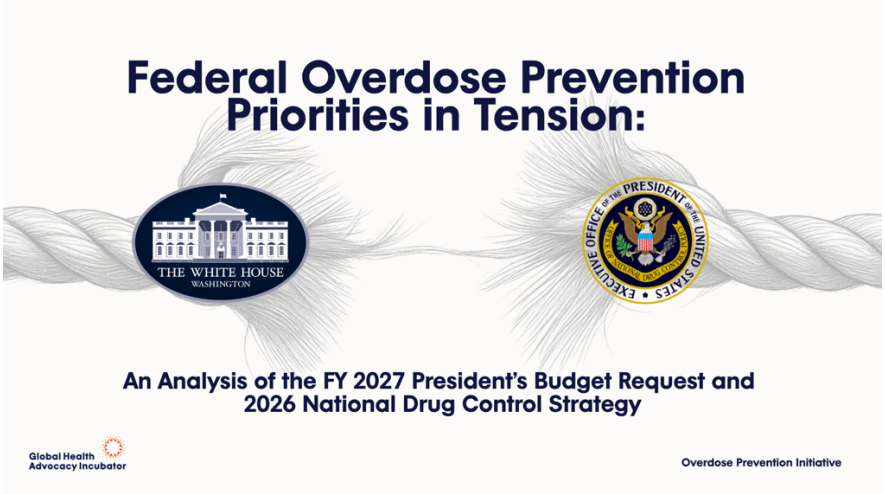

Federal Overdose Prevention Priorities in Tension: An Analysis of the FY 2027 President's Budget Request and 2026 National Drug Control Strategy

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Executive Summary

On May 4, 2026, the White House Office of National Drug Control Policy released the 2026 National Drug Control Strategy (NDCS) — a biennial document that sets out the Administration's whole-of-government approach to drug control and commits the federal government to expanding access to evidence-based prevention, treatment, recovery supports and overdose reversal. The strategy frames addiction as a chronic, treatable disease, pledges to make Food and Drug Administration (FDA)-approved medications for opioid use disorder (MOUD) readily available, calls for affordable naloxone within reach of anyone who needs it and commits to building the behavioral health workforce required to deliver care. These are, in important respects, the right priorities.

The FY 2027 President's Budget Request, released April 3, 2026, does not fund that vision. The Budget Request would weaken several parts of the federal overdose prevention and treatment infrastructure at once. It proposes more than $222 million in cuts to SAMHSA prevention programs and combines three major behavioral health formula grants into one pool, forcing substance use disorder and mental health programs to compete for the same dollars. It also cuts the federal behavioral health workforce pipeline by nearly 44 percent, eliminates housing programs the strategy calls foundational to sustained recovery and reduces ONDCP by 95 percent, even though federal law makes the office responsible for coordinating and certifying the federal drug control budget.

Provisional Center for Disease Control and Prevention (CDC) data show an estimated 68,632 drug overdose deaths in 2025, a 15 percent decline from the prior year. That progress reflects more than a decade of sustained federal investment in the exact programs now proposed for reduction or elimination. A strategy that acknowledges that progress and commits to building on it is welcome. But a strategy is a policy document. The programs that translate strategy into actual services — the treatment slots, the naloxone kits, the surveillance systems, the recovery housing, the reentry supports — exist, in large part, because of appropriated funding. When that funding disappears or shrinks, the strategy's commitments cannot be fully realized.

The Budget Request is the opening bid of the appropriations process, not the final word. Congress writes and passes the appropriations bills. When the Administration proposed comparably sweeping changes for FY 2026, Congress preserved funding for most of the affected programs on a bipartisan basis. Advocates, policymakers and partners who want to see that outcome repeated in FY 2027 have a narrow window to make the case. This analysis is designed to help them do that.

Introduction

Every two years, the Office of National Drug Control Policy (ONDCP) publishes a National Drug Control Strategy, as required by Congress. In the early months of each year, the White House Office of Management and Budget (OMB) releases a President's Budget Request. In theory, the two documents should reinforce each other — the strategy setting direction, the budget providing the means to pursue it. In practice, reading them side by side this year reveals a more complicated dynamic.

The 2026 National Drug Control Strategy (NDCS), released May 4, 2026, makes genuine commitments to combating the overdose crisis, the only active public health emergency. It calls for expanded access to FDA-approved medications for opioid use disorder, affordable naloxone, evidence-based prevention, a trained behavioral health workforce and coordinated overdose surveillance. It frames addiction as a chronic, treatable condition, acknowledges that recovery takes many forms and recognizes the life-and-death importance of employment and supports reentry from incarceration.

The FY 2027 President's Budget Request, released April 3, 2026, proposes to cut, consolidate or eliminate many of the programs that make those commitments operational. Prevention coalitions, behavioral health workforce grants, drug use surveillance systems, recovery housing, treatment and employment programs for justice-involved individuals, and the agency responsible for coordinating the entire federal drug control effort — all face proposed reductions. The gap between what the strategy promises and what the budget funds is the central policy problem this analysis examines.

Understanding that gap matters because federal strategy documents shape how agencies, states and communities frame their work. When the strategy sets a direction and the budget points elsewhere, the institutions, providers and people who depend on that funding are left navigating the contradiction. The Overdose Prevention Initiative's analysis walks through the four core areas of the 2026 strategy — prevention, treatment, recovery and overdose prevention — and traces what the budget actually proposes[1] for each.

What the 2026 National Drug Control Strategy Promises

The Office of National Drug Control Policy (ONDCP) is required by statute to produce the National Drug Control Strategy biennially and to certify that federal agency budget requests align with it. The 2026 strategy organizes its public health commitments around four areas: prevention, treatment, recovery and overdose response[2].

On prevention, the strategy emphasizes stopping drug use before it starts, particularly among youth. It calls for expanded access to evidence-based, faith-based and

[1] These four areas correspond to Chapters 5 through 8 of the 2026 National Drug Control Strategy: Chapter 5 (Prevention), Chapter 6 (Treatment), Chapter 7 (Recovery) and Chapter 8 (Overdose Response).
[2] These areas correspond to Chapters 5 through 8 of the 2026 NDCS.

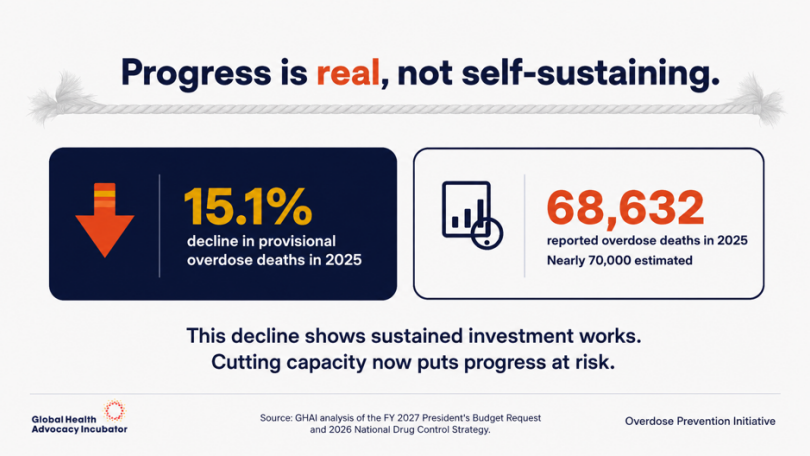
community-based prevention services, supports the Drug Free Communities Support Program and introduces a new Prevention Framework intended to guide federal and local prevention efforts.

On treatment, the strategy commits to ensuring that high-quality, evidence-based treatment is available to every American who needs it. It emphasizes early detection, expanded use of FDA-approved medications for opioid use disorder (MOUD) — buprenorphine, methadone and naltrexone — integration of substance use disorder (SUD) treatment into primary care and a trained workforce sufficient to deliver care across the country, including in rural and underserved areas.

On recovery, the strategy recognizes that there is no single path. It calls for expanding peer support services, building recovery-ready workplace programs, supporting community-based recovery infrastructure and ensuring that people leaving incarceration have access to the full continuum of care. It identifies stable housing, including recovery residences, as foundational to sustained recovery.

On overdose prevention, the strategy calls for accurate and timely surveillance data, expanded access to naloxone, support for drug checking programs, post-overdose linkages to treatment and development of new overdose reversal medications. It views each nonfatal overdose as an opportunity to connect someone to care.

Across all four areas[3], the strategy frames its commitments as building on progress already made — most notably the provisional 15 percent decline in overdose deaths in 2025, as reported by the Center for Disease Control and Prevention (CDC). It treats the evidence base, the existing infrastructure and the federal-state partnership as assets to be strengthened.



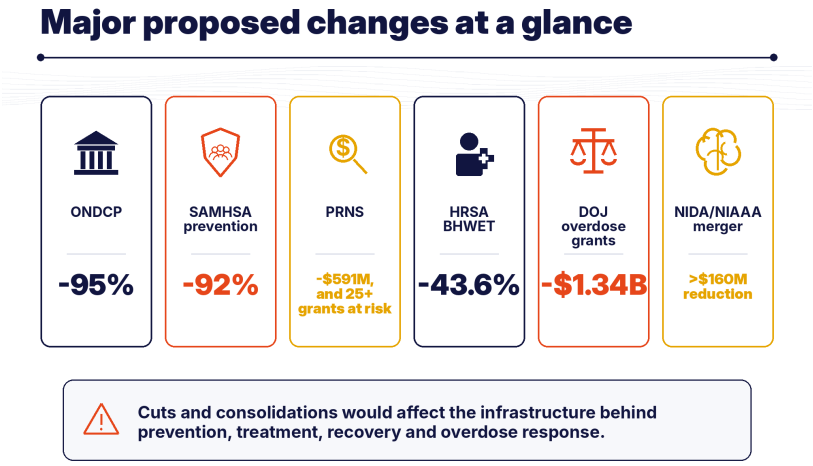
[3] These four areas correspond to Chapters 5 through 8 of the 2026 National Drug Control Strategy: Chapter 5 (Prevention), Chapter 6 (Treatment), Chapter 7 (Recovery) and Chapter 8 (Overdose Response).

What the FY 2027 President's Budget Request Proposes

The FY 2027 President's Budget Request, released by the Office of Management and Budget (OMB) on April 3, 2026, proposes significant reductions and structural changes across the federal behavioral health and overdose prevention systems.

At the Substance Abuse and Mental Health Services Administration (SAMHSA), the Budget Request proposes $222 million in total cuts to prevention programs — a 92 percent[4] decrease in discretionary budget authority for prevention. It proposes $591 million in cuts — from approximately $1.2 billion to roughly $600 million — to Programs of Regional and National Significance (PRNS), including the elimination of more than 25 PRNS grants that fund state and community programs. It proposes $74 million in total cuts to community-based treatment services and a $135 million cut to Health Surveillance and Program Support programs, including the proposed elimination of the Drug Abuse Warning Network (DAWN) — the national surveillance system that captures data on drug-related emergency department visits to help identify emerging overdose threats before they become outbreaks[5].

The Budget Request also proposes to consolidate SAMHSA's three primary behavioral health formula grants — the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant, the State Opioid Response (SOR) grants and the Mental Health Block Grant (MHBG) — into a single Behavioral Health Innovation Block Grant. While the proposal maintains overall dollar levels, the three current funding streams carry distinct statutory purposes and accountability requirements, and their consolidation would have significant implementation consequences, discussed below.



[4] The 92 percent cut reflects reductions to the Center for Substance Abuse Prevention (CSAP) and related programs — the primary SAMHSA programs funding prevention activities.
[5] DAWN is distinct from SAMHSA's National Survey on Drug Use and Health (NSDUH), which tracks population-level SUD behaviors. Both are discussed further in the Surveillance subsection below.

At the Health Resources and Services Administration (HRSA), the Budget Request proposes a $49 million, or 43.6 percent, reduction to the Behavioral Health Workforce Education and Training (BHWET) portfolio. It also proposes to eliminate $19 million in funding for other mental and behavioral health workforce grants and to eliminate the Behavioral Health Workforce Data and Development program, which tracks provider supply and demand nationally.

At the National Institutes of Health (NIH), the Budget Request proposes to merge the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) into a single new institute, with a combined budget reduction of more than $160 million — approximately 26 percent of their combined current funding. In practice, that reduction would shrink the federal research capacity for developing SUD medications and new overdose reversal agents, with direct consequences for the gaps in the current treatment toolbox. Reduced funding will also reduce the pipeline not only for new medications for stimulant use disorder and new synthetic substances, but also the number of new researchers available. The pipeline for developing them would narrow under a combined, underfunded institute at precisely the moment the drug supply is most volatile.

The Administration has also proposed a significant restructuring of the Department of Health and Human Services through its reorganization plan — including changes to how agencies like the Advanced Research Projects Agency for Health (ARPA-H) are organized and resourced. Even absent specific budget cuts, agency reorganizations create institutional disruption, transfer knowledge and delay program delivery. Advocates should monitor the HHS restructuring alongside the appropriations process[6].

Outside of HHS, several departments operating key overdose prevention grants would also experience funding cuts. At the Department of Housing and Urban Development (HUD), the Budget Request proposes to eliminate the Continuum of Care (CoC) program, the primary federal funding stream for permanent supportive housing for people experiencing homelessness, including those with SUD; the Community Development Block Grant (CDBG) program, which funds temporary recovery housing through HUD's Recovery Housing Program; and the Interagency Council on Homelessness, the coordinating body for federal housing and homelessness policy[7]. At the Department of Justice (DOJ), it proposes $1.34 billion in total cuts to overdose-related grant programs, including $650 million for Office of Justice Programs State and Local Law Enforcement grants, $65 million for Juvenile Justice Programs and $497 million for Community Oriented Policing Services.

Though not an agency, ONDCP oversees several critical discretionary programs. The Budget Request proposes a 95 percent funding reduction for ONDCP and would eliminate

[6] For current status of the HHS reorganization, see HHS.gov and relevant congressional committee communications.
[7] CoC funds permanent supportive housing without preconditions; CDBG funds temporary recovery housing through HUD's Recovery Housing Program; the Interagency Council on Homelessness coordinates housing policy across federal agencies.

or transfer all discretionary federal drug control programs, including a proposed $39 million, or 36 percent, reduction to the Drug Free Communities (DFC) Support Program[8] and the elimination of CARA Section 103 Community-Based Coalition Enhancement Grants[9].

Where the Strategy and Budget Align

The strategy and budget share some general framing. Both acknowledge that overdose deaths have declined and that maintaining progress requires continued federal engagement. Both reference the importance of MOUD and do not propose repealing federal authorities that support prescribing or dispensing of buprenorphine or methadone.

The Budget Request does not propose cutting the CDC Overdose Prevention and Surveillance portfolio's overall funding level, though it does propose relocating that portfolio — a distinction that carries its own risks, discussed below.

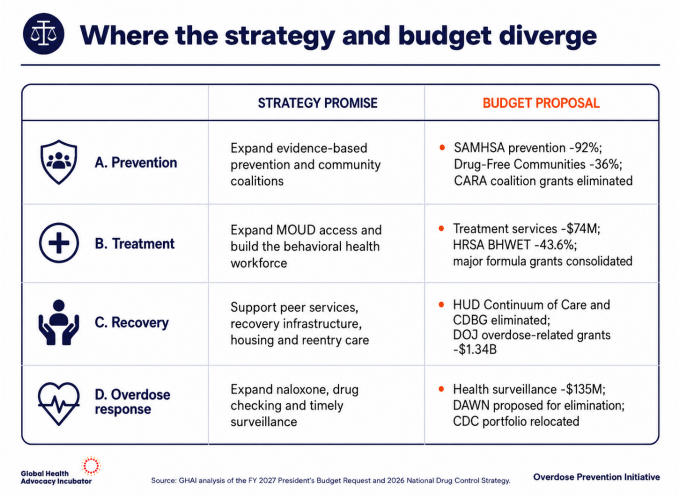
The strategy and the budget also share an emphasis on faith-based and community-based organizations as delivery partners, and both acknowledge the importance of evidence-based interventions, even where the budget does not fund the programs that carry them out.

These areas of nominal alignment are real, but narrow. They reflect shared rhetoric more than shared investment.

Where the Strategy and Budget Diverge

The following areas represent the most significant gaps between what the 2026 NDCS commits to and what the FY 2027 Budget Request proposes. Each is organized around the same three questions: *What does the strategy say? What does the budget propose? And why does the difference matter?*

[8] The DFC program funds community coalitions — typically involving schools, faith organizations, businesses and local government — to prevent youth substance use.
[9] CARA Section 103 grants are supplemental awards to existing DFC grantees specifically for opioid and stimulant prevention work.



Prevention

What the strategy says

The strategy calls for expanded, evidence-based prevention programming at the community level, explicitly highlighting the Drug Free Communities Support Program and local coalitions as the front line of prevention efforts. Chapter 5 introduces a new national Prevention Framework intended to guide federal and community-based prevention work.

What the budget proposes

The Budget Request proposes a 92 percent cut to SAMHSA prevention discretionary funding — reducing CSAP and related programs from approximately $241 million to roughly $19 million[i]. It also proposes a 36 percent reduction — $39 million — to the Drug Free Communities Support Program and the elimination of CARA Section 103 coalition enhancement grants, which are supplemental awards to DFC grantees specifically for opioid and stimulant issues[10]. These reductions sit within the broader $591 million proposed cut to SAMHSA PRNS, which would eliminate more than 25 grants currently supporting state and community programs.

Why it matters

The strategy identifies coalitions as essential to prevention. The budget proposes to eliminate the programs that fund them. A 36 percent cut to DFC and elimination of the CARA enhancement grants does not redirect that coalition activity; it stops it. Without the coalition infrastructure the strategy depends on, the Prevention Framework has no mechanism for reaching communities.

[10] CARA Section 103 grants are supplemental awards to existing DFC grantees specifically targeting opioid and stimulant prevention.

Treatment workforce

What the strategy says

The strategy commits to ensuring treatment is available to every American and explicitly recognizes that meeting that commitment requires a trained, adequate behavioral health workforce to deliver care — including in rural and underserved areas.

What the budget proposes

The Budget Request proposes a 43.6 percent reduction — approximately $49 million — to HRSA's BHWET portfolio. It also proposes eliminating $19 million in additional behavioral health workforce grants and the Behavioral Health Workforce Data and Development program, which is the federal mechanism for tracking provider supply and demand across the country. The country already faces serious behavioral health workforce shortages, particularly in rural areas, where 96 percent of counties are designated mental health professional shortage areas. The proposed cuts would deepen those shortages.

Why it matters

Ninety-six percent of rural counties are already designated mental health professional shortage areas. Cutting the provider training pipeline deepens those shortages in the places least equipped to absorb them. Eliminating the workforce tracking program at the same time means there is no federal mechanism to identify where need is greatest or whether any remaining investment is going to the right places.

Formula grant consolidation

What the strategy says

The strategy commits to ensuring that evidence-based SUD treatment is available to every American and frames the existing federal-state funding partnership as foundational infrastructure to be strengthened, not restructured.

What the budget proposes

The Budget Request proposes to consolidate the SUPTRS Block Grant, SOR grants and MHBG into a single Behavioral Health Innovation Block Grant. The proposal maintains overall dollar levels but eliminates the three separate funding streams and their distinct statutory purposes, allocation formulas and accountability requirements.

Why it matters

Level total funding in a merged pool is not the same as level funding for SUD. Without dedicated carve-outs, SUD programming would compete directly with mental health programming for the same flexible dollars. That is not a neutral structural change — SUDs have historically received less political attention than acute mental health emergencies, and that dynamic does not disappear when the two programs share a budget line. That consolidation lands at a particularly difficult moment: enacted changes to Medicaid under the One Big Beautiful Bill Act are projected to result in more than 1.6 million enrollees with SUD losing their insurance coverage, significantly increasing demand on block grant-funded services with no additional resources to meet it[11].

Surveillance

What the strategy says

The strategy calls for accurate, timely surveillance data as the foundation of a coordinated overdose response — identifying emerging threats, anticipating overdose clusters and directing resources to the communities at greatest risk before outbreaks expand.

What the budget proposes

The Budget Request proposes to eliminate DAWN, the national system that captures SUD-related emergency department data to determine community-level overdose risk before an outbreak. Staff overseeing SAMHSA's National Survey on Drug Use and Health (NSDUH) — the primary tool for tracking national SUD behaviors — have been fired or transitioned to contractors, raising concerns about the continuity and independence of future data collection. A SAMHSA Dear Colleague letter, a reversal from previous agency guidance, now prohibits the use of HHS funds for fentanyl test strips and other substance test kits. This would remove an early detection tool the strategy explicitly endorses.

Why it matters

Without DAWN and a functioning NSDUH, health departments and first responders lose the early warning capacity that allows communities to get ahead of outbreaks rather than react after deaths accumulate. The fentanyl test strip prohibition closes another detection channel the strategy specifically endorses. Removing these tools does not make drug use less visible; it makes it less measurable — and less measurable threats are harder to fund responses to.

[11] Source: American Progress analysis drawing on CBO and Urban Institute modeling.

Research

What the strategy says

The strategy commits to modernizing SUD medications and developing new overdose reversal agents, recognizing that the rapidly changing drug supply creates treatment challenges that current FDA-approved medications do not fully address.

What the budget proposes

The Budget Request proposes to merge NIDA and NIAAA with a combined budget reduction of more than $160 million — approximately 26 percent of their combined current funding. Separately, a SAMHSA clinical guidance letter has encouraged the tapering and discontinuation of MOUD, directly contradicting the strategy's stated commitment to making those medications readily available.

Why it matters

There are no FDA-approved medications for stimulant use disorder and no specific overdose reversal agent for xylazine, which is now present in a significant share of the nation's drug supply. Developing them requires sustained research investment. A combined institute with a reduced budget is a narrower pipeline for exactly the medications the strategy says it wants to make available. The MOUD guidance letter compounds the problem: patients and providers seeking consistent federal direction on evidence-based treatment are now receiving conflicting signals from the same Administration.

Housing

What the strategy says

The strategy identifies stable housing — including recovery residences — as a central component of recovery-ready communities and foundational to sustained recovery. The strategy frames housing as essential infrastructure, not a supplemental benefit.

What the budget proposes

The Budget Request proposes to eliminate HUD's Continuum of Care program, the Community Development Block Grant program and the Interagency Council on Homelessness[12]. It also proposes shifting federal homelessness policy from a Housing First model to a Treatment First model — replacing an approach that provides stable housing without preconditions with one that conditions access to housing on sobriety or treatment compliance. Addiction is a chronic, relapsing condition, placing more barriers to treatment will exacerbate, not resolve, these issues.

Why it matters

Housing First[13] is associated with reduced emergency department use, decreased criminal justice involvement and better long-term recovery outcomes for people with SUD. Treatment First[14] models require demonstrated sobriety or compliance before a person can access stable housing — a sequencing problem for people whose capacity to engage in treatment depends on first having a safe place to sleep. For many people with SUD, housing stability is what makes treatment adherence possible, not the other way around. The proposed policy shift and funding eliminations do not redirect the underlying need; they transfer it — most often to emergency shelters, hospitals and jails.

Supports for Justice-involved Populations

What the strategy says

The strategy emphasizes improving outcomes and reducing recidivism for individuals with SUD involved in the criminal justice system; while specifically highlighting first-responder deflection programs, drug courts, treatment courts and treatment and recovery support services in carceral settings — state prisons, local jails and community supervision.

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[12] CoC provides permanent supportive housing; CDBG funds temporary recovery housing through HUD's Recovery Housing Program; the Interagency Council on Homelessness coordinates federal housing policy.

[13] The **Housing First model** is a homeless assistance approach that provides permanent, unconditional housing to individuals experiencing homelessness as quickly as possible, without prerequisites like sobriety, employment, or psychiatric treatment. Once housed, participants are offered voluntary supportive services to maintain housing stability

[14] The **Treatment First** model is an approach to social services—particularly in homelessness and addiction treatment—that requires individuals to successfully complete psychiatric or substance abuse treatment before they can access permanent housing. Sobriety and psychiatric compliance are treated as strict prerequisites

What the budget proposes

The Budget Request proposes $1.34 billion in cuts to Department of Justice (DOJ) overdose-related grant programs that support first-responder deflection programs, treatment courts and other treatment and recovery initiatives, including $650 million for Office of Justice Programs State and Local Law Enforcement grants, $65 million for Juvenile Justice Programs and $497 million for Community Oriented Policing Services. Advocates should also verify whether proposed reductions affect Second Chance Act reentry and employment grant programs, which address the employment side of reentry the strategy references.

Why it matters

Evidence suggests that individuals are approximately 40 times more likely to die from an overdose in the two weeks following release from incarceration than the general population. The deflection programs, treatment courts and carceral treatment services the strategy highlights exist to reduce that risk. Cutting the grants that fund them reduces capacity at one of the highest-stakes intervention points in the system.

Enacted changes to Medicaid under the One Big Beautiful Bill Act also affect this population, though through a different mechanism than discretionary appropriations. The suspension-instead-of-termination requirement that took effect January 2026 requires states to maintain rather than terminate Medicaid coverage during incarceration. States can also use Medicaid Section 1115 waivers to support coverage continuity for up to 90 days prior to release. Notably, individuals who are or recently have been incarcerated are among those explicitly exempted from the Act's new work reporting requirements. Even so, states face real administrative and information challenges in correctly identifying and applying those exemptions — and states that do not adequately address those implementation details risk creating coverage gaps for exactly the population the strategy targets. The combination of DOJ grant cuts and Medicaid implementation risk makes continuity of care at reentry more fragile, not less.

Recovery-Ready Workplaces

What the strategy says

The NDCS commits to promoting recovery-ready workplace programs nationally — policies that help employees address SUD and sustain recovery while remaining in or returning to the workforce. The strategy highlights the business case for these programs: reduced turnover, increased productivity and stronger workplace culture. It calls for streamlining the recovery-ready certification process to increase employer uptake and explicitly cites HRSA's Substance Use Disorder Treatment and Recovery Loan Repayment

Program (STAR-LRP) as a tool for building the peer workforce that supports recovery-ready environments.

What the budget proposes

There is no dedicated federal funding stream for recovery-ready workplace programs, and the FY 2027 Budget Request does not create one. Currently, states mainly fund recovery-ready workplace initiatives by redirecting dollars from the State Opioid Response grant and opioid settlement funds — flexible sources not designed or sized for this purpose. The Budget Request proposes a $49 million, or 43.6 percent, cut to HRSA's Behavioral Health Workforce Education and Training portfolio, which includes programs that train the peer recovery specialists the strategy identifies as central to recovery-ready workplaces. The STAR-LRP, while not proposed for elimination, receives no proposed increase despite the strategy's explicit reliance on it to grow the peer workforce.

Why it matters

The strategy sets a national target for recovery-ready workplaces while proposing no dedicated funding to meet it. The peer workforce that makes recovery-ready workplaces functional — trained specialists who support employees navigating SUD and recovery — depends on HRSA training grants that are being cut. States already patching the gap with SOR dollars will face greater pressure to do so at the same time that the SOR grant faces consolidation into a single block grant where SUD programming competes openly with mental health for every dollar. The result is a strategy that calls for employer engagement in recovery without the workforce investment or dedicated infrastructure required to make that engagement possible.

ONDCP itself

What the strategy says

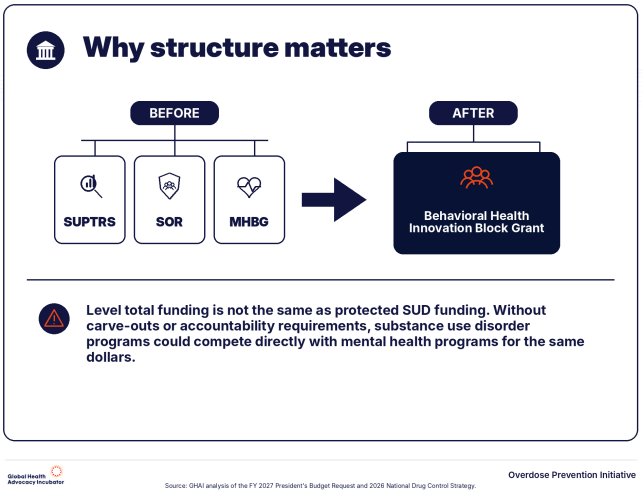
By statute, ONDCP is responsible for producing the National Drug Control Strategy and certifying that federal agency budget requests align with it. It is the coordinating mechanism that is supposed to ensure the rest of the federal government follows the strategy's direction.

What the budget proposes

The Budget Request proposes a 95 percent funding reduction for ONDCP and would transfer or eliminate all of its discretionary programs. Moreover, the opioid crisis has been an active public health emergency since 2017, and ONDCP has served as the coordinating body for the whole-of-government response.

Why it matters

An agency reduced to a fraction of its current capacity cannot credibly perform the coordination and certification functions the law requires — particularly in the same year the Administration releases a new two-year strategy. Reducing ONDCP by 95 percent does not slightly constrain its capacity; it functionally eliminates its ability to lead the coordinated response the strategy describes. The strategy becomes a document with no mechanism for enforcement.



Why Structure Matters, Not Just Topline Funding

Federal funding discussions often focus on dollar amounts. The more consequential question is frequently about structure: how money flows, which entities oversee it and what it is permitted to do. Several of the proposed changes in the FY 2027 Budget Request affect not just the amount of funding available but the governance architecture that ensures those funds reach the right programs. Understanding who is responsible for what — and what happens when that responsibility is diminished — is essential context for advocates engaging the appropriations process.

SAMHSA and the formula grant consolidation

SAMHSA is the primary federal agency responsible for administering behavioral health formula grants. The SUPTRS Block Grant, SOR grants and MHBG each carry specific statutory purposes, allocation formulas and reporting requirements. States have built SUD treatment systems, opioid response programs and overdose prevention networks around those structures. Opioid response coordinators, overdose prevention service providers, peer support programs and rural treatment networks have all been developed against the predictable, dedicated funding those grants provide.

A single consolidated block grant does not automatically protect any of those uses. Without carve-outs or minimum spending requirements, states face genuine pressure to direct flexible dollars toward whatever crisis is most visible at the moment of allocation. SUDs, which have historically received less political attention than acute mental health emergencies, are at risk of losing ground in that competition. Level funding in a merged pool is not neutral — it changes the terms on which SUD programming competes for every dollar.

HRSA and workforce tracking

HRSA's Behavioral Health Workforce Data and Development program provides the tracking infrastructure that identifies where provider shortages are worst and whether workforce investments are actually closing the gap. Eliminating it means there is no federal mechanism to connect training investments to need. Reducing BHWET training funding at the same time compounds the problem: the pipeline of new providers narrows precisely when the data infrastructure to target remaining investments is being removed.

ONDCP and coordination

ONDCP does not run treatment programs. Its role is coordination and certification — ensuring that what agencies propose to fund is consistent with the national strategy. A 95 percent budget reduction does not slightly reduce that capacity; it functionally eliminates the ability to perform it. Without a functioning ONDCP, there is no federal body with the authority and resources to hold the line between what the strategy says and what agencies actually budget.

HHS reorganization

The Administration's proposed restructuring of HHS — including changes to how agencies like ARPA-H are organized and resourced — adds a layer of structural concern beyond specific line-item cuts. Organizational transitions create gaps in institutional knowledge, disrupt established workflows and slow program delivery even when funding nominally remains in place. The effects of a reorganization can outlast the budget cycle that initiated it. Advocates should monitor the restructuring plan with the same attention they give to appropriations line items, because both shape what programs can actually do.

Structural integrity is what makes a program durable. When that structure is weakened — even when nominal dollar amounts are maintained — the practical result is often a loss of targeting, accountability and reach.

What This Means for Communities and Patients

The proposed cuts and structural changes described above are not abstract policy questions, they mean less accountability and oversight of funding decisions that have real impacts. Whether patients realize it or not, these programs shape their ability to access care, find stable housing, connect to a trained provider and receive consistent information about treatment.

A person seeking treatment for opioid use disorder in a rural county where the nearest prescriber is 60 miles away depends on HRSA workforce grants to ensure that a trained provider is reachable. A person leaving prison after a three-year sentence for a drug offense depends on Medicaid continuity and reentry-focused DOJ grants to connect to medication and care before the highest-risk window closes. A community health worker distributing naloxone in a neighborhood where overdose calls have spiked depends on PRNS grants and local coalition infrastructure to stay funded and operational.

State and local health departments depend on DAWN and the NSDUH to understand where new drug threats are emerging — fentanyl analogs, xylazine adulteration, polysubstance combinations — and to direct resources accordingly. When those systems are cut or restructured, the warning time that allows communities to respond compresses or disappears.

Recovery housing organizations that rely on HUD's Continuum of Care funding provide the stable platform that makes treatment adherence and long-term recovery achievable for people who have no other safe place to land. Eliminating that funding does not solve the underlying need; it transfers it — often to emergency shelters, hospitals and jails.

Prevention coalitions in rural and suburban communities — many of them funded through the DFC program and CARA coalition grants — deliver the community-based, faith-based and family-focused programming the strategy identifies as the front line of prevention. A 36 percent cut to DFC and elimination of the enhancement grants does not redirect that prevention activity; it stops it.

Each of these is a real consequence for a real community. The programs at stake are not redundant or duplicative; they are the connective tissue between the federal commitment in the strategy and the person who either receives care or does not.

What Advocates Should Watch

The Budget Request opens a congressional appropriations process that will unfold over the coming months. The following decision points for Congress deserve close attention from advocates.

Behavioral health formula grant consolidation

Whether Congress preserves the SUPTRS Block Grant, SOR grants and MHBG as separate, dedicated funding streams — or accepts some version of the proposed consolidation — will determine whether SUD programs have protected resources or compete openly with mental health for flexible dollars.

SAMHSA PRNS cuts

The proposed elimination of more than 25 Programs of Regional and National Significance would end dozens of grant programs that fund direct services at the state and community level. Advocates should identify which specific programs are proposed for elimination and build the case for their restoration based on delivery data and community impact.

HRSA behavioral health workforce funding

The proposed 43.6 percent cut to BHWET would reduce the federal investment in training the next generation of SUD treatment providers. Workforce shortages are already a limiting factor in treatment access; further cuts will widen the gap between need and available care, particularly in rural areas.

ONDCP capacity and budget coordination

Whether ONDCP retains sufficient staffing and funding to perform its statutory coordination and certification functions will shape the coherence of the entire federal drug control effort. Advocates should monitor whether ONDCP's final appropriation is sufficient to perform those statutory functions and flag the governance gap if it is not.

HHS Reorganization

The FY 2027 President’s Budget Request again outlines a major HHS restructuring, including the proposed creation of the Administration for a Healthy America (AHA), which would combine SAMHSA, HRSA, OASH and several CDC centers and programs into one entity. Congress would need to act on changes that alter appropriations accounts, statutory responsibilities or how federal funds are provided, though HHS may pursue some administrative changes under existing authority. A similar proposal appeared in the FY 2026 President’s Budget Request and Congress did not enact it in final FY 2026 funding decisions. Nevertheless, communities should treat the repeated proposal as a live policy signal. Even partial restructuring could affect how behavioral health agencies and programs are organized, resourced and held accountable, independent of specific appropriations decisions. Advocates should track the reorganization plan alongside the appropriations process and flag for congressional staff any structural changes that would disrupt program continuity or slow delivery of overdose prevention and SUD treatment programs.

Justice-Involved Populations: Deflection, Treatment Courts and Carceral Programs

Congress should examine whether the $1.34 billion in proposed DOJ cuts affects first-responder deflection grants, drug and treatment court funding, Second Chance Act reentry programs and treatment and recovery services in carceral settings — the exact programs the NDCS highlights as essential to improving outcomes and reducing recidivism. Advocates at the intersection of criminal justice and public health should coordinate with DOJ-focused partners to track these specific line items.

CDC surveillance portfolio relocation

Even if CDC's overdose prevention funding levels are maintained, a structural reorganization of the portfolio introduces transition risks. Advocates should monitor whether institutional knowledge and program continuity are preserved through any relocation and whether data collection remains uninterrupted.

NIDA/NIAAA merger

Congressional appropriators will decide whether to authorize or fund the proposed merger of the two institutes. Given the rapidly changing illicit drug landscape — including stimulant use disorder, xylazine adulteration and polysubstance combinations for which no FDA-approved medications currently exist — maintaining research capacity in both substance use disorder and alcohol use disorder has direct consequences for the treatment pipeline the strategy commits to strengthening.

Housing programs

HUD's Continuum of Care program and Community Development Block Grant are not typically framed as overdose prevention tools, but they are foundational to the recovery infrastructure the strategy describes. Advocates working on housing policy should connect those dots explicitly in their congressional engagement, citing the evidence on Housing First and recovery outcomes.

Conclusion

Provisional CDC data report an estimated 68,632 drug overdose deaths in 2025 — a 15.1 percent decline from the prior year. That is the clearest evidence in years that the overdose epidemic is not intractable. The decline reflects what sustained, targeted federal investment in prevention, treatment and recovery supports can accomplish when it reaches communities at scale.

The 2026 National Drug Control Strategy acknowledges that progress. It commits to building on it. It describes, in some detail, the systems that need to be strengthened, the gaps that need to be closed and the people who need to be reached.

The FY 2027 President's Budget Request, on the other hand, proposes to cut many of those systems. Reductions to prevention coalitions, treatment workforce programs, recovery housing, surveillance infrastructure, justice-involved treatment programs and the coordinating capacity of ONDCP are not minor adjustments. They are proposed changes that would reduce the reach and durability of the exact federal response the strategy calls for expanding.

More than 80 percent of Americans who meet the clinical criteria for a substance use disorder do not currently receive treatment — before any of the proposed reductions take effect. The country does not face a shortage of need; it faces a shortage of capacity to meet that need. The programs proposed for reduction are not peripheral; they are the capacity.

Congress will determine the final outcome. The FY 2026 process demonstrated that bipartisan support for these programs exists on Capitol Hill, and that the case for maintaining them can be made and won. Advocates who want to see that outcome repeated will need to make the case with specificity — program by program, community by community, consequence by consequence.

Overdose deaths are falling. That progress is not self-sustaining. It is the result of investment in systems that work, and it is reversible if those systems are defunded before the work is done.

This analysis was produced by the Overdose Prevention Initiative at the Global Health Advocacy Incubators (GHAI), an initiative of the Campaign for Tobacco-Free Kids. All budget figures reflect proposed amounts in the FY 2027 President's Budget Request and do not represent enacted law. Medicaid changes referenced in this analysis reflect enacted statutory provisions under the One Big Beautiful Bill Act. Congress determines final discretionary appropriations.

FY 2027 President's Budget Request vs. 2026 National Drug Control Strategy

What Hill offices need to know.

The 2026 strategy calls for stronger prevention, treatment, recovery and overdose response. The FY 2027 budget request proposes cuts, consolidations or eliminations across many of the programs that make those commitments operational.

TOP TAKEAWAY

15.1%
decline in provisional overdose deaths in 2025

68,632
reported provisional overdose deaths in 2025
Nearly 70,000 predicted

Progress is real, not self-sustaining.

WHERE THE STRATEGY AND BUDGET DIVERGE

	STRATEGY PROMISE	BUDGET PROPOSAL
A. Prevention	Expand prevention and community coalitions	• SAMHSA prevention -92%; Drug-Free Communities -36%; CARA coalition grants eliminated
B. Treatment	Expand MOUD access and build the behavioral health workforce	• Treatment services -$74M; HRSA BHWET -43.6%; major formula grants consolidated
C. Recovery	Support peer services, recovery infrastructure, housing and reentry care	• HUD Continuum of Care and CDBG eliminated; DOJ overdose-related grants -$1.34B
D. Overdose response	Expand naloxone, drug checking and timely surveillance	• Health surveillance -$135M; DAWN proposed for elimination; CDC portfolio relocated

MAJOR PROPOSED CHANGES AT A GLANCE

- **ONDCP** -95%
- **SAMHSA** prevention -92%
- **PRNS** -$591M, 25+ grants at risk
- **HRSA BHWET** -43.6%
- **DOJ** overdose grants -$1.34B
- **NIDA/NIAAA** >$160M proposed reduction

WHY STRUCTURE MATTERS

BEFORE: SUPTRS | SOR | MHBG → AFTER: New consolidated block grant — Behavioral Health Innovation Block Grant

Level total funding is not the same as protected SUD funding. Without carve-outs or accountability requirements, SUD programs could compete with mental health programs for the same dollars.

WHAT COMMUNITIES STAND TO LOSE

- Local prevention coalitions and community grants
- Workforce capacity, especially in rural areas
- Fast detection of new drug threats
- Reentry continuity and overdose protection
- Recovery housing and community supports

WHAT CONGRESS CAN DO NEXT

- Preserve dedicated SUD funding streams.
- Restore prevention, workforce, PRNS and acrveillance funding.
- Protect reentry supports and Medicaid continuity.
- Maintain ONDCP capacity and federal accountability.

Source: GHAI analysis of the FY 2027 President's Budget Request and 2026 National Drug Control Strategy.

Overdose Prevention Initiative

[i] SAMHSA FY 2027 Congressional Budget Justification. CSAP is the primary SAMHSA office responsible for prevention activities. Exact base figures should be confirmed against the final justification.