As a Psychiatrist, Addiction Psychiatrist, Forensic Psychiatrist, and Attorney, I gained a comprehensive perspective of the problems associated with opioid prescription medications. As the editor and author of the issue, I attempted to provide clinical and research experience and a comprehensive review of the available medical and scientific literature to the questions regarding efficacy for prescribing opioid medications for chronic pain. And why is the current policy to prescribe these medications on demand fueled by patients?

This issue of *Psychiatric Annals* on prescription opioid medications answers the following questions: Why are opioid medications prescribed in large quantities and high frequency when there is little or no proven efficacy for their therapeutic value? Why are opioids the most commonly prescribed medication in the United States when their adverse consequences continue to grow and mount? Why does the medical profession continue to prescribe opioid medications that result in increased pain, psychiatric and medical disability, and even death?

The articles in this issue present the latest in published clinical information augmented by authors with extensive clinical experience in evaluating patients prescribed opioid medications. The focus of the articles is to provide a systematic approach to evidence-based evaluation of the efficacy of longer-term prescribing of opioid medications for chronic pain and the associated risks and benefits.

When the evidence is reviewed, there is minimal support for long-term prescribing of opioid medications. An extensive review of over 2,000 publications did not find evidence to justify opioid medication for chronic pain. In addition, there were few articles that researched addiction despite opioid medications’ highly addicting pharmacologic properties. In fact, opioid addiction explains why doctors prescribe and patients consume opioids continuously with substantial risks of psychiatric and medical adverse consequences—and without benefit.

The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (*DSM-5*) provides for a diagnostic scheme for the frequent occurrence of substance or opioid-induced psychiatric disorders titled “Substance/Medication-Induced Depressive Disorder and Substance/Medication-Induced Anxiety Disorder.” In *DSM-5* the exclusionary criteria require accounting for psychiatric effects of opioid medications, such as depression and anxiety and withdrawal, before making diagnoses of depressive and anxiety disorders.

The efficacy for prescribing opioid medications for chronic pain is not only limited by their highly addicting nature, but also by a paradoxical response—opioid-induced hyperalgesia. Surprisingly, opioids induce pain through increased pain sensitivity locally at the site of the lesions or diffusively at nonpathologic sites. Thus, efficacy is severely limited by mounting subjective pain induced by opioids.

The engine that drives continued opioid use is, according to *DSM-5*, “Addictive and Opioid Use Disorders.” Opioid medications are scheduled medications defined by the Controlled Substance Laws as highly dangerous and addicting. The commonly prescribed opioid medications are schedule II, which Dr. Thomas Frieden, Director of the Centers for Disease Control and Prevention, recommends prescribing for no longer than 3 days except in extreme, justified cases due to their highly addicting nature.

Importantly, opioid addiction with its adverse consequences including but not limited to pain, depression,
anxiety, disability, and death, occurs in any population of users, whether prescribed or not or taken as prescribed or not. The defining characteristic of opioid addiction is the continued use despite risks and adverse consequences and lack of benefit in ameliorating pain. There is no difference pharmacologically and clinically if taken as prescribed especially if the doctor increases the dose for the patient, or if the patient increases the dose outside of the prescribing relationship.

We have a continuing crisis in prescribing opioid medications for chronic pain. The ultimate source of the crisis in the highly addictive pharmacologic potential of the opioid, the ignorance of physicians, and the reluctance of medical schools to teach the pharmacology and behavioral properties of opioid addiction. In summary, the policy to prescribe opioid medications on demand to meet patient satisfaction is not only counterproductive but also harmful, costly, and lethal.

In my opinion, legal and educational reform are reasonable steps to resolve this crisis and reduce harmful consequences due to the poor efficacy for prescribing opioid medications for chronic pain. As a physician and attorney, I find both legal and educational approaches challenging given the uniformed and misguided public policy and limited effective laws to protect the public from opioid addictive disorders. Roots of the opioid crisis are the pervasive policy to meet the public demand for addicting substances and the continued orphan status of addictive disease in medical education and clinical practice.

REFERENCE


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