The FY 2027 President's Budget Request: What's at Stake for Federal Substance Use Disorder and Overdose Prevention Funding

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What's at Stake for Federal Substance Use Disorder and Overdose Prevention Funding

On April 3, 2026, the White House released the Fiscal Year (FY) 2027 President's Budget Request (PBR). It proposes deep cuts to the federal substance use disorder (SUD) and overdose prevention programs that states and communities rely on. The PBR is not law — Congress writes the appropriations bills — but it does highlight where the Administration's priorities lie, and what could be at risk if those priorities carry over into the bill that passes.

The stakes are especially high right now because the country is finally making up ground. Provisional data from the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) estimates 68,632 drug overdose deaths in 2025, a 15.1% decline from the prior year. CDC and outside researchers credit a mix of factors for this decline: wider naloxone distribution, expanded access to medications for opioid use disorder (MOUD), changes in the drug supply and opioid settlement dollars benefitting hard-hit communities, all built on more than a decade of sustained federal investment.

And yet, roughly 70,000 people still died last year to overdose. Progress isn't a milestone you pass and forget. It's infrastructure, and it has to be maintained.

What the budget request proposes

At the top line, the budget request asks Congress for $1.5 trillion in defense spending — a 42% increase, or $445 billion, over FY 2026 — paired with a $73 billion (10%) cut to nondefense spending. The Department of Health and Human Services (HHS) would absorb

one of the largest hits, with $111.1 billion in discretionary funding proposed, $15.8 billion (12.5%) below FY 2026 enacted levels. The impact to overdose prevention isn't apparent in any single line item. It's the cumulative pressure on prevention, treatment, recovery, surveillance and response systems across the executive branch that took years to build out.

ONDCP: A smaller federal drug policy role

Among the structural shifts within the request is the White House Office of National Drug Control Policy (ONDCP). The request would strip ONDCP down to $21.785 million for salaries and expenses — a 95% cut from FY 2026 — and eliminate or transfer each of its discretionary federal drug control programs elsewhere. The High Intensity Drug Trafficking Areas (HIDTA) Program would shift to the Department of Justice (DOJ) at $196 million, a $102.6 million cut. The Drug-Free Communities (DFC) Support Program would move to HHS at $70 million, down from $109 million. Comprehensive Addiction and Recovery Act (CARA) Section 103 Community-Based Coalition Enhancement Grants, the Drug Court Training and Technical Institute, and the Model Acts Program would be eliminated outright.

The Administration frames this as letting ONDCP "focus on coordination." The public health concern is the opposite. Federal drug policy already spans prevention, treatment, recovery, enforcement, surveillance and research. When the central coordinating office shrinks and its programs scatter, alignment becomes harder — and moving HIDTA to DOJ while eliminating demand-side programs reads as a reorientation toward more punitive supply-side criminal justice approaches.

HHS and AHA: Consolidation with less money

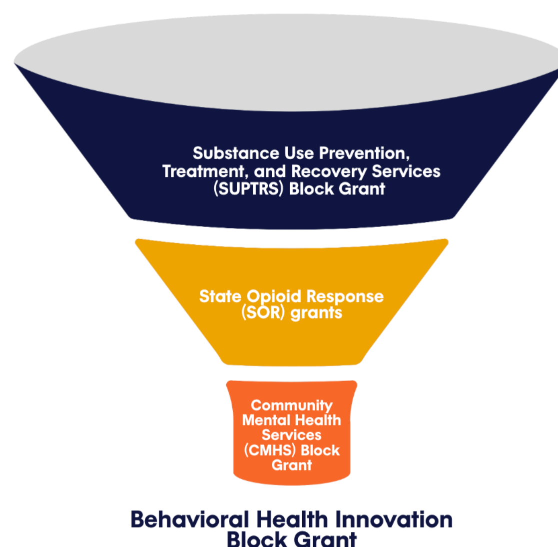
For the second time in as many years, the PBR attempts to revive the proposed Administration for a Healthy America (AHA), which would absorb select programs from the Office of the Assistant Secretary for Health (OASH), Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), and CDC into a single operating division. If adopted, more than 100 programs across HHS would be eliminated through reorganization and SAMHSA would cease to exist as the lead federal agency on substance use. HHS' SUD portfolio would primarily consist of the select programs transferred to AHA's Mental and Behavioral Health division. Congress rejected this same proposal last year and held SAMHSA intact at $7.4 billion in the final FY 2026 appropriations bill.

The total program funding level for AHA's Mental and Behavioral Health division in FY 2027 would be $6.8 billion for all transferred programs, $576.2 million below FY 2026 funding for the same programs. One of the most consequential proposals for overdose prevention is the proposed Behavioral Health Innovation (BHI) Block Grant, which would combine SAMHSA's three top behavioral health formula grants into a single, formula-based grant:

- Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant — $2.013 billion in FY 2026
- State Opioid Response (SOR) grants — $1.595 billion in FY 2026
- Community Mental Health Services (CMHS) Block Grant — $1.013 billion in FY 2026

The combined FY 2026 total is $4.625 billion. The FY 2027 request would maintain that total for the consolidated grant. The Administration calls it level funding. However, in practice, it would operate as a cut, with three distinct pots of money being replaced with a single pot, pitting allied behavioral health groups against one another for a piece of the same pie.

With the impending changes in January 2027 to Medicaid work requirements, eligibility redeterminations and federal funding from the *One Big Beautiful Bill Act (H.R.1/P.L. 119-21)* estimated to lead to more than 1.6 million Medicaid enrollees with SUD losing their insurance, the burden on these grants will be even higher. As the payer of last resort, the Block Grant will be required to fill the gap in treating the rise in the uninsured population. The grants will be expected to do more with the same amount of funding.



Flexibility isn't a bad thing on its own. States are more well versed and aware of the needs of their populations. But block grants only work when the underlying total covers the need,

and dedicated streams exist precisely so that overdose prevention, naloxone access, surveillance and rapid response don't get crowded out by other behavioral health pressures. Once those dollars disappear into a single line, tracking whether they actually reach overdose programming becomes much harder — for Congress, for states and for communities.

SAMHSA programs proposed for elimination

As part of HHS' consolidation, the budget request proposes to eliminate more than 25 of SAMHSA's Programs of Regional and National Significance (PRNS)— the competitive grants that fund specific initiatives targeting priority populations or areas of concern. These grants supplement the broader behavioral health formula grants in providing funding to states and local communities, including providers, to fill gaps in service delivery across the continuum of care. These targeted grants provide dedicated funding for a range of programs, including prevention coalitions, workforce development, crisis response and culturally specific care.

Combined, the PRNS cuts alone would result in $591.4 million fewer in prevention, treatment and recovery grants going to the providers and communities doing the work. Overall cuts to SAMHSA's discretionary budget authority would amount to $752.9 million (10.1%) compared to FY 2026, with prevention programs proposed to be hit the hardest— $222.2 million decrease (92.2%).

SAMHSA PRNS proposed for elimination in the FY 2027 PBR:

Prevention	Treatment	Mental Health
• Minority AIDS • Minority Fellowship • Sober Truth on Preventing Underage Drinking (STOP Act) • Strategic Prevention Framework-Partnerships for Success (SPF-PFS) • Tribal Behavioral Health	• Minority AIDS • Minority Fellowship	• Assertive Community Treatment for Individuals with Serious Mental Illness • Children and Family Programs • Consumer and Family Network Grants • Criminal and Juvenile Justice Programs • Eating Disorder Identification • Healthy Transitions • Homelessness • Homelessness Prevention Programs • Infant and Early Childhood Mental Health • Interagency Task Force on Trauma Informed Care • Mental Health Awareness Training • Mental Health Crisis Response Grants • Mental Health System Transformation • Minority AIDS • Minority Fellowship • Primary and Behavioral Health Care Integration • Project LAUNCH • Seclusion and Restraint • Tribal Behavioral Health

These aren't abstractions. They're the line items paying for prevention coalitions in schools, training for paramedics on naloxone, peer support for people leaving jails and prisons and the surveillance teams that catch an adulterated drug supply before it harms more people.

NIH and the research base

The request also seeks to restructure the National Institutes of Health (NIH), consolidating the National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA) into a proposed National Institute of Substance Use and Addiction Research (NISUAR). The combined FY 2026 total for NIDA and NIAAA is $2.258 billion. The FY 2027 request calls for $2.1 billion for NISUAR, a $160.7 million (7%) cut. Further, NIH's overall discretionary budget would be cut by $3.5 billion.

NIDA-funded research is the reason we know what works. A 2018 NIDA-funded study of more than 17,500 opioid overdose survivors in Massachusetts found that opioid-related deaths dropped 59% among people who received methadone and 38% among people who received buprenorphine, compared with people who got no medication. A more recent federal analysis of 137,000 Medicare beneficiaries found similar results. Despite this evidence, less than a third of overdose survivors actually receive these medications. NIDA's continued investment in SUD prevention, treatment and recovery research is driving new innovations every day to reduce the risk of overdose and other adverse effects of drug use.

Cutting the agencies that have produced these results doesn't just narrow the toolkit at the moment the field is learning how to use it; it weakens the infrastructure for evaluating what's working and spotting emerging threats in real time - a feedback loop communities need to target resources and track progress.

CDC Surveillance

CDC's National Center for Injury Prevention and Control (NCIPC) runs Overdose Data to Action (OD2A), the surveillance program that 90 state and local health departments use to rapidly track and respond to changes in fatal and nonfatal overdose trends. The Administration tried to eliminate the Injury Center in the FY 2026 PBR, and Congress fully restored it at $761 million. Even with full-year appropriations, the White House Office of Management and Budget (OMB) froze a portion of OD2A funding for months in 2025 before disbursement. The FY 2027 request yet again calls to move CDC's overdose portfolio under the AHA umbrella. When surveillance weakens, the early-warning system that catches drug-supply changes weakens with it — and the community response that depends on those signals slows at exactly the moment overdose risk shifts.

What this means for communities

Federal overdose money usually doesn't come labeled "federal overdose money." It shows up as a county epidemiologist who flags a fentanyl-xylazine spike before it gets worse. The naloxone in a deputy's glove box. The peer recovery support specialist who meets someone in the Emergency Department at 2 a.m. The SUPTRS-funded treatment slot in a town with no other openings.

If these proposed cuts moved forward as written, prevention coalitions would shrink. Treatment waitlists would grow. Recovery housing and reentry programs — often funded through the smaller, more vulnerable PRNS grants — would close first. Surveillance gaps would widen at the moment the drug supply is shifting fastest. That's not speculation. It's what happens when the infrastructure thins out.

What happens next

The President's Budget Request is the start of the appropriations conversation, not the end of it. Congress writes and passes the appropriations bills. The FY 2026 process is the recent precedent: the Administration proposed eliminating SAMHSA and the CDC Injury Center, and Congress — on a bipartisan basis — kept both intact and rejected the AHA consolidation. A similar dynamic will play out over the coming months for FY 2027, through committee markups, floor votes and conference negotiations.

For people working in addiction treatment, prevention, recovery and public health, the case for sustained funding is most persuasive when it's specific, local and grounded in what these programs actually do. The country has spent the last few years finally bending the overdose curve. Whether that progress holds depends, in real part, on whether the systems behind it stay funded.

For advocates who want to engage the federal budget process directly, the Overdose Prevention Initiative's U.S. Federal Advocacy Action Guide, available free on the Health Advocacy Training and Collaboration Hub (HATCH), walks through how the cycle works and how community-level evidence can inform it.