

Ohio's approach to drug addiction treatment is built around a practical idea: people need more than a single appointment, a short stay, or one kind of therapy. Substance use disorders, especially opioid use disorder and co-occurring drug addiction, often move through different phases. A person may need withdrawal support first, then structured treatment, then medication, then housing support, then peer connection, and often mental health care alongside all of it.

That is why Ohio law requires a community-based continuum of care for opioid and co-occurring drug addiction. The model is not limited to one setting. It includes detoxification services, outpatient treatment at different levels of intensity, medication-assisted treatment, peer support, residential services, recovery housing, and multiple pathways to recovery. The phrase "continuum of care" can sound administrative, but in practice it describes what many families learn the hard way: recovery usually depends on connected services, not isolated interventions.

A well-built community-based care model does not assume every person starts in the same place. One person may enter treatment after an emergency, another after a court referral, another because a spouse finally set a boundary, and another because they can no longer manage work while using substances. Some need medical stabilization. Some need intensive outpatient structure while remaining at home. Some need residential treatment because their living environment makes early recovery nearly impossible. Others need medication-assisted treatment and peer support more than they need a bed.

The strength of Ohio's model lies in requiring communities to account for those different needs. The challenge lies in making the pieces work together in real time.

What "community-based continuum of care" means in practice

A community-based model places treatment resources close enough to where people live, work, raise children, and return after higher levels of care. It recognizes that drug addiction treatment does not happen only inside a facility. Treatment may begin in a detox setting, continue in outpatient care, involve medication, include peer support, and depend on safe housing and family participation.

Ohio's required continuum for opioid and co-occurring drug addiction 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 component fills a different clinical or practical role. When one is missing, people can fall through gaps.

For example, detoxification without follow-up care leaves a person physically stabilized but still vulnerable to relapse. Outpatient counseling without medication-assisted treatment may be insufficient for someone with opioid use disorder who would benefit from medication as part of care. Residential treatment without recovery housing can discharge a person back into an unsafe environment. Peer support without clinical services may help with connection but may not address psychiatric symptoms, trauma, or medical needs.

The model is not meant to force everyone through every service. Rather, it gives communities the ability to match care to the person. That matching process is where good assessment, provider certification, clinical judgment, and coordination matter.

Certification and accountability in Ohio treatment services

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 addiction

care involves medical risk, behavioral health risk, privacy concerns, and vulnerable patients. Families may see a website, a brochure, or a promise of help, but the underlying question remains: is the provider authorized and accountable under Ohio's treatment standards?

Certification does not make every program identical. Programs may differ in setting, clinical philosophy, staffing model, therapies offered, and the populations they serve. Still, certification creates a baseline expectation that substance use disorder treatment is not simply informal support or wellness coaching. It is a regulated service.

This distinction is especially important in drug addiction treatment because families often search for help under pressure. They may be trying to act before someone changes their mind, before withdrawal worsens, before legal consequences deepen, or before a return to use becomes fatal. In those moments, it is easy to be persuaded by polished language. A community-based model works best when access is fast, but also when providers are properly certified and services are clearly described.

Detoxification: stabilization, not the whole answer

Detoxification is one of the required components in Ohio's continuum, including ambulatory and sub-acute detoxification. This reflects a key reality: withdrawal can be a major barrier to treatment entry. People often continue using not because they believe it is helping them, but because withdrawal feels unmanageable or frightening.

Ambulatory detoxification can allow appropriate patients to receive withdrawal support without a full inpatient admission. Sub-acute detoxification provides a more structured level of withdrawal management for people who need monitoring and support but may not require hospital-level care. The right setting depends on the substance involved, the person's medical status, psychiatric stability, prior withdrawal history, and safety at home.

Detox should be understood as a beginning. It may reduce immediate physical dependence or help a person stop using long enough to think clearly, sleep, eat, and engage. But detox alone rarely addresses the behavior patterns, cravings, mental health symptoms, family dynamics, housing problems, and social pressures that sustain addiction.

Experienced clinicians are careful about the "detox and done" mindset. A person may feel dramatically better after several days of stabilization and believe the problem has passed. Families may also feel relief and assume the crisis is over. Yet this is often a fragile period. Tolerance may be lower, cravings may return quickly, and the person may not yet have treatment supports in place. The continuum matters because detox needs a warm handoff into ongoing care.

Outpatient services: flexibility with structure

Ohio's required continuum includes both non-intensive and intensive outpatient services. That distinction is important because outpatient care covers a wide range. Some patients need periodic counseling, medication management, recovery support, and monitoring while maintaining work or family responsibilities. Others need several days of structured programming each week to interrupt a pattern of use and build recovery skills.

Non-intensive outpatient services may fit someone with a stable living situation, strong motivation, manageable symptoms, and enough outside support to remain safe. Intensive outpatient services may be appropriate when a person needs more frequent contact, group therapy, individual therapy, relapse prevention planning, and accountability, but does not require residential care.

The trade-off is straightforward. Outpatient care protects daily life when daily life is safe enough to support recovery. It lets people keep jobs, attend school, care for children, and practice recovery skills in the real

environment where they will need them. But if the home environment is chaotic, if substances are readily available, if relationships are dangerous, or if mental health symptoms are severe, outpatient care may not provide enough containment.

That is why a continuum must include multiple levels, not just one outpatient option. A person may step down from residential treatment into intensive outpatient care, then into less intensive ongoing services. Another person may start in outpatient care and move to residential services if the first plan is not enough. Good treatment planning leaves room for adjustment.

Medication-assisted treatment as a core service

Medication-assisted treatment is part of Ohio's required community-based continuum for opioid and co-occurring drug addiction. Its inclusion reflects the evidence-informed direction of modern addiction care: medication can be an essential part of treatment for many people, particularly those with opioid use disorder.

Medication-assisted treatment is sometimes misunderstood. Some patients and families worry that it simply replaces one substance with another. In clinical practice, that view can prevent people from receiving care that may reduce cravings, stabilize functioning, and support engagement in counseling and recovery activities. Medication is not a shortcut around recovery work. It is often what makes recovery work possible.

The most effective use of medication-assisted treatment depends on proper assessment, informed consent, monitoring, and coordination with counseling or other supports as clinically appropriate. Some people will need medication for a shorter period, others for much longer. The decision should be individualized rather than driven by stigma or arbitrary timelines.

Community-based care is especially important here because medication requires continuity. If a person begins medication but cannot access follow-up appointments, pharmacy coordination, transportation, counseling, or peer support, the treatment plan weakens. Medication-assisted treatment functions best when it is integrated into a broader system rather than treated as a stand-alone transaction.



The role of OARRS in safer prescribing and early intervention

Ohio's OARRS 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 a state care

model that includes opioid and co-occurring drug addiction, prescription monitoring is one of the tools that can help identify risk and guide safer clinical decisions.

OARRS is not treatment by itself. It does not replace assessment, conversation, or clinical judgment. But it can provide prescribers and pharmacists with information that may reveal unsafe medication combinations, multiple prescribers, concerning dispensing patterns, or other risks involving controlled substances. Used properly, that information can create an opportunity for intervention rather than punishment.

The tone of that intervention matters. A patient who feels accused may disappear from care. A patient who is approached with concern, clarity, and options may be more willing to talk. The best use of monitoring data is not simply to say “no,” but to say, “Something here raises concern, and we need to make a safer plan.”

That safer plan may involve referral to drug addiction treatment, adjustment of prescribing, medication-assisted treatment, counseling, or a more complete evaluation. In a community-based model, data should open doors to care, not merely close doors to medication.

Peer support and the value of lived experience

Peer support is another required element in Ohio’s continuum. Its inclusion acknowledges something clinicians, families, and patients often see firsthand: people in recovery may hear certain truths more clearly from someone who has lived through addiction and change.

Peer supporters can help translate treatment into daily life. They may help someone stay engaged after discharge, attend appointments, navigate recovery meetings or other supports, rebuild routines, and tolerate the discomfort of early recovery. They can also model hope in a way that professional credentials alone sometimes cannot.

The professional boundary still matters. Peer support is not a substitute for clinical treatment, medical care, or mental health therapy. It is part of a team-based approach. When integrated well, peer support helps bridge the gap between formal treatment and real life, especially during transitions that carry high risk.

Transitions are often where recovery plans fail. The day someone leaves detox. The first weekend after residential care. The first argument at home. The first paycheck. The first painful anniversary. Peer support can make those moments less isolating and more navigable.

Residential services and recovery housing

Residential services are required in Ohio’s continuum because some people need a protected treatment setting. Residential care can remove a person from immediate access to substances and provide structure throughout the day. It can also create space to address mental health symptoms, family issues, trauma histories, and behavioral patterns that are difficult to manage while living in an unstable environment.

Residential treatment should not be viewed as a sign that outpatient care “failed.” It is a different level of care for different needs. Some patients are clinically appropriate for residential services from the start. Others need residential care after repeated relapses, worsening psychiatric symptoms, unsafe housing, or inability to stabilize in outpatient treatment.

Recovery housing serves a different but related purpose. It provides a substance-free living environment that can support ongoing recovery after or alongside treatment. Housing is not a minor detail. A person leaving treatment for a home where drugs are present, conflict is constant, or basic safety is absent faces a significantly harder path.

Recovery housing can offer structure and community while a person rebuilds employment, relationships, and routines.

The edge case is worth naming: not everyone needs residential treatment or recovery housing, and unnecessary separation from work, family, or school can create its own harm. The goal is not to place people in the highest level of care by default. The goal is to place them in the right level of care at the right time, with a realistic plan for what happens next.

Multiple pathways to recovery

Ohio's model requires multiple pathways to recovery. That phrase carries clinical and cultural importance. Recovery does not look identical for every person. Some people rely heavily on medication-assisted treatment. Some connect deeply with peer support. Some benefit from therapy focused on trauma, mood symptoms, or relationship patterns. Some need faith-based support, mutual aid, family therapy, fitness routines, creative outlets, or a combination of approaches.

Multiple pathways do not mean "anything goes." Treatment still needs to be safe, ethical, and clinically appropriate. But it does mean the system should avoid one-size-fits-all thinking. A person with opioid use disorder and depression may need a different plan than someone using stimulants with no stable housing. A parent trying to retain custody may face different pressures than a young adult whose family has disengaged after years of crisis. A person with chronic pain and controlled-substance prescriptions may require careful coordination between addiction care and medical care.

The practical value of multiple pathways is retention. People are more likely to stay engaged when treatment feels relevant, respectful, and responsive. If one pathway does not fit, the system should have other doors.

Co-occurring conditions and the need for integrated care

The Ohio requirement specifically references opioid and co-occurring drug addiction. Co-occurring issues are common in addiction treatment settings, particularly when substance use overlaps with anxiety, depression, trauma symptoms, serious stress, or other behavioral health concerns. A person may use substances to manage emotional pain, then find that substance use worsens the same symptoms over time.

When mental health symptoms are ignored, drug addiction treatment can become too narrow. The person may learn relapse prevention language but still be overwhelmed by panic, grief, insomnia, shame, or intrusive memories. On the other hand, treating mental health symptoms without addressing active substance use may also fall short. Integrated care asks a better question: what combination of supports does this person need to become safer and more stable?

Some Ohio providers describe services that reflect this integrated direction. Recreate Behavioral Health Network identifies an Ohio location, Recreate Behavioral Health of Ohio, also referred to as Recreate Ohio, in Gahanna just outside Columbus. The organization states that its Ohio facility offers detox, residential or inpatient rehab, and outpatient treatment. It also describes the facility as providing a full continuum of care and offering primary mental health services in a residential treatment setting.

That combination is relevant because many patients do not arrive with a single, neatly defined problem. They arrive with addiction, strained relationships, psychiatric symptoms, poor sleep, legal stress, employment consequences, and fear. A setting that can address substance use disorder treatment while also recognizing mental health needs may be better positioned to help patients move from crisis stabilization into longer-term recovery planning.

Therapy modalities and practical treatment supports

Treatment quality depends not only on the level of care, but also on what happens inside that level of care. Recreate 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 represent different ways of addressing the patterns that often surround addiction.

Cognitive behavioral therapy can help patients identify thoughts, triggers, and behaviors that contribute to substance use. Dialectical behavior therapy is often associated with skills such as distress tolerance, emotional regulation, and interpersonal effectiveness. EMDR is commonly used in trauma-focused treatment contexts. Individual therapy gives patients private space to work through sensitive issues. Group therapy lets patients practice honesty, feedback, and connection. Family and couples therapy can address the relational damage and communication patterns that often develop around addiction.

No single therapy works equally well for every patient. Some people are ready for trauma-focused work early, while others first need stabilization, sleep, medication support, and basic coping skills. Some families benefit from participating in therapy, while others require boundaries before deeper repair is possible. A professional treatment team has to sequence care carefully. Moving too fast can overwhelm a patient. Moving too slowly can miss the urgency of change.

Holistic supports can also play a role when they are integrated responsibly. Recreate states that its Ohio facility may provide supports such as yoga and mindfulness, art therapy, adventure therapy, equine therapy, Reiki, acupuncture, chiropractic care, fitness and wellness activities, and nutrition education. These services should not be mistaken for replacements for core addiction treatment, but they may help some patients reconnect with their bodies, manage stress, establish routines, and experience sober activities that feel meaningful.

In early recovery, the nervous system is often unsettled. Sleep may be poor. Appetite may fluctuate. Anxiety may spike without warning. Shame may make ordinary conversation difficult. Practical supports such as movement, nutrition education, mindfulness, and creative expression can help patients tolerate discomfort while clinical work proceeds. The key is balance. Holistic care is most useful when it supports the treatment plan rather than distracting from it.

How the required services work together

The easiest way to understand Ohio's continuum is to imagine the patient journey as a set of connected doors. The first door may be detoxification. The next may be residential treatment, intensive outpatient care, or medication-assisted treatment. Peer support may begin early and continue through multiple stages. Recovery housing may become important when discharge planning reveals that home is unsafe or unstable. Mental health services may need to run throughout.

A strong care model pays attention to handoffs. It is not enough to tell someone to call a number after discharge. The more fragile the patient, the more active the transition should be. Appointment scheduling, medication continuity, transportation planning, family communication, and housing arrangements can make the difference between engagement and relapse.

The following elements are especially important when matching a person to services:

1. Current substance use pattern, including opioid involvement and other drug use.
2. Withdrawal risk, medical status, and psychiatric stability.
3. Living environment, family support, transportation, and safety.

4. Prior treatment history, including what helped and what did not.
5. Need for medication-assisted treatment, peer support, residential care, or recovery housing.

This is one of the few places where a checklist helps, because placement decisions can become emotional. Families may [Addiction Treatment in Ohio](#) push for residential care because they are exhausted. Patients may push for outpatient care because they fear disruption. Providers have to weigh preference against risk. The best recommendation is usually the one that can be defended clinically and carried out practically.

What families should look for when seeking treatment in Ohio

Families searching for drug addiction treatment in Ohio often move quickly, and rightly so. Addiction can create windows of willingness that open briefly. Still, speed should not eliminate due diligence. Since Ohio substance use disorder treatment providers must be certified by the Ohio Department of Mental Health and Addiction Services, families should pay attention to whether a provider is operating within the appropriate state framework.

They should also listen for specificity. A credible provider can explain what levels of care are available, how assessment works, whether detox is offered, how outpatient care is structured, whether medication-assisted treatment is available, what role peer support plays, and how discharge planning is handled. Vague promises are less useful than clear descriptions.

Good questions are direct but not hostile:

1. What levels of care are available at this location?
2. How do you determine whether someone needs detox, residential care, outpatient care, or another service?
3. Is medication-assisted treatment available when clinically appropriate?
4. How are mental health concerns addressed during treatment?
5. What planning occurs before a patient leaves one level of care?

The answers do not need to sound perfect. They need to sound grounded. Addiction treatment is complex, and honest providers acknowledge trade-offs. They may say that a patient needs assessment before placement, that some services depend on clinical appropriateness, or that family involvement varies by consent and circumstances. That kind of candor is usually a strength.

Why Ohio's model matters for communities

Drug addiction affects emergency departments, courts, employers, schools, child welfare systems, and neighborhoods. A fragmented treatment system pushes the burden outward. When detox is available but outpatient follow-up is not, people cycle through crisis services. When medication-assisted treatment is scarce or disconnected, patients may return to illicit opioid use. When residential care has no step-down plan, gains made in treatment can erode quickly. When recovery housing is unavailable, people may return to environments that undermine stability.

Ohio's community-based care requirement recognizes that addiction is not solved by a single professional discipline or a single facility type. It requires medical care, behavioral health treatment, peer connection, safe environments, and practical continuity. The model also recognizes that people recover in communities, not only in programs. The community must have enough treatment capacity and enough coordination to support that recovery.

Providers such as Recreate Behavioral Health of Ohio in Gahanna describe services that align with several parts of this broader continuum, including detox, residential or inpatient rehab, outpatient treatment, medication-assisted

treatment, therapy options, mental health services in a residential setting, and supportive holistic services. For patients and families near Columbus or elsewhere in Ohio, the central issue is not simply whether a program has many services listed. The issue is whether those services can be organized into a coherent plan that meets the person's needs.

The professional standard: right care, right time, real continuity

The phrase "drug addiction treatment" covers a wide range of services, but Ohio's community-based model gives it shape. Required services include withdrawal support, outpatient care at different intensities, medication-assisted treatment, peer support, residential services, recovery housing, and multiple recovery pathways. Those requirements reflect the reality that recovery is both clinical and practical.

The professional standard is not to move every patient through the same sequence. It is to assess carefully, place appropriately, adjust when needed, and maintain continuity. [Click here to find out more](#) A person may need detox today, residential care next week, outpatient treatment next month, and peer support throughout. Another may need medication-assisted treatment and non-intensive outpatient care from the beginning. Another may need recovery housing because the treatment plan cannot survive the home environment.

Ohio's model is demanding because addiction is demanding. It asks communities and providers to build systems that can meet people at different stages of readiness, severity, and stability. When those systems work well, treatment becomes less of a revolving door and more of a connected pathway. For individuals and families facing drug addiction, that connection can be the difference between another short-lived attempt and a recovery plan with enough structure to hold.