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Current status and challenges of peer support for young people who engage in over-the-counter medicine overdose in Japan: Practice-oriented perspectives

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Abstract: Over-the-counter (OTC) medicine overdose among adolescents and young adults is an increasingly visible concern in Japan, intersecting with suicide prevention priorities and unmet psychosocial needs. In this article, we share frontline perspectives from a semi-structured group interview with five peer supporters (women in their 20s–30s) who provide street outreach, social networking service (SNS) consultation, and drop-in place-making for young people, including those who overdose on OTC medicines. Using an inductive, data-driven thematic approach to organize participants' accounts, we highlight practice-relevant insights: *i*) an ecology shaped by offline isolation, SNS normalization, and easy access to OTC products; *ii*) low-threshold, non-judgmental engagement as a first door to care grounded in peer support principles; and *iii*) fragility and safety risks as complexity escalates, underscoring the need for structured professional backup, supervision, explicit escalation criteria, and reliable referral and crisis pathways.

***Keywords*:** outreach, social networking service (SNS), help-seeking, suicide prevention, recovery-oriented practice, negative capability

1. Introduction

Suicide prevention among adolescents and young adults remains a major public health priority in Japan (*1,2*). In parallel, over-the-counter (OTC) medicine overdose has become more visible in emergency departments and community settings as a form of distress that often does not connect readily to formal services. This pattern matters because OTC overdose may function as both a gateway to repeated self-harm and a signal of unmet support needs. In practice, many young people avoid the language of "consultation" or "support", meaning that service models that primarily wait for clinic-based help-seeking can miss those at highest risk.

National data suggest that OTC misuse and overdose is not a marginal phenomenon. A national general population survey estimated that 0.75% of respondents (approximately 650,000 people) had engaged in OTC medicine misuse/abuse in the previous year (*3*). Recent clinical work in Japan also describes an emerging profile of OTC overdose among emergency patients, reinforcing the need for prevention-oriented responses beyond acute care (*4*).

OTC products implicated in misuse in Japan span multiple categories, including antitussive/expectorant medicines (cough suppressants), combination cold remedies, antipyretic analgesics, sedatives, anti-allergy medicines (antihistamines), and caffeine products (*5*). These categories matter clinically because they are widely available, can be purchased repeatedly across retailers, and can be concealed as everyday "cold medicines", even when used for mood modulation or self-harm-related purposes. At the same time, overdose carries risks including acute toxicity, dependence-related patterns, and disinhibition, potentially amplifying further self-harm and other high-risk behaviors (*4,5*).

Online environments can further shape this ecology. Exposure to and active searching for self-harm and suicide-related information on the internet are common among young adults and are associated with individual and contextual factors (*6*). In participants' accounts, social networking service (SNS) spaces served as both an information source (*e.g.*, dosing practices) and a social context that can normalize overdose-related behaviors, while also being a channel through which outreach and consultation can reach young people who would not approach clinics, schools, or public offices.

2. Frontline perspectives from peer supporters

Peer support refers to mutual, person-centered support grounded in lived experience and an egalitarian

relationship, emphasizing hope, empowerment, and connection (*7,8*). In youth settings, peer supporters may operate as a low-threshold "first door", particularly when stigma or fear of being judged prevents formal help-seeking.

We conducted a semi-structured group interview in August 2025 with five peer supporters in Japan to examine how they engage with young people who use OTC medicines for overdose, as well as the challenges encountered and support needs arising in practice. Participants were all women (mean age: 28.2 years, SD = 2.59) and had experience supporting young people who overdose on OTC medicines (mean peer-support experience: 6.8 years, SD = 3.89). The interview lasted 81 minutes and was audio-recorded, transcribed verbatim, and organized using an inductive, data-driven thematic approach (*9*). The study was approved by the Ethics Review Committee of the Faculty of Nursing and Nutrition, Shukutoku University (approval number: N25-01R1). All participants provided written informed consent. Reporting was informed by the COREQ checklist (*10*). Consistent with editorial guidance, we present these findings as practice-oriented perspectives: we extract actionable insights from participants' accounts rather than claiming transferable empirical qualitative findings.

Why focus on peer supporters' perspectives? In emerging problem areas such as OTC overdose, frontline peer workers often detect patterns earlier than formal systems because they are approached in everyday settings and online spaces. Their work is neither "clinical treatment" nor casual friendship; it is a deliberate relational practice that aims to preserve autonomy while increasing safety, and it requires its own competencies (boundary-setting, risk recognition, and linkage skills) as well as organizational support (supervision and escalation pathways). Yet these practice details and limits are often under-described in the academic literature, especially in Japan. We therefore highlight what peer supporters say they can do well, where peer work becomes fragile, and what professional backup is needed for safety and sustainability.

3. Key practice-relevant insights

Table 1 provides an overview of the full set of themes and illustrative excerpts; in the main text, we foreground four practice-relevant insights that are most actionable for research, practice, and policy.

3.1. Low-threshold engagement as a first door

Participants consistently emphasized relationship-first engagement. Many young people who overdose did not initially seek "help" in formal terms, and some actively avoided services due to fear of reprimand, labeling, or loss of autonomy. Peers therefore deliberately lowered hierarchy through everyday language, careful attention to appearance and communication style, and avoidance of evaluative words. Being with the person over time—without forcing disclosure—was described as creating psychological safety, enabling gradual self-disclosure, and easing isolation. Once a young person felt "not judged", conversations could expand from overdose episodes to underlying stressors (*e.g.*, family conflict, school refusal, economic insecurity), making it easier to introduce options such as medical consultation or welfare support without triggering withdrawal. This relational function—connection as an intervention—reflects foundational principles of peer support (*7,8*).

3.2. Fragility when complexity and risk escalate

Peer supporters also described clear limits. When trauma, severe mental illness, developmental characteristics, or complex family adversity accumulated, engagement could become unstable and risk could rise quickly. Participants noted that interactions with authority figures may reactivate traumatic dynamics, and that system barriers sometimes narrowed safe options—for example, refusals by facilities once self-harm or overdose was disclosed. They also described emotional strain when meaningful change was slow and choices were limited, leaving peers with a sense that "waiting" might be the only possible action. These accounts underscore that peer support, while powerful relationally, is not a substitute for clinical care in high-risk contexts.

3.3. Safety work: Boundaries, triage, and supervision

To work safely, participants stressed knowledge of youth mental health and available systems, alongside practical skills: non-judgmental listening, boundary awareness, and knowing when to encourage professional assessment. They highlighted the need for shared team rules for triage and crisis response, rather than relying on individual judgment. In practice terms, this includes agreed-upon thresholds for escalation (*e.g.*, signs of acute intoxication, rapidly intensifying suicidal ideation, or repeated overdose), who to contact, and how risk information is documented and shared. Organizational practices—regular check-ins, debriefing, shared case tracking, and explicit permission to step back—were described as essential to prevent burnout, particularly given exposure to self-harm narratives and abusive online communication.

3.4. Professional backup for safe and sustainable peer work

Participants valued collaboration with healthcare and public health professionals and emphasized that peer support can remain an approachable entry point only when risk assessment and timely linkage to appropriate

Table 1. Overview of themes, subthemes, and illustrative excerpts from peer supporters' accounts

Theme	Subtheme	Illustrative excerpts
Theme 1: Ecology of OTC overdose among young people	Loneliness and lack of belonging	• There is an underlying feeling of loneliness. • They have no place to belong at school or within their family and cannot consult anyone. • If they are overdosing, they do not want people in their real-life relationships to find out.
	Social media facilitation of OTC overdose	• They obtain information from overdose posts on social media, which lowers the barrier to using. • They are influenced — or even encouraged — by people they admire on social media. • Media and social media portrayals can make overdose seem "fashionable".
	Ease of access to OTC medicines	• Unlike alcohol, tobacco, or illicit drugs, OTC medicines have few age restrictions or legal barriers, making it easy to start. • Some cannot go to hospital (*e.g.*, due to lack of parental support) and therefore turn to OTC medicines. • Because they are household medicines (*e.g.*, cold remedies), use can be easily concealed from caregivers.
	Escalation and high-risk behaviors	• They cannot stop overdosing; problems remain unresolved and the behaviour escalates. • They may start with OTC medicines, then collect prescription drugs and take them all at once. • When their memory is impaired by drugs, they may self-harm or jump impulsively.
	Perceived "benefits" of misuse	• They can temporarily forget painful feelings. • For better or worse, they feel more able to act — even to do things they usually cannot.
Theme 2: Low-threshold engagement through egalitarian relationships	Alleviating isolation and fostering a sense of safety	• By continuing simply to be with them, they gradually began to talk about themselves. • Even if nothing can be done immediately, they stay connected in a thin but lasting way. • Some say, "My desire to die might have lessened a little".
	Egalitarian relationship like friends	• They adjust their appearance (make-up, nails) to match the young person. • Depending on the person, they speak casually (not formally). • They approach naturally while imagining the other person's standpoint.
	Natural engagement that avoids "support" framing	• They avoid high-threshold words such as "consultation" or "support". • They frame it as everyday conversation — "Let's talk a bit". • They do not force talk about misuse; they stay with the person as a place to belong. • A sense of growing together through support.
Theme 3: Fragile points and limits of peer support	Complexity of intertwined needs	• Family environment, mental illness, developmental disorders, and other factors are intertwined. • Some have suicidal ideation and complex feelings, such as overdosing intentionally to be hospitalised. • Listening can trigger flashbacks of past verbal or physical abuse.
	Barriers to collaboration with families and social resources	• If there is overdose or self-harm, some facilities refuse admission. • Parents are also confused and struggle with how to respond.
	Prolonged support and a sense of helplessness	• When there is nothing to do, all they can do is wait. • They regret that the young person could not stay in a safer place with more supportive connections.
Theme 4: Knowledge and skills required for safe practice	Need for professional knowledge	• Basic knowledge is needed (mental illness, developmental disorders, and available welfare systems). • Sometimes we feel that knowledge of counseling and other areas is necessary.
	Interpersonal helping skills	• Most important is to listen without denying or judging (active listening). • They try to maintain appropriate distance and boundaries.
Theme 5: Psychological burden and coping among peer supporters	Risk of burnout	• Witnessing self-harm or suicide attempts is mentally distressing. • They may be exposed to verbal abuse and harsh words.

Table 1. Overview of themes, subthemes, and illustrative excerpts from peer supporters' accounts (continued)

Theme	Subtheme	Illustrative excerpts
	Team support and self-care	• Staff check in with each other ("Are you okay?"), share information, and do not carry cases alone. • They intentionally create time away from work.
Theme 6: Professional backup and collaboration as a safety net	Improving support quality through collaboration	• It was helpful to join hospital case conferences and discuss post-discharge life together. • Professional advice from public health nurses is very helpful.
	Service users' needs for professional involvement	• Many girls seem to want to speak with a female nurse. • They may want not only peers but also professionals to listen.

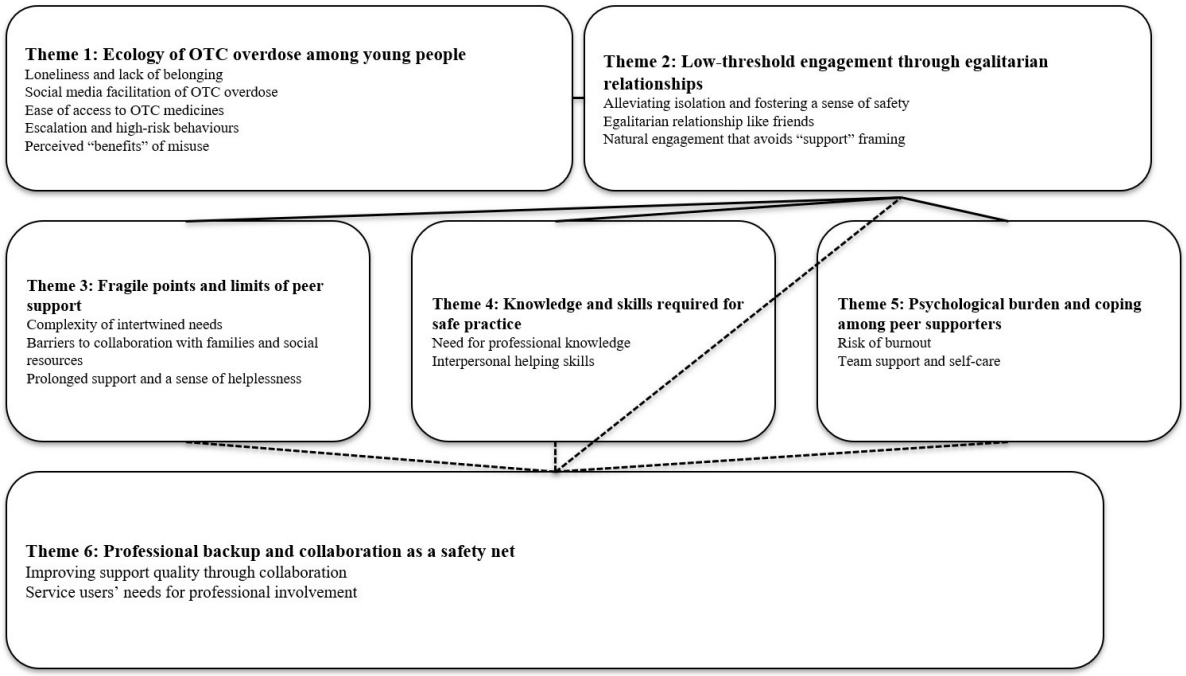

Figure 1. Inductively derived conceptual diagram of peer support for young people who overdose on over-the-counter (OTC) medicines. Solid arrows indicate the thematic pathway described by participants, from the ecology of OTC overdose (Theme 1) to low-threshold peer engagement (Theme 2) and the points where peer work becomes fragile (Themes 3–5). Dashed arrows indicate professional backup and collaboration (Theme 6) as a safety net that supports peer work across themes by enabling real-time crisis consultation, supervision, and concrete referral pathways.

services are feasible. They identified concrete needs for practice, including access to real-time crisis consultation, supervision, and reliable referral pathways that remain available even after overdose or self-harm is disclosed. We summarize the relationships among these insights in an inductively derived conceptual diagram (Figure 1), intended as a descriptive aid rather than a formal theoretical model.

4. Implications and call to action

OTC overdose among young people should not be framed as a medication issue alone. Easy access intersects with offline isolation and the pull of SNS communities that provide validation and practical know-how (*4,5*). This helps explain why models that primarily wait for clinic-based help-seeking may miss those at highest risk, and why outreach and SNS-based peer contact can function as a first door. For practitioners, the priority is to embed peer support within integrated support systems, so that relational engagement is paired with safety infrastructure.

For peer supporters, the practical challenge is to stay engaged without over-involvement and burnout. When uncertainty cannot be resolved quickly, peers may need the capacity to remain with not-knowing without rushing to premature solutions — Bion's stance of listening "without memory or desire", that is, an open stance that brackets prior assumptions and immediate solutions while staying with what emerges in the moment (*i.e.*, negative capability) (*11*) — while maintaining clear boundaries. Programs should

position peer support as a hub within an integrated network, with explicit escalation criteria, supervision, and reliable referral and crisis pathways so that peers can preserve the relational strengths of companionship while ensuring timely linkage to professional services when risk rises.

In practical terms, integrated support means that peer programs have named clinical and public health counterparts who can: (a) provide same-day consultation during crises, (b) accept referrals without excluding young people solely because overdose has occurred, and (c) co-develop shared plans for aftercare and relapse prevention. For policymakers and system leaders, actionable steps include strengthening low-threshold entry points (street outreach and SNS consultation), clarifying responsibilities and information-sharing rules across agencies, and supporting workforce sustainability through funded supervision structures. For researchers, the accounts reported here support implementation-focused studies that evaluate how professional backup, referral agreements, and escalation protocols affect outcomes such as linkage to care, repeat overdose, and peer supporters' wellbeing.

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