

Ohio's approach to drug addiction treatment is shaped by two forces that have to work together every day: the public systems that define access, safety, and minimum standards, and the providers that turn those standards into actual care for people and families. When the two align, treatment can feel coordinated and humane. When they do not, the person seeking help may experience delays, confusion, mismatched services, or abrupt transitions at exactly the moment when stability matters most.

The state's role is not abstract. Ohio law requires a community-based continuum of care for opioid and co-occurring drug addiction. 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. Those words matter because they recognize a practical truth: drug addiction does not present the same way for every person, and treatment cannot be limited to one setting, one philosophy, or one point in time.

At the provider level, the same truth becomes more personal. A person may need medical support during withdrawal, then a structured residential stay, then outpatient counseling while returning to work, then recovery housing or peer support to reduce isolation. Another person may enter care through an outpatient program, begin medication-assisted treatment, and never need a residential level of care. A third may have co-occurring mental health needs that require integrated clinical attention rather than a narrow focus on substance use alone. The structure of Ohio's system is designed to make room for those differences, but the quality of care depends heavily on how providers interpret and deliver that continuum.

The significance of a community-based continuum

A community-based continuum of care is more than a policy phrase. It is an acknowledgment that recovery often depends on services being available close enough, flexible enough, and coordinated enough to meet people where they are. If detoxification is available but outpatient care is not, the system has a gap. If residential care exists but there is no plan for recovery housing or ongoing peer support, the discharge may be clinically premature even if the program itself was competent. If medication-assisted treatment is technically available but poorly integrated into counseling, primary care, or behavioral health support, the person may receive a service without receiving a plan.

Ohio's required continuum includes several levels of care because drug addiction can change quickly. Withdrawal risk, psychiatric symptoms, housing instability, family stress, legal pressure, employment concerns, and relapse risk all influence what kind of treatment is appropriate. A person seeking help after a long period of opioid use may not be safe trying to stop without medical support. Someone with stimulant use and severe anxiety may need close behavioral health assessment even if traditional detoxification is not the central issue. Someone with repeated relapses after brief outpatient episodes may need a more structured residential environment for a period of time.

The state's framework also names co-occurring drug addiction, which is important. In practice, substance use rarely exists in isolation. Anxiety, depression, trauma symptoms, sleep disruption, grief, and chronic stress can all complicate recovery. A system that treats drug use as a standalone behavior often misses the forces that pull people back into use. By including co-occurring needs in the continuum, Ohio's model points providers toward more integrated care.

The phrase "multiple pathways to recovery" is equally important. It leaves room for different forms of recovery support rather than forcing every person into a single model. Some people benefit from medication-assisted treatment. Some rely heavily on peer support. Some need residential stabilization before they can make use of

outpatient therapy. Some progress through family work, spiritual support, clinical therapy, recovery housing, or a combination of these. A mature treatment system does not treat these paths as competitors. It treats them as tools.

Certification as the floor, not the ceiling

Ohio treatment providers that deliver substance use disorder treatment must be certified by the Ohio Department of Mental Health and Addiction Services under state law. Certification matters because it establishes a baseline expectation. People seeking drug addiction treatment are often making decisions under stress, sometimes after a crisis, a hospitalization, a family intervention, or a legal consequence. They should not have to guess whether a provider is operating within the state's regulatory structure.

Certification does not guarantee that every program will feel the same, or that every clinician will have the same style, or that every treatment plan will produce the same outcome. It does create a regulated environment in which providers are accountable to state standards. That accountability is especially important in addiction care because the stakes are high and the population being served may be medically, psychologically, and socially vulnerable.

The best providers understand certification as a floor rather than a ceiling. Compliance is the minimum. Strong care also requires careful assessment, honest communication, discharge planning, competent clinical supervision, thoughtful use of medication when appropriate, and a culture that treats people with dignity. A program can meet formal requirements and still feel fragmented if it fails to coordinate care across levels. Conversely, a well-run provider uses state requirements as a framework and then builds a more responsive clinical experience around them.

For families, certification should be one of the first practical questions. Is the provider certified to deliver the services it is offering? Does the program describe its levels of care clearly? Does it explain how a person moves from detoxification to residential care, or from residential care to outpatient treatment, if those steps are clinically indicated? Does it address co-occurring mental health needs? Those questions are not bureaucratic. They are the difference between entering a program and entering a treatment pathway.



OARRS and the safety side of prescribing

Ohio's OARRS system, the Ohio Automated Rx Reporting System, is the statewide electronic database for controlled-substance dispensing information. It supports safe prescribing and helps connect people at risk of

substance use disorder to resources. In practical terms, OARRS gives prescribers and pharmacists a clearer view of controlled-substance dispensing patterns than they would have if each office or pharmacy worked from its own isolated record.

This kind of monitoring is sensitive work. Used well, it can improve safety. It can help identify overlapping prescriptions, high-risk combinations, or patterns that suggest a person may need assessment or support. It can also inform clinical conversations about pain management, medication use, and substance use risk. The goal is not simply surveillance. The goal is safer prescribing and better connection to care.

For people with drug addiction, the way this information is handled matters. A punitive or shaming conversation can drive someone away from treatment. A careful conversation can open a door. A clinician might say, in plain language, that the prescribing history raises safety concerns and that the next step is to talk about support, not punishment. That tone can change the trajectory of the encounter.

OARRS also sits at the intersection of addiction treatment and general medical care. Many people who need help do not first present at a specialty addiction program. They may appear in a primary care office, urgent care setting, emergency department, dental practice, pain clinic, or pharmacy. A statewide monitoring system gives those touchpoints a way to recognize risk and respond more consistently. Still, the technology itself does not provide treatment. It depends on professionals who know how to interpret the information and connect the person to appropriate resources.

The provider's role in making the continuum real

A continuum of care exists on paper only until a provider operationalizes it. That means answering hard, concrete questions. Who evaluates the person when they call? How quickly can they be seen? What happens if they need detoxification? How are co-occurring mental health symptoms assessed? Is medication-assisted treatment available when clinically appropriate? What kind of outpatient care is offered after residential treatment? How does the program involve family when appropriate? What happens if the person leaves early or relapses?

These details matter because recovery is often vulnerable at transition points. The move from detoxification to residential care can be a moment of relief, but it can also be a moment when someone feels physically better and decides they no longer need treatment. The move from residential care to outpatient services can bring hope, but also exposure to old triggers, unresolved family conflict, or housing instability. The move from intensive outpatient services to less frequent care can feel like progress, but it can also reduce accountability before new routines are fully established.

A strong provider anticipates those weak points. It does not treat discharge as the end of responsibility. It treats discharge planning as part of treatment from the beginning. That planning may involve outpatient scheduling, peer support, family communication, recovery housing referrals where appropriate, and ongoing medication management if medication-assisted treatment is part of the plan.

The same principle applies to levels of intensity. Non-intensive outpatient services and intensive outpatient services are not interchangeable. Residential care and recovery housing are not the same thing. Detoxification and treatment are not the same thing either, though they are often confused. Detoxification can help a person become medically stable during withdrawal, but it does not by itself address the behavioral, emotional, relational, and environmental patterns that sustain addiction. Good providers are careful with this distinction. They do not oversell one service as a complete solution.

Recreate Ohio as an example of provider-level care

One example of how a provider may fit into Ohio's broader 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 location as offering detox, residential or inpatient rehab, and outpatient treatment. It also says the facility provides a full continuum of care and offers primary mental health services in a residential treatment setting.

That combination is relevant because many people entering drug addiction treatment need more than a single episode of care. A provider that offers multiple levels can potentially reduce the friction that occurs when a person must move between unrelated organizations. The person may still need careful assessment and individualized placement, but the presence of detox, residential treatment, and outpatient services under one provider framework can support continuity when the clinical fit is appropriate.

Recreate also states that treatment at its Ohio facility may include cognitive behavioral therapy, dialectical behavior therapy, EMDR, medication-assisted treatment, individual therapy, group therapy, family therapy, and couples therapy. These services reflect several different clinical needs. Cognitive behavioral therapy can help people identify patterns in thought and behavior. Dialectical behavior therapy is often associated with emotion regulation and coping skills. EMDR is commonly used in trauma-focused work. Medication-assisted treatment addresses the medical and neurobiological realities of certain substance use disorders. Individual, group, family, and couples therapy each engage a different part of the recovery environment.

The provider 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 services should be understood as supports rather than substitutes for clinically indicated addiction treatment. For some people, practices such as mindfulness, fitness, nutrition education, or expressive therapies can help rebuild routines, reduce stress, and make treatment feel less narrowly clinical. For others, the central needs may remain medication, psychiatric care, relapse prevention planning, and structured therapy. The value lies in matching services to the person rather than assuming every option is equally important for everyone.

<https://www.recreateohio.com/>

Matching services to the person, not the label

"Drug addiction" is a broad term. It can describe people with very different histories, risks, substances used, medical needs, and recovery goals. A person using opioids daily may face significant withdrawal risk and may benefit from medication-assisted treatment. A person using multiple substances may need a more layered assessment. A person with trauma symptoms may struggle in group settings until safety and stabilization are addressed. A person with strong family support may benefit from family therapy, while another person may need boundaries from family members who are actively destabilizing.

This is why assessment is not a formality. It is the clinical hinge on which good treatment turns. The wrong level of care can fail even when the provider is competent. Too little structure may leave a person exposed to immediate relapse risk. Too much structure may disrupt work, parenting, or community supports that are helping the person stay stable. A person who needs residential care should not be pushed into outpatient treatment simply because it is easier to schedule. A person who can succeed in outpatient care should not automatically be moved into residential treatment if a less restrictive setting is clinically appropriate.

Medication-assisted treatment illustrates this need for judgment. Ohio's continuum specifically includes it, and providers may offer it as part of treatment. For many people, medication can be a critical element of care. At the same time, medication works best when embedded in a broader plan that addresses behavior, relationships, mental health, and practical recovery supports. The old habit of separating "real recovery" from medication-

assisted treatment has harmed too many people. A more professional approach asks whether the treatment is clinically appropriate, monitored, and integrated.

Peer support also deserves careful attention. Peer support can reach people in ways formal clinical care sometimes cannot. Someone who has lived experience with recovery may be able to speak plainly about cravings, shame, relapse, and rebuilding trust. That does not make peer support a replacement for therapy, medical care, or medication when those are needed. It makes it a distinct and valuable part of the continuum.

A short practical checklist for families evaluating care

Families often enter this process quickly, with limited information and high emotion. A concise set of questions can help bring the conversation back to fundamentals.

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, outpatient services, medication-assisted treatment, peer support, or recovery housing connections?
3. How does the program assess co-occurring mental health needs?
4. What happens after the first level of care ends, and who helps arrange the next step?
5. How are family members involved when involvement is clinically appropriate and consent is in place?

These questions do not capture every detail, but they reveal how organized a provider is. Vague answers are a warning sign. Clear answers do not guarantee success, but they suggest the provider understands addiction treatment as a process rather than a transaction.

The hard part: transitions, timing, and capacity

Even in a well-designed state system, treatment can be difficult to coordinate. The need for help often appears suddenly. A person may agree to treatment in the morning and change their mind by evening. Withdrawal symptoms may intensify. A family may discover that the level of care they expected is not the level recommended after assessment. Outpatient appointments may not line up perfectly with discharge dates. Recovery housing may be appropriate, but the fit still has to be considered carefully.

This is where providers earn trust. A professional program communicates clearly about what it can and cannot do. It does not promise that every person will receive every service. It explains why a level of care is recommended. It prepares people for the next step before the current step ends. It treats relapse risk as a clinical issue to plan for, not as a moral failure to condemn.

The timing of care is also important. Detoxification without follow-up can become a revolving door. Residential treatment without outpatient continuation can leave people with insight but not enough practice in daily life. Outpatient care without adequate intensity can be too thin for someone in acute instability. Recovery housing without clinical support may not be enough for a person with active psychiatric symptoms. Each service has value, but only when placed correctly within the person's broader recovery plan.

Ohio's required continuum recognizes these realities, but implementation happens locally and personally. A statute can name the necessary components. A provider has to coordinate them. A clinician has to explain them. A patient has to participate in them. A family may need to support them without trying to control the entire process.

Co-occurring mental health care is not optional for many patients

The inclusion of co-occurring drug addiction in Ohio's continuum reflects what treatment professionals see repeatedly: mental health symptoms can drive substance use, and substance use can worsen mental health symptoms. Untreated depression can drain motivation. Anxiety can make early recovery feel unbearable. Trauma symptoms can make trust difficult. Sleep disruption can erode judgment. Relationship conflict can trigger cravings. These are not side issues. They often sit at the center of relapse risk.

Providers that offer primary mental health services in a residential treatment setting, as Recreate Ohio says it does, are responding to this overlap. The residential environment can create enough structure for deeper assessment and stabilization, particularly when someone has struggled to maintain safety or consistency in the community. Still, residential mental health support should connect to what happens afterward. People eventually return to less structured settings, and outpatient care must continue the work.

Therapies such as CBT, DBT, EMDR, individual therapy, group therapy, family therapy, and couples therapy each serve different purposes. The clinical question is not which therapy sounds most impressive. The question is what problem the therapy is being used to address. A person with destructive thought patterns and relapse triggers may benefit from CBT. A person with intense emotional swings may need DBT-informed skills. A person with trauma symptoms may be evaluated for trauma-focused work such as EMDR. A family caught in cycles of mistrust may need structured family therapy. A couple trying to rebuild communication may need couples therapy, if the relationship is safe and clinically appropriate to involve.

Good care avoids turning therapy into a menu of attractive labels. It builds a treatment plan that explains why each service is being used.

How public systems and private providers influence each other

State systems and providers are not separate worlds. State law and certification requirements define the boundaries within which providers operate. Providers, in turn, reveal where the system works well and where patients struggle. If many people repeatedly leave detoxification without entering ongoing care, that exposes a transition problem. If people with co-occurring needs cannot find integrated treatment, that exposes a service gap. If medication-assisted treatment is available in name but difficult to access in practice, that exposes an implementation problem.

The best treatment landscape is one in which regulation, funding, clinical practice, and community resources push in the same direction. The person seeking help should encounter a system that says, in effect, "We can assess what you need, place you at the right level of care, support your medical and mental health needs, and help you keep moving after this first step." That is a high standard, but it is the standard implied by a true continuum.

Providers also shape expectations. When a provider presents detox, residential treatment, outpatient services, medication-assisted treatment, therapy, family involvement, peer support, and holistic services as connected parts of care, it helps patients and families understand recovery as a process. When a provider oversimplifies treatment into a single stay or a single intervention, it risks setting people up for disappointment.

What a mature Ohio treatment pathway can look like

A mature pathway begins with assessment and placement. From there, the person receives the least restrictive level of care that can safely and effectively meet their needs. If withdrawal management is needed, detoxification comes first, but it is paired with a plan for ongoing treatment. If residential care is appropriate, the stay focuses not only on stabilization but also on skills, mental health needs, relapse prevention, and next-step planning. If outpatient care is appropriate, intensity matches risk. If medication-assisted treatment is indicated, it is integrated

into the plan rather than treated as an afterthought. If peer support or recovery housing can strengthen continuity, those supports are considered as part of the broader recovery environment.

One useful way to understand the continuum is to think in terms of function rather than labels.

| Service type | Practical role in recovery | |---|---| | Detoxification | Helps manage withdrawal and medical stabilization when needed | | Residential services | Provides structured treatment in a more intensive setting | | Outpatient services | Supports recovery while the person remains in the community | | Medication-assisted treatment | Uses medication, when clinically appropriate, as part of addiction care | | Peer support and recovery housing | Strengthens community connection, accountability, and daily stability |

No table can capture the complexity of a person's life, but this framing helps prevent a common mistake: assuming one service does the work of all the others. Each part of the continuum has a job. The art of treatment is knowing which parts are needed, in what order, and with what level of intensity.

Professional judgment still matters

Systems can require services. Certification can regulate providers. Databases such as OARRS can support safer prescribing. Facilities can offer multiple therapies and levels of care. None of that removes the need for professional judgment.

Judgment shows up in the first phone call, when staff decide whether a person needs urgent evaluation or a scheduled assessment. It shows up when clinicians distinguish between discomfort and medical risk, between family concern and actual clinical need, between motivation that is fragile but real and refusal that requires a different engagement strategy. It shows up when a provider recommends medication-assisted treatment without apology, or decides that a therapy should wait until the person is more stable, or tells a family that their involvement must respect the patient's consent and clinical boundaries.

Judgment also means humility. Addiction treatment is not a straight line. People may relapse. They may leave care early. They may resist the service that would help them most. They may improve in one area while struggling in another. A professional system does not interpret every setback as failure. It uses setbacks as information and adjusts the plan.

The measure of a better system

Ohio's treatment framework contains the essential idea: people with opioid and co-occurring drug addiction need access to a community-based continuum, not isolated fragments of care. Certification provides oversight. OARRS supports safer prescribing and connection to resources. Providers such as Recreate Ohio illustrate how a facility may offer multiple levels of care, including detox, residential or inpatient rehab, outpatient treatment, mental health services, medication-assisted treatment, therapy options, and holistic supports.

The measure of success is whether these pieces become usable for the person who needs help. Can someone move from crisis to assessment without getting lost? Can they receive the right level of care rather than the most convenient one? Can their mental health needs be treated alongside drug addiction? Can medication be used appropriately without stigma? Can the family receive guidance without taking over? Can the plan continue after the first episode of treatment ends?

Those are the questions that matter in Ohio and everywhere else. A strong state system creates the architecture. A strong provider makes the architecture livable. Recovery is built in the space between the two, one careful handoff, one honest assessment, and one sustained plan at a time.