

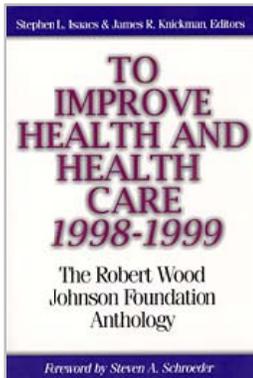
Adopting the Substance Abuse Goal: A Story of Philanthropic Decision Making

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Robert Wood Johnson Foundation

Chapter One,
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Anthology:
**To Improve Health
and Health Care,
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Editor's Introduction

A question frequently asked of anybody who works at a foundation is, How do you decide how to spend the money? The challenge of picking and choosing from among so many potentially worthy initiatives is ever present in philanthropy, and obviously of great interest to potential grantees. This chapter offers a candid look at how the Robert Wood Johnson Foundation went about deciding to devote a substantial part of its annual grantmaking budget to the problem of substance abuse.

The decision to make grants that would attempt to "reduce the harm caused by tobacco, alcohol and illegal drugs" was a significant departure for the Foundation. For its first fifteen years, the Foundation focused more on improving health *care* (particularly access to medical services) than on tackling determinants of health. Adoption of the substance abuse goal was a first step toward addressing both the *health* and *health care* aspects of the Foundation's mission.

The chapter describes the staff and board processes that led to shaping and adopting the substance abuse goal, and assesses the consequences over the next six years of adopting that goal. The author, Robert Hughes, who is currently a vice president of the Foundation, was actively involved in the planning process that took place in 1990 and 1991. He continues to do grantmaking in the area of substance abuse.

In 1991, the Robert Wood Johnson Foundation adopted three goals that would guide its grantmaking through the last decade of the twentieth century: to assure that Americans of all ages have access to basic health care, to improve the way services are organized and provided to people with chronic health conditions and to promote health and prevent disease by reducing harm caused by substance abuse.

The substance abuse goal constituted the biggest departure from past Foundation goals and grantmaking activities. Before 1991, substance abuse had been subsumed under the priority of reducing destructive behavior, one of ten Foundation priorities in the late 1980s. Substance abuse was not on the agenda at all before 1987. The emergence of substance abuse as one of three goals signaled a significant new direction for the Foundation. Early in 1997, it had become the single largest area targeted for Foundation investment, amounting to more than a fourth of the Foundation's \$900 million in commitments (grants

and programs authorized to be paid in the future). The magnitude of this investment reflects the impact of adopting a goal on subsequent Foundation grants.

THE IMPORTANCE OF ORGANIZATIONAL GOALS

A goal is important for a foundation because it sets boundaries, for both the philanthropy and the public, delimiting what the foundation's grantmaking will include or exclude. It is, fundamentally, a statement of organizational values—a judgment that the adopted goal is more important than competing goals, and that this judgment will be used in future funding discussions. It makes a claim about the worth of investing in a specified area and, moreover, delineates what will *not* be within the scope of consideration for funding. The more specific and narrow a goal, the greater the possible influence philanthropic investments may have, but the smaller the range of interests that can be accommodated under it. The broader a goal, the less focused are the philanthropic investments, but the greater range of interests that can be accommodated. This tension between focus and breadth is a central issue for foundations.

Compared with many other types of organizations, a philanthropy is unusually flexible in its ability to adopt goals. It does not confront the market discipline imposed by the need to attract new resources, and does not worry about selling a product to consumers. It does not have a responsibility to any public agency. A philanthropy is also unusually flexible in its ability to change once goals have been adopted. Most organizations are constrained from changing what they do because they have to perform a specific function—educate students, say, or produce a product—and they have staff expertise and investments in equipment or technology to facilitate that work. The work that philanthropies do—allocating resources, mainly through grants—can be refocused on different purposes. Indeed, although the influence of goals on behavior is probably overrated for most types of organizations, for philanthropies that influence may be underrated. Philanthropies are more insulated from outside influence, and the work of the organization itself can be changed with comparatively little disruption. But a foundation will still be influenced strongly by its own history, as was the case with the Robert Wood Johnson Foundation and its adoption of the substance abuse goal.

FOUNDATION GOALS IN HISTORICAL CONTEXT

The Robert Wood Johnson Foundation's mission, "to improve the health and health care of all Americans," has remained unchanged since it became a national philanthropy in 1972. The mission set the broad, long-term direction for the Foundation, but focused goals were needed to help potential grantees and the Foundation trustees and staff understand how that mission would be accomplished. In 1973, the Foundation decided on three areas that would guide grantmaking: the need for ready access to

personal health care, the need to improve the performance of the health care system in order to ensure quality care and the need to develop mechanisms for the objective analysis of public policies in health.

Over the next decade, the first of these areas—access to care—became a hallmark issue for the Foundation and accounted for 77 percent of all grants. The two other areas, though less visible and attracting less grant funding, helped shape the Foundation during its formative years. The focus on health care systems and trying to make improvements by first understanding how systems function and then devising ways to make them better has provided the conceptual underpinnings for many Foundation programs. Similarly, the value placed on objective analyses became firmly embedded in Foundation culture, reflected not only in support of projects that carried out analyses of public policies, but also in the practice of commissioning independent evaluations of the Foundation's own programs.

Between 1972 and 1991, the Foundation twice changed its goals. A review and revision of goals in 1981 was prompted by the changes in the health system that had occurred in the decade since the original ones were established. In 1987, the Foundation's goals were revised once more because of a change in leadership. That year, Leighton Cluff succeeded David Rogers as president. In the fall of 1989, Dr. Cluff announced his plans to retire, and the stage was set for a review of the Foundation's goals by the new leadership.

ADOPTING NEW GOALS

In 1990, when the Foundation's board of trustees selected Steven Schroeder as the third president and fellow trustee, they understood that one of his first activities would be to review the Foundation's goals. In his interviews with board members, Dr. Schroeder had conveyed an interest in taking the Foundation in the direction of working on substance abuse problems. The board was receptive to this direction, and had taken steps several years before to encourage the staff to address problems of illegal drug use and alcohol problems. As a result, the Foundation was already supporting projects directed at reducing substance abuse, most visibly the Partnership for a Drug-Free America, a national media campaign aimed at deglamorizing drug use, and Fighting Back, a national program that supported community coalitions working to reduce the demand for alcohol and illegal drugs. This program, launched in 1988, was the largest Foundation program to date. However, the Foundation had virtually no other substance abuse programs.

Initially, Schroeder was struck by the disparity between the mission, which included improving *health* and health care, and the programs, which were mainly in health care. This disparity suggested possibilities for

new directions that could enhance the Foundation's focus on improving health that did not rely on improving the health care system. This notion fit well with Schroeder's own experience as an internist seeing patients with problems caused by tobacco and alcohol use, and his training in public health and epidemiology. The evidence of the importance and the scale of health problems stemming from substance abuse was overwhelming, and the problem seemed to offer great promise as an area for Foundation work.

Schroeder's first board of trustees meeting after he joined the Foundation as president was in July, 1990. (See Figure 1.1.) At that meeting, he told his fellow board members that during the past few months he had received advice about the Foundation and its goals from perhaps forty people, including health experts, former Foundation officials and senior officers at other large philanthropies. At this initial meeting, Schroeder indicated his own preferences by listing "substance abuse (cigarettes, alcohol and cocaine)" first among a preliminary list of possible goal areas suggested to the board. The board agreed that as a next step the staff would develop a strategic plan and present it to the board in early 1991.

STAFF ENGAGEMENT IN THE PLANNING PROCESS

A consideration of new goals topped the agenda at the weekly program staff meeting (attended by the entire grantmaking staff) immediately after the July board of trustees meeting. Richard Reynolds, the Foundation's executive vice president, appointed two thirteen-member committees with the broad charge of identifying areas or goals that the Foundation should consider. The membership of these two committees included the Foundation's entire professional staff from program units, communications, financial monitoring, and research and evaluation. The two committees were to report their findings at the September 25, 1990 program staff meeting.

Both committees produced ten-page reports. Neither gave substance abuse the prominence it eventually achieved. In one report, alcohol and drug abuse was one of five proposed topics; in the other report, substance abuse was subsumed under a goal focusing on prevention. Equally noteworthy was the total absence of tobacco in one report, and only a passing reference to it in the other. In some ways, this was not surprising given the composition of the staff. Many had devoted their professional lives to the issues that access involved, had come to the Foundation specifically to work on them, and were most experienced with the ideas, problems and organizations associated with access to medical care. So it was understandable that few staff members spontaneously championed a goal largely outside their own work experiences. In addition, many staff members faced barriers similar to those the rest of the country still faced—a lack of understanding about the nature and the pervasiveness of substance abuse problems, the

stigma associated with addicted people, and a reluctance to come to grips with issues that lie outside the health care system and in the domain of personal behavior, organizational policy and societal values.

THREE PROPOSED GOALS

The timing of the reports allowed the Foundation's senior management to review the committees' reports and to draft language for goals well in advance of the October 1990 board meeting:

1. Improving access to basic health care by promoting the availability of services and their appropriate allocation.
2. Improving the health of people with complex needs requiring the integration of services in multiple settings.
3. Improving the health of people by reducing the incidence and the prevalence of significant preventable disease and disability. Under this goal, one of the priority areas suggested was reducing the demand for tobacco and illegal drugs and discouraging the irresponsible use of alcohol.

This initial synthesis of the two September 1990 staff reports established that the Foundation would aim to have only three goals, an important step in trying to achieve focus. Moreover, the phrasing of the third goal made important modifications to the language used in the staff reports. Now the priority area specifically included tobacco, listing it before illegal drugs and alcohol. In addition, this language began to wrestle with the differences among tobacco, alcohol and illegal drugs. The emerging scientific evidence that alcohol was not always harmful, and under some circumstances could be beneficial, made lumping it together with tobacco and illegal drugs problematic in terms of what the ultimate goal should be. For alcohol in particular, the experience of Prohibition provided a reminder of the need to describe carefully what the Foundation hoped to accomplish. The challenge was to develop a coherent idea and a direction for grantmaking that encompassed three substances with quite different social, historical, cultural and medical characteristics. And under closer examination, even the three terms—tobacco, alcohol and illegal drugs—describe remarkably different categories: a plant, a chemical compound and substances classified by the law. The thorniness of crafting the language is illustrated by the observation that at various times in the twentieth century the category "illegal drugs" included alcohol and excluded heroin, cocaine and marijuana, and that for children tobacco and alcohol are illegal drugs.

After several weeks of discussion of the three goals proposed in the initial synthesis, senior Foundation officials agreed on new language for the goals that would shape the next phase of staff work and outside review. The three proposed goals were:

1. Reducing the harmful effects and the irresponsible use of tobacco, alcohol and drugs.
2. Assuring that all Americans have access to basic health care.
3. Improving the availability and the utilization of services needed by people with complex, chronic health conditions and related conditions.

There were three important changes from the earlier draft of goals. First, substance abuse became a specific goal, not a priority within a broader goal. Second, this goal was now listed first instead of third. The new order was based on ideas about how the goals related to one another and to people's health, beginning with a goal that addressed behavior outside the health care system, progressing to a concern that all people get into the system for basic services, and that, once in the system, people with chronic health problems would get the care they needed. Third, the idea of reducing harmful effects provided a common aim across tobacco, alcohol and illegal drugs that did not require qualification because of differences among the three. This phrasing simplified the goal.

With the refined goals, organizational decision making entered the next phase. The board of trustees reviewed the history of the Foundation's mission and goals at its October meeting, along with the three proposed goals and a work plan for adopting new Foundation directions. The proposed work plan provided the steps for consulting with outside experts, preparing reports and obtaining periodic comments from board members. These steps would lead to a board of trustees retreat in February of 1991, to be devoted exclusively to future Foundation directions. The board approved the work plan, and staff work groups began to prepare a report on each goal.

The work group on the substance abuse goal prepared a twenty-four-page report that summarized the extent of substance abuse in the country, noted existing activities to address substance abuse, reviewed past Foundation work in the area and proposed a framework for future Foundation efforts, along with examples of possible programs. This report became part of the briefing book prepared for the board of trustees retreat.

THE FEBRUARY 1991 RETREAT

A substantial portion of the February retreat was devoted to a consideration of the Foundation's future goals. The board members reacted somewhat differently to each proposed goal. That they embraced the

access goal quickly and without extensive commentary was not surprising; it reaffirmed a long-standing institutional commitment. The proposed chronic care goal was accepted, but the discussion contained a bit of skepticism, stemming in part from the goal's breadth and complexity. However, the most active board discussions were generated by the proposed goal of reducing the harm caused by tobacco, alcohol and illegal drugs.

The board members considered important risks as well as rationales for adopting the substance abuse goal. The risks included moving into an area where the Foundation had little experience. Pursuing this goal could embroil the Foundation in controversial issues such as the legalization of substances or issues of personal behavior and cultural values or suggest moving into program areas with which the Foundation had scant familiarity, such as law enforcement. The board carefully considered the potential damage that could be done to the Foundation's reputation if it adopted this goal. The board's experience with and knowledge from the Partnership for a Drug-Free America and the Fighting Back program contributed to its understanding of illegal drug and alcohol issues. Including tobacco sharpened the focus of the discussion and highlighted the risk of Foundation-supported antitobacco projects that would attract industry attention and opposition and might embroil the Foundation in a controversy that could overshadow other work it supported. The board members understood well the economic strength of the tobacco industry and how influential the industry could be. In addition, they looked carefully at the decades-long decline in tobacco use and considered what the Foundation could bring to this issue when the trend was already going in the right direction.

Still, the data on tobacco and the harm it caused strongly supported the idea that tobacco should be included in the goal—a point most persuasively made by several former smokers and board members with expertise in clinical medicine. The estimates of deaths due to tobacco use—435,000 a year compared to 100,000 a year for alcohol and 20,000 a year from illegal drugs—made tobacco hard to ignore. Central to the discussion was the assessment of how well this goal fit with the Foundation's mission of improving the health and health care of all Americans. The board members considered the risks and the rationales and concluded that addressing the substance abuse problem in the United States—including tobacco—was, in the words of one trustee, "the right thing to do." They adopted the goal.

EARLY TRANSITIONS AND PROGRAM DEVELOPMENT

A goal is not self-implementing; it simply sets some boundaries and directions for the organization. In the process of reviewing proposals and developing programs, a primary use of the goal itself is being clear about what will not be considered. For both potential applicants and staff members, the main value of a

goal is to exclude projects or activities not related to it. A goal is not particularly useful in making choices among the large variety of proposed projects that can make legitimate claims to contribute toward its fulfillment. For unsolicited ad hoc proposals and staff-developed programs, being consistent with a goal is a necessary, but not a sufficient condition for securing Foundation support.

The boundaries that a goal provides are continuously being negotiated. People with project ideas that may not have addressed substance abuse directly recast their ideas to highlight the effects on substance abuse. Staff members developing program ideas, which undergo the same review and approval process as external proposals, make similar accommodations in their work. Indeed, a major challenge of philanthropic work is interpreting goals so that they remain useful in making decisions about specific projects and in determining how to allocate scarce resources.

Several specific circumstances served to spark the Foundation's early substance abuse programs after the goal was adopted. First was the chance to use the knowledge and the network developed in programs already under way—Fighting Back and the Partnership for a Drug-Free America. These contacts provided valuable ideas for new projects. Second, the board had directed staff members to begin grantmaking that targeted tobacco use with children's projects, because that area was seen as the one of broadest consensus. This led to staff work with Stop Teenage Addiction to Tobacco (STAT), and STAT received the first large tobacco-related grant given by the Foundation—\$1.2 million. Third, the Foundation actively recruited new staff members with expertise in substance abuse. Fourth, Joseph Califano, the former Secretary of Health, Education and Welfare, visited the Foundation and shared his vision for establishing a multidisciplinary "think/action tank" to focus on addiction in this country. Out of this visit came a planning grant, and eventual Foundation support for a new organization—the National Center on Addiction and Substance Abuse, or CASA, at Columbia University.

All did not fall into place quickly or smoothly, however. For example, the Foundation's senior management decided to form work groups from among the professional staff for each of the three major goals. To determine the membership for these groups, staff members were asked which goal group—access, chronic care, or substance abuse—they would prefer to work in. Twenty-one of thirty staff members selected access, and only four chose substance abuse. After some informal discussions between staff members and leadership about the need for each goal group to have roughly the same number of people, the substance abuse group got under way with eleven staff members.

Within the Foundation, goal groups develop and review program proposals and make initial recommendations for funding (or not). The substance abuse goal group, as it was called, had the challenge of learning about new issues and developing a portfolio of investments in the field. The largest investments are set forth in Exhibit 1.1 at the end of this chapter. They reflect a variety of approaches—from multisite demonstrations to research to communications projects—and address a range of problems—from children smoking to binge drinking to helping communities overcome problems stemming from alcohol and illegal drugs.

1991–1996: GROWTH, CONTROVERSY AND CHALLENGES

After only half a decade of Foundation grantmaking in the area of substance abuse, it is too early to judge the ultimate impact of adopting the substance abuse goal. But it is not too early to see how selected aspects of this work have unfolded. First, the development of the substance abuse portfolio occurred at a time of substantial growth in the Foundation's assets. The amount awarded for grants rose from \$129 million in 1991 to \$267 million in 1996. This means that the investments in substance abuse programs were not made at the expense of more traditional Foundation goals.

Second, this new goal energized the organization. It provided new challenges and substantive issues and forced substantial organizational learning among staff and board members over just a few years. And the feedback from the Foundation's various public audiences was positive. This feedback and organizational learning were mutually reinforcing, as the entire organization became more confident about the benefits and fit of these issues with the Foundation's mission. In particular, the more the organization understood the depth and pervasiveness of the health problems caused by tobacco, the greater the resolve to reduce tobacco use.

Third, working in substance abuse gave the Foundation greater experience in supporting programs that involved controversy. Of course, what is controversial can be relative. In 1991, the Foundation thought tobacco was a potentially controversial topic. Yet by 1994, when health care reform had risen to the top of the national agenda and strong criticisms were directed at the Foundation for its activities, one trustee asked, "Why can't we do something noncontroversial like go after tobacco?"

Fourth, the type and the mixture of interventions supported to reduce substance abuse, as displayed in Exhibit 1.1, were quite varied. At the February 1991 retreat, the board expressed a willingness to support different types of activities, and encouraged staff members to be creative in working toward the goals. The

relatively new substance abuse area provided opportunities and the new approaches tried in substance abuse have influenced Foundation work in its more traditional grantmaking areas.

Fifth, despite the specific focus of the goal, the array of Foundation-sponsored substance abuse projects resists conceptual coherence and programmatic integration. Tobacco, alcohol and illegal drugs cause different types of harm. Reducing teenage tobacco use requires approaches different from those aimed at reducing binge drinking on college campuses or helping former drug abusers leaving prison get off to a positive start in their home communities. Further, the diversification of programs—responding to the breadth of worthwhile approaches to reducing substance abuse—stretches the capability of any single conceptual framework.

Sixth, the substance abuse goal remains only loosely tied to other Foundation goals. The issues inherent in developing approaches to improve access to health care services and chronic care services intertwine to a certain extent. Substance abuse is less connected to access and chronic care than these two goals are to each other. In part, this reflects the separate status of substance abuse within health and health care historically. From treatment programs to payment systems to insurance coverage to prevention programs, substance abuse has been separate from other health and health care problems. These divisions have dampened the potential links that could have been made across Foundation goals—in access to substance abuse treatment, for instance, or viewing addiction to various substances as chronic illnesses. However, some recent programs such as Addressing Tobacco in Managed Care Organizations and Screening and Brief Intervention for Alcohol Abuse in Managed Care (see Exhibit 1.1) are beginning to make these links.

Seventh, the Foundation's selection of the substance abuse goal and its investment of substantial resources in support of the goal helped legitimize a field that had received little philanthropic support. Although some other philanthropies do grantmaking in this area, it remains woefully underfunded.

CONCLUSION

Choosing a new goal can help keep an organization vibrant by infusing new ideas, providing the opportunity to work on new problems and promoting a receptivity to different perspectives. Yet there is also great value in building on experience and sticking with established goals over time. Achieving the most productive balance—between continuity and change, between established approaches to problems

and untested new ones, between a focus on well-understood issues and unfamiliar ones—is among the most important challenges facing a Foundation's leadership.

Notes

EXHIBITS

1.1 Major (Over \$1 million) Foundation Investments to Reduce Substance Abuse

FIGURES

1.1 Chronology of Selected Events Leading to the Adoption of the Substance Abuse Goal