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"So When Will You Be Off It?" The Question a Family Can Afford to Drop

FAHU Research Desk

November 2026

facingaddictionwithhope.com

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"So When Will You Be Off It?" The Question a Family Can Afford to Drop

It is Sunday dinner, fourteen months in. Your son has held the same job since spring, he answers his phone, and he laughed at the table tonight the way he used to. You are proud of him, and you finally ask the question that has been sitting in you all year: "So how much longer do you have to be on that stuff?" He goes quiet. You meant it as encouragement. You heard it from people you trust, at a meeting, who told you a person isn't really clean until he is off everything.

The research on stopping buprenorphine or methadone associates the first weeks off medication with the sharpest rise in the risk of death, and, in a large study of US veterans, associates staying on medication with better survival for at least four years, far beyond a six-month or one-year finish line; a family's short deadline has no support in that evidence, and the kinder course is to drop the question and leave the timing of any taper to your loved one and the clinician who prescribes it.

The pressure to stop

Buprenorphine and methadone are prescribed, monitored medications for opioid use disorder. The doubt about them is widespread, and the research documents it in two places. Carroll and colleagues, researchers at North Carolina State University and partner institutions, ran what is sometimes called a secret-shopper study: trained callers posing as uninsured people who use heroin phoned every residential substance use program they could identify in the state (Carroll et al. 2024). Of the 66 programs they reached, only 7 offered this kind of medication on site, and staff at 33, half of them, made discouraging or stigmatizing remarks about it: that it substitutes one addiction for another, that it is not "true recovery." The picture is more mixed than a simple split between meetings and medicine. Programs that offered 12-step programming

were more likely to have the medication available, and the authors found it prohibited most often by unlicensed programs that imposed labor or 12-step mandates on residents. Their findings cover one state and the programs that answered.

That belief also reaches the people closest to someone in treatment. Brousseau and colleagues interviewed 52 people receiving methadone or buprenorphine, one on one at a rural and an urban treatment site, about what happened when they told others about their medication (Brousseau et al. 2022). The people they told included relatives, among them a mother and a daughter, and people on both medications met similar misinformed reactions. Some of those told urged participants to stop the medication early; one participant said of someone they had told, "She wants me to hurry up and get off of it." Participants described support that felt conditional, from people who "equated lower dosage with recovery progress." Some reported dropping out of support groups such as Narcotics Anonymous, or ending their medication early, after reactions like these. It is a small qualitative study: it describes what people experienced, not how often it happens.

This article will show what the research says about stopping: when risk rises, what happened to people who stopped after a long course, and how long staying on is associated with better survival. Then it will take on the strongest case for keeping a deadline. What turns on it for you is whether the question you have been asking has any support in the evidence.

When the risk rises

The largest picture comes from Santo and colleagues, an international team at the National Drug and Alcohol Research Centre in Sydney, who pooled 36 cohort studies covering 749,634 people with opioid dependence (Santo et al. 2021). The rate of death from any cause during treatment with methadone or buprenorphine was 0.47 times the rate during time out of treatment, that is, less than half. In the first four

weeks after treatment stopped, all-cause mortality was about six times higher (rate ratio 6.01), and it stayed about double for the rest of the time people were off treatment (rate ratio 1.81). These are associations from observational studies: they show when deaths cluster, not proof that stopping caused each one, and some of the people who stopped may already have been in trouble. Those are relative figures. For scale, in one large US veterans study discussed below, deaths after stopping ran at about 3 per 1,000 people per year (Hayes et al. 2026), so a sixfold rise is a rise in a risk that, for any one family, is far from certain.

"But he's been on it long enough"

A family can carry a private finish line: six months, a year. Williams and colleagues, psychiatrists and epidemiologists at Columbia and Rutgers, looked back through Medicaid claims records at adults who had already stayed on buprenorphine continuously for six to eighteen months and then stopped (Williams et al. 2020). In the six months after stopping, between 42 and 50 percent of them, depending on how long they had been treated, were seen in an emergency department, and about 5 percent had an overdose that needed medical care. Those treated for 15 to 18 months fared somewhat better than those who stopped after six to nine: about a quarter lower odds of an emergency visit (odds ratio 0.75) and a third lower odds of filling an opioid prescription (odds ratio 0.67). The study did not compare these people with others who stayed on treatment, so it cannot say how much of the risk stopping itself added. But the researchers' own conclusion was that the risk of acute care and overdose was high after stopping "irrespective of treatment duration." In this group, people who stopped after a respectable length of treatment still went on to high rates of emergency care and overdose.

How long staying on is associated with better survival

Hayes and colleagues, a team from the University of Arkansas for Medical Sciences, Columbia and the University of Cincinnati working

with Veterans Health Administration records, followed more than 32,000 veterans who started medication for opioid use disorder (most on buprenorphine or methadone, about 4,000 on extended-release naltrexone) and modeled how the chance of surviving six years, including the years after stopping, changed with how long people had been treated, adjusting for the patient characteristics the records could capture (Hayes et al. 2026). The largest gain from an extra year appeared to come around two years, compared with six months, and statistically significant gains continued through roughly four to five years. The authors concluded that the benefit of staying on treatment "continues through at least 4 years" and that six-month quality standards "may be insufficient." They are careful about the limits: the design cannot establish that more time on treatment causes better survival, factors such as motivation are not in the records, and they describe the findings as exploratory. Within those limits, the point where extra time stops showing a measurable gain sits years beyond a six-month or one-year mark.

What the research does not show

None of these studies measured what happens after a family asks "when will you be off it?" Brousseau's participants describe being urged to stop and, in some cases, stopping; the mortality studies describe what tends to follow stopping. Connecting the two is a judgement, not a finding. The honest claim is narrower: these studies associate the weeks after stopping with higher risk and longer treatment with better survival, and none of them offers a family a reason to set a short schedule. None of them compared fast and slow tapers, so nothing here says how a taper should be paced; that is a question for the prescriber.

The strongest case for keeping a deadline

The best argument on the other side has two parts, and both deserve to be heard in full.

The first is about values. Recovery, for many people, means being free: free of drugs, including the ones a clinic hands out. Your loved one may have said himself that he does not want to be on this forever. The meetings that helped your family may say the same thing, and Monico and colleagues, researchers at Friends Research Institute and the University of Maryland studying 300 African American patients receiving buprenorphine during a counseling trial, found that attending more Narcotics Anonymous meetings was associated with staying in treatment longer and with higher abstinence from heroin and cocaine over the first six months (Monico et al. 2015).

The second is about the evidence itself, and it is the stronger part. Hayes's own numbers show that after roughly four to five years, another year on medication no longer showed a statistically significant gain in survival. So, the argument runs, the research does point to a finish line; it is simply further away than a year. A family that says "four or five years, then let's talk about tapering" is following the data, not defying it. And every study here is observational, so some of the risk after stopping may belong to the people who stop rather than to stopping.

Much of that should be conceded. The data show association, not cause, and nothing in these six studies can rule out that part of the risk after stopping reflects who stops. A slow taper that a person chooses with their prescriber is a legitimate decision, and a horizon of several years is a reasonable thing for them to discuss. Monico's team found that meeting attendance was associated with better retention and abstinence, and that patients whose counselors required them to attend did no better than those who were not required; they advised clinicians to be aware of the potential philosophical conflict between 12-step approaches and medication.

But the plateau is weaker ground than it looks. Hayes and colleagues report that the levelling-off appeared for their lower-risk patients; for higher-risk groups they "did not observe a levelling," and the lack of a

significant difference beyond four years may partly reflect how few people stayed on treatment that long. A finish line drawn from that is not a finding that stopping at five years is safe; it is the edge of the data. And even taken at face value, it is a horizon of four years or more, nothing like the question asked at fourteen months. The decision about when, or whether, to taper belongs to the person taking the medication and the clinician who knows their case. A deadline set at the dinner table is what Brousseau's participants described as support that feels conditional. Your part is to stop supplying the clock.

Back at the table

Go back to Sunday dinner. Same son, same pride, a different question: "Is it helping? Is there anything you need from me?" If he does decide, with his prescriber, to taper, you will know what the research found: that the first weeks after stopping are when the risk has risen most sharply, a time to pay attention rather than to celebrate a finish line. You can be proud of him without a deadline, and dropping the deadline is the sane and morally defensible way to stand beside him.

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