, or "messes" as he called them, occur, and it is in this "inter-organizational domain" where intervention is sorely needed. He had in mind, for example, the various public and private institutions of which a city is comprised. But, according to Trist, the ability to intervene interorganizationally is in short supply.

In this paper the type of intervention studied is diagnosis. Although diagnosis can produce change, we are primarily concerned with how one goes about organizing to encourage learning within the system under consideration. Diagnosis refers to the arrangements made not only to permit the release of valid information about system dynamics but also to assemble relevant members of the system to learn about these dynamics.

A central tension runs through the paper: How does one organize to promote system learning in a system that is lacking in organization? The essentially integrative character of the intervention--as an activity calculated to bring people together to share and use information--is juxtaposed against the essentially disintegrative character of the interorganizational system.

The Setting and the Diagnostic Project

The interorganizational network consisted of eleven mental health agencies and a funding organization. The network was located near a large northeastern city in a wealthy county that had undergone rapid urbanization and population growth in the last quarter century without entirely losing its rural character.

The mental health agencies were small, private, nonprofit corporations with their own governing boards. Their staffs ranged from 5 to 40 (most of these professional) and often included volunteers. Only one agency was more than a few years old. Some of the agencies were purely mental health agencies while others only had mental health components and were funded proportionately by the funding organization.

The funding organization was the County Mental Health Organization (CMHO). It had been created ten years earlier by state and federal legislation to put control of mental

health services in communities. Like the mental health agencies, CMHO had a governing board and a staff. Its board members were appointed mainly by the state Governor and by the locally powerful county government. The CMHO staff consisted of a director and two support people. Federal, state and county monies were channelled through CMHO for programs in mental health and alcohol and drug abuse. CMHO was responsible for planning, grants management and program accountability, not for operation of programs or delivery of services.

Although this interorganizational network did not have formal goals of its own, there was an underlying sense of common purpose. All the units of the network shared the purpose of providing a human service. In this sense, the network had "domain similarity" (Van de Ven, 1976).

CMHO had authority within the network but not so much that the autonomy of the agencies was sacrificed. Every agency obtained funds from other sources, and although a few owed their primary allegiance to CMHO, others were also allied with the United Fund, with churches, or with a local chapter of a national charity. When asked on a questionnaire, "Does CMHO exercise significant control over the agencies?", representatives of CMHO and the agencies answered somewhat less than "to a moderate extent" (see Table 1).* Conversely, the answer of both groups was about the same to the question, "Are the agencies able to preserve their autonomy in relation to CMHO?" The means are just under "to a large extent."

Roles, especially in the relationship between CMHO and the agencies, were ambiguous and subject to conflict. An informal study, for example, showed little agreement either between or within the two groups as to what roles CMHO and the agencies would be expected to play in various eventualities. There was also conflict over whether CMHO ought to expand its role much beyond providing funds. In response to an item in another section of the questionnaire, CMHO saw a greater potential role for itself as "a non-financial resource" than did the agencies (3.75 vs. 2.90** on a five-point scale).

Membership within the network was reasonably stable. The network grew slowly as new agencies were admitted, but no

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*This was a questionnaire completed by 12 CMHO staff and board members and 30 agency staff and board members. The questionnaire was administered early in the project, before the diagnosis of agencies began. See Table 1 for the mean responses of both groups to this and other items.

**The two-tailed t-test result was: $t = 2.33$, $p < .05$, $df = 41$.

agency had left or been expelled. However, within member organizations, turnover of personnel was sometimes frequent, especially on the governing boards. The CMHO board, for example, retained only a core of dedicated and capable members from year to year. This turnover on the CMHO board was offset by the fact that the director had been there the entire ten years of CMHO's existence.

The network had abundant resources. In addition to state and federal funds, money was received from local sources. A county mental-health levy had been passed after two unsuccessful attempts.

Communication was constrained by the stratified relationship between CMHO and the agencies, and by the competition among the agencies for CMHO funds. The questionnaire, for example, included the item "Do the agencies keep the CMHO staff well acquainted with their operating problems?" CMHO and agency average response were at about the mid-point of the scale, but they differed. Average CMHO response was under a moderate extent and average agency response was between a moderate and large extent. Factors promoting communication included: the trust and respect of all parties for the CMHO director; the smallness of the system and the proximity of the agencies (all but one of the twelve organizational units was in one of the two neighboring towns, and three of the agencies were on the same floor of one building); the existence of integrative mechanisms, including a psycho-drama group which had members from several of the network units; the mental-health levy campaign which promoted a spirit of cooperation; and mutual membership in the county association of social work professionals.

The network's sense of common purpose, its smallness, its reasonably stable membership, its abundant resources, and its open communication all contributed to appreciable integration. One respected member of the system commented: "In similar situations you are apt to find much more competition among contract agencies and much more of an adversarial relationship between funder and agencies." Said one official from the State Department of Mental Health about the diagnostic project: "This may be the only CMHO in the state where this kind of thing is possible."

The integration of the network was further enhanced by the size of the population it served. A person with long experience in the helping professions said, "Because the community out here is a manageable size the problems look manageable. You don't feel like you're just batting your head against the wall." Although the network escaped the centrifugal and conflict-ridden fate of many of its big-city interorganizational counterparts, its internal coherence

should not be exaggerated. The questionnaire asked, for example: "Does CMHO together with the contract agencies constitute a cohesive working unit?" The answer from both sides was just under "to a moderate extent."

The Diagnostic Project*

The project was envisioned as: (a) diagnoses of the individual agencies and (b) communication to the CMHO about the state of each agency. The agency diagnoses consisted of a meeting or meetings to arrange the work; collection of data by interview, questionnaire and observation; the preparation of a confidential report with data aggregated by groups; and meetings to discuss the report and its implications. Each diagnosis was approached with five broad areas in mind--organizational goals, structure, climate, resources, and environment. Depending on the agency, one or two of these areas was chosen for in-depth examination.

By itself the diagnosis of individual organizations is nothing new, but organizational diagnoses in an interorganizational setting is quite rare. The diagnosis of individual agencies became entangled in the interorganizational context for two reasons. CMHO wanted to know the results of the agency studies, and access to the agencies could not readily be gained without coming to terms with the larger system.

The project actually began when CMHO approached the authors and invited them to submit a proposal to evaluate the organizational functioning of CMHO and the contract agencies. After several months of intermittent discussions, an agreement was made to begin with a day of diagnostic work with CMHO. With this step taken to nearly everyone's satisfaction, CMHO was ready to announce its intention to have the agencies engage in a similar "self-study." However, at the consultants' suggestion, an intervening step was inserted: a day devoted to an examination of the relationship between CMHO and the agencies. Representatives of the boards and staffs of all agencies and CMHO attended this session, which (a) introduced the agencies to self-study (by having those present examine the relationship of the agencies to CMHO), and (b) put forth the idea of agency diagnoses and solicited reactions to it. The result of that meeting was tentative support from the agencies, and CMHO and the consultants jointly arranged for funding from a foundation.

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*See Figure 1 for a chronology of major project events.

Entry

Entry into this system involved deciding whether to proceed at all, and, after deciding to go ahead, forming relationships with the agencies being diagnosed. Since the decision to evaluate the agencies was made by CMHO in consultation with the agencies, and the basic terms for conducting the diagnoses and sharing the results were agreed to jointly by the CMHO director and agency directors, the consultants had the commitment of the agency director when we arrived to begin diagnosis. If this prior commitment and the fear of jeopardizing CMHO funding obviated any real choice as to whether to participate, the agencies at least retained control over the extent of their involvement in the diagnosis. Moreover, one should not belittle the process of entry into groups already obligated by the powers that be. This degree of latitude was important, for without a high level of commitment a developmental exercise of this sort is a sham. Furthermore, each agency had an important say in designing its own diagnosis.

Entry into the interorganizational system required, as Alderfer (1976) predicted, more time and energy than entry into a single organization. The reason was the fragmentation of the network: a funding body and 11 autonomous agencies; the division of each component organization into staff and board; and the absence of a strong central authority. (CMHO possessed a degree of authority in the network but nothing compared to that in conventional organizations.) All told, we attended more than 50 entry meetings, including separate meetings for each staff and board, meetings with agency directors and board president, and meetings with all or part of each organization. In the larger agencies, the separate functional units were large enough to require their own entry meetings.

Entry into the agencies was a three-tiered process. CMHO, in consultation with the agency directors and related others, decided that the diagnoses would take place. The CMHO director and the agency directors together decided how to structure certain critical aspects of the diagnoses. Finally, each agency adapted the project design to its needs. At each point, the consultants served both as technical experts and catalysts.

The interorganizational and stratified nature of the system was frequently clear during the entry process. Agency personnel were aware of the involvement of CMHO in the project and tended to associate the project and the consultants with CMHO, especially at first. This often made us consultants lightning rods for the expression by the agencies of

negative feelings about CMHO. For example, at an entry meeting with the board of one of the agencies a board member attacked the consultants because he believed that the diagnosis was a veiled investigation of the agency on behalf of CMHO. However, we nearly always dispelled the idea that we were operating as agents of CMHO and, in fact, these meetings were important in conveying the notion that we were there to serve both CMHO and the agency--a difficult notion to grasp. The difficulty is expressed in the following exchanges between a director and a consultant that took place in a meeting with the agency directors:

> Director (to consultant): Could you tell us who's your boss? The CMHO or us in between?
>
> Consultant: We feel responsible to both the CMHO and the agencies. . . . Does that answer your question?
>
> Director: It just intensified the nebulousness, and it's hard for me to bite into.

When a split existed between CMHO and an agency, it was difficult to persuade the agency that we would serve both parties. (In one agency we were dubbed the "CMHO evaluators," a label that made us cringe because it denied our role as consultants to the agency.) Therefore, one task of the entry meetings was to establish our political neutrality, which is difficult, impossible or inadvisable in a loosely organized setting.

Entry was protracted not only because of the loosely organized nature of the interorganizational network but also because of the similar nature of some of its component parts. The network's leading part, for example, was also in important respects loosely organized. It was a year after the first conversations between the consultants and CMHO before the decision to go ahead was made and funding was secured. The instability of CMHO board membership was one factor: In the midst of conversations with the board, seven new members were added. Another factor was CMHO's limited resources. Although it could contribute partial support to the project, it could not afford to foot the entire bill for diagnoses of 11 agencies. Four months were needed to write a proposal and arrange funds from an outside source, and even this was an extremely short turnaround time.

Convening

Our next step was to bring the agency directors together as a group.* By this time it was clear to us that we could not hope to enter this loosely organized system by approaching the agencies separately. On important issues concerning the system as a whole, we knew we would have to negotiate with the agencies as a group. By convening the agency directors, we created a group with power that most of the agencies lacked individually with CMHO. Although this opened the door to a collective decision to oppose the project, it also opened up the possibility of collaboration that could further their interests and the interests of the project.

The first meeting with the agency directors, which took place before the project was actually funded, was energetic and stimulating and awakened them to the possibility of rewarding interaction. Once the project was funded, however, the reality of its imminence seemed to arouse anxiety in the directors. Their anxiety and their formative development as a group created a disjointed and unproductive atmosphere. As a way of focusing the group on the diagnostic task, we held individual meetings with each of the directors to explain what the project would entail and to learn more about the agency, including how the director and others would react to the study. When we brought them together again to resume planning, the group's ability to work together was greatly improved. There were several interesting later developments with the directors' group. Recognizing its potential, the CMHO director began to meet with the group every month to work on items of concern to him. Then, some months later, the directors began holding meetings, in secret. The stimulus for their secret meetings was the directors' uneasiness over sharing the results of their agency studies with CMHO,

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*Given the desirability of negotiating with the agencies collectively, the problem became one of finding a way to do it. No group that was representative of the agencies existed. The closest thing to it were the agency directors, most of whom gathered each month at the monthly CMHO meeting. In no sense, however, did the directors constitute a working group; they were simply a part of the larger audience attending the meeting. In the end we settled on this group as a means of making systems-level entry and this way we "convened" the system, or an important part of it. Or, in a different view, we "activated" it at a higher level (Laumann, Galaskiewicz, & Marsden, 1978). Thus, given the low level of organization in the interorganizational network, we could not enter the network without organizing it further.

as they had agreed to do. The directors then staged a mini-revolt, deciding as a group not to share the substance of the agency studies with CMHO. Instead they issued the following statement:

> The self-study process should be completed by informing the County Mental Health Organization that agency did participate in self-study in collaboration with the consultants hired by the CMHO, and that the results of the self-study will be utilized at the discretion of the agencies for the enhancement of service delivery.

As it turned out, the revolt was as much mock as real, and in a few days the directors had retreated from this extreme position. The declaration by the directors was nevertheless a potent move and it came as a shock to the CMHO director and board, as did the revelation that the directors had been meeting privately. For a few days we consultants worked hard to keep CMHO from overreacting. We were interested to learn that the directors' retreat was prompted, in part, by the fact that some of the agency boards disagreed with their action. We saw this split between directors and their boards was further evidence of the low integration of the system.

The revolt was later described by one of the directors as "muscle flexing." It was somehow fitting that the directors would choose this particularly threatening aspect of the project as a rallying point. To them the project represented an attempt by CMHO to expand its influence with the agencies, and they naturally banded together to counter this increased influence. In doing so, however, the directors entertained what seemed to us a fantasy of total group unity. They talked seriously, for example, of submitting a joint budget the following year, even though this ignored obvious differences among the agencies. It is interesting to note the interaction between these horizontal and vertical dimensions of interorganizational relations. As CMHO attempted to increase its authority (vertical), the agencies reacted by uniting (horizontal).

In a later development, the directors approached the CMHO director with suggestions for revising their work together. The directors wanted the power, along with the CMHO director, to place items on the agenda of their monthly meeting and they wanted to participate in the ongoing recruitment of new members for the CMHO board. The CMHO director agreed to both requests, which strengthened the working relationship of the two parties.

This attempt at convening was therefore reasonably successful, but another attempt failed. We had the idea, common in work with single organizations, of creating an internal

consultant group, a few individuals who would be available to us to assist periodically in tne diagnosis of one agency or another. (One precedent for this was the OD effort at TRW Systems, in which certain managers served part-time as consultants in areas of the organization other than their own [Davis, 1967].) The agency directors approved the idea in principle, and some of them expressed an interest in serving as consultants. Although a number of agency people wanted to become internal consultants, hardly any wanted an internal consultant to come into their agency. The agencies were concerned about invasion of privacy and about possible adverse publicity, however subtle and perhaps unwitting, to CMHO. As one staff member put it, "I don't want an internal consultant in here because staff from other agencies are our competitors. We don't mind if they see our good points but not our weak." One of the directors explained:

> Competition for funds is one of the things that divides the agencies. The one thing people keep secret from one another is how much money is in their budget and how it is spent. They are willing to talk about the mechanics of applying for funds, but they play it close to the vest when it comes to the details of their budget. In general, communication among directors is territorial. The basic feeling is that directors don't want people in their house. There are things about their agency that they don't want to talk about.

Although an internal consultant group would have been an important integrative device in the interorganizational scheme of things, the centrifugal forces of interagency relations--especially competition for funds--prevented its formation. This frustrated us, but gave us a valuable diagnostic indication of the state of interagency relations.

Feedback

The arrangements for releasing information about the agencies to CMHO were especially interesting. These arrangements were made during the entry phase, were challenged during the directors' revolt, but were eventually confirmed and elaborated as the time for feedback to CMHO approached.

We allowed the strength of organizational relationships to dictate how much sensitive information would be shared. We used two questionnaires to collect data on strength of relation and willingness to disclose the results of the diagnosis. Table 1 reports the data on strength of relation. The fifth and sixth items indicate that, compared to the CMHO board, the CMHO staff (primarily, the director) was seen as

being better acquainted with and as having a more trusting relationship with the agencies. This was a perception that both agency and CMHO people shared. Item 7 indicates that the CMHO board posed a greater threat to the agencies than the CMHO staff did, but in this case the degree of CMHO board threat was greater in the eyes of CMHO respondents than in the eyes of the agencies. We concluded that the agencies had an adequate relationship with the CMHO board and a good relationship with the CMHO director. From the last item in Table 1, we concluded that the relationship among the agencies was adequate and roughly comparable to the agency/CMHO board relationship.

The no-more-than-adequate relationship between the agencies and the CMHO board was accounted for by the limited internal integration of the board and by its political character. The high rate of turnover made new members unknown quantities. Said one exasperated agency director: "The CMHO board changes like crazy. You don't know what you're getting. You're not dealing with a rational group here." In addition, the board was linked with its own set of organizations, including the state department of mental health, the county government, and the county probate judge, all of which appointed members to the board. Some members were especially sensitive to political pressures and were not dependable in their support for mental health programs, particularly the controversial ones.

Table 2 contains data collected with a Disclosure Questionnaire, answered by the 11 directors before the diagnosis began, which shows that the willingness to disclose the results of the diagnoses corresponded to the strength of relation. The agency directors were willing to disseminate the results of their diagnoses within their own agencies, but were reluctant to disclose the results outside their agencies. They were clearly willing to turn over results to the CMHO director, but were ambivalent about doing so with the CMHO board. The strong relationship with the CMHO director supported a definite willingness to share with him, but the weaker bond with the CMHO board and with other agencies led to a reluctance to share with them.

At the time that the Relationship Questionnaire was administered, we interviewed the directors briefly about their responses to particular items. One director expressed nicely the distinction many drew between the CMHO director and the CMHO board:

> It's probably the factor of having a lot of trust and confidence from personal knowledge of the director. I know he would handle the information in a competent and professional way. With the board, I know at least half

> of the members and I'm sure that they would handle it in the same way, but there are four or five that I don't know. It isn't that I would expect them to abuse the information; it's just that I don't know.

With regard to sharing among the agencies, one director expressed the sentiment more vehemently than the others: "I don't know if it's any of their damned business."

The sharing of diagnostic reports among the agencies was not a priority in the project. The only formal occasion for this came at the end of the project when representatives of the system came together to discuss a report prepared by the consultants on the characteristics of the agencies as a group and the system as a whole. But from the beginning, exchange between each agency and CMHO was a priority, at least for CMHO. In light of the reluctance of the agencies to release their reports to the CMHO board, the question arose: What is a workable design for feedback to CMHO?

The problems posed by this question were evident from the beginning of the project when the consultants met with the agency directors to define the project. The CMHO director was not present at this meeting because he wanted to make sure that the directors could talk freely. They did just that. The entire discussion, lasting about an hour, focused on the threat that the release of diagnostic reports posed to the autonomy of the agencies. A typical comment was "If they [the CMHO] don't want to control us, there is no reason they have to know about the reports." When the CMHO director joined the meeting, he was presented with a summary of the directors' concerns. He replied at length. He argued that, out of the possible methods for evaluation, the self-study method was chosen because it required the least intrusion of CMHO into the agencies and held out the most promise of being useful to the agencies themselves. For the control of the diagnostic reports, he proposed a most unusual arrangement: CMHO would not receive the diagnostic reports, nor would the consultants divulge in any way what they learned about any agency. The only obligation was that after the diagnosis, agency representatives would meet with CMHO representatives and give an oral report on the state of the agency and its plans for the future. Each agency would decide for itself what it would share. The consultants would be present but only in the capacity of facilitators. Later a statement would be composed by the CMHO and agency director for wider distribution within CMHO. The directors accepted this arrangement. Although, as described earlier, the understanding broke down as the time for these agency-CMHO meetings drew closer, it was eventually reaffirmed.

The arrangement did, in fact, work. Representatives from one agency at a time met with CMHO representatives in a friendly and constructive climate, and the agencies were quite candid about strengths and weaknesses. CMHO representatives, which always included the director and rotating members of the board, responded with interest, and also shared an informal survey of their perceptions of the agencies, which included both assets and liabilities. Because the meetings were face-to-face, they "personalized" the other institution for those in attendance who had little direct contact with it. We felt that these meetings helped the relationship between each agency and CMHO, especially since there was serious talk of making them an annual event.

That the structure for sharing diagnostic reports was out of the ordinary was repeatedly brought home to us during the agency entry meetings. Since it was well known that CMHO had sponsored the project, people in each agency were interested to know what CMHO's involvement would be in the agency's diagnosis. When we explained that the report would be the property of the agency and that we would say nothing of what we came to know to CMHO or anyone outside the agency, we were often met with puzzlement or sheer disbelief. People had trouble understanding or believing that CMHO would not get direct access to their agency report. "Do you mean to say the CMHO is paying for this but they won't know what comes out of it?!" was the refrain.

The difficulty that the agencies had in believing this guarantee of confidentiality was further illustrated by the uproar that one sentence in a report caused at a feedback meeting with the board of one agency. The sentence raised the question of the legitimacy of that particular agency's claim to CMHO funding, a question that was alive within the agency. Despite our earlier assurances, representatives of the agency assumed that CMHO would receive the report, and a number of the agency's board members became incensed. It took an emphatic reiteration of the guarantee to calm down everyone. Thus, it was clear that this guarantee of confidentiality made a great deal of difference in our ability to gain the cooperation of the agencies; without it, trust and cooperation would have been a lot harder to come by.

Conclusion

The paper is a report of a case study of intervention in an interorganizational setting, with the latter being a special case of a loosely organized system. What have we learned about intervention in an LOS?

First, it is apparent that the nature of the social system impresses itself on the intervention. The experience of system members becomes the experience of the interventionist. If members of the system have trouble acting collectively, if the sense of collective purpose is weak, if there is no clear or strong authority to turn to, if it is difficult to know who to include in systems meetings and equally difficult for a newly assembled body to work effectively, then this will be more or less the fate of interventionists in the system. All of the ambiguity, lack of direction, and disorganization endemic to the system will rise up in the course of intervention. Whatever tension exists in the relations among system elements will reappear when the consultants attempt to navigate the space among system elements. If the consultants try to occupy the conflictful area between elements, they will experience strain unless they are able to assume a neutral position.

Second, entry into the system is profoundly affected by the nature of the LOS. Because of the system's lack of coherence, entry becomes an elaborate and protracted affair. The general difficulty of getting anything done at the systems level demonstrates itself in the difficulty of deciding whether to undertake the change project and how to do it. Far from the relatively simple matter of gaining the support of senior management in a bureaucratic organization, entry into an LOS sorely tests the patience and endurance of the interventionist.

Third, in order to enter a loosely organized system, it may well be necessary to constitute a group capable of representing the system. Whereas a bureaucratic organization might well provide a ready-made group consisting, for example, of general manager and the department heads, an LOS will probably lack any group or any effective group of this type. In this sense the interventionist needs to organize the group to enter it. Rather than intervene, the interventionist must convene the system (Brown, in press).

Fourth, feedback, which is the culmination of diagnosis, must be designed to fit the loosely organized character of the system. Structures for the exchange of feedback must correspond to the strength or weakness of connections among system elements; feedback channels must obey the hard limits on information flow within the system (with allowance made for some building of relationships that the consultant may be able to accomplish). Parties with weak or conflict-filled relationships will hardly agree to an open exchange of diagnostic results. In the case presented here, it would have been unwise, if not potentially self-destructive, for the agencies to be wide open with the CMHO board, a relatively unstable and political body. Furthermore, if the consultant

proposes unrealistic and unworkable arrangements for disseminating diagnostic information, his ability to enter the system and to win acceptance of the diagnosis will be greatly impaired. Thus, it is important to negotiate and create these arrangements with the parties affected (and to do so, the consultant may once again have to convene the appropriate people).

Fifth, the challenges of intervening in an LOS require particular skills. As in bureaucratic organizations, the much-heralded interpersonal competence stands the consultant in good stead. But in addition intervention in an LOS puts a premium on "reticular competence." The word reticular means "weblike" or "like a network," and reticular competence is defined as the ability to work effectively in social networks--that is, in settings much larger than a group and considerably more complex and disconnected. Friend, Power, and Yewlett (1974) coined the term, and meant by it not only to possess a diverse set of contacts in an "inter-corporate" network but also to know when to call upon them and in what configurations. Similarly, Brown (in press) suggested the need for political competence so that interventionists can fathom the value-laden conflicts of interest in a loosely organized system and manage their own values and positions amidst these conflicts.

As a final point, let us recognize the limits of the change strategy examined here. It is a cooperative one: It builds upon the sense of common purpose and mutual trust present in the social system. But beyond a certain threshhold of system disintegration, cooperative change strategies are assuredly out of place in an LOS. Boje (1979) argued that sharp conflicts among interest groups and intense struggles to protect or advance one's interests render cooperative strategies inappropriate. Neither feasible nor powerful enough to make a difference, these interventions must give way to more adversarial strategies. "The change agent will need to take sides, advocate one point of view over another, mobilize opposition forces, and take other steps which violate professional neutrality (Boje, 1979, p. 2). Brown (in press), in pointing up the need for political competence in the consultant, also pointed out the difficulty of maintaining professional neutrality in such settings.

The change project presented here used a cooperative strategy and achieved a modicum of success, and the success was due in no small part to the essentially favorable conditions in the social system. It was a benign instance of loose organization; the consultants were able, for example, to assume a position of political neutrality because the breach between organizations was not so wide that it could

not be straddled. Be that as it may, the case calls attention to the importance of sketching the range of usefulness of cooperative, integrative strategies in disintegrative systems.

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Table 1
Relationship Questionnaire Results

	Means		
	CMHO Board and Staff Members ($n \cong 10$)		Agency Board and Staff Members ($n \cong 30$)
1. Does CMHO exercise significant control over the agencies?	2.59		2.80
2. Are the agencies able to preserve their autonomy in relation to CMHO?	3.83	<—— * ——>	3.64
3. Do the agencies keep the CMHO staff well acquainted with their operating problems?	2.75		3.47
4. Does CMHO together with the contract agencies constitute a cohesive working unit?	2.83		2.80
5. Is CMHO well acquainted with the agencies?			
CMHO Staff	4.13 **		4.10 **
CMHO Board	3.08		2.87
6. Does high trust characterize the relationship between the agencies and the:			
CMHO Staff	4.00 **		3.90 **
CMHO Board	3.08		3.13
7. Is CMHO a threat to the agencies?			
CMHO Staff	1.62 *		1.26 **
CMHO Board	2.41	<—— * ——>	1.93
8. Are the CMHO contract agencies well connected to one another?	2.41	<—— * ——>	3.06

* $p < .05$, two-tailed t-test
** $p < .01$, two-tailed t-test

5 = completely
4 = to a large extent
3 = to a moderate extent
2 = to a small extent
1 = not at all

Table 2
Disclosure Questionnaire Results
(n = 11 agency directors)
(7 = very willing, 1 = very unwilling)

How do you feel about making the results of the evaluation known . . .

		Means
a.	Within your own agency?	6.46
b.	To the CMHO staff?	5.64
c.	To the CMHO board?	4.46
d.	To other CMHO agencies?	4.36

t-test results

a > b, $p < .01$ (one-tailed t-test)
b > c, $p < .01$ (two-tailed t-test)
c > d, $p < .05$ (two-tailed t-test)

Figure 1
Chronology of Major Project Events

1977	
August	Initial contact between CMHO and consultants.
September	Preliminary proposal submitted to CMHO for evaluation of CMHO and agencies.
1978	
February	CMHO approves an element of proposal--limited diagnosis of CMHO.
April	Diagnostic session held with CMHO board and staff.
June	Session held with representatives of CMHO and each of the agencies. Focus: The relationship between agencies and CMHO, and the proposed evaluations of the agencies.
July	Proposal for outside funding prepared and submitted.
September	Proposal approved. Project begins in earnest.
October	Consultants work with agency directors group. Terms for sharing evaluation results negotiated by agency directors and CMHO director.
November	Agency diagnoses begin.
1979	
March	Agency directors balk at disclosing results of diagnoses with CMHO. Original terms reaffirmed and elaborated.
May	Meetings begin between each agency and CMHO to discuss diagnosis results.
September	Diagnoses completed.
November	Project completed, with steps taken to perpetuate the "self-study" process.

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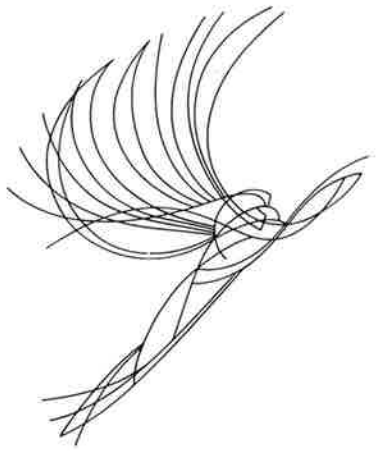

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