# Substance use disorders: Determining appropriate level of care for treatment

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## INTRODUCTION

Patients with chronic or relapsing substance use disorders (SUDs) make up 40 to 60 percent of individuals who receive SUD care [1-3]. These patients typically have marked impairments in functioning and high rates of co-occurring medical, mental health, and social problems that need to be addressed.

With increasing recognition of the substantial patient population with a chronic SUD (addiction), the SUD-treatment model is shifting from episodic to continuing care, based on the chronic care model [4]. In managing patients with chronic SUDs, the patient's clinical status and risk of relapse are monitored systematically and longitudinally. As the patient's addiction waxes and wanes over time (ie, experiences periods of abstinence, relapse, or fluctuations in risk of relapse), the intensiveness and types of treatment are adjusted.

This topic describes the continuum of care for SUDs, and factors that influence the determination of patients' level of care. Other aspects of continuing care for SUDs (ie, indications, features, efficacy, and implementation) are described separately. Treatment for individual SUDs are also described separately.

- (See "Continuing care for addiction: Components and efficacy".)
- (See "Continuing care for addiction: Implementation".)
- (See "Management of moderate and severe alcohol withdrawal syndromes".)

- (See "Alcohol withdrawal: Ambulatory management".)
- (See "Alcohol use disorder: Psychosocial management".)
- (See "Alcohol use disorder: Pharmacologic management".)
- (See "Opioid withdrawal: Medically supervised withdrawal during treatment for opioid use disorder".)
- (See "Opioid use disorder: Pharmacologic management".)
- (See "Stimulant use disorder: Psychosocial management".)
- (See "Cannabis use disorder: Clinical features, screening, diagnosis, and treatment".)

## CONTINUUM OF CARE

The "continuum of care" model for substance use disorder (SUD) services was established initially in the United States public sector, later adopted by private systems of care, and embedded in the United States payment model for SUD care in the United States.

There is little published research on implementation of a level of care model outside the United States. Services across the continuum range in intensity from a brief, office-based intervention to around-the-clock inpatient care, with multiple tiers in between. These levels of care differ in the types and intensity of services provided (eg, the number of hours per week, the variety of clinical disciplines involved, the treatment modalities available, and the extent of patient monitoring). Individuals will often move between levels as their clinical status and treatment needs evolve. Treatment is said to be "stepped down" when a patient is transferred from a higher to lower level of care – for example, after completing a treatment course while maintaining abstinence at the earlier level. Treatment is commonly "stepped up" when the current level of care proves inadequate – for example, when a patient relapses.

There are several level of care criteria that are used to guide SUD care in public and private United States health care systems. Examples include the American Society of Addiction Medicine [ASAM], the American Association of Community Psychiatrists, and New York state's Level of Care for Alcohol and Drug Treatment Referral. There is much agreement across these criteria.

This topic describes the ASAM's "Treatment Criteria for Addictive Substance-related and Co-occurring Conditions" [5]. These include dimensions for patient assessment, level of care criteria, and principles for matching patients to levels of care based on their clinical status, social circumstances, individual treatment needs, and preferences ( algorithm 1) [5]. ASAM categorizes levels of SUD care as follows [5]:

- Level 0.5 – Early intervention
- Level 1.0 – Outpatient services (including opioid treatment programs)
- Level 2.1 – Intensive outpatient services
- Level 2.5 – Partial hospitalization services
- Level 3.1 – Clinically managed low-intensity residential services
- Level 3.3 – Clinically managed population-specific high-intensity residential services
- Level 3.5 – Clinically managed high-intensity residential services
- Level 3.7 – Medically monitored intensive inpatient services
- Level 4.0 – Medically managed intensive inpatient services

An important component of any SUD continuum is facilitation between levels of care. An analysis of continuing care for adolescents with SUDs found that more assertive approaches can improve the initiation of continued care and a more rapid rate of initiation resulted in attenuation of substance use [6].

## LEVELS OF CARE

**ASAM level of care criteria** — Levels of substance use disorder (SUD) care based on the American Society of Addiction Medicine (ASAM) level of care criteria are described below [5].

**Early intervention** — Individuals at risk for an SUD may be identified in routine screening in primary care, emergency departments, by Employee Assistance Programs, by health care educators, and during driving under the influence assessments and then followed by a brief intervention. Identification of patients who use drugs for nonmedical reasons or consume alcohol greater than the National Institute of Alcohol Abuse and Alcoholism threshold for risky use – a risk factor for health consequences and progression to an SUD – may be followed by a brief intervention. (See "Brief intervention for unhealthy alcohol and other drug use: Efficacy, adverse effects, and administration" and "Screening for unhealthy use of alcohol and other drugs in primary care".)

**Outpatient care** — Individuals with an SUD who are not at risk for complicated withdrawal and who are medically and psychiatrically stable, living in a supportive recovery environment, and are approaching readiness to change are appropriate for outpatient care. Without treatment, this group of individuals would be at high risk for continued use or relapse.(See "Alcohol withdrawal: Ambulatory management" and "Opioid withdrawal: Medically supervised withdrawal during treatment for opioid use disorder".)

Outpatient treatment is delivered in a variety of office, clinic, and telehealth settings. Services include individual and/or group counseling, mutual help groups, pharmacotherapy, access to laboratory and toxicology services, and medical and psychiatric consultation. Telephone emergency services should be continuously available. (See "Substance use disorders: Psychosocial management".)

**Intensive outpatient programs** — Individuals appropriate for an intensive outpatient program (IOP) typically require close monitoring and frequent contact to reduce risk of continued use, relapse, and worsening mental health problems. Appropriate individuals should be medically stable and at minimal risk for severe withdrawal. In addition to the SUD, they may have mild psychiatric problems that need monitoring or lack a supportive recovery environment.

IOPs offer a higher level of care than a typical outpatient program. IOPs provide services in a planned format for a minimum of nine hours a week. IOPs can be located in outpatient, partial hospital, or hospital settings; their schedules often include evening and weekend sessions.

Clinical services provided include individual and/or group counseling, mutual help groups, pharmacotherapy, access to laboratory and toxicology services, medical and psychiatric consultation. Additional services available include family therapy, vocational services, and recreational therapy. Treatment goals are to attain or maintain sobriety, improve functioning, and maintain residence in the community.

Examples of IOP participants include individuals with:

- A history of failed outpatient treatment
- Co-occurring, poorly controlled depression
- Limited social support such as alienated family members or living with other people with an SUD

**Partial hospital programs** — Partial hospital programs (PHPs) are similar to IOPs; they share the same modalities and treatment goals, and may consist of the same programming, with PHP patients attending more frequently. PHPs provide a structured, intensive, nonresidential program with at least 20 hours of treatment per week by some definitions, including individual and group counseling, medication management, educational groups, and occupational therapy [5]. Medical or psychiatric consultation should be available within 8 hours by phone and 48 hours in person, either on site, via referral, or transfer to a higher level of care.

Participants in a PHP could include individuals with:

- A history of failing IOP treatment
- Recent residential care, stepping down to PHP
- Multiple risk factors contributing to a high risk of relapse

**Residential services** — Residential programs provide a 24-hour, drug- and alcohol-free environment, along with professional or peer support. Residential care addresses those aspects of patients' prior living environment that contribute to the potential for relapse. The decision to admit a patient to a residential program requires assessment of the patient's readiness to change. In contrast with other levels of care, these programs require a commitment to maintaining abstinence. There are a wide range of public- and private-sector residential programs for SUDs.

Residential programs have been shown to improve substance use, employment, and self-regulation outcomes. As an example, in a randomized trial, 150 patients discharged after SUD treatment were assigned to either a residential program versus treatment as usual. After 24 months, participants living in the residential program had a lower rate of relapse (46 versus 65 percent), higher monthly income, and lower incarceration rates compared with the control group [7].

Two types of clinically managed residential services are:

- **Clinically managed, low-intensity residential services** – Clinically managed, low-intensity residential services are appropriate for individuals who need time in structured sober housing to integrate recovery and coping skills. Short-term residential programs are intended to provide transitional support (eg, between inpatient care and independent living). Lengths of stay vary but are on the order of weeks to a few months. Low-intensity services can be offered on site or combined with outpatient and intensive outpatient programs. Community residential treatment facilities (CRFs) are one example of clinically managed, low-intensity residential services. CRFs provide transitional housing and treatment, often following inpatient treatment.

  Programs vary greatly in their staffing, the degree to which treatment is provided, the types of treatment, and their underlying philosophy. Three distinct models have been identified [8]:

  - Psychosocial model – These residential programs primarily provide psychosocial services such as individual and group therapy, social skills training, and self-help groups.

- Supportive rehabilitative model – In addition to psychosocial services, these programs provide work training and more specialized services such as recreational and occupational therapy.

- Intensive treatment model – In addition to the services above, these programs provide medical and psychiatric services, including medication treatment, couples and family counseling, and nutrition counseling.

Observational studies have described the CRF resident and program characteristics that are associated with better outcomes. In an observational study of approximately 2800 residents from a nationally representative sample of 88 CRFs, greater motivation for treatment, social and personal resources, and prior involvement with self-help groups were associated with better outcomes [9]. More severe SUDs and comorbid psychiatric problems were associated with worse outcomes. Additionally, a more structured approach to treatment had better retention rates and SUD outcomes than programs with a more generic approach [10].

- **Clinically managed, high-intensity residential services** – These programs have been developed to support individuals with significant functional limitations who cannot be managed without some type of rehabilitative services. These programs have 24 hour per day nursing care, 16 hours per day counselor availability, and physician services for medical and psychiatric problems as needed.

  Examples of individuals requiring this care include those with a substance-induced neurocognitive disorder or a comorbid neurocognitive disorder.

  Therapeutic communities traditionally provide residential care for individuals with severe SUDs, although the model has been applied to other levels of care and clinical conditions as well. The programs are highly structured, provide comprehensive services, and are based on an explicit set of principles, including a focus on the community as a means of facilitating individual change [11]. Treatment goals include changes in identity and lifestyle, including abstinence from substances, employment, cessation of antisocial behavior, and prosocial values. Lengths of stay are typically between 15 and 24 months. Most patients who enter therapeutic communities have extensive substance-use histories and significant psychosocial dysfunction.

**Medically managed intensive inpatient services** — Inpatient care mainly provides medically supervised withdrawal for substance-dependent individuals with 24-hour patient care and daily physician visits over brief lengths of stay (eg, two to five days). Medically supervised withdrawal (previously called detoxification) consists of close monitoring and treatment of withdrawal

symptoms with medication to diminish their severity. Medically supervised withdrawal takes place either in freestanding treatment centers or, for medically complicated patients, in hospitals. Inpatient programs usually include group treatment that provides education and support. Medication to prevent relapse may be started during an inpatient stay. (See "Management of moderate and severe alcohol withdrawal syndromes" and "Opioid withdrawal: Medically supervised withdrawal during treatment for opioid use disorder" and "Benzodiazepine use disorder", section on 'Withdrawal'.)

In the past, inpatient stays were often longer and included both medically supervised withdrawal and rehabilitation (ie, psychosocial treatment focused on preventing relapse). Clinical trials demonstrated that selected populations could be treated at lower, less resource-intensive levels of care [12], reserving inpatient treatment for more severe, medically or psychiatrically complicated cases of withdrawal. Far fewer patients receive inpatient rehabilitation today. More commonly, the rehabilitative phase of treatment that follows medically supervised withdrawal is provided at a lower level of care following inpatient discharge.

**Special considerations**

**Treatment integration for co-occurring conditions** — The National Survey on Drug Use and Health reported that almost 4 percent of the United States adults had both a SUD and a mental disorder [13]. The ASAM criteria [5] emphasize the need of availability of treatment for co-occurring mental disorders and medical conditions in conjunction with SUD care. Integration of care for SUD, mental disorders, and medical conditions at each level of care is generally recommended rather than parallel treatment. (See "Co-occurring schizophrenia and substance use disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment and diagnosis", section on 'Epidemiology' and "Pharmacotherapy for co-occurring schizophrenia and substance use disorder", section on 'Integrated treatment'.)

SUD treatment programs vary markedly in their capacity to treat these comorbidities. A standardized assessment of 180 community addiction programs across 11 states including outpatient, intensive outpatient, and residential treatment programs found that only approximately 20 percent were capable of delivering integrated or dual-diagnosis services [14]. Many partial-hospital and intensive-outpatient programs provide psychiatric and/or medical treatment as an integral part of their program. A minority of systems of care have integrated programs at each level of care for treatment of dual diagnoses. Increased service capacity for the dually diagnosed is clearly needed.

**Opioid use disorders** — Due to the worsening opioid overdose epidemic, which has escalated further during the COVID-19 pandemic, the treatment of opioid use disorders (OUDs) requires special consideration.

- **Comprehensive framework of care** – An OUD Cascade of Care framework has been proposed to improve treatment outcomes and reduce mortality from opioid overdoses and associated medical complications [15]. The OUD Cascade of Care expands beyond the ASAM level of care to include primary prevention to increase public awareness and reduce opioid exposure as well as secondary prevention aimed at prevention and screening in at-risk populations. Following identification of an OUD, the treatment cascade includes engagement in care, initiation of medications for OUD (MOUD), retention, and remission. Treatment of OUD can span across the ASAM level of care spectrum from office-based opioid treatment including MOUD, such as buprenorphine or naltrexone and methadone from a federally certified outpatient treatment program, to medically managed inpatient services. Similar to other SUDs, following engagement in care, individuals with an OUD may initially require a higher level of care and move within the continuum.

- **Medication-assisted treatment through telehealth** – The COVID-19 pandemic also catalyzed increased use of telehealth in the treatment of SUDs, particularly in the area of the provision of medication-assisted treatment for OUD [13,16,17]. In terms of buprenorphine prescribing for OUD, many states that prohibited prescribing by telehealth pre-COVID relaxed these restrictions to accommodate COVID needs. The provision of some level of SUD-treatment services via telehealth improves treatment access, is likely to become more standard, and may need to be considered when determining appropriate levels of care for individuals in the future.

## CERTIFICATION

In 2018, the Commission of Accreditation and Rehabilitation Facilities (CARF) and the American Society of Addiction Medicine (ASAM) developed a national certification for addiction treatment programs. The certification will assure that the program has the ability to deliver services consistent with the ASAM criteria [18]. Additionally, the three-year certification increases consumer confidence and builds transparency. Certification is an important step to implement consistent standards and ensure adherence to the criteria. The ASAM level of Care Certification Manual [19] and the ASAM Level of Care Preparation Workbook [20] are available to assist organizations in the certification process.

In 2019, CARF announced plans to launch an accreditation program for office-based opioid treatment for organizations delivering comprehensive treatment including buprenorphine or naltrexone for individuals with opioid use disorders [21].

## PATIENT ASSESSMENT

The determination of a patient's level of care should be made by a clinician familiar with services available and based on careful, thorough, and individualized patient assessment.

**Clinician assessment using ASAM dimensions** — The American Society of Addiction Medicine (ASAM) organizes this assessment into specific dimensions, described below, along with clinical questions that can be useful in assessing each dimension.

Research studies have suggested that clinical outcomes of patients with a substance use disorder (SUD) can be improved by serial, multidimensional assessments of the patient's clinical status and needs, and ongoing matching of treatment modalities and levels of care to assessment results [22]. Reassessment of the treatment plan over time and use of evidence-based therapies (such as contingency management, case management and therapeutic communities) are central to achieving optimal outcomes.

- Dimension 1 – Acute intoxication and withdrawal potential.
    - Need for management of intoxication (eg, treatment for acute alcohol poisoning; prevent from driving)? (See "General approach to drug poisoning in adults" and "Ethanol intoxication in adults" and "Methamphetamine: Acute intoxication" and "Cannabis (marijuana): Acute intoxication" and "Intoxication from LSD and other common hallucinogens" and "Acute opioid intoxication in adults".)
    - Need for medically managed withdrawal (eg, history of severe or complicated withdrawal, elevated vital signs, elevated score on withdrawal scale such as the Clinical Institute Withdrawal Scale or Clinical Opiate Withdrawal Scale)? (See "Management of moderate and severe alcohol withdrawal syndromes" and "Opioid withdrawal: Medically supervised withdrawal during treatment for opioid use disorder".)
        - Can withdrawal be managed on an outpatient basis? (See "Alcohol withdrawal: Ambulatory management".)
- Dimension 2 – Biomedical conditions and complications (need for physical health services).

- Need for treatment of acute or chronic medical problems that could complicate SUD treatment?
- For females, pregnant or risk of pregnancy?
- Presence of any communicable disease that could potentially affect the health of other patients and staff?

- Dimension 3 – Emotional, behavioral, or cognitive condition and complications (need for mental health services).
  - Any current co-occurring mental disorders that complicate treatment or create risk?
  - Any chronic mental disorders that require stabilization or ongoing treatment (eg, schizophrenia, bipolar disorder, anxiety disorders)? (See "Co-occurring schizophrenia and substance use disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment and diagnosis".)
  - Are signs and symptoms of emotional, behavioral, or cognitive problems part of the addiction or independent?
  - Any of the signs and symptoms severe enough to require immediate mental health treatment (eg, suicidal ideation, homicidal ideation, able to manage activities of daily living)?
- Dimension 4 – Readiness to change. (See "Substance use disorders: Motivational interviewing", section on 'Readiness to change'.)
  - Ready to stop or reduce use of substances/addictive behaviors?
- Dimension 5 – Relapse, continued use or continued problem potential (need for relapse prevention services). (See "Continuing care for addiction: Implementation".)
  - At risk of continued substance use or mental health distress?
  - Any relapse prevention skills to decrease risk of drug use or exacerbation of mental health problems?
  - Potential benefit of medications (psychotropic and addiction)?
    - History of use/benefit?

- Aware of relationship between substance use or behaviors involved in unhealthy pursuit of substances and adverse consequences?

- Dimension 6 – Recovery environment (need for services related to family/significant-other, housing, vocational, legal, transportation, or child care?).
  - Any relationships or situations that threaten safety, treatment engagement, or recovery?
  - Resources in place to support successful recovery (eg, supportive relationships, financial resources, work skill)?
  - Any mandates that may increase motivation for treatment (eg, legal, professional licensure, social services)?
  - Any housing, employment, transportation, or childcare issues that need to be addressed?

**Online patient self-assessment** — There has been a growing emphasis of patient involvement in their health care decisions as a key to change and learning how to manage chronic disease. In order to address this need, an online public Addiction Treatment Needs Assessment based on the ASAM level of care has been established [23]. The 13-question assessment tool provides feedback on the most appropriate level of care based on the results, along with secondary information about additional support such as mental health services. The link can be found at the OpenBeds-Treatment Connection website.

A link to the FindTreatment.gov website assists consumers locating treatment based on zip code or city and state.

## PATIENT PLACEMENT

Matching patients with substance use disorders (SUDs) to the appropriate level of care based on their clinical status and needs is a core element of SUD care. Most clinicians believe this has an important role in maximizing patient outcomes. However, testing of the matching process via clinical trials is challenging and results have been mixed. Additionally, factors other than level of care criteria often influence patient placement, including insurance restrictions and the availability of individual levels of care, both of which vary widely across plans and systems of care.

**Determining level of care** — Determination of the patient's initial and subsequent levels of care involves synthesis of his or her status in each dimension, the interaction among dimensions, and the types and intensity of services available at each level (see 'Clinician assessment using ASAM dimensions' above). Additional factors contributing to the determination are imminent risks requiring immediate attention (eg, suicidality) as well as specific patient needs and preferences [5]. Tools to determine the level of care include:

- The New York State Office of Addiction Services and Supports (OASAS) Level of Care for Alcohol and Drug Treatment Referral determination tool can be found on the OASAS website. This tool was developed with a greater number of level of care options, allowing for a direct match to the state's treatment system. Intermediate to good reliability was found when used by clinically trained individuals, and in a review of over 390,000 client records, the recommended level of care was overridden only 10 percent of the time, demonstrating the value of consistent standards and implementation [24].

- The American Society of Addiction Medicine (ASAM) criteria – These criteria provide a structured approach to the assessment/determination ( algorithm 2). The ASAM matrix utilizes a rating of 0 to 4 across each of the dimensions with 0 = no need for specific services and 4 = high-intensity services. The dimension with a highest risk rating identifies the need for immediate treatment. As examples:

  - In an individual with a risk of severe alcohol withdrawal including seizures or delirium tremens in Dimension 1, a referral for inpatient medically monitored withdrawal would be indicated. Further assessment of other dimensions would take place following admission and stabilization. If there is no immediate danger, the level of risk should be assessed in each dimension.

  - In an individual with a severe mental illness such as schizophrenia, who presents homeless, with an alcohol use disorder, and a mild exacerbation of psychotic symptoms (but not to the degree of requiring inpatient psychiatric hospitalization or medically supervised withdrawal) would require a moderate intensity of mental health services including case management, medication management, and medical monitoring. The SUD could be addressed in enhanced addiction services or an integrated mental health/SUD program if available. Temporary supportive living may be necessary at the onset. Care could be stepped down to assertive case management or outpatient care following reassessment after stabilization on medication.

**Efficacy** — The results of clinical trials on matching patients to levels of SUD care and treatment outcomes is mixed. While some studies report positive results [25,26] on SUD outcomes; others

have reported negative findings [27-34]. As examples:

- A clinical trial assessed 95 adult United States veterans with SUD, following medically supervised withdrawal, for appropriate level of care; patients were naturalistically assigned to residential rehabilitation blinded to the ASAM patient placement criteria recommendation [26]. Participants mismatched to a lower level of care utilized nearly twice as many hospital days over the subsequent year, suggesting undermatching may be associated with increased inpatient utilization.

- Two hundred forty-eight patients seeking treatment for alcohol use disorders were assigned to either intensive outpatient, inpatient rehabilitation, or outpatient care as usual following the computerized ASAM patient placement criteria and a clinical evaluation to determine if they were assigned to the appropriate level of care or mismatched [25]. Three months after admission, participants who were undertreated, for example receiving regular outpatient care rather the recommended intensive outpatient, had worse drinking outcomes compared with matched treatment. Of note, drinking outcomes were not improved with overtreatment.

- A study of 1252 patients treated for alcohol use disorder examined the predictive validity of level of care assignments on patient outcomes, positing that patients who were matched to criteria-determined levels of care would have better outcomes than patients treated at a less intensive level [29]. Twenty-two percent of patients were treated at a recommended level of care, while 49 percent were undertreated and 29 percent overtreated. Patients who received a recommended level of care did not have better outcomes, assessed after a mean of 9.7 months, than patients treated at a less intensive level (success rates of 43.9 versus 38.3 percent).

## SUMMARY AND RECOMMENDATIONS

- **Introduction –** The treatment model for chronic/relapsing substance use disorders (SUDs) in the United States is shifting from episodic treatment to continuing care, based on the chronic disease model. Serial patient assessment and monitoring is an important part of this model, with modification of patients' level of care over time based on their phase of illness, clinical status, co-occurring conditions, and treatment needs/preferences. (See 'Introduction' above.)

- **Levels of care** – SUD treatment is provided via a continuum of care, ie, multiple tiers of clinical services that vary by setting, types of treatment, and intensity of services. Standard

levels of care include inpatient, residential, partial hospital, intensive outpatient, and outpatient care. (See 'Levels of care' above.)

- **Level of care criteria** – The American Society of Addiction Medicine's (ASAM) Treatment Criteria are widely used to match patients to appropriate levels of care based on a thorough clinical assessment. Domains of ASAM's framework for patient assessment include (see 'Patient assessment' above):
  - Intoxication/potential for withdrawal (see "Management of moderate and severe alcohol withdrawal syndromes" and "Opioid withdrawal: Medically supervised withdrawal during treatment for opioid use disorder")
  - Medical conditions and complications (see 'Treatment integration for co-occurring conditions' above)
  - Mental disorders and complications (see 'Treatment integration for co-occurring conditions' above)
  - Readiness to change (see "Substance use disorders: Motivational interviewing", section on 'Readiness to change')
  - Risk of SUD relapse or continued use
  - Recovery environment
- **Determining level of care** – The patient's clinical status and risk of relapse are monitored systematically and longitudinally. As the patient's addiction waxes and wanes over time (ie, experiences periods of abstinence, relapse, or fluctuations in risk of relapse), the intensiveness and types of treatment are adjusted along with the level of care at which treatment is delivered. (See 'Determining level of care' above.)
- **Treatment integration** – Co-occurring mental disorders and medical conditions occur in conjunction with SUDs. Integration of care for SUD, mental disorders, and medical conditions at each level of care is generally recommended rather than parallel treatment. (See 'Treatment integration for co-occurring conditions' above.)
- **Opioid use disorders** – Due to the worsening opioid overdose epidemic, which has escalated further during the COVID-19 pandemic, the treatment of opioid use disorders (OUDs) requires special consideration. An OUD Cascade of Care framework has been proposed to improve treatment outcomes and reduce mortality from opioid overdoses and associated medical complications. (See 'Opioid use disorders' above.)

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