

The Evolution of the Robert Wood Johnson Foundation's Approach to Alcohol and Drug Addiction



Robert Wood Johnson
Foundation

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Editors' Introduction

This chapter by Victor Capoccia, a senior program officer at the Robert Wood Johnson Foundation and head of the team that shapes its grantmaking in preventing and treating alcohol and drug addiction, offers an inside look at the Foundation's strategies that have shaped its billion-plus dollars in investments to reduce the harm caused by alcohol and drug misuse in America. One of a number of *Anthology* chapters that examine how the Foundation has addressed prevention and treatment of drug and alcohol addiction,² it sets the Foundation's work into the context of national policy and traces its evolution since its first grants in the 1980s.

The public perception and the politics of addiction prevention and treatment have been shaped by a cultural war over the reasons for substance abuse. Whether addiction is viewed as a criminal problem, a moral failing, a social problem, or a chronic health care condition (and it has been seen as all of these) will influence the approaches to addressing it. These can range from the incarceration of drug users to self-help programs such as Alcoholics Anonymous and from community-based prevention programs to medical treatment.

As Capoccia observes, the Foundation, influenced by recent scientific knowledge about the biological and neurological causes of addiction, considers addiction to be a chronic health condition. As such, it should be treated like other chronic conditions. Capoccia also makes it clear that, given the scientific evidence that some people are going to become addicted no matter what is done to prevent addiction, prevention efforts alone will not solve the problem; an approach combining both prevention and treatment is needed.

1. The author would like to thank Kristin Schubert and Emily Day for their research assistance and Molly McKaughan for identifying reports on past grants.

2. Hughes, R. G. "Adopting the Substance Abuse Goal: A Story of Philanthropic Decision Making." In *Anthology 1998-1999* (1998); Mangione, T., Howland, J., and Lee, M. "Alcohol and Work: Results from a Corporate Drinking Study." In *Anthology 1998-1999* (1998); Diehl, D. "Recovery High School." In *Anthology, Vol. V* (2002); Brodeur, P. "Combating Alcohol Abuse in Northwestern New Mexico: Gallup's Fighting Back and Healthy Nations Programs." In *Anthology, Vol. VI* (2003); Wielawski, I. M. "The Fighting Back Program." In *Anthology, Vol. VII* (2004); Jellinek, P., and Schapiro, R. "Join Together and CADCA: Backing Up the Front Line." In *Anthology, Vol. VII* (2004); Parker, S. G. "Reducing Youth Drinking: The 'A Matter of Degree' and 'Reducing Underage Drinking Through Coalitions' Programs." In *Anthology, Vol. VIII* (2005); Chapter Six in this volume.

Few fields have felt the ages-old clash between belief and science more acutely than that of alcohol and drug dependence. Over the past half century—and in the last ten years in particular—science has made great strides in understanding the nature of addiction and how it can be treated. Addiction research has demonstrated that alcohol or drug misuse alters the brain’s natural patterns for satisfaction and gratification; that dependence on alcohol and drugs is treatable; and that the harmful effects of alcohol and drug abuse on young people can be reduced by making it more difficult for them to acquire alcohol and drugs. What’s more, recent science has led to the view that the misuse of alcohol and drugs is not only a public health issue but also an issue of personal health. In other words, such misuse has come to be seen as a chronic illness—one that requires new policy and new programmatic responses.

Even so, alcohol abuse and drug dependence are still often not recognized as chronic illnesses or treated as such. And although treatment for these conditions is known to be as effective as treatment for asthma, diabetes, and other chronic illnesses, the nation’s health system generally does not recognize and treat the condition. When it does, it is set up to treat only 20 percent of the need. And that need is great. Nearly one in ten Americans over the age of twelve has a problem with alcohol or drugs—some 22 million people in all.¹ Alcohol and drugs have been estimated to be the cause of more than 144,000 deaths a year and 20 percent of the nation’s hospital costs.^{2,3} They are also a significant factor in child welfare cases and family problems.

Given the enormous personal and social costs that could be avoided by preventing and treating alcohol and drug dependence, why isn’t more being done? One answer is that in the formation of public opinion and public policy, belief has trumped science. In other words, despite the advances in scientific research, despite a substantial body of empirical evidence to the contrary, much of the public still believes that the abuse of alcohol and drugs is a willful act—essentially a personal, moral failing. Unfortunately, this belief does not acknowledge the recent scientific research that has shown alcohol and drug dependence to derive from a powerful confluence of biological, social, and environmental factors that also form the basis of other chronic illnesses.

From the time it was established as a national philanthropy, in 1972, the Robert Wood Johnson Foundation has invested more than a billion dollars on programs to combat the harmful effects of alcohol and drugs, and in that time its programs have gone through three stages. These stages have reflected the struggle within society and within the Foundation of three ways of viewing alcohol and drug misuse: first, that it is primarily a social issue—rather than a health issue—that leads to crime and community disintegration; second, that it is largely a matter of behaviors deeply rooted in complex societal norms that can be affected by interventions that modify behavior or reduce access to the substances; and third, that it is a health issue involving a preventable and treatable chronic condition.

Phase I: Help for Alcoholics

Although Robert Wood Johnson, in his personal philanthropy, had an interest in helping, in his words, “men with drinking problems,” in its very earliest days the foundation named after him had at best a passing interest in the issue of alcohol misuse. The Robert Wood Johnson Foundation’s first formal involvement began in 1982 with a staff proposal to the board of directors suggesting a Foundation initiative to help address the problems of alcohol-related illness.

The proposal was stimulated by a 1980 Institute of Medicine report, *Alcoholism, Alcohol Abuse, and Related Problems: Opportunities for Research*, which provided the first comprehensive review of research on alcohol use and abuse and called for increased research on the topic. According to Robert Blendon, who was a Foundation senior vice president at the time and is currently a professor at the Harvard School of Public Health, the proposal was developed because the costs to society and to the health care system were significant, and there was a great need to know more about misuse and how to treat it.

The 1982 proposal demonstrated a clear understanding of the excessive use of alcohol as a health condition as well as a major social problem. It noted that despite the tremendous cost that alcoholism and alcohol abuse imposed on society, 85 percent of problem drinkers and alcoholics received no treatment for their condition. Furthermore, it reported that the gap between the numbers of those who needed treatment and those who received it existed for three reasons: societal ambivalence about whether alcoholism was a disease or more of a moral issue; a lack of information about which methods were effective in treating the condition; and society’s unwillingness to pay for treatment. The proposal concluded with a call for the staff to encourage individual proposals that would seek to evaluate the cost-effectiveness of specific treatments for alcohol-related health problems, and their applicability in different settings. This recommendation marked the first step in developing the Foundation’s understanding of alcoholism not as a social problem but as a medical condition with social implications.

The board ultimately turned down the staff proposal, largely because it ran counter to a policy that avoided disease-specific, or condition-focused, investments. But in 1983 the Foundation did award a one-year \$57,000 grant to Boston University for the first phase of a study on alcoholism treatment in industry. (The full study was eventually supported by National Institute of Alcoholism and Alcohol Abuse.) The project was justified as part of a Foundation initiative on cost containment and health services research. This study, which involved employees of a large aircraft engine plant, compared the costs and outcomes of alcohol-abuse treatment offered at an inpatient hospital versus treatment offered through employee assistance or self-help programs.⁴

While the 1982 staff proposal was noteworthy for its focus on alcoholism as a treatable health condition, it did not touch on three issues that later emerged as the Foundation’s strategic priorities: reducing underage drinking; preventing excessive alcohol use; and curbing drug use. These issues were not unknown at the time. According to a national survey on drug abuse in 1979, some 50 percent of young people from ages twelve to seventeen reported alcohol use in the preceding month.⁵ Data collected annually since 1975 have shown that nearly 80 percent of young people eighteen and under have consumed alcohol by the time they reach the twelfth grade, and that 12

percent of eighth-graders have consumed five or more drinks on a single occasion in the two weeks preceding the survey.⁶

The omission of drug use from the Foundation's priorities was surprising, given the political environment of the period. At that time, considerable attention was given to the problem of drug abuse, in part through Nancy Reagan's Just Say No campaign and in part through television ads showing drug-abused brains as eggs in a frying pan. Society viewed drug use more as a social and criminal issue than as a health issue. Harsh penalties for possessing and selling drugs appeared in new state and federal laws. Most federal, state, and local funding was directed toward interdiction of drugs. No person running for political office could risk being soft on crime or sympathetic to drug users. Moreover, at the time, there was only the beginning of an academic, governmental, and treatment infrastructure that focused on illegal drug use, and it was distinct from the infrastructure concerned with alcohol. In the early 1980s, states typically had an office of alcohol services within their public health structure, and several offices concerned with drugs within public safety and mental health agencies. Thus, at the time, it was easy for the Foundation to view drugs as primarily a social problem that was outside the purview of an organization devoted to health and health care.

Phase II: Recognition of Drugs and Tobacco Use and Focus on Underage Alcohol Use

By the middle and later 1980s, even though the prevalence of drug use had remained relatively stable, social and political conditions and the kinds of drugs that were widely available had changed since the early years of the decade, leading to a shift in the federal government's policy focus. The changes can be seen in three events.

1. The death of Len Bias in 1986 from a cocaine overdose forced a nation that had overlooked the growth of cocaine and crack use to confront this reality. Bias played basketball at the University of Maryland, was an All-American, and was a first-round draft choice of the Boston Celtics. He died less than forty-eight hours after being drafted. More than any other single factor, Bias's death prompted the media to take a hard look at the extent and the costs of cocaine use.
2. An influential national movement of middle-class parents concerned about their children's use of marijuana developed.⁷ The parents' movement exercised political influence beyond its numbers by dint of perseverance, belief, and focused communications about the threat of casual drug use. The voices of concerned parents found a receptive ear in first lady Nancy Reagan, who adopted the prevention of illicit drug use as her special project. The issue of drug use among young Americans was framed as part of a "culture war" and a threat to values. Clearly, the parents' movement did not define drug use as a health issue, and apparently never viewed underage alcohol use as a similar threat.
3. The government's response to the strong public concern over drug use was crystallized in Congress's establishing the Office of National Drug Control Policy in 1988 to coordinate drug policy in the United States, with Cabinet-level authority in the Office of the President. President George H. W. Bush appointed William Bennett, who brought previous Cabinet-level experience as President Reagan's Secretary of Education, and certifiable conservative credentials, to the position

of the nation's first drug czar. Bennett used the office to foster his belief that drug use was a deviant behavior, reflecting moral breakdown. Throughout this period, the Office of National Drug Control Policy did not consider the drug problem as a health issue.

In this political and social climate, the Robert Wood Johnson Foundation responded with two overlapping efforts. The first began in 1986 with a staff report that presented strategies for addressing the problems of "substance abuse" and dependence. The second began in 1991 with a staff report that led to board approval of three goal areas, including substance abuse, and presented a comprehensive framework for the Foundation's work in the alcohol and drug field.

The 1986 Staff Report and Its Implications

The 1986 staff report summarized recent opinion polls that documented society's view of and concern with widespread drug use, and emphasized the cost and mortality associated with alcohol and drug misuse. It recommended that the Foundation support two or three institutions with active treatment programs and a strong interest in prevention, which would be demonstrated through a wide range of activities, including genetic and epidemiological studies, improved methods of treatment matching, testing of new treatment models, evaluation of treatment and prevention programs, and training clinical researchers as well as community service providers.

Two years later, the Foundation developed its first major program to address substance abuse—one that took an approach different from that proposed in the 1986 staff report. In July 1988, the board approved a \$26 million program to support community initiatives to reduce the demand for illegal drugs and alcohol, which became known as *Fighting Back*.⁸ The Foundation eventually invested \$88 million over fifteen years to demonstrate and evaluate the benefits of this approach. *Fighting Back* was based on the idea that if the right combination of leaders in a community worked together in a coalition to address drugs and alcohol, the threat that these represented to neighborhoods could be significantly reduced, if not eradicated.

The 1986 staff report and the *Fighting Back* program departed from the orientation of phase one in three ways.

- The Foundation not only recognized the issue of problem drug use but also came to regard drugs and alcohol as a single problem area. This connection was significant in a nation that had separated funding, regulation, research, and treatment systems for each substance.
- The Foundation, which was comfortable supporting specific program interventions, such as halfway houses, school-based health clinics, and health care for homeless persons, was now willing to fund a community process that might or might not lead to program interventions. This was not a classic health approach to a medical condition.
- The Foundation explicitly supported a program that focused on mitigating the social dimensions of a health issue. Coalitions were to concentrate on increasing public awareness, promoting activities for young people that kept them away from drugs and alcohol, reducing crime, reducing work-related absence and accidents, improving neighborhoods, and screening for alcohol and drug problems.

The Partnership for a Drug-Free America was another initiative that received funding in the late 1980s. Created by Phil Joanou, a former advertising executive who recognized the potential of communications and marketing as a tool to discourage the demand for drugs, the Partnership enlisted major advertising agencies to volunteer their creative talent and resources to produce anti-drug advertisements. Often, the federal government provided the funds that paid for ads on television and radio and in print media.

The 1991 Goal Report and Its Programmatic Implications

By 1991, the Foundation was deeply involved in the issue of alcohol and drugs through the Fighting Back program—an approach that the federal government replicated by allocating more than \$300 million to support some 251 coalitions in forty-five states in a program called the Community Partnership Demonstration Grant Program. And 1991 also marked the first year of Steven Schroeder’s twelve-year tenure as president of the Foundation. In his interview with the trustees when he was a candidate for the Foundation’s presidency, Schroeder stressed the harm caused by alcohol, drugs, and tobacco, and promised to devote some of the Foundation’s resources to addressing this issue. This was especially appealing to James Burke, then a member of the Foundation’s board, who also served on the board of directors of the Partnership for a Drug-Free America and was chairman of the President’s Drug Advisory Council.

In 1991, the Foundation’s board approved three broad goal areas, one of them having to do with alcohol and drugs. These were the goals:

- To assure access to basic health care.
- To improve the way services are organized and provided to people with chronic health conditions.
- To reduce the harm caused by “substance abuse,” including tobacco, alcohol, and “illicit” drugs.

The discussion about whether to make “substance abuse” a formal goal of the Foundation was guided by a 1991 staff report that cited both the alarming use of alcohol, tobacco, and drugs, especially among young people, and the social and health-related costs of what was then considered to be a problem of epidemic proportions. The report zeroed in on two dimensions not seen in earlier work: tobacco as a substance of concern, and patterns of alcohol and tobacco use among young people as a target of concern. The report offered two overarching strategies to guide the Foundation’s future work: (1) improving the understanding of the causes of substance abuse, and (2) expanding the understanding of problem alcohol and drug use and the capacity for delivering effective interventions. The report offered a broad societal perspective as a context for alcohol and drug use: “We are confronted with a problem affecting all segments of our society, one that has effects far beyond the immediate health risks associated with the use and abuse of substance.” The board accepted this broad perspective and avoided language that would imply personal responsibility for the misuse of alcohol and drugs.

An initiative to reduce substance abuse among Native Americans, known as *Healthy Nations*, followed the goal report. Authorized in 1991 Healthy Nations provided technical assistance and grants to Native American governmental and not-for-profit organizations to develop culturally relevant prevention and treatment programs.

In 1992, the Foundation adopted the recommendations made in a staff report to the board, which guided its grantmaking throughout the 1990s. In practical terms, the Foundation's programs during most of the decade were structured around four categories of grantmaking:

1. One category focused on research and policy change, gathering prevalence data and developing policies to reduce the harmful effects of alcohol, drugs, and tobacco. The *Bridging the Gap* program (1992–2006) supports surveys to track the prevalence of alcohol, drug, and tobacco use among the young, as well as studies of state and local practices aimed at curbing such use. The *Substance Abuse Policy Research Program* (1994–2007) funds studies on policies or the policy implications of practices aimed at curbing the harmful effects of alcohol, drug, and tobacco use. The program, and its predecessor, the Tobacco Policy Research and Evaluation Program, documented, for example, the effect of increased tobacco taxation on lowering smoking rates.
2. Another category aimed at building the fields of alcohol, drug, and tobacco prevention and treatment. The Foundation funded the creation of the Center on Addiction and Substance Abuse at Columbia University to conduct and disseminate research that focused attention on alcohol and drug addiction, as well as on the means to prevent and treat it (1991–2002). It also funded Join Together to provide technical assistance and a communications strategy to disseminate the latest research and findings to prevention and treatment practitioners (1991–2005). Join Together On Line, created in 1991, was ahead of the curve in using Web-based technology to report on innovation. The *Developing Leadership in Reducing Substance Abuse* program (1998–2007) was created to train leaders who could advance research on the prevention and treatment of alcohol, drug, and tobacco problems. *Innovators Combating Substance Abuse* (1998–2006) honored creativity and exemplary accomplishment in understanding, preventing, and treating alcohol, drug, and tobacco issues. Recipients of the Innovators award have advanced alcohol screening in emergency departments, employed art to communicate the consequences of addiction, and led innovations in clean indoor air policies.
3. Yet another category focused on prevention. The Community Anti-Drug Coalitions of America (1996–2005) trained thousands of volunteer members of community coalitions to use the latest research findings on preventing drug and alcohol use among young people. *Free to Grow* (1992–2005) was created to build on the Head Start program and mobilize parents and community leaders to become aware of and combat the misuse of alcohol and drugs.
4. A final category focused on preventing underage alcohol use. The *A Matter of Degree* program (1995–2007) mobilizes colleges and neighboring communities to work together to curb drinking on and near campus. The *Reducing Underage Drinking Through Coalitions* program funds state and community coalitions to reduce drinking among high school students. The Center for Alcohol Marketing to Youth (2002–2006) analyzes target audiences for television, radio, and print advertising sponsored by

the alcoholic beverage industry. Its findings documented the presence of alcohol advertising whose target audience represents a disproportionately large share of people under twenty-one.

The programs funded by the Foundation during this second phase were based on the view that alcohol, drug, and tobacco use is deeply rooted in complex individual and societal norms and that this behavior can be changed through societal interventions that seek to decrease access to harmful substances. This view sees addiction as a behavior that has health risks rather than as an illness that is preventable and amenable to treatment. Prevention, therefore, is focused on the behavior and the environment of individuals, as it might be with any other problem that is primarily social in nature. In addressing other chronic medical conditions, the focus of prevention is often on the interaction of biological, genetic, behavioral, and environmental factors. Consistent with the perspective that views addiction as a social problem is the relative absence of emphasis on treatment. Most preventable health conditions are accompanied by well-developed treatment protocols and delivery systems addressing illness that has not been successfully prevented. Emergency departments, for example, are poised to treat accident victims who didn't wear seat belts; insurance pays for medications that mitigate diabetes when nutrition and exercise do not succeed. In the case of drug and alcohol addiction, only episodic attention had been given to the quality or the availability of treatment.

**Phase III: The Impact
Framework—Addiction
Prevention and Treatment**

In the 1990s, alcohol and drug use essentially stabilized when compared with the rates of the previous two decades. Between 81 and 84 percent of people twelve and older reported using alcohol in this decade, compared with a high of 89 percent in 1979.⁹ Drug use, while relatively stable through the 1990s, at between 33 and 36 percent for the lifetime use of any drug, increased slightly from the 31 percent reported in 1979. In 1993, Bill Clinton took office as president, and he publicly acknowledged his family's history of addiction.

Professionals in the field of prevention and treatment welcomed the new administration's support for the idea of reducing the demand for alcohol and drugs among young Americans. The hope was that this support would result in a new policy aimed at reducing demand and also in new resources to combat addiction. These heightened expectations went unmet, however. There were no significant new resources and no significant change in the policy of previous administrations, which allocated two-thirds of every government dollar spent in the so-called War on Drugs to interdicting the supply in foreign lands or on the streets of America. For the most part, the 1990s were socially conservative years, a time when individuals who were dependent on alcohol or drugs were denied disability benefits and addicted pregnant women were, in some states, incarcerated for child endangerment.

Still, the decade did see a significant growth in the scientific understanding of addiction and in the means to prevent and treat it. Both the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse developed research programs that advanced the understanding of the brain's response to alcohol and other specific drugs; research also advanced the understanding of pharmaceuticals that block or neutralize the effects of alcohol and drugs on the brain. The neurological dimension became crucial to understanding addiction as a medical condition. Research established a genetic link to alcohol problems and dependence. Moreover, the National Institute of

Drug Abuse and the federal Substance Abuse and Mental Health Services Administration commissioned the Institute of Medicine to conduct a study to determine and recommend how the positive results of clinical trials of pharmaceutical and behavioral interventions could be quickly adopted by treatment organizations. By 1998, the concept of addiction as “a brain disease” began to achieve prominence among professionals in the field.

The challenge was to get what was known to be effective into generally accepted practice. Building on the recommendations of the Institute of Medicine report, *Bridging the Gap Between Practice and Research*, the National Institute on Drug Abuse and the Substance Abuse and Mental Health Services Administration created initiatives designed to translate research into practice. Both linked treatment organizations and professionals directly with clinical researchers in networks created to design, conduct, and disseminate proven interventions. The model was lifted directly from the clinical trial network of the National Cancer Institute.

These developments provided the external political and scientific context that shaped the third phase of the Robert Wood Johnson Foundation’s work with alcohol and drug prevention and treatment.

A staff report to the board in 2000 and a new programming framework—drawing directly from the reservoir of scientific understanding of neurology, biology, and the psychosocial dimensions of addiction—described the role that dopamine receptors in the brain play in satisfying reward centers and cravings; the medications and proven clinical interventions available to treat addiction; and the significant gap between need, on the one hand, and available resources (including insurance) on the other. Viewing addiction as a chronic medical condition, the report concluded by recommending that the Foundation give priority to increasing access to quality treatment.

Even before this report, however, the Foundation had begun to move in a new direction with a \$21 million five-year program called *Reclaiming Futures*, which was authorized in 1999. The program aimed at helping adolescents caught up in the criminal justice system because of alcohol or drugs remain with their families and in school. To build connections among courts, families, treatment resources, and schools, the program provides training for judges, probation officers, and counselors as well as technical assistance and financial resources for courts and treatment agencies.

After the 2000 report, the Foundation authorized a series of new programs. *Paths to Recovery*, authorized in 2001, is a \$9.5 million five-year program that, among other things, seeks to redesign admission processes to promote quick access for patients, revamp intake systems to minimize intrusion and redundancy, and deploy counselors to increase retention in treatment programs. In 2002, the federal Substance Abuse and Mental Health Services Administration became a full partner in this effort through an initiative called Strengthening Treatment Access and Retention, effectively doubling the program’s size. Today there are more than forty treatment organizations, four states, and three managed care organizations participating in the program. Another Foundation-funded program, the \$3 million, four-year *Resources for Recovery*, which began in 2002, aims at maintaining or increasing the resources available to prevent and treat addiction, even at a time when states face severe fiscal constraints. It provides funds for experts in state financing to help the states draw full

potential benefits from the major federal and state programs targeted to addiction prevention and treatment.

Other programs that the Foundation funded in the early 2000s were aimed at developing treatment guidelines for adolescent services; studying the implications of California's Proposition 36 (approved by 61 percent of the voters in 2001, Prop 36 mandated treatment programs rather than jail for people convicted of minor drug offenses); and developing, in conjunction with governmental and nongovernmental partners, initial performance measures of effective treatment that can guide the buyers of drug treatments. Also, in response to a growing number of studies that showed the Drug Abuse Resistance Education program, or DARE, to be ineffective, the Foundation funded a \$13 million, five-year effort to redesign the DARE curriculum.

In January 2003, Risa Lavizzo-Mourey, who had recently become the Foundation's president and chief executive officer, presented the board with an "impact framework" to guide the Foundation's grantmaking. Improving the quality of addiction treatment was one of eight strategic objectives set forth in the statement. Specifically, the Foundation sought to improve the quality of addiction treatment by "increasing the number of addiction treatment settings that employ proven interventions."¹⁰ In carrying out the strategy, the Foundation would identify and address barriers to receiving effective care, including organizational obstacles that discourage continued patient engagement and reimbursement practices that discourage the adoption of effective interventions. It would also focus on the need to recognize and act on addiction as a chronic illness.

As one indication of the change in emphasis (and to avoid reinforcing the stigma of addiction), the name of the team working on this new approach within the Foundation was changed from the Alcohol and Illegal Drugs Team to the Addiction Prevention and Treatment Team. Also, the term "substance abuse" was dropped and replaced by such terms as "alcohol or drug problem or addiction" and "substance use disorder." The change in language reinforced the view that addiction is a health condition and avoided the stigmatizing implications of words such as "abuse," and "illicit"—terms better suited to a social problem addressed in the criminal justice system.

In the two years since the board adopted the impact framework, the Foundation has taken a number of steps to reach its objective of increasing the use of proven treatment practices:

First, grants were made to develop program-level measures of such practices. The aim is to work with federal and other partners to have a standard set of indicators for proven practices that can be included in national surveys of treatment programs. To date, the National Quality Forum, an organization in Washington, D.C., that develops standards for measuring health care improvement, has held a workshop that identified five practical candidates for inclusion in surveys:

- The appropriate use of screening and brief intervention tools.
- Assessment of patients with alcohol and opiate-specific diagnoses for pharmacologic interventions.
- Availability of proven behavioral interventions, such as motivational interviewing and contingency management.

- The use of aftercare and follow-up to maintain engagement.
- The use of “wraparound” supports such as job training and transitional housing and child care.

Second, federal, provider, consumer, and research groups have met and begun to identify principles for a demonstration program that will help treatment programs remove the obstacles to adopting proven practices.

Third, since the states, through health, child welfare, transitional assistance, and criminal justice programs, are the single largest purchasers and regulators of addiction treatment, a set of principles has been identified that can be used in a demonstration initiative to encourage states to use their influence to improve the quality of treatment. Examples of these principles include

- Buying services from networks rather than individual programs so that patients can move seamlessly across levels of care managed by different providers.
- Identifying and modifying policies that unintentionally discourage quality—such as reimbursement practices that prohibit payment for medication while reimbursing other services.
- Promoting diversity to better serve patients whose language, cultural, racial, or other attributes are different from those of the providers of treatment.
- Promoting practices that increase the role of the patients in managing the treatment and aftercare for their condition.

Even as phase III programs (those treating addiction as a chronic condition) are being developed, many phase II programs (those viewing addiction as a behavioral and societal issue) are being continued. These include the Partnership for a Drug-Free America, Community Anti-Drug Coalitions of America, the Center on Addiction and Substance Abuse, and Join Together, as well as the programs focused on reducing underage drinking. For programs whose funding is completed, such as Free to Grow, the Foundation is working to consolidate the knowledge gained and to share what was learned. For programs that continue, especially research and field-building initiatives such as the Substance Abuse Policy Research Program and Bridging the Gap, the Foundation is striving to align the remaining work with the phase III objectives.

The Road Ahead

The Foundation’s programming in the fields of alcohol and drug addiction will no doubt continue to evolve and reflect external events, current science, and internal perspectives. The Foundation is committed to increasing the number of treatment settings that employ evidence-based interventions. In addition to developing new programs, the Foundation recognizes the importance of maintaining the momentum of the earlier investments in the field.

Over the long run, the Foundation is looking toward an approach to treating drug and alcohol addiction that is based on a widely accepted model of treating chronic illness. This model has five core components:

Community Policies and Resources

These provide the context in which prevention, early intervention, treatment, and aftercare occur. In the past, an eclectic combination of practices developed, based on views of alcohol and drug use that ranged from criminal behavior to willful act to bio-psycho-social condition. Such views have led, in some instances, to policies that dictate the incarceration of drug users and then limit the educational, health, and other benefits needed for successful aftercare. In other instances, prevention efforts are managed exclusively by local law enforcement officials and are unconnected to screening or primary care opportunities. In yet others, policies governing health insurance allow the exclusion or the restriction of benefits and services for persons who seek help for alcohol and drug addiction. The future requires a continuum of prevention, screening, early intervention, treatment, and aftercare, supported by policies that prevent and treat addiction to alcohol or drugs rather than punish the people who are addicted.

A Responsive Delivery System

The delivery system should be available when the patient needs it and offer the level of care required by the patient at the time. Today's addiction prevention and treatment system is an aggregation of some fourteen thousand programs across the country. It lacks the capacity for coordinating care on behalf of a patient. The financially fragile system is still steeped as much in belief systems as in the science of prevention and treatment. Strengthening the system through infrastructure development, consolidation where it is appropriate, adoption of proven approaches, and use of quality improvement practices is critical to bringing about a responsive delivery system.

Clinical Information Systems

These systems provide the ability to consider all dimensions of a patient's needs over time. For alcohol and drug addiction diagnoses, privacy protections have been in place for many years, modeled on the anonymity principles of Alcoholics Anonymous. These provisions have served to protect patients from stigma and discrimination in the workplace and the community, but they have also served to isolate clinical information about addiction from other health-related conditions. Integrating clinical information, within the privacy protections of the law, is important not only to treat addiction effectively but also to treat other medical conditions that are affected by the use of alcohol and drugs.

Decision Supports

Decision supports guide and promote effective practice in any prevention or treatment activity. A sizable literature has shown what practices are effective in preventing and treating alcohol and drug misuse. For example, the Substance Abuse and Mental Health Service Administration's Treatment Improvement Protocol Series and the National Registry of Effective Programs and Practices document approaches and protocols applicable to preventing and treating alcohol and drug problems. The challenge is adopting what has been shown to work.

Active and Engaged Consumers

Committed patient-participants are essential to monitoring progress, educating others, and advocating for the resources needed to manage chronic illness. On one hand, the addiction treatment field excels at creatively using patients. The self-help movement represents an aftercare peer support network that is the envy of any system that treats chronic illness. Until recently, as many as 50 percent of the counselors working in addiction treatment were themselves at one time problem users or were addicted to alcohol and drugs.¹¹ On the other hand, alcohol and drug treatment programs are known for rules that forbid patient contact with social and family networks and discharge patients for violating essentially procedural rules or not complying with protocols and similar practices that marginalize the patient. A newly emerging consumer movement has the potential to build on the strengths derived from the heavy involvement that consumers traditionally have had in this field and to become a force for more and better resources at the community level.

Spanning the Prevention-Treatment Divide

Every year, as the new school year begins, the government releases data from tracking surveys that detail past month, past year, and lifetime reported use of alcohol and a large number of specific drugs by age group for people twelve and older. The reports cite variations in reported use from the previous year that, depending on the direction of the trends, are cause for alarm or for cautious celebration and become focal points for further action.¹²

Less often is a long-term view taken on prevalence in these reports. That long-term view would show generational changes in drug and alcohol use but not wide variation of use patterns within ten-year intervals.¹³ If there is a relatively constant rate of prevalence for alcohol and drug use over many generations, it would seem logical to conclude that multiple strategies are needed until sufficient knowledge is gained about the interaction of neurological, biological, and genetic predispositions with the social context that results in addiction. The divide between those who view addiction to alcohol and drugs as totally preventable and those who view it as totally treatable has been based more on assertion and belief than on science. Learning from other chronic illness, the nation's health authorities have put in place broad prevention strategies and education aimed at informing the behaviors of Americans to exercise, eat right, and avoid environmental and behavioral risks. These are demonstrated approaches to reducing cardiovascular disease and diabetes. In addition to this knowledge and these demonstrated approaches to preventing illness, the nation maintains a standing capacity for treating these conditions in both primary and specialty care settings. Now the nation needs the same capacity for reducing exposure to alcohol and drugs and for preventing and treating addiction.

Notes

1. Office of Applied Studies. "Highlights of Findings." 2002 *National Survey on Drug Use and Health*. Rockville, Md.: Substance Abuse and Mental Health Services Administration (SAMHSA). DHHS Publ. No. SMA 03-3774, 2002, pp. 6–10.
2. McGinnis, J. M., and Foege, W. H. "Mortality and Morbidity Attributable to the Use of Substances in the United States." *Proceedings of the Association of American Physicians*, 1998, 111(2), 109–118.
3. D'Onofrio, G., et al. "Patients with Alcohol Problems in the Emergency Department, Part 1: Improving Detection." *Academic Emergency Medicine*, 1998, 5(12), 1200–1209.
4. Walsh, D. C., et al. "A Randomized Trial of Treatment Options for Alcohol-Abusing Workers." *New England Journal of Medicine*, 1991, 325, 775–782.
5. Office of Applied Studies. Table 2.8, Trends in Reporting Alcohol and Tobacco Use in the Past Month by Age Group: 1979–1998. *National Household Survey on Drug Abuse: Main Findings 1998*. Rockville, Md.: Substance Abuse and Mental Health Services Administration (SAMHSA). DHHS Publ. No. SMA 99-3327, 2002, p. 31.
6. NIAAA, Press Release. "Youth Drinking Trends Stabilize, Consumption Remains High." Sept. 14, 2004, p. 1.
7. For a full discussion of the parents' movement, see Massing, M. *The Fix*. New York: Simon and Schuster, 1998, pp. 166–176.
8. Wielawski, I. "The Fighting Back Program." *To Improve Health and Health Care. Vol. VII: The Robert Wood Johnson Foundation Anthology*. San Francisco, Jossey-Bass, 2004.
9. Office of Applied Studies. Table 2.2, Trends in Percentage of Respondents Aged 12 and Older Reporting Drug Use in Their Lifetime: 1979–1998. *National Household Survey on Drug Abuse: Main Findings 1998*. Rockville, Md.: Substance Abuse and Mental Health Services Administration (SAMHSA). DHHS Publ. No. SMA 99-3327, 2002, p. 25.
10. In January, 2005, the Foundation's board of trustees approved extending the time frame of this work through 2009.
11. Roman, P., et al. National Treatment Center Study, Summary Report. University of Georgia (Athens campus), Sept. 2004, p. 8; see also Northwest Frontier Addiction Technology Transfer Center. *Advancing the Current State of Addiction Treatment: A Regional Needs Assessment of Substance Abuse Treatment Professionals in the Pacific Northwest*. Salem, Ore.: Author, 2004, p. 18.
12. Monitoring the Future survey; for a complete description, see (www.monitoringthefuture.org).
13. Office of Applied Studies. Table 2.6, Trends in Percentage Reporting Drug Use in the Past Year, by Age Group: 1979–1998. *National Household Survey on Drug Abuse: Main Findings 1998*. Rockville, Md.: Substance Abuse and Mental Health Services Administration (SAMHSA). DHHS Publ. No. SMA 99-3327, p. 29.