

This interview will be part of *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care*, the second in a series of monographs on recovery management published by the Great Lakes Addiction Technology Transfer Center (ATTC).



Creating a Recovery-Oriented System of Care

An Interview with Thomas A. Kirk, Jr., PhD
By William L. White, MA

INTRODUCTION

Across the country, references to the State of Connecticut pepper discussions about behavioral health systems transformation. Many states are attempting special recovery-focused initiatives and pilots, but Connecticut stands at the forefront of attempts to totally transform a state behavioral health care system into one permeated with this recovery orientation. I conducted the following interview with Tom Kirk, Commissioner of the Connecticut Department of Mental Health and Addiction Services, on September 26, 2006, on behalf of the Great Lakes Addiction Technology Transfer Center (Great Lakes ATTC). This interview provides one of the most probing examinations to-date of the process of behavioral health systems transformation.

William L. White, MA
Senior Research Consultant
Chestnut Health Systems

GREAT LAKES ATTC: Could you summarize your background before becoming Commissioner of the Connecticut Department of Mental Health and Addiction Services (DMHAS)?

DR. KIRK: My graduate training in psychology was at Catholic University in Washington, DC, after which I joined the faculty of Virginia Commonwealth University (VCU) in Richmond, Virginia. While still on faculty, I did some part-time consulting work at one of the larger adult prisons in Virginia. It was around this time that drug use and related offenses were placing extraordinary pressure on correction systems. I eventually left my tenured position at VCU and established a private consulting practice which emphasized criminal justice system and addiction-related issues. Thereafter, my professional journey included increasingly responsible

public-sector positions focusing on the design and management of services for persons with substance use and co-occurring (mental health) disorders in the Washington, DC area.

GREAT LAKES ATTC: When and how did you first come to Connecticut?

DR. KIRK: I came to Connecticut in 1990 to direct Liberation Programs, Inc., a rather large substance abuse prevention and treatment agency in Stamford. In that position I interacted with my colleagues in other community-based addiction service agencies who were under contract with the Single State Addiction agency. In July of 1995, John Rowland became governor of Connecticut and proposed to merge or create a new agency that combined mental health and addiction services. My concern, frankly, was that the mental health component (Department of Mental Health) was so much bigger that the addictions component would be neglected. After I had voiced my concerns about this, some people asked me whether I would be interested in being considered for a Deputy Commissioner's position in this new department, to oversee addictions services. One thing led to another, and in October of 1995, I became the Deputy Commissioner for addiction services in this new Department of Mental Health and Addiction Services (DMHAS). When the Deputy Commissioner for Mental Health subsequently left and the Commissioner retired, I was asked to be the Commissioner and assumed this role in May of 2000.

GREAT LAKES ATTC: When would you pinpoint the beginning of the recovery initiative in Connecticut?

Dr Kirk: When you are interviewed for appointed positions, you must go before the legislature, who will then vote on your nomination. During that process you provide written testimony and are queried about the service philosophy you will bring to the agency for which you are being considered. In my interview and testimony in October, 1995, I talked about the need for recovery as a driving force for service design—and have done so in every subsequent reappointment session with the legislature, and periodically read those testimonies to remind myself of that focus. At the same time, the heavy emphasis really didn't take hold until around 1997.

GREAT LAKES ATTC: Were there conditions in the late 1990s in the addiction and mental health fields that really contributed to this, sort of ramping this up as a major initiative?

DR. KIRK: One such condition was the sense in both mental health and addiction services that a lot of people were repeatedly going in and out of this system without achieving stable, long-term recovery. One of the things that I wanted to do was to identify persons who were high service utilizers—people who were recycling in detox and rehab—and to see what we were missing in our work with them. One of the strategic goals that we worked on, beginning in 1998 and heavily through 2002, was to revamp services for those who were either poorly served or underserved in our service system. The recognition of high service utilizers and the dollars we were investing in them without positive outcomes was prompting legislators and staff from the Governor's Office of Policy Management to suggest restrictions on how many times someone could be admitted in a year. These were difficult fiscal times in Connecticut, so the pressure to cut or restrict services was intense. That forced us to look at what we were doing and how to respond better to people with severe problems and long and complex service histories. The fiscal pressures created extraordinary challenges but, in retrospect, were opportunities for changes in the system.

GREAT LAKES ATTC: How did you respond to these challenges?

DR. KIRK: Rather than batten down the hatches or just close things down, we began to ask, “How do we rethink what we are doing and move forward in an informed way?” So the fiscal pressures forced us to examine quality-of-care issues and conclude, “What we are doing is just not good enough; something has to be done.” So we started moving from the acute-care mentality and the acute-care funding system to what some people are calling a chronic-care or recovery-management model.

GREAT LAKES ATTC: You seem to have involved the recovery advocacy organizations very early in this process.

DR. KIRK: In late 1998 and early 1999, we started asking the question, “What does recovery really mean?” and we involved our DMHAS-funded addictions and mental health advocacy organizations to help us answer that question and to help us formulate core recovery values and principles. Those groups started out like oil and water but eventually came together under the leadership of Bob Savage, the founder and first director of the Connecticut Community for Addiction Recovery, Inc. (CCAR) and Yvette Sangster of Advocacy Unlimited, Inc. (AU), to create the Recovery Principles and Core Recovery Values that have been the foundation of our subsequent work.

GREAT LAKES ATTC: It is amazing the role that service consumers have played in reshaping behavioral health services in Connecticut.

DR. KIRK: One of the things I’ve learned, and I don’t pay as much attention as I should, is to listen to the people who actually are the recipients of services and those who’ve moved on to long-term stable recovery. They’ll give you a better idea what it is that you should be doing or could be doing. They may not always be right or have the complete picture, but they can help keep you focused on the things that are important. I remember presenting some really complicated structural proposals—fancy PowerPoint presentations and all that sort of stuff—to a mental health consumer group in the northwest part of the state, in the Danbury area, and when I was finished a guy in the front row says, “All I want to know is, am I still going to have a case manager?” From his point of view, his case manager was the system.

GREAT LAKES ATTC: How did you go about the process of planning the kind of system transformation you have led in Connecticut?

DR. KIRK: There were several key steps. The first one was to refine our vision and our plan. We came up with an initial strategic plan that had four major goals. The first goal—to promote an infrastructure that would support quality services—was based on the belief that service quality is the driving force of recovery. The second strategic goal was to focus on underserved, poorly served populations, including a stronger emphasis on cultural competence. The third goal was to enhance the management effectiveness of DMHAS. And the last goal was to be aggressive in our development of resources and partnerships.

Let me elaborate on some of these. Our work on the first goal included identifying recovery values and principles in collaboration with Bob Savage and Yvette Sangster. This in turn led to discussions about quality measures, recovery outcomes, and how to assess an agency’s degree of recovery orientation.

One component of the second goal involved several strategic decisions. We made informed decisions to focus our attention on four or five issues that we felt could quickly elevate service quality. The issues we chose to focus on were culture, gender, trauma, and co-occurring disorders. We believed a focus on these issues in terms of information, training, service enhancement, etc. would produce a measurable improvement in the quality of the system. Our work in these areas has been significant and sustained, and has achieved that goal

The third goal, to enhance our management capability, involved a major change in our system that had begun with a decision made by my predecessor. That decision was to not turn over management of the contractual funds that drove our service system to a private managed care company. We decided to use managed care principles, but to administer that process ourselves. We chose not to lose 20 percent of our funds via an outside management contract. But that meant we needed to recruit a different caliber of player into the state agency system. We needed and found individuals who had managed care experience in the private sector, but who were open to administering such a system within the framework of public sector values.

The fourth goal, aggressively pursuing additional funding, led to sophisticated approaches to garnering increased federal dollars to support our system. Since 1998, we've brought in over \$120 million in federal grant awards to help build and sustain parts of our service system. We hired people to help us procure that money, with the understanding that we would never go after grant dollars for the sake of grant dollars, but to strategically seek dollars that would support our larger vision.

GREAT LAKES ATTC: Creating that vision at the same time you were forging a new agency must have been an incredible challenge.

DR. KIRK: My predecessor had a great line. He said, "We are not merging mental health and addictions. We're creating a new agency, and one plus one is going to give us three." We had to create a new culture. The addictions and mental health cultures are both so strong. It wasn't a surprise to us that shaping this new culture took some time, but through this effort we ended up with a new culture that not only respects the best and brightest and most sensitive components of each of the two systems, but also moved us to a new level. We redefined ourselves as a healthcare agency, not a social service agency. People with substance abuse and psychiatric conditions have a healthcare condition. They share illnesses with behavioral components rooted in the chemistry of the brain. Seeing ourselves as a healthcare agency helping people manage and recover from these illnesses served as a bridge between the mental health and addiction cultures. It gave us a common platform. Our mission is to promote wellness and health and to help people with behavioral health disorders regain their health and reclaim their lives.

GREAT LAKES ATTC: How were you able to transform your system and still maintain its maintenance functions?

DR. KIRK: That's the key. You're trying to reengineer the system at the same time you have to keep it running. One of the things that I did was to say to Arthur Evans, PhD, my Deputy Commissioner at the time: "I want you to run a research and development component within DMHAS." I freed him of most operational responsibilities and asked him to form work groups to look at everything we had done in recent years, including the federal initiatives, and to pick the best ideas and practices. I asked him take the recovery values that our advocacy groups had put together and to translate them into DMHAS policies. So we created a draft Commissioner's Recovery Policy outlining the move toward a recovery-oriented service system, and then met in

retreats with boards, providers, consumers, our own staff, and all sorts of other groups to complete our foundational recovery policy. (See www.dmhas.state.ct.us, then click on “Recovery” under “Major Initiatives”.) That statement is as valid and important now as when we first signed it in 2002. Arthur Evans skillfully created and guided much of this development effort, and also added Dr. Larry Davidson from Yale University and others within DMHAS to help us implement this new recovery vision. Dr. Evans eventually left his position to assume responsibility for a large public entity in Philadelphia, while Dr. Davidson subsequently established and staffed at Yale a special program on recovery. Both of these professionals were critical to driving the changes we were implementing

GREAT LAKES ATTC: How did this R & D unit relate to your operations staff?

DR. KIRK: We made a mistake early in the process in keeping Arthur’s group separated from operations a bit longer than we should have. We had one track that was improving service operations and a separate track with our recovery initiative. They were both progressing so well that they almost took on lives of their own. You had two different focuses in the agency, and people were not necessarily tying the two of them together. So we reached an awareness that we needed to bring these two tracks together. I brought together all of our key leaders in the agency, as well as the private non-profits, and said, “We’re not moving away from the four major goals, but we’re going to come up with one single overarching goal that integrates our work on these goals.” And that overarching strategic goal was to develop and maintain a value-driven, recovery-oriented service system. We had to convince our own staff and the service providers that this was not a “flavor of the month” thing but an overriding philosophy that would shape everything in the coming years.

We had to stop people from thinking, “It’s the *project du jour*. Don’t spend too much energy here, because it’s going to be something different a year from now.” We had to convince everyone that we were going to seek the highest quality of service at the most realistic cost. And we had to help people operationalize their understanding of what a recovery-oriented system would mean for their programs and their roles. To do that, we had to promote recovery-oriented concepts such as recovery capital, recovery supports, sober housing, recovery-conducive employment, etc. We said, “We want you to continue to focus on co-occurring, on gender, on culture, on trauma, and on some other areas that truly are improving the overall value index of the service system, but we want you to place all of these initiatives within this larger recovery orientation.” We did that in 2002-2003.

Staying the course with some basic core elements is extraordinarily important, and the recovery practice guidelines that we just recently put together form a crucial piece that has defined our recovery policy in practice terms.

GREAT LAKES ATTC: As you went from the conceptual to changes in practice, what obstacles did you encounter, both inside DMHAS and with your provider community?

DR. KIRK: The first challenge was people saying, “We’re already doing that; this is not new.” There were two variations on this. First, there were people who really had been pushing this and had not been heard. Some of these people were angry that it took us so long to get to this orientation. Some said, “I’ve been talking about this for 10 years, and no one has listened, and you come along in 2000 and talk about recovery as if this is the latest and best thing. I’ve been championing this for years before you ever got here.” So we had to listen to these people and get them on board with us. This was a group who did believe in this orientation and were already doing it to the best of their abilities. Others said, “We’re doing it,” but when we looked at

the way they ran their agencies and the way their services were provided, they were a long way from the recovery values we were extolling. For them, we had to define these recovery values at a practice level, so they could see the ways in which they were really not providing recovery-oriented care.

GREAT LAKES ATTC: Helping agencies self-evaluate their recovery orientation must have been a crucial part of this process.

DR. KIRK: Yes. Larry Davidson worked with us to develop a scale that could help agencies measure their degree of recovery orientation. This work (“Findings from the DMHAS Recovery Self Assessment”) is posted on the DMHAS website (www.dmhas.state.ct.us) under “Major Initiatives,” “Recovery,” “Reports and Position Papers.” We built recovery orientation into the language of all our contracts, along with a contractual requirement that each agency had to conduct a recovery self-assessment process. We are currently working on further refining recovery outcome measures. We followed that self-assessment process with coaching and technical assistance to move toward greater recovery orientation. We also created something called “The Recovery Institute,” a training curriculum consisting of a series of recovery-focused courses designed particularly for people working in private non-profit service agencies. More than 5,000 people have attended one or more of these courses. After establishing “The Recovery Institute,” we set up what we call “Centers of Excellence.” This consisted of a competitive process that would provide funding for agencies to receive consultation in one of six areas, such as outreach, strength-based assessments, culturally informed services, and so on. We picked agencies that either saw themselves as particularly good in these areas or really wanted to become excellent in their competencies in these areas. Considering we were only paying for consultation services through the financial assistance of SAMHSA technical assistance, we were amazed at how many applicants responded to this RFP. We made a big to-do out of it, recognizing those we selected as Centers of Excellence in Connecticut. They ranged from hospitals to private addiction or mental health agencies, to some of the state-operated mental health components.

GREAT LAKES ATTC: Did you also take steps during this early period to support recovery advocacy and support organizations, and to ensure their involvement in the system-transformation process?

DR. KIRK: We increased funding to such groups, to allow them to expand their operations on a statewide basis. There was federal money supporting some of their activities, e.g., CCAR, and we added state dollars to supplement this. We’ve since increased our state funding of these advocacy organizations. This has helped strengthen consumer involvement in our system and expand peer-based recovery support services. We also met with the executive director and board representatives of each of the person-in-recovery/consumer groups under contract with DMHAS. We discussed their contract requirements, listened to their vision and goals, and focused on affirming our joint vision and mission.

GREAT LAKES ATTC: How did you manage the system-transformation process inside DMHAS?

DR. KIRK: A couple of different ways. The communication strategy was very important. In late 2000, we started putting out “Messages from the Office of the Commissioner.” This communication piece came out every two weeks or so and was sent to everybody in the service system, external and internal, including all of our 3,500 DMHAS staff. The messages the first couple years were typically from me, but then we involved other people in crafting these messages, such as a message from Bob Savage [who was then Director of the Connecticut

Community of Addiction Recovery] or a message from members of my executive staff. To-date, there have been over 130 such Messages. So there was a steady emphasis on this recovery initiative and what it would mean to everyone in the system and in DMHAS. A second communication piece started in 2000 was “INFORMATION...foundation of good policy.” It is a one-page brief, based on data, and released several times a year. Approximately 80 have been published since 2000. The “Messages from...” and the “INFORMATION” documents cover numerous angles—recovery management, recovery support services, our work with high-service utilizers, linkage to care, employment, housing, and new approaches to public managed care. We used these communications to highlight what we were doing and the kind of problem solving we were trying to do. All are at www.dmhas.state.ct.us.

GREAT LAKES ATTC: Could you provide some examples of such problem solving?

DR. KIRK: We have a state-operated facility in Hartford that provides detox and residential services, and in the same neighborhood a private non-profit treatment agency that provides similar services. I kept hearing that people couldn't get into either facility. I put in place a daily census count that each facility needed to call in to the central office, and we continued to get complaints that people couldn't get in, even when our counts showed empty beds. So we did a review and came up with something called SATEP: Substance Abuse Treatment Enhancement Project. We reconfigured the beds and added some supplemental services, such as a 24-hour access telephone line and transportation funds that allowed people in need to get transported by taxi to treatment, or from one service component to another. These strategies increased service access.

Another problem we had was with people who were opiate dependent who would repeatedly use primary treatment services but fail to follow through on any continuing-care services. We started OATP, an Opiate Agonist Treatment Program that identified these individuals and assigned them a recovery specialist, who tracked them through the system and assertively linked them to continuing-care services. This service also increased service utilization rates within many of our funded agencies. We took the same capacity and increased access and improved linkage to follow-up care. This lowered the admissions of our high service utilizers and opened up beds for other people. To achieve that system wide meant we had to confront various bureaucratic stupidities. For example, we had one of our state-operated programs that had a policy that they did not admit on Friday afternoons. Needless to say, we changed such policies that had emerged as roadblocks to people's recoveries.

A third area involved our use of alternative living centers. These are not treatment centers but sober living environments used by long-term substance users who had achieved sobriety. Providing such sanctuaries helped these people achieve stable recovery and became an important step-down level of care within our system that further decreased admissions by our high service utilizers. And we did it for a fraction of the cost of a detox or residential treatment day. Staff heard so much about recovery and these recovery-focused problem-solving efforts that it just became a part of the internal culture.

GREAT LAKES ATTC: It sounds like the whole understanding of levels of care changed through this process.

DR. KIRK: We dramatically expanded the range of services. This is really important. We modified ASAM criteria, what we call Connecticut ASAM, to get providers as well as the people seeking services more focused on what people needed rather than what was available. We pushed a widened definition of levels of care with more precise admission and continued-stay

criteria. Our goal was to get out of a situation where, if you showed up at a clinic that does A, B, and C, you would get A, B, C, even when you needed D, E, F. Our efforts to expand the service menu and refine the process of matching people based on their needs helped shape a service system in which both service providers and consumers made more informed choices about levels of care. Adding some really good measures helped that. One of our most critical measures was continuity of care, e.g., was each client actually linked (not just referred) to follow-up care within 7 days of his or her discharge? This had a significant influence on our readmission rates.

GREAT LAKES ATTC: You have made a significant investment in Connecticut in developing non-clinical recovery support services within your behavioral health care system. Could you describe the impact these services have had?

DR. KIRK: The recovery support services have had a significant impact on decreasing repetitive use of acute high-cost services. Recovery support services have served as an important vehicle for reaching out and engaging people in treatment and recovery processes. They have also served as an effective bridge in moving people across different levels of care within the clinical service system. Recovery support services have represented a relatively low-cost means of sustaining people's recovery without the need for sustained treatment or the multiple treatment episodes that might otherwise be required.

GREAT LAKES ATTC: What would you recommend to directors in other states who don't currently have recovery advocacy and support organizations?

DR. KIRK: I would recommend that a director and his or her staff get to as many forums as possible that provide opportunities to interact with people in recovery. And I would suggest they keep a log of what they have heard in these forums. I gave a talk last year at the annual meeting of the National Alliance on Mental Illness. I had someone help me put it together, and I junked a good part of it because it just wasn't people oriented enough. Instead I added "What I heard along the way." Let me just give you a couple examples, because I think that this is something that anybody could do. One of the things I heard along the way is, "when I get too functional, I lose my services." In the acute-care system of addiction treatment, people actually get penalized via loss of support when they get better. Another message I heard was, "When I come to this clinic, I feel like I'm a junkie, and I'm not a junkie anymore." What does that say about our service system? I asked another person I met in one of our clubhouses, "If you could ask for something, what would you ask for?" He said, "I just wish people had more time to talk to me." These are things that any state director and his or her staff can get by going into these situations and listening and asking themselves the implications of such comments for the design changes needed in the service system.

You have to work with and nurture the development of peer advocacy and support organizations, and you have to help them mature beyond the "us against the world" stance that often characterizes the early days of such organizations. As I told one advocate, "You have to understand when you're beginning to win something and stop chasing windmills all the time, because, after a while, people don't pay any attention to you anymore." It's not only working with these organizations; it's helping them mature as organizations. I'm more comfortable with an approach that doesn't place the advocates as employees of the state agency. We've shifted from these groups being our watchdogs to these groups being our partners in transforming our system of care.

GREAT LAKES ATTC: How do you think financing models are going to have to change to become congruent with this recovery model?

DR. KIRK: Great question, and an interesting one, because we're in the midst of that issue right now. I'll give you one example. We just had a needs assessment. We asked some folks to conduct a survey for us that, in part, identified about 850 service consumers who were having significant problems of one type or another. One of the striking findings was that a significant percentage of these people were assigned to services judged to be what they needed, but in which the people were not participating. For whatever reasons, they were not engaging in what others saw them needing. This is a clinical question, but it is also a fiscal question. If the services we are paying for are not engaging those they are intended to serve, perhaps it is time we altered the service menu. And that may include paying for things, such as peer support services, which have not been historically reimbursable services. We need funding guidelines that allow us to think outside the box and support services that are responsive to recovery needs. If post-treatment recovery support is critical to long-term recovery outcomes, we need to fund such services, as we recently did by funding our recovery advocacy agency to provide telephone-based recovery support services to people for 12 weeks following their discharge from primary treatment.

We have to ask: What are the components that would serve to engage people and link them between different levels of care more effectively? What new levels of care do we need to add to the existing service system? What are the components that would dramatically increase access to and utilization of existing services? If sober housing is critical to recovery maintenance, then we need to think about supporting housing initiatives. Tying recovery support services with existing levels of care challenges traditional funding mechanisms, through which the former were not reimbursable services. We're looking at different ways of combining components into a service level of care, to achieve good continuity of care. In short, we are building on the work of Tom McLellan, Bill White, and others to shift towards treating severe addiction as a chronic or continuing-care disorder like my high cholesterol or somebody else's high blood pressure. What would that mean? You could move toward a system that was not based solely on fee-for-service and that redefines an episode of care.

Let's say that Tom Kirk shows at agency X, and based on an assessment it is determined that I will likely need involvement in formal treatment across multiple levels of care for the next year. And the formal treatment might be—I don't know—detox. It might be intensive outpatient. Based upon that, we say that we will fund the agency to have responsibility for providing this episode of care for me during the year, up to a set dollar value. They can spend the money on services for me at their discretion, as long as it supports my recovery process.

This new definition of an episode of care could involve different combinations of clinical and recovery support components that I could benefit from, and that my service provider or I could purchase on my behalf. We could tie outcome measures to my entering and remaining in what I call a "recovery zone"—sober and stable functioning in the community. What are being paid for are services that support my stability, not just high-cost crisis interventions. What does that mean in terms of financing? One of the approaches we're looking at for the future is the idea of "covered lives"—paying agencies to provide comprehensive services for a given number of people per year, rather than paying for delivered service units.

GREAT LAKES ATTC: Do you see primary healthcare integrated into this vision of sustained recovery support?

DR. KIRK: This is an extraordinarily important issue. One of the things I'll pay attention to over the next year is the primary healthcare needs of the people we have in our private non-profit and state-operated service system. On the mental health side, the lifespan of a person with psychiatric disability is something like 15 years less than other persons, and when we look at the data for people we have in our service system, they're not dying of suicide; they're not dying of drug overdoses. They're dying of cardiac conditions, respiratory conditions, and the kinds of things that the rest of us suffer from. So if we're really going to talk about a recovery-oriented holistic system, we have to pay attention to primary healthcare needs.

One of the major priorities for my medical director is to focus on a greater linkage between the physical healthcare needs of our people and their substance abuse or mental health needs. We have what's called PARS. PARS is our Performance Assessment Reviews for all of our managers. I just finished identifying the things that I would expect them—including the 10 CEOs of the major state-operated facilities—to focus upon this year. One of them relates to addressing the physical healthcare needs of the people we have in our service system. Co-occurring disorders, employment, physical healthcare, and recovery orientation are the four major initiatives that we are focusing upon this year in terms of improved services.

GREAT LAKES ATTC: Did you run into regulations inside DMHAS, or federal regulations, that actually got in the way of the system transformation that you've been attempting?

DR. KIRK: Yes, particularly licensing authorities. The program licensing authority in the State of Connecticut is the Department of Public Health (DPH), which is very medically oriented. Here's the kind of situation that comes up. In the programs for women and children that we run, a mother may come in for services, and she might have one or two young children come with her, and other women may watch her children while she is in group or meeting with her counselor. Public Health looks at this and declares that we must have separate therapeutic childcare for such situations, which is extraordinarily expensive. Those are the kinds of conflicts we're trying to work through with DPH. It's a conflict in philosophies. They may cite a program for not being medical model oriented at the same time we are trying to move that program from a medical model to a more peer-based recovery model. I meet with the Public Health Department once a month to work out such issues. There've been dramatic changes in some ways, yes, but it's a process. Being in a process, we still have a long way to go.

GREAT LAKES ATTC: Have the federal agencies that you work with been supportive of the directions that you're going?

DR. KIRK: We've gotten good support from CSAT and CMHS as well as CSAP in the recovery focus. We're one of the Mental Health Transformation states, as well as an Access to Recovery state and one of the Strategic Prevention Framework states. Between the technical assistance they gave us in support of the Centers of Excellence and the Strategic Prevention Framework grant we have from CSAP, the federal agencies have been supportive of our system-transformation efforts. The real challenge is with Medicaid regulations. We've had site visits where their philosophies and ours conflict, and we've had to balance our recovery orientation with meeting the regulations that flow from their medical model.

GREAT LAKES ATTC: When you look back over the history of the recovery initiative, what do you personally feel best about?

DR. KIRK: I feel best about the direction we set and the fact that the resulting focus and energy are producing real change in the way people who receive services in our system think about themselves and their hope for recovery. I feel good that our recovery philosophy is filtering throughout the system. You hear people talking about things today that we talked about two years ago, but they've made it a part of them. There's a bumper sticker that says, "When people lead, their leaders will follow." I think in an interesting sort of way we've been able to create a movement where people—service consumers and people in recovery—are becoming more and more energized, and they're guiding the system-transformation process in ways that the service professionals could never do by ourselves. If I got fired tomorrow, I would feel real comfortable that the movement would continue long after I left the system.

The question is, "How do you institutionalize things so that people take ownership of these innovations and carry them forward?" I strongly believe that we all stand on the shoulders of the people who came before us. I talk about the recovery stuff so much, and I spend so much time talking with the Governor and legislators about it, that I now hear them using the words. It's something to listen to the Governor talking about behavioral health systems transformation in her own words.

GREAT LAKES ATTC: As you look ahead, what do you see as the next steps in the system-transformation process in Connecticut?

DR. KIRK: As much progress as we have made, we still have a long way to go in the recovery-oriented focus, because it involves total system change, not just one program. So we will continue to identify "lessons learned" from our experiences—how Access to Recovery or related activities can be embedded into the service system versus being the latest grant. I also believe that we have to work on identifying and cultivating staff—management and line staff—whose leadership and other skill sets can serve to model what a recovery-oriented system really is like. We will be intensely focusing on things like employment, the addition of recovery support services to the basic service menu, and physical healthcare and co-occurring disorder services. Another focus will be on pushing the service design toward wellness promotion and recovery support services that groups of people in different areas of the state need, rather than toward what the historical structures dictate that we continue to fund. A third area will be shifting the financing of the overall system to support a continuing-care model. We must change the financing mechanisms.

GREAT LAKES ATTC: As a final question, are there any tips you would offer your counterparts on how to manage similar efforts at systems transformation?

DR. KIRK: One tip would be to focus the transformation process through an overall message that allows people to see the individual initiatives as fitting into a whole. System transformation will fail if it is just seen as a bunch of discrete initiatives. You have to continue to hammer away about how existing things and new initiatives tie into this larger picture. You also have to honor what people have done in the past and not inadvertently demean their efforts. The message is, "We want to take the gems that we can learn from you, based upon your experience, and elevate them within what we are building." When I was at the agency in Stamford talking about some of this, a guy who had been running our methadone program from day-one said, "Sometimes when I hear you talk about this, it's as if I've been doing the wrong stuff for the last 20 years." That's not the message we want to convey. We need to understand what they've been doing in the trenches, what they've learned, and build on that.