This issue of *Psychiatric Annals*, guest edited by Norman S. Miller, MD, JD, PLLC, presents us with a major problem in medical practice. I remember a time when treatment for pain in medicine was withheld, but it seems that has now shifted, with a mandate for pain treatment in many settings. Aggressive therapy for pain has resulted in chronic prescribing of opioid medications.

Few psychiatrists prescribe opiates, however, and our specialty is not in pain management, despite the fact that we are seen as having expertise in treating psychic pain, stemming from depression, anxiety, psychosis, and a range of psychiatric disorders.

We are now witnessing rapidly increasing numbers of patients taking opiates over the past 20 years, a surge in overdose deaths, and an increase in opiate dependence. A related heroin epidemic is also skyrocketing. We see in the articles in this issue evidence that prolonged opiate use may actually increase chronic pain, leading to increased use and dependence disorders. Yet, the public has been led to believe that chronic opiate treatment will help long-lasting, nonmalignant pain, whereas the high addiction potential is played down.

The problem of the increasing prescribing of this medication is now overlapping with psychiatry because evidence shows that prolonged opiate treatment can induce depression and anxiety disorders. Overprescribing and the high addiction potential from long-term opiate treatment is not widely discussed. This leads to patients insisting on exercising their “right” to continue to receive opioid medications through a physician’s prescription.

What can we do, besides passively watching more patients become addicted to opiates or developing depression and anxiety disorders as a consequence? Psychiatrists should become experts in pain care, and earn a respected position on the care team, using both alternative medications to opiates and effective behavioral techniques for managing pain. The field has become accepted in consultation liaison medicine, which may make a contribution to pain management, but this area is massive enough for psychiatry to have its own specialty area in it.

To curve the rampant misuse of opioids, addiction, and overdose deaths, the medical community has to come clean with the populace. It has to be admitted that opiates are likely to make the situation worse when used for chronic, nonmalignant pain management, and that addiction and depression or anxiety disorders are likely outcomes. We need a team approach to pain management as well as outcome studies. This set of articles is important in bringing attention to this problem. I thank Dr. Miller and all of the contributors for confronting and defining this crisis.