Overmedicalisation of young people's distress is undermining and disempowering families

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In today's society, cases of mild or transient distress in young people are increasingly viewed as problems that require medical intervention. As CAMHS clinicians, we argue that this overmedicalisation undermines the value of social support within the family and community, and funding cuts to non-medical support services have only compounded the problem.

In the past five years, referrals to child and adolescent mental health services (CAMHS) in England have more than doubled, partly due to the increase in rates of mental health problems in this population[1,2]. There are many young people who need better access to medical services and support. However, we argue here that an additional contributing factor to increased referrals is *overmedicalisation*, the process by which some problems are inappropriately considered to be illnesses that require medical diagnoses and treatment[3]. In other words, we argue that some young people's emotional and behavioural difficulties are now too readily being viewed as problems that require (and only require) medical intervention, typically in the form of assessment and one-to-one treatment from a mental health professional. We write as a CAMHS consultant psychiatrist (EF), CAMHS principal family therapist (SRP) and academic psychologist (LF). In this Comment, we outline potential consequences of this overmedicalisation, drawing on fictionalised case studies based on our (EF, SRP) clinical observations. We end by considering how to reduce the overmedicalisation of young people's distress.

Consequences of overmedicalisation

Consider the case of B, a 15-year-old girl who went to see her GP because she was very anxious after being bullied by her peers and no longer wanted to attend school. The GP referred her to CAMHS, where her parents were given advice and recommendations of

parenting information to read, and B was placed on a waiting list for therapy. Ten months later, when an appointment was available, the clinician contacted the family. The parents said that the school had successfully intervened with the bullying and their daughter now talked to them more at home. They said B's mood and peer relationships had improved, she was attending school, and they did not need the services further.

B's case highlights a number of issues. First, while many children and adolescents have mental health problems that follow a chronic or recurrent course[4], some will experience distress and recover or significantly improve with support that does not involve medical intervention[5]. In these cases of transient, temporary distress, we believe that overmedicalisation can disempower teachers and parents because it makes them feel less able to provide the non-medical social support to young people that could really help. Qualitative research has repeatedly indicated that school staff feel inadequately trained to identify and support young people with mental health problems, and that they are concerned about missing cases of significant distress and disorder[6]. Referrals to CAMHS and other mental health services are entirely understandable, given the well-publicised increase in mental health problems in young people and the resultant climate of fear and anxiety around this population's mental health[2,7]. However, a side effect is that, even for less severe problems, teachers and other staff request input from external professionals[8]. We are concerned that unnecessary referrals can lead some young people to languish on waiting lists instead of receiving the social support at school and home that would truly benefit them.

Second, B's case highlights how overmedicalising can unfairly locate the problem within the young person. Sometimes, young people are distressed because they are experiencing significant challenges or adversity in their lives, such as food poverty, domestic abuse or bullying. If a young person presents with internalising or externalising symptoms and the problem is assumed to be dysfunction within the individual, adults can overlook environmental adjustments that might help (e.g. antibullying interventions). This could feasibly add to the young person's distress: for example, a recent school-based CBT intervention for anxiety led to an *increase* in anxiety, but only for children eligible for free school meals, perhaps because the source of their anxiety was not amenable to change from child-led CBT exercises.[9] When adults and systems overmedicalise distress, they are less able to engage with a more holistic, systemic approach, and this can ultimately be unhelpful for the young person and their family.

We are concerned that overmedicalising is not only unhelpful, but can actively contribute to further distress. Consider the case of J, a 16-year-old boy who was distressed following a break up with a girlfriend. The night after the break up, J self-harmed by superficially cutting his arms, and his mother called 111 (the NHS's non-emergency helpline). On their advice, they went to A&E in the early hours of the morning, where they waited five hours to be seen. J did not need any physical care and was not found to have a mental health problem. They were discharged home with advice on how to increase their communication with each other and a safety plan about how to manage distress in the future. The experience of spending the night in A&E was frightening and upsetting for both J and his mother, highlighting that systems and individuals can cause harm by overreacting to a young person's distress, just as they can by underreacting to it. For cases of milder, transient

distress or superficial self-harm, such as in J's case, containing and navigating these difficulties within a supportive home or school environment might be more beneficial for everyone.

How to reduce overmedicalising of young people's distress

To reduce overmedicalising, we advocate for a shift in the public narrative to make clear that some emotional and behavioural difficulties in young people are transient, and need not be treated or labelled as a mental health problem. Public mental health awareness campaigns have had an unfortunate side effect: even mild cases of anxiety and low mood are now viewed as problems that require professional intervention. This cultural shift has been termed 'psychiatrisation'[10]. In today's society, it seems as though a young person's distress is only valid if it is defined in psychiatric language and treated as a medical problem. As clinicians (EF and SRP), we have both assessed young people and their families who are disappointed, upset or angry when they do not meet criteria for a mental disorder. This is understandable, since such diagnoses offer a framework for people to understand their difficulties and are often a requirement for accessing certain support (e.g. within schools). However, being told that you do not have a mental disorder should be considered a good thing. We can only achieve this if there is a significant shift of the public narrative to reduce unnecessary psychiatrisation, and if people can still access meaningful support without needing a diagnosis (whether that is social support at home or in the community, adjustments at school, or treatment within the NHS).

Our second suggestion is that, within services and in society at large, we should value and support parents more. For example, we should offer parenting support to new families via

open-access family hubs, parenting classes in schools, support via home school link workers, and early help services in social care and youth groups. Today, the job of raising children is squeezed, undervalued and under-recognised. Funding for community support services in England have been cut, despite the significant positive impact of such services[11], and parents often do not have an extended network (e.g. grandparents) to provide emotional and practical support. In addition, the considerable volume of advice now available to parents via books, television and the internet can give the impression that there is only one 'right' way to raise children, making it harder for parents to trust themselves and their knowledge of their child. We therefore advocate for more funding for non-medical early intervention and support services in the community where families can access practical support, build confidence and develop peer relationships.

Empowering families and communities

Increased awareness of young people's mental health problems has been beneficial in many ways, and there are still many young people who need better access to medical interventions. However, it is also vital that individuals and systems do not unnecessarily medicalise all instances of distress. Relying only on mental health services undervalues parents and undermines all adults' capacity to help. We need more funding for services such as community support workers, family hubs, health visitors and school nurses. In society at large, alongside raising awareness about mental health problems, we must promote and value parents and systemic, non-medical solutions to young people's distress.

Author contribution statement

All authors contributed equally to the writing (conceptualising, drafting, editing) of this manuscript. All authors saw and approved the final version of the manuscript.

Competing interests

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