

Medication-assisted treatment, often shortened to MAT, tends to provoke strong reactions. Some families hear the word “medication” and worry that it means replacing one substance with another. Some clients arrive after years of trying to stop opioid use through willpower, detox, meetings, or short residential stays, and they are exhausted by the cycle of withdrawal, relapse, guilt, and starting over. Clinicians, meanwhile, see another side of the picture: people who stabilize enough to sleep, participate in therapy, rebuild relationships, and make practical decisions because medication has reduced the biological pressure that was pulling them back into use.

At Recreate Ohio, medication-assisted treatment is not presented as a stand-alone answer. It fits into a broader continuum of services that may include detox, residential or inpatient rehab, outpatient treatment, therapy, mental health care, peer support, and holistic recovery supports. That matters. Drug addiction treatment is rarely effective when it treats only one piece of a person’s life. Withdrawal symptoms, trauma, depression, anxiety, family strain, housing instability, work stress, shame, and chronic pain can all become part of the same knot. MAT can loosen one of the tightest strands, especially for opioid use disorder, but it works best when the rest of the treatment plan is strong enough to hold the person as life starts to change.

Recreate Behavioral Health of Ohio, also referred to as Recreate Ohio, is located in Gahanna, just outside Columbus. The facility describes its services as a full continuum of care, including detox, residential or inpatient rehab, and outpatient treatment. Recreate also identifies medication-assisted treatment as one of the clinical tools that may be included alongside therapies such as CBT, DBT, EMDR, individual therapy, group therapy, family therapy, and couples therapy. The key word is “alongside.” MAT is most useful when it is integrated into care rather than treated as a shortcut around it.

MAT answers a biological problem, not a moral one

One of the most important shifts in modern drug addiction treatment is the recognition that addiction is not simply a pattern of bad choices. Choice is involved, of course. Recovery asks people to make difficult choices every day. But substance use disorder also changes reward pathways, stress response, memory, sleep, pain sensitivity, and emotional regulation. For many people with opioid addiction, stopping use is not just uncomfortable. It can feel physically and mentally intolerable, especially during the early stages.

Medication-assisted treatment is designed to reduce that intensity. Depending on the diagnosis, clinical presentation, and prescribing standards, medications used in addiction care may help relieve withdrawal symptoms, reduce cravings, lower the risk of return to use, or block the effects of certain substances. The medication does not do the work of recovery for the person. It does not repair trust with family, teach coping skills, process trauma, or build a sober support network. What it can do is create enough stability for those parts of treatment to become possible.

That distinction is not academic. A person who is shaking, vomiting, unable to sleep, and consumed by cravings may sit in a therapy group and hear almost nothing. Someone whose nervous system is in constant alarm may agree to a relapse prevention plan and then be unable to follow it once symptoms spike. MAT can give the clinical team a better chance to reach the person while motivation is still present and before the body drags them back toward use.

This is especially relevant in Ohio, where state law recognizes the need for 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. The law reflects something treatment professionals see

every day: people do not all recover in the same way, and they do not all need the same level of care at the same time.

Where MAT fits in the Recreate Ohio continuum

Recreate Ohio's stated continuum includes detox, residential or inpatient rehab, and outpatient treatment. Medication-assisted treatment may have a role at different points along that path, depending on the individual's needs and the clinical judgment of the treatment team.

In detox, the immediate concern is safety and stabilization. Detox is not the same thing as full treatment. It is often the first medical and clinical step, particularly when a person is physically dependent on substances. For opioid addiction, withdrawal may not always be medically dangerous in the same way that alcohol or benzodiazepine withdrawal can be, but it can be profoundly distressing and is strongly associated with return to use. During detox, appropriate medication support can help reduce symptoms and make it more likely that a person continues into the next level of care instead of leaving early.

In residential or inpatient rehab, the role of MAT can shift. The person may no longer be in acute withdrawal, but cravings, sleep disturbance, mood swings, anxiety, pain, and fear of relapse may still be present. Residential treatment gives the team time to observe patterns, adjust the care plan, and connect medication support with therapy. A resident might begin to see, for example, that cravings intensify after trauma work, family phone calls, boredom, or conflict with peers. Medication can reduce the baseline intensity, while therapy helps the person understand and manage the triggers.

In outpatient treatment, MAT can support continuity. This is often where the real test begins. A person leaves the structure of a residential setting and returns to traffic, bills, relationships, old neighborhoods, work schedules, and unexpected stress. Outpatient care can help bridge that transition. Medication-assisted treatment, when clinically appropriate, may reduce the risk that one difficult evening becomes a full return to drug use. It also gives the treatment team a reason for ongoing contact, monitoring, and adjustment.

The best use of MAT is not passive. It should be woven into a plan that asks practical questions: Is the medication helping? Are cravings decreasing? Is the person attending therapy? Are side effects interfering with daily life? Is the level of care still appropriate? Is there co-occurring depression, anxiety, trauma, or another mental health concern that needs direct treatment? Recreate Ohio states that it offers primary mental health services in a residential treatment setting, which is significant because substance use and mental health concerns frequently overlap.

Why “medication-assisted” does not mean “medication-only”

The phrase itself can be misleading. Medication-assisted treatment is not a prescription with a discharge packet. In a responsible clinical setting, medication is paired with counseling, behavioral therapies, monitoring, education, and recovery planning. This combination is the point.

Recreate Ohio identifies several therapy options that may be part of care, including CBT, DBT, EMDR, individual therapy, group therapy, family therapy, and couples therapy. Each addresses a different part of recovery.

CBT, or cognitive behavioral therapy, helps people notice the connection between thoughts, emotions, and behavior. A person may learn that the thought “I already ruined everything” leads to hopelessness, isolation, and cravings. CBT gives that person tools to challenge the thought before it becomes a relapse pathway.

DBT, or dialectical behavior therapy, is often useful when emotions feel unmanageable. Many people in treatment do not return to substance use because they want to get high in a simple sense. They return because anger, grief,

panic, shame, or numbness feels unbearable. DBT skills can help with distress tolerance, emotional regulation, and interpersonal conflict.

EMDR, or eye movement desensitization **Addiction Treatment in Ohio** and reprocessing, may be used when trauma is part of the clinical picture. Trauma does not have to be dramatic to be powerful. It may involve childhood instability, violence, loss, medical events, abandonment, or repeated humiliation. For some people, substances became a way to quiet memories or body sensations long before addiction was recognized as a problem.

Family and couples therapy can address the relationship system around the person. Families often arrive with a mixture of love, anger, fear, and exhaustion. They may have tried rescuing, threatening, pleading, cutting off contact, or monitoring every move. Therapy can help relatives understand addiction without excusing harmful behavior. It can also help the person in treatment hear the impact of their use without collapsing into shame.

MAT can support all of this work by helping the person remain present. When cravings dominate the mind, insight has nowhere to land. When the body is calmer, therapy has more room to work.

The stigma that still follows MAT

Despite strong clinical support for medication-assisted treatment in appropriate cases, stigma remains common. Some of it comes from misunderstanding. Some comes from painful lived experience. Families may have watched a loved one misuse medication in the past and understandably feel cautious. People in recovery communities may hold different beliefs about what sobriety should look like. A client may feel embarrassed to need medication, especially if they have been told that “real recovery” means taking nothing.

Those concerns deserve respectful conversation, not dismissal. Recovery is personal. There are multiple pathways, and Ohio’s own framework recognizes that reality. For some people, MAT may be a vital part of early recovery, long-term recovery, or both. For others, it may not be clinically indicated or may not align with their needs after assessment. The goal is not to force everyone into the same model. The goal is to reduce harm, support stability, and help people build lives that are not organized around drug use.

A useful way to discuss MAT with families is to compare it with treatment for other chronic conditions. Medication does not replace lifestyle change for diabetes, hypertension, or asthma. It works with it. A person with diabetes still needs nutrition guidance, monitoring, education, and daily decisions. A person with opioid use disorder who receives medication still needs therapy, accountability, coping skills, social support, and relapse prevention. The medication is not a moral verdict. It is a clinical tool.

The trade-off is that medication requires structure. It may involve appointments, monitoring, careful prescribing, coordination between providers, and honest reporting about cravings or side effects. It may also involve uncomfortable conversations if a person is not taking the medication as prescribed or is continuing to use other substances. Those realities do not make MAT flawed. They make it health care.

Ohio’s treatment environment and the importance of certified care

Substance use disorder treatment in Ohio is not meant to operate informally. 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 treatment involves vulnerable people, controlled medications, complex diagnoses, and high-risk transitions. Families looking for care should pay attention not only to the warmth of a facility’s message, but also to whether services are delivered within the state’s regulatory expectations.

Ohio also operates OARRS, the statewide electronic database for controlled-substance dispensing information. OARRS supports safe prescribing and helps connect people at risk of substance use disorder to resources. In the context of MAT and broader drug addiction treatment, systems like this can help clinicians prescribe more responsibly, identify concerning medication patterns, and make better-informed decisions. It is not a substitute for clinical judgment or a therapeutic relationship, but it is part of the safety infrastructure.

This matters because addiction treatment can fail at the seams. A person may receive detox but no follow-up. A medication may be started without enough therapy or monitoring. Mental health symptoms may be missed because the substance use is so visible. Family dynamics may be ignored until the person returns home. Recreate Ohio's described full continuum of care is relevant because continuity reduces the number of times a client has to start over with a new team, new paperwork, and a new explanation of everything that happened.

What MAT can and cannot do

Medication-assisted treatment can be powerful, but it has limits. Overselling it does a disservice to clients and families. It is not a cure in the simple sense. It does not erase consequences. It does not guarantee that a person will never experience cravings or relapse. It does not automatically treat trauma, grief, loneliness, or mental illness. It also does not remove the need for daily recovery behavior.

What MAT may do, when appropriate, is reduce the pressure that makes early recovery feel impossible. It may help a person stay in treatment longer. It may lower the chance that a craving turns into immediate use. It may help the brain and body stabilize enough for therapy to become productive. It may give families a little more time to rebuild trust because the person is not constantly cycling through crisis.

A practical treatment conversation about MAT often includes several questions:

1. What substance use pattern, withdrawal risk, and craving level is the person experiencing?
2. Are there co-occurring mental health symptoms that need treatment at the same time?
3. What level of care is safest right now: detox, residential or inpatient, outpatient, or another placement?
4. How will therapy, family support, peer support, and recovery planning be integrated?
5. What monitoring and follow-up are needed to use medication safely and effectively?

These questions keep MAT where it belongs, inside a thoughtful care plan. They also prevent two common mistakes: treating medication as the whole solution, or rejecting it before the clinical picture is understood.

The role of mental health treatment alongside MAT

Recreate Ohio states that its facility offers primary mental health services in a residential treatment setting. That detail is important because many people seeking treatment for drug addiction are also dealing with depression, anxiety, trauma-related symptoms, mood instability, or severe stress. Sometimes the substance use came first and mental health symptoms followed. Sometimes the mental health struggle came first and substances became a form of self-medication. Often the timeline is tangled.

If co-occurring mental health concerns are not addressed, MAT may help cravings but leave the person vulnerable. For example, someone with untreated panic symptoms may stabilize from opioid withdrawal but still feel terrified in their own body. Someone with unresolved trauma may stop using but remain hypervigilant, sleepless, and reactive. Someone with depression may interpret early recovery as emptiness rather than healing. In each case, medication for addiction may be necessary but not sufficient.

Therapies such as CBT, DBT, and EMDR can help fill that gap. So can individual and group therapy. Group work has a particular value in addiction treatment because it interrupts isolation. People often believe they are uniquely damaged or uniquely deceptive or uniquely beyond help. Hearing another person describe the same thought pattern can soften shame. It can also challenge denial. A peer may say something in a group room that a therapist has said three times, and suddenly it lands.

Family and couples therapy add another layer. Addiction often trains families into crisis roles. One person becomes the rescuer. Another becomes the investigator. Another withdraws completely. When treatment focuses only on the individual, the home environment may remain unchanged. Family work can help create clearer boundaries, more honest communication, and a better understanding of what support should and should not look like.

Holistic supports are not a substitute, but they can strengthen recovery

Recreate Ohio 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. In a professional treatment setting, these services should not be confused with the core medical and clinical elements of addiction care. Yoga does not replace detox. Art therapy does not replace MAT when medication is clinically indicated. Nutrition education does not replace trauma therapy.

Still, holistic supports can matter more than people expect. Recovery is not only about stopping drug use. It is also about learning how to live in a body and a daily routine without relying on substances to regulate every discomfort. Many clients are disconnected from hunger cues, sleep rhythms, movement, creativity, and calm. Some have spent years in survival mode. A mindfulness practice may be the first time they notice a craving rise and fall without acting on it. Fitness or wellness activities may help restore energy and confidence. Art therapy may give shape to emotions that are difficult to explain in direct conversation.

The value is often cumulative rather than dramatic. A person sleeps slightly better after movement. They eat more regularly after nutrition education. They feel less trapped in their thoughts after mindfulness practice. They disclose something in individual therapy after first expressing it through art. None of those moments alone completes recovery, but together they can make treatment more humane and more sustainable.



For someone receiving MAT, holistic services can also support identity change. Instead of seeing themselves only as a patient taking medication, they begin to experience themselves as a person practicing recovery in multiple

ways. That distinction can be motivating. It expands the recovery story beyond symptom control.

Detox, residential treatment, and the risk of stopping too soon

One of the most common problems in drug addiction treatment is premature relief. A person enters detox in crisis. After several days, they feel better than they have felt in weeks. The nausea settles. Sleep improves. The panic drops. Family members hear a clearer voice on the phone and feel hopeful. The person begins thinking, "Maybe I do not need more treatment after all."

That moment is risky. Feeling better is not the same as being stable. Detox can clear the immediate physical crisis, but it does not automatically build relapse prevention skills, repair relationships, address trauma, or prepare someone for high-risk environments. For opioid addiction especially, reduced tolerance after a period without use can increase danger if the person returns to the same amount they used before treatment.

This is where a continuum of care becomes practical rather than theoretical. If detox leads into residential or inpatient rehab, the person has a chance to keep building. If residential care leads into outpatient treatment, the person has support while practicing recovery outside the facility. MAT can fit across these transitions, but the transitions themselves need planning.

A well-planned step-down process considers the person's living environment, family dynamics, access to transportation, work obligations, mental health symptoms, peer supports, and relapse history. Someone returning to a stable home with supportive relatives may need a different outpatient structure than someone returning to a lonely apartment near people they used with. Someone with repeated relapse after short treatment episodes may need a more intensive plan than someone entering care early in the course of addiction. Clinical judgment matters.

How families can think about MAT without fear or false hope

Families often want a clear answer: Is MAT good or bad? The better answer is that MAT is appropriate or not appropriate depending on the person, diagnosis, risks, goals, and clinical plan. It should be evaluated by qualified professionals and revisited over time.

It helps families to separate three concerns that often get mixed together. The first is safety: Is the medication being prescribed and monitored responsibly? The second is recovery engagement: Is the person participating in therapy, groups, planning, and behavioral change? The third is long-term direction: Is the care team regularly assessing what level of support is needed?

When those questions are addressed, families can move away from arguing about labels and toward observing function. Is the person showing up? Are they more honest? Are they learning to tolerate distress? Are they taking responsibility? Are they following the treatment plan? Are they building sober supports? Medication status alone does not answer those questions.

Families should also expect mixed emotions. Relief and skepticism can coexist. Trust may return slowly. A loved one may be doing real work in treatment while the family is still carrying memories of overdoses, disappearances, financial harm, or broken promises. Family therapy can help create space for both truths: the person in treatment deserves support, and the family's pain deserves recognition.

A realistic picture of integrated care at Recreate Ohio

Based on Recreate Ohio's described services, medication-assisted treatment is one part of a larger treatment environment. The facility's location in Gahanna places it just outside Columbus, and its services include detox, residential or inpatient rehab, and outpatient treatment. It describes a full continuum of care and may include MAT, evidence-based therapies, individual and group work, family and couples therapy, primary mental health services in residential treatment, and holistic supports.

That range matters because recovery needs more than a single intervention. A person may begin with detox because withdrawal is the immediate barrier. They may need residential care because their home environment or symptom severity makes outpatient care too fragile at first. They may need MAT because cravings and opioid dependence create a high risk of return to use. They may need DBT skills because anger or panic keeps blowing up relationships. They may need EMDR because trauma keeps pulling them out [alcoholism treatment](#) of the present. They may need family therapy because the people closest to them do not know how to help without losing themselves. They may need outpatient treatment because discharge is not the finish line.

The professional challenge is sequencing. Too much intensity for too long can feel restrictive and may not match the person's progress. Too little structure too soon can leave them exposed. Medication can be started, adjusted, continued, or reconsidered based on clinical need, but it should not float separately from the rest of the plan. It belongs in the same conversation as therapy attendance, mental health symptoms, relapse risk, family involvement, and daily functioning.

Recovery is built through coordinated support

Drug addiction treatment works best when it respects both biology and biography. Biology explains why withdrawal, craving, tolerance, and brain adaptation matter. Biography explains why this person used, what the substance did for them, what pain they carry, who they trust, what they fear, and what kind of life they are trying to build.

Medication-assisted treatment speaks strongly to the biological side, but at Recreate Ohio it fits within services that also address the personal, relational, and behavioral sides of recovery. That is the right frame. MAT may help a person get steady enough to do the deeper work. Detox may help them move safely through the first stage. Residential or inpatient rehab may provide structure and immersion. Outpatient treatment may support the return to daily life. Therapy may help change patterns that medication cannot touch. Holistic supports may help restore a sense of connection to the body, creativity, and routine.

No single service carries the whole weight. The value is in the combination, guided by assessment and adjusted as the person changes. For individuals and families facing opioid or co-occurring drug addiction, that integrated approach offers something more useful than a slogan. It offers a practical path: stabilize the body, engage the mind, involve the family when appropriate, treat mental health needs, build recovery skills, and continue care long enough for those changes to take root.