

NATIONAL INSTITUTE OF BEHAVIORAL HEALTH

CONGRESSIONAL JUSTIFICATION
FY 2026

Department of Health and Human Services
National Institutes of Health

[THIS PAGE INTENTIONALLY LEFT BLANK]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

National Institute of Behavioral Health

FY 2026 Budget Table of Contents

Summary.....	3
Major Changes.....	4
Budget Mechanism Table.....	6
Summary of Changes	7
Budget Graphs	8
Justification of Budget Request.....	9
Appropriations History	18
Budget Authority by Object Class.....	19
Detail of Positions	20

General Notes

1. The proposed National Institute of Behavioral Health (NIBH) will consolidate the research activities of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the National Institute of Mental Health (NIMH). Figures for FY 2024 and FY 2025 in this document aggregate NIAAA, NIDA, and NIMH to provide for comparability to the FY 2026 estimates for NIBH.
2. FY 2025 Enacted levels cited in this document reflect the FY 2025 full-year continuing resolution (Public Law 119-4) and include the effects of the FY 2025 HIV/AIDS transfer.
3. FY 2026 FTE levels reflect estimates and are subject to change.
4. Detail in this document may not sum to the subtotals and totals due to rounding.

[THIS PAGE INTENTIONALLY LEFT BLANK]

Summary

The National Institute of Behavioral Health (NIBH) will be a newly streamlined Institute consisting of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the National Institute of Mental Health (NIMH). The mission of these Institutes will be integrated into NIBH.

NIAAA generates and disseminates fundamental knowledge about the adverse effects of alcohol on health and well-being, and applies that knowledge to improve the diagnosis, prevention, and treatment of alcohol-related problems, including alcohol use disorder, across the lifespan. Specifically, NIAAA addresses alcohol misuse in the context of whole person health, which could lead to a more comprehensive understanding of commonly co-occurring mental and physiological conditions, as well as novel, integrated strategies to improve overall health. Accordingly, basic, translational, and clinical research advances are key to NIAAA's mission.

NIDA supports research to advance science on drug use and addiction and to apply that knowledge to improve individual and public health. Specifically, NIDA works to prevent and treat drug use and addiction; to help people recover from substance use disorders (SUD); and to reduce the risk of overdose and other drug-related harms. As part of its mission, NIDA supports research to improve nationwide monitoring of substance use trends and seeks to find effective prevention and treatment approaches to help millions of Americans lead healthier lives, reduce their overdose risk, and recover from SUD.

NIMH is the lead federal agency for research on mental illnesses, with a mission to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. Specifically, NIMH supports and conducts research on mental illness, health services, and the underlying basic science of the brain and behavior; supports the training of scientists in basic and clinical mental health research; and communicates with scientists, patients, providers, and the public about mental health research advances and priorities. NIMH's vision is a world in which mental illnesses are prevented and cured.

Through continued investments across a broad range of scientific approaches, goals, and objectives, NIBH research holds enormous promise to reduce the burden of addiction and mental illness and improve quality of life for all Americans.

The FY 2026 budget request for NIBH is \$2,784.7 million, consisting of \$2,687.2 million in general fund budget authority and \$97.5 million derived by transfer from the NIH Innovation Account under the 21st Century Cures Act.

Major Changes in the Budget Request

Major changes by budget mechanism and/or budget activity detail are briefly described below. Note that there may be overlap between budget mechanism and activity details and these highlights will not sum to the total change for the FY 2026 President's Budget request for NIBH. The FY 2026 President's Budget request is \$2,784.7 million, a decrease of \$1,712.9 million compared to the FY2025 Enacted level. The request includes \$97.5 million provided through the 21st Century Cures Act.

Research Project Grants (-\$1,287.0 million; total \$1,654.4 million):

NIBH expects to award 3,065 competing and noncompeting Research Project Grants (RPG) in FY 2026. Funding is reduced by \$1,287.0 million from FY 2025, due in part to a lower number of awards and to a policy to cap indirect costs for grant awards to 15 percent of direct costs. Noncompeting awards are reduced by 668 awards and \$863.9 million. Competing RPGs are expected to decrease \$346.5 million for a reduction of 181 awards compared to the FY 2025 Enacted level. The FY 2026 request will continue the FY 2025 NIH policy of allocating half of the budget for competing RPGs for awards that fully fund their outyear commitments as part of the initial grant awards. The RPG reductions are distributed across all programmatic areas and basic, epidemiology, translational or clinical research.

Research Centers (-\$61.2 million; total \$139.7 million):

NIBH expects to support 83 awards, a reduction of 15 awards compared to the FY 2025 Enacted level. Costs to fund Research Center awards are reduced in FY 2026 due to implementation of the 15 percent limit on indirect costs.

Other Research (-\$111.7 million; total \$215.4 million):

NIBH expects to support 805 Other Research awards, a reduction of 194 awards and \$111.7 million compared to the FY 2025 Enacted level. Costs to fund Research Center awards are reduced in FY 2026 due to implementation of the 15 percent limit on indirect costs.

Ruth L Kirchstein Training (-\$23.7 million; total \$76.0 million):

NIBH expects to fund 1,168 training awards, a reduction of 414 full-time training personnel relative to the FY 2025 Enacted level, including funding fewer new and competing awards.

Research & Development (R&D) Contracts (-\$115.2 million; total \$136.3 million):

NIBH will decrease funding for this activity by \$115.2 million under the reduced overall NIBH request for FY 2026, for a reduction of 212 contracts.

Intramural Research Program (-\$58.4 million; total \$369.3 million):

NIBH expects to decrease the intramural research budget by \$58.4 million under the reduced NIBH request, including a reduction of 64 FTE, continuing to fund innovative research studies conducted by the Institute's intramural scientists.

Research Management and Support (-\$55.7 million; total \$193.7 million):

NIBH will reduce this activity by \$55.7 million under the reduced NIBH budget request, including a reduction of 193 FTE, and will continue to support oversight and management of scientific programs critical to fulfilling the Institute's mission.

BUDGET MECHANISM TABLE

NATIONAL INSTITUTES OF HEALTH National Institute of Behavioral Health

Budget Mechanism ^{*,1}

(Dollars in Thousands)

Mechanism	FY 2024 Final		FY 2025 Full-Year CR		FY 2026 President's Budget		FY 2026 +/- FY 2025	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount
<u>Research Projects:</u>								
Noncompeting	3,158	\$2,064,775	3,111	\$2,094,384	2,443	\$1,230,446	-668	-\$863,938
Administrative Supplements	(281)	\$31,624	(244)	\$28,029	(15)	\$1,750	-(229)	-\$26,279
<u>Competing:</u>								
Renewal	102	\$69,248	63	\$65,203	110	\$43,726	47	-\$21,477
New	1,022	\$657,987	628	\$619,189	378	\$255,054	-250	-\$364,135
Supplements	3	\$838	2	\$852	24	\$39,930	22	\$39,077
Subtotal, Competing	1,127	\$728,073	693	\$685,245	512	\$338,710	-181	-\$346,535
Subtotal, RPGs	4,285	\$2,824,472	3,804	\$2,807,658	2,955	\$1,570,906	-849	-\$1,236,752
SBIR/STTR	184	\$136,062	178	\$133,706	110	\$83,460	-68	-\$50,245
Research Project Grants	4,469	\$2,960,533	3,982	\$2,941,364	3,065	\$1,654,366	-917	-\$1,286,997
<u>Research Centers</u>								
Specialized/Comprehensive	92	\$190,134	98	\$200,822	83	\$139,657	-15	-\$61,166
Clinical Research	0	\$0	0	\$0	0	\$0	0	\$0
Biotechnology	0	\$0	0	\$0	0	\$0	0	\$0
Comparative Medicine	0	\$0	0	\$0	0	\$0	0	\$0
Research Centers in Minority Institutions	0	\$0	0	\$0	0	\$0	0	\$0
Research Centers	92	\$190,134	98	\$200,822	83	\$139,657	-15	-\$61,166
<u>Other Research:</u>								
Research Careers	783	\$141,242	791	\$143,706	645	\$96,830	-146	-\$46,876
Cancer Education	0	\$0	0	\$0	0	\$0	0	\$0
Cooperative Clinical Research	27	\$52,562	27	\$59,450	17	\$37,354	-10	-\$22,096
Biomedical Research Support	4	\$1,937	0	\$0	0	\$0	0	\$0
Other Biomedical Research Support	0	\$2,784	0	\$1,371	0	\$0	0	-\$1,371
Other	202	\$146,702	181	\$122,592	143	\$81,225	-38	-\$41,367
Other Research	1,016	\$345,227	999	\$327,118	805	\$215,408	-194	-\$111,710
Total Research Grants	5,577	\$3,495,894	5,079	\$3,469,304	3,953	\$2,009,431	-1,126	-\$1,459,873
<u>Ruth L. Kirschstein Training Awards:</u>	<u>FTTPs</u>		<u>FTTPs</u>		<u>FTTPs</u>		<u>FTTPs</u>	
Individual Awards	551	\$27,035	577	\$28,890	356	\$16,981	-221	-\$11,909
Institutional Awards	931	\$62,715	1,005	\$70,836	812	\$58,998	-193	-\$11,838
Total Research Training	1,482	\$89,750	1,582	\$99,726	1,168	\$75,979	-414	-\$23,747
Research & Develop. Contracts	313	\$279,694	311	\$251,476	99	\$136,293	-212	-\$115,184
SBIR/STTR (non-add)	(9)	(\$4,249)	(9)	(\$5,307)	(3)	(\$4,177)	-(6)	-(\$1,129)
Intramural Research	505	\$427,939	514	\$427,686	450	\$369,309	-64	-\$58,377
Res. Management & Support	769	\$244,857	765	\$249,442	572	\$193,726	-193	-\$55,715
SBIR Admin. (non-add)		(\$395)		(\$394)		(\$15)		-(\$379)
Construction		\$0		\$0		\$0		\$0
Buildings and Facilities		\$0		\$0		\$0		\$0
Total, NIBH	1,274	\$4,538,134	1,279	\$4,497,634	1,022	\$2,784,738	-257	-\$1,712,896

* All items in italics and brackets are non-add entries.

¹ Of which \$86.0 million in FY 2024, \$45.5 million in FY 2025, and \$97.5 million in FY 2026 is derived by transfer from the NIH Innovation Account under the 21st Century Cures Act.

SUMMARY OF CHANGES

NATIONAL INSTITUTES OF HEALTH National Institute of Behavioral Health

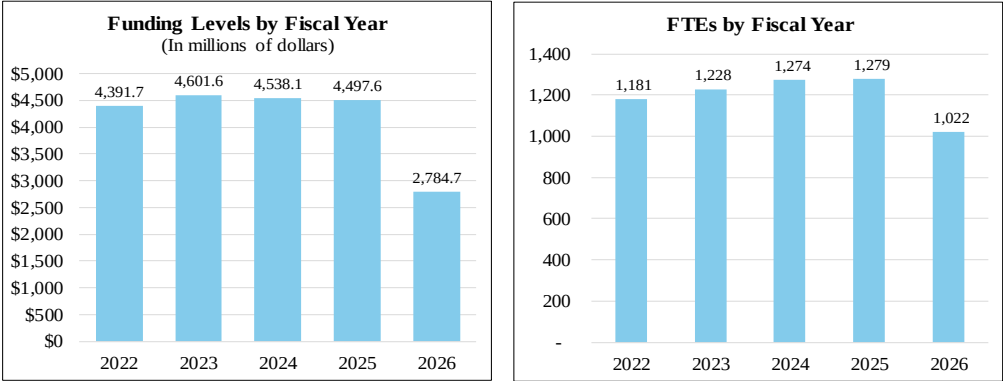
Summary of Changes

(Dollars in Thousands)

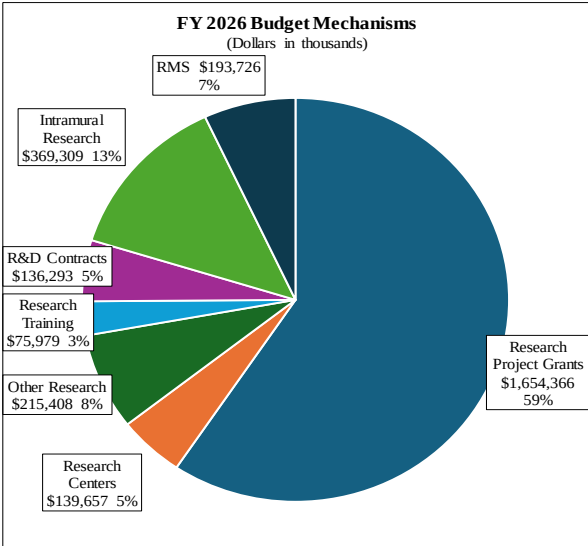
FY 2025 Full-Year CR	\$4,497,634
FY 2026 President's Budget	\$2,784,738
Net change	-\$1,712,896

CHANGES	FY 2025 Full-Year CR		FY 2026 President's Budget		Built-In Change from FY 2025 Full-Year CR	
	FTEs	Budget Authority	FTEs	Budget Authority	FTEs	Budget Authority
A. Built-in:						
1. Intramural Research:						
a. Annualization of FY 2025 pay and benefits increase		\$145,490		\$132,556		\$882
b. FY 2026 pay and benefits increase		\$145,490		\$132,556		\$322
c. Paid days adjustment		\$145,490		\$132,556		\$0
d. Differences attributable to change in FTE		\$145,490		\$132,556		-\$18,114
e. Payment for centrally furnished services		\$64,096		\$51,829		-\$12,267
f. Cost of laboratory supplies, materials, other expenses, and non-recurring costs		\$218,099		\$184,924		-\$5,951
Subtotal						-\$35,128
2. Research Management and Support:						
a. Annualization of FY 2025 pay and benefits increase		\$147,780		\$111,058		\$890
b. FY 2026 pay and benefits increase		\$147,780		\$111,058		\$341
c. Paid days adjustment		\$147,780		\$111,058		\$0
d. Differences attributable to change in FTE		\$147,780		\$111,058		-\$33,311
e. Payment for centrally furnished services		\$13,035		\$12,496		-\$539
f. Cost of laboratory supplies, materials, other expenses, and non-recurring costs		\$88,627		\$70,173		-\$2,489
Subtotal						-\$35,109
Subtotal, Built-in						-\$70,237
CHANGES	FY 2025 Full-Year CR		FY 2026 President's Budget		Program Change from FY 2025 Full-Year CR	
	No.	Amount	No.	Amount	No.	Amount
B. Program:						
1. Research Project Grants:						
a. Noncompeting	3111	\$2,122,413	2443	\$1,232,196	-668	-\$890,217
b. Competing	693	\$685,245	512	\$338,710	-181	-\$346,535
c. SBIR/STTR	178	\$133,706	110	\$83,460	-68	-\$50,245
Subtotal, RPGs						-\$1,286,997
2. Research Centers	98	\$200,822	83	\$139,657	-15	-\$61,166
3. Other Research	999	\$327,118	805	\$215,408	-194	-\$111,710
4. Research Training	1582	\$99,726	1168	\$75,979	-414	-\$23,747
5. Research and development contracts	311	\$251,476	99	\$136,293	-212	-\$115,184
Subtotal, Extramural						-\$1,598,804
6. Intramural Research	514	\$427,686	450	\$369,309	-64	-\$23,249
7. Research Management and Support	765	\$249,442	572	\$193,726	-193	-\$20,606
8. Construction	0	\$0	0	\$0	0	\$0
9. Buildings and Facilities	0	\$0	0	\$0	0	\$0
Subtotal, program changes						-\$1,642,659
Total built-in and program changes	1279	\$4,497,634	1022	\$2,784,738	-257	-\$1,712,896

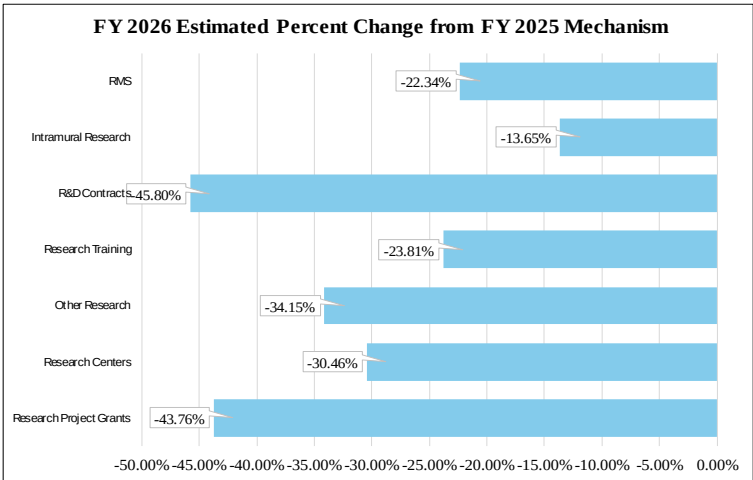
History of Budget Authority and FTEs:



Distribution by Mechanism:



Change by Selected Mechanisms:



JUSTIFICATION OF BUDGET REQUEST

National Institute of Behavioral Health

Budget Authority (BA):

	FY 2024 Final	FY 2025 Enacted	FY 2026 President's Budget	FY 2026 +/- FY 2025
General Fund BA	\$4,538,134,000	\$4,452,134,000	\$2,687,238,000	-\$1,764,896,000
Cures BA	<u>86,000,000</u>	<u>45,500,000</u>	<u>97,500,000</u>	<u>52,000,000</u>
Total BA	\$4,538,134,000	\$4,497,634,000	\$2,784,738,000	-\$1,712,896,000
FTE ¹	1,274	1,279	1,022	-257

Program funds are allocated as follows: Competitive Grants/Cooperative Agreements; Contracts; Direct Federal/Intramural and Other.

Overall Budget Policy: The FY 2026 President's Budget request for the National Institute of Behavioral Health (NIBH) is \$2,784.7 million, a decrease of \$1,712.9 million or 38.1 percent compared to the FY 2025 Enacted level. The request includes \$97.5 million from the 21st Century Cures Act. NIBH will be a newly streamlined Institute consisting of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the National Institute of Mental Health (NIMH). The mission of these Institutes will be integrated into NIBH.

Program Descriptions and Accomplishments

Addiction and alcohol misuse are strongly influenced by social and environmental factors. The developing brain is particularly susceptible to the adverse effects of alcohol, drugs, and negative social interactions. Research is key to informing innovative diagnosis, prevention, and treatment strategies for such influences. Understanding how those factors combine with a person's unique biology, especially in early life, is critical to understanding who is at risk for substance misuse or cognitive health disorders.

Several key initiatives fill in critical knowledge gaps in adolescent brain research including a multi-site longitudinal study to identify brain characteristics in humans that may predict alcohol misuse or occur due to adolescent alcohol exposure. A recent study showed specific changes in connectivity between brain areas involved in executive function that could underlie impairments in decision making and the ability to abstain from risky behaviors.² Animal models show mechanisms by which risky behavior, such as adolescent drinking, leads to changes in brain structure and function that persist into adulthood.

¹ FY 2026 FTE levels reflect estimates and are subject to change.

² pubmed.ncbi.nlm.nih.gov/38137124/

One of the most tragic outcomes of untreated mental illness is suicide. NIH continues to lead the research response to the country's ongoing mental health crisis, which disproportionately impacts certain populations including but not limited to veterans, caregivers, medical professionals, and youth. NIH is committed to confronting the mental health crisis by supporting and conducting research that aims to transform how mental health is understood and how mental health treatments and services are accessed – not only in healthcare settings, but also in communities, educational settings, and other contexts.

With support from across NIH, several large studies are exploring early-life factors and their influence on addiction, alcohol misuse, and mental health throughout the lifespan.

Improving Mental Health

Technology and Digital Media (TDM) on Youth Mental Health

Children and adolescents have increasing access to and use of TDM, including social media. Data shows that up to 95 percent of youth ages 13 to 17 and 40 percent of youth ages 8 to 12 are on social media.^{3,4} However, there is limited evidence and knowledge concerning its impact on development and mental health. NIH is supporting studies exploring the relationship between social media use and mental illness, psychiatric symptoms, and risk or resilience for psychopathology among youth. For example, NIH funds projects that aim to identify risk and resilience trajectories, study the link between environmental stressors and social media use, measure differential effects of mental health promoting versus damaging content, and determine whether social media use has a causal effect on poor mental health outcomes. In some studies, researchers are exploring the impacts of social media use on specific mental disorders, such as anxiety and binge-eating disorder, as well as suicidal thoughts and behaviors, while other projects are focused on specific populations. Additionally, NIH continues to support research on strategies that leverage technology to increase the reach, efficiency, and quality of mental health interventions. For example, NIH is funding research on the feasibility and acceptability of imHere4U, an intervention designed to support adaptive coping responses to cyberbullying and motivate help-seeking behavior among adolescents, thereby reducing suicide risk.⁵

Precision Psychiatry Initiative: Individually Measured Phenotypes to Advance Computational Translation in Mental Health (IMPACT-MH)

Effective treatments for mental illnesses exist, yet tailoring treatment for individuals is often a trial-and-error process that can lead to unacceptable delays in receiving effective treatment. To address this pressing challenge, NIH launched the Precision Psychiatry Initiative, an ambitious research program that will target two parallel areas of need: biomarker development and precision assessments. The precision assessment effort, IMPACT-MH, aims to support studies that use behavioral measures and computational methods to better predict patient prognosis and optimize treatment. These studies have the potential to combine data from behavioral tasks and measures with clinical records data to support individual-level prediction and improve clinical decision-making for mental disorders.

³ [pewresearch.org/internet/2022/08/10/teens-social-media-and-technology-2022/](https://www.pewresearch.org/internet/2022/08/10/teens-social-media-and-technology-2022/)

⁴ commonsensemedia.org/sites/default/files/research/report/8-18-census-integrated-report-final-web_0.pdf

⁵ reporter.nih.gov/project-details/10701842

Leveraging Technology to Understand Autism Spectrum Disorders

While early autism screening typically depends on the use of parent questionnaires, data suggest that the accuracy of these assessments may vary across settings and populations. Objective measurement tools could help improve screening in real-world settings and improve accuracy in early screening and identification. In an NIH-supported study, researchers tested a tablet-based app during pediatric primary care well-child visits for toddlers (17–36-month-old).⁶ A tablet camera captured the range of behavioral variations that children with autism may show, including gaze patterns, facial expressions, and whether the child responds to their name. The app used machine learning to analyze behavioral data, providing a diagnostic classification and a prediction confidence score indicating the reliability of that classification. Overall, the app showed high accuracy for classifying children with autism compared to neurotypical children. Importantly, classification accuracy was consistent regardless of the child’s sex, age, and other characteristics, which provides evidence that objective digital screening tools may help improve early autism screening, although more work is needed to establish this app’s performance across varied populations and settings. This same research team is now examining screening accuracy when parents administer the app at home on their own devices, and whether the app can be used to detect early behavioral signs of autism in infants as young as 6-9 months.⁷ Digital screening tools like these have the potential to be included alongside other tools (including parent-report questionnaires and other data sources such as electronic health records) toward enhancing early autism screening.

Advancing Research on Substance Use and its Impact on Children and Adolescents

Adolescent Brain Cognitive Development Study

Launched in 2016, the Adolescent Brain Cognitive Development (ABCD) Study is the largest long-term study of brain development and child health in the United States. ABCD has been collecting a consistent series of data from 12,000 young people, starting at ages 9-10 since its inception. The study is illuminating early-life risk and resilience factors that could serve as targets for SUD prevention interventions, as well as time windows where interventions are likely to have the most impact.⁸ The ABCD Study® exemplifies NIH’s commitment to applying data science to challenges in addiction, as well as making data and analytics tools available for broader research. The ABCD Study embraces an open science model and gives qualified researchers access to anonymized data that cannot be traced back to individual study participants. Over 100 terabytes of data—equivalent to 25 million high-resolution photos—are now available and have been used by more than 200 NIH-funded grants and 1,200 scientific publications.

HEALthy Brain and Child Development Study

The HEALthy Brain and Child Development (HBCD) study, launched in 2021 by the NIH Helping to End Addiction Long-term (HEAL) Initiative, aims to better understand brain development during childhood and build on the substantial research base on prenatal alcohol exposure to determine how exposure to opioids and other substances alone or in combination with alcohol influence brain development. The study began enrolling in July 2023 and will track brain development in about 7,000 children from birth to age 10, collecting data on opioid,

⁶ pubmed.ncbi.nlm.nih.gov/37783967/

⁷ reporter.nih.gov/project-details/10909162

⁸ psychiatryonline.org/doi/10.1176/appi.focus.20240016

substance, and other exposures during pregnancy, genetics, prenatal health, nutrition, social factors such as parent-child relationships, and childhood physical and mental health.

While studies like these are critical for informing prevention strategies, there is often a gap between epidemiology and prevention science. In FY 2025, NIH launched a Translational Resource Centers program that will bring together investigators in these fields and speed the translation of SUD risk and resilience factors into prevention interventions.

Fetal Alcohol Spectrum Disorders (FASD)

FASD-related impairments range from mild to severe and contribute to lifelong challenges that may include medical and learning problems, self-regulation problems, attention and memory deficits, gross or fine motor delay, communication issues, and social challenges. NIH is facilitating development of a consensus classification system to harmonize research efforts and accelerate progress in FASD early detection, diagnosis and treatment. The importance of this effort is emphasized by recent research that examined three commonly used FASD diagnostic systems and found large differences in the number of individuals classified as having FASD with each system.

Prior research suggests that adults with FASD may be at higher risk for chronic health conditions. New NIH-funded research suggests that cognitive deficits due to prenatal alcohol exposure can persist at least into middle age,⁹ implying that individuals with FASD may require continued support through adulthood to reduce the negative impact of cognitive impairments as well as other health effects.

Disease-based Study and Treatment of Addiction and Overdose

Americans suffering from addiction cannot be cabined away from the Department's efforts to end the chronic disease epidemic. To that end, NIH-funded research in basic neuroscience has helped establish that addiction is a chronic, treatable brain condition, from which people can recover. This is a sea change that will inform the development of innovative, cost-effective, and *life-saving* treatments. Today, NIH prioritizes basic research to better understand how the brain and body respond to drugs, with modulation by genes and the environment. For example, addictive drugs exert their rewarding effects by hijacking brain circuits that respond to natural rewards, such as food. Investigators have found that in mice, drug rewards not only take over these circuits, but even the same individual neurons involved in food rewards, with a gene called *Rheb* playing an essential role.¹⁰ These new findings help further define anatomic and molecular pathways involved in SUD that could serve as novel targets for therapy.

With the assistance of a new program funded by the NIH Brain Research Through Advancing Innovative Neurotechnologies® (BRAIN) Initiative, cutting edge research could inform more objective measures of drug craving and seeking. The Brain-Behavior Quantification and Synchronization program supports studies to observe and quantify complex behaviors—like walking, reaching-and-grabbing, vocalization, and other social interactions—and map them to brain activity. Such research could one day enable higher-precision neuromodulation therapies (which deliver stimulation to the brain to activate or de-activate specific brain circuits),

⁹ pubmed.ncbi.nlm.nih.gov/37864533

¹⁰ pubmed.ncbi.nlm.nih.gov/38669575

potentially with the capacity to monitor a person's symptoms and then deliver stimulation at just the right time to treat those symptoms.

Promising Treatments and Therapies

When the prescription opioid overdose epidemic began in the 1990s, methadone was the only medication approved by the Food and Drug Administration (FDA) for treating opioid use disorder (OUD); for a variety of reasons, it is available only at methadone clinics. With NIH support, researchers began working toward other medications for OUD (MOUD), which led to two more FDA-approved options—buprenorphine in 2002 and naltrexone in 2010—that are available from doctors' offices. NIH also supported development of the first naloxone nasal spray to reverse opioid overdose, approved in 2015, as well as newer forms available over the counter. Today, the synthetic opioid fentanyl—which is up to 100 times stronger than morphine—dominates the illicit drug supply, and NIH has led development of stronger overdose reversal agents. Recent FDA approvals include high-dose intranasal naloxone and intranasal and auto-injector forms of nalmefene, a longer-lasting reversal agent. NIH also supported development of lofexidine, the first FDA-approved medication for opioid withdrawal.

NIH is leading the development of other innovative therapeutics for SUD. Since 2018, NIH-funded research has generated more than 60 Investigational New Drug applications and 3 Investigational Device Exemptions, filings the FDA requires for new drugs and devices to enter clinical trials. Ongoing studies are exploring diverse strategies, including new analyses of existing medications. A recent NIH-funded clinical trial examined whether cytisine, an old medicine used for decades in Europe to treat tobacco addiction, could be applied to the modern problem of nicotine addiction associated with e-cigarettes. The trial found that cytisine performed better than placebo at helping adults quit nicotine e-cigarettes.¹¹ Other therapeutics being pursued through NIH-funded research include immunotherapies and sequestrants to clear drugs from the body, neuromodulation-based therapies to adjust brain circuits involved in SUD, and GLP-1 agonist medications (FDA-approved for diabetes and obesity) to reduce drug cravings. NIH also funds research examining whether psychedelic and dissociative drugs, such as psilocybin and ketamine, have potential benefits for treating SUD that outweigh their risks.

Helping to End Addiction Long-term® (HEAL) Initiative

The NIH HEAL Initiative aims to accelerate scientific solutions to the opioid crisis. NIH coordinates several innovative HEAL program and projects that are developing and testing evidence-based interventions for opioid misuse and overdose in all populations and settings.

HEAL-funded projects are working toward non-addictive treatments for chronic pain, including non-opioid medications and behavioral interventions. For example, a first-in-human study is examining the safety and pharmacology of Kindolor—a novel drug that may interrupt the nerve signals underlying pain.¹² The Integrative Management of chronic Pain and OUD for Whole Recovery (IMPOWR) program is testing interventions for patients with co-existing chronic pain and OUD, such as yoga, physical therapy, pain coping skills, and novel MOUD dosing regimens.

¹¹ pubmed.ncbi.nlm.nih.gov/38709500

¹² pubmed.ncbi.nlm.nih.gov/33117893

HEAL also supports studies to improve the reach of approaches such as drug checking, naloxone distribution, and HIV and hepatitis testing. Strategies under study include delivering these services via mobile vans and digital lock boxes, and use of mobile health (such as smartphone apps) to provide overdose prevention resources.

The Recovery Research Networks are working to better integrate MOUD treatment into recovery settings. In the United States, recovery support has traditionally been the domain of treatment providers and peer support groups, with the latter sometimes stigmatizing the use of MOUD. Recovery community centers (RCCs) are a newer recovery model, offering peer support and other services, such as basic needs assistance. A recent Networks survey found that most RCCs also link their clients to MOUD providers, thus combining the benefits of peer support with improved access to MOUD treatment.¹³

Alcohol Misuse

Alcohol misuse exacts an immense toll on individuals, families, and communities. In the United States, each year nearly 29 million people meet criteria for alcohol use disorder (AUD) and more than 178,000 people die from alcohol-related problems, making alcohol a leading preventable cause of death.^{14,15} Alcohol misuse is linked to more than 200 diseases and injury-related conditions, accounting for approximately 50 percent of liver disease deaths, 5 to 6 percent of cancer cases, and 4 percent of cancer deaths. Alcohol-related traffic fatalities have increased to the highest level since 2008, accounting for 32 percent of overall traffic fatalities in 2022.¹⁶

Preventing and reducing alcohol-related health consequences among populations at higher risk for alcohol misuse is another major focus. A recent analysis of over 2 million Veterans found that approximately 15 percent of Veterans and 20 percent of young Veterans (age 18-39) reported alcohol misuse following the COVID-19 pandemic.¹⁷ The results emphasize the need for routine assessment of alcohol misuse and timely connection to appropriate resources and treatment for Veterans.

Many people are unaware of the relationship between alcohol consumption and health conditions, including breast cancer, cardiovascular disease, mental health disorders, and many more. To raise awareness of the adverse health impacts of alcohol, NIH leverages different outreach strategies and resources to disseminate evidence-based information to health care professionals, educators, the public and get information into the hands of the people who need it.

Biology of Alcohol Misuse

Alcohol misuse has powerful effects on the brain and behavior, as well as the rest of the body. Research has shown that people who misuse alcohol have a greater risk of liver disease, heart disease, depression, stroke, and gastrointestinal problems, as well as certain cancers. Basic research supported by NIH includes studies to understand the brain cells and circuits that

¹³ pubmed.ncbi.nlm.nih.gov/38426533

¹⁴ nccd.cdc.gov/DPH_ARDI/Default/Default.aspx

¹⁵ pubmed.ncbi.nlm.nih.gov/32733836/

¹⁶ crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/813560

¹⁷ pubmed.ncbi.nlm.nih.gov/38052382/

underlie and are altered by alcohol misuse and the complex relationships between alcohol misuse and its physiological effects throughout the body.

Investment in basic research lays the foundation for informing prevention and treatment of alcohol-related problems. For example, in 1975, NIH-funded scientists first linked alcohol misuse directly to liver disease.¹⁸ The liver is the primary site of alcohol metabolism in the body and is particularly susceptible to alcohol-related injury. In the decades since this discovery, basic research on the interconnectivity of the brain, liver, gut, and immune system have contributed to a deeper understanding of alcohol's effects on the liver and informed research on novel and integrated treatment strategies for alcohol-associated liver disease (ALD) and AUD. Currently, there are no treatments approved by the FDA to specifically treat ALD. Though corticosteroids are often used as the standard of care, many people do not respond to them, making effective ALD treatment a major unmet need.

Basic research is also helping to understand the molecular mechanisms through which alcohol contributes to dysfunction of the immune, lung, pancreas, liver, and other organ systems. For example, a recent study found that activation of the immune regulator gene (IRF3) in brain cells by alcohol-induced cellular stress increased levels of genes associated with inflammation and alcohol craving.¹⁹ Use of the AUD medications acamprosate and naltrexone reversed the effects of this cellular stress and mitigated increases in immune response and alcohol craving genes. These results suggest a novel biological target for identifying future AUD medications.

NIH also supports studies focused on the mechanisms through which alcohol misuse contributes to other diseases, such as cardiovascular disease (CVD), cancer, and dysfunction of the lung, pancreas, gut, immune system, and skeletal muscle. For example, in a recent study, researchers identified 10 molecules in the body associated with long-term alcohol consumption and CVD risk.²⁰ Relatedly, NIH-supported research focuses on understanding how AUD increases the risk for more severe outcomes from severe acute respiratory distress syndrome including that caused by COVID-19. In addition to elucidating the mechanisms by which alcohol misuse causes or exacerbates diseases, such studies identify potential biomarkers of increased risk for alcohol-related disease as well as potential treatment targets.

Preventing and Treating Alcohol Misuse

Epidemiological research has shown that female adolescents and young adult women are now more likely to drink and to binge drink than young men,²¹ which may be linked to social reasons, coping with stress, and other factors.²² A better understanding of these risk factors can inform the development of evidence-based prevention and treatment interventions tailored to the unique needs of these populations. NIH is supporting research on the etiology, prevention, and treatment of alcohol misuse and how environmental factors influence resilience and vulnerability to negative alcohol-related health effects.

¹⁸ niaaa.nih.gov/our-work/niaaa-50th-anniversary-milestones

¹⁹ pubmed.ncbi.nlm.nih.gov/38531832/

²⁰ pubmed.ncbi.nlm.nih.gov/37968697/

²¹ 2002-2022 National Survey on Drug Use and Health (NSDUH)

²² pubmed.ncbi.nlm.nih.gov/38795320/

NIH-supported research has resulted in the development of effective evidence-based screening tools and therapies for AUD, which include behavioral therapies and FDA-approved medications. Still, AUD and other alcohol-related health conditions are underdiagnosed and undertreated. Given the diverse biological processes that contribute to AUD, new medications are needed to provide a larger menu of effective treatment options that can be tailored to individual needs.

To help close the alcohol treatment gap, NIH supports research to develop improved diagnosis and treatment of alcohol-associated conditions, to expand treatment options, and to enhance long-term recovery. Moreover, efforts to advance integrated care between alcohol-related conditions, such as AUD and ALD, and to improve whole person health are underway. For example, researchers found that alcohol screening and brief intervention (SBI) in primary care significantly improved drinking outcomes independent of AUD treatment, and reduced both alcohol use and blood pressure in patients with hypertension.²³ The results demonstrate that integrating alcohol SBI into routine care can not only increase the chances that an alcohol-related problem is identified and addressed but also improve other health conditions that are affected by alcohol misuse.

Another focus of NIH is understanding the neurobiological mechanisms underlying AUD, and mechanisms by which commonly co-occurring conditions such as sleep disorders, pain disorders, and mental health disorders interact with AUD to ultimately identify novel treatment targets for these conditions. For example, alcohol misuse increases the risk for anxiety and mood disorders. Conversely, drinking alcohol to cope with anxiety, trauma, or chronic stress increases the risk for developing AUD. A recent human positron emission tomography imaging study found that an enzyme that helps regenerate the stress hormone cortisol had increased availability in brain regions known to be altered during AUD.²⁴ These results suggest that increased brain cortisol may contribute to the development and perpetuation of AUD. These human studies followed extensive preclinical studies linking dysfunction in the body's stress response to compulsive-like alcohol intake in animal models. In addition, NIH supports programs such as the Integrative Neuroscience Initiative on Alcoholism which utilizes translational, multidisciplinary, and collaborative research approaches to examine brain mechanisms that underlie alcohol misuse and their relationships to brain stress and neuroimmune systems to AUD. NIH also focuses on applying this knowledge to identify novel treatment targets for AUD.

Polysubstance Use

Polysubstance use is a growing factor in fatal overdose and increases the risk of other adverse outcomes, including HIV, hepatitis, and prolonged drug-related hospitalizations. People with OUD and a co-occurring SUD also have lower odds of staying in treatment for OUD.

NIH leads several research efforts to better understand, treat, and prevent polysubstance use. For example, a continuing program supports research on mechanisms and outcomes of polysubstance use, including harms associated with xylazine exposure. Xylazine is a veterinary sedative commonly found as an adulterant in illicit fentanyl and has been associated with severe

²³ pubmed.ncbi.nlm.nih.gov/36657762/

²⁴ pubmed.ncbi.nlm.nih.gov/38304303/

withdrawal. NIH-funded studies suggest that xylazine exacerbates fentanyl withdrawal rather than causing a unique withdrawal syndrome.

Active HEAL-funded programs seek to better understand polysubstance use motivations, patterns, risk factors, and outcomes to improve intervention. One project has found that among people with a history of injection drug use, those using both opioids and stimulants have higher rates of depression, homelessness, incarceration, and unemployment. This underscores the importance of addressing mental health and social factors as part of polysubstance use intervention. Another project is analyzing medical records data to determine if people with co-occurring OUD and AUD experience better outcomes when treated with GLP-1 agonists in addition to first-line medications for OUD and AUD.

Other studies are testing interventions for polysubstance use in primary care settings. For example, collaborative care interventions emphasize shared decision-making between patients and their healthcare providers and have shown efficacy for treating chronic illness in primary care.²⁵ NIH's Co-Care study is investigating whether primary-based collaborative care can reduce polysubstance use and overdose risk.²⁶

²⁵ pubmed.ncbi.nlm.nih.gov/31517791/

²⁶ ctnlibrary.org/protocol/ctn0139/

NATIONAL INSTITUTES OF HEALTH
National Institute of Behavioral Health

Appropriations History^{1,2}

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2017	\$3,036,668,000	\$3,187,777,000	\$3,211,351,000	\$3,176,147,000
Rescission				\$0
2018	\$2,471,255,000	\$3,266,754,000	\$3,338,501,000	\$3,647,951,000
Rescission				\$0
2019	\$3,218,704,000	\$3,706,015,000	\$3,817,708,000	\$3,815,731,000
Rescission				\$0
2020	\$3,379,220,000	\$4,002,219,000	\$4,122,752,000	\$4,045,763,000
Rescission				\$0
2021	\$3,773,981,000	\$4,086,956,000	\$4,209,181,000	\$4,138,291,000
Rescission				\$0
2022	\$4,636,242,000	\$4,665,836,000	\$4,621,439,000	\$4,386,101,000
Rescission				\$0
2023	\$4,620,879,000	\$4,733,364,000	\$4,608,336,000	\$4,595,856,000
Rescission				\$0
2024	\$4,801,634,000	\$4,456,856,000	\$4,705,856,000	\$4,531,856,000
Rescission				\$0
2025	\$4,815,908,000		\$4,950,856,000	\$4,491,356,000
Rescission				\$0
2026	\$2,784,738,000			

¹ FY 2017 Budget Estimate to Congress includes mandatory financing.

² Includes funds derived by transfer from the NIH Innovation Account under the 21st Century Cures Act.

BUDGET AUTHORITY BY OBJECT CLASS

**NATIONAL INSTITUTES OF HEALTH
National Institute of Behavioral Health**

Budget Authority by Object Class ¹

(Dollars in Thousands)

	FY 2025 Full-Year CR	FY 2026 President's Budget	FY 2026 +/- FY 2025
Total compensable workyears:			
Full-time equivalent	1,279	1,022	-257
Full-time equivalent of overtime and holiday hours	1	1	0
Average ES salary	\$214	\$215	\$0
Average GM/GS grade	13.0	13.1	0.1
Average GM/GS salary	\$147	\$146	-\$2
Average salary, Commissioned Corps (42 U.S.C. 207)	\$130	\$134	\$4
Average salary of ungraded positions	\$167	\$152	-\$15
OBJECT CLASSES	FY 2025 CR	FY 2026 President's Budget	FY 2026 +/- FY 2025
Personnel Compensation			
11.1 Full-Time Permanent	\$129,061	\$100,667	-\$28,395
11.3 Other Than Full-Time Permanent	\$55,604	\$45,693	-\$9,911
11.5 Other Personnel Compensation	\$6,586	\$6,217	-\$368
11.7 Military Personnel	\$944	\$946	\$2
11.8 Special Personnel Services Payments	\$28,170	\$27,682	-\$488
11.9 Subtotal Personnel Compensation	\$220,366	\$181,206	-\$39,160
12.1 Civilian Personnel Benefits	\$69,253	\$62,076	-\$7,177
12.2 Military Personnel Benefits	\$84	\$81	-\$3
13.0 Benefits to Former Personnel	\$3,567	\$251	-\$3,317
Subtotal Pay Costs	\$293,270	\$243,613	-\$49,657
21.0 Travel & Transportation of Persons	\$4,608	\$3,965	-\$643
22.0 Transportation of Things	\$353	\$308	-\$46
23.1 Rental Payments to GSA	\$10	\$10	\$0
23.2 Rental Payments to Others	\$0	\$0	\$0
23.3 Communications, Utilities & Misc. Charges	\$1,575	\$1,567	-\$8
24.0 Printing & Reproduction	\$3	\$3	\$0
25.1 Consulting Services	\$195,981	\$132,881	-\$63,099
25.2 Other Services	\$61,684	\$53,335	-\$8,349
25.3 Purchase of Goods and Services from Government Accounts	\$330,123	\$226,962	-\$103,161
25.4 Operation & Maintenance of Facilities	\$756	\$485	-\$271
25.5 R&D Contracts	\$30,611	\$28,603	-\$2,008
25.6 Medical Care	\$1,458	\$1,308	-\$151
25.7 Operation & Maintenance of Equipment	\$15,776	\$14,350	-\$1,426
25.8 Subsistence & Support of Persons	\$0	\$0	\$0
25.0 Subtotal Other Contractual Services	\$636,388	\$457,923	-\$178,465
26.0 Supplies & Materials	\$14,842	\$10,844	-\$3,998
31.0 Equipment	\$8,574	\$6,751	-\$1,823
32.0 Land and Structures	\$376	\$383	\$7
33.0 Investments & Loans	\$0	\$0	\$0
41.0 Grants, Subsidies & Contributions	\$3,537,592	\$2,059,329	-\$1,478,263
42.0 Insurance Claims & Indemnities	\$0	\$0	\$0
43.0 Interest & Dividends	\$43	\$42	\$0
44.0 Refunds	\$0	\$0	\$0
94.0 Financial Transfers	\$0	\$0	\$0
Subtotal Non-Pay Costs	\$4,204,364	\$2,541,125	-\$1,663,239
Total Budget Authority by Object Class	\$4,497,634	\$2,784,738	-\$1,712,896

¹ Includes FTEs whose payroll obligations are supported by the NIH Common Fund.

DETAIL OF POSITIONS

NATIONAL INSTITUTES OF HEALTH
National Institute of Behavioral Health

Detail of Positions ¹

GRADE	FY 2024 Final	FY 2025 Full-Year CR	FY 2026 President's Budget
Total, ES Positions	3	3	3
Total, ES Salary	\$624,308	\$642,606	\$643,697
General Schedule			
GM/GS-15	187	179	158
GM/GS-14	247	243	196
GM/GS-13	286	284	213
GS-12	158	155	121
GS-11	55	59	47
GS-10	0	0	0
GS-9	29	26	16
GS-8	11	7	4
GS-7	10	8	5
GS-6	1	1	0
GS-5	1	1	0
GS-4	1	1	1
GS-3	1	1	1
GS-2	0	0	0
GS-1	0	0	0
Subtotal	987	965	762
Commissioned Corps (42 U.S.C. 207)			
Assistant Surgeon General	0	0	0
Director Grade	1	1	1
Senior Grade	3	3	3
Full Grade	2	2	2
Senior Assistant Grade	0	0	0
Assistant Grade	0	0	0
Junior Assistant	0	0	0
Subtotal	6	6	6
Ungraded	357	333	277
Total permanent positions	1,036	1,009	790
Total positions, end of year	1,353	1,307	1,048
Total full-time equivalent (FTE) employment, end of year	1,274	1,279	1,022
Average ES salary	\$208,103	\$214,202	\$214,566
Average GM/GS grade	13.0	13.0	13.1
Average GM/GS salary	\$143,796	\$147,441	\$145,501

¹ Includes FTEs whose payroll obligations are supported by the NIH Common Fund.