THE ROBERT WOOD JOHNSON FOUNDATION

Annual Report 2000

THE CHALLENGE OF SUBSTANCE ABUSE

Ten Years of Grantmaking

Provide *Build* *Establish* *Create* *Integrate* *Develop*

SIX STRATEGIES FOR COMBATING SUBSTANCE ABUSE

In 1991, The Robert Wood Johnson Foundation made reducing the harm caused by substance abuse one of its goals. Since then, we have pursued six strategies to build capacity and support for substance abuse treatment and prevention: provide long-term support for innovative institutions; build public interest and support; establish community-based service and demonstration projects; create and communicate new knowledge; integrate prevention and treatment strategies into the legal and medical systems; and, develop careers in substance abuse fields.

OPEN FLAP TO SEE AN OVERVIEW OF OUR EFFORTS IN FIGHTING SUBSTANCE ABUSE

The Robert Wood Johnson Foundation's Fight Against Substance Abuse

TEN YEARS OF GRANTMAKING

Prior to 1988, The Robert Wood Johnson Foundation (RWJF) made only six grants targeting substance abuse. In 1988, the Foundation began to address alcohol and drug abuse under the priority area of "reducing destructive behavior." In 1991, the Foundation made "to promote health and prevent disease by reducing harm caused by substance abuse" one of its four funding goals. In 1996, the goal was amended. Since then, it has been "to promote health and reduce the personal, social, and economic harm caused by substance abuse—tobacco, alcohol, and illicit drugs." From 1988 through 2000, the Foundation authorized nearly $780 million to support projects designed to address substance abuse, including alcohol and tobacco. The timeline below features a representative selection of projects funded over the years.*

1991 RWJF ADOPTS A GOAL TO COMBAT SUBSTANCE ABUSE

	1987	1988	1989	1990	1991	1992	1993	1994	1995
TOTAL # OF GRANTS	377	364	427	360	416	584	587	549	754
TOTAL # OF SUBSTANCE ABUSE GRANTS	3	7	21	32	45	75	86	107	83

1988 — Vanderbilt University receives funding as the national program office for *Fighting Back: Community Initiatives to Reduce Illegal Drugs and Alcohol.*

1989 — The Media-Advertising Partnership for a Drug-Free America, Inc., is funded to undertake a national media drug abuse prevention program.

1990 — The Intergovernmental Health Policy Project at George Washington University receives support to produce reports for state policymakers on substance abuse issues.

1991 — Stop Teenage Addiction to Tobacco is funded to implement community-wide projects in Perth Amboy, N.J., Springfield, Mass., San Jose, Calif., and Seattle, Wash., to reduce adolescent tobacco use.

1992 — The Harvard University School of Public Health is funded to conduct a national study of drinking patterns and practices among college students.

1993 — The American Medical Association receives funding as the national program office for *SmokeLess States: Statewide Tobacco Prevention and Control*.

1994 — The American Alliance for Rights & Responsibilities receives funding for *One Church—One Addict*, a program to train members of church congregations to become support teams for individuals in recovery from substance abuse.

1995 — The Foundation authorizes *A Matter of Degree: Reducing High-Risk Drinking Among College Students*, with the American Medical Association as the national program office.

* Authorized funds are approved in the year indicated and paid in that year or subsequent years.

947 172	1,048 178	1,001 163	756 156	822 168
1996	1997	1998	1999	2000

1996

The Foundation provides major funding to establish The National Center for Tobacco-Free Kids, a free-standing, communications-oriented organization seeking to reduce tobacco use among youth. Co-funders include the American Cancer Society, the Annie E. Casey Foundation, and the Hilton Foundation.

1997

The Brown University Center for Alcohol and Addiction Studies is funded to study the impact of community policing on the reduction of substance abuse.

1998

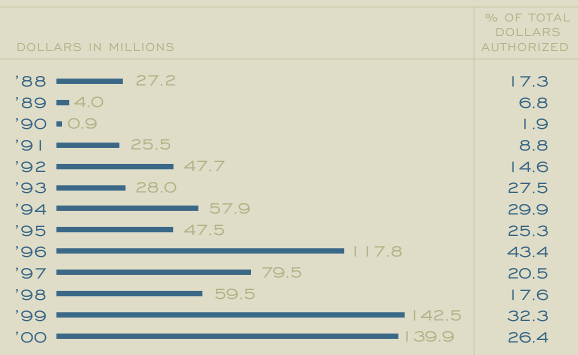
The Entertainment Industries Council, Inc., receives funding to encourage the accurate portrayal of substance abuse and addiction by the entertainment industry.

1999

The Public Relations Society of America Foundation Inc., is funded to conduct Kids in a Drug-Free Society, a communications-based initiative to increase discussion between parents and their children about drugs.

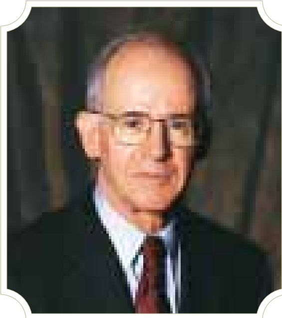
2000

Brigham and Women's Hospital in Boston is funded to conduct a randomized controlled trial of a sustained release drug for prevention of relapse in women who quit smoking during pregnancy.



The Challenge of Substance Abuse

TEN YEARS OF GRANTMAKING



STEVEN A. SCHROEDER, MD
President and CEO

Today The Robert Wood Johnson Foundation (RWJF) is deeply invested in combating the devastating effects of illegal drug use and the abuse of alcohol and tobacco. It is one of three goals that define our grantmaking priorities. In 2000, 26 percent of the grant money we authorized*—almost $140 million—went toward programs to address substance abuse.

But we have not always been so committed to addressing substance abuse. Before the late 1980s substance abuse was hardly on our radar screen. Looking back, it is striking that a Foundation whose mission is "to improve the health and health care of all Americans" overlooked smoking, the number one preventable cause of death—not to mention drug and alcohol abuse, which do so much damage to our nation's health and social fabric.

It was in 1991 that the Foundation formally adopted a goal of reducing substance abuse. Since then we have learned a great deal about the problem, efforts to address it, and the nature and extent of the role one philanthropy can play. Our 10-year experience has given us a perspective on the future, one that teaches us what we are best suited to do, and gives us hope for continued progress.

HISTORY

Why did we not see combating substance abuse—especially tobacco use—as a worthy philanthropic initiative? Part of this was due to RWJF's heavy focus on the health care portion of its mission—especially access to care—in its first 20 years. But other obstacles also prevented the Foundation from taking the plunge into the field of substance abuse, including tobacco control. Many of our efforts have been staff driven and in our early years, there were no advocates on staff who pushed for our involvement. Related to that was the stigma of substance abuse, which made this issue difficult for some people to embrace. Also, tobacco was part of our culture, as reflected in the smoke-filled meetings of our own Board. Finally, there was deep concern because taking on tobacco use and alcohol abuse meant a position against some powerful industries.

EARLY EFFORTS

Although my comments only pertain to our Foundation's role, I think our efforts track philanthropy's course in this field. Grantmaking is only as good as the understanding of an area—its gaps, opportunities, leadership, and levers for change. The

*Authorized funds are approved in the year indicated and paid in that year or subsequent years.

STRATEGY 1

Provide

LONG-TERM SUPPORT FOR INNOVATIVE INSTITUTIONS

MATTHEW MYERS

Matthew Myers is the president of The National Center for Tobacco-Free Kids®.

"Over the last 35 years a great deal of progress has been made in the effort to reduce tobacco use. But until the creation of the Center, there was no organization with meaningful resources or significant staff devoted exclusively to reducing tobacco use, particularly among children.

The first thing the Center did was to involve tobacco control advocates and people in relevant fields, such as social marketing and advocacy, in a detailed planning process. The goal was to develop a long-term multi-disciplinary plan to change the environment in which tobacco use and public policy decisions concerning tobacco are made.

The Center's use of social marketing and paid advertising have broken new ground for the movement. The Center's ability to think longer term, to use polling and scientific research and to react quickly has enabled the public health community to better set the agenda and frame the debate on tobacco issues and has provided the media with a credible resource of information. And with our ability to look ahead, the Center is now a catalyst for setting and implementing policy priorities."

Matthew L. Myers

STRATEGY 2

Build
PUBLIC INTEREST AND SUPPORT

MARY SUE COLEMAN, PhD

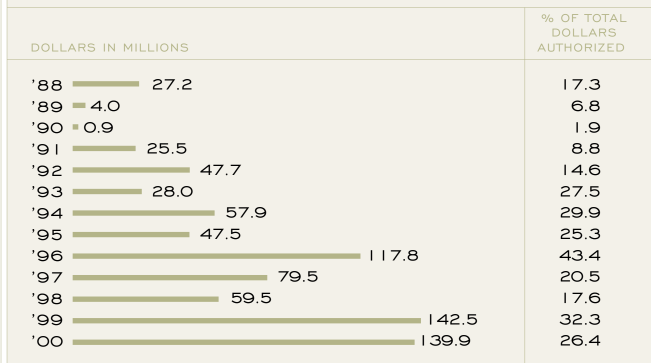
Mary Sue Coleman is president of the University of Iowa. The University of Iowa is a grantee of A Matter of Degree: Reducing High-Risk Drinking Among College Students.

"I've been president of the University of Iowa for six years. Six months before I started, an 18-year-old fraternity brother died as the result of alcohol poisoning. This was a terrible tragedy that shocked the campus. So, the issue of excessive drinking has long been a concern of mine.

We call our project Stepping Up and it involves not just the university but the whole community. We're focusing on sensitizing the community to the secondary effects of alcohol abuse such as vandalism, sexual assault, and disorderly conduct in public. We know how much this affects local business. Basically, we took a page from the fight against big tobacco: Concentrate on the secondary effects.

In the past five years, I believe that we've raised consciousness both on campus and in the community. But, we have a long way to go. One of the things we need to do in the future is reach out to kids when they're in high school. That's when excessive drinking starts and it's when expectations about excessive drinking in college are learned."

Mary Sue Coleman



Source: The Robert Wood Johnson Foundation.
*Includes items coded >50% substance abuse.

investment choices philanthropies make reflect the understanding of significant opportunities.

RWJF began to recognize substance abuse as a target for philanthropic investment in the late 1980s. In 1988, when Leighton E. Cluff, MD, became our second president, 10 new specific areas of priority were adopted; alcohol and drug abuse were included under the priority of "reducing destructive behavior." Tobacco, however, was not included.

Our first significant effort was *Fighting Back®: Community Initiatives to Reduce Demand for Illegal Drugs and Alcohol*, a multisite program authorized in 1988. The $26.4-million investment was not only RWJF's largest program to date, but at that time it was the single largest commitment of private funds in this country to combat drugs. In fact, it equaled the combined funding for drug and alcohol abuse from all other foundations in 1987.

In 1989, RWJF provided $3 million to help launch The Partnership for a Drug-Free America, a national media campaign aimed at taking the glamour out of illegal drug use. We are still funding Fighting Back and the Partnership.

These were big steps for RWJF and for philanthropy. But from my perspective as a clinician not yet working for the Foundation, these concerns were hardly a match for the destruction wrought by substance abuse. Like every clinician, I saw alcohol and illegal drugs ravage the health of patients. I also watched with dismay as tobacco industry marketing continued to reel in new smokers. And my years as an epidemiologist at The Centers for Disease Control and Prevention (CDC) also dramatized for me the public health impact of substance abuse on our nation. So when I interviewed with the Board of Trustees for the job of president at RWJF, I said that I would like to see the Foundation consider a greater presence in the substance abuse field, including tobacco.

FORMALIZING THE GOAL

In 1991, after I joined the Foundation, we held a retreat with our Board of Trustees to discuss adopting a new goal area. Among the three proposed goals was one that would target substance abuse. While there was no disagreement about the strength of the public health case, the discussion was spirited. Our trustees had serious concerns about what a commitment to substance abuse would mean for the Foundation.

They had some tough questions: Would we become embroiled in controversial issues like the legalization of drugs? Would we become entangled with law enforcement? How would the corporations that produce and sell tobacco and alcohol products react? How would we steer through the complicated issues of personal choice when legal products are involved? Further, how would we deal with the fact that alcohol is apparently healthy at some doses? What could all this controversy do to the Foundation's reputation?

Some trustees did not want to include tobacco and alcohol because they are legal substances with powerful industries behind them, but others argued that since they take a heavier toll than illegal drugs, there was no public health justification for omitting them. Tobacco caused the most consternation, but a handful of trustees pushed hard for it, drawing heavily on the public health data.

Finally, a compromise was crafted. Our efforts to combat substance abuse would include alcohol and tobacco, but those efforts were to focus initially on youth, for whom the substances are illegal. It was tough sledding getting there, and we almost didn't make it. But ultimately, for the first time in its history, RWJF had a goal that focused on the health part of its mission.

SIX STRATEGIES

Our initial focus on youth naturally led us to emphasize substance abuse prevention and treatment. Early on in this endeavor we recognized that we would only make significant gains if the nation focused more on substance abuse prevention and treatment than on combating the illegal drug trade. So we have worked to build capacity and support for prevention and treatment efforts in six ways.

First, we have provided long-term support for innovative institutions to bring the best resources to bear on the problem. One example is The National Center on Addiction and Substance Abuse at Columbia University, New York City, which is helping to provide leadership and raise the quality and visibility of research on substance abuse. Another example is *The National Center for Tobacco-Free Kids®*, a collaborative effort with other foundations and associations. The National Center for Tobacco-Free Kids was the first ongoing institution created to counter the tobacco industry's aggressive campaign to hook kids. The Center's $13-million annual budget is small

STRATEGY 3

Establish

COMMUNITY-BASED SERVICE AND DEMONSTRATION PROJECTS

JEANNIE VILLARREAL

Jeannie Villarreal has worked in several capacities at the Vallejo Fighting Back Partnership including development specialist and recovery coordinator. At present, she is a project coordinator there.

"If a community wants to admit there's a problem with substance abuse, it becomes a very scary thing if they don't have the tools to address the problem. At the state level it's too impersonal, and at the personal level it's too difficult. At the community level, it's personal enough because people see the direct results. They can do so much more together than they could individually. What we've done here in Vallejo is we've let people realize that they can be part of the solution.

Fighting Back is unique. It brings everyone to the table. Not just professionals who work on one aspect of the problem, but addicts are brought to the table, parolees come to the table, prostitutes. I work with RAFT, Recovering Advocates for Treatment. By coming together as an organization, we lend support to each other, we're much more credible. People don't think that people have long-term recovery. By changing public perceptions, people will be more invested in supporting treatment."

J Villarreal

STRATEGY 4

Create

AND COMMUNICATE NEW KNOWLEDGE

LORRAINE COLLINS, PhD

Lorraine Collins is a senior research scientist at the Research Institute on Addictions at the University at Buffalo, State University of New York. Dr. Collins serves as a senior program consultant to the Substance Abuse Policy Research Program (SAPRP).

"Clinical and policy research have played important roles in reducing the suffering caused by substance abuse.

Past policy approaches to substance abuse were largely based on individual and anecdotal experiences. This occurred during an era when substance abuse wasn't even considered a medical problem; there was a general attitude of denial and ignorance about the effects of drugs and alcohol. Dependence was a moral issue. Then it became clear that we also needed to work on preventing substance abuse.

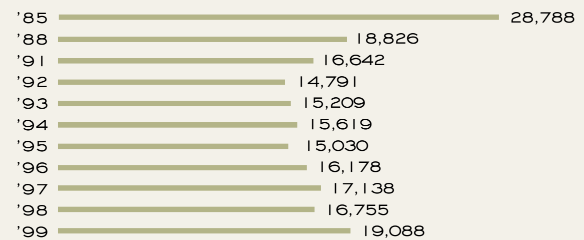
Policy and prevention work hand in hand. Substance abuse is a very complex problem. So, we have to study the many factors that contribute to it.

SAPRP funds research that tries to identify policies that both prevent and promote the use of alcohol, tobacco, and illicit drugs. Information from both perspectives is important. With our funding, investigators are able to explore all aspects of substance abuse policy; the sort of work that is typically not funded by other agencies. Results of SAPRP-funded research have played an important role in informing substance abuse policy at the national, state and local levels, as well as at private institutions."

L. L. Collins

NUMBER OF PEOPLE AGE 12 AND OLDER WHO REPORTED ANY ILLEGAL DRUG USE DURING THE PAST MONTH, 1985–1999

IN THOUSANDS



Sources: 1997 and 1999 National Household Survey on Drug Abuse. *Substance Abuse and Mental Health Services Agency [Online]. Available at http://www.samhsa.gov/oas/NHSDA/1997 Main/nhsda1997mfWeb-15.htm #Table2.4. [1999, April]*, and *http://www.samhsa.gov/oas/NHSDA/1999/Chapter4.htm #P167_10740 [2000, August]*, respectively. Historical National Population Estimates: July 1, 1900 to July 1, 1999. *U.S. Census Bureau [Online]*. Available at *http://www.census.gov/population/estimates/nation/popclockest.txt [2000, June 28]*.

compared to the approximate $5 billion the tobacco industry spends on marketing each year. But it is an important, powerful counterpunch that has increased the visibility of the problem of youth smoking in this country.

Our second approach is to build public interest and support. This means overcoming not just public apathy but public antipathy toward substance abusers—some of the same attitudes we struggled with internally when we first began to consider taking on this issue. We are working to change public perceptions about the substance abuser and the causes of substance abuse, largely through the media.

Our support of public education efforts began on a large scale with the support of The Partnership for a Drug-Free America in 1989. More recently, we are proud to have funded Bill Moyers' extraordinary 1998 PBS® series, "Moyers on Addiction: Close to Home," and the extensive outreach effort that accompanied it. Our media initiatives also include the PRISM™ awards, which we co-sponsor with the National Institute on Drug Abuse. These are awards given to Hollywood filmmakers for excellence in creative work dealing with substance abuse.

Our public education efforts are not limited to the media. We also support an effort to enlist and help the spouses of state governors to serve as state and national spokespersons on the issue of underage drinking. As of this writing, 29 spouses are participating in the effort.

Research underpins these communication efforts. Henry Wechsler's work on college binge drinking, for example, is helping to move public attitudes toward college drinking from an acceptable rite of passage to the serious social and public health crisis that it is. Similarly, a grant we gave to The Public Relations Society of America Foundation, Inc., to help parents talk with their kids about substance abuse is supported by results from The Partnership for a Drug-Free America's Attitude Tracking Study that found a majority of parents "wish they knew better what to say," and, results from the National Longitudinal Study on Adolescent Health from the University of North Carolina at Chapel Hill that found that parental influence can help kids avoid dangerous behaviors.

A third strategy is to establish community-based service and demonstration projects to combat the sense of hopelessness and complacency in communities

SUBSTANCE ABUSE TREATMENT IN JUVENILE CORRECTIONAL FACILITIES, 1997

3,561	Total Number of Juvenile Correctional Facilities [a]
1,143	Number of Juvenile Facilities Offering Substance Abuse Treatment [b]
105,790	Number of Juvenile Offenders in Residential Placement [c]
27,152	Number of Residents in Juvenile Correctional Facilities Receiving Treatment for Substance Abuse [d]

Note: There is little research on the number of Juvenile Facility Residents who need substance abuse treatment. However, unpublished research done in Cook County, Illinois by Linda Teplin found that 49% of boys and 46% of girls in juvenile detention met the clinical criteria for substance abuse and dependence.

Sources: (a) and **(c)** Census of Juveniles in Residential Placement: 1997 Databook, *Office of Juvenile Justice and Delinquency Prevention [Online]. Available at http://www.ojjdp.ncjrs.org/ojstatbb/Cjrp97/cjrp.html #ResponseRate [2000, October 20]* and *http://www.ojjdp.ncjrs.org/ojstatbb/cjrp97/openpage.asp [2000, October 20]*, respectively.

(b) and **(d)** Substance Abuse Treatment in Adult and Juvenile Correctional Facilities: Findings from the Uniform Facility Data Set 1997 Survey of Correctional Facilities. *Substance Abuse and Mental Health Services Agency [Online]. Available at http://www.samhsa.gov/oas/UFDS/CorrectionalFacilities97/4alle.htm [2000, April]* and *http://www.samhsa.gov/oas/UFDS/CorrectionalFacilities97/8juvb.htm [2000, April]*, respectively.

beleaguered by substance abuse. An important part of these efforts is expanding treatment for substance abusers. Our alcohol and drug abuse programs extend from the hard-hit urban and rural areas participating in our Fighting Back program, to the college campuses where we are trying to reduce binge drinking. We also provide technical assistance for community efforts through our support for Join Together and the Community Anti-Drug Coalitions of America.

A fourth approach is to create and communicate new knowledge, particularly about prevention and treatment. RWJF's premier contribution in this category has been long-term support of our *Substance Abuse Policy Research Program (SAPRP)*. This investigator-initiated research program has informed policy debates and stimulated policy action at all levels of government. For instance, one SAPRP-sponsored study showed that putting an annual cap of $10,000 per member on substance abuse treatment benefits under managed care—as compared to offering an unlimited benefit—only saves six cents per member per year. It is an important finding because dispensing with a cap will increase access to high quality substance abuse treatment for those who need it.

Fifth, we are working to integrate the most effective prevention and treatment strategies into the legal and medical systems. Our Board recently approved a new component of Join Together to foster policies at the national, state, and local levels that would expand treatment opportunities. The Board also approved a program aimed at expanding treatment for young people caught up in the juvenile justice system. Currently, there is little appropriate treatment in this system for youths with substance abuse problems. Working with juvenile court judges and communities, the program will develop new service delivery models that integrate comprehensive care into the juvenile justice system and promote community-based care for young offenders. We also have programs to help integrate smoking cessation efforts and techniques to address alcohol abuse into managed care settings.

Our sixth approach is career development, which is at an earlier stage. SAPRP illustrates how a foundation can seed and grow a field. Although nearly a third of the investigators we have funded since 1997 had little or no prior experience in the field, about three out of four have reported that their SAPRP grant has lead to additional work in substance abuse policy.

STRATEGY 5

Integrate

PREVENTION AND TREATMENT STRATEGIES INTO THE LEGAL AND MEDICAL SYSTEMS

JAMES RAY, JD

The Honorable Judge James Ray is the administrative judge of the Lucas County Juvenile Court in Toledo, Ohio. Judge Ray was an invited participant in the Juvenile Justice and Substance Abuse National Planning Meeting which contributed to the development of the Reclaiming Futures™ national program.

"Our data shows that 75–80 percent of youths who commit crimes are harmfully involved with alcohol and other drugs. Many are under the influence when they commit the crime. I ask them, "Would you have done this had you been straight?" And, they say "No." That tells you that they're not criminals—yet. They have a substance abuse problem.

Say there's a kid who smokes marijuana every day and gets drunk a few times a week. He breaks into a home to steal something to sell and buy drugs. He's caught. He's brought to court. The presenting issue is the theft, not drug abuse. Often as a judge your hands are tied. There are some jurisdictions where you can't order treatment for alcohol or drug abuse unless there is a finding of delinquency based on an alcohol or drug offense.

The ideal situation would be that we can effect an intervention addressing the substance abuse immediately which will prevent future crime. We need assessment on demand, intervention on demand. When needed, treatment should begin within 72 hours. But, more often than not, the resources just aren't there."

James Ray

STRATEGY 6

Develop

CAREERS IN SUBSTANCE ABUSE FIELDS

JOHN SLADE, MD

John Slade is the director of the Program in Addictions at the University of Medicine and Dentistry of New Jersey, School of Public Health. Dr. Slade has directed a number of programs for the Foundation and is presently director of two national programs: Developing Leadership in Reducing Substance Abuse and Innovators Combating Substance Abuse.

"Among the diverse callings in the health field, working in substance abuse has a low status and is far less glamorous than most. This is a pity because of the enormous good that can be done.

One of the things that discourages people from entering the field is that the way society at large stigmatizes addictions is often reflected in professional training. As a result, there are few mentors cultivating the next generation in the field. This is a shame because the prospects for making a substantial difference are great.

Compared to many other diseases, recovery rates from addiction are very high.

For a long time, doctors in training were taught that it was only worthwhile to help addicts when they were ready to address the problem. Up to that point, there was nothing to offer. We now know that this harsh line is wrong. Gradually, we've gotten better at understanding the impact of the environment and at learning the ways that motivation can be enhanced. Moreover, environmental approaches prevent addiction."

Now we are trying to build the field with two new programs. *Developing Leadership in Reducing Substance Abuse* is a program designed to attract and inspire new leaders to the field of substance abuse prevention; *Innovators Combating Substance Abuse* recognizes five senior researchers each year who have made significant contributions to the field.

Together, these six strategies are intended to build an infrastructure of institutions and individuals that work at the national level, the community level, and across the two. They also work to provide evidence, examples, and a platform from which to highlight the problems of substance abuse and to bring prevention and treatment into the mainstream.

CHALLENGES

The main challenge for all of us is moving the issue of substance abuse onto the public agenda—getting policymakers, professionals, and the public to engage and make it a high priority. Why has it been so difficult to get people to care?

Certainly a significant factor is stigma—the certain distaste some have for working with people with addictions. We saw some of that at the Foundation when, early on, staff and trustees were not eager to take on the issue.

We also have a defining civil liberty/free choice ethos in this country that gives people the right to abuse themselves. And yet when people do that, we blame them for it and we are less inclined to help them.

It is a real paradox that as a nation we are willing to spend lots of money to try to cure patients with diseases that have dismal prognoses, such as pancreatic cancer and amyotrophic lateral sclerosis (ALS), yet we dismiss substance abuse treatment programs with higher success rates—15 to 20 percent cured, or as high as 90 percent in the case of returning Vietnam veterans addicted to heroin. Somehow we have to overcome this double standard.

Our concern for substance abuse by youths often clashes with ideas of how young people become adults. Lifetime addictions often begin with youthful experimentation—that's why so much effort is going into preventing substance abuse by young people. But such experimentation is also seen as a rite of passage. We often have trouble distinguishing when that early smoke or drink is just "kids being kids," from when it is a warning sign of serious trouble. We are dealing with substances that require us to try to draw a

line between the natural adolescent tendency to experiment, the natural human tendency to seek pleasure, and the need to prevent harm. It is difficult to imagine a social consensus anytime soon on where to draw that line.

A sense of futility also plagues the issue. I have been struck by the pervasive sense of hopelessness that I have encountered when talking to editorial boards and others. "Why bother?" they say. "It is hopeless." Substance abuse has not been a field with easy or obvious fixes. And substance abuse is often so entwined with other life problems that it is easy to get overwhelmed and to despair that the task is beyond us.

The field also has a leadership problem. At the grassroots level, there is a striking lack of leaders—particularly in tobacco and illegal drug use. We don't have parents' groups up in arms over youth smoking or families that have been devastated by drug abuse mobilizing for more treatment or prevention programs.

Recently, many families which have members with mental health problems have overcome their sense of embarrassment and stigma and formed powerful advocacy groups. Perhaps new knowledge about genetic contributions to mental illness made it easier for parents to overcome their previous reticence, knowing that poor parenting did not "cause" their children's illness. My hope is that similar advocacy groups will soon appear on behalf of those afflicted with substance abuse.

At the national level, leadership is noticeably fragmented. People become exceptionally invested in a particular approach and thus, close-minded to others. Sporadic, unpredictable, and fragmented funding has left "orphans" who resent others getting funds ahead of them. They have become martyrs and it is difficult for them to shed that embattled mentality. There is infighting and divisiveness, as we saw over the money from the tobacco settlement, and a sense that some players value being correct more than being successful.

As I mentioned earlier, the field lacks sufficient incentives to draw in the best and the brightest. The leadership suffers from a lack of diversity. I recall an early meeting we held with Bill Moyers and substance abuse experts as we began planning for his PBS show on addiction. Every expert was a white male.

Sources: Substance Abuse: The Nation's Number One Health Problem, p-61. *Schneider Institute for Health Policy, Brandeis University, February 2001.*

Another formidable obstacle to effective policy change has been the power of the tobacco and alcohol industries and the fact that they deal with legal substances. It loomed in our Board meetings, as it has at all levels of government. These companies use sophisticated marketing to drive sales and we all know that they play hardball with anyone who tries to get in their way. This intimidation has been an enormous weapon.

HOPE NOW AND FOR THE FUTURE

These barriers and frustrations challenge all of us. But looking at the Foundation, I am heartened by how comfortable our staff and trustees now feel on this issue. As we came to appreciate the staggering impact of substance abuse, our engagement and commitment deepened. When I think back to how controversial tobacco seemed in 1991, I can laugh at a comment made a couple of years later by a trustee who had been a vocal opponent of including tobacco. The Foundation was considering grants regarding health care reform, and he pleaded, "Can't we do something non-controversial, like smoking?"

Just as the hesitation in the philanthropic world a decade or so ago mirrored the larger society, I think the commitment and increased sense of possibility we now see at the Foundation has a promising counterpart there. So I see a number of reasons for optimism at this stage. Let me mention a few of them.

We all should take heart and celebrate some remarkable progress in the last 10–15 years. Think of that sense of hopelessness I heard from editorial boards, all the hand wringing that was going on in the 1980s about taming the substance abuse beast, and look at the social turnaround we have seen.

The number of people who use illegal drugs monthly dropped from 23.3 million in 1985 to 13.6 million in 1998. That's 9.7 million fewer users, a 42 percent drop. Criminologists tell us that reductions in crack cocaine use were important factors behind remarkable declines in murder and violent crimes in the 1990s. Homicide rates have gone from 9.4 per 100,000 inhabitants in 1990 to 5.7 per 100,000 in 1999; aggravated assaults dropped from 424.1 to 336.1 per 100,000 inhabitants during the same time. Rates of drug and tobacco use among youth were also on the rise and now are stabilizing or even declining. Arrests for driving under the influence have dropped—down 18 percent from 1990 to 1997, even as the number of licensed drivers rose 15 percent. And the declines

DEATHS FROM ALCOHOL-RELATED TRAFFIC INJURIES CONTINUE TO DECLINE, 1985–1999

	TOTAL NUMBER OF TRAFFIC FATALITIES	ALCOHOL-RELATED TRAFFIC FATALITIES	
		NUMBER	PERCENT
'85	43,825	22,716	52
'86	46,087	24,045	52
'87	46,390	23,641	51
'88	47,087	23,626	50
'89	45,582	22,404	49
'90	44,599	22,084	50
'91	41,508	19,887	48
'92	39,250	17,858	46
'93	40,150	17,473	44
'94	40,716	16,580	41
'95	41,817	17,247	41
'96	42,065	17,126	41
'97	42,013	16,189	39
'98	41,501	15,935	38
'99	41,611	15,786	38

Source: Substance Abuse: The Nation's Number One Health Problem, p-52.
Schneider Institute for Health Policy, Brandeis University, February 2001.

in motor vehicle-related deaths are in large part due to reductions in drunk driving.

An array of research and communication efforts is giving substance abuse high public visibility. The power of the numbers helped persuade our Foundation to give the field priority, and that message about the impact of substance abuse and the effects of current policies is reaching the public like never before.

Public Service Announcements (PSAs) are improving as we become increasingly adept at drawing on the tools of Madison Avenue for a burgeoning social marketing campaign. Additionally, a number of efforts are moving beyond trying to place PSAs for free and are purchasing air time to ensure their spots run in the best time slots. The American Legacy Foundation, which was funded out of the tobacco settlement, is boosting this effort.

Public attitudes are changing. Thirteen years ago we had a smoke-filled board room at The Robert Wood Johnson Foundation, and no one thought much about it. Today we expect smoke-free workplaces and public spaces. The longtime public image of the tobacco industry as invincible has collapsed in the wake of successful lawsuits. Also, the FDA initiative has put the industry on the defensive like never before. And the focus on smoking as a pediatric disease has given the issue greater resonance and urgency for many people.

The dangers of youth drinking have sparked successful citizen activist groups like Mothers Against Drunk Driving® and Students Against Drunk Driving. They are changing public perceptions as they are changing local laws. And, as I mentioned, drunken driving arrests and motor vehicle fatalities are declining.

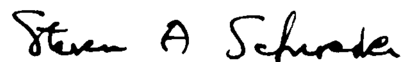
Cutting edge research, particularly in the neurosciences, is another plus. New findings about common pathways in the brain—and brain changes induced by addictive substances—have treatment and policy implications that could significantly change how we approach addicts and addiction. As Alan Leshner, PhD, director of the National Institute on Drug Abuse, has said, we are recognizing that addiction is also a brain disease, not simply a failure of will. Already this work has underscored the need to overcome the fragmentation in the field of substance abuse and focus more on commonalities among addictive substances.

Epidemiological work, too, is leading us in new, more promising directions—the identification of gender differences in addiction, for example.

These discoveries have long-term implications for treatment. Already, treatment options are improving. We are identifying more effective ways to help people break their addictions. We are expanding coverage for treatment within the medical care system, though too slowly. We also are beginning to put in place alternatives to prison for drug abusers so that drug abuse is not a one-way ticket to incarceration. Some of these offenders will instead be rehabilitated. Of course, the new developments in psychopharmacology can cut both ways, and we must be wary of new generations of designer drugs with the potential for abuse.

The challenge now will be to continue to tear at the barriers by building leadership, the knowledge base, and public and political will. Whether the initial impulse to abuse substances comes from loneliness, despair, peer pressure, curiosity, or the understandable desire to expand feelings and consciousness, too many people end up trapped in a place they never contemplated. The staggering personal and social costs must be addressed.

This is such an important cause. Substance abuse has a tragic public cost and even small gains translate into huge benefits, not only for affected individuals but also for their families and our society. I salute those of you who have been in this field over the long haul and welcome those of you who have recently joined this challenging effort. Together we can make a difference. And we will!



Steven A. Schroeder, MD
President and CEO

Program Update

The year 2000 was the first full year of work under a new organizational structure. While we continue to pursue our three goals of assuring access to care for all Americans; promoting health and reducing the harm caused by substance abuse; and, improving care and support for people with chronic conditions, we have organized into two programming groups. One group is devoted to improving the health of all Americans and the other is devoted to improving the health care we receive. Within these groups are 11 Program Management Teams, each addressing key aspects of our mission. What follows are highlights of the work done in 2000 by the 11 teams.

Health

ALCOHOL AND ILLEGAL DRUGS

Reducing the negative health and social consequences of alcohol and illegal drug abuse.

The Alcohol and Illegal Drugs (AID) Team built on its strong portfolio of activities in 2000, focusing on continuing and expanding a number of programs.

The *Substance Abuse Policy Research Program*, which is designed to identify and assess policies to reduce the harm from substance abuse, was reauthorized for $25 million over five years.

Our long-standing support for Join Together, a national resource center that helps communities reduce the demand for alcohol and illegal drugs, was renewed with a new focus on treatment. Under the five-year, $15-million grant, Join Together will work to help communities enhance the availability of substance abuse treatment; get more abusers to seek treatment; and improve the policy environment for substance abuse treatment.

In July, the Foundation authorized $9.6 million for an additional four years of support for sites in our *Reducing Underage Drinking through Coalitions* program. A related project which enlists and trains governors' spouses as state and national spokespersons on the issue of underage drinking received $3 million to support its second phase of work.

We also provided $1.9 million to the Harvard University School of Public Health in support of the fourth phase of their College Alcohol Study. The study looks at rates of binge drinking and other associated problems across 128 college campuses.

There is growing evidence that risks of subsequent substance abuse can be lowered during early childhood. In 2000, the Foundation authorized an additional $8 million over four years to *Free to Grow: Head Start Partnerships to Promote Substance-Free Communities*. RWJF funds, matched by federal funds from local Head Start programs, will help up to 20 sites implement this prevention model.

The AID Team plans to continue its work to prevent and reduce alcohol and illegal drug use by youth, and increase its emphasis on expanding and improving substance abuse treatment opportunities.

COMMUNITY HEALTH

Understanding how social isolation contributes to poor health and strengthening social support and connectedness.

Building on our long-standing work in school-based health the Foundation authorized $6 million over four years to create the Center for Health and Health Care in the Schools. The authorization was a joint effort between the Community Health and Priority Populations Teams. The Center will work to test and promote effective models of school-based health services, including mental and dental health services.

The Foundation also provided $2.7 million to the Developmental Studies Center to replicate a model of prosocial schooling that has been shown to reduce substance abuse and delinquent behavior. And the Foundation continued its support of

Best Friends®, a school-based health risk prevention program that targets girls in grades four through nine.

Also targeting youth, we provided $250,000 to the KidsPeace Corporation in support of TeenCentral®, an interactive Web site that helps isolated adolescents get advice and help about health-related problems.

The Foundation also renewed its support for *Family Support Services Program*, a national program that works to help develop state networks of community-based family support centers. The three-year, $9-million award will also expand the number of participating states from eight to twelve.

The Team plans to focus on helping the nation better understand the epidemiology and health consequences of social isolation and pursue community-oriented efforts to address the problem.

HEALTH AND BEHAVIOR

Increasing physical activity among Americans and promoting health behavior change as part of routine medical care.

Seeking to build a stronger knowledge and policy base from which to promote active living, the Foundation authorized a four-year, $12.5-million project to support research on environmental and policy approaches that can help introduce physical activity back into our daily lives. The project includes a strong communications component to help publicize key findings with target audiences.

The Foundation also provided support to The National Center for Bicycling and Walking (NCBW) to establish a clearinghouse and support center on creating physically active communities. In addition, the NCBW will work in partnership with The Centers for Disease Control and Prevention to provide technical assistance and training in targeted states.

The Team is also working on a blueprint for increasing the activity levels of Americans age 50 and older, for whom the rates and health risks of a sedentary lifestyle are highest. In the future, it also plans to look at opportunities to help integrate behavior change techniques into primary care.

PORTION OF AMERICANS WHO REPORT NO LEISURE-TIME PHYSICAL ACTIVITY DURING THE PAST MONTH

YEAR	AGE 18–34	35–49	50–64	65+
'90	22.7	26.8	33.8	40.1
'91	21.9	26.6	34.5	42.4
'92	22.9	27.0	33.5	39.0
'94	21.3	27.1	32.9	42.6
'96	22.3	26.7	33.0	37.4
'98	20.8	26.5	33.0	38.3
'99	20.2	24.5	32.0	35.7

There is no data available for 1993, 1995 and 1997.
Source: Behavioral Risk Factor Surveillance System, 1990–99. *Center for Disease Control and Prevention [Online]. Available at: http://apps.nccd.cdc.gov/brfss/Trends/agechart.asp?qkey=10020&state=US [2000, August 28].*

POPULATION-BASED HEALTH SCIENCES

Promoting leadership and tool development for population-wide approaches to health improvement.

Building on our eight-year investment in *All Kids Count*, an effort to increase immunization rates among children through computer-based registries, the Foundation provided The Task Force for Child Survival and Development with a three-year, $5-million grant to create a technical resource center to help develop more integrated preventive health information systems. One focus of the effort will be the development and testing of confidentiality standards.

The Foundation also awarded nearly $12 million to 21 states under *Turning Point: Collaborating for a New Century in Public Health*. The program is designed to improve public health leadership and performance. The funding will support participation in the implementation phase of the program, including participation in five national collaboratives carrying out systems change efforts that cross boundaries.

In the future, the Team will be working to improve leadership and the nation's understanding of

population-based health, including efforts to help communities measure and improve population health.

TOBACCO

Decreasing the number of people who use tobacco.

In August 2000, the Foundation co-hosted the 11th World Conference on Tobacco OR Health with the American Cancer Society® and the American Medical Association. More than 5,000 people from around the world attended the Chicago event, including RWJF grantees and staff. The focus of the Conference was to strengthen national, regional, and global leadership networks dedicated to tobacco use prevention and control.

Also in 2000, states continued to decide how to spend their portions of the $246-billion settlement from US tobacco companies for the health costs of tobacco-related diseases. The settlement created an opportunity for states to rethink and step up their tobacco cessation and control policies. To help maximize the impact of these efforts, the Foundation reauthorized and substantially expanded its SmokeLess States program. The new three-year, $52-million authorization of the program, now called *SmokeLess States®: National Tobacco Policy Initiative*, makes grants available to coalitions in all 50 states and the District of Columbia to seek policy changes that deter tobacco use and decrease its social acceptability.

Our *Smoke-Free Families* program, which seeks to develop and evaluate new interventions to help women quit smoking before, during, and after pregnancy, stepped up its efforts by funding a new $1.2-million national dissemination office at the University of North Carolina at Chapel Hill.

The Tobacco Team plans to continue its focus on helping addicted users quit and will seek to stimulate stronger anti-tobacco policies.

Health Care

CLINICAL CARE MANAGEMENT

Helping reduce the gap between what is known about the best ways to care for people with chronic disease and what is actually practiced.

Much of the Clinical Care Management (CCM) Team's work in 2000 focused on specific chronic conditions. Depression is the fourth leading cause of disability in the United States and accounts for up to $53 billion annually in lost worker productivity and direct medical costs. Yet research has shown that depression frequently goes undetected, and when detected, is often not treated adequately. To address this problem, the Foundation authorized $12 million for a five-year program intended to improve the treatment of depression in primary care settings.

The CCM Team also continued its work to improve the care of pediatric asthma through a $2.4-million grant to the University of Michigan School of Public Health to improve the training of primary care physicians in the delivery of asthma care. The project includes the development of a tool kit and interactive seminars designed to enhance clinicians' therapeutic and patient counseling skills.

The Foundation also supported an effort to implement and evaluate a model of coordinated acute and primary health care and supportive services in managed care settings for Alzheimer's disease and dementia. The model works to facilitate early identification of people with possible dementia and Alzheimer's, provide more appropriate acute and primary care, and better coordinate health care and supportive services.

Of a more exploratory nature, about $1 million was provided to support the Pittsburgh Regional Health Care Initiative, an effort spearheaded by area business, health care, and philanthropic leaders to dramatically improve the quality of care in the

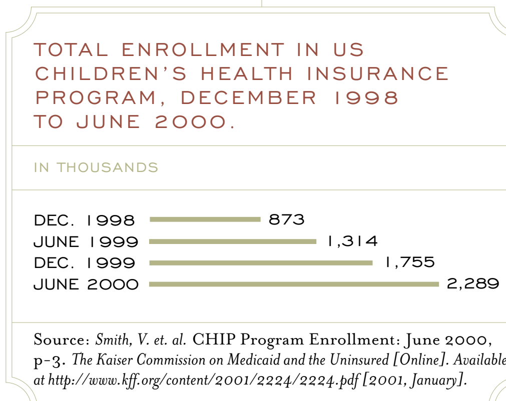
region. Initially, the Initiative is attempting to eliminate in-hospital infections and medication errors.

In the future, the CCM Team plans to continue its efforts to advance care of specific diseases, help patients better manage their care, and advance the ability of health care purchasers to improve their quality.

INSURANCE COVERAGE

Increasing the number of Americans with health insurance.

The year saw a continuation and expansion of our efforts to increase the number of Americans with health insurance. In January, we approved a $26-million strategic communications campaign to support *Covering Kids*™, our national initiative designed to maximize the participation of eligible children in available coverage programs.



Source: *Smith, V. et. al.* CHIP Program Enrollment: June 2000, p-3. *The Kaiser Commission on Medicaid and the Uninsured [Online]. Available at http://www.kff.org/content/2001/2224/2224.pdf [2001, January].*

In another effort related to Covering Kids, the Foundation approved *Supporting Families after Welfare Reform: Access to Medicaid, SCHIP, and Food Stamps*. The $6.8-million program is intended to help states and large counties solve problems in their eligibility processes that make it difficult for low-income families, particularly those moving from welfare to work, to access and retain Medicaid coverage, the State Children's Health Insurance Program, or Food Stamps.

As part of the Team's work to educate opinion leaders and the public about the problems of the uninsured, we also provided $3.7 million to the Institute of Medicine for a three-year project that will assess the evidence about the health, economic and social consequences of uninsurance for individuals, families, business, the health care system and communities.

Building on Health Coverage 2000—a successful conference at the beginning of the year that brought together a diverse group of organizations to discuss the issue of the uninsured and look for common ground—the Foundation also supported a series of regional meetings intended to develop local input and continue to raise the profile of the issue.

We also provided $10 million to the University of Michigan to undertake a research initiative to help the country better understand the relationship between the labor market and health insurance coverage, and the effect of insurance on worker productivity and health.

The Coverage Team plans to continue its efforts to help eligible children enroll in available coverage programs and to highlight for the nation the problems of people without health insurance.

END-OF-LIFE CARE

Increasing the number of Americans who receive high-quality palliative care at the end of life.

September saw the broadcast on PBS of "On Our Own Terms: Moyers on Dying." The four-part documentary by the award-winning journalist Bill Moyers was an important part of the End-of-Life (EOL) Team's efforts to help people be more comfortable having conversations about death and dying, and to raise expectations when it comes to care of the dying. The Foundation contributed $2.75 million to the production, much of it focused on outreach and support for community coalitions formed as a result of the series.

The work of the Team is also focusing on the professional arena. Research has shown that medical and nursing education curricula do not give enough attention to all aspects of end-of-life care, including pain and symptom control, ethical considerations, and communications and legal issues. To help address this problem, the Foundation provided $2.2 million to the American Association of Colleges of Nursing to train at least 500 nursing school faculty and other key nursing leaders in end-of-life care. This project will make use of teaching materials being developed at the University of Washington School of Nursing under an earlier Foundation grant.

Other research has shown that too many cancer patients do not receive appropriate pain management, even though guidelines indicate that cancer pain can be controlled up to 90 percent of the time. The Foundation provided $1.4 million to the University of Wisconsin-Madison Medical School to support state cancer pain initiatives to promote improved management of pain. This effort takes advantage of new pain standards being developed by the Joint Commission on Accreditation of Healthcare Organizations and revised cancer pain guidelines being issued by the Agency for Healthcare Research and Quality.

In the future, the EOL Team will continue its work around professional education, institutional change, and public engagement.

PORTION OF AMERICANS WHO SAY IT'S HARD FOR PEOPLE WITH CHRONIC CONDITIONS TO GET:

Care from Primary Care Physicians	72%
Prescription Medicines	74%
Help from Family	78%
Adequate Insurance Coverage	89%

Source: Chronic Illness and Caregiving: Survey of the General Public, Adults with Chronic Conditions and Caregivers, p-6. *Harris Interactive Inc., [Online]. Available at: http://www.harrisinteractive.com/news/downloads/Chronic_Conditions_MainResults_2_26_01.pdf [2000, February 26].*

INFORMATION/TRACKING

Improving public and private policymaking by making available timely, accurate, and relevant information about the health system.

As part of the Information Team's work to provide public and private policymakers with better information, the Foundation continued its support of research into the changes our health care system is undergoing. In April, we approved $43.5 million to continue the work supported under our *Health Tracking* project. The two-year grant funds four separate research projects. These include The Center for Studying Health System Change's core Community Tracking Study, which is looking at how changes in the delivery system are affecting people's access to care; work at the University of California, Berkeley, looking at the role of physician organizations in care management; and, two projects at The RAND Corporation, one assessing the quality of care nationally and across markets, and one tracking variations in employer-sponsored health insurance coverage.

At the same time more decisions over health care policy are being made at the state level, more states have instituted term limits. As a result, many legislators are unfamiliar with the range and detail of health policy issues. To help improve state legislators' understanding of issues, the Foundation provided a three-year, $2-million grant to the National Conference of State Legislatures (NCSL). Under the current project, which is a renewal and expansion of a previous effort, the NCSL will hold meetings and conferences, and disseminate a variety of information products designed to help state legislators do their jobs in a more informed manner.

The Information Team will continue its work to enhance the links between policymakers and researchers, including efforts to find new ways to package and disseminate information.

PRIORITY POPULATIONS

Improving access to health care for underserved population groups.

Continuing to help address the persistent access to care problems in the rural South, the Foundation awarded nearly $6 million to seven states participating in the implementation phase of our *Southern Rural Access Program*. The states are pursuing a variety of strategies, including efforts to train, recruit, and retain primary care providers, and create loan funds to help build the health infrastructure in rural communities.

Safety net providers who care for the bulk of the uninsured often do not have access to the most effective care management techniques. To address this, the Foundation provided a grant to The Lewin Group, Inc., to do case studies of 24 high-quality, frontline innovators of safety net care to learn how to best design and implement clinical care management programs for the uninsured. The Team also supported a set of research projects designed to better understand factors that influence Latinos' access to primary and preventive care.

In seeking to eliminate disparities in care, the Team plans initially to focus on Latinos, smaller urban communities, and oral health.

SUPPORTIVE SERVICES

Preparing for increased future demand for long-term care support and services.

As a result of the baby boom generation aging, the number of older adults in America is projected to grow almost 80 percent over the next 30 years. Because older age is associated with increased risk of chronic illness and disability, the Supportive Services Team is working to help the nation meet the future demand for long-term care support and services.

The Foundation authorized $28 million in 2000 for a new program, *Community Partnerships for Older Adults*. The program is designed to help communities build comprehensive long-term care systems that include a range of social and health services to support vulnerable older adults, promote independent living, and increase access for patients and families to better long-term care information.

As part of its work to raise the awareness of the public and opinion leaders about the health, social, and emotional issues related to the care of people with chronic conditions, the Foundation provided $1.2 million to Fred Friendly Seminars, Inc., to produce a television program that explores the effects of chronic illness. The grant also includes funds to conduct outreach efforts, including a Web site for the show and town hall meetings.

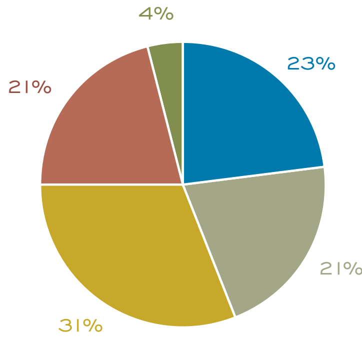
Faith In Action®, the Foundation's effort to encourage organized interfaith volunteer efforts to help those in need, made grants to 70 projects in 2000, raising the number of projects funded to 1,161.

Future efforts of the Supportive Services Team will continue in the area of informal caregiving and expand to include a focus on work force development.

Distribution of 2000 Funds

During 2000, the Foundation made 723 grants and 98 contracts, totaling $399.49 million in support of programs and projects to improve health and health care in the United States. These grant funds, viewed in terms of the Foundation's principal objectives, were distributed as follows.

DISTRIBUTION OF AWARDS BY AREAS OF INTEREST ($399.49 MILLION)



23% $90.76 million for programs that assure that all Americans have access to basic health care at reasonable cost.

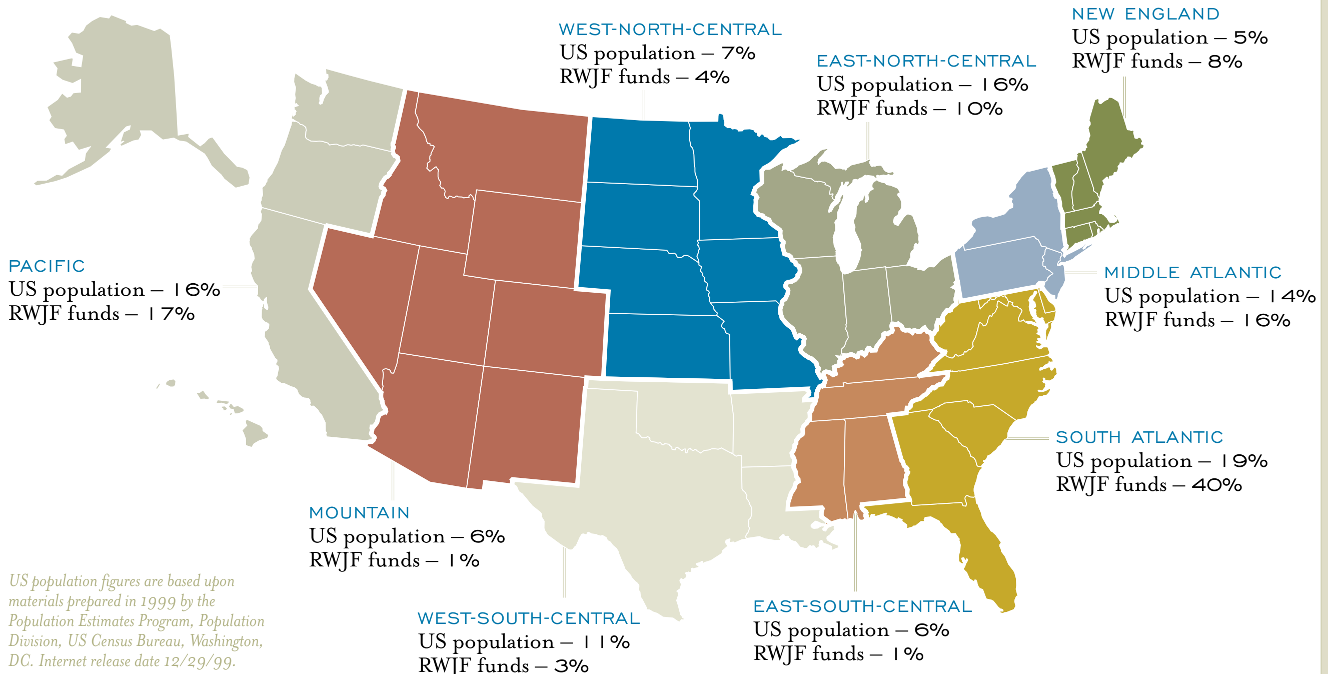
21% $84.76 million for programs that improve care and support for people with chronic health conditions.

31% $124.74 million for other health and health care programs, including our work force training programs and grants that are consistent with the foci of our Program Management Teams.

21% $83.36 million for programs that promote health and reduce the personal, social, and economic harm caused by substance abuse—tobacco, alcohol, and illicit drugs.

4% $15.87 million for general philanthropy purposes, primarily projects addressing the Foundation's mission in the New Brunswick, New Jersey area where the Foundation originated.

AWARDS BY GEOGRAPHICAL REGION ($399.49 MILLION)



US population figures are based upon materials prepared in 1999 by the Population Estimates Program, Population Division, US Census Bureau, Washington, DC. Internet release date 12/29/99.

Financial Statements

The annual financial statements for the Foundation for 2000 appear on pages 64 through 71. A listing of awards in 2000 begins on page 28.

In 2000 the net assets of the Foundation increased 2.7 percent. This modest increase was achieved notwithstanding the overall poor performance in most sectors of the capital markets. The Foundation awarded grants and contracts totaling $399.5 million. Program development, evaluation, and general administration for the year were $41.9 million or 10.5 percent of total awards. This represents a $12.3 million increase over last year, primarily due to accelerated depreciation charges associated with construction of our new headquarters building.

Investment expenses totaled $27.6 million reflecting an increased investment in limited partnership interests. Federal and state taxes amounted to $9.9 million.

The Internal Revenue Code requires private foundations to make qualifying distributions of 5 percent of the fair market value of assets not used in carrying out the charitable purpose of the Foundation. These distributions are to be made within a 24-month period. The Foundation has fulfilled its 1999 requirement ($407.1 million). The 2000 requirement ($397.5 million) will be met in mid-2001.

Peter Goodwin
Vice President and Treasurer

Report of Independent Accountants

To the Trustees of
The Robert Wood Johnson Foundation:

In our opinion, the accompanying statements of financial position and the related statements of activities and cash flows present fairly, in all material respects, the financial position of The Robert Wood Johnson Foundation ("the Foundation") at December 31, 2000 and 1999, and the changes in its net assets and its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of the Foundation's management; our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with auditing standards generally accepted in the United States of America, which require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

PricewaterhouseCoopers LLP

New York, New York
February 14, 2001

STATEMENTS OF FINANCIAL POSITION

At December 31, 2000 and 1999 (in thousands)	2000	1999
Assets:		
Cash and cash equivalents	$ 273,918	$ 124,514
Receivable on pending security transactions	20,220	13,654
Interest and dividends receivable	14,703	14,208
Contribution receivable	15,681	17,371
Investments at fair value:		
Johnson & Johnson common stock	5,312,133	5,339,528
Other equity investments	2,343,899	2,342,359
Fixed income investments	757,573	749,920
Program related investments	13,811	15,737
Other assets	41,854	23,117
Total assets	$8,793,792	$8,640,408
Liabilities and Net Assets:		
Liabilities:		
Accounts payable and accrued expenses	$ 11,611	$ 8,947
Payable on pending security transactions	45,576	58,745
Unpaid grants	355,599	399,980
Deferred federal excise tax	108,266	114,845
Accumulated postretirement benefit obligation	8,287	8,617
Total liabilities	529,339	591,134
Net assets—unrestricted	8,264,453	8,049,274
Total liabilities and net assets	$8,793,792	$8,640,408

See notes to financial statements.

STATEMENTS OF ACTIVITIES

For the years ended December 31, 2000 and 1999 (in thousands)	2000	1999
Investment income	$ 152,047	$ 144,241
Less: Federal and state tax	1,893	1,225
Investment expense	27,626	21,288
	122,528	121,728
Contribution income	2,310	1,256
	124,838	122,984
Program costs and administrative expenses:		
Grants, net	298,978	375,481
Program contracts and related activities	42,494	30,455
Program development and evaluation	22,543	18,772
General administration	19,332	10,852
	383,347	435,560
Excess of program costs and expenses over income	(258,509)	(312,576)
Other changes to net assets, net of related federal excise tax:		
Realized gains on sale of securities	804,746	502,316
Unrealized (depreciation) appreciation on investments	(331,058)	568,472
	473,688	1,070,788
Change in net assets—unrestricted	215,179	758,212
Net assets, beginning of year—unrestricted	8,049,274	7,291,062
Net assets, end of year—unrestricted	$ 8,264,453	$ 8,049,274

See notes to financial statements.

STATEMENTS OF CASH FLOWS

For the years ended December 31, 2000 and 1999 (in thousands)	2000	1999
Cash flows from operating activities:		
Change in net assets	$ 215,179	$ 758,212
Adjustments to reconcile change in net assets to net cash used in operating activities:		
Depreciation	8,845	2,519
(Increase) decrease in interest and dividends receivable	(495)	665
Decrease in contribution receivable	1,690	1,744
Net realized and unrealized gains on investments	(473,688)	(1,070,788)
Decrease in program related investments	1,926	1,722
Increase in accounts payable and accrued expenses	2,664	6,356
(Decrease) increase in unpaid grants	(44,381)	91,545
(Decrease) increase in accumulated postretirement benefit obligation	(330)	815
Other	(6,867)	(756)
Net cash used in operating activities	(295,457)	(207,966)
Cash flows from investing activities:		
Proceeds from security sales	3,243,393	2,441,472
Cost of security purchases	(2,777,492)	(2,256,386)
Acquisition of property and equipment	(21,040)	(5,517)
Net cash provided by investing activities	444,861	179,569
Net increase (decrease) in cash and cash equivalents	149,404	(28,397)
Cash and cash equivalents at beginning of year	124,514	152,911
Cash and cash equivalents at end of year	$ 273,918	$ 124,514
Supplemental data:		
Federal and state taxes	$ 9,659	$ 5,624

See notes to financial statements.

Notes to Financial Statements

NOTE 1: ORGANIZATION:

The Foundation is an organization exempt from Federal income taxation under Section 501(c)(3), and is a private foundation as described in Section 509(a) of the Internal Revenue Code.

The Foundation's mission is to improve the health and health care of all Americans. The Foundation concentrates its grantmaking in three areas:

- to assure that all Americans have access to basic health care at reasonable cost;
- to improve care and support for people with chronic health conditions; and
- to promote health and reduce the personal, social, and economic harm caused by substance abuse—tobacco, alcohol and illicit drugs.

NOTE 2: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES:

Cash and cash equivalents represent cash and short term investments purchased with an original maturity of three months or less. The carrying value approximates fair value.

Marketable securities are reported on the basis of quoted market value as reported on the last business day of the year on securities exchanges throughout the world. Realized gains and losses on investments in securities are calculated based on the first-in, first-out method. Investments in limited partnership interests are stated at fair value based on financial statements and other information received from the partnerships. Fair value is the estimated net realizable value of holdings priced at quoted market value, where market quotations are available, historical cost or other estimates including appraisals. Because of the uncertainty of valuations for certain of the underlying investments which do not have quoted market values, the values for those investments could differ had a ready market existed. The realization of the Foundation's investment in these partnership interests is dependent upon the general partners' distributions during the life of each partnership.

Property and equipment are capitalized and carried at cost. Maintenance and repairs are charged to expense as incurred. Depreciation of $8,844,870 in 2000 and $2,519,375 in 1999 is calculated using the straight-line method over the estimated useful lives of the depreciable assets.

During the year, the Foundation started construction on a significant addition to its headquarters facility. As a result of this decision, the useful life of much of the property and equipment currently being used has been sharply reduced, resulting in an increase in depreciation expense for 2000 from what it would otherwise have been.

The Internal Revenue Service provides that each year the Foundation must distribute within 12 months of the end of such year, approximately 5% of the average fair value of its assets not used in carrying out the charitable purpose of the Foundation. The distribution requirement for 1999 has been met and the 2000 requirement is expected to be met during 2001.

Deferred federal excise taxes are the result of unrealized appreciation on investments being reported for financial statement purposes in different periods than for tax purposes.

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting period. The Foundation makes significant estimates regarding the value of limited partnership investments, discounts for contributions receivable and unpaid grants, and useful lives of property and equipment. Actual results could differ from these estimates.

Certain amounts in the prior year financial statements have been reclassified to conform to the current year presentation.

NOTE 3: FEDERAL TAXES:

The Internal Revenue Code imposes an excise tax on private foundations equal to 2 percent of net investment income (principally interest, dividends, and net realized capital gains, less expenses incurred in the production of investment income). This tax is reduced to 1 percent for foundations that meet certain distribution requirements. In 2000 and 1999, the Foundation satisfied these requirements and is, therefore, eligible for the reduced rate.

In 2000, the Foundation has become liable for federal and state unrelated business income tax in connection with its limited partnership interests. The amount paid in 2000 was $649,464.

The provision for federal excise tax consists of a current provision on realized net investment income and a deferred provision on unrealized appreciation of investments. The current provision for 2000 on net investment income at 1 percent was $9,284,135. The current provision for 1999 at 1 percent was $6,244,429. The change in unrealized appreciation reflected on the Statements of Activities includes a provision for deferred taxes based on net unrealized appreciation of investments at 2 percent. The decrease in unrealized appreciation in 2000 and increase in 1999 resulted in a change of the deferred federal excise tax liability of ($6,578,557) and $11,711,892, respectively.

NOTE 4: CONTRIBUTION RECEIVABLE:

The Foundation recorded as contribution receivable the present value of the estimated future benefit to be received as a remainderman in a trust and the estimated amount to be received as a beneficiary in an estate. The interest rate used to discount the trust receivable to present value ranges from 6.0% to 6.5%.

NOTE 5: INVESTMENTS:

At December 31, 2000 and 1999, the cost and fair values of the investments are summarized as follows (in thousands):

	2000		1999	
	COST	FAIR VALUE	COST	FAIR VALUE
Johnson & Johnson Common Stock 50,562,854 and 57,260,354 shares in 2000 and 1999, respectively	$ 60,395	$ 5,312,133	$ 68,394	$5,339,528
Other equity investments:				
Domestic equities	629,796	717,750	580,717	864,028
International equities	489,638	507,621	320,811	449,041
Emerging market equities	–	–	180,074	247,665
Limited partnership interests	962,030	1,118,528	668,339	781,625
Fixed income investments	789,248	757,573	797,616	749,920
	$2,931,107	$8,413,605	$2,615,951	$8,431,807

Pursuant to its limited partnership agreements, as of December 31, 2000, the Foundation had unfunded commitments of approximately $602 million which are expected to be funded over the next three to five years.

The net realized gains on sales of securities for 2000 and 1999 were as follows (in thousands):

	2000	1999
Johnson & Johnson Common Stock	$ 593,477	$ 393,603
Other securities, net	219,310	113,732
Less, Federal excise tax	(8,041)	(5,019)
	$ 804,746	$ 502,316

NOTE 6: PROPERTY AND EQUIPMENT:

At December 31, 2000 and 1999, property and equipment, a component of other assets, was comprised of (dollars in thousands):

	2000	1999	DEPRECIABLE LIFE IN YRS.
Land and land improvements	$ 2,902	$ 2,902	15
Buildings	13,550	13,048	40
Furniture and equipment	21,975	19,148	3-15
Construction in progress	24,690	907	
Total	63,117	36,005	
Less, Accumulated depreciation	(25,577)	(16,732)	
Property and equipment, net	$ 37,540	$ 19,273	

NOTE 7: UNPAID GRANTS:

At December 31, 2000 the unpaid grant liability is expected to be paid in future years as follows (in thousands):

2001	$ 156,299
2002	122,499
2003	70,826
2004	39,130
2005 and thereafter	6,571
	395,325
Less, Discounted to present value	(39,726)
	$ 355,599

Generally accepted accounting principles require contributions made ("unpaid grants") to be recorded at the present value of estimated future cash flows. As of December 31, 2000, the Foundation has discounted the amount of unpaid grant liability by applying interest rate factors ranging from 6% to 6.5% and an estimated cancellation rate of 3%. At December 31, 1999, the unpaid grant liability was discounted to present value by $51,044,228.

NOTE 8: BENEFIT PLANS:

Retirement Plan

Substantially all employees of the Foundation are covered by a retirement plan which provides for retirement benefits through a combination of the purchase of individually-owned annuities and cash payout. The Foundation's policy is to fund costs incurred. Pension expense was $2,006,143 and $1,433,419 in 2000 and 1999, respectively.

Postretirement Benefits

The Foundation provides postretirement medical and dental benefits to all employees who meet eligibility requirements. In addition, the Foundation has adopted supplemental benefit plans to provide additional benefits for certain key employees who meet certain requirements.

	2000	1999
Benefit obligation at December 31	$ 9,189	$ 8,583
Fair value of plan assets at December 31	–	–
Funded status	$ (9,189)	$ (8,583)
(Accrued) benefit cost recognized in the statement of financial position	$ (8,287)	$ (8,617)
Weighted-average assumptions as of December 31		
Discount rate:		
Medical and dental plans	7.00%	7.25%
Supplemental benefit plans	6.00%	6.48%
Expected return on plan assets	N/A	N/A

For measurement purposes, a 6.5% annual rate of increase in per capita cost of covered health care benefits was assumed for 2001. The rate was assumed to decrease gradually to 5.5% for 2005 and remain at that level thereafter.

	2000	1999
Benefit cost	$ 1,547	$ 1,034
Employer contributions	1,876	220
Plan participants' contributions	–	–
Benefits paid	1,876	220

The Secretary's Report

In January 2001, Wendy W. Hagen, Edward J. Hartnett, and Robert Wood Johnson IV were elected to the Board of Trustees. Ms. Hagen is an advertising executive with more than 25 years of advertising experience and is executive vice president, account group director with Arnold Worldwide. Mr. Hartnett is the retired company group chairman of Johnson & Johnson; he joined the company in 1961. Mr. Johnson is a member of the founding family of Johnson & Johnson and chairman and CEO of The Johnson Company, Inc., New York City.

Also at the January 2001 meeting of the Board, David R. Clare and John J. Heldrich, trustees of the Foundation, were each elected to the office of trustee emeritus. Both Mr. Clare and Mr. Heldrich served as trustees since July 1990. At their election as trustees emeriti, Mr. Clare and Mr. Heldrich were cited by the Board for their faithful, distinguished, and valuable service to the Foundation.

STAFF CHANGES

In May 2000, Patricia A. McFadzean joined the Foundation as senior human resource generalist. Prior to joining the Foundation, Ms. McFadzean held the position of manager of compensation and classification at the New Jersey Institute of Technology, Newark. Ms. McFadzean received a BS in business administration from Seton Hall University.

In June 2000, Neil C. Pompan, CMP, joined the Foundation as director of administration. Mr. Pompan was the assistant general manager of the Meristar Hotels and Resorts' Doral Forrestal Conference Center Resort, Princeton, New Jersey. Mr. Pompan has a BS in hotel and restaurant administration from the University of Massachusetts, Amherst.

In August 2000, Gregory Hall, MCP, joined the Foundation as program officer. Prior to joining the Foundation, Mr. Hall was a consultant with a number of nonprofit agencies, including the Alzheimer's Association and the National Council on the Aging, and was a program associate at The Pew Charitable Trusts. Mr. Hall received a BA degree with a concentration in gerontology from New College, Sarasota, Florida, and a Master of City Planning degree from the University of Pennsylvania.

In October 2000, Calvin C. Bland, MS, was appointed interim group director, Health Care, succeeding Jack C. Ebeler, MPA. Mr. Bland joined the Foundation in February 2000 as senior program advisor. Previously, he served as president and CEO of St. Christopher's Hospital for Children in Philadelphia. Mr. Bland was a program officer at the Foundation from 1974 to 1977. He earned a BS in economics at the University of Pennsylvania, The Wharton School, and an MS in administrative medicine at Columbia University, the Mailman School of Public Health.

In November 2000, Pamela G. Williams Russo, MD, MPH, joined the Foundation as senior program officer. Prior to joining the Foundation, Dr. Russo was associate professor of medicine at Cornell University Medical Center in New York City and associate attending physician at both the Hospital for Special Surgery and The New York Hospital. Dr. Russo earned a BS from Harvard College; an MPH from the University of California, Berkeley, School of Public Health; and an MD from the University of California, San Francisco.

In January 2001, Terry L. Bazzarre, PhD, joined the Foundation as senior program officer. Prior to joining the Foundation, Dr. Bazzarre was staff

scientist at the American Heart Association, Dallas, Texas. Dr. Bazzarre earned his BS in biology, an MS in human nutrition, and a PhD from the Virginia Polytechnic Institute and State University, Blacksburg, Virginia.

Also in January 2001, Victor A. Capoccia, PhD, joined the Foundation as senior program officer. Prior to joining the Foundation, Dr. Capoccia was a principal with Dougherty Management Associates, Inc., Lexington, Massachusetts. Dr. Capoccia earned his BA and his MSW from Boston College. He earned his MA from the University of Iowa and his PhD from The Florence Heller Graduate School for Advanced Studies in Social Welfare at Brandeis University.

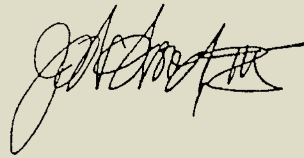
Also in January 2001, Paul E. Moran, MBA, joined the Foundation as administrative officer in the Communications Office. Prior to joining the Foundation, Mr. Moran led Moran Associates, a management consulting firm. Mr. Moran earned his BA in sociology from Gannon University and his MBA from Fordham University Graduate School of Business.

Since the date of the last Annual Report, the following individuals were promoted to the offices indicated: Karen K. Gerlach, PhD, MPH, senior program officer; M. Katherine Kraft, PhD, senior program officer; Michelle A. Larkin, RN, MS, program officer; and Marco Navarro, program officer.

Those departing the Foundation since the last Annual Report were the following: Elize M. Brown, JD, program officer; Jack C. Ebeler, MPA, senior vice president and director, health care group; Pamela E. Johnson, MHS, program officer; Harold A. Pincus, MD, special consultant; Christina M. Reiger, director of information systems; and, Jonathan A. Showstack, PhD, MPH, visiting scholar.

BOARD ACTIVITIES

The Board of Trustees met five times in 2000 to conduct business, review proposals, and appropriate funds. In addition, the Nominating, Human Resources, Finance, and Audit committees met as required to consider and prepare recommendations to the Board.



J. Warren Wood, III
Vice President, General Counsel and Secretary

This report covers the period through January 31, 2001.

This document, as well as many other Foundation publications and resources, is available on the Foundation's Web site:

www.rwjf.org

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