

Ohio's approach to drug addiction treatment is built around a practical reality that families, clinicians, courts, hospitals, and community agencies see every day: recovery rarely happens in one setting, during one appointment, or through one method. A person may need medical stabilization first, then residential care, then outpatient therapy, then recovery housing, then peer support that continues long after formal treatment has ended. Another person may begin with intensive outpatient services while continuing to work, start medication-assisted treatment, and rely on family therapy to rebuild trust at home.

Ohio law recognizes that range. The state requires a community-based continuum of care for opioid and co-occurring drug addiction, and that continuum includes ambulatory and sub-acute detoxification, non-intensive and intensive outpatient services, medication-assisted treatment, peer support, residential services, recovery housing, and multiple pathways to recovery. That wording matters. It does not describe treatment as a single door. It describes a framework, one that is supposed to meet people at different stages of illness, readiness, withdrawal risk, mental health need, and social stability.

For a person seeking help, or for a family trying to understand what to do next, the terms can blur together. Detox sounds like treatment. Residential rehab sounds like the whole answer. Outpatient care can sound too light, while medication-assisted treatment is sometimes misunderstood as replacing one dependency with another. Recovery housing may be confused with residential treatment, though the two serve different roles. Ohio's framework makes more sense when each part is viewed as one piece of a longer clinical and community process.

## **Why Ohio's continuum matters**

Drug addiction does not usually present as a clean, isolated problem. Many people arrive with overlapping needs: withdrawal symptoms, anxiety, depression, trauma histories, unstable housing, legal pressure, chronic pain, strained relationships, or a work schedule they are afraid to lose. Some are using opioids. Others are dealing with alcohol, stimulants, sedatives, or multiple substances. Some have already been through treatment before. Some are entering care for the first time after an overdose, an arrest, a family ultimatum, or a private moment of exhaustion.

A continuum of care gives providers and families more than one option. It allows care to intensify when risk is high and step down when stability improves. It also reduces the false choice between "go away to rehab" and "just attend meetings." Both may have a place, but neither is the full framework by itself.

In Ohio, the legal expectation is community-based care. That phrase carries weight. Treatment should not exist only as a distant institution removed from daily life. It should connect to local systems: outpatient clinics, certified providers, hospitals, peer supports, recovery housing, prescribers, mental health services, and community recovery pathways. When that network functions well, a person can move from detox to residential treatment, from residential treatment to outpatient therapy, from outpatient therapy to recovery housing, and from recovery housing into a more independent life with supports still in reach.

The system is not perfect. Access varies by region, insurance, transportation, bed availability, workforce capacity, and the person's clinical needs. But the framework is sound: drug addiction treatment works best when it is flexible enough to match the person, not when the person is forced to match a rigid program.

## **Detox is stabilization, not the finish line**

Detoxification is often the first urgent need. It is also one of the most misunderstood parts of treatment. Detox addresses the body's immediate adjustment when substance use stops or decreases. Depending on the substance, withdrawal can range from deeply uncomfortable to medically dangerous. Ambulatory detoxification may be appropriate for some people who can safely receive care without staying in a 24-hour setting. Sub-acute detoxification offers a higher level of support for people who need more monitoring but may not require hospital-level care.

The purpose of detox is stabilization. It is a doorway, not the house.

Families sometimes breathe a little too easily after detox. The person is no longer intoxicated, the worst withdrawal symptoms may have eased, and everyone wants to believe the crisis has passed. Clinically, that is a vulnerable moment. The person may feel physically raw, emotionally exposed, ashamed, restless, or overconfident. Tolerance may have changed. Cravings may return quickly. If detox is not connected to the next level of care, the risk of returning to use can remain high.

A strong Ohio treatment plan treats detox as the beginning of engagement. The right next step may be residential treatment, outpatient services, medication-assisted treatment, mental health care, peer support, or recovery housing. Often it is more than one of these. The best handoffs are warm and specific: an appointment scheduled before discharge, transportation discussed, medications coordinated, family members educated, and relapse risks named plainly.

Detox also gives clinicians a first opportunity to assess co-occurring concerns. A person who used opioids to quiet panic attacks, stimulants to function through depression, or alcohol to sleep after trauma may need far more than withdrawal management. Ohio's continuum explicitly includes care for opioid and co-occurring drug addiction, which reflects the reality that substance use and mental health symptoms often travel together.

## **Residential treatment and the value of a protected setting**

Residential services give people time away from immediate triggers and daily pressures. That separation can be essential. Someone returning each night to the same apartment where they used drugs, the same phone contacts, the same conflict, or the same loneliness may not be ready to stabilize in outpatient care alone. A residential setting can create structure around sleep, meals, therapy, medication management, group work, and recovery planning.

Residential treatment is not simply "being away." Its value depends on clinical programming, licensed and credentialed staff, assessment, individualized planning, and continuity after discharge. Ohio substance use disorder treatment providers must be certified by the Ohio Department of Mental Health and Addiction Services under state law. Certification does not guarantee that every program will fit every person, but it establishes an important baseline: providers delivering substance use disorder treatment are expected to meet state requirements rather than operate informally outside the system.

A protected setting can be especially useful when addiction has become entangled with mental health needs. Recreate Behavioral Health Network, for example, identifies its Ohio location, Recreate Behavioral Health of Ohio, also referred to as Recreate Ohio, as being in Gahanna, just outside Columbus. The organization states that the Ohio facility offers detox, residential or inpatient rehab, and outpatient treatment, and describes the site as providing a full continuum of care. It also says the Ohio facility offers primary mental health services in a residential treatment setting. That combination reflects an important part of modern addiction care: many people do not need substance use treatment or mental health treatment. They need both addressed with coordination.

The therapies described by Recreate for its Ohio facility include cognitive behavioral therapy, dialectical behavior therapy, EMDR, medication-assisted treatment, individual therapy, group therapy, family therapy, and couples

therapy. These are not interchangeable services. CBT may help a person identify and change patterns that lead to use. DBT may support emotional regulation and distress tolerance. EMDR is often associated with trauma treatment. Family and couples therapy can address the relational damage that addiction leaves behind. Medication-assisted treatment can reduce cravings and support stability for appropriate patients. A good treatment plan does not throw every service at every person. It selects what fits the clinical picture.

## **Outpatient care: where recovery meets ordinary life**

Outpatient treatment is where many people do the hardest and most durable work. It is less dramatic than detox and less contained than residential care, but it is often where recovery is tested against real conditions: work stress, parenting, bills, grief, social invitations, pain, boredom, and conflict.

Ohio's continuum includes both non-intensive and intensive outpatient services. That distinction matters. Non-intensive outpatient care may involve regular therapy, medication management, or recovery support while the person maintains daily responsibilities. Intensive outpatient treatment offers a more structured schedule and more frequent contact, often serving people who need substantial support but do not require a residential level of care, or who are stepping down from residential treatment.

The decision between non-intensive and intensive outpatient care should not be based on pride or convenience alone. Someone may want the least disruptive option, especially if they are afraid of losing income or privacy. But if cravings are severe, home life is unstable, psychiatric symptoms are active, or relapse has followed lower levels of care before, intensive outpatient treatment may be a safer bridge. On the other hand, not everyone needs residential treatment. A person with stable housing, strong support, lower withdrawal risk, and a willingness to attend frequent sessions may succeed in outpatient care if the plan is clinically appropriate.

Outpatient treatment also allows family systems to be involved in a realistic way. It is one thing to practice communication skills in a therapy room. It is another to use them after a tense dinner, a missed paycheck, or a suspicious late-night text. When outpatient care is strong, it helps people rehearse recovery in the environment where they actually live.

## **Medication-assisted treatment belongs in the framework**

Medication-assisted treatment is part of Ohio's required continuum for opioid and co-occurring drug addiction. Its inclusion is important because medication can be one of the most effective tools for reducing cravings, supporting stabilization, and helping people stay engaged in care when clinically appropriate.

The phrase "medication-assisted treatment" can trigger strong opinions. Some families worry that medication means the person is not truly sober. Some people entering treatment worry they will be judged. Some communities still carry stigma around using medication for addiction, even while accepting medication for depression, diabetes, blood pressure, or seizure disorders. Clinically, the better question is not whether medication fits someone's philosophy. The better question is whether it fits the person's diagnosis, risk profile, history, and treatment goals.

Medication is not a stand-alone cure. It works best when integrated with counseling, monitoring, peer support, recovery planning, and attention to mental health. It also requires responsible prescribing and coordination, particularly for patients with complex medication histories or other controlled substances in the picture.

Ohio's OARRS system, the statewide electronic database for controlled-substance dispensing information, supports safe prescribing and helps connect people at risk of substance use disorder to resources. For clinicians, a monitoring system can provide a clearer view of controlled-substance patterns. For patients, it can feel

uncomfortable to know that dispensing information is tracked, but the purpose is safety: reducing dangerous combinations, identifying risk, and supporting more informed care.

## Peer support and multiple pathways to recovery

Peer support holds a distinct place in drug addiction treatment because it offers something professional services cannot fully replicate: credible lived experience. A peer supporter can often say, “I know what that kind of morning feels like,” in a way that lands differently than clinical interpretation. Peer support is not a replacement for therapy, medical care, or medication when those are needed. It is a complementary relationship that can reduce isolation and help people navigate recovery in practical terms.

Ohio’s framework also recognizes multiple pathways to recovery. That phrase is more than polite inclusivity. People recover through different combinations of treatment, mutual support, medication, faith communities, therapy, recovery housing, family repair, work, service, and personal discipline. Some people connect deeply with a 12-step approach. Others benefit from non-12-step mutual aid. Some lean heavily on medication-assisted treatment and outpatient therapy. Others need residential care followed by sober housing and peer mentorship.

A rigid recovery culture can push people away. If someone is told there is only one legitimate path, they may hide what is actually helping them, or leave care altogether. Multiple pathways do not mean anything goes. They mean the plan should be clinically sound, ethical, safe, and responsive to the person’s needs.

A practical recovery plan often includes a few essentials:



- A clear next appointment after each level of care
- A medication plan, if medication is part of treatment
- A sober and stable place to sleep
- A response plan for cravings, missed sessions, or return to use
- At least one supportive person who knows the truth

That short list looks simple on paper. In practice, each item can take real work. A next appointment requires scheduling and transportation. Medication may involve insurance, pharmacy access, side effect management, and [opioid recovery services](#) follow-up. A safe place to sleep may require recovery housing or a family agreement with firm boundaries. A return-to-use plan requires honesty before a crisis. Support requires someone willing to stay involved without enabling.

# **Recovery housing: the bridge many people underestimate**

Recovery housing is included in Ohio's continuum because housing stability is not a side issue. It is often central to whether treatment gains hold. A person can complete detox and residential treatment, understand their triggers, begin medication-assisted treatment, and still struggle if they leave care with nowhere safe to go.

Recovery housing is not the same as residential treatment. Residential treatment is a clinical level of care. Recovery housing is a living environment designed to support recovery. It can provide structure, accountability, peer community, and distance from high-risk settings. For some people, it is the bridge between treatment and independent living.

The need for recovery housing often becomes obvious during discharge planning. A person may say they are ready to go home, but "home" may mean a couch in an apartment where others are using substances. It may mean returning to a partner who is actively using. It may mean isolation in a motel room. It may mean a family home filled with love but no boundaries, where old patterns resume within days.

Recovery housing can also create trade-offs. Some people resist shared living. Some worry about rules. Others need to work and want independence. Families may view recovery housing as unnecessary if their loved one has already completed treatment. But stability in early recovery is fragile. A structured living environment can give the person time to build routines before taking on every pressure at once.

The best fit depends on the person's needs, the quality of the housing environment, expectations around treatment participation, and how well the housing connects to outpatient care, peer support, employment goals, and family relationships. Recovery housing should not become a warehouse for people with nowhere else to go. Its purpose is recovery support, not merely shelter.

## **The role of certified providers and responsible selection**

Because Ohio requires substance use disorder treatment providers to be certified by the Ohio Department of Mental Health and Addiction Services, families should treat certification as a basic screening point. It is not rude to ask whether a provider is certified. It is responsible. Addiction care is too consequential to leave to vague promises, glossy marketing, or charismatic claims.

Choosing a provider involves both verification and fit. A program may be legitimate and still not be the right match for a particular person. Someone with severe withdrawal risk needs appropriate detox capability. Someone with significant trauma symptoms may need trauma-informed therapy. Someone with depression, anxiety, or other mental health concerns may need integrated mental health services. Someone who has returned to use repeatedly after short stays may need a stronger step-down plan. Someone who cannot leave work or children may need outpatient care that is realistic without being clinically inadequate.

For example, Recreate Ohio describes a range of services at its Gahanna-area location, including detox, residential or inpatient rehab, outpatient treatment, and primary mental health services in a residential setting. It also identifies therapeutic approaches and supportive services that may include CBT, DBT, EMDR, medication-assisted treatment, individual and group therapy, family and couples therapy, yoga and mindfulness, art therapy, adventure therapy, equine therapy, Reiki, acupuncture, chiropractic care, fitness and wellness activities, and nutrition education. For a patient or family, the practical question is how those services are assessed, selected, coordinated, and carried forward after discharge. A long menu matters less than a coherent plan.

Holistic supports can be valuable when they are integrated thoughtfully. Mindfulness may help a person tolerate cravings without acting on them. Fitness and nutrition can support sleep and mood. Art therapy may help someone express material that is hard to verbalize. Family therapy can help relatives stop cycling between rescue

and resentment. At the same time, holistic services should not be mistaken for the clinical backbone of addiction treatment. They work best as supports around evidence-informed care, medical oversight when needed, therapy, recovery planning, and continuing support.

## **What coordinated care looks like in real life**

A coordinated Ohio treatment pathway might begin when a person seeks help after opioid withdrawal becomes unmanageable. The first step could be ambulatory or sub-acute detoxification, depending on medical assessment and safety. During detox, clinicians would evaluate substance use history, mental health symptoms, medication needs, family support, and living situation. If residential care is appropriate, the person might transition directly into that setting rather than returning home to wait.

In residential treatment, the focus would broaden. The person might participate in individual therapy, group therapy, medication-assisted treatment if appropriate, and family sessions. If trauma symptoms are prominent, a therapy such as EMDR may be considered by qualified clinicians. If emotional dysregulation drives use, DBT skills may be useful. If thinking patterns and high-risk behaviors are central, CBT may help. The important point is sequencing. Early treatment often requires stabilization before deeper trauma work or complicated family repair can safely proceed.

After residential care, the person may step down to intensive outpatient treatment. This is where the plan meets real life again. The person might live in recovery housing rather than returning immediately to a high-risk environment. Peer support may help with accountability between clinical sessions. Medication appointments continue. Family therapy may shift from crisis repair to boundary setting and communication. Over time, the person may move from intensive outpatient to non-intensive outpatient care, then remain connected through peer support, medication management if applicable, and community recovery pathways.

That sequence is only one example. Another person may never need residential treatment. A third may need residential care more than once. A fourth may enter through outpatient services and later require detox. A continuum works because movement through it is based on need, not shame. Stepping up to a higher level of care should not be treated as failure. It may be exactly what prevents a worse outcome.

## **Questions families should ask before choosing a level of care**

Families often call treatment providers during a crisis, when everyone is tired and frightened. It helps to have a few grounded questions ready. The goal is not to interrogate staff. The goal is to understand whether the program can match the person's needs and provide safe continuity.

- Is the provider certified to deliver substance use disorder treatment in Ohio?
- Which levels of care are available, and how is the appropriate level determined?
- How are co-occurring mental health symptoms assessed and treated?
- Is medication-assisted treatment available or coordinated when clinically appropriate?
- What happens after detox, residential care, or outpatient treatment ends?

These questions expose the quality of the handoff. A provider that discusses discharge planning from the beginning is usually thinking beyond the immediate admission. That matters. Addiction treatment should not end with a handshake and a folder. It should end with the next step already active.

## **The family's role without taking over**

Families can be powerful allies in recovery, but they are rarely neutral observers. They arrive with fear, anger, guilt, hope, exhaustion, and sometimes years of broken promises behind them. A professional framework helps families shift from crisis reaction to informed support.

The family's job is not to become the treatment team. It is not to monitor every mood, search every room, or argue someone into recovery each night. The family's job is to support engagement, maintain honest boundaries, participate in therapy when appropriate, reduce enabling patterns, and learn what addiction does to decision-making and relationships.

Family or couples therapy, when clinically appropriate, can be especially useful because addiction damages trust in specific ways. The person in recovery may want immediate forgiveness because they feel different now. The family may want proof before offering trust. Both positions are understandable. Therapy can slow the conversation down and make it more concrete: What does accountability look like this week? What information will be shared? What are the boundaries around money, housing, transportation, and contact with high-risk people? What happens if there is a return to use?

Good family work avoids two extremes. It does not shame the person with addiction as morally defective. It also does not ask the family to ignore harm. Recovery requires truth on both sides.

## **The quiet importance of transitions**

The most dangerous gaps in care are often transitions. Leaving detox before the next appointment. Waiting two weeks after residential discharge to start outpatient therapy. Moving back into an unsafe home because recovery housing was not arranged. Running out of medication because follow-up was unclear. Missing one group, then two, then disappearing.

Ohio's continuum addresses this by naming the full range of services, but naming services is only the beginning. The quality of transition determines whether the continuum feels like a connected bridge or a series of disconnected doors. Clinicians know this. Families learn it the hard way. People in recovery feel it in the space between one level of support and the next.

A strong transition plan is specific. It names dates, providers, medications, transportation, housing, warning signs, and emergency steps. It also accounts for ambivalence. Many people leave a structured setting with sincere intentions and then feel overwhelmed within days. That does not mean they lied. It means early recovery is stressful, and plans must be built for stress.

## **A framework built for real recovery**

Ohio's drug addiction treatment framework is strongest when it is understood as a continuum rather than a menu. Detox stabilizes withdrawal. Residential treatment provides structure and clinical intensity. Outpatient care brings recovery into daily life. Medication-assisted treatment supports appropriate patients with evidence-informed medical care. Peer support reduces isolation and offers lived guidance. Recovery housing creates a safer bridge toward independence. Multiple pathways recognize that people recover through different combinations of support.

For patients and families, the practical task is to find the right starting point and insist on the next step. A person does not need to understand the entire system before asking for help. But someone in the process should be asking the continuity questions: What level of care fits now? What risks need attention? What mental health needs are present? What support continues after this service ends? Where will the person sleep? Who will know if things begin to unravel?

Drug addiction treatment works best when it is honest about complexity without becoming paralyzed by it. Ohio's framework gives communities the shape of a response. The work, day by day, is to make that response coordinated, certified, clinically sound, and humane enough that people can move from crisis stabilization toward a life that no longer revolves around addiction.