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Psychiatry without thresholds: Ethical and clinical lessons from low-triage systems

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Perspective

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Abstract

Psychiatric practice in high-income countries typically relies on implicit triage pathways that filter patients through primary and stepped care before specialist review. In many low- and middle-income settings, however, psychiatrists manage the entire spectrum of distress without such filters. This absence reshapes hierarchies of severity, alters diagnostic and ethical reasoning and influences how clinical priority is determined. Drawing on practice realities from India, this article argues that severity in such systems becomes a dynamic and socially negotiated construct rather than a fixed clinical category. Without institutional thresholds, urgency may become performative: social visibility, family advocacy and the ability to articulate distress can influence prioritization more than clinical need, producing a pattern of reverse triage, in which socially mediated visibility displaces genuine urgency. Language compatibility may further intensify this dynamic, as patients unable to communicate in the clinician's working language risk remaining unheard in undifferentiated clinical spaces. As mental health systems worldwide face rising demand and limited capacity, these observations highlight triage not as exclusion but as an ethical mechanism for balancing equity of access with fairness of prioritization.

Impact statement

In many psychiatric outpatient settings across low- and middle-income countries, patients often present without appointments or referral pathways, and no formal mechanism exists to determine clinical priority. In such environments, prioritization may be shaped less by medical need than by social visibility: individuals who are more articulate, visibly distressed or supported by family are more readily recognized, while patients with quieter but severe illness – or those unable to communicate in the clinician's working language – may receive less timely attention. This article argues that these patterns reflect not only resource limitations but also the ways in which health system design itself shapes the recognition of severity. By introducing the concepts of performative severity and reverse triage, the article offers a new framework for understanding how open-access psychiatric systems can inadvertently disadvantage those most severely ill. As mental health systems globally confront rising demand and constrained capacity, these insights highlight the importance of structured yet accessible triage. The article proposes practical, low-cost approaches to introduce triage at the point of entry and to monitor whether prioritization remains aligned with clinical need.

Introduction

A typical outpatient clinic begins with a familiar paradox. A young man with florid psychosis sits quietly at the back, accompanied by an elderly parent. Nearby, a distressed student insists on being seen immediately, fearing imminent collapse before an examination. A third patient arrives with agitation and family conflict, demanding urgent intervention. There is no appointment system to distinguish them, no referral letter to signal urgency – only a shared waiting area and undifferentiated demand.

In such spaces, severity ceases to be a fixed category. It becomes negotiated in real time, shaped by family advocacy, social disruption and a patient's ability to make their suffering visible. Those who are quiet, withdrawn or cognitively impaired fade into the background, while those whose distress disrupts or demands attention move forward. Urgency is performed, not prescribed.

This is not a moral failure but an adaptation to structure without filters. When formal triage is absent, prioritization becomes intuitive and situational. Minor but visible crises may receive immediate care, while severe but silent illnesses risk neglect. Psychiatry in such contexts operates without thresholds – defined by improvisation and immediacy rather than ordered progression.

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The architecture and performance of urgency

In well-resourced systems, triage is so embedded it becomes invisible: distress is sifted through layers – informal support, primary care and brief interventions – before specialist psychiatry. Even under pressure, the architecture of stepped care persists, structuring and operationalizing severity (Thornicroft et al., 2016; Berger et al., 2022).

By contrast, in many regions of South Asia, Africa and Latin America, psychiatric services function as open-access points where patients commonly present through self-referral, family initiative or emergency departments, with the psychiatrist often serving as the first and only professional contact (Jacob, 2001; Fagbiye et al., 2025). Government spending on mental health in most low- and middle-income countries (LMICs) remains far below what is needed based on the proportionate burden of mental disorders (Rathod et al., 2017). Triage is absent not because it failed but because it was never structurally established.

This distinction matters because triage shapes how severity is recognized and how clinical time is distributed. In structured systems, referral pathways pre-validate seriousness, and psychiatrists refine judgments that have already been partially made. In unfiltered systems, that scaffolding disappears. Each consultation must simultaneously serve as an emergency assessment, diagnostic evaluation and initiation of treatment – often within minutes, with no guarantee of follow-up.

Without institutional thresholds, urgency becomes performative. Visibility, advocacy and social capital determine who receives attention first. Those with families who can mobilize help or the confidence to articulate distress are prioritized, while those with severe but quiet illnesses, such as catatonia, chronic psychosis or depression masked by somatic symptoms, wait silently at the periphery. The result is a clinical reversal: in structured systems, severity grants access; in threshold-free environments, access itself comes to define perceived severity. Where socially mediated visibility, rather than clinical need, determines priority, the outcome is a form of reverse triage, unintended and emergent, a structural consequence of absent thresholds rather than a designed clinical decision and distinct from the emergency medicine usage of the term, where reverse triage describes a deliberate surge strategy.

Clinical compression and temporal collapse

Working without triage profoundly reshapes clinical reasoning. Psychiatrists must move rapidly between widely divergent presentations, leaving little space for reflective formulation or diagnostic uncertainty. The process compresses into an accelerated sequence – assessment, decision and intervention.

This compression encourages treatment-driven reasoning: the question shifts from "What is the diagnosis?" to "What can I do now?" Subtle distinctions among disorders blur, and pharmacological interventions are often initiated swiftly – not out of overzealousness but out of necessity. With limited psychological services and uncertain follow-up, clinicians act to avoid risks of under-treatment, relying heavily on pharmacological solutions for psychosocial problems (Jacob, 2001; Nadkarni et al., 2015).

Such decisions are not lapses in rigor but adaptive intelligence. In environments without longitudinal continuity, psychiatrists must convert uncertainty into immediate action. The threshold for treatment is lowered not by preference but by structural necessity.

Time itself collapses in these systems. Organized mental health care depends on temporal distinctions – acute versus routine, assessment versus review – but in threshold-free environments, such distinctions vanish. Each encounter may serve as both the first and the last, the acute and the ongoing. There is no guarantee of a return, so every consultation must encompass crisis containment, diagnosis and initiation of treatment. Watchful waiting – a cornerstone of good psychiatry – becomes impossible.

Clinicians adapt by cultivating pragmatic reasoning: decisions are "good enough" rather than ideal, and the ability to act becomes as vital as the ability to deliberate. The psychiatrist's time horizon contracts to the immediacy of the moment, where each encounter is both definitive and provisional.

Ethics, equity and adaptation

When all forms of distress converge in the same space, distinctions among disorder, crisis and adversity blur. Emotional pain without a psychiatric disorder can appear as urgent as psychosis. The risk is false equivalence: everyday suffering becomes medicalized, while enduring illness is normalized as "one among many."

Open-door systems embody equity of entry but not necessarily fairness of recognition. Equal access does not guarantee proportionate attention. Clinicians must continually navigate between empathy and medicalization, deciding within moments whose distress reflects pathology and whose reflects circumstance.

Such environments are often described through the lens of burnout or overload, yet this framing overlooks an essential truth: clinicians adapt. Psychiatrists develop rapid alliance-building, reliance on family narratives and intuitive triage heuristics. They learn to prioritize through a blend of empathy, improvisation and experience – not diminished standards but refined contextual intelligence. Over time, clinicians become adept at assessing risk, managing crises and making actionable decisions under constraint. Such adaptations, though rarely acknowledged, may represent psychiatry's most resilient knowledge base.

Universal access to mental health care remains a moral imperative. Yet without structured triage, it can paradoxically disadvantage those most in need. Self-referral assumes the ability to articulate distress and navigate systems – capacities often eroded in severe mental illness. Those with schizophrenia, major depression or cognitive impairment may be least equipped to seek help. Multiple structural barriers – including workforce shortages, fragmented services and lack of integrated care pathways – compound these challenges in low-resource settings (Wainberg et al., 2017).

Psychiatric care relies heavily on communication, making language compatibility an often-overlooked determinant of access and prioritization. In multilingual settings, such as South Asia, patients frequently seek care from clinicians who do not share their primary language. Because psychiatric assessment depends on narrative description, emotional nuance and contextual meaning, language discordance may obscure symptom expression and complicate clinical interpretation. Evidence indicates that language barriers are associated with reduced access to mental health services and poorer quality of psychiatric assessment when interpreter support or language concordance is lacking (Ohtani et al., 2015).

In high-volume outpatient settings, clinicians may also inadvertently prioritize patients with whom communication is easier, thereby influencing triage patterns. Within threshold-free systems where prioritization often depends on visible and articulate distress, linguistic disadvantage may therefore intensify reverse triage, rendering

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vulnerable patients less likely to be recognized and prioritized for care.

Triage, despite its exclusionary potential, protects the invisible by ensuring that need, not noise, determines priority. Equity without structure risks chaos. Access must be accompanied by mechanisms that safeguard fairness, not merely widen entry.

Global lessons and reframing severity

Although this reflection arises from Indian and similar contexts, its relevance is increasingly global. In the United Kingdom, prolonged waiting times and fragmented pathways have eroded traditional triage structures. Accident and Emergency departments now function as default psychiatric gateways, as prolonged waiting times – often exceeding 12 weeks – drive many patients to seek help through emergency services, crisis helplines or digital self-referral platforms that multiply entry points without continuity (Royal College of Psychiatrists, 2022, 2023).

The number of consultant psychiatrists has grown minimally despite escalating demand. These patterns mirror broader global challenges in which mental health systems struggle to match service capacity to expanding demand, regardless of national income level (Patel et al., 2018).

What once seemed a feature of low-resource settings now mirrors pressures in high-income systems. When demand expands faster than differentiation, psychiatry everywhere begins to resemble a threshold-free model. The contexts differ, but the phenomenology – urgency without hierarchy – is strikingly similar.

Traditionally, psychiatry has understood severity as an intrinsic property of illness, moderated by vulnerability and context. The experiences described here suggest a more complex picture: severity is not simply discovered but constructed within systems of care. It emerges from the intersection of pathology, social visibility and institutional design (Patel et al., 2018).

Recognizing severity as a systemic construct invites psychiatry to rethink how clinical priority is defined. As access expands globally, it becomes essential to view severity as dynamic and context-dependent rather than static. Visibility and advocacy profoundly shape who is recognized as "severe," while triage – often criticized as exclusionary – must instead be reframed as an ethical mechanism that protects fairness. Acknowledging that systems themselves co-create severity reframes psychiatry's ethical and operational challenges.

This raises an uncomfortable question: can fairness in access truly coexist with discernment in priority, or must psychiatry develop new frameworks that balance openness with the capacity to see – and prioritize – those whose suffering is least visible? Similar pressures are increasingly visible across mental health systems globally as demand rises and traditional referral pathways weaken.

Way forward: Implementing and monitoring triage in psychiatry OPDs

Recognizing the ethical and clinical implications of threshold-free psychiatric systems must be accompanied by practical steps toward structured prioritization. Introducing triage in psychiatric outpatient departments does not necessarily require complex infrastructure; rather, it depends on deliberate organizational processes that help differentiate clinical urgency within high-volume services.

A practical starting point is the registration or intake stage, where brief screening by trained administrative staff, nurses or junior clinicians can categorize patients into broad operational groups: emergency, urgent or referral-based and routine consultations. Emergency presentations – including acute psychosis, suicidality, severe agitation or significant medical comorbidity – can then be prioritized for immediate assessment, while referral-based consultations, supported by documented prior professional contact, can be appropriately prioritized when capacity is constrained. Routine consultations, numerically the largest group, benefit from an organized appointment or token system that reduces crowding and permits adequate time per patient. Evidence supports the effectiveness of this approach: structured triage processes, particularly nurse-led models using validated assessment tools, have demonstrated meaningful reductions in waiting times and improvements in clinical prioritization in high-demand mental health services (Wand et al., 2021; Mokhwelepa et al., 2025).

In linguistically diverse settings, triage systems may also incorporate language compatibility – for example by allocating patients to clinicians who share their primary language or by deploying bilingual staff or trained community health workers at the point of entry. Such measures can reduce communication barriers that may otherwise obscure clinical need and contribute to inequities in access to psychiatric care (Ohtani et al., 2015). Similarly, designated consultation timings for specific institutional populations, such as students or staff, may help prevent socially advantaged groups from disproportionately occupying shared clinical time in crowded outpatient services.

Implementation should be accompanied by simple monitoring indicators to ensure that triage remains aligned with its ethical purpose. Relevant indicators include waiting times across triage categories, the proportion of emergency cases assessed within a defined timeframe, instances in which severe cases are initially categorized as routine, referral-to-self-referral ratios as a proxy for primary care integration and follow-up attendance as a measure of continuity of care.

Monitoring such measures helps ensure that clinical need – rather than social visibility – remains the primary determinant of priority. Ultimately, introducing simple triage mechanisms is not about restricting access but about ensuring that those whose suffering is least visible are not systematically overlooked. Frameworks for evaluating mental health service quality emphasize that systematic measurement and periodic feedback are essential for sustaining equitable and responsive systems of care (Kilbourne et al., 2018).

Conclusion

Psychiatry without thresholds reveals how deeply systems shape clinical judgment. When every presentation feels urgent, psychiatrists must continuously prioritize without formal rules, balancing need, visibility and time. Such practice should neither be glorified as improvisational heroism nor dismissed as chaos. It exposes psychiatry's hidden assumptions that severity is not merely found in patients but co-constructed by systems of access. As global demand for mental health care grows and systems strain under volume, the experience of low-triage psychiatry offers vital lessons. Access must be accompanied by discernment; openness must not come at the cost of invisibility. The way forward is neither utopian nor beyond reach – it begins with structured sorting at the point of entry and continues through regular monitoring that ensures clinical need, rather than social advantage, determines priority. In designing

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future systems, psychiatry must learn not only how to open doors but how to see clearly once everyone is inside, ensuring that equity of access coexists with equity of attention.

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