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A Narrative Review on Overservicing in Mental Health: Definitions, Risks, and Implications for Recovery

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Overservicing, Overtreatment, Mental health recovery, Psychiatry, Social work

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ABSTRACT

Overservicing refers to the provision of mental health services that exceed what is clinically indicated within a shared treatment plan. Such practices may undermine autonomy, reduce treatment accountability, distort power dynamics, and impede recovery. Conversely, underservicing can also produce significant countertherapeutic effects, contributing to unmet needs and poorer outcomes. This article examines overservicing in mental health care, clarifies its conceptual boundaries, and analyses its implications for recovery-oriented practice. A narrative review approach was used, drawing on peer-reviewed literature and established clinical guidelines to synthesise current evidence on overservicing, related constructs, and their impacts. Conceptual analysis was applied to distinguish overservicing from overdiagnosis, overtreatment, excessive referral, and fraudulent practices. Overservicing contributes to dependency, inflates healthcare costs, and disrupts recovery processes. Evidence highlights the importance of clinician self-awareness, clear communication, and comprehensive biopsychosocial assessment in preventing unnecessary or excessive interventions. Strengthening health literacy and ensuring adherence to evidence-based, person-centred treatment planning are key strategies for reducing both over- and underservicing. Overservicing is a significant barrier to recovery-oriented mental health care. Clinicians, particularly social workers, play a central role in mitigating this risk through thorough assessment, collaborative treatment planning, and consistent application of clinical guidelines. Although overservicing is widely discussed in health economics, it remains underexamined within mental health service delivery. This article offers an operational definition tailored to mental health contexts and proposes practical, evidence-informed strategies to prevent both overservicing and underservicing.

Introduction

Overservicing in mental health is a complex and context-dependent phenomenon, shaped by intertwined technical, legal, ethical, and professional considerations (Davies and Salisbury, 2025). Because clinical presentations vary widely and recovery needs differ across individuals, determining what constitutes appropriate, insufficient, or excessive care is not always straightforward. As a result, overservicing cannot be judged uniformly; decisions about whether care exceeds what is clinically indicated often rely on nuanced clinical reasoning and shared treatment planning.

In mental health settings, overservicing may manifest through

excessive therapy sessions, unnecessary psychological tests, overprescribing medication, providing more psychosocial support than required, or making referrals that do not align with a person's treatment goals (Thombs et al., 2019a). In this sense, overservicing refers to any intervention that extends beyond established treatment protocols or exceeds what is reasonably required to support recovery. Although the term is sometimes used interchangeably with concepts such as overdiagnosis, overtreatment, or overmedication, these constructs represent related but distinct forms of excessive care.

Overdiagnosis occurs when an individual is assigned a diagnosis that would not have caused harm or contributed meaningfully to their recovery (Nielsen, 2025). This risk is heightened in mental health, where assessments rely heavily on self-reported symptoms and where diagnostic boundaries are often ambiguous. Overtreatment, by contrast, involves interventions that exceed clinical necessity or fail to align with a person's contextual recovery needs. Mental health care also faces the paradox of both under-recognition of mild symptoms and simultaneous tendencies toward overtreatment and over-medicalisation. These patterns are influenced by broader systemic forces, including pharmaceutical industry interests and the expansion of diagnostic categories that may encourage increased service use (Barbour et al., 2013).

Together, these dynamics illustrate why overservicing requires careful conceptualisation: while it shares features with overdiagnosis and overtreatment, it encompasses a broader set of practices that can undermine autonomy, distort recovery trajectories, and misallocate limited mental health resources.

This article examines overservicing from a clinician's perspective, illustrating how mental health practitioners, through frequent and ongoing contact with service users, may knowingly or unknowingly provide care that exceeds what is clinically required. This perspective highlights the complexity and situational nature of mental health service delivery, where decisions about treatment intensity, referrals, and support levels must be continually balanced against individual recovery needs.

The discussion is informed by practice-based insights from work within an adult acute community mental health team at Grampians Health Area Mental Health and Wellbeing Services (GHAMHWS), a public mental health provider in the Grampians region of western Victoria, Australia. Within this multidisciplinary, case-management model, clinicians deliver community-based clinical and psychosocial services to adults aged 25–65 years residing in the Grampians Health Ballarat catchment. Ballarat, a major regional centre in Victoria, provides a representative context for exploring how overservicing may emerge in routine mental health practice. The examples presented throughout this article draw on observed patterns within community mental health service delivery and are used to illustrate how overservicing can manifest in everyday clinical processes. These examples are not intended as generalisations but as practice-informed illustrations that complement the broader literature and support the conceptual analysis developed in this paper.

Causes of overservicing in mental health

A growing body of research suggests that the mental health sector is increasingly medicalised, characterised by frequent referrals to specialised treatment even for mild symptoms and a tendency to rely on pharmaceutical interventions as the primary response (Ortiz-Lobo et al., 2011). Although diagnostic and treatment guidelines are designed to promote clarity and consistency, major classification frameworks such as the DSM-5 have been criticised for being influenced by experts with financial ties to industries that benefit from expanding diagnostic categories (Cosgrove and Krimsky, 2012). Within this context, mental health clinicians, who maintain direct, ongoing therapeutic relationships with service users, play a critical role in recognising and mitigating practices that may constitute overservicing.

Kale and Korenstein (2018) identified several systemic drivers of overservicing, including increased reliance on advanced diagnostic technologies, financial incentives for clinicians, a medical culture that favours more testing and treatment, broadened disease definitions, limited evidence supporting certain diagnostic practices, and low awareness among both clinicians and patients. Confusion around medical terminology further compounds these challenges. Similarly, Merten et al. (2017) observed that clinicians often depend on heuristics rather than evidence-based assessment, may receive incomplete or inaccurate information from caregivers, and face organisational pressures such as the need to assign diagnoses for reimbursement. Ambiguities within major diagnostic systems intensify these risks, contributing to inconsistent decision-making and unnecessary interventions.

Although overservicing in mental health care is widely assumed to be common, it remains poorly defined, underscoring the need for systematic research to clarify its boundaries and implications (Thombs et al., 2019a). While overservicing is frequently discussed in relation to physical health conditions such as thyroid disorders, cancer, chronic kidney disease, and respiratory illnesses, Kale and Korenstein (2018) emphasise that similar patterns occur in mental health treatment for conditions including depression, autism, ADHD, and psychosis. These parallels highlight the importance of examining overservicing within mental health settings, where diagnostic uncertainty, systemic pressures, and expanding treatment options create unique vulnerabilities.

Examples of overservicing

Overdiagnoses

Overdiagnosis, misdiagnosis, and inconsistent diagnosis can cause significant psychological, behavioural, financial, and health-related harm. These diagnostic errors are major contributors to overtreatment in the mental health sector, leading to potential medication toxicity, psychological distress, financial strain, and in severe cases, death from adverse side effects (Kale and Korenstein, 2018). Overdiagnosis can also generate unnecessary anxiety, feelings of worthlessness and hopelessness, and increased suicide risk, with some deaths linked to complications

from overtreatment (Singh et al., 2018). Recent data show that autism diagnoses in Australia are among the highest globally, with 290,900 Australians (1.1%) diagnosed in 2022, a 41.8% increase from 205,200 (0.8%) in 2018, and a rate in children that is more than 450% higher than in 2015 (Australian Bureau of Statistics, 2024).

Long inpatient psychiatric admission

Frequent or prolonged psychiatric inpatient stays can intensify anxiety and depressive symptoms, negatively affecting patients' psychological well-being (Alzahrani, 2021). In line with the MHWA 2022, services should prioritise the least restrictive treatment options within patients' local communities (Bhusal, 2025a). Repeated or extended admissions can be counter-therapeutic, disrupting social functioning and placing unnecessary strain on hospital resources.

Frequency of treatment sessions

A study found that low session frequency early in treatment is associated with poorer outcomes and a more chronic symptom course; however, session intensity should gradually decrease to support patients' independence and resilience (Tiemens et al., 2019). Providing excessive support can limit individuals' ability to manage stress autonomously, undermining their dignity of risk. Another common issue is scheduling a fixed number of sessions in advance without ongoing progress monitoring, a practice that increases dependency and drives up healthcare costs. Ultimately, such approaches foster reliance on therapy and reduce opportunities for self-management.

Too many screenings and tests

Unnecessary psychological examinations or diagnostic tests can increase both stress and costs. For instance, a client with clear symptoms of generalized anxiety disorder or a recent diagnosis may not require repeated comprehensive assessments such as the Rorschach test. These evaluations add little clinical value while increasing financial burden and emotional strain. Repeatedly recounting personal experiences can also be re-traumatizing, particularly for individuals with significant stress or trauma histories. Such duplication fosters frustration and distrust, delaying appropriate support and worsening distress. Streamlining intake procedures and improving information-sharing between teams is essential to reduce client burden and enhance their overall care experience.

Overprescribing medications

Prescribing medications beyond what is clinically necessary can contribute to overservicing (Aasan et al., 2022). For instance, a client with mild depression or anxiety may be given multiple antidepressants or anxiolytics without first considering non-pharmacological options such as Cognitive Behavioural Therapy or lifestyle modifications. Similarly, if a client experiences weight gain from Olanzapine and is immediately prescribed Metformin to manage this side effect, rather than initially exploring behavioural changes, it can foster medication dependency, introduce avoidable side effects, increase healthcare costs, and diminish quality of life. These patterns reflect overmedication, which is sometimes linked to countertransference dynamics (Aasan et al., 2022).

Too many referrals

Connecting clients to multiple specialists without clear justification can also lead to overservicing. For example, a client presenting with social isolation due to social anxiety and depression could be effectively treated by a Cognitive Behavioural Therapist. However, if I refer her to a psychologist, general practitioner, dietitian, supported group programs, and a peer support worker, it can lead to confusion, increased healthcare costs, and fragmented care. The client is likely to receive conflicting advice from multiple specialists, exacerbating her anxiety and feeling of being overwhelmed.

Vouchers and coupons

Based on my experience, offering unnecessary vouchers, coupons, and gift cards to assist clients with psychosocial hardships can be countertherapeutic and lead to dependency, as it can lead to over-expectation and false hopes, inadvertently creating dependency rather than fostering self-sufficiency. For instance, if a client experiencing homelessness presents to me and, without completing a social work assessment to explore her existing resources, social networks, and possible support from family or friends, I offer her crisis accommodation, I may overlook her strengths and potential support.

False billing

Engaging in fraudulent billing and overcharging is a severe form of overservicing. For example, on 9 March 2024, 9 News reported that a disability service provider was allegedly caught billing $1 million in fraudulent NDIS claims in a single month, and another service provider used 50 separate ABNs to charge for fake services (9News, 2024). Documenting more billable time than the actual amount of time the clinician was engaged with the individual with mental illness is also an example of false billing. Such practices not only exploit the system and clients but also significantly erode trust in the healthcare system.

Overservicing is countertherapeutic

Overservicing has the potential to diminish service users' independence and resilience, which may contribute to increased reliance on services over time. Rather than promoting empowerment, excessive or unnecessary interventions can add to psychological distress, inflate healthcare costs, and divert limited mental health resources (Thombs et al., 2019a). While excessive service provision does not inherently prevent recovery, clinical observations suggest that individuals who receive more support than is clinically indicated may be more likely to re-engage with services, potentially affecting their confidence in managing daily life and maintaining social roles.

Overservicing may also conflict with core principles of recovery-oriented practice, particularly those emphasising autonomy, dignity of risk, and person-centred decision-making. By weakening opportunities for self-efficacy and resilience-building, overservicing can hinder progress toward recovery goals and

may inadvertently limit individuals' sense of agency and human rights. Practice-based experiences indicate that when services exceed what is necessary, some individuals may experience reduced confidence, diminished self-esteem, or a sense of dependency on the mental health system. In some cases, this pattern may contribute to a form of service-based institutionalisation, where individuals struggle to navigate community life without ongoing professional involvement. Although more empirical research is needed to fully understand these dynamics, existing literature and clinical experience together suggest that overservicing can impede opportunities for developing coping strategies, strengthening community connections, and fostering long-term resilience. In this way, overservicing risks patronising rather than empowering service users, potentially limiting their autonomy and capacity for self-directed recovery.

Abandonment and underservicing

Abandonment refers to the psychological and emotional distress that arises from the actual or perceived experience of loss, rejection, or neglect (Lovelace et al., 2018). Such experiences can contribute to what has been described as abandonment trauma, characterised by feelings of worthlessness, being unwanted, hopelessness, and a belief that one is unsupported (Bowker, 2016). These emotional states may intensify symptoms such as anxiety, interpersonal difficulties, low self-esteem, emotional numbness, and, in severe cases, self-harm or suicidal behaviour (Kale and Korenstein, 2018). Although these reactions vary across individuals, they illustrate how insufficient or inconsistent care can undermine psychological safety and stability.

Underservicing is defined as the provision of inadequate or insufficient mental health support. It can produce consequences that are as detrimental as those associated with overservicing. When individuals do not receive the level of care required to address their mental health needs, symptoms may remain untreated or worsen, leading to reduced quality of life and increased distress. Instances of abandonment and underservicing often reflect systemic shortcomings and may constitute breaches of duty of care or professional responsibility (Mapukata, 2019) These failures can erode therapeutic rapport, weaken trust in services, and strain the moral contract between mental health professionals and the communities they serve (Wallström et al., 2021). Therefore, while emphasizing on overservicing, mental health service providers must pay equal attention to prevent abandonment and underservicing.

From a recovery-oriented perspective, both overservicing and underservicing represent deviations from person-centred, collaborative, and autonomy-enhancing practice. Overservicing may limit opportunities for self-efficacy and resilience-building, while underservicing may leave individuals without the support necessary to pursue recovery goals. Although the mechanisms differ, both forms of service imbalance can impede progress by disrupting continuity of care, diminishing agency, and constraining individuals' ability to participate meaningfully in their own recovery. Therefore, while it is important to recognise the risks associated with overservicing, equal attention must be given to preventing abandonment and underservicing to ensure that mental health care remains aligned with recovery principles and responsive to individual needs.

The way forward

Neuropsychiatric disorders account for more than 13% of the global burden of disease, and over a quarter of the world's disability burden arises from mental and behavioural conditions (Murray et al., 2012). Despite this scale, mental health continues to receive insufficient political and policy attention (Freeman, 2022). Within this context, social workers are well positioned to advocate for a paradigm shift that elevates mental health as a local, national, and global priority.

Across the reviewed studies, several systemic and clinical contributors to overservicing and underservicing emerge. Shahid et al. (2022) highlight low health literacy as a driver of both inadequate care and unnecessary interventions, underscoring the need for evidence-based communication strategies. Kale and Korenstein (2018) emphasise the importance of clarifying diagnostic terminology, strengthening clinician self-awareness, and promoting unified diagnostic standards to reduce variability in practice. Merten et al. (2017) similarly call for standardised assessment procedures, multidisciplinary collaboration, and a shift from a predominantly medical model to a biopsychosocial approach. These authors also draw attention to cognitive biases and systemic pressures, such as reimbursement requirements and managerial expectations, that may inadvertently shape clinical decision-making.

Collectively, this literature suggests that overservicing is not solely the result of individual clinician behaviour but is embedded within broader organisational, cultural, and structural dynamics. Limited clinician self-awareness, inadequate psychoeducation, compromised professional integrity, and corporate influences on healthcare systems (Bhusal, 2025b) all contribute to service imbalances. These findings point to the need for interventions that address both practitioner-level competencies and systemic conditions.

As both an applied profession and an academic discipline, social work plays a vital role in reducing overservicing in mental health settings. By gathering comprehensive information, social workers gain a clear understanding of clients' needs and can develop contextual, person-centred treatment plans. They are well positioned to lead multidisciplinary teams in creating, monitoring, and regularly reviewing these plans to ensure care remains appropriate, neither excessive nor insufficient.

Considering these insights, several practical strategies can support balanced, recovery-oriented service delivery:

1. Comprehensive biopsychosocial assessment: Conducting a thorough assessment at the outset of care helps ensure that interventions are tailored to individual needs and remain clinically justified. A thorough biopsychosocial assessment should be completed at the start of service delivery to guide evidence-based care. Treatment planning must involve the informed participation of the client, their support worker, carers, and family. Regular review ensures interventions re-

main clinically appropriate. Tools such as the Wellness and Recovery Plan help set clear, measurable goals that prioritise self-defined outcomes.
2. Collaborative treatment planning: Involving clients, carers, support workers, and families in shared decision-making promotes autonomy and reduces the likelihood of both over- and underservicing.
3. Regular review of treatment goals: Ongoing monitoring ensures that interventions remain appropriate and aligned with recovery trajectories. Tools such as Wellness and Recovery Plans can help establish clear, measurable, and person-defined goals.
4. Strengthening clinician self-awareness: Understanding one's emotional responses, limitations, and potential biases is essential for ethical and effective practice (Kale and Korenstein, 2018; Merten et al., 2017; Pereira et al., 2024). Recognising how clinical work can psychologically affect practitioners supports ethical practice and self-efficacy, while helping identify signs of burnout, over- or under-functioning in both clinicians and the people they support (Pereira et al., 2024).
5. Promoting health literacy: Enhancing clients' understanding of diagnoses, treatment options, and recovery principles can reduce dependency and support informed participation.
6. Upholding professional integrity: Prioritising ethical standards over managerial or financial pressures is crucial for maintaining trust and ensuring that care remains person-centred.

In summary, the reviewed studies point to limited clinician self-awareness, inadequate patient psychoeducation, compromised professional integrity, and corporate influence on healthcare system, all compounded by growing managerial pressures (Bhusal, 2025b). The biopsychosocial model, stronger clinician self-awareness, and thorough intake assessments to guide person-centred goals are identified as key strategies for reducing overservicing. With their grounding in person-centred practice, empirical research, biopsychosocial frameworks, and advocacy for systemic and professional integrity, social workers are well positioned to lead efforts to prevent overservicing in mental health service delivery (Boland et al., 2021; Long et al., 2025).

Limitation and future direction

As a narrative and concept-driven analysis, this article does not include a systematic review of all available evidence, nor does it present empirical data. Some examples draw on practice observations, which may limit generalisability. Additionally, the absence of region-specific data, particularly from low and middle-income countries, highlights the need for broader contextual research.

Further empirical studies are needed to operationalise overservicing in mental health, examine its prevalence across diverse service settings, and explore its relationship with recovery outcomes. Research that compares overservicing and underservicing across cultural and health-system contexts, including Nepal and other under-resourced regions, would strengthen global understanding. Future work should also investigate organisational, policy, and workforce factors that contribute to service imbalance, as well as interventions that promote ethical, recovery-oriented decision-making.

Conclusion

This manuscript contributes to the emerging discourse on overservicing by offering a practice-informed conceptualisation tailored to mental health settings. Overservicing in mental health represents a significant challenge to recovery-oriented practice. While this article highlights that excessive or unnecessary interventions can undermine autonomy, resilience, and person-centred care, it also emphasises the importance of balanced, evidence-based service delivery. Clinicians can minimise the risk of overservicing by adhering to treatment guidelines, conducting comprehensive biopsychosocial assessments, engaging in shared decision-making, and maintaining clear, recovery-focused communication. Social workers, with their grounding in holistic assessment and collaborative practice, are particularly well positioned to support personalised and ethically grounded care.

Implications

- Overservicing in mental health can hinder recovery by increasing dependency and psychological distress, rather than promoting autonomy and resilience.
- Clinicians' self-awareness, effective communication and thorough biopsychosocial assessments that clearly outlines the treatment needs and goals can reduce overservicing.
- Social workers, as a change agent, are to play a crucial role in reducing overservicing.

Artificial Intelligence (AI) Use and Disclosure

In the preparation of this manuscript, COPILOT AI tool was utilized for grammatical accuracy and to improve logical flow of paragraphs, closely considering journal's academic integrity guidelines.

Similarity and Originality Confirmation

The manuscript is original, not under review elsewhere, and complies with TUJ publication ethics.

Conflict of Interest

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