The First 100 Days: The Trump Administration and Changes to Addiction Policy

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STRUCTURAL CHANGES

The nation's drug policy strategy, including both public health and supply reduction efforts, is by statute the purview of the White House Office of National Drug Control Policy (ONDCP). ONDCP is legally required to issue the Administration's drug policy priorities in the first year of a new Administration.[1] In April 2025, ONDCP issued drug policy priorities, a 5-page document that prioritized reducing the supply of illicitly manufactured fentanyl, as well as prevention strategies to reduce overdose deaths and youth substance use. This document establishes the drug policy priorities for the entire Administration, not just ONDCP.[2] Once the Administration issues priorities, each drug control agency is to develop budgets that support these priorities.[3] In the first 100 days of the Administration, the US Department of Health and Human Services (HHS) also renewed the public health emergency.[4]

This year, of course, is different. The Administration's drug policy priorities are not reflected in a recent US Department of Health and Human Services (HHS) "pass-back" document obtained by *The Washington Post*.[5] The Office of Management and Budget (OMB) issues guidance on an annual basis to federal agencies in advance of the President's budget request to Congress.

The document proposes the merger of various HHS subagencies, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of the Assistant Secretary, and the Health Resources and Services Administration. These agencies would be subsumed, along with others, into a new agency called the "Administration for a Healthy America," with a combined $20 billion budget. The ostensible reason for the new organizational structure is to "coordinate chronic care and disease prevention."[6] Other structural changes include reorganizing the National Institutes of Health (NIH) and combining the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Institute of Mental Health (NIMH). A similar effort to combine NIDA and NIAAA was attempted over a decade ago, but alcohol industry objections helped to squelch the idea.[7]

BUDGETARY AND PERSONNEL CHANGES

The Administration has been aggressively cutting HHS staff, including at SAMHSA and the Centers for Disease Control and Prevention (CDC). HHS plays a critically important role in carrying out the Administration's drug policy, but it is not the entirety of the federal government's drug control effort. To date, agencies with a supply-focused mission have not been greatly affected by cuts, although certain personnel from the US Department of Justice (DOJ) have been reassigned away from drug trafficking cases.[8] Cuts have also been made to DOJ grant programs, including those that prevent opioid deaths.[9]

The elimination of 20,000 HHS positions has resulted in a significant loss of expertise. In some instances, entire work groups have been eliminated. For example, the SAMHSA work group overseeing the National Survey on Drug Use and Health (NSDUH) has been terminated, and a sole employee remains in the NIH Office of Pain Policy and Planning.[10]

On the funding side, the Administration has clawed back billions of dollars appropriated by Congress in the American Rescue Plan. Litigation has temporarily halted this claw back, yet the future of these funds is uncertain.[11]

The pass-back document targeted several other SAMHSA grant programs for elimination, many of which have strong congressional support and a solid evidence base. However, 2 other SAMHSA programs, the State Opioid Response (SOR) grant and the Substance Use, Treatment, and Recovery Services (SUPTRS) block grant, were not on the eliminated grants list. These grants form the backbone of funding for state addiction services programs, but are insufficient to address the complexity of today's drug policy issues.

One of the most consequential programs for addiction services is Medicaid, administered by the Centers for Medicaid & Medicare Services.[12] Congress has not yet decided the fate of the Medicaid program. However, the congressional budget resolution directs the House Energy and Commerce to find savings of $880 billion over 10 years; savings of this magnitude are virtually impossible without Medicaid cuts.

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While most grant programs for substance use in the states are distributed through SAMHSA, the CDC is instrumental to state opioid responses. Unfortunately, the Injury Prevention Center at the CDC is reported to have lost key employees, which has broader implications for CDC work on overdose prevention.

National Institute of Health (NIH) grant terminations have focused heavily on grants considered inconsistent with the Administration's priorities. Grants addressing diversity, equity, and inclusion, and those designed to engender diversity in the scientific workforce have been terminated. Nearly one-third of terminated grants are HIV/AIDS-related, with many involving substance use/addiction research.[13]

DATA COLLECTION CHANGES

The drug supply is constantly evolving, making this among the most challenging aspects of drug policy, especially during an era of synthetic drugs. However, data sets such as the Drug Abuse Warning Network (DAWN) have been targeted for elimination. The DAWN system collects data from emergency departments, providing policymakers and clinicians with early warnings about new drug trends. Early identification of new drugs in individuals presenting in emergency rooms helps health care providers understand how to address the health issues associated with new drugs. Public safety professionals also use this information to stay informed about new illegal drug trends.

Another essential data set facing an uncertain future is the National Survey on Drug Use and Health (NSDUH). NSDUH is the sole survey on substance use and mental health issues for individuals 12 and older. NSDUH provides policymakers and the public with information about emerging drug use and mental health issues. NSDUH helps to ensure that efforts are spent on today's substance use issues, especially important to prevention efforts reliant upon current drug trends among new initiates.

The Youth Risk Behavior Survey and Monitoring the Future surveys are not currently at risk. These surveys identify youth use of alcohol, tobacco, and other drugs. However, these data sets do not have NSDUH's breadth of information.

CONCLUSIONS

These wholescale changes make it difficult to predict the impact on clinical care for patients and others affected by substance use. Changes to Medicaid will have ramifications for patients, as it is one of the primary payors for addiction treatment. Changes to data collection may result in reduced early warning and challenges in tracking the impact of treatment efforts. Research efforts, and hence progress, that address diversity, equity, HIV/AIDS, and pain—all important challenges and comorbidities among people who use drugs—will be slowed.

Upcoming budget discussions are an important inflection point for the US approach to addiction. These times demand that those who work in the addiction field pay close attention.

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