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Psychiatric care in Gaza: prescribing amid systematic health care collapse

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The mental health crisis in Gaza has reached catastrophic proportions. As one of the few psychiatrists serving more than 2 million people under siege, I witness daily the collapse of psychiatric care standards that would be unconscionable in any other setting. This Correspondence documents the prescribing crisis that exemplifies the broader humanitarian catastrophe.

Gaza had fewer than one psychiatrist per 100 000 people before the war.[1] According to recent WHO data, there are now only three board-certified psychiatrists, five residents and fewer than 20 other doctors who prescribe psychotropics (unpublished). In Ministry of Health facilities, each psychiatrist sees 50–100 patients daily—a caseload that precludes adequate assessment or follow-up. The most common presentations recorded in Ministry of Health dispensary logs are post-traumatic stress disorder, major depression, generalised anxiety disorder, acute psychosis, and chronic schizophrenia—all exacerbated by ongoing trauma.

The prescribing crisis operates on multiple levels. First-generation antipsychotics (such as haloperidol and chlorpromazine) are now prescribed more frequently than newer agents, not by clinical choice but by availability. These medications, with their burden of extrapyramidal symptoms, negative symptoms, and sedation, create a secondary crisis of non-adherence. When patient conditions stabilise, medication disruptions[2]—now occurring monthly—precipitate predictable relapses.

The clozapine shortage exemplifies this systematic failure. A high proportion of patients with treatment-resistant schizophrenia, stable for years on clozapine, have relapsed following supply disruptions. Without alternatives or monitoring capacity, clinicians must resort to cocktails of available first-generation antipsychotics, transforming manageable chronic illness into acute crisis. The opportunity for rationalising treatment is lost. When

patients transfer between scarce providers, high-dose polypharmacy becomes difficult to manage, with each change risking destabilisation. Insufficient trial periods when starting new medications have become the norm. Medications are changed after 1–2 weeks rather than the 4–6 weeks required for an adequate assessment. This stems not from clinical impatience but from practical impossibility: patients are displaced by bombardment, psychiatrists rotate between overwhelmed facilities, medications become unavailable mid-treatment, and evolving trauma creates new symptoms that obscure medication effects.

Prescribing authority has necessarily expanded beyond psychiatrists. Initially, nurses, pharmacists, and general practitioners prescribed psychotropics without supervision. Although now more controlled, psychiatric nurses and residents continue prescribing for chronic cases without specialist oversight. This task-shifting, essential for coverage, can result in over-prescribing for minor conditions and under-treating severe illness.
The absence of coordination compounds these challenges. No central database tracks medication distribution across the Ministry of Health, WHO, and international non-governmental organisations. Donations arrive irregularly, distributed without a systematic assessment of need.

The psychological support infrastructure has similarly degraded. Ministry facilities lack privacy for therapy sessions, with multiple consultations occurring in shared spaces. Although some international organisations (Médecins Sans Frontières, Médecins du Monde, Medical Aid for Palestinians, and International Medical Corps) provide good quality psychological services, they can only serve a fraction of those in need. Doctors trained through the mental health Gap Action Programme provide basic care but cannot address the complex presentations dominating the caseload.

This prescribing crisis reflects the deliberate destruction of health-care infrastructure.[3] When psychiatrists cannot maintain consistent medication supplies, when pharmacies stock only drugs with intolerable side-effects, and when follow-up becomes impossible due to displacement and siege, this constitutes not merely a health crisis, but a systematic denial of the right to mental health care.

The international psychiatric community must recognise that evidence-based practice becomes meaningless when evidence-based medications are unavailable. Guidelines developed in stable settings become cruel fiction when applied to a population under siege. The principle of do no harm is violated not by individual practitioners, but by the conditions imposed upon them.

Immediate actions are required. First, humanitarian corridors must include psychotropic medications, particularly second-generation antipsychotics and mood stabilisers, in their priorities Second, a centralised medication tracking system accessible to all providers could prevent duplication and shortages. Third, international psychiatric associations should establish crisis prescribing guidelines that acknowledge systematic constraints. Fourth, the documentation of medication-related harm must be recognised as evidence of the broader humanitarian crisis.

The mental health needs of Gaza's population will persist long after any ceasefire. Every relapse due to medication unavailability, every extrapyramidal symptom from the forced use of older agents, and every death by suicide during a medication gap represents preventable harm. The international community must work to ensure consistent psychiatric medication supply, or risk complicity in this systematic denial of mental health care.

As I write this between patient consultations—each impossibly brief, most ending with prescriptions I know might not be obtained—I document not individual clinical failures but the collapse of an entire system of care. The psychiatric crisis in Gaza demands not just humanitarian aid but accountability for the conditions that make ethical psychiatric practice impossible.

Competing Interests

I declare no competing interests.

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