

Ohio's approach to drug addiction treatment is built around a practical idea: recovery rarely happens in one setting, through one service, or on one timetable. A person may need detoxification first, then residential care, then outpatient therapy, then peer support and recovery housing. Another person may never need residential treatment but may do well with medication-assisted treatment, counseling, and steady community support. Someone else may enter care because of opioid use and also need treatment for depression, trauma, anxiety, or another co-occurring condition.

That range of need is exactly why Ohio law requires a community-based continuum of care for opioid and co-occurring drug addiction. The phrase can sound administrative, but the concept is straightforward. A continuum of care means people should be able to move through different levels of support as their condition changes, rather than being forced into a single model that may be too little, too much, or simply the wrong fit.

This matters because drug addiction treatment is not only a clinical service. It is also a local service. People recover in real communities, near families, jobs, schools, courts, health systems, faith communities, and recovery networks. Ohio's model recognizes that treatment cannot be reduced to a hospital bed or a weekly appointment. It has to include stabilization, therapy, medication when appropriate, housing support, peer connection, and pathways that make sense for different people.

A continuum instead of a single door

The strongest feature of Ohio's framework is that it names multiple levels of care rather than treating addiction services as one broad category. For people facing opioid addiction or co-occurring drug addiction, the required 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.

Each part of that continuum serves a different purpose. Detoxification helps with the medical and physical process of withdrawal, but detox by itself is not the same as recovery. Outpatient treatment can keep people connected to therapy and medication while they remain in the community. Residential services create a more structured environment when someone needs a higher level of support. Recovery housing can provide stability during the fragile period after acute treatment, when returning to an unsafe or chaotic living situation may threaten progress. Peer support brings in people with lived experience who can help translate recovery from a clinical plan into daily life.

The key is movement. A well-functioning continuum does not trap someone in one level of care. It allows treatment intensity to rise when risk rises and taper when stability improves. In practice, that may mean a person begins with sub-acute detoxification, transitions to residential care, steps down to intensive outpatient treatment, and later continues with non-intensive outpatient counseling, medication-assisted treatment, and peer support. Another person may start with intensive outpatient services and never require residential care. The point is not that everyone follows the same sequence. The point is that the system should have enough options to respond to real clinical need.

That flexibility is important because addiction does not present neatly. A person may arrive after a period of opioid use, but also struggle with alcohol, stimulants, trauma symptoms, sleep problems, or strained family relationships. A treatment plan that focuses only on stopping one substance may miss the conditions that keep the cycle alive. Ohio's emphasis on opioid and co-occurring drug addiction reflects that reality.

Why community-based care matters

Community-based treatment changes the center of gravity. Instead of assuming that care happens only in isolated specialty settings, it places services closer to where people live and where relapse risks often emerge. That does not make treatment easy. It does make treatment more realistic.

A person leaving residential care still has to handle transportation, work schedules, parenting responsibilities, court dates, prescriptions, cravings, and relationships. If the next level of care is disconnected from the person's community, the handoff can fail. Missed appointments become more likely. Medication routines can break down. People may return to old environments without enough support. Community-based services are meant to reduce those gaps by creating more points of connection.

There is also a dignity issue. Many people delay treatment because they believe care will require them to disappear from their life entirely. Sometimes a higher level of care is necessary, including residential or inpatient treatment. But for many people, especially those with family or work obligations, outpatient services and medication-assisted treatment can make care more accessible. Community-based models can meet a person where they are without waiting for every circumstance to be perfect.

In the field, one of the most common mistakes is treating motivation as if it stays steady. It does not. A person may be ready for help on Monday and ambivalent by Friday. A community-based continuum gives providers more ways to respond during those windows of readiness. If a bed is not the right option, outpatient services may be. If therapy alone is not enough, medication-assisted treatment may be considered. If someone needs support after a formal session ends, peer support may help bridge the gap.

Detoxification is a beginning, not a complete treatment plan

Ohio's continuum includes ambulatory and sub-acute detoxification. That distinction matters because withdrawal management can happen in different settings depending on the person's condition, risks, and clinical needs. Some people can be managed without a hospital-level stay. Others may need closer observation and more structured support. The purpose is not simply to "get through withdrawal," but to create a safer transition into ongoing care.

Families often misunderstand detox. They may believe that once a person completes withdrawal, the addiction has been treated. Clinicians know the more difficult work usually begins after the acute physical symptoms settle. Cravings, triggers, mood changes, sleep disruption, grief, shame, and relationship conflict can all surge after detox. Without a next step, detox can become a revolving door.

That is why a continuum is so important. Detoxification should connect to ongoing drug addiction treatment, whether that means residential services, outpatient care, medication-assisted treatment, therapy, or peer support. The handoff has to be concrete. A vague instruction to "follow up" is weaker than a scheduled appointment, a clear medication plan, a transportation discussion, and a warm connection to a recovery support.

Sub-acute and ambulatory detox services also show how treatment intensity can vary. Not every person needs the most restrictive environment, and not every person is safe in the least restrictive one. Good placement decisions require judgment. They consider medical stability, substance use history, co-occurring conditions, home environment, support systems, and the risk of leaving care too early.

Outpatient care keeps treatment connected to daily life

Ohio's continuum includes both non-intensive and intensive outpatient services. These levels of care often serve as the backbone of community-based treatment because they allow people to receive clinical support while remaining connected to daily responsibilities.

Intensive outpatient treatment can be especially useful when someone needs more structure than a weekly appointment but does not require residential care. It can support people stepping down from detox or residential treatment, and it can also serve people stepping up from standard outpatient care when symptoms or relapse risk increase. Non-intensive outpatient services may include ongoing counseling, recovery planning, relapse prevention work, and support for co-occurring mental health concerns.

The trade-off is obvious. Outpatient care preserves real-world connection, but it also leaves people exposed to real-world triggers. Someone may attend a productive therapy session at 10 a.m. And face family conflict, workplace stress, or drug availability by evening. That is why outpatient treatment works best when it is not treated as a stand-alone appointment. It needs coordination with medication when appropriate, peer support, recovery housing when needed, and practical planning around the person's environment.

Effective outpatient care often focuses on the details that sound ordinary but determine whether recovery holds. Who can the person call at 8 p.m. When cravings spike? How will they get to appointments if their license is suspended or transportation is unreliable? What happens if they miss a session? Is the home environment supportive, neutral, or actively unsafe? These questions are not peripheral. They are treatment questions.

Medication-assisted treatment and clinical judgment

Medication-assisted treatment is part of Ohio's required continuum for opioid and co-occurring drug addiction services. Its inclusion reflects a broad clinical reality: for many people with opioid addiction, medication can reduce risk and support stability when used as part of a treatment plan.

The phrase "medication-assisted treatment" sometimes carries stigma, especially among people who believe recovery must look one particular way. Ohio's framework, by including medication-assisted treatment alongside peer support, outpatient services, residential services, recovery housing, and multiple pathways to recovery, avoids that narrow view. It recognizes that recovery can involve medication, counseling, community support, behavioral therapy, and practical stabilization.

Medication is not a substitute for all other care. It also should not be dismissed when it is clinically appropriate. The better question is not whether medication "counts" as recovery, but whether the treatment plan reduces harm, supports function, addresses co-occurring needs, and helps the person build a sustainable life. In some cases, medication-assisted treatment may be paired with intensive outpatient care. In others, it may continue after residential treatment or alongside non-intensive outpatient therapy.

Clinical judgment matters because people differ. A person with repeated opioid relapse after detox may need a different plan than someone entering care early. A person with co-occurring mental health symptoms may need integrated services rather than a narrow substance-only plan. The continuum gives clinicians and patients room to make those decisions.

Peer support and the value of lived experience

Peer support has a distinct place in Ohio's community-based continuum. It is not the same as therapy, case management, or medical treatment. Its value comes from credible connection. A peer supporter can often reach a person in ways that formal systems cannot, especially when shame, mistrust, or fatigue have built up.

People in early recovery frequently need help interpreting the everyday parts of change. They may understand the treatment plan but struggle with what to do after a difficult family conversation or how to sit through a holiday gathering without using. They may need someone who can say, with authenticity, “I have been through something like this, and here is how I got through the next hour.” That kind of support can lower isolation and make recovery feel less theoretical.

Peer support also helps with navigation. Treatment systems can be difficult to understand, even for professionals. For someone in withdrawal, early sobriety, or emotional distress, the system may feel impossible. A peer can help explain options, encourage follow-through, and reinforce hope without replacing clinical care.

The boundary is important. Peer support is most effective when integrated with a broader treatment structure. It should complement medical care, therapy, medication-assisted treatment, recovery housing, and outpatient services where appropriate. When those pieces communicate, people are less likely to fall through gaps.

Residential services and recovery housing are not the same thing

Ohio’s continuum includes both residential services and recovery housing. They are related in the sense that both provide a supportive living environment, but they serve different roles.

Residential treatment is a clinical level of care. It provides structured treatment in a setting where the person can step away from immediate environmental risks and focus more fully on stabilization and recovery work. For some people, that structure is essential. They may have tried outpatient care and continued to relapse. They may have an unstable living environment. They may need more intensive support for co-occurring mental health needs or behavioral patterns that are difficult to address while living at home.

Recovery housing, by contrast, is generally part of the recovery support environment rather than the same thing as residential clinical treatment. Its purpose is stability. Housing can make or break recovery. A person leaving treatment and returning to a setting where drug use is active, conflict is constant, or basic routines are absent faces a much harder path. Recovery housing can give people a place to practice structure, accountability, and sober living while continuing outpatient care, peer support, employment steps, or family repair.

A common edge case involves people who complete residential services and are clinically improved but not yet ready to return home. They may not need the same intensity of treatment, but they do need a safe place to live. Recovery housing can help fill that gap. Another edge case involves people in outpatient treatment whose home environment undermines every gain they make. In those situations, housing support may be just as important as therapy attendance.

Certification and accountability in Ohio treatment services

Ohio requires substance use disorder treatment providers to be certified by the Ohio Department of Mental Health and Addiction Services under <https://www.recreateohio.com/addiction/drug-addiction/> state law. Certification is a core accountability measure. It signals that providers delivering these services must meet state requirements rather than simply offering addiction treatment without oversight.

For families searching for help, certification should be treated as a basic checkpoint. Addiction treatment can be an emotional purchase. People often make decisions during crisis, after an overdose scare, a court event, a family rupture, or a painful relapse. In that state, it is easy to be persuaded by polished language. Certification does not answer every question about quality, fit, or clinical approach, but it is an important starting point.

A practical way to evaluate a treatment option is to ask direct questions about services and coordination:

1. Is the provider certified to deliver substance use disorder treatment in Ohio?
2. Which levels of care are available, such as detoxification, residential treatment, intensive outpatient services, or non-intensive outpatient care?
3. Does the program offer or coordinate medication-assisted treatment when clinically appropriate?
4. How are co-occurring mental health concerns assessed and treated?
5. What support exists after discharge, including peer support, outpatient follow-up, or recovery housing connections?

Those questions keep the conversation grounded. They also reveal whether a program sees treatment as an episode or as part of a longer recovery process. A provider does not need to offer every possible service under one roof to be useful, but it should be clear about what it provides, what it does not provide, and how it helps people transition to the next needed service.

OARRS and safer prescribing

Ohio's OARRS system, the statewide electronic database for controlled-substance dispensing information, plays a different but related role in the addiction treatment landscape. It supports safe prescribing by giving prescribers and pharmacists access to controlled-substance dispensing information. It is also used to help connect people at risk of substance use disorder to resources.

Prescription monitoring is not treatment by itself. It does not replace assessment, counseling, medication-assisted treatment, detoxification, residential care, or peer support. But it can help identify risk patterns and support safer clinical decisions. In a state-level strategy, that matters. Drug addiction treatment does not begin only when someone enters a specialty program. Opportunities for intervention may appear in primary care, pharmacies, emergency settings, behavioral health appointments, or pain management contexts.

The ethical challenge is to use monitoring tools in a way that promotes safety without driving people into secrecy or abrupt abandonment. A person identified as at risk needs connection, not just denial of medication. The best use of systems like OARRS is not punitive reflex. It is informed prescribing, careful conversation, and a path toward appropriate resources when substance use disorder may be present.

Multiple pathways to recovery

Ohio's continuum explicitly includes multiple pathways to recovery. That phrase deserves attention because it keeps the system from confusing one philosophy with the entire field.

People recover through different combinations of care. Some rely heavily on medication-assisted treatment. Some find peer recovery communities central. Some need residential services before outpatient care can take hold. Some benefit from family therapy, trauma-focused therapy, cognitive behavioral approaches, dialectical behavior therapy skills, or other evidence-informed clinical methods when offered by a qualified provider. Some need recovery housing to stabilize the basics before deeper therapeutic work can stick.

Multiple pathways do not mean "anything goes." Treatment still requires clinical standards, certification, assessment, and accountability. But it does mean the system should avoid rigid assumptions about what recovery must look like. A person's plan should reflect their condition, risks, preferences, history, and response to care.

This is especially important for co-occurring drug addiction and mental health concerns. If someone uses substances partly to manage trauma symptoms, panic, depression, or emotional dysregulation, a narrow abstinence-only message may not be enough. They may need integrated therapy and psychiatric support as part

of the recovery pathway. Conversely, someone with strong community support and lower clinical complexity may do well with outpatient services and peer connection. The pathway should fit the person, not the other way around.

An Ohio example: Recreate Behavioral Health of Ohio

One example of a provider operating within Ohio's treatment landscape is Recreate Behavioral Health of Ohio, also referred to as Recreate Ohio, located in Gahanna just outside Columbus. The organization describes its Ohio facility as offering detox, residential or inpatient rehab, and outpatient treatment. It also describes the location as providing a full continuum of care and offering primary mental health services in a residential treatment setting.

That combination reflects a broader direction in addiction care: treating substance use and mental health needs together rather than pretending they can always be separated. Many people entering drug addiction treatment have more than one issue in motion. A residential setting that includes primary mental health services may be relevant for people who need structured care and support for co-occurring symptoms.

Recreate says treatment at its Ohio facility may include cognitive behavioral therapy, dialectical behavior therapy, EMDR, medication-assisted treatment, and individual, group, family, and couples therapy. Each of those services points to a different dimension of recovery. Cognitive behavioral therapy can help people identify and change patterns of thought and behavior. Dialectical behavior therapy skills may support emotional regulation and distress tolerance. EMDR is commonly associated with trauma-focused treatment when clinically appropriate. Family and couples therapy recognize that addiction often strains relationships and that recovery may require new communication patterns at home.

The facility also describes holistic supports that may include yoga and mindfulness, art therapy, adventure therapy, equine therapy, Reiki, acupuncture, chiropractic care, fitness and wellness activities, and nutrition education. These supports should not be confused with the core medical and clinical components of addiction treatment, but they may help some people engage more fully in care. In practice, supportive activities can give patients healthier ways to manage stress, reconnect with their bodies, and build routines that do not revolve around substance use.

The professional judgment lies in balance. Holistic supports are most useful when they sit inside a serious treatment structure, not when they replace assessment, therapy, medication-assisted treatment when appropriate, detoxification, or continuing care. A person considering any program should look at the whole picture: certification, levels of care, clinical services, mental health support, transition planning, and fit.

What “full continuum” should mean for a patient

The phrase “full continuum of care” can sound reassuring, but patients and families should understand what it means in practical terms. At its best, it means a person is not left to rebuild the treatment plan from scratch every time their needs change. They can move from one level of care to another with coordination, documentation, and a shared understanding of goals.



A strong continuum pays attention to the moments when people are most vulnerable. Admission is one of them. A person may arrive frightened, ambivalent, physically ill, or under pressure from family or legal systems. Discharge is another. People often feel hopeful when leaving a structured setting, but the first week back in the community can expose weak spots quickly. Step-down planning from residential care to outpatient treatment, peer support, medication management, or recovery housing is not a formality. It is risk management.

The same applies when a person is doing better. Treatment should not remain unnecessarily intensive just because that is where the person started. If someone gains stability, a lower level of care may support autonomy and confidence. A continuum allows care to become less restrictive while maintaining connection.

There is also a financial and logistical reality. Higher levels of care require more time away from work, school, caregiving, and normal routines. Lower levels of care require more self-management. Neither is inherently superior. The right level depends on safety, stability, clinical need, and the likelihood that the person can follow through.

The role of families without making families the treatment team

Families often become the first responders to addiction, whether they are prepared or not. They notice changes, absorb crises, search for programs, manage fear, and sometimes set boundaries after years of exhaustion. Ohio's community-based approach can help families because it offers more than a single option, but families still need realistic expectations.

A family cannot detox a loved one at home through willpower. It cannot provide medication-assisted treatment without a prescriber. It cannot substitute for certified substance use disorder treatment. But family members can support engagement, ask informed questions, participate in family therapy when appropriate, and help create an environment that does not undermine recovery.

The hard part is knowing when help becomes control. Addiction often trains families into surveillance: checking phones, counting pills, tracking movements, interpreting tone of voice. Some of that comes from fear and experience. Still, long-term recovery cannot depend entirely on family policing. Professional care, peer support, and recovery housing can relieve some of that pressure by creating support outside the family system.

Family and couples therapy, when clinically appropriate and offered by a provider, can help repair communication and clarify boundaries. It can also help loved ones understand that relapse risk is not managed by hope alone. It is managed through planning, support, honesty, and appropriate levels of care.

Choosing care in Ohio during a crisis

When someone needs drug addiction treatment, the search often happens under stress. It may follow a relapse, a medical scare, a relationship breakdown, or a moment when the person finally says they are willing to go. The best choice is not always the first program that answers the phone, though speed matters. The safest decision balances urgency with verification.

Families and patients should listen for specificity. A credible treatment conversation should clarify what level of care is being recommended and why. It should address detoxification needs if withdrawal is a concern. It should ask about co-occurring mental health symptoms. It should explain whether medication-assisted treatment is available or coordinated. It should discuss what happens after the first phase of care.

Warning signs are often found in vagueness. If a program cannot clearly explain its services, certification, clinical approach, or transition planning, that is a concern. If it promises a guaranteed outcome, that is also a concern. Recovery can be supported, treated, monitored, and strengthened, but it cannot be guaranteed by a slogan.

A grounded treatment decision usually considers five practical factors:

1. The person's immediate safety and withdrawal risk.
2. The presence of co-occurring mental health symptoms.
3. The stability of the home environment.
4. The availability of appropriate levels of care and medication-assisted treatment.
5. The plan for continuing support after discharge or step-down.

These factors do not remove uncertainty, but they make the decision more clinical and less reactive. They also match the logic of Ohio's continuum, which treats recovery as a progression through supports rather than a single event.

The promise and limits of a community-based model

Ohio's community-based framework has real strengths. It recognizes different levels of need. It includes medication-assisted treatment. It values peer support and recovery housing. It requires certified providers. It acknowledges multiple pathways to recovery. It connects addiction treatment with broader systems, including safe prescribing through OARRS.

But no framework works automatically. A continuum is only as strong as its access points, coordination, workforce, and follow-through. If a person completes detox and cannot connect to the next level of care, the continuum breaks. If outpatient services do not coordinate with medication-assisted treatment, the plan weakens. If recovery housing is needed but not available or appropriate, risk increases. If co-occurring mental health concerns are missed, substance use may return as a form of self-management.

The model also depends on honest matching. Residential care can be life-changing for the right person, but it should not be used as the answer to every situation. Outpatient care can be effective and humane, but it may be insufficient when someone's environment is unsafe or symptoms are severe. Peer support can be powerful, but it is not a replacement for clinical treatment. Medication-assisted treatment can be essential, but it should be integrated into a broader plan.

The best systems accept these trade-offs instead of hiding them. They build care around the person's current condition, then adjust as the person changes.

A recovery system built around real life

Ohio's approach to drug addiction treatment through community-based services reflects a mature understanding of recovery. People need more than a referral and more than a short stay. They need a continuum that can meet withdrawal, stabilize mental health, support behavior change, provide medication when appropriate, offer peer connection, address housing instability, and leave room for different recovery pathways.

For patients, the practical message is that help in Ohio can exist at several levels. Detoxification, residential services, intensive outpatient treatment, non-intensive outpatient care, medication-assisted treatment, peer support, and recovery housing each have a role. The right combination depends on the person, not on a fixed script.

For families, the message is equally important. Ask clear questions. Verify certification. Look for programs that explain transitions and continuing care. Be cautious of simple promises. Drug addiction is treatable, but treatment works best when it is structured, coordinated, and connected to the community where recovery has to be lived.

The community-based model does not make recovery effortless. It makes recovery more reachable. That distinction matters. A person does not need every service at once, and no single service solves every problem. But when Ohio's continuum works as intended, it gives people multiple doors into care, multiple supports along the way, and a better chance to build a life beyond addiction.