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The SUPPORT for Patients and Communities Reauthorization Act of 2025: Section-by-Section Summary

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The SUPPORT for Patients and Communities Reauthorization Act of 2025: Section-by-Section Summary

The SUPPORT for Patients and Communities Reauthorization Act (P.L. 119-44) was enacted on December 1, 2025. The act primarily reauthorized or amended existing behavioral health (i.e., mental health and substance use) programs originally authorized or reauthorized by the SUPPORT for Patients and Communities Act (SUPPORT Act; P.L. 115-271) in 2018. The SUPPORT Act of 2018 authorized or reauthorized discretionary appropriations for (1) behavioral health-related programs related to substance use disorder prevention, treatment, and recovery activities; (2) programs that seek to expand consumer education on opioid use; and (3) training for the medical and behavioral health workforce, among other activities. Many of those authorizations of appropriations expired at the end of FY2023, though most existing programs received annual appropriations in FY2024 and continued to operate. The SUPPORT Reauthorization Act of 2025 generally reauthorizes appropriations for many of these programs through FY2030. Several authorizations included in the SUPPORT Act of 2018 were not reauthorized by P.L. 119-44.

In summary, the titles of the SUPPORT for Patients and Communities Reauthorization Act address the following:

- *Title I—Prevention* focuses on activities related to the prevention of substance misuse and overdose and associated harms, including federal programs that target pregnant woman and infants, youth, and overdose prevention efforts.
- *Title II—Treatment* focuses on substance use disorder treatment activities, including federal programs that support behavioral health workforce training, disseminate best practices in the treatment of substance use disorders, and promote the use of approved medications for opioid use disorder and related overdoses.
- *Title III—Recovery* focuses on substance use disorder recovery efforts, including federal programs that support a spectrum of recovery-related services and resources.
- *Title IV—Miscellaneous* focuses on federal laws that regulate the delivery and dispensing of controlled substances and the training requirements for prescribing practitioners.

The SUPPORT for Patients and Communities Reauthorization Act of 2025 is an authorizing law; it does not appropriate any funds. Not all programs amended or reauthorized by the law have received explicit appropriations.

This report provides a section-by-section summary of the SUPPORT for Patients and Communities Reauthorization Act of 2025, organized by title of the act. It includes relevant background information, followed by a summary of each provision. **Table 1** identifies expired authorizations of appropriations in the SUPPORT Act of 2018, annual appropriations associated with the authorization, and whether P.L. 119-44 reauthorizes the provision.

SUMMARY

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February 26, 2026

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Introduction

The SUPPORT for Patients and Communities Reauthorization Act was enacted on December 1, 2025. The act primarily reauthorized or amended existing behavioral health (i.e., mental health and substance use) programs originally authorized or reauthorized by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, or the SUPPORT for Patients and Communities Act (SUPPORT Act; P.L. 115-271), enacted on October 24, 2018. The SUPPORT Act built on previous efforts by the federal government to address the opioid crisis.[1] Broadly, the SUPPORT Act imposed tighter oversight of prescription opioid production and distribution; required additional reporting and safeguards to address fraudulent prescribing of opioid medications; and limited coverage of prescription opioids, while expanding coverage of and access to opioid use disorder treatment services.

The SUPPORT Act of 2018 authorized or reauthorized several discretionary appropriations for behavioral health-related programs administered by various departments and agencies. These authorizations related primarily to substance use disorder prevention, treatment, and recovery activities; programs that seek to expand consumer education on opioid use; and training for the medical and behavioral health workforce. Many of those authorizations of appropriations expired at the end of FY2023.[2] The SUPPORT Reauthorization Act of 2025 generally reauthorizes appropriations for many of these programs through FY2030. Several authorizations included in the SUPPORT Act of 2018 were not reauthorized.

CRS previously published a series of reports on the SUPPORT Act of 2018. The specific sections of the SUPPORT Act referenced in this report are described in more detail in the following CRS reports:

- CRS Report R45423, *Public Health and Other Related Provisions in P.L 115-271, the SUPPORT for Patients and Communities Act*;
- CRS Report R45405, *The SUPPORT for Patients and Communities Act (P.L. 115-271): Food and Drug Administration and Controlled Substance Provisions*; and
- CRS Report R45449, *The SUPPORT for Patients and Communities Act (P.L.115-271): Medicare Provisions*.

Most of the provisions amended by the SUPPORT Reauthorization Act of 2025 authorize grant programs administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services (HHS).[3] SAMHSA is the federal agency primarily responsible for supporting community-based mental health and substance use disorder treatment and prevention services. SAMHSA provides federal funding to states, local communities, and individual organizations through block grants and other formula and discretionary grants. Through such grants, SAMHSA supports activities that include

[1] For background information on the opioid crisis, see CRS In Focus IF12260, *The Opioid Crisis in the United States: A Brief History*, and CRS Video WVB00631, *The Opioid Crisis*.

[2] Most programs received appropriations in FY2024 and therefore continued despite an expired authorization of appropriations in their authorizing statute. For more information, see **Table 1**.

[3] For more information on SAMHSA, see CRS Report R46426, *Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs*. Of note, SAMHSA underwent some organizational restructuring in 2025, in part due to significant reductions in force made by the Trump Administration. For more information, see Jessie Hellmann, "Addiction, Mental Health Agency Eviscerated Under Trump," *Roll Call*, November 6, 2025, https://rollcall.com/2025/11/06/addiction-mental-health-agency-eviscerated-under-trump/.

education and training, prevention programs, early intervention activities, treatment services, and technical assistance. SAMHSA does not provide mental health or substance abuse treatment. Rather, the agency supports states' efforts in providing community-based behavioral health services. SAMHSA derives most of its statutory authority from the Public Health Service Act (PHSA). More specifically, Title V and Title XIX of the PHSA contain most authorities for SAMHSA programs and activities. Many of the provisions in the SUPPORT for Patients and Communities Reauthorization Act amend or reauthorize statutory authorizations in the PHSA.

Other SUPPORT Reauthorization Act provisions amend or reauthorize activities carried out by the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and the Department of Housing and Urban Development (HUD).[4]

The SUPPORT for Patients and Communities Reauthorization Act of 2025 (P.L. 119-44) passed the House in June 2025. It passed the Senate without amendment by Unanimous Consent in September and was signed by the President on December 1, 2025.

This report provides a section-by-section summary of the SUPPORT for Patients and Communities Reauthorization Act of 2025, organized by title of the act. It includes relevant background information, followed by a summary of each provision. **Table 1** identifies expired authorizations of appropriations in the SUPPORT Act of 2018, annual appropriations associated with the authorization, and whether P.L. 119-44 reauthorizes the provision.

The SUPPORT for Patients and Communities Reauthorization Act: At a Glance

In summary, the titles of the SUPPORT for Patients and Communities Reauthorization Act address the following:

- *Title I—Prevention* focuses on activities related to the prevention of substance misuse and overdose and associated harms, including federal programs that target pregnant woman and infants, youth, and overdose prevention efforts.
- *Title II—Treatment* focuses on substance use disorder treatment activities, including federal programs that support behavioral health workforce training, disseminate best practices in the treatment of substance use disorders, and promote the use of approved medications for opioid use disorder and related overdoses.
- *Title III—Recovery* focuses on substance use disorder recovery efforts, including federal programs that support a spectrum of recovery-related services and resources.
- *Title IV—Miscellaneous* focuses on federal laws that regulate the delivery and dispensing of controlled substances and the training requirements for prescribing practitioners.

[4] HRSA and CMS were among the HHS agencies affected by reductions in force in 2025. It is unclear what effects, if any, these personnel changes have on administration of programs described in this report. For more information, see Sophie Gardner, Ruth Reader, Lauren Gardner, et al., "Thousands Laid Off as Kennedy and Musk Take Aim at Health Agencies," *POLITICO*, April 1, 2025, https://www.politico.com/news/2025/04/01/kennedy-lays-off-thousands-across-the-health-bureaucracy-00262913.

The SUPPORT for Patients and Communities Reauthorization Act of 2025 is an authorizing law; it does not appropriate any funds. Not all programs amended or reauthorized by the law have received explicit appropriations.

In this report, "Secretary" refers to the HHS Secretary unless otherwise noted.

Title I—Prevention

Section 101. Prenatal and Postnatal Health

Background

PHSA Section 317L (under the heading "Prenatal and Postnatal Health") authorizes the Secretary, acting through the CDC Director, to collect data and carry out research and programs regarding the incidence, prevalence, and health outcomes associated with prenatal and postnatal smoking, alcohol use, and other substance use. In 2018, SUPPORT Act Section 7064 required the CDC director to collect additional data, such as data on prevention and long-term health outcomes; to assess the effectiveness of treatment programs (in addition to educational and cessation programs); and to issue specified public reports, among other activities. Section 317L also authorizes the Secretary to award grants or enter into contracts with states, local governments, and public and nonprofit entities such as scientific and academic institutions and federally qualified health centers (FQHCs).

To carry out these activities, Section 317L authorizes the Secretary to provide technical assistance to program grantees; ensure data sharing between states, tribes, and the CDC; ensure that data collection is conducted in a manner consistent with applicable privacy laws; and coordinate with the Office of the National Coordinator for Health Information Technology to assist states and tribes with implementing systems that are interoperable with other health information technology systems.

PHSA Section 317L previously authorized such sums as may be necessary to be appropriated for each of FY2019-FY2023.

Provision

Section 101 reauthorizes the activities in PHSA Section 317L. PHSA Section 317L(d) now authorizes $4.25 million to be appropriated for each of FY2026-FY2030.

Section 102. Monitoring and Education Regarding Infections Associated with Illicit Drug Use and Other Risk Factors

Background

PHSA Section 317N ("Surveillance and Education Regarding Infections Associated with Illicit Drug Use and Other Risk Factors") authorizes CDC to carry out programs or award grants for the surveillance and education regarding infections associated with illicit drug use. In 2018, SUPPORT Act Section 7141 replaced the previous text of PHSA Section 317N[5] and allowed the

[5] The previous authorization in PHSA 317N pertained to the prevention, detection, treatment, and awareness of hepatitis C infections.

CDC to address illicit drug-related infectious diseases—directly or through grants to public and nonprofit private entities—by monitoring infections commonly associated with illicit drug use, conducting public outreach, educating health professionals, and offering testing and treatment to individuals, among other activities.

PHSA Section 317N(d) previously authorized $40 million to be appropriated for each of FY2019-FY2023.

Provision

Section 102 reauthorizes the activities in PHSA Section 317N. PHSA Section 317N(d) now authorizes $40 million to be appropriated for each of FY2026-FY2030.

Section 103. Preventing Overdoses of Controlled Substances

Background

CDC conducts a variety of activities to address overdoses due to controlled substances (drugs), including (1) providing evidence-based tools, recommendations, and guidance for health care providers to improve prescribing of controlled substances; (2) providing public education and awareness regarding the risks of prescription drugs; (3) providing funding, resources, and information to states to prevent substance misuse, abuse, and overdose; (4) improving collaboration and communication between public health and public safety officials; and (5) collecting and analyzing data on drug-related overdoses and overdose deaths.[6] CDC derives the authority to conduct these activities from its general authorities, as well as from several specific provisions in the Public Health Service Act and other drug-related laws like the Comprehensive Addiction and Recovery Act (CARA; P.L. 114-198).

In 2018, SUPPORT Act Section 7161(a) added a new PHSA Section 392A, entitled "Preventing Overdoses of Controlled Substances." The provision allows the CDC Director to conduct activities related to overdoses of controlled substances, such as prevention programs, surveillance and data collection activities, and education and awareness. The provision also authorizes the CDC Director to award additional grants for innovative projects for rapid response and other evidence-based activities for preventing controlled substance misuse, abuse, and overdose. Subsection (b) of PHSA Section 392A allows the CDC Director to conduct controlled substance overdose data collection activities.

PHSA Section 392A(e) previously authorized $496 million to be appropriated for each of FY2019-FY2023 to carry out the activities in PHSA Section 392A, PHSA Section 399O (as amended by SUPPORT Act Section 7162), and CARA Section 102 (as amended by SUPPORT Act Section 7161(b)).[7]

Provision

Section 103 amends PHSA Section 392A in several places. Several amendments direct CDC to include activities related to the risks associated with drug-related overdoses in its overdose prevention efforts. Several other amendments expand the class of drugs beyond opioids to be addressed in authorized programs, adding any substances causing overdose (including emerging

[6] CDC, "CDC's Role in the Opioid Epidemic," https://www.cdc.gov/drugoverdose/prevention/cdc-role.html.

[7] For more information, see CRS Report R45423, *Public Health and Other Related Provisions in P.L 115-271, the SUPPORT for Patients and Communities Act*.

substances that can cause overdose) to several of the provisions (such as those authorizing data collection activities and additional grants for innovative prevention approaches for emerging public health crises).

The provision amends the authorization for additional grants in PHSA Section 392A(3), providing greater detail on the authorized activities of innovative projects to detect, identify, and rapidly respond to changing patterns of drug use and overdoses—including the use of innovative, evidence-based strategies such as wastewater surveillance.[8]

Section 103 reauthorizes the activities in PHSA Section 392A and extends the authorization of appropriations. PHSA Section 392A(e) now authorizes $505.579 million to be appropriated for each of FY2026-FY2030 to carry out the activities in PHSA Section 392A, PHSA section 399O, and CARA Section 102.[9]

Section 104. Support for Individuals and Families Impacted by Fetal Alcohol Spectrum Disorder

Background

PHSA Title III Part O ("Fetal Alcohol Syndrome Prevention and Services Program"; Sections 399H-399K)[10] authorized both a Fetal Alcohol Syndrome and Fetal Alcohol Effect prevention and services program and a National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect[s]. As the result of a sunset provision specified in PHSA Section 399K, Sections 399H-399K were no longer applicable as of October 25, 2007 (as described below). The following sections describe PHSA Sections 399H-399K prior to their omission.[11]

PHSA Section 399H required the Secretary to establish a comprehensive Fetal Alcohol Syndrome and Fetal Alcohol Effect prevention, intervention, and services delivery program. This program was authorized to include education and public awareness campaigns, care coordination strategies, applied research programs, related technical assistance activities, and the dissemination of diagnostic criteria. PHSA Section 399H also required the Secretary to establish the National

[8] For more information on wastewater-based surveillance, see, for example, Centers for Disease Control and Prevention, "Mapping Community Opioid Exposure Through Wastewater-Based Epidemiology as a Means to Engage Pharmacies in Harm Reduction Efforts," GIS Snapshots, vol. 17, August 20, 2020, https://www.cdc.gov/pcd/issues/2020/20_0053.htm, and Tamara Wright and Atin Adhikari, "Utilizing a National Wastewater Monitoring Program to Address the U.S. Opioid Epidemic: A Focus on Metro Atlanta, Georgia," *International Journal of Environmental Research and Public Health*, vol. 20, no. 7 (March 28, 2023).

[9] The new authorization matches the amount appropriated by Congress for these activities in FY2023 and FY2024 (see **Table 1**). In 2022, Section 1271 of the the Restoring Hope for Mental Health and Well-Being Act amended PHSA Section 392A by adding a new subsection (c) that allows the CDC Director to prioritize jurisdictions with a disproportionately high rate of drug overdoses or overdose deaths in awarding the opioid overdose prevention and data collection grants authorized in PHSA Section 392A subsections (a) and (b). The provision also makes a technical edit, renumbering the subsections accordingly.

[10] 42 U.S.C. §§280f et seq.

[11] In the 2006 Edition, Supplement II of the *United States Code*, 42 U.S.C. §§280f et seq. were omitted as of January 5, 2009. According to the U.S.C., "Sections 280f to 280f–3, which provided for the establishment of a Fetal Alcohol Syndrome prevention and services program, were omitted pursuant to section 280f–3 which provided that this part would no longer apply on the date that was 7 years after the date on which all members of the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect established under section 280f(d)(1) were appointed, which occurred May 17, 2000." Following the enactment of P.L. 119-44, 42 U.S.C. §§280f et seq. were reestablished in the *United States Code*, as amended by the law.

Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect[s] (hereinafter Task Force) and outlined the Task Force's key membership, functions, and reporting requirements.[12]

Section 399I provided eligibility criteria for applicants to the Fetal Alcohol Syndrome or Fetal Alcohol Effect prevention, intervention, and services program described in Section 399H.

Section 399J authorized $27.0 million to be appropriated for each of FY1999-FY2003. Section 399J also limited the amount that could be used for the National Task Force (outlined in PHSA 399H) to $2 million.

Section 399K authorized the expiration (or "sunset") of Sections 399H-399J to occur seven years after the date on which all members of the National Task Force had been appointed.

As a result of the expiration date authorized under Section 399K, Sections 399H-399J were no longer applicable after October 25, 2007—the date seven years after which all Task Force members had been appointed (i.e., October 24, 2000).[13]

Other programs and activities related to Fetal Alcohol Spectrum Disorders (FASD)[14] remain authorized through appropriations and other authorities, such as those established in PHSA Section 317C and authorities established in Title V, Section 501, of the Social Security Act.

Provision

Section 104 amends the previously omitted PHSA Title III Part O by replacing it with a new Part O (Sections 399H through 399J). Section 104 renames Part O as the "Fetal Alcohol Spectrum Disorders Prevention, Intervention, and Services Delivery Program" and replaces the previously used "Fetal Alcohol Syndrome or Fetal Alcohol Effect" with "Fetal Alcohol Spectrum Disorders" (hereinafter FASDs) throughout all of Part O.

New PHSA Section 399H(a) authorizes the Secretary to establish or continue a comprehensive FASD education, prevention, identification, intervention, and service delivery program. According to PHSA Section 399H(a)(1), the program may target the broader audience of health profession schools (previously only medical schools were specified); the program may also include the provision of services to infants in addition to the previously specified groups of children, adolescents, and adults with FASDs.

[12] The Task Force was chartered on May 17, 2000, by CDC's National Center on Birth Defects and Developmental Disabilities (NCBDDD) and issued its first recommendations on September 20, 2002. See Mary Kate Weber, R. Louise Floyd, Edward P. Riley, et al., *National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect: Defining the National Agenda for Fetal Alcohol and Other Prenatal Alcohol-Related Effects*, CDC, National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect, Morbidity and Mortality Weekly Reports (MMWR), vol. 51, RR14, September 20, 2002, pp. 9-12, https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5114a2.htm. In 2007, a Congressional

[13] In October 2007, prior to the Task Force's expiration, Congress directed the Task Force to submit a progress report outlining the Task Force's contributions to the prevention and reduction of FASDs, future plans, and programmatic and funding priorities (S.Rept. 110-107). See Kristen L. Barry, Raul Caetano, Grace Chang, et al., *Reducing alcohol-exposed pregnancies*, U.S. Department of Health and Human Services, A Report of the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect, Atlanta, GA, March 2009, https://stacks.cdc.gov/view/cdc/11566.

[14] In 1996, the Institute of Medicine of the National Academy of Science introduced the term "fetal alcohol spectrum disorders," or FASDs, as an umbrella term to reflect the full spectrum of defects that may arise from fetal alcohol exposure. FASDs include Fetal Alcohol Syndrome (FAS), which was previously named in PHSA Title III Part O, in addition to other conditions. For more information, see Institute of Medicine, *Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment*, Consensus, Washington, DC, 1996, https://doi.org/10.17226/4991, and Centers for Disease Control and Prevention, *About Fetal Alcohol Spectrum Disorders (FASDs)*, https://www.cdc.gov/fasd/about/index.html.

PHSA Section 399H(a)(2) reestablishes and revises prior authorities regarding research on FASD diagnosis and prevention. These authorities include a newly added focus on developing culturally and linguistically appropriate interventions for preventing prenatal alcohol exposure and the authority to include interventions that may co-occur with exposure to other substances.

PHSA Section 399H(a)(3) includes a new provision to build State and tribal capacity for the identification, treatment, and support of individuals with FASDs and their families. These activities may include the use and adaptation of existing federal, state, or tribal programs to include FASD-related activities, developing expanded screening and diagnostic capacities, evaluating interventions, providing training, and disseminating information about FASDs, among other activities. Section 399H(a)(4) reestablishes the authority of the Secretary to conduct the applied research program on FASDs.

PHSA Section 399H(b) authorizes the Secretary to establish grants and provide technical assistance. Part(b)(2) clarifies the list of eligible entities to include states, tribes or tribal organizations, local governments, scientific or academic institutions, or nonprofit organizations, and adds requirements regarding grant applications. These requirements are further detailed in Part (b)(3).

Section 399H(c) establishes a definition for the term "FASD-informed."

PHSA Section 399H does not include a subsection authorizing a national task force for FASD or its membership and functions, unlike prior versions. Additionally, Section 399H does not require the dissemination of diagnostic criteria (see above).

Section 399I directs the Secretary to award grants for the purposes of building local, tribal, state, and nationwide capacities to prevent the occurrence of FASD. Such grants may be used for developing public education activities, acting as a clearinghouse for evidence-based resources on FASD, increasing awareness of screening tools or intervention services, and providing technical assistance to other grantees established under PHSA Section 499H.

Section 399J authorizes $12.5 million to be appropriated for each of FY2026-FY2030. The provision also directs the Secretary to provide, no later than four years after enactment and every year thereafter, a report to specified congressional committees containing a review and evaluation of the activities carried out under PHSA Sections 399H and 399I.

PHSA Title III Part O, as amended, does not include sections that specify a sunset date or sections that would explicitly establish a new task force.

Section 105. Promoting State Choice in PDMP Systems

Background

PHSA Section 399O ("Prescription Drug Monitoring Program") requires the Secretary, acting through the CDC Director, to award grants to each state to establish or improve state programs to monitor the dispensing of controlled substances, referred to as prescription drug monitoring programs (PDMPs). SUPPORT Act Section 7162 replaced PHSA Section 399O with new language and established the program under the CDC Director, specifying system attributes, usage strategies the Secretary must encourage, activities required or authorized by a grantee, the information that must be reported by grantees, and other rules and requirements.

In the Notice of Funding Opportunity materials for FY2020, CDC required grant recipients to ensure that state PDMP systems interoperate with the designated PDMP data sharing system of

the Department of Justice's Bureau of Justice Assistance (BJA), known as "RxCheck."[15] CDC issued subsequent guidance clarifying the RxCheck award conditions.[16] For more information, see the "Interstate Information Sharing and Interoperability" section in CRS Report R42593, *Prescription Drug Monitoring Programs*.

Provision

Section 105 amends PHSA Section 399O(h) by adding a provision clarifying that the authorization does not allow the Secretary to require states to use a specific vendor or interoperability connection in their PDMPs.

Section 106. First Responder Training Program

Background

PHSA Section 546 ("First Responder Training") requires the Secretary to award grants to states, local government entities, Indian Tribes and tribal organizations to train and provide resources to first responders and others to administer drugs or devices "approved or cleared" by the FDA for emergency treatment of opioid overdose.

The provision also includes grants for technical assistance and training on the use of these approved drugs, requires that grants be awarded to entities in both urban and rural areas, and requires a program evaluation as specified.

In 2018, SUPPORT Act Section 7002 amended PHSA Section 546 and increased the program's authorization of appropriation from $12 million to $36 million for each of FY2019-FY2023.

Provision

Section 106 amends PHSA Section 546 to specify that the grants support training first responders or other members of key community sectors to administer a drug or device approved, cleared, "or otherwise legally marketed" by FDA for emergency treatment of opioid overdose.[17]

Section 106 reauthorizes the First Responder Training Grants. PHSA Section 546(h) now authorizes $57 million to be appropriated for each of FY2026-FY2030.

[15] Centers for Disease Control and Prevention, *Overdose Data to Action*, Notice of Funding Opportunity (CDC-RFA-CE-19-1904) Appendix 11: CDC Award Grant Conditions, March 5, 2019, https://www.grants.gov/search-results-detail/309335. BJA's designated PDMP hub, "RxCheck," was operated by the technical contractors Integrated Justice Information Systems Institute and Tetrus, Inc.

[16] CDC, *CDC-RFA-CE19-1904: Overdose Data to Action (OD2A) Inclusion of Funding Award Conditions to Connect to the RxCheck Hub*, Frequently Asked Questions, March 28, 2019, https://www.cdc.gov/drugoverdose/pdf/CDC_OD2A_AwardConditionsFAQs_032819.pdf. See also Darius Tahir, "Fed Mandate to Use Opioid Data-Sharing Technology Angers States," *POLITICO*, April 12, 2019, https://www.politico.com/story/2019/04/12/opioid-data-sharing-angers-states-1320532.

[17] For example, some drugs or devices could be legally marketed under FDA's Emergency Use Authorization (EUA) authority while not "approved or cleared." For more information, see U.S. Food and Drug Administration, *Emergency Use Authorization*, September 25, 2025, https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.

Section 107. Donald J. Cohen National Child Traumatic Stress Initiative

Background

Since its initial authorization in the Children's Health Act of 2000 (P.L. 106-310), the National Child Traumatic Stress Initiative (NCTSI) has raised awareness about the impact of trauma on children and adolescents. PHSA Section 582 ("Grants to Address the Problem of Persons Who Experience Violence Related Stress") authorizes grants to support the continued operation of NCTSI and the development of evidence-based practices (EBPs) for treating disorders of children that result from witnessing or experiencing a traumatic event.[18] It requires the NCTSI coordinating center to collect, analyze, and publish treatment and outcome data for children and families served by grantees. The provision also requires the coordinating center to facilitate training initiatives in trauma-informed, evidence-based practices, among other activities.

In 2018, SUPPORT Act Section 7133 reauthorized the NCTSI, increasing the authorization of appropriation in PHSA Section 582(j) from $46.9 million to $63.9 million for each of FY2019-FY2023.

Provision

Section 107 amends PHSA Section 582 by amending the section heading to "Grants to Address the Problems of Persons Who Experience Traumatic Events" and by specifying that the grants also support *the dissemination* of knowledge regarding EBPs for treating disorders related to witnessing or experiencing a traumatic event. The provision adds a second paragraph to subsection (d) on training, requiring all NCTSI grantees to collaborate in carrying out the development and dissemination of knowledge on EBPs for treating children with related disorders. Section 107 specifies that eligible grantees must submit an application for a grant. In addition to a required plan for evaluating grant-funded activities, the application must now include a description of how grantees will support efforts by the Secretary or NCTSI coordinating center in evaluating activities carried out under this section.

Section 107 also makes technical amendments to PHSA Title V, redesignating a second Part G to Part J and renumbering the accompanying sections accordingly. It also capitalizes the terms "Tribes" and "Tribal" in the NCTSI authorization.

Section 107 reauthorizes the NCTSI. PHSA Section 582(j) now authorizes $98.887 million to be appropriated for each of FY2026-FY2028 and $100 million for each of FY2029 and FY2030.

Section 108. Protecting Suicide Prevention Lifeline from Cybersecurity Incidents

Background

PHSA Section 520E-3 ("National Suicide Prevention Lifeline Program") authorizes the National Suicide Prevention Lifeline (Lifeline), a national hotline providing crisis counseling and referral services to individuals experiencing suicidal thoughts or other mental distress. The 21st Century Cures Act (Cures Act; P.L. 114-255) codified the program in PHSA Section 520E-3 in 2016,

[18] The 21st Century Cures Act (P.L. 114-255), enacted in 2016, authorized the continued operation of the NCTSI.

though the Lifeline had operated since 2005.[19] The authorization for the Lifeline requires that SAMHSA coordinate a network of 24-hour crisis centers and maintain the suicide prevention hotline to connect callers with local emergency services. Lifeline services have consisted primarily of immediate crisis counseling through the hotline along with referrals, as needed, to local follow-up services. In 2022, the Lifeline transitioned from a 10-digit phone number to a three-digit 9-8-8 hotline (and rebranded as the *988 Suicide & Crisis Lifeline*).[20] On December 1, 2022, the Lifeline voice calling function experienced a nearly daylong outage due to a cybersecurity incident that affected the call center contractor.[21]

The SUPPORT Act did not amend the authorization for the Lifeline in 2018. In 2022, the Restoring Hope for Mental Health and Well-Being Act (Division FF, Title I of P.L. 117-328) added more requirements to the Lifeline authorization and reauthorized the program.[22]

Provision

Section 108 amends PHSA Section 520E-3 by requiring the Secretary take the necessary steps to eliminate cybersecurity vulnerabilities and ensure that the suicide Lifeline is protected from cybersecurity incidents. The provision requires the Lifeline's local and regional crisis centers to report identified cybersecurity vulnerabilities or incidents to the network administrator, and for the network administrator to report those to the SAMHSA Assistant Secretary. The provision specifies that participating local and regional crisis centers and the network administrator are responsible for overseeing the technology used by the crisis centers.

Section 108 requires the U.S. Government Accountability Office to conduct and complete a study evaluating cybersecurity risks and vulnerabilities of the Lifeline and to submit a corresponding report to specified congressional committees. The report is due no later than 180 days after enactment of P.L. 119-44 (May 30, 2026).

Section 109. Monitoring and Reporting of Child, Youth, And Adult Trauma

Background

Adverse childhood experiences (ACEs) is a public health term to describe "all types of abuse, neglect, and other traumatic experiences that occur to individuals under the age of 18."[23] In 1998, a joint CDC and Kaiser Permanente study found a strong association between exposure to adverse childhood experiences and later adult chronic conditions and health risk behaviors, including

[19] Cures Act §9005.

[20] While the Lifeline is now known as the *988 Suicide & Crisis Lifeline*, the authorizing provision in Title V of the PHSA (§520E-3; 42 U.S.C. §290bb-36c) maintains the "National Suicide Prevention Lifeline Program" title.

[21] Amanda Seitz, "Feds Say Cyberattack Cause Suicide Helpline's Outage," *AP News*, February 3, 2023, https://apnews.com/article/technology-health-mental-76f75061bdc4ff3c4ec024f337e9a426.

[22] For more information, see CRS Report R47910, *The Restoring Hope for Mental Health and Well-Being Act of 2022 (Division FF, Title I of P.L. 117-328, the Consolidated Appropriations Act, 2023): Section-by-Section Summary*.

[23] CDC, "Adverse Childhood Experiences: Looking at how ACEs affect our lives and society," https://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html.

illicit drug use.[24] Numerous subsequent studies have supported this association.[25] The Behavioral Risk Factor Surveillance System (BRFSS) is a national telephone survey, coordinated by CDC, on "health-related risk behaviors, chronic health conditions, and use of preventive services."[26] Since 2009, 32 states have added questions related to ACEs to at least one year of their BRFSS survey.[27] Similarly, the Youth Risk Behavior Surveillance System (YRBSS) is a school-based survey conducted among high school students on youth health-related behaviors, including drug use.[28]

SUPPORT Act Section 7131 allows the CDC Director to collect and report biennial data on ACEs through relevant public health surveys, including BRFSS and YRBSS, in cooperation with the states. The provision previously authorized $2 million to be appropriated for each of FY2019-FY2023 to carry out the section.

Provision

Section 109 reauthorizes SUPPORT Act Section 7131. SUPPORT Act Section 7131(e) now authorizes $9 million to be appropriated for each of FY2026-FY2030.

Section 110. Bruce's Law

Background

SUPPORT Act Section 7102(c)(3) requires the Secretary, in consultation with the Secretary of Education, to identify the development of evidence-based best practices for the prevention of substance abuse by children, adolescents, and young adults. Best practices must address primary prevention, medications for opioid use disorder, and effective communication for outreach, such as via social media. The Secretary is required to disseminate these best practices, as appropriate, to specified entities. The Secretary must submit a report to Congress no later than October 1, 2022, summarizing the effectiveness of the program.

SUPPORT Act Section 7102(c)(4) requires the Secretary, in consultation with the Secretary of Education, to administer a youth prevention and recovery initiative to "provide support for communities to support prevention of, treatment of, and recovery from" SUDs. This program requires the Secretary, in consultation with Department of Education (ED), to award competitive three-year grants to educational or community-based entities to support evidence-based SUD prevention, treatment, and recovery programs for children, adolescents, and young adults.

SUPPORT Act Section 7102(c)(9) authorizes $10 million to be appropriated for each of FY2019-FY2023 to carry out the activities under Subsection (c).

SUPPORT Act Section 7022 requires the Secretary, in coordination with the Director of National Drug Control Policy, to establish an interagency SUD coordinating committee (the

[24] Vincent J. Felitti, Robert F. Anda, and Dale Nordenberg, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences Study," *American Journal of Preventive Medicine*, vol. 14, no. 4 (May 1998), pp. 245-258.

[25] Centers for Disease Control and Prevention, *Adverse Childhood Experiences (ACEs)*, Resources, https://www.cdc.gov/aces/communication-resources/index.html.

[26] CDC, "Behavioral Risk Factor Surveillance System," September 4, 2018, https://www.cdc.gov/brfss/index.html.

[27] CDC, "About Behavioral Risk Factor Surveillance System ACE Data," https://www.cdc.gov/violenceprevention/acestudy/ace_brfss.html.

[28] CDC, "Youth Risk Behavior Surveillance System (YRBSS) Overview," https://www.cdc.gov/healthyyouth/data/yrbs/overview.htm.

Interdepartmental Substance Use Disorder Coordinating Committee) within three months of enactment. The provision specifies federal and nonfederal committee membership, biannual meetings, and certain specified duties related to making recommendations for improving SUD-related federal programs and activities. SUPPORT Act Section 7022(g) allowed the committee to establish working groups composed of committee members for carrying out the required duties. SUPPORT Act Section 7022(i) specified that that the committee will terminate six years after its establishment.

Provision

Section 110 amends SUPPORT Act Section 7102(c)(3) to incorporate strategies that increase education and awareness of the dangers of synthetic opioids (such as fentanyl) into the best practices for primary prevention.[29]

Section 110 amends SUPPORT Act Section 7102(c)(4) to incorporate strategies to increase education and awareness of the dangers of synthetic opioids (such as fentanyl) into the prevention activities supported by grants funded under this authorization. Section 110 does not reauthorize appropriations to carry out the activities in SUPPORT Act Section 7102(c).

Section 110 amends SUPPORT Act Section 7022(g) to require the Secretary, acting through the Interdepartmental Substance Use Disorder Coordinating Committee, to establish an additional Federal Interagency Work Group on fentanyl contamination of illegal drugs. The provision requires the Work Group to consult with relevant stakeholders and subject matter experts and specifies the Work Group's duties to include (1) examining federal efforts to prevent overdoses by fentanyl-contaminated illicit drugs; (2) identifying strategies to improve state, tribal, and local response to fentanyl-contaminated overdoses; (3) coordinating with the HHS Secretary to raise public awareness of synthetic opioids and other emerging drug issues; (4) making recommendations to Congress for improving related federal programs; and (5) making recommendations for educating youth on the potency and dangers of drugs contaminated by fentanyl.

Section 110 amends SUPPORT Act Section 7022(i) to specify that the Interdepartmental Substance Use Disorder Coordinating Committee shall terminate on September 30, 2030.

Section 111. Guidance on At-Home Drug Disposal Systems

Background

SUPPORT Act Chapter 6 ("Access to Increased Drug Disposal"; Sections 3253-3260) built on previous efforts by the federal government to assist individuals and jurisdictions in their ability to properly and safely dispose of controlled substances (including opioid medications). It provides the Attorney General with authority to make grants to states in an effort to increase participation rates of eligible collectors as authorized collectors. Grant recipients (and any subrecipients of the grant) may use grant funds only toward the costs associated with participating in authorized disposal activities. SUPPORT Act Section 3260 authorized such sums as may be necessary to be appropriated to the Attorney General for carrying out the activities under Chapter 6.

[29] SUPPORT Reauthorization Act Section 304 also amends SUPPORT Act Section 7102(c). See "Section 304. Youth Prevention and Recovery" below.

Provision

Section 111 requires the HHS Secretary, in consultation with the Drug Enforcement Administration (DEA) Administrator, to publish guidance to facilitate the use of at-home safe disposal systems for applicable drugs. The provision requires the contents of the guidance to include (1) recommended standards for meeting FDA requirements for drug disposal systems, (2) recommended instructions to disseminate regarding at-home drug disposal systems, (3) best practices and educational tools to support the use of at-home drug disposal systems, and (4) recommended use of health providers for disseminating information on at-home drug disposal systems.

Section 112. Assessment of Opioid Drugs and Actions

Background

An analgesic drug is one that is used to reduce pain. Analgesic drugs may belong to one of several classes of drugs, such as nonsteroidal anti-inflammatory drugs (NSAIDS) or opioids.[30] While opioid drugs may pose risks for addiction, drug products from other analgesic classes may not. In 2018, Section 3001(b) of the SUPPORT Act directed the Food and Drug Administration (FDA) to issue or update existing guidance to address challenges to developing nonopioid medical products to treat pain. In 2025, FDA published a draft version of this guidance, which was intended to assist drug sponsors in the development of such nonopioid analgesic products.[31] FDA has also engaged in other activities to support the development of nonopioid medical products. For example, on January 30, 2025, FDA approved a first-in-class nonopioid analgesic to treat moderate to severe acute pain in adults.[32]

As part of the review process for the approval of prescription drugs, FDA assesses the risks and benefits of the drug in the context of its use, as indicated in the product's labeling.[33] For opioid products, FDA also considers the broader public health effect of these drugs, which involves considering "the risks related to misuse, abuse, opioid use disorder, accidental exposure, and overdose, for both patients and others."[34]

Provision

Section 112 directs the Secretary to publish, within a year of enactment (i.e., December 1, 2026), a report on FDA's website that outlines a plan for assessing approved prescription brand and generic opioid analgesic drugs. The report must address the broader public health effects of these drugs as part of a benefit-risk assessment and the activities of the FDA that relate to facilitating the development of nonaddictive medical products. The section further directs the Secretary, in

[30] Daniel A. Queremel Milani and Donald D. Davis, "Pain Management Medications," *StatPearls*, July 3, 2023, https://www.ncbi.nlm.nih.gov/books/NBK560692/.

[31] FDA, *Development of Non-Opioid Analgesics for Chronic Pain: Guidance for Industry (Draft Guidance)*, September 2025, https://www.fda.gov/media/188612/download.

[32] FDA, "FDA Approves Novel Non-Opioid Treatment for Moderate to Severe Acute Pain," press release, January 30, 2025, https://www.fda.gov/news-events/press-announcements/fda-approves-novel-non-opioid-treatment-moderate-severe-acute-pain.

[33] CRS Report R41983, *How FDA Approves Drugs and Regulates Their Safety and Effectiveness*.

[34] FDA, *Opioid Analgesic Drugs: Considerations for Benefit-Risk Assessment Framework Guidance for Industry (Draft Guidance)*, June 2019, https://www.fda.gov/media/188612/download.

the development of this report, to provide an opportunity for public input regarding FDA's regulation of opioid analgesic drugs.

Section 113. Grant Program for State and Tribal Response to Opioid Use Disorders

Background

Since 2022, Section 1003 of the 21st Century Cures Act ("Grant Program for State and Tribal Response to Opioid Use Disorders"), as amended, authorizes the State Opioid Response (SOR) grant program for states and Tribes to address opioid and stimulant misuse.[35] Section 1003(b)(4) of the Cures Act specifies uses of funds, which may include implementing SUD prevention activities (including primary prevention) and other public health-related activities addressing substance misuse and use disorders, among other activities. SAMHSA, the federal agency that administers the SOR grants, has explicitly permitted the purchasing and distribution of drug-checking technologies—including fentanyl and xylazine test strips—as allowable activities, though these activities are not specified in the statutory authorization.[36]

In 2018, SUPPORT Act Section 7181 amended and reauthorized the activities included in Cures Act Section 1003.[37] In 2022, Section 1273 of the Restoring Hope for Mental Health and Well-Being Act replaced Section 1003 of the Cures Act with a new, explicit authorization for the SOR grants.[38]

Provision

Section 113 states that the substance use disorder and overdose prevention activities authorized in Cures Act Section 1003(b)(4)(A) may include facilitating access to drug-checking products such as fentanyl and xylazine test strips, to the extent that the purchase and possession of such products is consistent with federal and state law.

Title II—Treatment

Section 201. Residential Treatment Program for Pregnant and Postpartum Women

Background

PHSA Section 508 (under the heading "Residential Treatment Programs for Pregnant and Postpartum Women") requires the Director of SAMHSA's Center for Substance Abuse Treatment

[35] The SOR grant appropriation has included a set-aside for Indian Tribes and Tribal organizations—known as the Tribal Opioid Response (TOR) grants. For more information, see CRS In Focus IF12116, *Opioid Block Grants*.

[36] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *FY2024 State Opioid Response Grants*, Notice of Funding Opportunity (NOFO) No. TI-24-008, Rockville, MD, pp. 16, 19, https://www.samhsa.gov/sites/default/files/grants/pdf/fy-2024-sor-nofo-ti-24-008.pdf.

[37] For more information, see CRS Report R45423, *Public Health and Other Related Provisions in P.L 115-271, the SUPPORT for Patients and Communities Act*.

[38] For more information, see CRS Report R47910, *The Restoring Hope for Mental Health and Well-Being Act of 2022 (Division FF, Title I of P.L. 117-328, the Consolidated Appropriations Act, 2023): Section-by-Section Summary*.

to award grants and cooperative agreements or contracts to public and nonprofit entities through the Residential Treatment for Pregnant and Postpartum Women grant program.[39] This grant program provides residential or outpatient SUD and recovery support services to pregnant and postpartum women and pediatric care (and other supplemental services) to their children.

In 2018, SUPPORT Act Section 7062(b) reauthorized the program, increasing the authorization of appropriation in PHSA Section 508(s) from $16.9 million to $29.9 million for each of FY2019-FY2023.

Provision

Section 201 amends PHSA Section 508 by making a technical correction to the list of required supplemental services specified in PHSA Section 508(d)(11)(C). Section 201 also clarifies the detail related to outreach services that must be provided in a funding agreement, as specified in PHSA Section 508(g).

Section 201 reauthorizes the Residential Treatment for Pregnant and Postpartum Women grant program. PHSA Section 508(s) now authorizes $38.931 million to be appropriated for each of FY2026-FY2030.

Section 202. Improving Access to Addiction Medicine Providers

Background

PHSA Section 597 ("Fellowships") requires the Secretary to maintain a Minority Fellowship Program to award fellowships, which may include stipends, for post-baccalaureate training for mental health professionals in the fields of psychiatry, nursing, social work, marriage and family therapy, mental health counseling, and substance use disorder and addiction counseling. The SAMHSA-administered Minority Fellowship Program provides grants to professional associations (e.g., the American Psychiatric Association and the American Nurses Association) to offer stipends to minority doctoral students who are studying for degrees in a mental or behavioral health profession.

The SUPPORT Act did not amend the authorization for the Minority Fellowship Program. In 2022, the Restoring Hope for Mental Health and Well-Being Act (Division FF, Title I of P.L. 117-328) reauthorized the program. PHSA Section 597 authorizes $25 million to be appropriated for each of FY2023-FY2027.

Provision

Section 202 adds addiction medicine to the list of professional disciplines eligible for the fellowship program. The provision adds, as a stated purpose of the program, increasing the knowledge of behavioral health practitioners on the issue of "diagnosis" (in addition to prevention, treatment, and recovery of mental health and substance use disorders).

[39] 42 U.S.C. §290bb-1(a).

Section 203. Mental and Behavioral Health Education and Training Grants

Background

PHSA Section 756 ("Mental and Behavioral Health Education Training Grants") authorizes the Behavioral Health Workforce Education and Training (BHWET) Program, which was codified in the Helping Families in Mental Health Crisis Reform Act of 2016 (Division B of the 21st Century Cures Act).[40] The program provides grants to support the training of the behavioral health workforce, including paraprofessionals. The program's authorization of appropriations of $50 million has been reauthorized several times, including in 2018 by SUPPORT Act Section 7073 and most recently via the Restoring Hope for Mental Health and Well-Being Act of 2022.[41] PHSA Section 756(f) previously authorized $50 million to be appropriated for each of FY2023-FY2027.

Provision

Section 203 reauthorizes the BHWET Program. PHSA Section 756(f) now authorizes $50 million to be appropriated for each of FY2026-FY2030.

Section 204. Loan Repayment Program for Substance Use Disorder Treatment Workforce

Background

The federal government supports a number of health workforce programs that are administered by HHS's Health Resources and Services Administration (HRSA). Among the largest of these programs is the National Health Service Corps (NHSC), which provides scholarships and loan repayment to health care providers—including those who treat behavioral health conditions—in exchange for a two-year or more service commitment in a health professional shortage area (HPSA).[42] The program permits a number of behavioral health providers to participate; it generally provides a lump sum of loan repayment in exchange for a two- or three-year service commitment, depending on the program. NHSC providers generally provide care in outpatient primary care-focused facilities.

In 2018, SUPPORT Act Section 7071 created a new PHSA Section 781 ("Loan Repayment Program for Substance Use Disorder Treatment Workforce"), which authorized a new loan repayment program called the Substance Abuse Treatment and Recovery (STAR) Loan Repayment Program.[43] The STAR Loan Repayment Program differs from the NHSC in a number

[40] See CRS Report R44718, *The Helping Families in Mental Health Crisis Reform Act of 2016 (Division B of P.L. 114-255)*.

[41] For more information, see CRS Report R47910, *The Restoring Hope for Mental Health and Well-Being Act of 2022 (Division FF, Title I of P.L. 117-328, the Consolidated Appropriations Act, 2023): Section-by-Section Summary*. The most recent year of final funding data are from FY2024, when an appropriation of $197 million was provided for behavioral health workforce training. See Health Resources and Services Administration, "FY2024 Operating Plan" https://web.archive.org/web/20250319093217/https://www.hrsa.gov/about/budget/operating-plan.

[42] CRS Report R44970, *The National Health Service Corps*. For more information about health professional shortage areas (HPSAs), see U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, "Shortage Designation," https://bhw.hrsa.gov/shortage-designation.

[43] CRS Report R45423, *Public Health and Other Related Provisions in P.L 115-271, the SUPPORT for Patients and Communities Act*.

of ways: (1) it permits a broader range of behavioral health providers to participate, (2) it provides loan repayment awards of one-sixth of the participant's loan balance annually for a six-year service commitment, and (3) it permits program participants to fulfill their service commitment at inpatient behavioral health-focused facilities, among other differences. Another key difference is that the STAR Loan Repayment program awards are taxable, whereas NHSC awards are not. The STAR Loan Repayment Program is funded as part of behavioral health workforce programs discussed in Section 203.[44]

PHSA Section 781 previously authorized $25 million to be appropriated for each of FY2019-FY2023.

Provision

Section 204 reauthorizes the STAR Loan Repayment Program. PHSA Section 781(j) now authorizes $40 million to be appropriated for each of FY2026-FY2030.

Section 205. Development and Dissemination of Model Training Programs for Substance Use Disorder Patient Records

Background

The privacy of health information is governed primarily by the HIPAA (Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended) Privacy Rule, which establishes requirements for covered entities' (health plans, providers, and clearinghouses) and their business associates' use and disclosure of protected health information (PHI).[45] The Privacy Rule requires authorization for the use and disclosure of PHI by covered entities and their business associates, except when it establishes an exception; for example, PHI may generally be used or disclosed without authorization for treatment, payment, or health care operations.[46] All health information is generally treated similarly under the HIPAA Privacy Rule, with certain exceptions in place relating to the use and disclosure of psychotherapy notes.

In contrast, stricter federal privacy requirements outlined in the "Part 2" rule[47]—promulgated pursuant to PHSA Section 543, "Confidentiality of Records"[48]—restrict the use and disclosure of individually identifiable patient information received or acquired by federally assisted substance use disorder (SUD) programs. Specifically, the Part 2 rule governs records that would identify a patient as having or having had a SUD and that are obtained or maintained by a federally assisted SUD program for the purpose of treating a SUD or making a diagnosis or referral for that treatment.[49] Part 2 requirements apply to "Part 2 Programs." These include an individual or entity

[44] In FY2024, the program received an appropriation of $40 million. See Health Resources and Services Administration, "FY2024 Operating Plan" https://web.archive.org/web/20250319093217/https://www.hrsa.gov/about/budget/operating-plan.

[45] 45 C.F.R. Part 164, Subparts A, E. For more information about the HIPAA Privacy Rule, see CRS In Focus IF12759, *The HIPAA Privacy Rule: Overview and Issues*.

[46] 45 C.F.R. §164.506.

[47] 42 C.F.R. Part 2.

[48] 42 U.S.C. §290dd-2.

[49] 42 C.F.R. §2.12(a)(1).

(other than a general medical facility) that is federally assisted[50] and provides—and holds itself out as providing—diagnosis, treatment, or referral for SUD treatment.[51]

In 2020, the CARES Act (P.L. 116-136) made changes to PHSA Section 543 to align it with the HIPAA Privacy Rule in an effort to balance improved care coordination for individuals with substance use disorders with the privacy interest around this sensitive information. This alignment reflected significant changes to the health care system, health care information, and the exchange of health care information since the SUD confidentiality requirements first became law in 1970.[52] The CARES Act amended PHSA Section 543 to allow for, pursuant to initial written consent, the use or disclosure of SUD patient records by a covered entity, business associate, or a Part 2 program for purposes of treatment, payment, and health care operations as permitted by the HIPAA Privacy Rule.[53] SUD patient records disclosed pursuant to this exception are to be subsequently redisclosed in accordance with the HIPAA Privacy Rule. The CARES Act required the Secretary to revise Part 2 (or other regulations) as necessary to implement the changes made by the law such that they applied with respect to uses and disclosures of SUD patient records one year after enactment. However, the final regulation was published in February of 2024 and became effective in April of the same year.[54]

SUPPORT Act Section 7053[55] required the Secretary, not later than one year after enactment, to identify or develop model programs and materials, including those to train health care providers in the permitted uses and disclosures of SUD patient records in compliance with 42 C.F.R. Part 2 and those to educate families and patients on their right to protect and obtain information under 42 C.F.R. Part 2. The section required that the model programs and materials be periodically updated and disseminated, and that their development, identification, and updating include input from relevant stakeholders. SUPPORT Act Section 7053(e) authorized $4 million to be appropriated for FY2019, $2 million for each of FY2020 and FY2021, and $1 million for each of FY2022 and FY2023 to carry out the activities in the section. CRS identified no explicit appropriations for this authorization, nor any publicly available information on whether these activities were completed by the Secretary.

Provision

Section 205 strikes SUPPORT Act Section 7053(e), which contained the authorization of appropriations for the activities required in this provision.

Section 206. Task Force on Best Practices for Trauma-Informed Identification, Referral, and Support

Background

SUPPORT Act Section 7132 established the Interagency Task Force on Trauma-Informed Care. This task force is required to make recommendations and submit a final report regarding best

[50] "Federally assisted programs" include programs that are carried out in whole or in part by the federal government or are supported by federal funds. See 42 C.F.R. §2.12(b).

[51] 42 C.F.R. §2.11.

[52] 42 U.S.C. §290dd-2.

[53] 42 U.S.C. §290dd-2(b)(1).

[54] 89 *Federal Register* 12472, February 16, 2024.

[55] 42 U.S.C. §290dd-2 note.

practices with respect to children and families who have experienced trauma. The task force is also required to recommend ways that federal agencies can better coordinate responses to families affected by substance use disorders and trauma. In identifying the best practices, the task force is required to include guidelines for several specified front-line service providers. Section 7132(b) specifies a minimum of 29 federal task force members, including the heads of several agencies and offices within HHS and other specified federal executive branch departments, agencies, and offices.

SUPPORT Act Section 7132(i) specified that the task force will sunset 60 days after the submission of the final report but not later than September 30, 2023.

Provision

Section 206 adds the Administration for Community Living to the specified agencies represented on the task force. The provision also adds "developmental disability service providers" to the specified front-line workers for whom the guidelines are developed. Section 206 amends SUPPORT Act Section 7131(i) by amending the date the task force is to sunset to September 30, 2030.

Section 207. Grants to Enhance Access to Substance Use Disorder Treatment

Background

Under the Controlled Substances Act (CSA, 21 U.S.C. §§801 et seq.), the Drug Enforcement Administration (DEA) has primary responsibility for regulating controlled substances.[56] The CSA requires medical practitioners to register with DEA to dispense (i.e., prescribe or administer) controlled substances for medical purposes. Prior to 2022, practitioners who met certain criteria were required to obtain a separate waiver via DEA and SAMHSA (known as a *DATA* waiver or *X* waiver) in order to dispense buprenorphine to treat opioid use disorder (OUD) outside of a federally certified opioid treatment program (OTP).[57]

In 2018, SUPPORT Act Section 3203(a) established a grant program for medical schools to develop curricula that meet the training requirements outlined in CSA Section 303(g)(2)(G)(ii), as amended by SUPPORT Act Section 3202.[58] SUPPORT Act Section 3203(b) authorized $4 million to be appropriated for each of FY2019-FY2023. Congress has not provided an explicit appropriation for the grant program authorized in SUPPORT Act Section 3203.

In 2022, the Restoring Hope for Mental Health and Well-Being Act Section 1262 repealed the DATA/X waiver requirement in CSA Section 303(g)(2). Thus, any practitioner registered with DEA to dispense controlled substances is authorized to use buprenorphine to treat OUD outside of an OTP without a separate waiver that requires additional training, subject to state laws.

[56] The CSA assigns drugs and other substances to one of five schedules based on accepted medical use, potential for misuse, and severity of potential psychological or physical dependence. Schedule I contains substances that have no currently accepted medical use and are not available by prescription. Schedules II, III, IV, and V include substances that have recognized medical uses and are progressively less dangerous and pose fewer risks.

[57] For more information, see CRS In Focus IF12348, *Medications for Opioid Use Disorder*.

[58] SUPPORT Act Section 3202 amended the qualifying criteria in CSA Section 303(g)(2)(G)(ii), including the training requirements, for practitioners receiving DATA/X waivers.

Provision

Section 207 removes the authorization of appropriations in SUPPORT Act Section 3203.

Section 208. State Guidance Related to Individuals with Serious Mental Illness and Children with Serious Emotional Disturbance

Background

PHSA Title XIX Subpart I ("Block Grants for Community Mental Health Services") authorizes SAMHSA's Community Mental Health Services Block Grant (MHBG). The MHBG supports state efforts in providing community mental health services for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).[59] SAMHSA distributes MHBG funds to states according to a formula specified in Title XIX of the PHSA.[60] Each state may distribute MHBG funds to local government entities and nongovernmental organizations to provide community mental health services in accordance with the state's plan. States have flexibility in the use of MHBG funds within the framework of the state plan and federal requirements.[61] The statutory authorization for the MHBG contains funding set-asides, such as the requirement that a state must expend 10% of the funds to support evidence-based programs that address the needs of individuals with early serious mental illness.[62]

The Consolidated Appropriations Act, 2016 (P.L. 114-113), increased the set-aside from 5% to 10% and specified that set-aside funds support activities that include those that address psychotic disorders.[63] The Joint Explanatory Statement accompanying the FY2016 appropriations law further specified that the set-aside funds are to be used only for programs that target first-episode psychosis and show strong evidence of effectiveness.[64] The report language also directed SAMHSA to provide information by June 2016 on each state's allotment and a description of the program implemented. SAMHSA offers resources to grantees for identifying and supporting evidence-based programs that address first-episode psychosis.[65] The SUPPORT Act did not amend this authority in 2018.

Provision

Section 208 requires the Secretary, acting through the SAMHSA Assistant Secretary, to conduct a review of state use of MHBG set-aside funds for first-episode psychosis. The review must consider how the state uses evidence-based treatments and services according to the standard of care for individuals with SMI and children with SED, the percentages of state set-aside funding

[59] SAMHSA's definitions of adults with SMI and children with SED were provided in a 1993 *Federal Register* notice (May 20, 1993; 58 *Federal Register* 29422).

[60] 42 U.S.C. §§300x et seq.

[61] For more information, see CRS Report R46426, *Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs*.

[62] PHSA §1920(c); 42 U.S.C. §300x-9(c).

[63] See also Substance Abuse and Mental Health Services Administration, *Guidance for Revision of the FY2016-2017 Block Grant Application for the New 10 Percent Set-Aside*, February 8, 2016, https://www.samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf.

[64] Rep. Rogers, Proceedings and Debates of the 114th Congress, First Session, *Congressional Record*, vol. 161, no. 184—book III (December 17, 2015), p. H10287.

[65] SAMHSA, *Block Grant Resources*, Rockville, MD, last updated September 26, 2025, https://www.samhsa.gov/grants/block-grants/resources.

expended on early SMI and first-episode psychosis, and the number of individuals served. The provision requires the Secretary to submit to specified congressional committees a report with findings and recommendations for changes to the MHBG no later than 180 days after completion of the review. The provision also requires the Secretary, no later than a year after the report is submitted, to update the guidance on coordinated specialty care and other evidence-based services based on the report findings.

Section 209. Reviewing the Scheduling of Approved Products Containing a Combination of Buprenorphine and Naloxone

Background

Buprenorphine is a medication used in the treatment of opioid use disorder (and sometimes in the treatment of pain).[66] Buprenorphine is a partial opioid agonist, meaning it binds to the same opioid receptors in the brain as full opioid agonists but activates the receptors less strongly. Buprenorphine has potential for misuse, dependence, and overdose, but less so than full opioid agonists like methadone, heroin, fentanyl, and some prescription medications. Some FDA-approved formulations of buprenorphine (such as Suboxone) include naloxone—an opioid antagonist that blocks opioid receptors from being activated, thereby reducing the risk of misuse and overdose.[67]

Buprenorphine was first approved by the FDA as a pain reliever in 1981.[68] Buprenorphine was classified as a Schedule V controlled substance under the CSA when used and marketed as a low-dose, injectable narcotic analgesic to treat pain. It was later reclassified as a Schedule III controlled substance in 2002 following the FDA approval of two new buprenorphine products for the treatment of opioid use disorder.[69] Buprenorphine and all products containing buprenorphine are Schedule III controlled substances.

According to DEA and Section 812 of the CSA, Schedule III controlled substances have moderate to low potential for physical and psychological dependence. They are considered to have less abuse potential than Schedule I and II controlled substances but more than substances in Schedules IV and V.[70] Substances in Schedules IV and V have a low potential for abuse and low risk of dependence.[71]

Generally, as the schedules increase, applicable restrictions, reporting requirements, and oversight lessen.[72] Prescriptions for substances in Schedule III and IV may be refilled up to five times

[66] For more information, see CRS Report R45279, *Buprenorphine and the Opioid Crisis: A Primer for Congress*.

[67] The naloxone in these formulations is activated only if the drug is misused (i.e., crushed and used intranasally or intravenously). Naloxone is also used on its own to reverse an opioid overdose. For more information, see CRS In Focus IF12490, *Naloxone for Opioid Overdose: Considerations for Congress*.

[68] HHS, FDA, *Approval Date(s) and History, Letters, Labels, Reviews for NDA 018401*, Buprenex, December 29, 1981, https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&ApplNo=018401.

[69] Drug Enforcement Administration, "Schedules of Controlled Substances: Rescheduling of Buprenorphine From Schedule V to Schedule III," 67 *Federal Register* 62354, October 7, 2002.

[70] Other examples of Schedule III controlled substances include ketamine, anabolic steroids, and testosterone.

[71] Examples of Schedule IV drugs include alprazolam and diazepam. Schedule V controlled substances generally consist of preparations containing limited quantities of certain narcotics, and are generally used for "antidiarrheal, antitussive, and analgesic purposes." For more information, see Drug Enforcement Administration, *Drug Scheduling*, https://www.dea.gov/drug-information/drug-scheduling; and 21 U.S.C. §812.

[72] For more information, see CRS Report R45948, *The Controlled Substances Act (CSA): A Legal Overview for the 119th Congress*.

within six months after the date of the original prescription, while substances in Schedule V are not subject to prescription limitations in the CSA (but must be distributed or dispensed "for a medical purpose").[73] Refilling a prescription for a substance in Schedule II is prohibited. Recent studies on availability of buprenorphine have raised concerns about limited access to the drug at retail pharmacies.[74]

Provision

Section 209 requires the Secretary to review relevant data pertaining to the scheduling of products containing a combination of buprenorphine and naloxone (e.g., Suboxone) that have been approved by the FDA and, if appropriate, request that the Attorney General initiate rulemaking proceedings to revise the scheduling accordingly. Section 209 then requires the Attorney General to review any such request and determine whether to initiate proceedings to revise the scheduling.

Section 210. References to Opioid Overdose Reversal Agents in HHS Grant Programs

Background

When administered during an overdose, certain medications (such as opioid *antagonists*) can reverse the overdose and prevent adverse consequences, such as death. Naloxone (e.g., Narcan) is the most commonly used medication to reverse opioid overdose.[75] However, other medications that work in a similar manner, such as nalmefene, have also been approved for use by the FDA.[76] Several federal grants authorize the purchase and distribution of opioid overdose reversal medications in their statutory authorizations or via their Notice of Funding Opportunity announcements.

Provision

Section 210 requires the Secretary to ensure that references to opioid overdose reversal drugs include any overdose reversal drug that has been approved or otherwise authorized by the FDA for emergency treatment of an opioid overdose. The provision applies to future regulations or guidance for federal grants addressing opioid misuse and use disorders, and requires the Secretary to update existing references no later than one year after enactment (i.e., December 1, 2026).

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[73] 21 U.S.C. 289(a). See also Department of Justice, Drug Enforcement Administration, *Practitioner's Manual*, An Informational Outline of the Controlled Substances Act, Revised 2023, https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-071)(EO-DEA226)_Practitioner%27s_Manual_(final).pdf.

[74] See, for example, Jenny S. Guadamuz, Sarah Axeen, and Dima Mazen Qato, "Trends in the Availability of Buprenorphine at US Retail Pharmacies, 2017-23," *Health Affairs*, vol. 44, no. 9 (September 2025), https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00349; and Substance Abuse and Mental Health Services Administration, *SAMHSA/DEA Virtual Town Hall: Expanding Buprenorphine Access in Pharmacies to Treat Opioid Use Disorder*, Rockville, MD, https://www.samhsa.gov/sites/default/files/virtual-town-hall-buprenorphine-access-pharmacies.pdf.

[75] Centers for Disease Control and Prevention, *Naloxone Dispensing Rate Maps*, November 7, 2024, https://www.cdc.gov/overdose-prevention/data-research/facts-stats/naloxone-dispensing-rate-maps.html.

[76] U.S. Food and Drug Administration, *Information About Naloxone and Nalmefene*, August 8, 2024, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-naloxone-and-nalmefene.

Section 211. Roundtable on Using Health Information Technology to Improve Mental Health and Substance Use Care Outcomes

Background

The Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) is tasked with developing an interoperable information technology (IT) framework for the use and exchange of health information nationwide.[77] To promote interoperability, ASTP/ONC oversees the ONC Health IT Certification Program (Certification Program), under which health IT developers may voluntarily obtain health IT certification. The Certification Program incentivizes conformity across electronic health record (EHR) systems through a combination of evolving standards, implementation specifications, and certification criteria issued by the HHS Secretary, thus facilitating the access, exchange, and use of electronic health information (EHI).

The Centers for Medicare & Medicaid Services (CMS) has also been active in health information interoperability efforts, often working in tandem with ASTP/ONC. In 2009, CMS was provided appropriations via the Health Information Technology for Economic and Clinical Health Act (HITECH Act; P.L. 111-5) to incentivize and guide the development and adoption of a nationwide health IT infrastructure.[78] Thereafter, in 2011, CMS established the Medicare and Medicaid EHR Incentive Programs (renamed the Medicare and Medicaid Promoting Interoperability Programs in 2018), which initially provided incentive payments to eligible clinicians and hospitals that demonstrated meaningful use of ASTP/ONC-certified EHR technologies.[79] Many behavioral health providers were not eligible to participate in these programs.[80]

Though the majority of mental health and substance use service providers use electronic systems in some way, health IT adoption in such settings lags compared with hospital and physician practices "due to technical, workforce, cost, and policy factors," including in part a lack of financial incentives that were offered through initiatives like the CMS Medicare and Medicaid EHR Incentive Programs.[81] Without interoperable health IT systems, mental health and substance use service providers and patients may be disadvantaged when attempting to share EHI due to a lack of streamlined data sharing, efficient care coordination, decision support for providers, and easily accessible medical records for patients.[82] In related efforts, SUPPORT Act Section 6001 amended SSA Section 1115A(b)(2)(B) to add a model for mental health or substance use disorder

[77] For more information regarding ASTP/ONC and its initiatives, see CRS In Focus IF12352, *Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC)*.

[78] American Recovery and Reinvestment Act of 2009 (P.L. 111-5), HITECH Act, Division B, Title IV (Medicare and Medicaid Health Information Technology; Miscellaneous Medicare Provisions).

[79] CMS, "Promoting Interoperability Programs," December 12, 2024, https://www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs.

[80] See *Background* writeup for "Section 6001. Testing of Incentive Payments for Behavioral Health Providers for Adoption and Use of Certified Electronic Health Record Technology" in CRS Report R45449, *The SUPPORT for Patients and Communities Act (P.L.115-271): Medicare Provisions*.

[81] Michelle Dougherty et al., *Health Information Technology Adoption and Utilization in Behavioral Health Settings*, RTI International, December 2024, pp. 3, 5, https://aspe.hhs.gov/sites/default/files/documents/b9f858a38ff71660528cf1e4b8df00fa/HIT-adoption-utilization-bh-settings.pdf.

[82] Dougherty et al., *Health IT Adoption and Utilization in BH Settings*, p. 8.

providers using certified EHR to the list of models the Center for Medicare and Medicaid Innovation (CMMI) within CMS could test to improve care quality and reduce expenditures.[83]

Provision

Section 211 requires that the National Coordinator for Health Information Technology (the Coordinator) convene a public roundtable not later than 180 days after enactment (i.e., May 30, 2026) to examine how greater use of EHRs by mental health and substance use service providers can improve outcomes in associated settings and how best to increase EHR adoption among such providers. The Coordinator must ensure that roundtable participants include private and public sector stakeholders. No later than 180 days after the roundtable's conclusion, the Coordinator must submit a report on information gathered during the roundtable to specified congressional committees. The report shall include roundtable participant recommendations and unique considerations for stakeholders associated with health IT and EHR systems used in mental health and substance use treatment settings. The report must also examine, in such settings, EHR system use, EHR system benefits, and resources and barriers to increasing EHR system adoption, among other topics.

Title III—Recovery

Section 301. Building Communities of Recovery

Background

PHSA Section 547 ("Building Communities of Recovery") authorizes the Building Communities of Recovery (BCOR) grant program to help recovery community organizations increase resources and enhance long-term recovery services, as specified. SAMHSA awards BCOR grants to support the development, enhancement, expansion, and delivery of recovery support services, and education about recovery.[84]

In 2018, SUPPORT Act Section 7151 amended PHSA Section 547 to make adjustments to certain aspects of the BCOR grant program. SUPPORT Act Section 7151 reauthorized the program, increasing the authorization of appropriations in PHSA Section 547(f) from $1 million to $5 million for each of FY2019-FY2023.

Provision

Section 301 reauthorizes the Building Communities of Recovery grant program. PHSA Section 547(f) now authorizes $17 million to be appropriated for each of FY2026-FY2030.

[83] For more information regarding CMMI, see *Background* writeup for "Section 6001. Testing of Incentive Payments for Behavioral Health Providers for Adoption and Use of Certified Electronic Health Record Technology" in CRS Report R45449, *The SUPPORT for Patients and Communities Act (P.L.115-271): Medicare Provisions*.

[84] SAMHSA, *Building Communities of Recovery*, Notice of Funding Opportunity (NOFO) TI-24-003, February 28, 2024, https://www.samhsa.gov/grants/grant-announcements/ti-24-003.

Section 302. Peer Support Technical Assistance Center

Background

In 2018, SUPPORT Act Section 7152 added a new PHSA Section 547A ("Peer Support Technical Assistance Center)," which establishes the National Peer-Run Training and Technical Assistance Center for Addiction Recovery Services. The center is required to provide technical assistance and support, as specified, to recovery community organizations and peer support networks. This support includes training on identifying signs of SUDs, resources to assist individuals with SUDs, and best practices for delivery of support services; data collection to support research; capacity building; and evaluation activities, among other activities. The provision also requires the center to periodically issue best practices for use by recovery community organizations and peer support networks. PHSA Section 547A(e) previously authorized $1 million to be appropriated for each of FY2019-FY2023.

Provision

Section 302 amends PHSA Section 547A to specify that the capacity building functions of the center include professional development of peer support specialists and making recovery support services available in nonclinical settings. The provision adds a new subsection (d), which allows the Secretary to establish a regional technical assistance center to assist in carrying out activities within the regional center's geographic area. The provision requires the Secretary to evaluate the regional center and submit a report, with specified findings, to congressional committees. The provision specifies that subsection (d) will terminate on September 30, 2030.

Section 302 reauthorizes the National Peer-Run Training and Technical Assistance Center for Addiction Recovery Services. PHSA Section 547A(f), as redesignated, now authorizes $2 million to be appropriated for each of FY2026-FY2030.

Section 303. Comprehensive Opioid Recovery Centers

Background

In 2018, SUPPORT Act Section 7121 created a new PHSA Section 552 ("Comprehensive Opioid Recovery Centers"), which establishes a grant program for the operation of comprehensive opioid recovery centers. PHSA Section 522 requires the Secretary to award no fewer than 10 competitive grants, with grant period, eligibility, priority, and preference specified. Each center is required, at a minimum, to carry out certain specified activities, either directly, through referral, or through contractual arrangements. These activities include providing the full continuum of treatment services, which include all FDA-approved medications for opioid use disorder, withdrawal management, counseling by a licensed provider, treatment for co-occurring mental disorders, residential rehabilitation, recovery housing, peer recovery support services, and job training and placement assistance, among other activities. Grantees are required to submit annual data regarding programs, activities, and outcomes, as specified. Section 7121 requires the Secretary to submit a preliminary report to Congress no later than three years after the date of enactment (i.e., October 24, 2021), and a final report not later than two years after the preliminary report, with an evaluation of the effectiveness of the centers and further recommendations.[85]

[85] Congress did not provide an explicit appropriation for the Comprehensive Opioid Recovery Centers authorized in (continued...)

PHSA Section 522(j) previously authorized $10 million to be appropriated for each of FY2019-FY2023.

Provision

Section 303 amends PHSA Section 552 by specifying certain requirements for grant applications and reporting by grantees, particularly in regard to activities carried out through referral or contractual agreements.

Section 303 reauthorizes the Comprehensive Opioid Recovery Centers grant program. PHSA Section 522(j) now authorizes $10 million to be appropriated for each of FY2026-FY2030.

Section 304. Youth Prevention and Recovery

Background

SUPPORT Act Section 7102(c) requires the Secretary, in consultation with the Secretary of Education, to administer a youth prevention and recovery initiative to "provide support for communities to support prevention of, treatment of, and recovery from" substance use disorders. This program requires the Secretary, in consultation with the U.S. Department of Education (ED), to award competitive three-year grants to educational or community-based entities to support evidence-based SUD prevention, treatment, and recovery programs for children, adolescents, and young adults. The provision specifies the program eligibility and application process. The provision requires the Secretary to conduct an evaluation of each grant funded and to provide technical assistance for grantees. Grantees must submit to the Secretary a report describing how they used grant funds and how the grant program made an impact on the intended outcomes, such as student success, SUD prevalence, number of overdoses, and other indicators as the Secretary deems appropriate.

SUPPORT Act Section 7102(c)(9) previously authorized $10 million to be appropriated for each of FY2019-FY2023 to carry out the activities under Subsection (c).

Provision

Section 304 amends SUPPORT Act Section 7102(c) by adding "a consortium of local educational agencies" to the list of eligible grantees, replacing "high schools" with "secondary schools" (as defined) and making other technical edits. The provision adds to the grant application a requirement that grantees include a plan to sustain the activities carried out under the grant program after the grant has ended. It changes the due date by which the Secretary must submit the report to specified congressional committees from October 1, 2022, to October 1, 2028.

Section 304 reauthorizes the Youth Prevention and Recovery Initiative. SUPPORT Act Section 7102(c)(9) now authorizes $10 million to be appropriatedfor FY2026, $12 million for FY2027, $13 million for FY2028, $14 million for FY2029, and $15 million for FY2030.

PHSA Section 522 until FY2023. Congress appropriated $2 million for the Comprehensive Opioid Recovery Center grant program in FY2023 and FY2024. For more information, see SAMHSA, *Comprehensive Opioid Recovery Centers*, Notice of Funding Opportunity (NOFO) TI-23-020, March 17, 2023, https://www.samhsa.gov/grants/grant-announcements/ti-23-020.

Section 305. CAREER Act

Background

SUPPORT Act Section 7183 requires the Secretary, in consultation with the Secretary of Labor, to award competitive grants to treatment and recovery service providers to carry out evidence-based programs that support individuals in SUD treatment and recovery to live independently and participate in the workforce. The provision specifies the application procedures, grantee reporting requirements, and a formula to be used when prioritizing grants, which includes the following:

- the amount by which the state's drug overdose death rate is above the national rate, as determined by CDC;
- the amount by which the state's unemployment rate, based on data from the Bureau of Labor Statistics (BLS), is above the national average for the preceding five calendar years for which there are available data; and
- the amount by which the state's labor force participation rate, based on data from BLS, is lower than the national average for the preceding five calendar years for which there are available data.

The provision requires the Secretary, no later than two years after the end of the first year of the grant period,[86] to submit to Congress a preliminary report that includes certain specified elements. The provision also requires the Secretary, no later than two years after the preliminary report was submitted, to submit to Congress a final report that includes information on the use of grant funding and recommendations.

The resulting grant program administered by SAMHSA, known as the Treatment, Recovery, and Workforce Support Grant program (or Workforce Support), provides funding to domestic or private nonprofit entities that provide treatment and recovery services for individuals with SUDs.[87] Grantees are required to coordinate with statewide employment and training activities to support recipients funded under the Support to Communities: Fostering Opioid Recovery Through Workforce Development grant program,[88] by providing employment identification, vocational rehabilitation training, interview and job training, job placement, and transferable skill development, among other supports.

SUPPORT Act Section 7183 previously authorized $5 million to be appropriated for each of FY2019-FY2023.

Provision

Section 305 amends SUPPORT Act Section 7183 by adding "Treatment, Recovery, and Workforce Support Grants" to the section title. It amends the factors in the formula for prioritization, specifying the formula is to be based on "average" rates for calendar years 2018 through 2022. The provision further amends the formula rates to the following:

- the highest age-adjusted rates of drug overdose deaths for CY2018 through CY2022 based on CDC data,

[86] The first grant period for the Treatment, Recovery, and Workforce Support grant program was FY2020.

[87] Previous grants were awarded to recipients in Florida, Kentucky, Illinois, New Jersey, North Carolina, Ohio, Pennsylvania, Tennessee, and West Virginia. For more information, see https://www.samhsa.gov/grants/archive.

[88] Authorized under SUPPORT Act §8041. See "Section 306. Addressing Economic and Workforce Impacts of the Opioid Crisis" below.

- the highest average rates of unemployment for CY2018 through CY2022 based on BLS data, and
- the lowest average labor force participation rates for CY2018 through FY2022 based on BLS data.

Section 305 adds to the allowable use of funds, stating that grantees may use not more than 5% of grant funding for transportation provided to individuals participating in specified grant-supported activities. The provision precludes the Secretary from requiring grantees to use grant funding for activities not specified in the statutory authorization. It adds to grantee reporting requirements. The provision also specifies that the timeline for the preliminary report to Congress pertains to grants awarded prior to December 1, 2025, and that the final report is due by September 30, 2030. The provision makes other conforming amendments.

Section 305 reauthorizes the Treatment, Recovery, and Workforce Support grant program. SUPPORT Act Section 7183(k) now authorizes $12 million to be appropriated for each of FY2026-FY2030.

Section 306. Addressing Economic and Workforce Impacts of the Opioid Crisis

Background

SUPPORT Act Section 8041 authorizes the Secretary of Labor, in consultation with the HHS Secretary, to carry out a pilot program of competitive grants to "to address economic and workforce impacts associated with a high rate of a substance use disorder." Eligible entities include state workforce agencies, outlying areas, and tribal entities. The Support to Communities: Fostering Opioid Recovery Through Workforce Development grant program is administered by the Department of Labor (DOL). The grant program supports efforts to address the economic and workforce-related impacts of the opioid crisis.[89] Such support includes workforce development activities, training and employment services, outpatient SUD treatment and recovery, and other supportive services, among other activities.

SUPPORT Act Section 8041 previously authorized the Secretary of Labor to use up to $100 million of the funds from the National Dislocated Worker Grant program authorized by Section 170 of the Workforce Innovation and Opportunity Act (WIOA) for each of FY2019-FY2023.

DOL used the authority provided by SUPPORT Act Section 8041 to provide $20 million in grant awards in September 2020. These grants came to a close in 2024.[90] Between 2018 and 2024, DOL used the WIOA National Dislocated Worker Funding to support a series of National Health Emergency Disaster Recovery Dislocated Worker Grants to provide workforce services in communities affected by the opioid crisis, including services to reintegrate workers affected by the crisis and to train individuals to work in mental health treatment, addiction treatment, and

[89] Department of Labor, *SUPPORT Act Grants*, Support to Communities Opioid Recovery Grants, https://www.dol.gov/agencies/eta/dislocated-workers/grants/supportact.

[90] Department of Labor, "Opioid Response Grants," https://www.dol.gov/agencies/eta/dislocated-workers/grants/health-emergency.

pain management.[91] DOL did not explicitly cite the SUPPORT Act authority for these National Health Emergency Disaster Recovery Dislocated Worker Grants.[92]

Provision

Section 306 amends SUPPORT Act Section 8041 to extend the definition of "covered fiscal year" through FY2030. SUPPORT Act Section 8041 now authorizes DOL to utilize up to $100 million of the National Dislocated Worker Grant funding for activities under Section 8041 of the SUPPORT Act through FY2030.

Section 307. Review of Information Related to Funding Opportunities Under Programs Administered by SAMHSA

Background

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency primarily responsible for supporting community-based mental health and substance use disorder treatment and prevention services. SAMHSA does not provide mental health or substance use treatment. Rather, the agency supports states' efforts in providing community-based behavioral health services, primarily through its grantmaking authorities. Located within HHS, SAMHSA provides federal funding to states, local communities, and private entities by administering block grants and other formula and discretionary grants, including competitive grants. Through such grants, SAMHSA supports activities that include education and training, prevention programs, early intervention activities, treatment services, and technical assistance.

Provision

Section 307 requires the Secretary to convene a public meeting to improve awareness of and access to SAMHSA funding opportunities. Topics of the meeting include opportunities to improve the functionality of HHS websites that include SAMHSA funding opportunities (such as Grants.gov), other models for disseminating SAMHSA funding information, and strategies to improve the application process for SAMHSA grants. The provision requires the Secretary to implement improvements based on stakeholder feedback at the meeting, to the extent feasible. It also requires the Secretary to submit a report to specified congressional committees summarizing the findings of the meeting and how the feedback has been implemented to improve the HHS websites and awareness of SAMHSA grants. SAMHSA announces grant funding opportunities through Notice of Funding Opportunities (NOFOs) posted on the SAMHSA website,[93] as well as Grants.gov.[94] Prospective grantees can sign up for email alerts from SAMHSA and Grants.gov to be notified when new grants are forecasted or posted.

[91] Department of Labor, National Health Emergency Disaster Recovery DWGs, https://www.dol.gov/agencies/eta/dislocated-workers/grants/health-emergency/phase-2-disaster.

[92] This National Dislocated Worker Grant funding was authorized under WIOA and therefore is not included in **Table 1**.

[93] SAMHSA, Grants Dashboard, https://www.samhsa.gov/grants/grants-dashboard.

[94] Connect with Grants.gov, https://www.grants.gov/connect.

Title IV—Miscellaneous Matters

Section 401. Delivery of a Controlled Substance by a Pharmacy to a Prescribing Practitioner

Background

Controlled Substance Act (CSA) Section 309A ("Delivery of a Controlled Substance by a Pharmacy to an Administering Practitioner") specifies the conditions under which a pharmacy can deliver a controlled substance to a practitioner. SUPPORT Act Section 3204 amended CSA Section 309A(a)[95] to allow a pharmacy to deliver a schedule III, IV, or V controlled substance if the controlled substance is delivered to the prescribing practitioner or the practitioner administering the controlled substance, for maintenance or detoxification treatment, and administered by injection or implantation, among other requirements.[96]

In some instances, FDA has recommended or required additional measures to be placed on certain medications to minimize the risk associated with taking them. Under Section 564 of the Federal Food, Drug, and Cosmetic Act, FDA is authorized to require risk evaluation and mitigation strategies (REMS) for certain drugs. A REMS is a required risk management plan that uses risk mitigation strategies beyond FDA-approved professional labeling. As part of a REMS, a drug manufacturer may be required to provide certain information to patients and health care providers or to impose restriction on a drug's distribution or use via one or more "Elements to Assure Safe Use" (ETASU). For example, an ETASU could require that pharmacies, practitioners, or health care settings that dispense the drug be specially certified, or that the patient using the drug be subject to monitoring (e.g., regular pregnancy testing for a drug associated with birth defects).[97]

Provision

Section 401 replaced paragraph (2) of CSA Section 309A(a), adding a new subparagraph that allows for the delivery of schedule III, IV, or V controlled substances not administered by the practitioner (i.e., self-administered), provided the controlled substances are subject to a REMS that requires post-administration monitoring by a health care provider.

Section 402. Required Training for Prescribers of Controlled Substances

Background

Controlled Substances Act Section 303 ("Registration Requirements") specifies the requirements for practitioners registering with DEA to dispense (i.e., prescribe or administer) controlled substances.[98] In 2022, Section 1263 of the Restoring Hope for Mental Health and Well-Being Act amended CSA Section 303 by adding a new subsection (l) requiring that practitioners registering

[95] 21 U.S.C. 289a(a).

[96] For more information, see CRS Report R45405, *The SUPPORT for Patients and Communities Act (P.L. 115-271): Food and Drug Administration and Controlled Substance Provisions*.

[97] For more information, see CRS Report R44810, *FDA Risk Evaluation and Mitigation Strategies (REMS): Description and Effect on Generic Drug Development*.

[98] 21 U.S.C. §823.

with DEA to prescribe controlled substances complete a one-time training on treatment and management of patients with opioid or other substance use disorders.[99] The provision specifies time requirements (no less than eight hours) and allowable training providers for physicians and nonphysicians, including the American Society of Addiction Medicine or any professional organizations accredited by the Accreditation Council for Continuing Medical Education (ACCME), among other specified training providers. The provision exempts physicians and other practitioners who meet certain specified requirements from the training.

Provision

Section 402 amends CSA Section 303 to add several specified organizations to the list of approved providers of the required training.[100] In addition, the provision adds any organization accredited by the Council on Podiatric Medical Education to the list of approved providers of the required training for physicians; it also adds any organization approved or accredited by the American Academy of Family Physicians to the list of approved providers of the training for nonphysicians. The provision specifies that physicians who recently graduated (i.e., within five years) from accredited schools of podiatric medicine, in addition to the other specified fields, and who have completed a comprehensive podiatric medicine curriculum that included eight hours of training on pain management and on treating and managing patients with a substance use disorder (SUD), satisfy the training requirements. Similarly, the provision specifies that nonphysicians who recently graduated (i.e., within five years) from an accredited school of pharmacy that included at least eight hours of training on treating and managing patients with SUDs also satisfy the training requirements. Section 402 specifies that the amendments made by the section take effect as though they were enacted on December 29, 2022.

The provision makes other technical changes, redesignating the second subsection (l) (added by the Restoring Hope for Mental Health and Well-Being Act) as subsection (m).

[99] The safe management of dental pain and screening, brief intervention, and referral for treatment for patients with opioid and other substance use disorders is also included in the training. The provision exempts veterinarians from the training requirement. CSA Section 303 had been recently amended around the time of enactment of the Restoring Hope for Mental Health and Well-Being Act, and a new subsection (l) was added after the existing subsection (l), resulting in two subsections (l).

[100] The approved providers of the training for physicians now includes the American Academy of Family Physicians, the American Podiatric Medical Association, the Academy of General Dentistry, and the American Optometric Association. The approved providers of the training for nonphysicians now includes the American Pharmacists Association, the Accreditation Council for Pharmacy Education, the American Psychiatric Nurses Association, the American Academy of Nursing, and the American Academy of Family Physicians.

Table 1. Expired Authorizations of Appropriations in the SUPPORT for Patients and Communities Act (P.L. 115-271)

New Authorization of Appropriations in P.L. 119-44 and Amount Appropriated, FY2020-FY2024 (dollars in millions)

SUPPORT Act (P.L. 115-271) Provision	Authorizing Law	Authorization of Appropriations	P.L. 119-44 Reauthorization	New Authorization of Appropriations	Annual Appropriations[a]				
					FY2020	FY2021	FY2022	FY2023	FY2024
Section 3203 Grants to Enhance Access to Substance Use Disorder Treatment	SUPPORT Act	$4 million for each of FY2019-FY2023	Section 207 strikes subsection (b), which previously authorized appropriations	0	0	0	0	0	0
Section 3260 Grants to states to enable states to increase drug disposal	SUPPORT Act	Such sums as may be necessary to the Attorney General to carry out Chapter 6 of Title III (Section 3251-3260) for each of FY2020-FY2024[b]	Not reauthorized by P.L. 119-44	—	0	0	0	0	0
Section 7002 First Responder Training	PHSA Section 546(h)	$36 million for each of FY2019-FY2023	Section 106	$57 million for each of FY2026-FY2030	41.000	42.000	46.000	56.000	57.000
Section 7011 Pilot Program for Public Health Laboratories to Detect Fentanyl and Other Synthetic Opioids	SUPPORT Act	$15 million for each of FY2019-FY2023	Not reauthorized by P.L. 119-44	—	No explicit appropriation[c]				

SUPPORT Act (P.L. 115-271) Provision	Authorizing Law	Authorization of Appropriations	P.L. 119-44 Reauthorization	New Authorization of Appropriations	Annual Appropriations[a]				
					FY2020	FY2021	FY2022	FY2023	FY2024
Section 7053 Development and Dissemination of Model Training Programs for Substance Use Disorder Patient Records	SUPPORT Act	$4 million for FY2019 $2 million for each of FY2020-FY2021 $1 million for each of FY2022-FY2023	Section 205 strikes subsection (e), which previously authorized appropriations	0	0	0	0	0	0
Section 7062(b) Residential Treatment Programs for Pregnant and Postpartum Women	PHSA Section 508(s)	$29.931 million for each of FY2019-FY2023	Section 201	$38.931 million for each of FY2026-FY2030	31.931	32.931	34.931	38.931	38.931
Section 7064 Prenatal and Postnatal Health	PHSA Section 317L(d)	Such sums as may be necessary for each of FY2019-FY2023	Section 101	$4.25 million for each of FY2026-FY2030	No explicit appropriation[c]				
Section 7071 Loan Repayment Program for Substance Use Disorder Treatment Workforce	PHSA Section 781(j)	$25 million for each of FY2019-FY2023	Section 204	$40 million for each of FY2026-FY2030	12.000[d]	16.000[d]	24.000[d]	40.000[d]	40.000[d]
Section 7073(a) Program for Education and Training in Pain Care	PHSA Section 759	Such sums as may be necessary for FY2019- FY2023	Not reauthorized by P.L. 119-44	—	0	0	0	0	0

SUPPORT Act (P.L. 115-271) Provision	Authorizing Law	Authorization of Appropriations	P.L. 119-44 Reauthorization	New Authorization of Appropriations	Annual Appropriations[a]				
					FY2020	FY2021	FY2022	FY2023	FY2024
Section 7073(b) Mental and Behavioral Health Education Training Program	PHSA Section 756(f)	$50 million for each of FY2019-FY2023	Section 203	$50 million for each of FY2026-FY2030	36.916[e]	37.916[e]	39.053[e]	44.053[e]	44.053[e]
Section 7081 Program to Support Coordination and Continuation of Care for Drug Overdose Patients	SUPPORT Act	$10 million for each of FY2019-FY2023	Not reauthorized by P.L. 119-44	—	0	0	0	0	0
Section 7101 Establishment of Regional Centers of Excellence in Substance Use Disorder Education	PHSA Section 551(f)	$4 million for each of FY2019-FY2023	Not reauthorized by P.L. 119-44	—	0	0	0	0	0
Section 7102 Youth Prevention and Recovery	SUPPORT Act	$10 million for each of FY2019-FY2023	Section 304[f]	$10 million for FY2026 $12 million for FY2027 $13 million for FY2028 $14 million for FY2029 $15 million for FY2030	0	0	0	2.000	2.000

SUPPORT Act (P.L. 115-271) Provision	Authorizing Law	Authorization of Appropriations	P.L. 119-44 Reauthorization	New Authorization of Appropriations	Annual Appropriations[a]				
					FY2020	FY2021	FY2022	FY2023	FY2024
Section 7121 Comprehensive Opioid Recovery Centers	PHSA Section 552	$10 million for each of FY2019-FY2023	Section 303	$10 million for each of FY2026-FY2030	2.000	4.000	5.000	6.000	6.000
Section 7131 CDC Surveillance and Data Collection for Child, Youth, and Adult Trauma	SUPPORT Act	$2 million for each of FY2019-FY2023	Section 109	$9 million for each of FY2026-FY2030	4.000	5.000	7.000	9.000	9.000
Section 7133 National Child Traumatic Stress Initiative	PHSA Section 582(j)	$63.887 million for each of FY2019-FY2023	Section 107	$98.887 million for each of FY2026-FY2028 $100 million for each of FY2029-FY2030	68.887	71.887	81.887	93.887	98.887
Section 7134 Grants to Improve Trauma Support Services and Mental Health Care for Children and Youth in Educational Settings	SUPPORT Act	$50 million for each of FY2019-FY2023	Not reauthorized by P.L. 119-44	—	0	0	0	12.000	12.000

SUPPORT Act (P.L. 115-271) Provision	Authorizing Law	Authorization of Appropriations	P.L. 119-44 Reauthorization	New Authorization of Appropriations	Annual Appropriations[a]				
					FY2020	FY2021	FY2022	FY2023	FY2024
Section 7141 Reauthorization and Expansion of Program of Surveillance and Education Regarding Infections Associated with Illicit Drug Use and Other Risk Factors	PHSA Section 317N(d)	$40 million for each of FY2019-FY2023	Section 102	$40 million for each of FY2026-FY2030	10.000	13.000	18.000	23.000	23.000
Section 7151 Building Communities of Recovery	PHSA Section 547(f)	$5 million for each of FY2019-FY2023	Section 301	$17 million for each of FY2026-FY2030	8.000	10.000	13.000	16.000	17.000
Section 7152 Peer Support Technical Assistance Center	PHSA Section 547A(f)	$1 million for each of FY2019-FY2023	Section 302	$2 million for each of FY2026-FY2030	1.000	1.000	1.000	2.000	2.000
Section 7161 Preventing Overdoses of Controlled Substances	PHSA Section 392A(d) and 399O; CARA Section 102	$496 million for each of FY2019-FY2023	Section 103	$505.579 million for each of FY2026-FY2030	475.579	475.579	490.579	505.579	505.579
Section 7183 CAREER Act	SUPPORT Act	$5 million for each of FY2019-FY2023	Section 305(a)	$12 million for each of FY2026-FY2030	4.000	6.000	10.000	12.000	12.000

SUPPORT Act (P.L. 115-271) Provision	Authorizing Law	Authorization of Appropriations	P.L. 119-44 Reauthorization	New Authorization of Appropriations	Annual Appropriations[a]				
					FY2020	FY2021	FY2022	FY2023	FY2024
Section 8071 Pilot Program to Help Individuals in Recovery from a Substance Use Disorder Become Stably Housed	SUPPORT Act	Such sums as may be necessary for each of FY2019-FY2023	Section 305(b)	Such sums as may be necessary for each of FY2019-FY2030	25.000	25.000	25.000	30.000	30.000
Section 8092 Reauthorization of the Comprehensive Opioid Abuse Grant Program	Omnibus Crime Control and Safe Streets Act of 1968 Section 1001(a)(27)	$330 million for each of FY2019-FY2023	Not reauthorized by P.L. 119-44	—	180.000	185.000	185.000	190.000	189.000
Section 8202 Reauthorization of the Office of National Drug Control Policy	Office of National Drug Control Policy (ONDCP) Reauthorization Act of 1998 Section 714	$18.4 million for each of FY2018-FY2023	Not reauthorized by P.L. 119-44	—	18.400	18.400	18.952	21.500	21.785
Section 8203 Reauthorization of the Drug-Free Communities Program	National Narcotics Leadership Act of 1988 Section 1024	$99 million for each of FY2018-FY2023	Not reauthorized by P.L. 119-44	—	101.250	102.000	106.000	109.000	109.000
Section 8204 Reauthorization of the National Community Anti-Drug Coalition Institute	National Narcotics Leadership Act of 1988 Title I Subtitle A Chapter 2	$2 million for grants for each of FY2018-FY2023	Not reauthorized by P.L. 119-44	—	2.500	2.500	2.500	2.500	2.500

SUPPORT Act (P.L. 115-271) Provision	Authorizing Law	Authorization of Appropriations	P.L. 119-44 Reauthorization	New Authorization of Appropriations	Annual Appropriations[a]				
					FY2020	FY2021	FY2022	FY2023	FY2024
Section 8205 Reauthorization of the High-Intensity Drug Trafficking Area Program	ONDCP Reauthorization Act of 1998 Section 707	$280 million for each of FY2018-FY2023	Not reauthorized by P.L. 119-44	—	285.000	290.000	296.600	302.000	298.579
Section 8206 Reauthorization of Drug Court Program	Omnibus Crime Control and Safe Streets Act of 1968 Section 1001(a)(25) (A)	$75 million for each of FY2018-FY2023	Not reauthorized by P.L. 119-44	—	80.000	82.000	88.000	95.000	89.000
Section 8207 Drug Court Training and Technical Assistance	ONDCP Reauthorization Act of 1998 Section 705(e)(2)	$2 million for each of FY2018-FY2023	Not reauthorized by P.L. 119-44	—	2.500	3.000	3.000	3.000	3.000
Section 8217 Amendments to Administration of the Office	ONDCP Reauthorization Act of 1998 Section 704(i)(2)	$1.25 million for each of FY2018-FY2023	Not reauthorized by P.L. 119-44	—	0	0	0	0	0
Section 8218 Emerging Threats Committee, Plan, and Media Campaign	ONDCP Reauthorization Act of 1998 Section 709(g)	$25 million for each of FY2018-FY2023	Not reauthorized by P.L. 119-44	—	0	0	0	0	0

Sources: SUPPORT for Patients and Communities Act, 2018 (P.L. 115-271); SUPPORT for Patients and Communities Reauthorization Act of 2025 (P.L. 119-44); Consolidated Appropriations Act, 2020 (P.L. 116-93); Further Consolidated Appropriations Act, 2020 (P.L. 116-94); H.Rept. 116-62, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2020; Consolidated Appropriations Act, 2021 (P.L. 116-260); Consolidated Appropriations Act, 2022 (P.L. 117-103); "Explanatory Statement Submitted by Mrs. Lowey, Chairwoman of the House Committee on Appropriations Regarding H.R. 1158, Consolidated Appropriations Act, 2020," House of Representatives, *Congressional Record*, daily edition, vol. 165, no. 204—Book II (December 17, 2019), pp. H10613-H11060 and "Explanatory Statement Submitted by Mrs. Lowey, Chairwoman of the House Committee on Appropriations Regarding H.R. 1865, Further Consolidated Appropriations Act, 2020," House of Representatives, *Congressional Record*, daily edition, vol. 165, no. 204—Book III (December 17, 2019), pp. H11061-H11484;

"Explanatory Statement Submitted by Mrs. Lowey, Chairwoman of the House Committee on Appropriations Regarding H.R. 133, Consolidated Appropriations Act, 2021," House of Representatives, *Congressional Record*, daily edition, vol. 166, no. 218—Book III (December 21, 2020), pp. H7879-H8309; "Explanatory Statement Submitted by Mrs. Lowey, Chairwoman of the House Committee on Appropriations Regarding H.R. 133, Consolidated Appropriations Act, 2021," House of Representatives, *Congressional Record*, daily edition, vol. 166, no. 218—Book IV (December 21, 2020), pp. H8311-H8851; "Explanatory Statement Submitted by Ms. DeLauro, Chair of the House Committee on Appropriations, Regarding the House Amendment to the Senate Amendment to H.R. 2471, Consolidated Appropriations Act, 2022," House of Representatives, Congressional Record, daily edition, vol. 168, no. 42—Book III (March 9, 2022), pp. H1789-H2352; "Explanatory Statement Submitted by Ms. DeLauro, Chair of the House Committee on Appropriations, Regarding the House Amendment to the Senate Amendment to H.R. 2471, Consolidated Appropriations Act, 2022," House of Representatives, Congressional Record, daily edition, vol. 168, no. 42—Book IV (March 9, 2022), pp. H2669-H3043; Consolidated Appropriations Act, 2023 (P.L. 117-328); "Explanatory Statement Submitted by Mr. Leahy, Chair of the Senate Committee on Appropriations, Regarding H.R. 2617, Consolidated Appropriations Act, 2023," Senate, *Congressional Record*, daily edition, vol. 168, No. 198, Book II (December 20, 2022), pp. S8553-S9323; Further Consolidated Appropriations Act, 2024 (P.L. 118-47); "Explanatory Statement Submitted by Ms. Granger, Chair of the House Committee on Appropriations, Regarding H.R. 2882, Further Consolidated Appropriations Act, 2024," House of Representatives, *Congressional Record*, vol. 170, no. 51—Book II (March 22, 2024), pp. H1501-H2070.

Notes: CARA = Comprehensive Addiction and Recovery Act; CDC = Centers for Disease Control and Prevention; FY = Fiscal Year; ONDCP = Office of National Drug Control Policy; PHSA = Public Health Service Act; SSA = Social Security Act.

SUPPORT Act Section 7031 ("National Recovery Housing Best Practices") created a new PHSA Section 550 that initially authorized $3 million to be appropriated for the period of FY2019-FY2021. The Restoring Hope for Mental Health and Well-Being Act (Division FF, Title I of P.L. 117-328, the Consolidated Appropriations Act, 2023) Section 1236 reauthorized $5 million to be appropriated for the period of FY2023 through FY2027. For more information, see CRS Report R47910, *The Restoring Hope for Mental Health and Well-Being Act of 2022 (Division FF, Title I of P.L. 117-328, the Consolidated Appropriations Act, 2023): Section-by-Section Summary*. No explicit appropriation for the activities authorized in PHSA Section 550 has been made.

SUPPORT Act Section 7065(a) amended the Child Abuse Prevention and Treatment Act (CAPTA) to authorize grants to states for the development and implementation of plans of safe care for infants born with prenatal substance exposure, and for their families. The SUPPORT Act did not authorize new funding for these grants but instead permitted HHS to use funding otherwise appropriated for CAPTA's state grant program to implement the new grants through the sunset date of FY2023. HHS did not opt to do this. However, prior to the enactment of the SUPPORT Act, Congress increased FY2018 appropriations for CAPTA state grants (P.L. 115-141), indicating through accompanying explanatory statement language that this was intended for states to "improve their response to infants affected by substance use disorder and their families" and calling on states to "prioritize" development of plans of safe care. (See CRS Report R45270, *Child Welfare Funding in FY2018*.) The enhanced CAPTA state grant funding level and similar report language continued for subsequent years, and HHS included the call for states to prioritize these plans of safe care in annual guidance to states related to receipt of CAPTA state grant funding.

SUPPORT Act Section 7091 ("Emergency Department Alternatives to Opioids Demonstration Program") initially authorized $10 million to be appropriated for each of FY2019-FY2021. The Restoring Hope for Mental Health and Well-Being Act Section 1221 reauthorized $10 million to be appropriated for each of FY2023-FY2027. For more information, see CRS Report R47910, *The Restoring Hope for Mental Health and Well-Being Act of 2022 (Division FF, Title I of P.L. 117-328, the Consolidated Appropriations Act, 2023): Section-by-Section Summary*. The Emergency Department Alternatives to Opioids program has received the following appropriations: $5 million for FY2020, $6 million for each of FY2021 and FY2022, and $8 million for each of FY2023 and FY2024.

SUPPORT Act Section 7181 ("State Response to the Opioid Abuse Crisis") amended Section 1003(h) of the 21st Century Cures Act to authorize $500 million to be appropriated for each of FY2019-FY2021. The Restoring Hope for Mental Health and Well-Being Act Section 1273 amended this provision, replacing the authorization for the State Targeted Response (STR) grants for an authorization for the State Opioid Response (SOR) grant program, which supports similar activities. For more information, see CRS In Focus IF12116, *Opioid Block Grants*.

a. All appropriation values have been rounded to the nearest thousand. Appropriations values denote amounts made in annual appropriations acts; they do not reflect supplemental appropriations for these programs. For more information on supplemental appropriations, see CRS Report R46711, *U.S. Public Health Service: COVID-19*

Supplemental Appropriations in the 116th Congress; CRS Report R46834, *American Rescue Plan Act of 2021 (P.L. 117-2): Public Health, Medical Supply Chain, Health Services, and Related Provisions*; and CRS Report R47310, *Bipartisan Safer Communities Act (P.L. 117-159): Section-by-Section Summary*.

b. Described in Section 3259 of the bill as for "each of the first 5 fiscal years beginning after the date of enactment of this Act."

c. Appropriated funding for programs administered by CDC are often included within broader CDC appropriations accounts. See Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), *Justification of Estimates for Appropriation Committees: Fiscal Year 2023*, March 28, 2022.

d. Amount is included in the amount appropriated for the Behavioral Health Workforce Education and Training (BHWET) program as noted in the FY2020, FY2021, FY2022, FY2023, and FY2024 Appropriation column for Section 7073(b). For the BHWET program, $102 million was appropriated in FY2020, $112 million was appropriated in FY2021, $123 million was appropriated in FY2022, and $153 million was appropriated in each of FY2023 and FY2024.

e. The Behavioral Health Workforce Education Training Program (BHWET), administered by the Health Resources and Services Administration (HRSA), which funds similar activities under the same PHSA authority, was appropriated an additional $102 million in FY2020, $112 million in FY2021, $123 million in FY2022, and $153 million in each of FY2023 and FY2024.

f. Section 110 of the SUPPORT for Patients and Communities Reauthorization Act of 2025 also amended SUPPORT Act Section 7102.

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