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A Review of UNRWA's Community Mental Health Programme in the Gaza Strip

A Content-Analysis of CMHP's Information System and a Mixed-Methods Survey of Counselors' Work Needs and Experiences

Yumi Terahata

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Dedication

To all the girls and boys I had the privilege and pleasure to work with during my 5 years in Rafah, for teaching me so much about what it means to be truly resilient.

Yumi Terahata

Declaration

I certify that this thesis submitted for the degree of Master is the result of my own research except where otherwise acknowledged, and that this thesis (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed _____

Yumi Terahata

Date _____

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Definitions

Beneficiaries / Clients

For the purposes of this study, beneficiaries refer to UNRWA-registered refugees who are eligible and/or who received the services of UNRWA's CMHP counselors, the majority of which are students attending UNRWA's elementary and preparatory schools or clients of UNRWA's health clinics. The terms beneficiary and client will be used interchangeably throughout this report.

Complex Emergency

The official definition of a complex emergency used by the Inter-Agency Standing Committee (IASC), the primary mechanism for inter-agency coordination of humanitarian assistance involving both UN and non-UN humanitarian partners, is "a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single agency and/ or the ongoing United Nations country program (IASC, 1994)."

Such "complex emergencies" are typically characterized by extensive violence and loss of life; massive displacements of people; widespread damage to societies and economies; the need for large-scale, multi-faceted humanitarian assistance; the hindrance or prevention of humanitarian assistance by political and military constraints; and/or significant security risks for humanitarian relief workers in some areas (OCHA, 1999).

Complex emergencies typically have social effects, or as International Federation of the Red Cross and Red Crescent (IFRC) defines them, "the shared experiences of disruptive events that affect the relations between people – not only as a result of the events but also of death, separation and sense of loss. This also includes an economic and political dimension, since many people suffer multiple consequences of disasters or armed conflicts (IFRC, 2009)."

Community Mental Health

Community mental health is a decentralized pattern of mental health, mental health care, or other services for people with mental illnesses. Community-based care is designed to supplement and decrease the need for more costly inpatient mental health care delivered in hospitals. Community mental health care may be more accessible and responsive to local needs because it is based in a variety of community settings rather than aggregating and isolating patients and patient care in central hospitals (Encyclopedia of mental disorders, 2009).

Mental health

Mental health, as defined by the World Health Organization, is a state of complete mental wellbeing including social, spiritual, cognitive and emotional aspects, in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. In this sense, mental health is the foundation for well-being and effective functioning for an individual and for a community (WHO, 2009).

Psychosocial Wellbeing

The term psychosocial was first commonly used by psychologist Erik Erikson in the 1950's in his stages of social development, referring to an individual's psychological development in and interaction with a social environment (Erikson, 1950). It refers to the mutually-influencing relationship between the individual and the collective aspects of any social entity.

Psychological Effects

The 'psychological' effects are caused by a range of experiences that affect the emotions, behavior, thoughts, memory and learning capacity of an individual. To a large extent, the psychological effects depend on the way in which these events are perceived and given meaning by the individual.

Psychosocial Support

Psychosocial support has been defined as an ongoing process of meeting emotional, social, mental and spiritual needs, all of which are considered essential elements of meaningful and positive human development. It goes beyond simply meeting people's physical needs. It places great emphasis on their psychological and emotional needs, and their need for social interaction (International HIV/AIDS Alliance , 2009).

It is usually used in the context of "psychosocial intervention," which is commonly used alongside psycho-educational interventions. Psychosocial support is an approach to victims of disaster, catastrophe, or violence to foster resilience of communities and individuals. It aims at easing resumption of normal life, facilitate affected people participation to their convalescence and preventing pathological consequences of potentially traumatic situations (Wikipedia, 2008).

The terms *mental health* and *psychosocial support* are closely related and are often used in an overlapping fashion. Aid agencies outside the health sector tend to speak of *supporting psychosocial well-being*. Health sector agencies tend to speak of mental health, yet have also used the terms *psychosocial rehabilitation* and *psychosocial treatment* to describe non-biological interventions for people with mental disorders. Exact definitions of these terms vary between and within aid organizations, disciplines and countries. The composite term *mental health and psychosocial support* is used by IASC “to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder (Ibid).”

Social Effects

Social effects are the shared experiences of disruptive events that affect the relations between people – not only as a result of the events but also of death, separation and sense of loss. It also includes an economic and political dimension, since many people suffer multiple consequences of, for example, disasters or armed conflicts (IFRC, 2009).

Abstract:

As the largest provider of psychosocial services in the Gaza Strip, UNRWA faces the challenge of having to serve a large refugee population with limited resources, including caregivers with limited qualifications and training. This study focused on getting a better understanding of the existing documented information provided by UNRWA's Community Mental Health Programme's (CMHP) to inform on the psychosocial/mental health needs of CMHP's client population in the Gaza Strip and the effectiveness of services provided by CMHP, specifically through a content-analysis of the CMHP database. Specific methodological approaches included: a literary review to inform documentation review, a review of all CMHP monthly reports, and a detailed analysis of the CMHP database focusing on individual counseling session records. Data quality issues included lack of quality checks, weak database design, and lack of focused data analysis. Analysis revealed trends in CMHP services, such as significant differences in client population for UNRWA health centers and schools including client age group, reported problems, and referral sources.

An extensive mixed-methods (quantitative and qualitative) questionnaire survey of all CMHP counselors was also conducted to explore counselors' views on training, their work environment, perceived needs and job satisfaction. Counselors' responses to various items on the questionnaire seemed to suggest that in general counselors felt themselves to be part of an isolated and perhaps undervalued department (CMHP), as evidenced by requests for psychological support and encouragement for counselors themselves, calls for better communication between and cooperation with different UNRWA departments, more interaction with local organizations, and more PR about CMHP to the public through written material and promotional activities. The collection of training topics requested by counselors ranged from pronunciation problems to psychological testing, raising questions as to exactly what counselors expected themselves to be able to handle in their work and whether or not these expectations are realistic.

Results of this study indicated that CMHP's database system needed to be systematically redesigned to be more practical for the fieldworkers who collect the data, including simplified data fields and clearer definitions of terminology. A thorough assessment should be undertaken to establish necessary and feasible data to be collected, based on clear and measurable indicators. Data quality should be regularly checked at various stages of data collection and processing. More specific and context-oriented analysis should be done by CMHP, utilizing all available data fields.

تقييم برنامج الصحة النفسية في وكالة الأمم المتحدة لإغاثة وتشغيل اللاجئين في قطاع غزة.

إعداد: يومي تيراهاتا

إشراف: الدكتور/ احمد أبو طواحينة

الملخص:

تعتبر وكالة الغوث الدولية أكبر مزود للخدمات النفسية في قطاع غزة، حيث تواجه عقبة في تزويد عدد كبير من الاجئين بمصادرها المحددودة و مثال ذلك تزويد الخدمات الصحية بمؤهلات وتدريب غير كافي. هدفت هذه الدراسة على الحصول لفهم أفضل للمعلومات الموثقة والمقدمة من برنامج الصحة النفسية في وكالة الغوث, وللتعرف الى الاحتياجات النفسية والاجتماعية والعقلية للمجتمع في قطاع غزة, وفعالية الخدمات المقدمة من قبل برنامج الصحة النفسية و ذلك من خلال دراسة تحليل محتوى لقاعدة البيانات للبرنامج. و كذلك تم استخدام طرق محددة في البحث مثل: مراجعة الوثائق وجمع البيانات والأدبيات التي تناولت ووثقت هذه البيانات, و مراجعة كل التقارير الشهرية للبرنامج, وتحليل مفصل لبيانات البرنامج مع التركيز على سجلات جلسات الارشاد الفردي ، و قد أظهر التحليل أن هناك اتجاهات كثيرة في الخدمات المقدمة من وكالة الغوت وبرنامج الصحة النفسية مثل الاختلاف الواضح في عدد الاشخاص متلقي الخدمات الارشادية بين المراكز الصحية والمدارس التابعة لوكالة الغوث متضمنا الفئة العمرية, المشاكل المرصودة, ومصادر التحويل.

تم استخدام استبيان كأداة للدراسة متضمنا المكونات النوعية والكمية لجميع مقدمي الخدمات الارشادية في برنامج الصحة النفسية ليكشف وجهة نظر الاخصائيين في التدريب, وأجواء العمل, واحتياجاتهم, والرضى الوظيفي.

ولقد أظهرت نتائج تحليل الاستبيان بان الأخصائيين في برنامج الصحة النفسية بشكل عام يرون بأنهم في قسم مفصول أو لا يهتم به, وهذا ما استدل عليه من خلال طلبهم للحصول على الدعم

النفسي والتشجيع, وكذلك طلب تواصل وتعاون أفضل بين الأقسام المختلفة في وكالة الغوث وتفاعل أفضل مع المنظمات المحلية.

و قد أظهرت النتائج أيضا بان قواعد بيانات برنامج الصحة النفسية تحتاج وبشكل مستمر إلى إعادة تقييم ومراجعة وهيكلة بشكل منتظم لتصبح أكثر عملية للعاملين في هذا الحقل, ولتتضمن بيانات مبسطة وسهلة, وأيضا لتشتمل على تعريفات واضحة للمصطلحات المستخدمة، و كذلك أظهرت النتائج بأنه يجب عمل تقييم موسع (شامل) لنظام البيانات الموجودة في البرنامج وتأسيس نظام بيانات سهل وواضح ويمكن العمل من خلاله, كذلك يجب فحص وتقييم جودة البيانات بشكل دوري.

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Chapter One

Introduction

This chapter will give a brief outline of psychosocial support and mental health in the context of disasters and armed conflict, with a focus on the need for an evidence base to justify the effectiveness of intervention, particularly when implementing western-developed psychological approaches in non-western settings. It will then present a short overview of mental health information systems, as outlined by the World Health Organization. It will conclude with the researcher's justification for this study, general and specific objectives, and the specific questions the researcher aims to address.

1.1 Psychosocial Support / Mental Health in Conflict

During the last 20 years, the serious psychological consequences of disasters and armed conflict upon individuals and their communities have been widely recognized as undermining the long-term mental health and psychosocial well-being of the affected population (Van Ommeren et al, 2005; IASC, 2007). Within this context, there has also been growing concern about the short- and long-term effects of armed conflict on children and adolescents in their physical, mental and emotional development (Michel, 1996). This concern is reflected in article 39 of the Convention of the Rights of the Child, which binds all signing parties by international law to take every appropriate measure to ensure children's physical and psychological recovery and social reintegration (United Nations, 1989).

Whether expressed in terms of increased psychological morbidity, the disruption of children's developmental progress, or the violation of human rights and dignity, such human dimensions of suffering are now broadly accepted as an appropriate focus for humanitarian assistance (Psychological Working Group, 2002). From this understanding, mental health and psychosocial interventions have become a common component of many humanitarian programs. This

recognition has led to a wide proliferation of mental health and psychosocial programs in places of conflict.

The majority of psychosocial interventions used in such programs were developed in western countries and put into practice in non-western countries, a reflection of the globalization of the Western cultural inclination to medicalize distress and of the rise of psychological therapies. However, critics have argued that the common western approach based on individual and introspective clinical techniques may be less appropriate in other cultures (Summerfield, 1996).

Even in the West, the evidence base for the efficacy of mental health services in assisting recovery from highly aversive events like war and atrocity has been less than persuasive (Van Ommeren et al, 2005). Western studies of psychological debriefing, for example, have reported contradictory findings regarding the effectiveness of such techniques (Katz et al, 2002). The effectiveness of other techniques such as the provision of self-help information has also been questioned (Turpin et al, 2005).

Moreover, there is a great lack of evidence-base supporting the effectiveness of western-based interventions in non-western disaster and conflict settings. One of the dangers in this lack of evidence-base is that well-intended psychosocial interventions can have unintended consequences. Strengthening methods of evaluation for current therapies is crucial to identifying ineffective or potentially harmful interventions. In addition to adapting interventions to local cultures, more research is urgently required to test the effectiveness of the interventions being implemented, focusing on both the capacity of the intervention to reduce symptoms and the willingness of practitioners to embrace the intervention (Bryant and Njenga, 2006).

Similarly, little is known about the cost-effectiveness of western-developed mental health treatments when applied in non-western community settings. In developing countries, cost-effectiveness analyses are particularly essential for informing treatment selection to ensure the most efficient use of what are typically very limited resources (De Jong, 2004).

This realization has increasingly led to a call to improve standards and strengthen the evidence-base for this field (Mollica et al, 2004). Recently there have been efforts to develop consensus policy derived from best practice for emergency psychosocial and social interventions, such as

the SPHERE standards project (Sphere project, 2004) and the IASC Task Force on Mental Health and Psychosocial Support Guidelines (IASC, 2007). Guidelines such as these have stressed the need for ongoing monitoring and evaluation practices not only to inform planning and policy but to strengthen the evidence-base for psychosocial and mental health interventions (Ibid).

1.2 Overview of Mental Health Information Systems

According to the World Health Organization, mental health information systems assist service providers with a means of recording and monitoring the needs of service users and reporting the interventions that are used. The information compiled from this system then ideally would enable managers and service providers to make well-informed decisions in how to improve the effectiveness and efficiency of the services. Therefore, it exists not simply for the purpose of gathering data but also for the purpose of enabling informed decision-making, whether in terms of evaluating, planning, or policy-making (WHO, 2007). It must also be useful for the workers who collect the data in the first place.

The WHO outlines 5 stages of a mental health information system (Ibid):

- **Collection** –*What data can be feasibly gathered?*
- **Processing** –*How are the data transmitted, collated, and prepared?*
- **Analysis** – *How are the data examined and analyzed?*
- **Dissemination** – *How are the results of the analysis communicated?*
- **Use** – *How are the data applied to making decisions?*

Common Problems with Health Information Systems include:

Collection

- Data collected are often of poor quality.
- Sometimes staff are not informed as to why they are required to gather data and how it will be used.
- Management may not have clear policy and regulations.

Processing

- A large proportion of the data collected goes straight to the national level without being used locally.
- Frequently, information systems are designed primarily for senior managers and policy-makers and not for use by the service staff and managers at the recording and reporting level.

Analysis

- Much of the data collected and processed remains unanalyzed.
- If it is analyzed, the analysis often consists of simple aggregations that lack denominators or are inaccurate.
- The aggregation of data at higher levels often prevents data from being sufficiently specific for appropriate local application.

1.3 Study Justification

The researcher hopes that the results of this study will provide accountability for program results, improve program relevance, methods and outcomes for UNRWA, generate lessons that may be generalized to other programs or situations, and can also be used as an advocacy document for presentation to donors to secure continued funding for the program.

1.4 Objectives

General

This study had two main objectives:

1. To get a better understanding of the existing documented information provided by UNRWA's Community Mental Health Programme's (CMHP) to inform on the psychosocial/mental health needs of CMHP's client population in the Gaza Strip and the effectiveness of services provided by CMHP.

2. To explore CMHP counselors' views on training, their work environment, perceived needs and job satisfaction.

Specific

1. To gain insight to the existing documented information being used by UNRWA's Community Mental Health Programme (CMHP).

2. To examine its current information system, specifically through a content-analysis of the CMHP database.

3. To extract, from available data, information on psychosocial/mental health needs of UNRWA CMHP's client population and the effectiveness of services provided.

4. To gain insight to the issues faced by and experiences and perceptions of UNRWA's CMHP counselors through a mixed-methods (quantitative and qualitative) questionnaire survey.

1.5 Research Questions

Related to the CMHP Information System:

1. What kind of information is being presented by the CMHP?

2. What kind of information system is the CMHP using to document the psychosocial / mental health needs of its client population?

3. What kinds of data variables are collected and analyzed by the CMHP?

4. What kinds of data trends and client population characteristics can be extracted from the data collected by CMHP?

Related to CMHP Counselors' Experiences and Needs:

1. What kinds of training have the counselors undertaken?

2. What are the counselors' perceived training needs?

3. What kinds of support do the counselors feel they need?

4. What are the major problems / obstacles the counselors face in their work environments?

Chapter Two

Literature Review

Since the vast majority of this study's target sample (94% of all UNRWA CMHP counselors) work in one of UNRWA's elementary or preparatory schools, this chapter will begin with an overview of the role of the school counselor, particularly in the United States. School counselor perceptions, school staff perceptions of school counselors, and issues related to data collection and continued accountability will be emphasized. The chapter will continue with an examination of psychosocial support in the Occupied Palestinian Territories (oPT), presenting how psychosocial health emerged as a justifiable concern, the consequent attempts to create a psychosocial / mental health system and the rise of psychosocial programs in the oPT. It will list some of the major issues stemming from this phenomenon, including the limited qualifications and capacities of caregivers and the scarcity of adequate monitoring and evaluation procedures to assess the effectiveness of psychosocial services provided to clients.

2.1 The Role of the School Counselor

2.1.1 School Counselors' Struggle with Role Definition

A school counselor is a counselor and educator who works in elementary, middle, and high schools to provide academic, career, college readiness, and personal/social competencies to all students through advocacy, leadership, systemic change, and teaming and collaborating with other stakeholders as part of a comprehensive developmental school counseling program. (ASCA, 2005).

With educational outcomes receiving increased debate in the 1990s, the school counseling profession intensified its focus on defining its role within the schools to adapt to standards-based

education. Significant to this role definition was the passage of the No Child Left Behind Act (U.S. Department of Education, 2002). According to this federal law, academic achievement in public schools is directly measured through standardized testing, and public schools are required to prepare students who can demonstrate specified levels of academic achievement. Schools that are not in compliance with NCLB face the risk of being put under external control, leading to the possible replacement of administration, staff, and curricula (Erford, 2007).

Within this climate of increased accountability, the American School Counselor Association (ASCA, 2005) released two editions of the ASCA National Model. The standards contained in this model advocated a shift from the service/activity approach that has been traditionally adopted by school counselors to a programmatic approach that is comprehensive and developmental and measures program effectiveness and achievement of attitudes, skills, and knowledge by students (Dollarhide & Saginak, 2008).

Despite the fact that the history of school counseling can be traced back to the 1880s, school counselors have continued to struggle with defining their role within the school (Coy, 1999). Paisley and McMahon (2001) noted that role definition is one of the most considerable challenges facing school counselors today. For years, school counselors have fought to clearly identify their position and their roles were not uniformly expressed from state to state and school district to school district (Sink, 2002).

The role statement of the American School Counselor Association (ASCA, 1999) recommends that counselors focus at least 70% of their rime on direct services to students with a maximum counselor-to-student ratio of 1:250. However, in the 2004 research study by Perusse, Goodnough, Donegan, and Jones revealed no clear agreement from either principals or school counselors about which tasks would be appropriate or inappropriate for school counselors to perform. Looking at the inappropriate tasks performed by counselors, their data shows that the exact same tasks that were also the most highly endorsed by school principals at the elementary and secondary level were also the most frequently performed inappropriate tasks by school counselors at each level (Perusse et al, 2004). The data illustrates that school principals are very influential in determining the role of school counselors at every level.

Principals continue to believe that clerical tasks such as registration, scheduling of all new students, administrating assorted tests and maintaining student records are all appropriate uses of a school counselors time (Ibid). On the other hand, elementary school counselors and principals showed substantial agreement on the national standards for school counseling programs.

Sears and Granello (2002) suggest that school counselors and counselor educators have contributed to role confusion. Some school counselors have accepted unclear position descriptions that mirror teachers' responsibilities instead of school counselor responsibilities. School counselors are increasingly spending much of their time in non-counseling, administrative tasks (Morse & Russell, 1988). Napierkowski and Parsons (1995) observed that counselors' roles have become more "quasi-administrative," with counselors performing gatekeeper and custodial work.

One of the most challenging and complex issues that schools and school counselors have had to face during the past decade has been school violence. Dykeman, Daehlin, Doyle, and Flamer (1996) observed that not only are children committing violent crimes at younger ages, they are also involved with violence as victims and witnesses. As school administrators struggle with ways to prevent acts of violence from occurring within their schools, they increasingly turn to school counselors for leadership and help with establishing policies regarding violence prevention and school safety (Fryxell & Smith, 2000). Thus, counselors striving for innovative ways to help curb school violence may become frustrated as additional demands are placed upon them. Olson and Dilley (1988) observed that as add-on roles for counselors have increased, no other roles have been decreased.

As school counselors make efforts to implement the ASCA National Model, they also must comply with increasing demands for their time and skills (Baggerly & Osborn, 2006). Given these recent paradigmatic shifts in the modern school counselor's job expectations, it is imperative that researchers comprehensively assess multiple components of school counselors' job perceptions (satisfaction as well as frustration), in order to better understand the evolution of the school counseling profession in light of these changing expectations.

2.1.2 School Counselor Job Satisfaction

Job satisfaction contributes to how effectively individuals perform their jobs (Bacharach, Bamberger, & Mitchell, 1990; Schuler, Aldage, & Brief; 1977; Spector, 1997). Many studies indicate that job satisfaction influences the emotional and physical well-being of an individual (Olson & Dilley, 1988). Conversely, job dissatisfaction is associated with stress and burnout (Kesler, 1990; Leiter & Meechan, 1986; Lobban, Husted, & Farewell, 1998; Martin & Schinke, 1998). Decreased job satisfaction also has been associated with a number of potentially damaging personal and professional symptoms (Van Sell, Brier, & Schuler, 1981). Olson and Dilley (1988) stated that counselors' mental health and the quality of their work are related; job satisfaction is necessary to ensure continuous and high quality services to children and the adults who work with them. School counselors often enter the profession because of their desire to help students (Ribak-Rosenthal, 1994). School counselors frequently are expected to serve as prevention specialist, consultant, and community organizer without adequate training (Cunningham & Sandhu, 2000). When counselors are expected to perform roles and functions without feeling they have the necessary skills, serve too many students, or be involved with activities that detract from their primary duties, job dissatisfaction may result.

Among the few existing studies on school counselor job satisfaction, DeMato and Curcio (2004) examined how elementary school counselors in Virginia reported their job satisfaction over the past decade. Results indicated that while a vast majority of Virginia elementary school counselors surveyed in 2001 were satisfied or mostly satisfied in their positions (90.4%), many also reported deep concerns regarding mandated statewide accountability testing, cutbacks in personnel, school violence, and increasingly having to take on non-guidance duties. Specifically, 65% of surveyed counselors reported that state-mandated accountability testing negatively affected their job satisfaction.

In a similar 2002 study conducted in Florida, Baggerly and Osborn (2006) surveyed school counselors across all three levels (elementary school, middle school, and high school). Their findings indicated that while a majority of respondents across the three levels reported being either "very satisfied" in their positions (39.8%) or "somewhat satisfied" (44.7%), they also

reported that over the past 2 years their positions had become "much more stressful" or "somewhat more stressful" (87% of elementary school counselors, 95% of middle school counselors, and 92% of high school counselors). This study also asked respondents to report the frequency with which they performed appropriate and inappropriate school counselor duties as defined by ASCA. School counselor respondents who implemented appropriate duties more frequently indicated greater job satisfaction, while those who implemented inappropriate duties more frequently indicated decreased job satisfaction (Ibid).

A more recent national study of school counselor job satisfaction examined the relationships between mattering to others, job-related stress, and job satisfaction (Rayle, 2006). Significantly, Rayle determined that school counselors at all three levels currently running comprehensive curriculum-based guidance (CCBG) programs reported greater perceptions of mattering to others. Moreover, school counselors who rated themselves as mattering more to others in the workplace reported higher rates of job satisfaction along with reduced levels of job-related stress (Ibid). Rayle concluded that the school counseling profession needs to continue utilizing the ASCA National Model as a means of defining and advocating for the role of the school counselor, including further delineating appropriate and inappropriate activities for school counselors to be performing.

Bryant and Constantine (2006) studied the relationships between multiple role balance, job satisfaction, and life satisfaction in a national sample of women school counselors. The results indicated that women school counselors who reported greater role balance in their personal and professional lives and who concomitantly reported greater job satisfaction were more satisfied with their lives overall. Feeling overwhelmed by excessive or imbalanced roles might thus be predictive of lower overall life satisfaction. Bryant and Constantine provided recommendations for addressing the diminished job satisfaction that comes when school counselors are expected to serve in capacities that are often incompatible with their own professional expectations or training. Specifically, Bryant and Constantine recommended the ongoing development of counselor role statements that strengthen and clearly define the job roles for school counselors. Further, they suggested that school counselors have greater access to consistent clinical supervision and recommended that school counselors bolster their professional identities through active involvement in state and national school counseling associations. According to Bryant and

Constantine, school counselors must advocate for themselves in shaping the roles that they are to have within school systems.

Przytula's (2008) study attempted to determine the relationship between five methods of supervision and the frequency of supervision of New York State School Counselors with the counselors' career self-efficacy, job-satisfaction, role analysis and planned career longevity. Electronic survey responses from 303 secondary school counselors were analyzed in which counselors rated their career self-efficacy using questions from the COSE (Counselors Self-Estimate Inventory.) Counselors were also asked to provide information about their supervisor, the frequency of supervision and the method of supervision used: (1) Clinical; (2) Peer; (3) Developmental; (4) Administrative; or, (5) none. Based on Albert Bandura's theories on self-efficacy, it was expected that counselors receiving clinical and peer supervision would be more satisfied, show more self-efficacy and would plan on remaining in their jobs longer.

The Major findings of this study included: (a) over 30% of the counselors reported having received no supervision in the last year; (b) another 22% reported having received supervision only once in the last year; (c) over 14% of the counselors reported administrative supervision, a form of supervision that does not involve direct observation of the counselor, as the most frequent form of supervision; (d) no significant relationship was found between the method of supervision the amount of time counseling students; (e) satisfaction with supervision did correlate significantly with career planned longevity and job satisfaction but did not correlate with career self-efficacy; (f) the only factor found to correlate with career self-efficacy was the amount of time spent counseling students. The study was able to find eight variables that together attributed to 12% of the variance in planned career longevity and 23% of the counselor job satisfaction (Ibid).

2.1.3 Implications of ASCA's National Model on School Counseling

The influence of the ASCA National Model on the school counseling profession has been unparalleled. As a result, many state departments of education and state school counselor associations have refined or redesigned their program guidelines and published second-generation documents aligned with the ASCA National Model (ASCA, 2005). Twenty-first-century school counselors are urged to shift their focus from the delivery of a menu of ancillary services to demonstrated outcomes that show student benefits from comprehensive programs (Stone & Dahir, 2007; Whiston, 2002).

To support this perspective, researchers have shown that accountability practices and comprehensive school counseling programs can positively change the view of school counseling contributions in the context of a contemporary reform agenda (Burnham & Jackson, 2000; Dahir & Stone, 2003; Gysbers, 2004). Recent studies have revealed that students who participate in comprehensive school counseling programs earn higher grades, are involved in fewer classroom disruptions, and show improved peer behavior (Brigman & Campbell, 2003; Sink, 2005). The ASCA National Model suggests that school counselor commitment to school improvement, a willingness to use data to address equity, and a social justice approach are essential mindsets to succeed with 21st-century students (Stone & Dahir, 2007).

The substantial changes in school counseling over the past 10 years lead to the following profound question: "To what degree have school counselors acquired the attitudes and skills that will support their ability to successfully implement comprehensive school counseling programs?" A review of school counselor associations and Web sites of departments of education revealed little or no targeted professional development to support the implementation process of the ASCA National Model or the newly adopted state documents (ASCA, 2005). Although extensive in-service and staff development programs are used to prepare teachers and school leaders in the new paradigms of teaching, learning, and assessment, the majority of school counselors have not benefited from targeted and focused professional development that supports comprehensive school counseling program development, implementation, and accountability.

Awareness and understanding is power and motivates school counselors' desire to align beliefs with behaviors for the benefit of improving student achievement and school success (Dahir & Stone, 2003). School counselors should become more cognizant of where they are in the implementation process, and identify and reflect on the skills and knowledge essential to move forward. Presently, many school counselors deem themselves powerless as they struggle between crisis intervention, administrative directives, non-counseling duties, and their desire to help every child succeed (Ibid).

2.2 Psychosocial Support in the Occupied Palestinian Territories (oPT)

2.2.1 Psychosocial Health as a Concern in oPT

Psychosocial health as a legitimate focus of attention is a relatively new phenomenon in the occupied Palestinian Territories (oPT), otherwise known as the West Bank and Gaza Strip. This transformation probably dates back to the late 1980's and early 1990's, influenced by the growing international awareness of the negative effect of conflict and mass violence on the population. Prior to this time, a very limited and strictly biomedical-psychiatric model of care existed within the governmental health system, with very few models of psychosocial / mental health care being operational in oPT (Giacaman, 2004).

Initial psychosocial concern focused particularly on the Palestinian youth and the possible negative impact of acute periods of conflict on their wellbeing. During the first Intifada (1987-1993), schools closed down for lengthy periods of time, economic activity ground nearly to a halt, and much violence and destruction took place, causing the death, injury and permanent disablement of many, primarily young people. Studies have indicated that a high percentage of Palestinian children were experiencing mental and behavioral problems linked to the prolonged conflict (Garbarino & Kostelny, 1996; Quota & Sarraj, 2004).

There are still very few reliable mental health data indicating incidence and prevalence of mental illnesses in the oPT. However, some studies of Palestinian children and adolescents have

reported high levels of distress and hopelessness (Giacaman et al, 2005) and of post-traumatic stress disorder (Abu Hein et al, 1993; Thabet & Vostanis, 2000; Thabet et al, 2002). Anecdotal accounts from mental health sources highlight the elevated levels of acute and chronic stress in the oPT due to the socio-political situation, including stressors present in everyday Palestinian life such as population density, severe restrictions on freedom of movement, high levels of unemployment, significant direct experience of trauma, injury, humiliation and bereavement to individuals and other violations of human rights, and poverty, all of which have a potentially serious impact on personal, familial and community functioning. Such stressors also increase the vulnerability of the general population to mental health problems and, in particular, to a higher incidence of symptoms of anxiety and/or depression (WHO, 2004).

Studies have also outlined many positive demographic characteristics of the Palestinian population which may have a protective effect on the mental health of its citizens. These include the high levels of social capital such as a supportive extended family culture, the importance of religion, a strong sense of national identity, purpose, and unity, and high rates of literacy (Punamaki et al, 2001).

2.2.2 Attempts to Create a Psychosocial / Mental Health System in oPT

After the 1993 Oslo Accords, when various social responsibilities were handed over by the Israeli government to the Palestinian Authority, there have been attempts to create a psychosocial/mental health system in the occupied Palestinian Territories.

In 1994, the Ministry of Health listed mental health as a priority in the Palestinian National Health Plan. In 2001, various local and international non-governmental organizations (NGOs) and governmental organizations including the Palestinian Legislative Council, World Health Organization (WHO), and United Nations (UN) agencies, drafted the *Palestinian Code of Conduct for Psychosocial Interventions*, to be adopted by all institutions, agencies and programs working in psychosocial interventions. This document emphasized the need to (1) frame psychosocial policy and activities in accordance with Palestinian culture, social context, and the

existing infrastructure; (2) ensure that services have far-reaching and sustainable effect on as large a number of affected children and caretakers throughout oPT as possible, (3) coordinate efforts between all local and international actors to ensure that resources are appropriately allocated and disseminated without duplication, and (4) ensure all service-providers in oPT adhere to the necessary minimum standards of quality (National Plan of Action for Palestinian Children Secretariat , 2001).

In 2003, the Ministry of Health created a Steering Committee on Mental Health, represented by the Ministry of Health, the local NGO community, the UN system and the international donor community. In its *Plan on the Organization of Mental Health Services in Palestine* (2004), the committee stressed the need for psychosocial and mental health system building in the occupied Palestinian Territories and called for greater collaboration between all service sectors, higher levels of training for caregivers, revised mental health legislation, and improved results of services for mental health service users and their families (Steering Committee for Mental Health, 2004).

2.2.3 The Rise of Psychosocial Programs in oPT

The number of psychosocial projects and programs in the occupied Palestinian Territories also grew starting the 1990's, run by various governmental and non-governmental organizations. In a similar vein to programs implemented in many disaster and conflict areas of the non-Western world, the majority of psychosocial programs in oPT were funded and designed by international agencies based on Western perceptions (i.e., the bio-psycho-medical approach).

The Ministry of Education had set up a counseling program in all the public schools by 1996; by 2003, there were 382 school counselors working in governmental schools in the West Bank and 150 in Gaza Strip. The United Nations Relief and Work Agency engaged 55 school counselors in its own schools for registered refugees in the West Bank and 85 in Gaza Strip during the same year (Giacaman & Mikki. 2003).

However, school counseling programs were established and expanded rapidly without appropriate planning and model-building, largely influenced by donor pressure and funding issues (Ibid). Little consideration had been given to the essentials required to ensure programmatic success, such as adapting counseling to the Palestinian context, understanding the capacity of local human resources and building on their strengths, creating a proper management system for program implementation, making structural changes within the school system to accommodate the new program, and developing instruments needed for the monitoring and evaluation of this program (Ibid). Furthermore, reservations about counseling with its emphasis on individual therapy and emotional ventilation unfamiliar in the Palestinian cultural setting, were expressed fairly widely within the community. There was also the issue of stigma, which remains a cultural obstacle (Afana et al, 2004).

Another significant concern was the qualification and capacity of the caregivers employed to implement psychosocial interventions in the oPT. The majority of psychosocial / mental health workers were educated at local universities, whose curriculum was not designed to prepare its graduates for practical work as professional counselors. Although many organizations provided training courses for its counselors, it is unclear how effective these courses were (Giacaman, 2004).

According to Giacaman's 2004 survey of psychosocial caregivers in the West Bank and Gaza Strip, counselors identified what they perceived to be their learning and developmental needs and requested training courses remarkably similar to previous training courses in which they had participated, raising doubts as to how much knowledge and practice the trainees gained from their training. One of the issues identified through this survey was that, after completing training courses, staff was not supported in practice to consolidate, develop, and extend what they have learned in the training programs. The training undertaken may also not have been relevant or perhaps culturally appropriate to the work they were doing at the time. Developmental and supportive clinical supervision was reportedly rarely provided (Ibid).

In the same survey, an eclectic range of intervention approaches were mentioned by counselors, without evidence of a coherent approach to assessment and intervention. There was also insufficient evidence of the effectiveness of these approaches within a Palestinian context (Ibid).

Giacaman concluded in her study that a serious commitment to continuing professional development required a careful analysis of job requirements, an identification of the learning needs of counselors in relation to job specifications, and the provision of appropriate and evaluated learning opportunities. The role and responsibilities of psychosocial / mental health workers also needed to be more clearly defined and referral systems between primary and secondary (specialist) level services needed to be developed, including establishing links with primary health care services (Ibid).

2.3 Overview of the Gaza Strip

More than 1.4 million Palestinians live in the Gaza Strip, the narrow piece of land approximately 40km long and 10km wide (360 square km) along the Mediterranean coast between Israel and Egypt. The majority of the population are refugees who fled to the Gaza Strip as a result of the 1948 Arab-Israeli war were from Jaffa, towns and villages south of Jaffa, and from the Beer Sheva area in the Negev. In all, some 200,000 refugees came to Gaza, whose original inhabitants numbered only 80,000. The influx of refugees into the narrow strip of land has given Gaza one of the highest population densities on earth, mostly concentrated in cities and refugee camps. Over three-quarters of the current estimated population of the more than 1.4 million are registered refugees; they comprise 22 per cent of all UNRWA-registered Palestine refugees (UNRWA, 2009). Three-fourths of the population are below the age of 30 (OCHA, 2009). As of 2006, the average household size has been 7.4 persons (PCBS, 2009).

Egypt administered over the Gaza Strip from 1948-67. Israel took control over the Gaza Strip after the 1967 Arab-Israeli War. Although Israel pulled out its troops out of the Gaza Strip along with thousands of Jews who had settled in the territory in 2005, Israel still exercises military control over most of Gaza's land borders, as well as its territorial waters and airspace.

Although the Gaza Strip is not recognized internationally as being part of any sovereign country, it is claimed by the Palestinian National Authority as part of the Palestinian territories. Since the June 2007 internecine battle between Fatah and Hamas factions, political control of the area is in the hands of the Hamas *de facto* government.

For many years Israel has restricted entry to and exit from Gaza, effectively removing what had been the main source of income for the population. Israel has intensified its blockade of Gaza after the Hamas takeover in June 2007, forcing the Gaza Strip's population to rely on less than a quarter of the volume of imported supplies they received in December 2005. At times, significantly less than that has gone into Gaza, causing severe shortages. Only basic humanitarian items have been allowed in, and virtually no exports permitted, paralyzing the economy. Consequently, there are high levels of poverty, deprivation and unemployment in the Gaza Strip.

Over the years, the Gaza Strip has also been subject to Israeli air strikes targeting militants in the densely populated areas, attacks which have often killed and injured bystanders as well. The Israeli military offensive against a largely civilian population, shelling and bombardment of civilian areas, closures and siege policies and spiraling poverty have all produced conditions precipitating a state of generalized and/or acute psychological distress amongst the population (Giacaman, 2004).

2.4 Overview of UNRWA

The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) began operations on 1 May 1950, following the 1948 Arab-Israeli conflict. It was established by United Nations General Assembly Resolution 302 (IV) on 8 December 1949, with a mandate to provide shelter, water, basic food, sanitation services, primary health care and other relief and social services to refugees. UNRWA's services are available to over 4.6 million Palestine refugees registered with UNRWA in its 5 areas of operations (Jordan, Lebanon, Syrian Arab Republic, the West Bank and Gaza Strip).

UNRWA defines a Palestinian refugee as "a person "whose normal place of residence was Palestine between June 1946 and May 1948, who lost both their homes and means of livelihood as a result of the 1948 Arab-Israeli conflict". UNRWA's definition of a Palestinian refugee also covers the descendants of persons who became refugees in 1948.

Most of UNRWA's funding comes from voluntary contributions of donor states, the largest being the United States, European Commission, the UK and Sweden. A small portion comes from non-governmental organizations and concerned individuals. UNRWA's biennium regular budget for 2008 and 2009 is just under 1.1 billion dollars, although it reports that expenditure will likely be less because of forecast shortfalls in donation income.

Due to the humanitarian crisis in the occupied Palestinian territory caused by the conflict and Israeli closures, UNRWA has launched repeated emergency appeals for emergency food, employment and cash assistance. In 2008 the Agency asked for an additional $262 million to cover these emergency needs (UNRWA, 2009).

2.5 UNRWA's Community Mental Health Programme (CMHP) in Gaza Strip

2.5.1 Overview of UNRWA's CMHP

In response to the increased level of violence and high rates of stress-related disorders reported in the Gaza Strip and in order to alleviate resulting psychological distress, UNRWA began two separate psychosocial support programs in 2002, one running under its Education Department with French financial support, the other running independently with Canadian funding. In 2005, with funding from the European Commission, the two programs were merged into one psychosocial support program, since renamed the Community Mental Health Programme. The program is now funded through UNRWA's Emergency Appeals with some project funding. Its objective is to encourage coping strategies and to promote mental well-being among the refugee population (UNRWA Fact sheet, 2008).

As of August 2008, CMHP had 183 active counselors. The vast majority of counselors each work in one of the UNRWA schools, with169 (or 92% of all) counselors in schools and 14 (8%) in one of UNRWA's health centers. CMHP counselors provide interventions including individual counseling, group counseling, group guidance, awareness meetings, and home visits. School counselors reportedly use a variety of approaches to help children and their families cope with the stressful environment of the Gaza Strip, including drama techniques, behavioral techniques, simplified cognitive techniques and self-care practices. Counselors working in health centers provide psycho-education and assist in managing the treatment of chronically-ill patients through lifestyle modifications (Ibid).

2.5.2 Distribution of Counselors in UNRWA Installations

Due to the low number of staff relative to the number of schools, CMHP only covers 79% of all UNRWA schools (169 out of 213 schools). Although there are a few exceptions where a

counselor would spend half the working week in one school and the other half in another, the ratio is usually 1:1, or one counselor working full-time in one location.

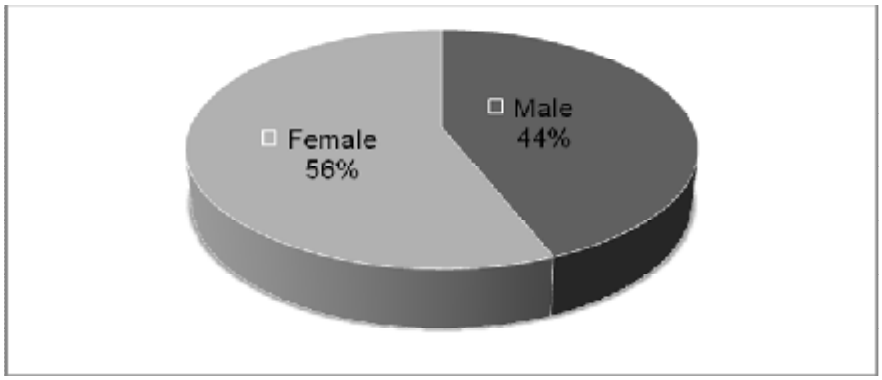
Although more elementary schools than preparatory schools have CMHP counselors (91 elementary schools compared to 78 preparatory schools), 92% of its preparatory schools have at least one mental health counselor while only 72% of all UNRWA elementary schools are covered. School coverage in terms of gender also favors girls, with 87% of all-girls schools having a counselor and 76% of the Co-ed and 78% of all-boys schools having one. (It should be clarified that, in the Gaza Strip, "Co-ed" schools are only in the elementary school level, and those schools categorized as "Co-ed Prep" in the chart below are actually combination Co-ed Elementary and all-girls Preparatory Schools.)

Table 2.1: UNRWA Schools and CMHP Counselors

School Level	All UNRWA Schools				UNRWA Schools with a CMHP Counselor				% of all Schools
	Boys	**Coed**	**Girls**	**Grand Total**	**Boys**	**Coed**	**Girls**	**Grand Total**	
Elementary	42	69	16	**127**	28	52	11	**91**	72%
Preparatory	50	6	30	**86**	44	5	29	**78**	91%
Total	**92**	**75**	**46**	**213**	**72**	**57**	**40**	**169**	79%
% of All Schools					78%	76%	87%		

The difference in school coverage by gender most likely has to do with the male/female ratio among the mental health counselors employed by the program. Out of 183 counselors, 103 (or 56%) are female and 80 (or 44%) are male.

Figure 2.1: Gender Balance of CMHP Counselors



The higher coverage of all-girls schools reflects the local cultural norm of positioning male counselors in male schools and female counselors in female schools. Additionally, all 14 counselors working in the clinics are female, possibly reflecting the assumption that clinics cater more to women and children and that therefore the beneficiaries would be more comfortable speaking with a female counselor.

2.5.3 Academic Background of Counselors

Out of 183 counselors, 45% hold a BA in Psychology while 55% hold a Bachelor's Degree (BA) in other fields including Sociology, Social Work, and Education. 171 out of 194 (89%) got their BA from a local Gazan university; 10 (5%) from a university in the West Bank, and 12 from a university outside of oPT. As Giacaman's study points out, while "the level of education in local universities may be relevant initial qualifications to work in the field of counseling, these undergraduate courses were not designed to prepare graduates to work in psychosocial or mental health care in a full professional capacity (Giacaman, 2004)." 179 counselors (98%) hold only Bachelor's Degrees, while 4 (2%) have gone on to receive Master's Degrees from local graduate schools. Master's Degrees from local graduate schools tend to give a more theoretical rather than practical or clinical education, as is implied by the curriculum(Islamic University website) All 14 counselors working in the health clinics have Bachelor's degrees (10 counselors have Bachelor's Degrees in psychology; 4 counselors have degrees in other fields).

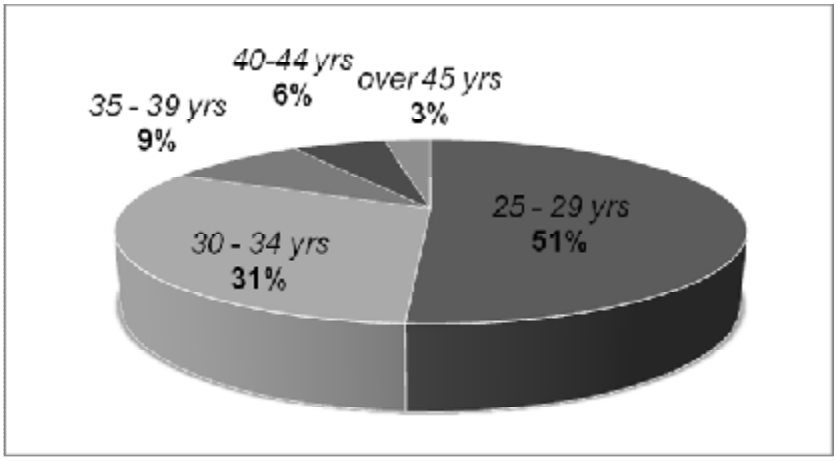
2.5.4 Work Experience of Counselors

The counselors have very limited work experience before their position in UNRWA's CMHP. Of the total, 161 counselors (88%) received their Bachelor's degree between 2000 and 2004, out of which 70 (38%) received their degree in 2002, which coincides with the time UNRWA began recruiting staff for its psychosocial projects. For most of the counselors, UNRWA provided them with their first work experience outside of university. Out of all the counselors, supervisors and assistant supervisors, 193 employees in total, 117 (61%) were working in UNRWA's psychosocial projects prior to the 2005 establishment of the program. In 2005, these 117 and an additional 76 candidates were officially hired as permanent UNRWA staff to work in its now-official psychosocial program.

2.5.5 Age Range of Counselors

The counselors are a young group; currently 93 counselors (51%) are between the ages of 25 and 29, placing them in their early 20's when they began working for UNRWA. The second largest age bracket, between the ages of 30 and 34, consists of 57 (31%) of the counselors.

Figure 2.2: Age Range of CMHP Counselors



2.5.6 Academic Background of Supervisors and Assistant Supervisors

The 183 mental health counselors are supervised by one of 3 area supervisors and one of 6 assistant supervisors. Supervisors and assistant supervisors are responsible for, among other things, "[*supervising the counselors in their fieldwork through individual and group supervision to assist counselors in understanding their weaknesses and strengths in addition to helping them manage their clients; modeling [sessions] for the counselors and the assistant supervisors, [and] support[ing] the mental health counselors in technical and administrative matters relating to the different activities of the programme (UNRWA, 2007).*

The limitation to education levels and professional training that applied to counselors similarly applies to those of supervisory roles. The academic backgrounds of the current 9 senior staff members (excluding the Program Manager) are as follows:

Table 2.2: Academic Background of CMHP Supervisors & Assistant Supervisors

Position in CMHP	BA Degree	MA Degree	Misc
Supervisor	BSc in Science & Education (Department of Mathematics)	MSc in Educational & Training Systems Design	High Diploma in Psychology
Supervisor	BA in Social & Familial Development		
Supervisor (Acting)	BA in Social Work (psychology minor)		
Assistant Supervisor	BA in Social Science		Postgraduate Diploma in Social Science
Assistant Supervisor	BA in Nursing	MA in Public Health (Community Mental Health)	
Assistant Supervisor	BA in Psychology		Postgraduate Diploma in Community Mental Health; Certificate in Professional Supervision
Assistant Supervisor (Acting)	BA in Arabic	MA in Psychology	
Assistant Supervisor (Acting)	BA in Psychology		
Assistant Supervisor (Acting)	BA in Psychology		Diploma in School & Family Counseling

3 out of 9 senior staff members have a Bachelor's Degree in Psychology, all of whom are or acting as Assistant Supervisors. None of the supervisors have a Bachelor's Degree in psychology.

2.5.7 Previous Evaluations of UNRWA's CMHP, 2002 to 2006

Between 2002 and 2006, there were a handful of evaluations of UNRWA's psychosocial program, conducted at different times by different parties. The earliest available document is a report summary compiled by evaluator(s) for France's Priority Solidarity Fund (FSP), the project aid instrument of its Ministry of Foreign Affairs and which financed one of UNRWA's two psychosocial projects from 2002 until 2005. The report brought to attention the lack of quantifiable indicators of program success due to the failure to define such indicators at the beginning of the project (Government of France Priority Solidarity Fund, 2004). It was also noted that Gaza did not have sufficient resources for supervising and training counselors compared with the West Bank. In conclusion, the report recommended that the program "[*harmonize the counselor's framework of intervention to strengthen their work with groups and awareness-raising in preference to individual care*" and "[*provide adequate training for counselors, in particular in running socio-cultural activities and improve supervision to make the best use of expertise on psychosocial issues* (Ibid)."

A WHO technical assessment mission on UNRWA's Health Programme pointed out the limited information available about the kind, coverage, and adequacy of UNRWA's mental health services and the outcome of the interventions (WHO, 2005). It also urged for the development of a comprehensive mental health program within UNRWA, including integration of mental health care with primary health care facilities, public mental health education, and a review of the ongoing psychosocial counselor program (Ibid).

In an internal report to the Director of Operations in Gaza, the then-Programmme Manager of UNRWA's Community Mental Health Programme outlined critical issues in the program, including the lack of "*meaningful training or supervision of counselors in Gaza…since programme inception*" (UNRWA, CMHP, 2006) and the unfocused attempt of the program *"to*

treat everything from sexual abuse, school violence, IDF bombing and unemployment through to schizophrenia (Ibid, 2006)". The report emphasized the need for solid epidemiological research into needs assessment, program focus and direction, and targeted outcomes in order for UNRWA's psychosocial program to be a success (Ibid, 2006).

The last documented evaluation of UNRWA's psychosocial program was a joint WHO-UNRWA mental health mission to Gaza and West Bank, conducted from 6 to 14 November 2006. Again the mission found inadequate documented information to inform on psychosocial / mental health needs of the population, effectiveness of services provided, capability of counselors to provide care, or the adequacy of counselor support and supervision (Murthy & Zakhary, 2006). From its brief study, the mission assessed that *"the care of the severely mentally ill [was] highly unorganized, the care of psychosocial / mental health problems in clinics [were] extremely limited and the care at the level of schools and community [were] poorly defined (Ibid)."*

Attached to the draft report was a report by the current Programme Manager of UNRWA's Community Mental Health Programme. Obstacles for counselors at schools were identified as: (1) an oppositional relationship between school teachers and mental health counselors; (2) lack of role definition; (3) administrative problems / lines of authority; (4) counselors' lack of experience, and (5) lack of facilities to enable counselors to conduct their work with confidentiality. Similar problems were identified for counselors in health clinics, with additional issues of lack of planning and clear scheduling (Ibid). The report also stressed the limited capacity of counselors, inadequate training "*that did not deliver many essential skills that counselors would need to be able to carry out their duties"*, and the insufficient knowledge or skills of supervisors to properly follow up on and train counselors (Zagout, 2006).

2.6 Previous Evaluations of Mental Health Information Systems

The researcher was unable to find any studies specifically evaluating the efficiency and effectiveness of any mental health information systems, indicating a dearth in this much-needed area of focus.

Chapter Three

Methodology

This chapter will present the study design and a definition of the study population and sample. The mixed-methods (quantitative and qualitative) questionnaire survey conducted on UNRWA's CMHP counselors is explained at length, including the designing, pre-testing, and implementation of the questionnaire. Data analysis procedures are explained, and issues that may have affected the outcome of the questionnaire and the limitations of the study are also outlined.

3.1 Study design

Specific methodological approaches included:

- A literary review to inform documentation review
- A review of all CMHP monthly reports submitted to UNRWA's Field Office (Office of the Director of Operations) between March 2007 and August 2008.
- Site visits to CMHP Area offices and several schools where CMHP counselors worked; informal discussions with CMHP staff members including senior staff (supervisors and assistant supervisors) and counselors.
- A detailed content-analysis of the CMHP database, focusing on individual counseling session records.
- An extensive mixed-methods (quantitative and qualitative) questionnaire survey of CMHP counselors to explore their views on training, their work environment, perceived needs and job satisfaction.

Site visits were conducted between July and December 2008, and analysis of CMHP monthly reports and database was conducted between September and December 2008.

For CMHP Information System

To get a better understanding of what kind of data related to CMHP activities were available (e.g., what kind of information was being disseminated by CMHP), the researcher first analyzed the statistics presented by CMHP in its monthly reports, between March 2007 and August 2008.

CMHP's data collection process was observed by the researcher during site visits at all 3 CMHP Area Offices and CMHP's main office in UNRWA Headquarters, Gaza City. Data-entry clerks and other CMHP staff including senior staff and counselors were interviewed to confirm the process.

All statistical analysis was also done using Excel software. Since all of the data was in Arabic, the researcher translated the merged file into English before commencing with the analysis, basing translation on terminology used in CMHP Monthly Reports (written in English) and in an English version of the database key obtained from CMHP management. For the purposes of this study, the content-analysis focused on individual counseling records dated between September 2007 and August 2008. The time period was chosen to be representative of the data trend for one complete school year and to eliminate complications due to significant differences in problem categories inputted before and after September 2007.

Questionnaire Survey

In order to gain insight to the experiences and perceptions of CMHP counselors in a systematic, standardized manner, the researcher conducted a comprehensive questionnaire survey among all CMHP counselors. The researcher utilized hand-out surveys in order to capitalize on having as many participants as possible available during a limited timeframe.

In the survey for this study, the researcher used a mixed-methods approach, converging quantitative and qualitative data collection in order to provide a comprehensive analysis of counselors' perception of work-related issues including training, work environment, and job

satisfaction. The researcher collected both forms of data at the same time, with the expectation that the results of one method will help develop or inform the other, and integrated the information in the interpretation of the overall results.

The survey instrument (questionnaire) was developed between November and December 2008; the survey was conducted at each of the 3 CMHP area offices between 15 and 17 December 2008, respectively. Participant anonymity in the survey was assured by asking staff members not to identify themselves on their questionnaires. Staff members working at UNRWA's Health Centers were asked to identify their venue only, so as to differentiate their data from those submitted by school counselors. 170 out of 183 counselors participated in the survey. The remaining 13 counselors were not available to participate in the survey due to personal reasons unrelated to the survey (sick leave, maternity leave, or extended leave without pay). Questions in the survey focused on institutional infrastructure, systems of worker supervision and support and views on training needs, as well as cases dealt with, approaches taken, significant issues encountered at work, and what they perceived were their learning and development needs.

3.2 Population and Sample

3.2.1 Study Population

The population of this study was all CMHP counselors working in UNRWA installations (health centers and schools) throughout the Gaza Strip.

3.2.2 Study Sample

Out of 183 counselors, 103 (or 56%) were female and 80 (or 44%) were male. 93 counselors (51%) were between the ages of 25 and 29, placing them in their early 20's when they began working for UNRWA. The second largest age bracket, between the ages of 30 and 34, consisted of 57 counselors (31%).

3.3 Ethical Considerations Related to Participants of the Survey

With regards to the questionnaire survey, as the researcher had an obligation to respect the rights, needs, values, and desired of the participant(s), the following safeguards were employed to protect the participants' rights:

1. The research objectives were articulated verbally so that they were clearly understood by the participants, including a description of how data would be used.

2. Participant anonymity was assured by asking the participants not to reveal their names in their questionnaire. The only characteristic identified on the questionnaire was the counselor's venue (i.e., counselors working in UNRWA health centers were asked to write "clinic" on the top of their questionnaire form, to differentiate their data from those of counselors working in schools). Gender, age, specific venue, etc., were not identified. This strategy was adopted in an effort to facilitate honest feedback and disclosure by the participants.

3. A cover letter to the questionnaire included information about the purpose and importance of the survey, assured respondents of anonymity and confidentiality, explained how results may be used to inform and improve program services.

4. Participants were assured that they would be informed of the written interpretation and reports of the questionnaire.

3.4 Instruments of the study

3.4.1 Structure of the Questionnaire

The entire questionnaire was composed of 95 questions, divided into 2 parts:

1. The first part of the questionnaire consisted of 79 statements, divided into 5 sections:

a) On CMHP Training (19 statements)
b) On Work Environment, Resources and Support (20 statements)
c) On Supervision (17 statements)
d) On Communication with CMHP Management (8 statements)
e) On Job Satisfaction (15 statements)

Respondents were asked to choose their answer for each statement from a 5-point Likert scale: (1) Strongly Disagree, (2) Disagree, (3) Neither Disagree nor Agree, (4) Agree, or (5) Strongly Agree.

2. The second part of the questionnaire consisted of 16 questions, 14 of which were open-ended (i.e., requiring written narrative). Many of the questions related to the counselor's work environment, including perceived training needs, needed resources and support, and various problems among their clients.

3.4.2 Pre-testing of the Questionnaire

The questionnaire was originally drafted by the researcher in English. It was then reviewed critically by several UNRWA colleagues including senior management. Suggestions that enhanced the questionnaire were heeded, and after careful revision and examination, the questionnaire was translated into Arabic by a native-Arabic speaker. The translated version was again reviewed critically by at least 5 native-Arabic speaking colleagues working at UNRWA, to ensure that the wording and instructions were as clear as possible to all.

Due to time restrictions, the researcher was unable to pilot-test the questionnaire on a sample group of CMHP counselors to further ensure clarity, which may have affected the outcome of the survey. To keep any misunderstandings or misinterpretations to a minimum, the researcher was present during the survey and was available to answer any questions by the counselors regarding the questionnaire.

The complete questionnaire is attached to this study as Annex 9.

3.4.3 Conducting the Questionnaire

The questionnaire was conducted over three consecutive days in the three UNRWA CMHP area offices in the North, Middle, and South Area, respectively. To reduce disruption to their work schedules counselors were asked to participate in the survey either before or after their work commenced, depending on their shifts (e.g., the morning shift counselors came to the office in the afternoon; the afternoon shift counselors came to the office in the morning to fill in the questionnaire).

Out of 183 active counselors, 170 participated in the survey during these three days. Of these 170 counselors, 159 worked in UNRWA schools while 11 worked in UNRWA health centers. The remaining 13 were unavailable to participate due to personal reasons unrelated to the survey, including sick leave and maternity leave.

The majority of counselors completed the questionnaire in approximately one hour. Counselors were given as much time as they needed to complete the questionnaire.

3.4.4 Data Analysis Procedures

Each questionnaire was given a unique identification number by the researcher. All data in the particular questionnaire was inputted into a Microsoft Excel file along with the corresponding code. The quantitative portion of the questionnaire was carefully entered into a spreadsheet and triple-checked for inaccuracies.

The qualitative portion of the questionnaire was translated from Arabic into English with the assistance of a native Arabic-speaking UNRWA staff (i.e., the assisting staff member read each respondent's answer out loud in Arabic; the researcher then translated what was read into English and inputted the translation into the Excel file).

3.4.5 Issues Possibly Affecting the Questionnaire Results

Some well-documented phenomena for participants in questionnaires in general (Hartge & Cahill, 1998) may have had an effect on the results of this survey as well and so should be taken into account:

- Toward the end of a lengthy questionnaire, respondents tend to respond similarly to all remaining questions (all positive or all negative) (Aday, 1996). As the questionnaire was relatively lengthy (95 questions in all, taking an average of an hour to complete), the survey may have induced response fatigue among respondents and resulted in uniform and inaccurate answers.

- Respondents may have had trouble taking the time and energy to answer open-ended questions. In this study, this particular phenomenon was suggested by significantly similar responses among questionnaires submitted consecutively (as the researcher tended to collect questionnaires from participants as they were seated).

- Where questions on satisfaction may cause problems, respondents tend to give positive answers when answering questions on satisfaction (Aday, 1996).

- In what is referred to as the "faking bad" phenomenon, respondents answer negatively to appeal for more support. For example, in a question such as "which of the following problems do you have", respondents may tend to check more problems than they really have (Ibid).

- In what is referred to as the "faking good" phenomenon, respondents may systematically alter questionnaire responses in the direction they perceive to be desired by the researcher. Socially undesirable answers tend to be under-reported (Foddy, 1993).

- Completing a questionnaire can be a learning experience for the respondent about the hypotheses and expected answers in a study. Having thought about prior questions can

affect the respondent's answer to subsequent questions through the learning process as the questionnaire is completed, which might have happened in the open-ended second part of the questionnaire in relation to the close-ended first part.

- Since participants were being asked about past events (e.g., the number and types of training undertaken in the past two years), respondents may have had inaccurate or incomplete recall and provided imprecise information.

3.5 Limitations of Study

- *Database Analysis:* Due to time and resource restrictions, the focus of database content analysis was only on individual counseling sessions and not on the contents of the entire database.

- *Site Visits*: Due to tight time constraints, the researcher was only able to visit a sample of UNRWA schools. To compensate for not visiting UNRWA's health centers, during visits to the Area Offices the researcher engaged in informal discussions with health center counselors and with supervisors / assistant supervisors to get a sense of the circumstances under which health center counselors worked and how their situations might differ from those of the school counselors.

- *Survey:* The questionnaire for the CMHP counselor survey could not be piloted due to time restraints. However, the questionnaire was peer-reviewed by several UNRWA colleagues and those of higher management to ensure clarity, consistency and relevance.

- *Language:* As the researcher is not a native Arabic speaker, there may have been some errors in translation when converting the data from Arabic into English (both for the CMHP database and for the questionnaire survey). The researcher made every effort to keep such translation errors to a minimum by checking with native Arabic speakers for clarification / confirmation on any unclear terminology.

- *Potential for Observer Bias*: The researcher was conscious of the potential for the researcher's observer bias in interpretations and analysis and made every effort to keep to a minimum by focusing on written documentation, reported figures, and actual reports from staff members.

Chapter Four

Results

This chapter presents the findings of this study. First, an analysis of UNRWA CMHP's monthly reports will be presented, focusing on the statistics published. Relevant concerns with data interpretation are addressed, including issues with overly-general figures lacking sufficient context and non-mutually-exclusive categorization of counseling problems.

This is followed by a presentation of a comprehensive contents-analysis of CMHP's database system, specifically concerning the individual counseling sessions reported by the CMHP counselors. Problems with the database are discussed, such as an inadequate data collection process and a problematic database design. Data trends extracted from CMHP's database records for the time period between September 2007 and August 2008 are then presented, including pertinent differences between figures reported for UNRWA schools and for UNRWA's health centers such as reported age groups, most-frequently reported problems, referral sources for clients, types of reported interventions used during sessions, and reported outcome of sessions. Client numbers are compared with session numbers, and the average number of counseling sessions per client is presented. Problem categories are further analyzed, including cross-translation issues and an analysis of pre-August 2007 manually-inputted problem terminology.

The results of the mixed-methods questionnaire survey on UNRWA's CMHP counselors are presented. Counselors' satisfaction level (overall, on training, on their work environment, on supervision, on communication with CMHP management, and their job satisfaction) are examined. CMHP counselors' detailed responses regarding the topics listed above are summarized and quantified. Finally, CMHP counselors' suggestions to improve CMHP are presented.

4.1 Analysis of UNRWA CMHP Monthly Reports

4.1.1 Statistics on CMHP Activities in Monthly Reports

In each monthly report, the 6 General Types of CMHP Interventions (Activities) described by CMHP (UNRWA, 2008) are:

- Individual Counseling – "*counselors [meet] with [a] beneficiary suffering from disturbed behavior impacting his normal life… through [a] series of sessions [the counselor] tr[ies] to help him overcome his suffering using [a] variety of techniques and coping methods like cognitive behavioral and life skills training interventions.*"
- Group Counseling – "*the counselor ha[s] 6-9 clients having similar problems… [who] are encouraged gently to share their experiences and learn from each others.*"
- Group Guidance – "*these are… conducted in schools through a series of developmental stage appropriate mental health topics [including] adolescent] development for preparatory] class students… and [on] overcoming exam anxiety at times of exams.*"
- Public Awareness Meetings – "*adults [are] invited for [a] meeting about [a] certain mental health topic.*"
- Home Visits – visits to the homes of beneficiaries
- Other Activities – (listed as part of CMHP's Community and Psychosocial intervention but not specifically defined in available documents)

Each CMHP monthly report gave figures related to the 6 CMHP's interventions, tallying the total number of sessions by all the counselors combined (over the whole of the Gaza Strip) for each intervention category, as shown in Annex 1 (a).

For each of the 6 types of interventions, each monthly report also presented a breakdown of figures for the entire Gaza Strip by:

- The number of sessions

- The number of beneficiaries
- The number of beneficiaries over the age of 18 (adults)
- The number of beneficiaries according to gender (male / female)
- The number of beneficiaries according to place (school / clinic / association)
- Counseling Coefficient, or the average number of sessions a counselor spends with a particular client until that client no longer requires counseling
- Percentage Rates (rate of improvement / recovery / no change, respective of the total number of sessions)
- The number of referrals

An example of how CMHP presented the above data is shown in Annex 1 (b).

Some obstacles to the interpretation of this data are:

- It is indeterminable which of the reported sessions and beneficiaries were new cases, follow-up cases, relapses, etc.

- The reported numbers of beneficiaries were divided by gender, location, etc., but were not subdivided within categories to give a clearer picture of client characteristics (e.g., the number of female clients in clinics)

- The statistics were presented without a denominator (e.g., the school's total population) to better put the figure into context

- It is unclear how the total number of beneficiaries and session numbers for each month were divided among the approximately 183 active CMHP counselors working at various UNRWA schools and clinics during the period under review. For example, it cannot be determined from the data whether certain counselors, venues, areas, saw more clients or conduct more activities than others.

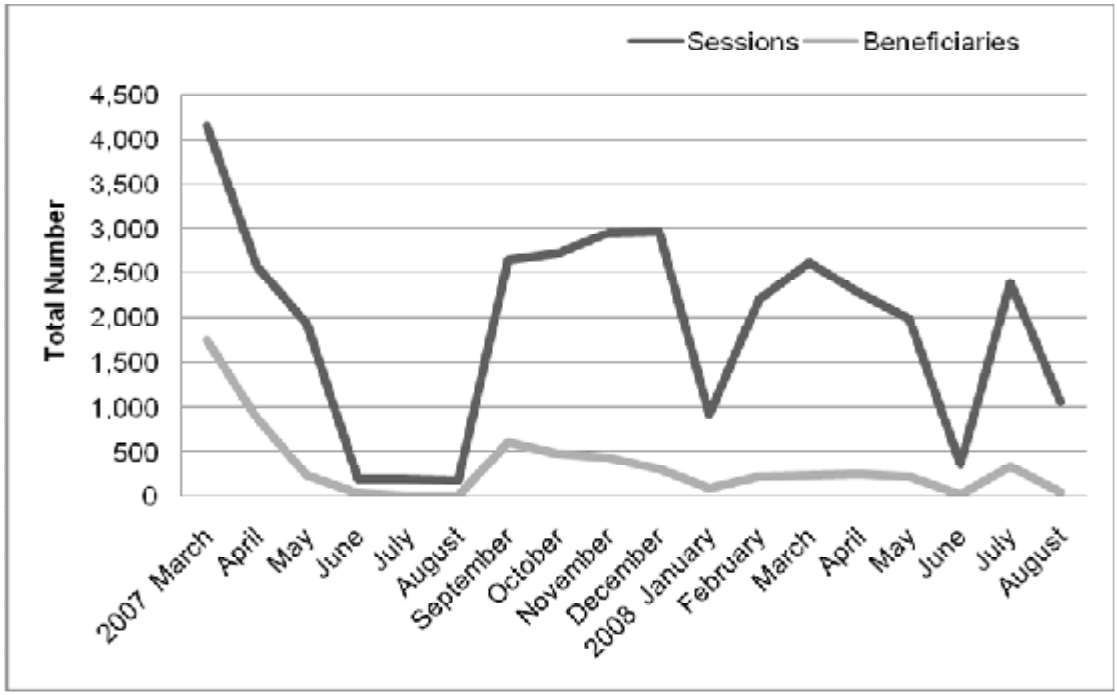
- According to CMHP, the "Counselor Coefficient" is the average number of sessions in which any given client participates before concluding counseling, but different problems would likely require different lengths of intervention periods. It is also unclear how this figure could be calculatedly on a monthly basis, unless all clients finished their sessions within the same month they began seeing the counselor.

- In either individual or group counseling sessions, it is unclear how the percentage rates of improvement, recovery, and no-change were calculated or how such figures could be generalized across the whole of the Gaza Strip, irrespective of age, gender, venue, etc. There is also no indication of any deterioration or voluntary discontinuation (dropout) of cases, which are phenomena commonly reported in the counseling field.

4.1.2 Individual Counseling Sessions Reported in CMHP Monthly Reports

The total figures reported for individual counseling sessions between March 2007 and August 2008 were compiled by the researcher for purposes of comparison (see Annex 2).

Figure 4.1: Total Numbers of Sessions and Beneficiaries, March 2007 - August 2008



When the figures were compared along the 18-month span, some interesting trends in the data were:

- **A large variation in total number of sessions per month**: The reported number of sessions ranged from the high-hundreds (the lowest number reported was 172 sessions during August 2007) to the thousands (the highest number reported was 2,967 sessions during December 2007). Session numbers were predictably highest during the school year, decreasing between 30 and 60% during the months of midterm and final exams (January and June, respectively), since the majority of counselors work in UNRWA schools.

- **A large variation in total number of clients per month:** The reported number of clients ranged from the tens (13 clients in July 2007) to the hundreds (615 clients in September 2007), with number fluctuations likewise affected by the school term.

- The great increase in figures reported in July 2007 (188 sessions and 13 clients) and July 2008 (2,393 sessions and 340 clients) was likely due to the increased role of CMHP counselors in the Summer Remedial classes offered by UNRWA during the latter period.

- **A small number of referred cases:** Very few referred cases were reported, ranging between 2 to 18 cases per month for the entire Gaza Strip, with 18 cases in March 2008 being unusually high compared to the other months (i.e., a total of 10 cases for the month was the second highest tally) . In 12 out of the 15 months between March 2007 and August 2008, CMHP reported less than 10 cases per month (March to May 2007 did not report any referred cases). The average number of referred cases per month was 6.1.

- **A large variation in Counseling Coefficient:** The Counseling Coefficient ranged from 2.2 sessions per client to 18.3 sessions (August 2008). The larger figure is also interesting in that it means the average beneficiary attended 18.3 counseling sessions, an unlikely figure and completely out of the range of any other reported Coefficient figure.

4.1.3 CMHP Monthly Problem Statistics

The CMHP monthly reports between March 2007 and August 2008 included a breakdown tally of problems reported by the CMHP counselors during individual counseling sessions for the particular month (see Annex 1 (c)).

Some issues apparent from this data are similar to those mentioned in Section 4.1.1:

- The cases were not broken down into new, follow-up or relapse
- The figures were not broken down by venue (health centers, schools, associations), though each venue would likely cater to different groups of clients.
- The cases were also not broken down by gender or by age group, which would have given the audience more insight to problems reported among particular groups.

4.1.4 Types of Reported Problems during Individual Counseling Sessions

When all the individual counseling session problems reported in each CMHP monthly report were compiled (see Annex 3), the following points were observed:

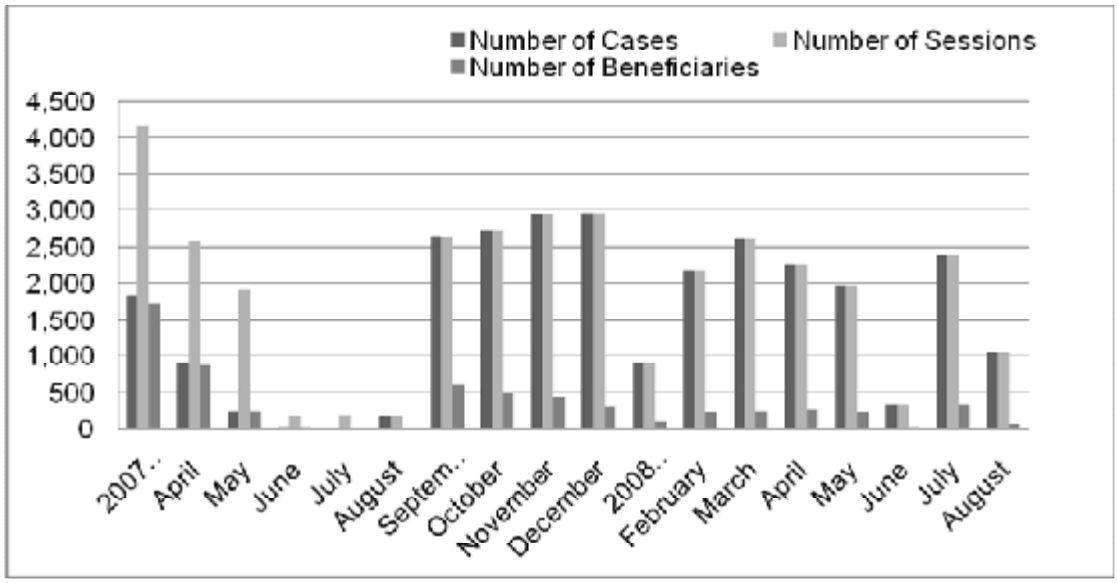
- **A sudden inconsistency in the number of cases starting August 2007:** There is a discrepancy between the reports' use of the term "cases" (the number of clients) and the term "sessions" (the number of meetings a counselor has had with a particular client).

  Between March 2007 and July 2007, the total number of reported cases was nearly or equal to the total number of beneficiaries, whereas between August 2007 and August 2008, the total number of reported cases was equal to the total number of sessions.

  March 2007-July 2007: Total # of Cases = Total # of beneficiaries
  August 2007 – August 2008: Total # of Cases = Total # of Sessions

  Due to this sudden divergence, between March 2007 and August 2008 CMHP reported a total of 28,287 cases, 34,306 sessions, and 6,253 beneficiaries treated by its counselors in individual counseling sessions (i.e., CMHP reported a significantly higher number of cases than beneficiaries).

Figure 4.2: Numbers of Cases, Sessions, and Beneficiaries Reported in CMHP Monthly Reports, March 2007 - August 2008



- **CMHP reports an extensive range of problems:** The problem categories ranged from the minor and very specific (e.g., "*nail-biting"*), to the general (e.g., "*family problems*"), to the highly-specialized disorders requiring assessment by qualified professionals (e.g., "*personality disorder*"). Some of the categories are also open to multiple interpretations (e.g., the criteria used for "*aggression*").

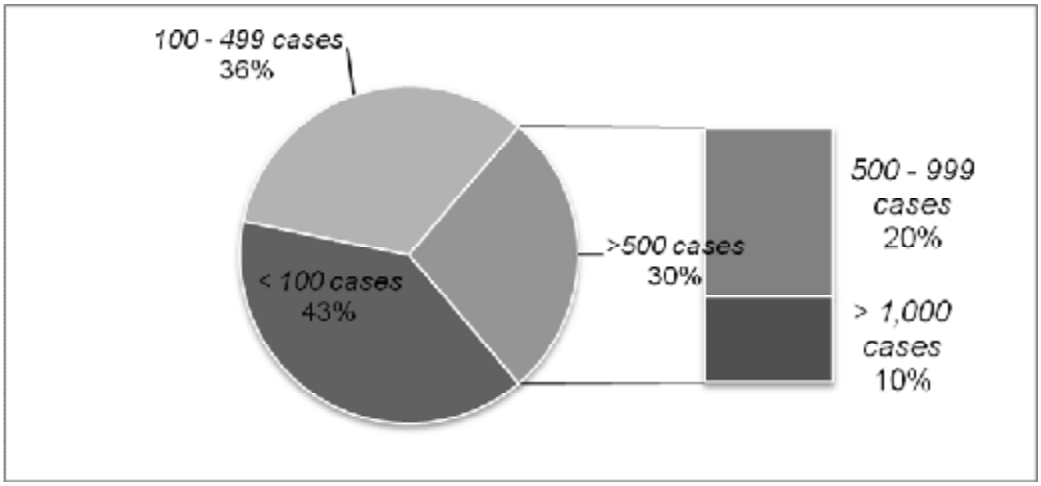
- **85 problem categories were reported between March 2007 and August 2008:** During the 18 months, a total of 85 separate problem categories were reported in the CMHP Monthly Reports. The total number of problem categories varied depending on the month. The highest number was reported in March 2008 at 63 types of problems, and the lowest number was reported in August 2007 at 34 types. An average of 52.8 problems types a month were reported by CMHP during this time period.

  Comparing the different problem categories across 18 months, it is apparent that some problem categories underwent changes in August 2007 (i.e., a number of categories stopped being reported at that time, while other categories started being reported). The researcher combined terms that were likely related (e.g., enuresis and bedwetting, one being the technical term for the other; messiness and sloppiness, etc.), using the latter

terminology, bringing the total number of problem categories from 85 down to 69 (see Annex 3).

- **Not all problems were reported equally.** 43%, or 30 out of 69 problems, each reported less than 100 cases for the entire 18 months, respectively. 36%, or 25 of 69 problems, totaled between 100 and 500 cases for the same duration. 20%, or 14 of 69 problems, totaled more than 500 cases, of which only 7 problems totaled more than 1,000 cases.

Figure 4.3: Individual Counseling Problems, Divided by Total Number of Reported Cases, March 2007 - August 2008



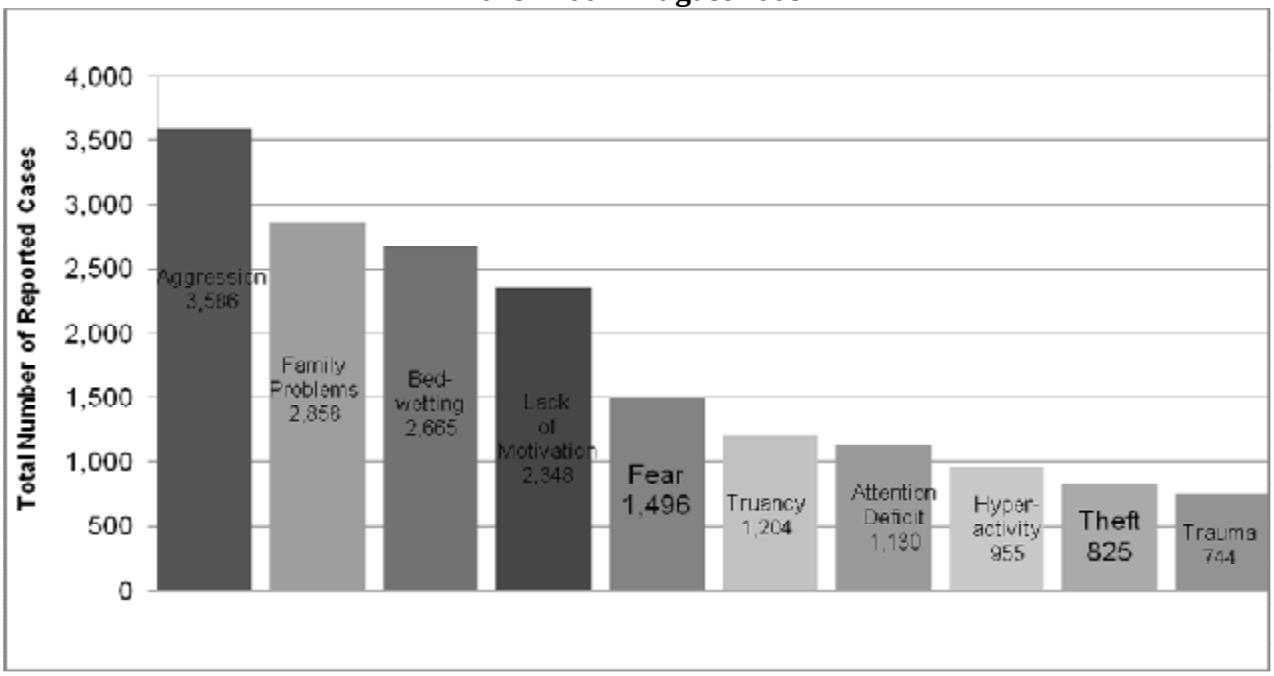
- The most commonly-reported problem for individual counseling was "*Aggression*", totaling 3,586 reported cases for the 18 months.

- The total number for "*Aggression*" (the most reported problem) was 2.4 times the total number for "*Fear*" (the 5th most reported problem) and nearly 5 times the total for "*Trauma*" (the 10th most-reported problem).

- The least-reported problem was "*Conduct Disorder*", a mere 4 cases during this time period.

Figure 4.4 below shows the 10 problems most reported by counselors for individual counseling sessions between March 2007 and August 2008.

Figure 4.3: Most-Reported Problems for CMHP Individual Counseling, March 2007 -August 2008



4.1.5 Categorization of the CMHP Problems

As previously mentioned, the individual counseling problems reported in the CMHP monthly reports extended from the relatively minor (e.g., "*thumb-sucking*") to the highly-specialized disorders requiring assessment by qualified professionals (e.g., "*autism"*).

To demonstrate the wide-ranging assortment of reported problems, the researcher divided the 69 problems into 4 groups, utilizing the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is the internationally-recognized manual published by the American Psychiatric Association and utilized by mental health professionals from a variety of disciplines

and backgrounds for a wide range of purposes, including clinical, research, administrative, and educational that contains a listing of psychiatric disorders and their corresponding diagnostic codes. Each disorder included in the manual is accompanied by a set of diagnostic criteria and text containing information about the disorder, such as associated features, prevalence, familial patterns, age-, culture- and gender-specific features, and differential diagnosis. The current version of the DSM, called the DSM-IV-TR, was published in July 2000.

The problems were divided into the following 4 groups (see Table 4.4):

- *Focus of Intervention* – a general category too vague to be a criterion for diagnosis
- *Symptom* – a possible criterion for a DSM disorder
- *Formal DSM Disorder* - a psychological or behavioral pattern that occurs in an individual and is thought to cause distress or disability that is not expected as part of normal development or culture
- *DSM Category* – A general category under which a number of formal disorders are organized

Table 4.4: CMHP Problem Categorization, According to DSM-IV-TR

Focus of Intervention	Symptom	Formal DSM Disorder	DSM Category
- Bad Company - Bad Studying Habits - Daydreaming - Eating Problems - Family Problems - Fear - Inappropriate Language - Inappropriate Sexual Behavior - Joking - Low Self-Esteem - Messiness - Nail Biting - Over-Dependency - Perfectionism - Prejudice - Rivalry - Selfishness - Sensitivity to Critics - Shyness - Social Isolation - Temper Tantrums - Thumb Sucking - Time Misuse - Trauma	- Aggression - Anxiety - Cheating - Compulsivity - Cruelty - Destructiveness - Disobedience - Egocentricity - Fire Setting - Hyperactivity - Lack of Motivation - Running Away (from home) - Self-Harm - Sleep problems - Sleep walking - Stammering/Stuttering - Substance Misuse - Telling Lies - Theft - Truancy - Tic	- Attention Deficit - Autism - Bed Soiling (Encopresis) - Bed Wetting (Enuresis) - Bipolar Disorder - Conduct Disorder - Depression - Generalized Anxiety Disorder - Mental Retardation - Nightmare Disorder - Sleep Terror Disorder - Obsessive-Compulsive Disorder - PTSD - Panic Disorder - Schizophrenia - Simple Phobia - Social Phobia - Somatization Disorder	- Dissociative Disorder - Eating Disorder - Learning Disability - Personality Disorder - Sleep Disorder - Substance Use Disorder - Sexual Disorder - Mood Disorder
24	**21**	**18**	**8**

It must be emphasized that the above table is only one possibility of how the 69 problems could possibly be categorized. Some terms, depending on the context in which the terms are used and interpreted, could easily transfer to any of the other categories. For example, depression is a term used both as a layman's description of a mood and in clinical terms, as in clinical depression, or Major Depressive Disorder. The researcher hopes that the table above illustrates the **categorical differences between the reported problems** and the difficulties that may arise for counselors who use this terminology when reporting on their clientele.

The figures published in the **CMHP reports also do not mention co-morbidity**, a common factor in mental and physical health. In psychology and mental health counseling, co-morbidity refers to the presence of more than one diagnosis occurring in an individual at the same time. In psychiatry, co-morbidity does not necessarily imply the presence of multiple diseases, but instead can reflect the inability to supply a single diagnosis that accounts for all symptoms (First,

2005). For example, eating disorders often include depression; learning disabilities often lead to frustration, which a teacher may potentially interpret as disobedience in the classroom.

Other information that may add more practical and analytical value to the figures reported regarding individual counseling problems include:

- **Multiple variables** (e.g., the most common problem among girls in secondary school in the Khan Younis)
- A breakdown of the **referral sources** (e.g., who referred the client to the counselor), linked with the reported problem
- A breakdown of **the types of "intervention**" used with the clients, linked with specific problems
- A breakdown of **outcomes** of individual counseling sessions, linked with specific problems
- Referrals (and breakdown of specific problems) and **follow-up of referral cases**

4.2 Analysis of the CMHP Database

4.2.1 CMHP Data Collection Process

CMHP's data collection process was observed by the researcher during site visits at all 3 CMHP Area Offices and CMHP's main office in UNRWA Headquarters, Gaza City. Data-entry clerks and other CMHP staff including senior staff and counselors were interviewed to confirm the process.

The data collection process was as follows:

1) Each CMHP counselor fills in a standardized bimonthly report on each of the 6 CMHP interventions (see Section 3.1). The reports are generally written in Arabic, and the details correspond to the database variables, listed in Table 7.

2) The counselors submit a hard-copy summary of their report to their area CMHP office.

3) The data-entry clerk at each Area Office inputs the data in each counselor's bimonthly report to an Access file developed by CMHP. All data are also inputted in Arabic.

4) At the end of every month, each area office sends its database file to CMHP headquarters in Gaza Field Office. The headquarters' data-entry clerk combines the 3 area databases into one merged file for that particular month. In other words, CMHP has a separate database for every month of every year, each database file completely unlinked to any of the other months.

5) Every month, CMHP headquarters' data-entry clerk tallies the total of all three areas and compiles the information for the CMHP Monthly Report.

Some issues arising from this data collection process include:

- **Lack of data quality checks**: The researcher did not observe any systematic cross-checking or data validation either at the counselor level or at the data-entry clerk level to ensure quality data.

- **Lack of data dissemination among CMHP staff**, especially counselors: The results of the data collection were not disseminated from the CMHP headquarters either to any of the Area Offices or among the CMHP counselors. This lack of feedback may influence the quality of data collection, as there may not be enough incentive for counselors, data-entry clerks, etc., to make sure they collect the data correctly (e.g., they cannot gain the practical knowledge resulting from their fieldwork data collection).

4.2.2 CMHP Database Overview

CMHP's database utilizes software called Microsoft Access, which is a relational database management system that combines a database system with a graphical user interface. This software is designed for storing, managing and retrieving information in the form of tables. Microsoft Access is also considered ideal for storing and searching vast interrelated tables of information and is well suited for individual and workgroup use across a network (MacDonald, 2007).

Database tables consist of columns and rows. Each column contains a different type of attribute and each row corresponds to a single record. In CMHP's database, one complete "individual counseling session" record has 17 fields, as shown in Annex 1 (d).

4.2.3 Compilation of CMHP Databases

For analytical purposes, the researcher merged the individual counseling records from each separate database file (from March 2007 until August 2008) into one Microsoft Excel file. All statistical analysis was also done using Excel software.

As seen in the table below, the total number of records in each month's database roughly corresponds to the reported number of "cases" in the CMHP monthly reports, confirming that in its reports CMHP had been using the term **"cases" to mean "counseling sessions"**, not "beneficiaries":

Table 4.5: Comparison of Database (DB) Record Numbers and Figures in CMHP Monthly Reports

Month	# of DB Records	# of Cases in CMHP Monthly Report	# of Beneficiaries in CMHP Monthly Report
2007-Mar	4,161	4,161	1,741
2007-Apr	2,581	2,581	884
2007-May	1,935	1,929	243
2007-Jun	184	182	35
2007-Jul	190	188	13
2007-Aug	172	172	17
2007-Sep	2,645	2,645	615
2007-Oct	2,724	2,724	486
2007-Nov	2,950	2,950	442
2007-Dec	2,970	2,967	317
2008-Jan	918	918	96
2008-Feb	2,205	2,203	226
2008-Mar	2,616	2,614	235
2008-Apr	2,506	2,272	257
2008-May	1,999	1,992	221
2008-Jun	353	353	27
2008-Jul	2,394	2,393	340
2008-Aug	1,062	1,062	58
Total	**34,565**	**34,306**	**6,253**

4.2.4 Translation of the Database

Since all of the data was in Arabic, the researcher translated the merged file into English before commencing with the analysis, basing translation on terminology used in CMHP Monthly Reports (written in English) and in an English version of the database key obtained from CMHP management.

Two general issues with the database records before translation were:

- *Data-Entry Errors:* Several fields had spelling errors and unidentifiable entries in key fields such as the counselor's name and workplace. These type errors likely occurred either because the counselors were not clear in writing their information or the database

clerks made mistakes entering the data to the database. All records with key data undecipherable because of data-entry errors were removed from the analysis.

- *Missing Fields in the CMHP Database Records:* There were a number of fields missing, mostly in the early months. Empty fields decreased significantly after this, with the sole exception of October 2007's database file, which had 2,724 records with 1,538 empty fields. In total, between March 2007 and August 2008 the CMHP database had 34,565 records with 40,411 empty fields.

Where possible, the researcher made every effort to fill in missing information and correct obvious mistakes in data-entry. For example, if the record showed the counselor's name and a date, the research was able to fill in missing data on the counselor's workplace. In this manner, the researcher was able to fill in 5,894 Work Place fields, 1,382 Counselor's Name fields, and 5,929 Area fields. However, other data were impossible to fill in (e.g., Client ID number). Records with empty key fields (missing names, locations, dates) were removed from the study.

For the purposes of this study, the analysis focused on individual counseling records dated between September 2007 and August 2008. The time period was chosen to be representative of the data trend for one complete school year and to eliminate complications due to significant differences in problem categories inputted before and after September 2007.

Although the records for this duration included data for 185 counselors, records for two counselors were removed from the analysis because their data were incomplete for the time period (i.e., one counselor passed away while the other counselor was promoted to Acting Assistant Supervisor mid-year). Additionally, the analysis focused only on health centers and schools, since CMHP reported its activities to be mainly at these two venues. In total, 25,380 records between September 2007 and August 2008 were analyzed.

To facilitate analysis, the researcher also added 5 fields to the original database:

- ***Elem/Prep**:* Elementary School, Preparatory School, and n/a (for Health Center locations)
- ***B/G/Coed***: Boys, Girls, or Co-educational School, and n/a (for Health Center locations)
- ***Governorate**:* Beit Hanoun, Jabalia, Gaza, Nuseirat, Bureij, Der Balah, Maghazi, Khan Younis, and Rafah
- ***Area**:* North, Middle, and South of the Gaza Strip

4.2.5 Analysis of CMHP Individual Counseling Sessions

Several variables in the database were examined to get a better understanding of the population who reportedly participated in CMHP individual counseling sessions:

- Client age groups
- Most-frequently reported problems
- Referral sources for clients (who brings each client to the CMHP counselor)
- Types of reported interventions used during sessions
- Reported outcome of sessions

Since it can be assumed that counselors at health centers might have different clients to those at schools (e.g., a school counselor would normally deal with his/her school's students, while a health center counselor would deal with a much broader age group), database records were also sorted by venue and compared to determine similarities and differences.

4.2.6 Reported Age Groups of Clients per Session

4.2.6.1 CMHP Clients at UNRWA Health Centers

- The client ages at health centers ranged from 0 to 66 years (excluding 2 obvious data-entry errors, such as ages 117 and 222).

- The total number of sessions for females was nearly twice the number of sessions for males (3,089 for females, 1,564 for males). The gender difference becomes more obvious when calculated for adult clients (age 18 and older); **female adult clients outnumbered male adult clients 11 to 1** (1,843 for females, 162 for males).

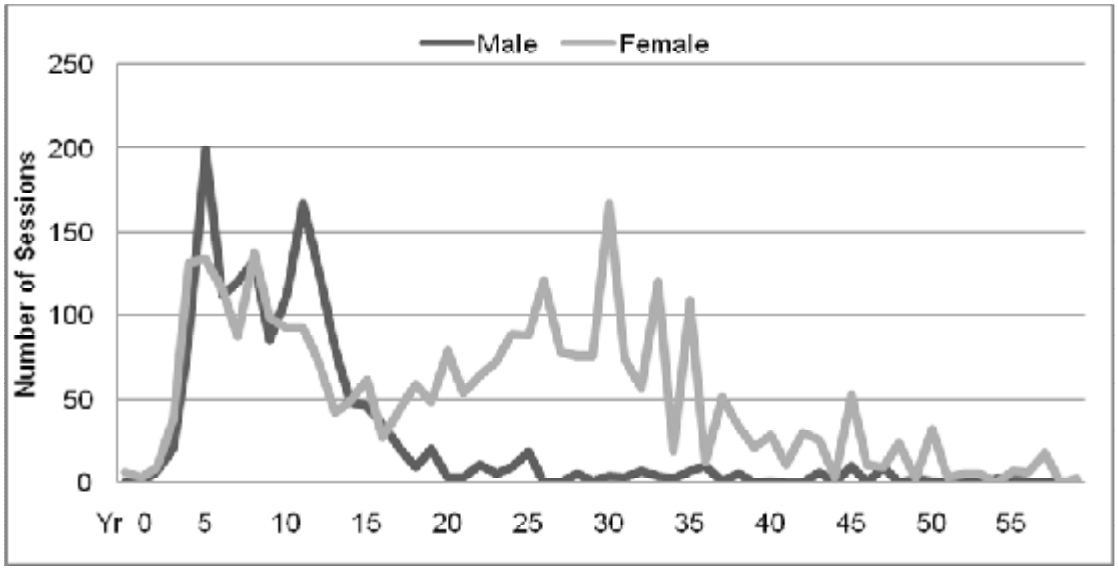
- **For males**, the number of sessions was highest between the **ages of 5 and 12** (1,055 records, or 67% of all individual counseling sessions for males in UNRWA health centers).

- The largest frequency for males was for clients 5 years of age (199 records). After the age of 12, counseling sessions for males decreased significantly, going from 80 sessions at Age 13 down to 21 sessions at Age 17, and ranging from 0 to 20 sessions from the ages of 18 to 66. The concentration of male clients under the age of 13 seems to reflect the tendency for more females to attend health centers than males (the male clients likely being brought in by their mothers).

- **For females**, there were two significant clusters of frequencies: (a) between the **ages of 4 and 12** (965 records, or 31% of all female individual counseling sessions in UNRWA health centers), and (b) between the **ages of 26 and 35** (897 records, or 29% of all female sessions).

- The highest frequency of sessions was for females aged 30 (167 records).

Figure 4.4: Ages of CMHP Clients at UNRWA Health Centers, per Session (0 - 66 yrs)



4.2.6.2 CMHP Clients at UNRWA Schools

As the majority of CMHP counselors work in UNRWA schools (which are either elementary or preparatory), it can be safely assumed that the majority of clients seen by counselors would be of corresponding ages, between approximately 6 to 15 years of age (grades 1 through 9).

To include students who may have been held back and were thus older than their peers, the researcher calculated the records for all UNRWA school clients between the ages of 6 to 18 years. 441 records (or 2% of the total), ages 1 to 5 and 19 to 198, were excluded from this portion of the analysis.

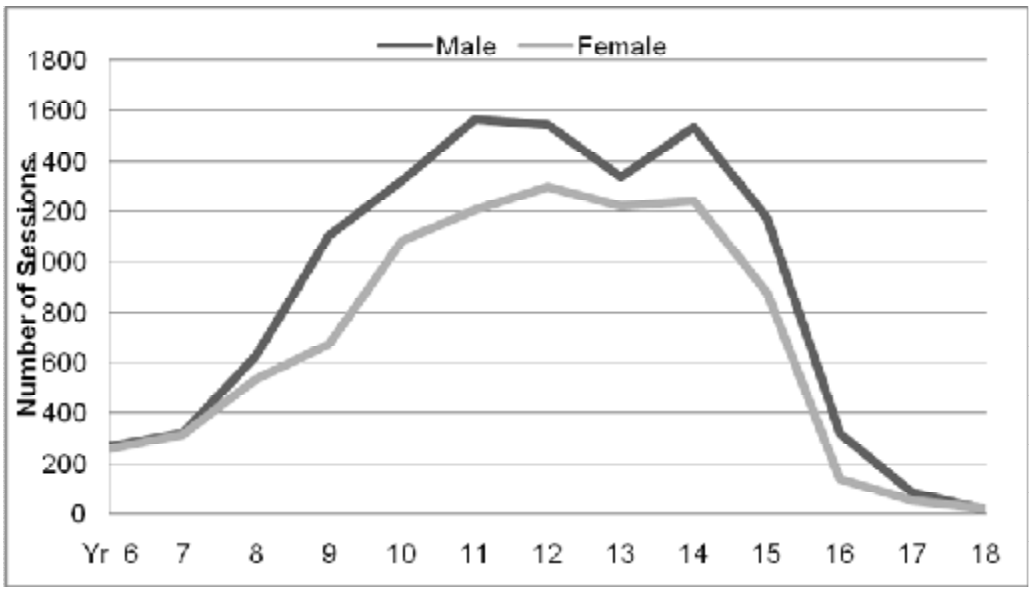
- The total number of sessions for males was higher than for females in UNRWA schools (11,218 for males, 8,943 for females, or **56% of the total for males, 44% for females**).

- **For both genders**, the highest frequency of sessions reportedly occurred with clients between the **ages of 10 and 14 years (usually grades 5 to 8)**. **For males**, 7,303 records, or **65%** of all individual counseling sessions in UNRWA schools, were for students

between the ages of 10 and 14; **for females**, 6,051 records, or **80%** of all individual counseling sessions in UNRWA schools, were for students between the ages of 10 and 14.

- The numbers of sessions increased and decreased for both genders following a fairly similar pattern, as can be observed in Figure 4.5 below.

Figure 4.5: Ages of CMHP Clients at UNRWA Schools, per Session (6 - 18 yrs)



4.2.7 Reported Target Groups for Individual Counseling Sessions

Target groups reported for each venue were also examined:

- At UNRWA health centers, children reportedly comprised nearly 60% of the total client population, whereas at UNRWA schools they made up 98% of the total.

- There seems to be lack of consistency in the definition of target groups "*Adult*" and "*Mother/Father*". If a client was categorized in the target group "*Mother*" for "*Anxiety*", was the counselor treating the client for the problem or giving the client advice to treat the client's child? If the latter explanation was the case, why, for example, were so many

sessions for "*Bedwetting*" reported under the target group "*Child*", even though 80% of all bedwetting cases were reportedly for clients under the age of 13? In addition, why did none of the 684 "*Bedwetting*" records that also listed "*Parent*" as the referral source list either parent as the target group?

- The target group "*Father*" was hardly ever used in records for either venue; at health centers, "*Fathers*" comprised 0.4% of the client population, while at schools they comprised 0.2%. This result again corroborates the assumption that women (e.g., mothers) are much more likely than men to utilize CMHP counseling sessions.

Figure 4.6: Target Groups for Individual Counseling Sessions at UNRWA Health Centers

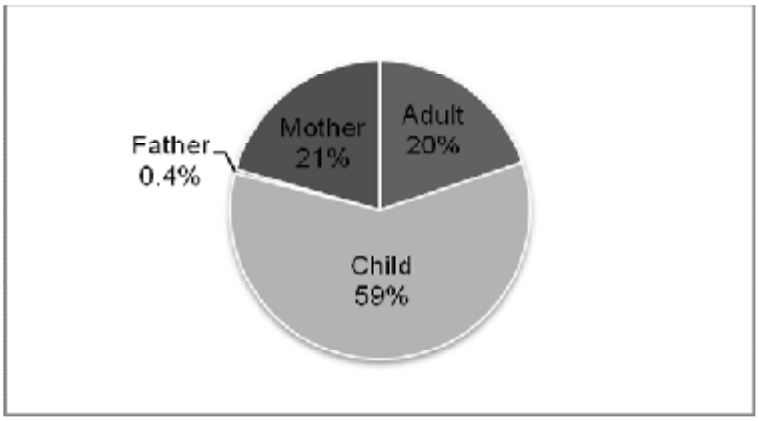
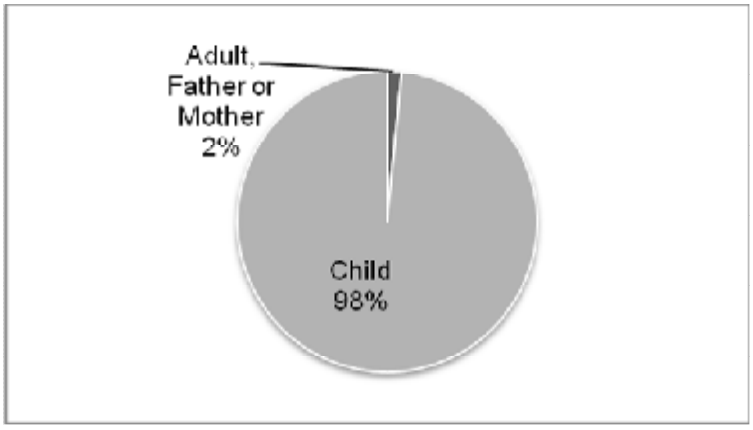


Figure 4.7: Target Groups for Individual Counseling Sessions in UNRWA Schools



4.2.8 Most Commonly-Reported Problems by Venue

Comparing the most-commonly reported problems in individual counseling sessions by venue, it was demonstrated that counselors working in the two venues differed in the amount of time they spent on various problems.

4.2.8.1 Client Problems in UNRWA Health Centers

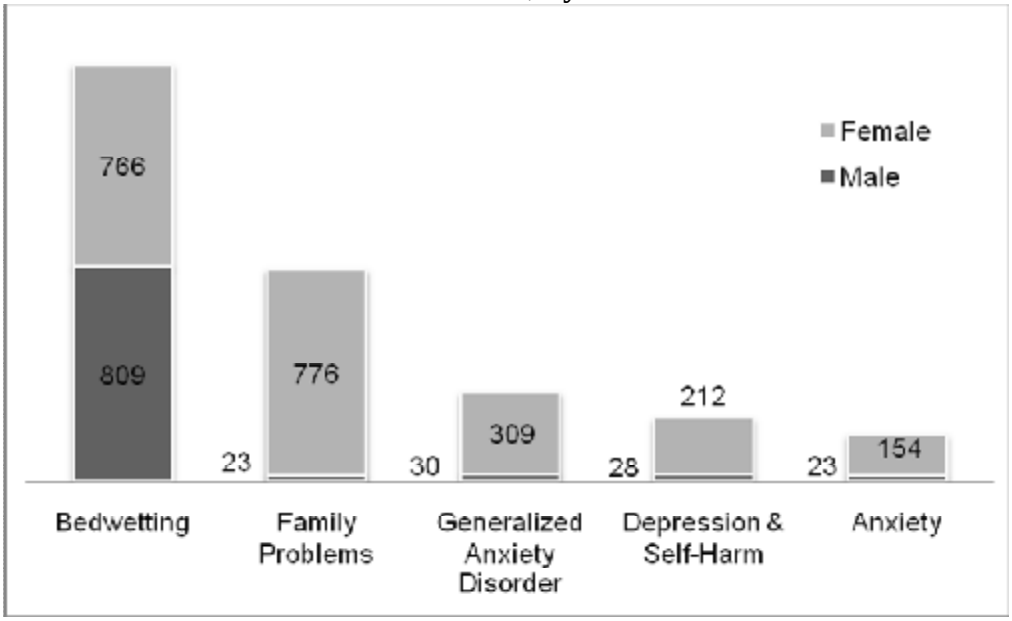
- The most commonly-reported problem by Health Center counselors between September 2007 and August 2008 was "**Bedwetting"** (1,575 sessions).

- "*Bedwetting*" sessions overwhelmingly outnumbered other reported problems, numbering twice the total reported for "*Family Problems*" (the 2nd most commonly-reported problem, at 799 sessions) and nearly 5 times the total for "*Generalized Anxiety Disorder*" (the 3rd most-commonly reported problem, at 339 sessions).

- Overall, female clients outnumbered male clients at health centers 2 to 1 (females 67%, males 33% of the total).

- While "*Bedwetting*" sessions were nearly equally divided between female and male clients(females, 48.6%; males, 51.4%), the majority of the other problems with high session numbers were mostly female clients (e.g., for individual counseling sessions for "*Family Problems*", over 97% were with female clients; for "*Generalized Anxiety Disorder*", 91% were female clients, etc).

Figure 4.8: 5 Most-Reported Problems for CMHP Individual Counseling in UNRWA Health Centers, by Number of Sessions



4.2.8.2 Client Problems in UNRWA Schools

- "***Aggression*" and "*Lack of Motivation*" were the two most-commonly reported problems by school counselors**, corroborating the assumption that children usually present with two main types of problems in schools, inadequate academic performance and unacceptable behavior (McWhinney , 1986).

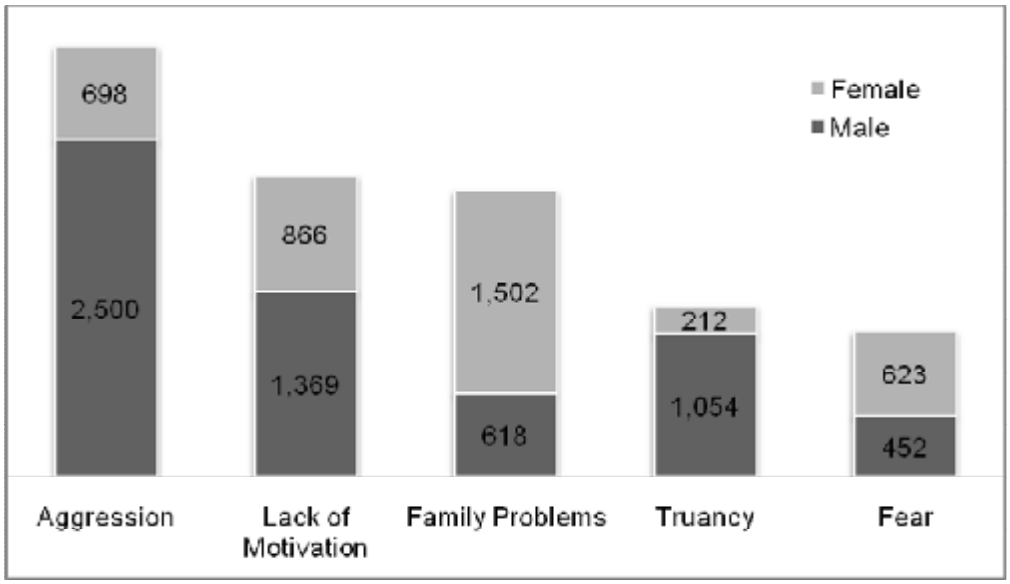
- "*Aggression*" (3,198 sessions) was reported 1.4 times more than "*Lack of Motivation*" (the 2nd most-commonly reported problem, at 2,235 sessions) and 1.5 times the total for "*Family Problems*" (the 3rd most-commonly reported problem, at 2,120 sessions).

- In contrast to health center clients, school clients were overall more equally divided by gender, with a higher percentage of male clients (females 45%, males 55%).

- For "*Aggression*", male clients made up the majority of sessions (78%); for "*Lack of Motivation*", males made up 61% of the total.

- Female clients accounted for 71% of the total for "*Family Problems*" and 58% of "*Fear*".

Figure 4.9: 5 Most-Reported Problems for CMHP Individual Counseling in UNRWA Schools, by Number of Sessions



There was also a difference in the number of sessions reported per problem according to the educational level of the school, as demonstrated in Figure 4.11 below.

- For 4 of the 5 most-reported problems in UNRWA schools, the number of individual counseling sessions in elementary schools was higher than in preparatory schools. Most notably, the number of sessions for "*Aggression*" in UNRWA elementary schools was 1.7 times that in preparatory schools, and the total for "*Fear*" in elementary schools was nearly twice that reported in preparatory schools.

- For "*Lack of Motivation*" and "*Truancy*", the total number of sessions in elementary schools was slightly higher (for "*Lack of Motivation*", 1.3 times higher; for "*Truancy*", 1.2 times higher) than in preparatory schools.

- For "*Family Problems*", elementary and preparatory schools were nearly equal in session numbers.

It must also be reiterated here that 91 elementary schools as opposed to 78 preparatory schools are covered by CMHP counselors; the difference in session numbers is likely affected by this distribution.

Figure 4.10: Most-Reported Problems in UNRWA Schools, Broken Down by Education Level

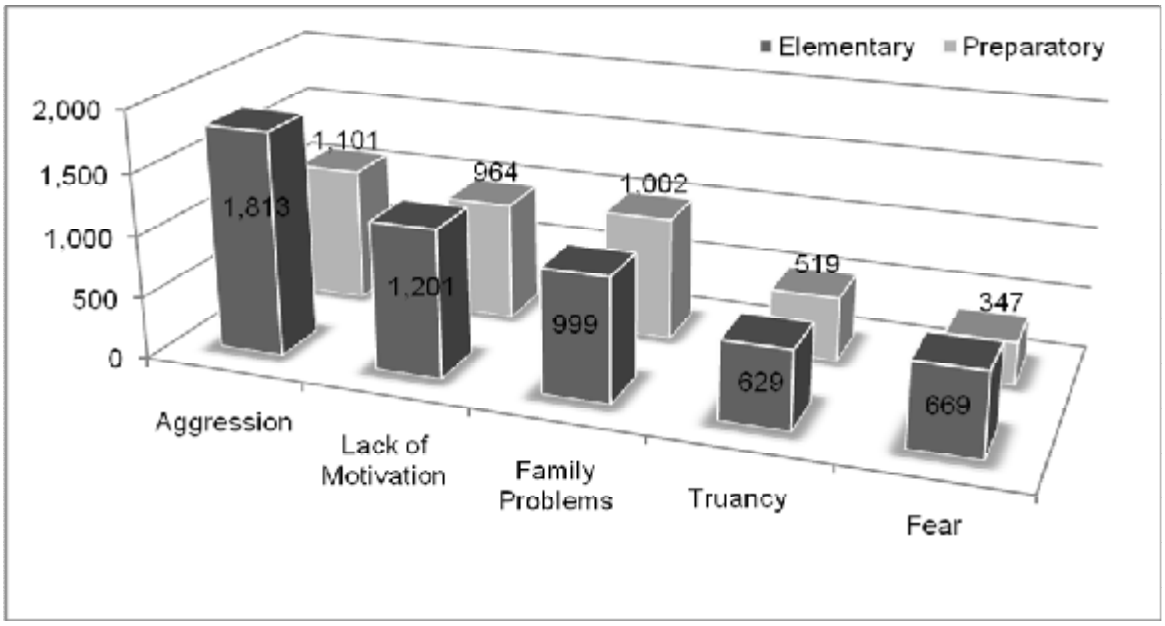


Figure 4.11: Most-Reported Problems in UNRWA Schools, Broken Down by Education Level and Gender

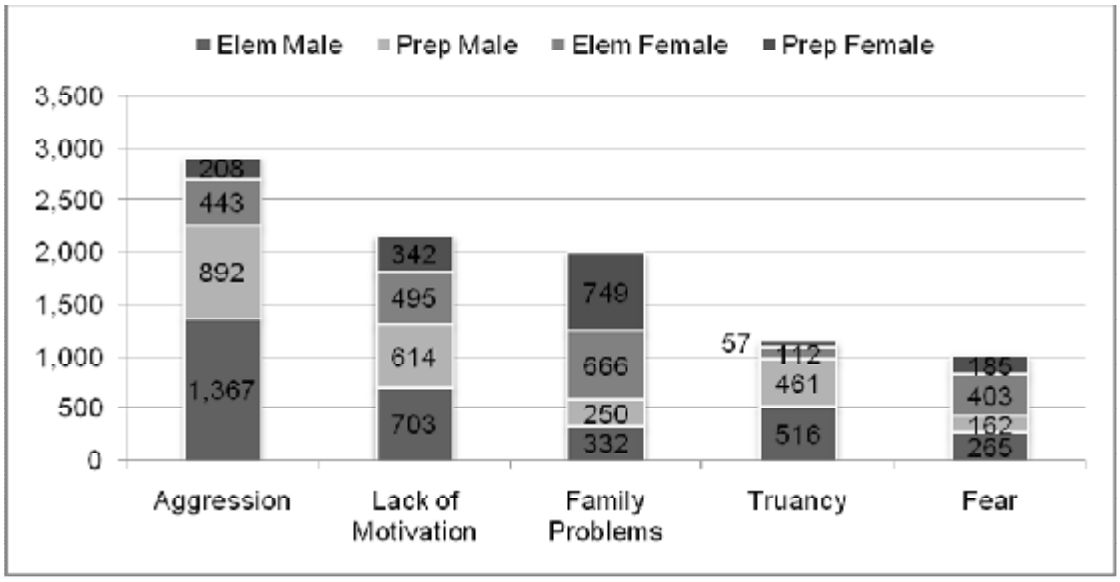


Table 4.6 compares the 10 most-commonly reported problems in UNRWA elementary schools and preparatory schools. The total number of sessions is listed next to each problem to demonstrate the difference in quantity between rankings:

- For both educational levels, "*Aggression*" ranks as the most-reported problem among clients. Other problems ranked among the top 10 most-reported for both levels are similar, with slight variations in rank order.

- The only major difference between the two education levels is that in elementary schools "*Trauma*" is on the list, while in preparatory schools "*Inappropriate Sexual Behavior*" is among the top 10. However, "*Trauma"* and "*Inappropriate Sexual Behavior*" respectively comprise only 5% of the cumulative total for the top 10 most-reported problems in each educational level.

- "*Aggression*" alone makes up 23% in elementary schools and 20% in preparatory schools of the cumulative total for the 10 most-common problems.

- The 3 most-common problems in elementary schools ("*Aggression"*, "*Lack of Motivation*", and "*Family Problems*") together comprise 51% in elementary schools and 55% in preparatory schools of the cumulative total for the 10 most-reported problems.

Table 4.6: Comparison of Most-Reported Problems in UNRWA Schools, Elementary and Preparatory

Rank	***Elementary Schools***	***# of Sessions***	***Preparatory Schools***	***# of Sessions***
1	*Aggression*	1,813	*Aggression*	1,101
2	*Lack of Motivation*	1,201	*Family Problems*	1,002
3	*Family Problems*	999	*Lack of Motivation*	964
4	*Fear*	669	*Truancy*	519
5	*Attention Deficit*	637	*Bedwetting*	381
6	*Truancy*	629	*Fear*	347
7	*Bedwetting*	510	*Attention Deficit*	346
8	*Hyperactivity*	481	*Hyperactivity*	327
9	*Theft*	480	*Theft*	302
10	*Trauma*	367	*Inappropriate Sexual Behavior*	259

4.2.9 Most Commonly-Reported Problems by Gender

Table 4.7: Comparison of 5 Most-Reported Problems by Gender

Rank	***Male***	***# of Sessions***	***Female***	***# of Sessions***
1	*Aggression*	2,373	*Family Problems*	2,155
2	*Lack of Motivation*	1,348	*Bedwetting*	1,273
3	*Bedwetting*	1,164	*Lack of Motivation*	854
4	*Truancy*	978	*Aggression*	682
5	*Hyperactivity*	680	*Fear*	680

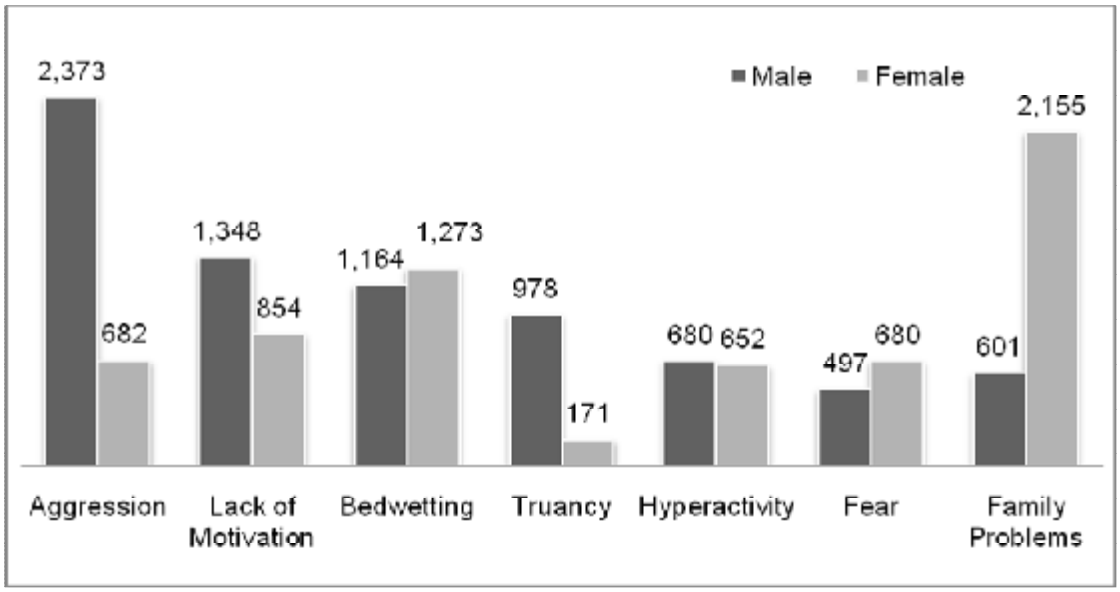
- As can be observed by comparing figures in Tables 4.6 and 4.7, there is a difference in the exact number of reported sessions (e.g., in "Aggression", the total male report states 2,500, while the figure below totals 2,373. This discrepancy is due to inconsistent figures in the database, where venue, gender, etc., have been inputted incorrectly. For example,

some records with school names also were inputted as being a "health center". Since it was not time-effective to go back through and correct all the records in the database, analysis was conducted with this discrepancy in mind).

- Among male clients, "*Aggression*" was by far the most reported problem of all sessions, totaling 1.8 times more sessions than did the 2nd most reported problem of "*Lack of Motivation*". Among female clients, the number of sessions for "*Family Problems*" was 1.7 times more than the 2nd most-reported problem of "*Bedwetting*".

- Both genders share in common 3 of their respective 5 most-reported problems ("*Bedwetting*", "*Lack of Motivation*", and "*Aggression*"). However, male clients had 3.5 times as many sessions for "*Aggression*", 1.6 times as many sessions for "*Lack of Motivation*", and 5.7 times as many sessions for "*Truancy*" than did female clients. Female clients had 1.4 times as many sessions for "*Fear*" and 3.6 times as many sessions for "*Family Problems*" than did male clients.

Figure 4.12: Most-Reported Problems for Individual Counseling Sessions, by Gender



4.2.10 Reported Referral Sources for Individual Counseling Sessions

A key issue in identifying the clients utilizing CMHP services is to examine each client's referral source (who had brought the client to the CMHP counselor for the individual counseling session).

The CMHP database lists 8 referral sources:

- *Guidance Counselor*: These individuals are teachers in UNRWA schools who are given the additional responsibility to act as guidance counselors for the students. The majority of schools have one designated guidance counselor, regardless of whether or not there is a CMHP counselor at that school. Whereas the CMHP counselor works under CMHP, the guidance counselors work under the Department of Education.

- *Group Guidance*: Clients who were catalogued in the database under "group guidance" as a referral source were supposedly identified by the CMHP counselor him/herself during "Group Guidance", where CMHP counselors give lectures to a class on topics related to mental health.

- *Head Teacher*: the principal at the client's school
- *Parent*: self-explanatory
- *Peer*: self-explanatory
- *Physician*: presumably, a physician in an UNRWA health center
- *Self*: self-explanatory
- *Teacher*: self-explanatory

4.2.10.1 Referral Sources in UNRWA Health Centers

According to the CMHP database,

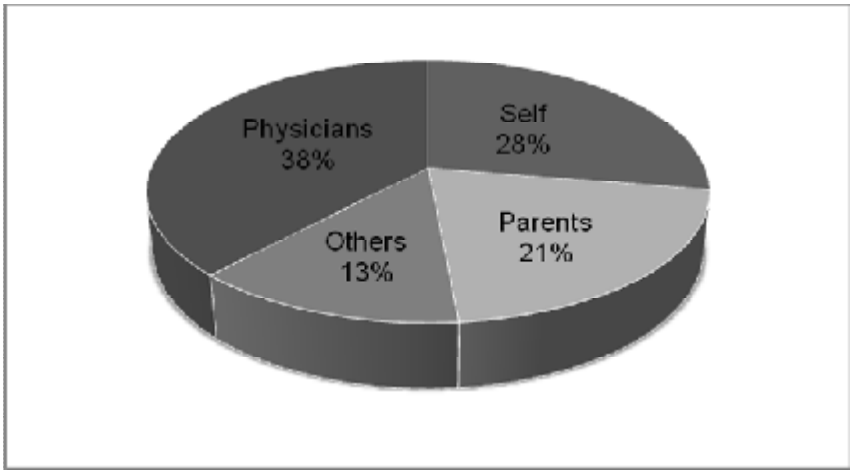
- 1,774 individual counseling sessions were conducted with clients referred to the counselor by a *physician* (38% of the health centers' total). It is likely that physicians would be one of the primary referral sources for CMHP clients at health centers, since individuals tend to go to health centers for treatment of physical ailments and complaints.

- 1,288 sessions were conducted with clients who came to the counselor themselves ("*Self*", 28% of the total). Interestingly, when cross-referenced with target groups, 250 out of these 1,288 sessions (19%) were reportedly children (target group "*Child*"), raising the question of whether children would go by themselves to health centers for counseling services. 672 of this same referral source (50%) were categorized under "*Mother*", again raising the question of who was the target of these counseling sessions: was the term "*Mother*" chosen as a characteristic of the client? If so, why was it chosen over "*Adult*"?

- *Parents* made up the 3rd largest percentage of referral sources in UNRWA health centers, with 973 sessions (21% of the total).

- Other referral sources totaling 623 sessions (13% of the total) included "*Guidance Counselor*" (71 sessions, 1.5%), "*Group Guidance*" (531 sessions, 11%), "*Head Teacher*" (2 sessions, 0.04%), "*Peer*" (11 sessions, 0.2%), and "*Teacher*" (8 sessions, 0.2%). It is likely that at least some of these referral sources were data-entry errors, since it is improbable (although not impossible) that these sources would refer clients to health centers (e.g., group guidance seems to be limited to schools, head teachers and teachers are unlikely to go to health center counselors for assistance, etc.)

Figure 4.13: ***Referral Sources of UNRWA Health Center Sessions***



4.2.10.2 Referral Sources in UNRWA Schools

According to the CMHP database,

- *Teachers* comprised the highest percentage of referral sources in UNRWA schools, with 3,022 individual counseling sessions (39% of the schools' total).

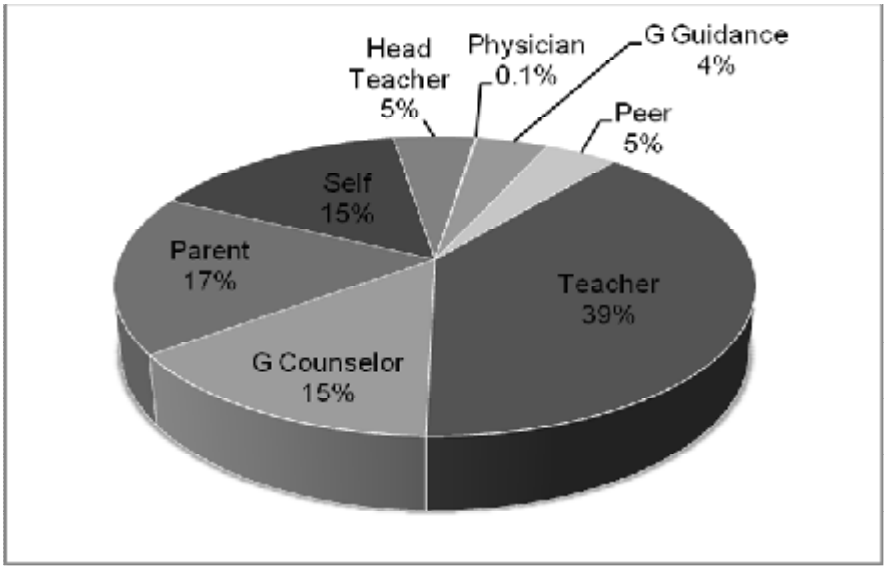
- *Parents, guidance counselors*, and *self*-referrals were relatively close in total numbers: *parents* were the referral source for 3,539 sessions (17%), followed by *self*-referral (3,158 sessions, or 15%) and *guidance counselors* (3,022 sessions, or also 15%).

- Referrals by *Head Teachers* (1,003, or 5%), by clients' *peers* (892, or 5%), and through *Group Guidance* (879, or 4%) comprised the remainder of counseling sessions.

- *Physicians* were reportedly the referral source for 24 counseling sessions (0.1%); this figure is also likely due to data-entry errors, since it is improbable that a physician would refer clients to school counselors.

- When *self*-referrals were again cross-referenced with target groups, 109 sessions were categorized under "Adult" and 112 sessions under "*Mother*", once more underlining the lack of clarity over who was the focus of the counseling session.

Figure 4.14: Referral Sources of UNRWA School Sessions



4.2.10.3 Referral Sources According to Problems

The issue becomes clearer when the referral sources (the individual who brought the client to the counselor in the first place) for each problem are examined. The referral sources in individual counseling sessions for the 5 most-reported problems are illustrated in Figures 18 – 22.

- *Teachers* were the most-commonly cited referral sources for "*Aggression*" (1,640 sessions, or 53% of the total) and "*Lack of Motivation*" (960, or 44% of the total). For

both problems, *guidance counselors* came in second place (for "*Aggression*", *guidance counselors* were the referral sources for 435 sessions, or 14% of the total; for "*Lack of Motivation*", they were the referral sources for 551 sessions, or 25% of the total).

- *Physicians* made up the largest percentage of referral sources for "*Bedwetting*" (954 sessions, or 39% of the total), with *parents* making up the 2nd largest percentage (688 sessions, or 28%).

- *Self*-referrals were the highest percentage for "*Family Problems*" (1,158 sessions, or 42% of the total), followed by *teachers* (546, or 20%) and *parents* (327, or 12%).

- *Parents* were the most-reported referral source for "*Fear*" (387 sessions, or 32% of the total), followed by *self*-referrals (313, or 26%) and *teachers* (227, or 19%).

Figure 4.15: Referral Sources for Individual Counseling Sessions:
<u>Rank #1. Aggression</u>

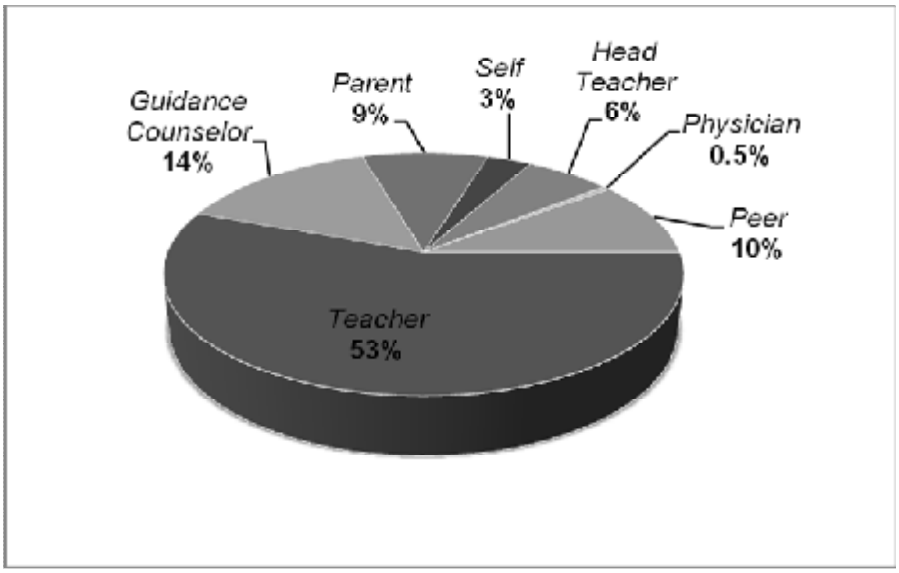
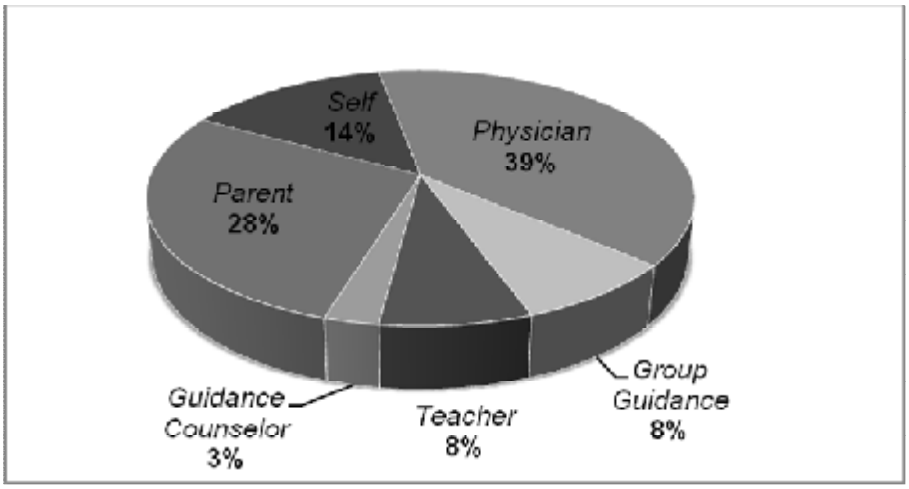


Figure 4.16: Referral Sources for Individual Counseling Sessions: Rank #2. Bedwetting



In "Bedwetting", Head Teacher (1 session) and Peer (6 sessions) were excluded from the illustration because they were statistically insignificant (less than 0.5% of the total).

Figure 4.17: Referral Sources for Individual Counseling Sessions: Rank #3. Family Problems

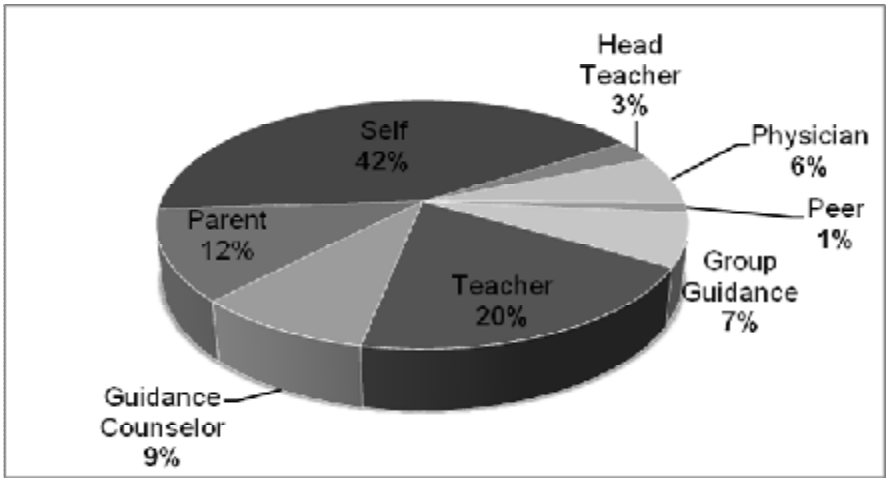


Figure 4.18: Referral Sources for Individual Counseling Sessions: <u>Rank #4. Fear</u>

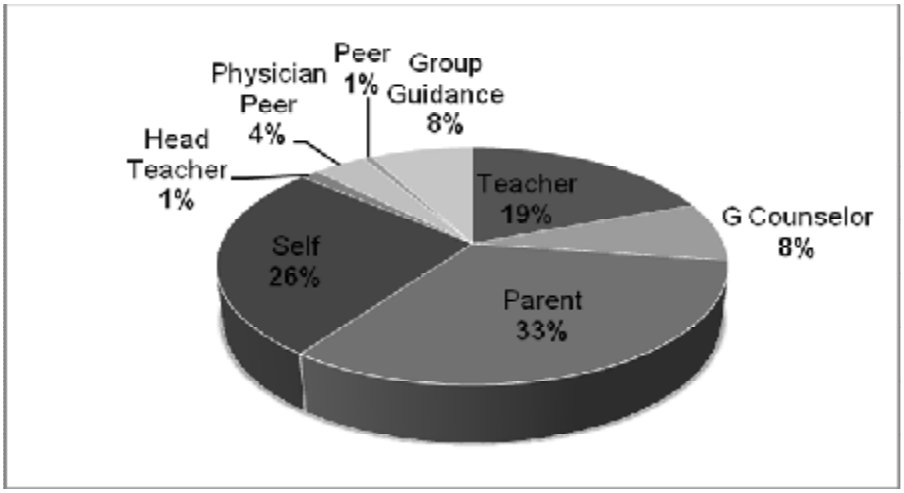
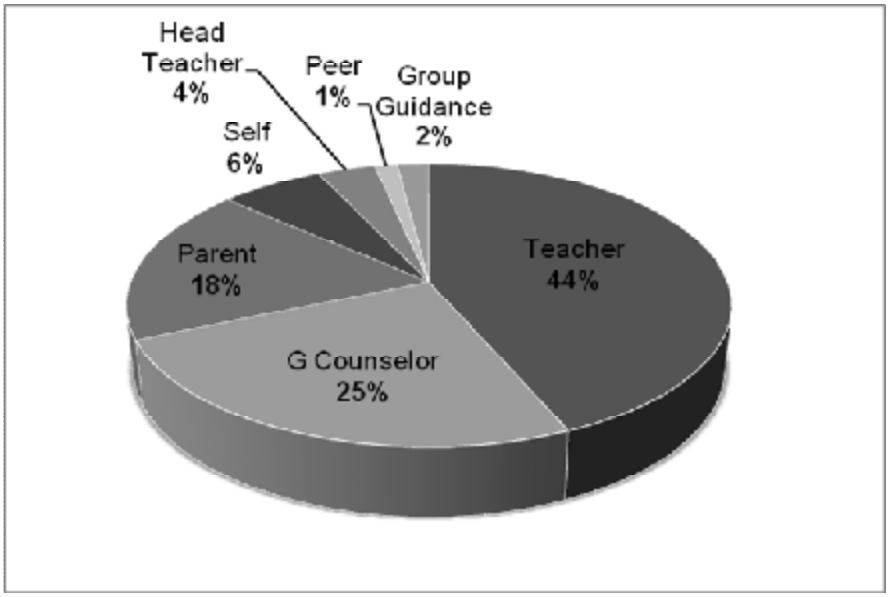


Figure 4.19: Referral Sources for Individual Counseling Sessions: <u>Rank #5. Lack of Motivation</u>



"Physician" (2 sessions) was excluded from the illustration for the purpose of clarity because this category amounted to less than 0.5% of the total.

4.2.11 Reported Interventions Used for Individual Counseling Sessions

The CMHP database lists 16 types of interventions reportedly used by its counselors during individual counseling sessions:

- *Activation*
- *Assessment*
- *Awareness Counseling*
- *Awareness Raising*
- *Basic Counseling*
- *Behavioral Counseling*
- Cognitive Behavioral Counseling
- Cognitive Counseling
- *Drama Counseling*
- *Family Intervention*
- *Modeling*
- *Positive Reinforcement*
- *Relaxation*
- *Spiritual Counseling*
- Systematic Desensitization
- Ventilation

Similar to the 69 problems listed in the database, the types of interventions span a wide selection of choices, ranging from specific techniques (e.g., "*Modeling*") to entire schools of psychological theory (e.g., "*Behavioral Counseling*"). The researcher was not able to obtain any documentation from CMHP that defined the above terminology. The analysis that follows was based on varying definitions given to the researcher during informal discussions with CMHP counselors and supervisory staff.

4.2.11.1 Analysis of Interventions

- **Many of the intervention terms are not mutually-exclusive**. For instance, *"Modeling"*, "*Systematic Desensitization*", and "*Positive Reinforcement*" are all counseling techniques attributed to Behavioral Theory.

- It is unclear how counselors differentiate between "*Behavioral Counseling*", "*Cognitive-Behavioral Counseling*", and "*Cognitive Counseling*", since behavioral theory and

cognitive theory have greatly influenced each other and now most commonly fall under the same umbrella-term of Cognitive-Behavioral Therapy.

- After discussions with various CMHP staff members, it remained unclear to the researcher what many of the intervention terms meant. What did "*Awareness Counseling*" and "*Spiritual Counseling*" entail? How did "*Awareness Counseling*" differ from "*Awareness Raising*"?

- Broad terms such as "*Basic Counseling*" and "*Family Intervention*" would seem to cover the majority of other intervention terms.

To demonstrate the full range of intervention types, the researcher categorized the terms into 4 groups:

- **Technique**: terms such as relatively specific procedures
- **Counseling Theory**: terms related to psychological theory (e.g., Cognitive) or a general style of treatment (Drama)
- **General**: very broad terms that seem to apply in various cases
- **Unknown:** terms that are unclear and thus cannot be placed under other groups

Table 4.8 Categorization of CMHP Interventions

Technique	Counseling Theory	General	Unknown
- Ventilation (venting) - Relaxation - Activation (exercise) - Modeling (type of behavioral counseling) - Systematic Desensitization (type of behavioral counseling) - Positive Reinforcement (type of behavioral counseling)	- Cognitive Counseling - Behavioral Counseling - Cognitive-Behavioral Counseling - Drama Counseling	- Family Intervention - Basic Counseling - Awareness Raising - Assessment	- Awareness Counseling - Spiritual Counseling

4.2.11.2 Types of Interventions

Individual counseling sessions categorized under each type of reported intervention were tallied and compared. The results are illustrated in Figure 4.20 below:

- "*Ventilation*", or verbal expression of emotions, was the most-reported intervention used during individual counseling sessions (3,824 of 25,454 sessions, or 15% of the total), followed closely by "*Cognitive-Behavioral Counseling*" (3,788 sessions, or 15%).

- When sessions categorized under intervention techniques such as "*Modeling*", "*Positive Reinforcement*", and "*Systematic Desensitization*" were merged with those sessions under "*Cognitive-Behavioral Counseling*" and "*Behavioral Counseling*", they made up 44% of all reported interventions.

- "*Drama Counseling*" was the least-reported intervention, tallying only 40 sessions, or 0.2% of the total. Other interventions that were rarely reported in the database, in cumulative order of percentage, include "*Awareness Counseling*" (271 sessions, or 1%), "*Activation*" (552 sessions, or 2%), *Relaxation* (670 sessions, or 3%), and "*Spiritual Counseling*" (776 sessions, or 3%).

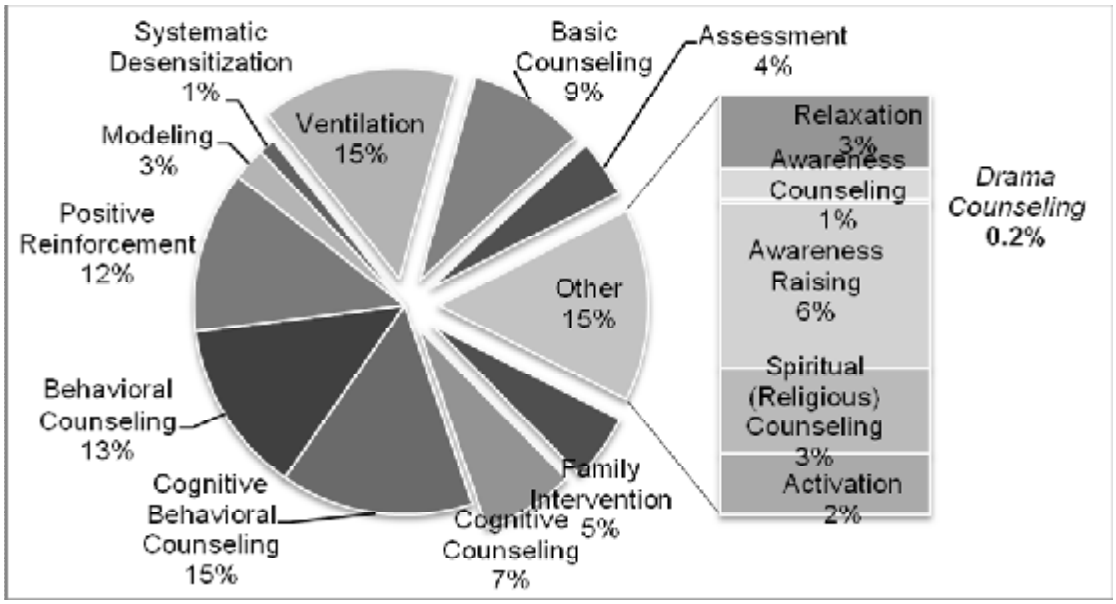
- Only 1,120 sessions (4% of all sessions) were categorized under "*Assessment*". Since assessment of a client is an essential procedure in the beginning stages of any kind of intervention, "*Assessment*" was cross-referenced with all 1st sessions recorded in the database. **"*Assessment*" made up only 871 of 8731 sessions, or 10% of all records of 1st sessions**. For all 2nd sessions, "*Assessment*" was the intervention for 191 of 6,258 records (3% of the total).

- Likewise, reports of "*Family Intervention*" were also limited in number; 1,328 (or 5% of) sessions were categorized under this type. When sessions reported under "*Family Intervention*" were cross-referenced with target groups, only 42 of 1,167 sessions (4% of the total) were with either parent (target groups "*Father*" or "*Mother*").

- The average CMHP counselor reportedly utilized 10 of the 16 listed intervention types. Of 183 counselors, 98 (or 54%) reported using between 9 and 12 of the interventions. Only 5 counselors (3%) reported using 1-3 interventions; 46 counselors (25%) reported using 5 -8 of the interventions, and 36 counselors (20%) reportedly used more than 13 of the interventions.

- "*Ventilation*" was utilized by 176 of 183 counselors (or 96%), followed in popularity by "*Behavioral Counseling*" (170 counselors, or 93%) and "*Positive Reinforcement*" (160, or 87%). In contrast, "*Drama Counseling*" was reportedly used by only 19 counselors (10%); "*Awareness Counseling*", by 48 counselors (26%).

Figure 4.20: Reported Types of Intervention Used in CMHP Individual Counseling Sessions



4.2.11.3 Types of Interventions, According to Problem Groups

To determine whether CMHP counselors reported utilizing certain types of "interventions" depending on types of problems, the 69 problems in the database were categorized into 6 groups:

- **Academic Problems**: 8 problems related to academic success (*Attention Deficit; Daydreaming; Lack of Motivation; Learning Disabilities; Bad Study Habits; Stammering; Time Misuse*)

- **Behavioral Problems**: 17 problems related to behavior but not directly harmful to others (*Bedwetting; Bed Soiling; Compulsivity; Eating Problems; Hyperactivity; Messiness; Nail-Biting; Prejudice; Running Away; Selfishness; Shyness; Sibling Rivalry; Social Isolation; Thumb Sucking; Sleep Problems; Sleep Walking; Tics*)

- **Discipline-Related Problems**: 13 behavioral problems related to classroom/parental discipline (*Aggression; Bad Company; Cheating; Cruelty; Destructiveness; Disobedience; Fire Setting, Inappropriate Language, Inappropriate Sexual Behavior; Joking; Telling Lies; Temper Tantrums; Theft*)

- **Emotional Problems**: 7 problems related to mood and affect (*Anxiety; Depression & Self-Harm; Fear Low Self-Esteem; Over-Dependency; Sensitivity to Critics; Trauma*)

- **Family Problems:** this problem was left in a group by itself because of the general nature of the category

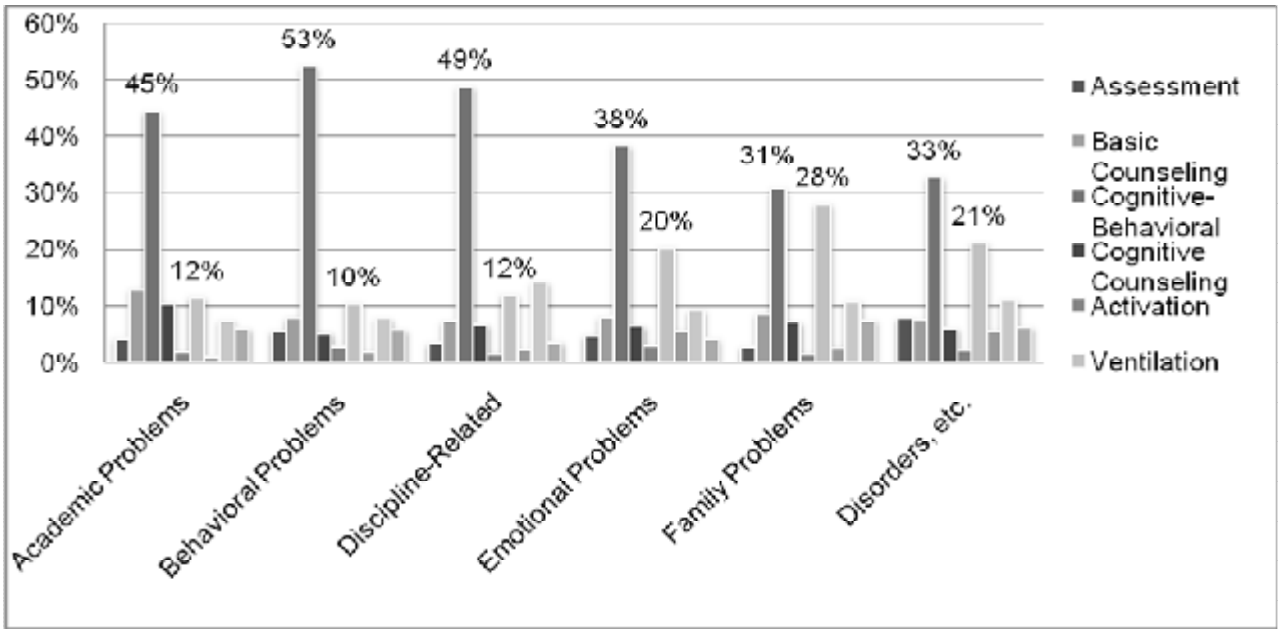
- **Disorders, etc:** 20 clinical disorders (*Autism; Bipolar Disorder; Conduct Disorder; Dissociation Disorder; Eating Disorder; Generalized Anxiety Disorder; Mental Retardation; Nightmare Disorder; Obsessive-Compulsive Disorder; Panic Disorder; Personality Disorder; PTSD; Schizophrenia; Sexual Disorder; Simple Phobia; Sleep Disorder; Social Phobia; Somatization Disorder; Substance Use Disorder*)

- For the sake of clarity, the following 5 "interventions" were merged under "Cognitive-Behavioral Counseling": "*Cognitive-Behavioral Counseling*"; "*Behavioral Counseling*" (because "purely behavioral" therapy such as that pioneered by B.F. Skinner is unlikely to be utilized in a counseling setting); "*Modeling"; "Positive Reinforcement*"; and "*Systematic Desensitization*". When these interventions were combined, "Cognitive-Behavioral Counseling" was most often reported for all problem categories.

- Predictably, sessions reportedly using cognitive-behavioral techniques were especially high for those involving behavioral, discipline-related, and academic problems (e.g., positive reinforcement, or rewarding good behavior and effort, is a commonly-used strategy by adults to deal with children).

- "*Ventilation*" was also high for emotional problems (20%) and family problems (28%).

Figure 4.21: Types of Interventions Reportedly Used, by Problem Category



4.2.12 Reported Outcomes for Individual Counseling Sessions

The CMHP database lists 6 types of outcomes for individual counseling sessions:

- *Deterioration*
- *Drop out*
- *Improvement*
- *No change*
- *Recovery*
- *Referral*

The sessions categorized under each outcome were tallied and compared, as illustrated in Figure 4.23.

- **For both UNRWA health centers and schools, over 94% of counseling sessions fell into one of two outcome categories, "*Improvement*" or "*No Change*";** 94% of all counseling sessions at UNRWA health centers and 96% of those at UNRWA schools were reportedly as either type.

- At UNRWA health centers, counseling sessions that ended with "*Improvement*" totaled 2,034 or 45% of the total, while those with "*No Change*" totaled 2,220 or 49%.

- At UNRWA schools, the "*Improvement*" percentage was higher, with 11,642 or 56% of the all sessions. "*No Change*" was the outcome for 8,258 or 40% of all sessions.

- The cumulative total number of sessions categorized under the remaining 4 types of outcomes, "*Deterioration*", "*Drop Out*", "*Recovery*" and "*Referral*", was less than 6% of all sessions for both venues. It is particularly notable that "*Deterioration*" and "*Drop Out*" numbers were so low (58 sessions or 2% for "*Deterioration*" for health centers, 205 sessions or 1% for schools; for "*Drop Out*", 10 sessions or 0.2% for health centers, 39

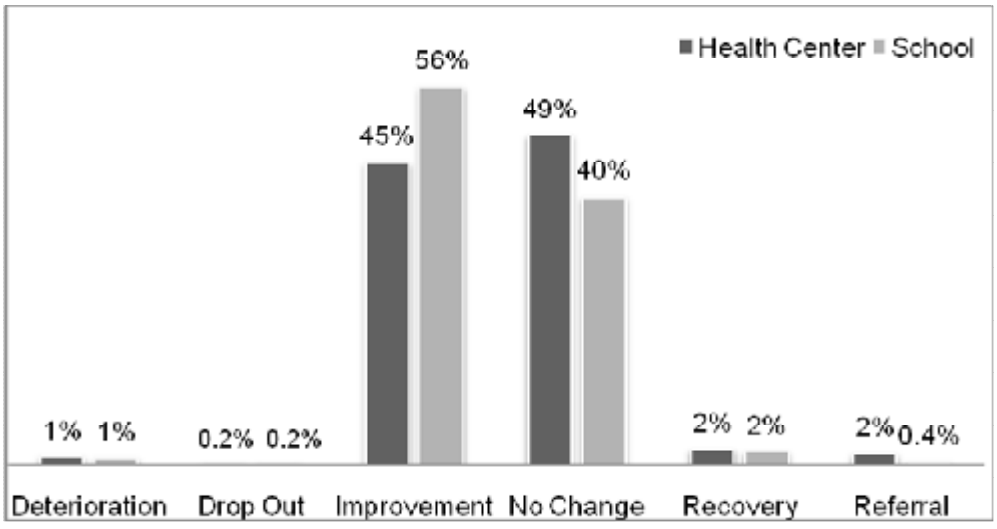
sessions or 0.2% for schools), considering both categories are well-known and accepted phenomena in the counseling field.

- The only straightforward outcome, "*Referral*", also seemed under-represented in the CMHP database (78 sessions or 1% of all health center sessions; 77 sessions or 0.4% of all school sessions), particularly considering there were over 1,400 sessions reported for various clinical disorders at both venues. It is unclear whether this lack of reported referrals suggested a deficiency in outside referral resources and therefore a problem for the counselors, or the counselors' (perceived) capability to deal with disorders on their own.

- The criteria of any of these outcomes are unclear. What would "*Improvement*" entail, and how would it be objectively measured?

- There is also uncertainty regarding the timing for the counselors to determine the outcome of a particular session. Did they decide on the success of the intervention immediately after the session? Could the outcome of any intervention be judged so quickly?

Figure 4.22: Total Number of Sessions by Reported Outcome



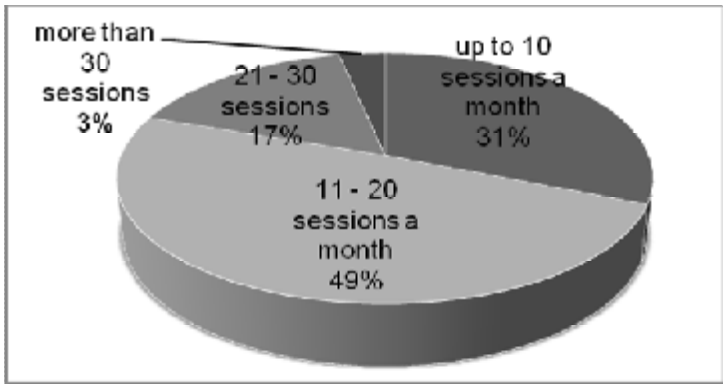
4.2.13 Individual Counseling Sessions and Numbers of Clients

4.2.13.1 Monthly Individual Sessions per Counselor

- Individual counseling sessions were not distributed equally among the 183 CMHP counselors in the CMHP database. Between September 2007 and August 2008, **the number of individual counseling sessions for a CMHP counselor ranged anywhere from 2 to 101 sessions in a given month**. The minimum average of monthly sessions for a counselor was 4.5 sessions (Nuseirat Elementary Girls "D"), while the maximum was 58.3 monthly sessions (Maan Health Center).

- As demonstrated in Figure 26, **90 of all counselors (49%) averaged between 11 and 20 individual counseling sessions a month**, or between 3 – 5 counseling sessions per 6-day workweek. The 2nd biggest percentage of counselors, 57 of the total (31%) averaged between 1 and 10 counseling sessions a month (up to 2.5 sessions a week). The remaining 36 counselors (20%) averaged more than 30 sessions a month.

Figure 4.23: Average Number of Monthly Sessions per CMHP Counselor

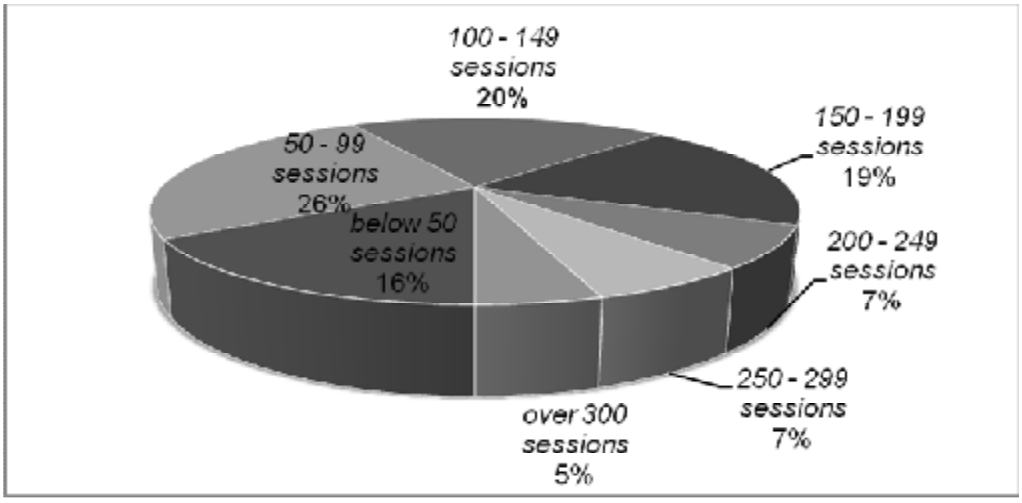


- **Most counselors had months without any counseling records:** Only 6 of 183 counselors (3%) had records for every month between September 2007 and August 2008, 5 of whom worked at Health Centers. Other counselors had between 1 to 9 months during the year without any reported individual sessions. The average counselor had 3.8 months without any records for individual counseling. This gap may have been caused by a number of reasons, including data collection issues (records not properly entered into the database or records having to be removed by the researcher due to incomplete key fields) and work focus (e.g., counselors concentrating on other activities, counselors taking maternity leave, etc).

4.2.13.2 Total Number of Individual Counseling Sessions per CMHP counselor

The yearly total of individual counseling sessions were tallied for each of the 183 CHP counselors, as illustrated in Figure 4.24:

Figure 4.24: CMHP Counselors by Total Number of Individual Counseling Sessions



- 114 counselors (62%) reportedly conducted less than 150 individual counseling sessions between September 2007 and August 2008. 25 counselors (17%) reportedly conducted

between 150 and 300 sessions and only 9 counselors (5%) reported more than 300 sessions during this period.

- Maan Health Center had the highest number of individual counseling sessions, with a total of 699 sessions between September 2007 and August 2008. The lowest reported number of sessions was seen in 2 schools, Nuseirat Elementary Girls "D" and Hashem Elementary Boys "A", which each reported only 18 individual counseling sessions for the duration.

Listed below are the 5 locations with the most-reported number of individual counseling sessions, divided by venue.

Table 4.9: Comparison of Highest Total Number of Sessions, by Venue

UNRWA Health Centers			UNRWA Schools		
Rank	**Location**	**Total # of Sessions**	**Rank**	**Location**	**Total # of Sessions**
1	Maan Health Center	699	1	Beit Hanoun Prep Boys "A"	536
2	Beit Hanoun Health Center	606	2	Beit Hanoun Prep Girls	445
3	Bureij Health Center	372	3	New Jabalia Elem Girls	311
4	Nuseirat Health Center	371	4	Fukhari Elem Co-ed "A"	298
5	Rafah Health Center	347	5	Ibn Rashd Prep Boys	264

4.2.13.3 Counselors' Actual Caseloads in the CMHP Database

So far in this study, the data in the CMHP database had been examined from various angles according to the total number of individual counseling sessions, not according to the number of clients. This was largely because:

a) Since the majority of data presented by CMHP in its Monthly Reports were based on individual counseling session records, the data in the study had to be the same for comparison purposes; and

b) the specific design of the CMHP database organized all records in this fashion, dictating focus on the total number of sessions.

To establish the caseload of CMHP counselors, it is necessary to focus on exactly how many actual clients each counselor saw for individual counseling sessions during the set time period. As mentioned earlier, each record in the CMHP database includes a client identification number, a unique number assigned to the client by their counselor to ensure client anonymity. Since the design of the CMHP database did not allow for extrapolation of client numbers, in order to determine counselors' caseloads the researcher divided the database records for each of the 183 CMHP counselors then counted the unique client identification numbers reported within each counselor's records. Table 4.10 shows an example of how the client numbers for a particular counselor were calculated: Counselor No.1 reported a total of 71 individual counseling sessions, but counting the different Client ID numbers reveals a total of 11 clients. (Each number below a particular month represents the number of counseling sessions a client had during that month.)

Table 4.10: An Example of Calculating Client Numbers for a CMHP Counselor

MHC ID. No.	Client ID No.	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	**Grand Total**	**Total # of Clients**
1	*1*	1	1				3		3	1		1		**10**	**11**
	2	1	1		1		2	5	2	1		1		**14**	
	3	2					1	2				1		**6**	
	4	1	2		1		1	1				1		**7**	
	5		2		1				1	1		1		**6**	
	6	2	1	2	1					1		1		**8**	
	7			2	1					1				**4**	
	8	1		3	1									**5**	
	9	1		2	1				1					**5**	
	10		3	1										**4**	
	12							1	1					**2**	
Total Sessions		**9**	**10**	**10**	**7**		**7**	**9**	**8**	**5**		**6**		**71**	

After determining the actual number of clients per counselor, it was found that:

- According to the database, there were **a total of 8,541 clients for all CMHP counselors between September 2007 and August 2008**, 2.6 times larger a client population than the 3,320 clients reported in the CMHP Monthly Reports for this duration.

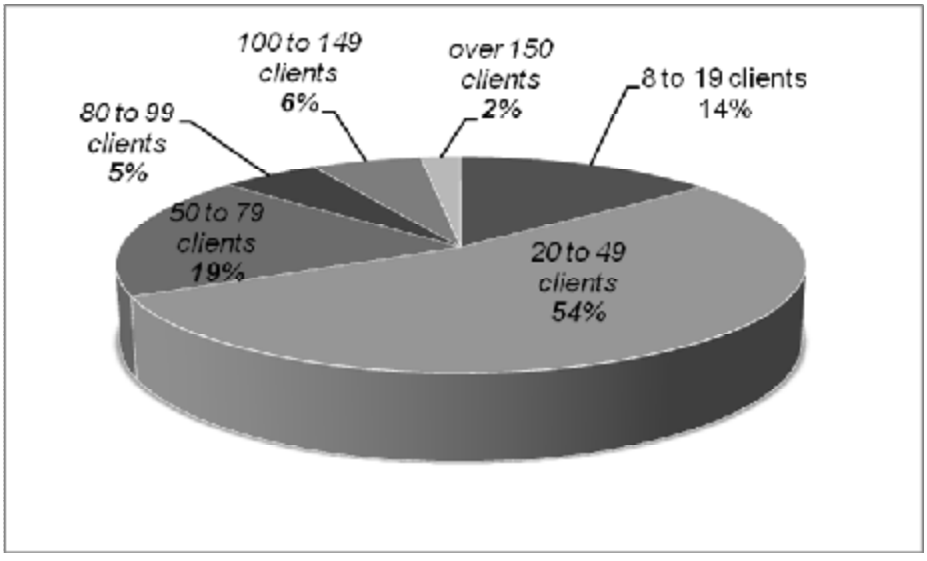
- The highest number of clients for a single counselor for the period between September 2007 and August 2008 was 247 clients, with whom the counselor had had a total of 699 sessions.

- The lowest number of clients for a counselor for this duration was 8 clients, with whom the counselor has 18 individual counseling sessions.

- **98 counselors (54%) each had a yearly caseload of between 20 and 49 clients**. 44 counselors (24%) had between 50 and 99 clients. 26 counselors (14%) had less than 20 clients for the entire year.

- Only 15 counselors (8%) had more than 100 clients for this same time period, among which only 4 (2% of all counselors) had more than 150 clients.

Figure 4.25 CMHP Counselors by Caseloads (Number of Clients)



To put the counselors' caseloads into perspective, Figures 4.26 and 4.27 contrast the actual client numbers against the number of sessions for the locations reporting the highest number of sessions, according to venue.

- Caseloads did not increase or decrease uniformly according to the number of sessions. For instance, Rafah Health Center, the UNRWA health center with the 5th highest number of individual counseling sessions, actually had the 3rd highest number of clients of all locations.

- Khan Younis Health Center, which with 200 sessions ranked 34th in the total number of counseling sessions, actually ranked 2nd highest in caseload, above Rafah Health Center (180 clients compared with the latter's 166 clients).

- Conversely, a high number of counseling sessions did not necessitate a high number of clients. For example, Beit Hanoun Health Center, reporting 610 sessions, had only 89 clients, while Fukhari Elementary Coed "A" reported 298 sessions but 128 clients.

Figure 4.26: Comparison of Sessions and Client Numbers for 5 Health Center Counselors with Highest Number of Sessions

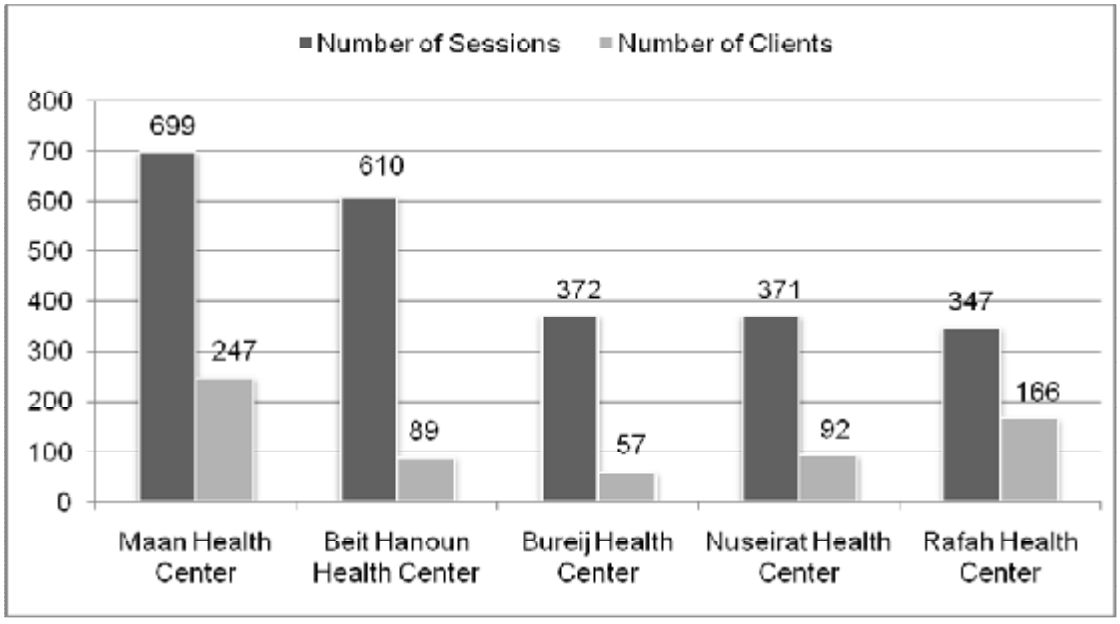


Figure 4.27: Comparison of Sessions and Client Numbers for School Counselors with Highest Number of Sessions

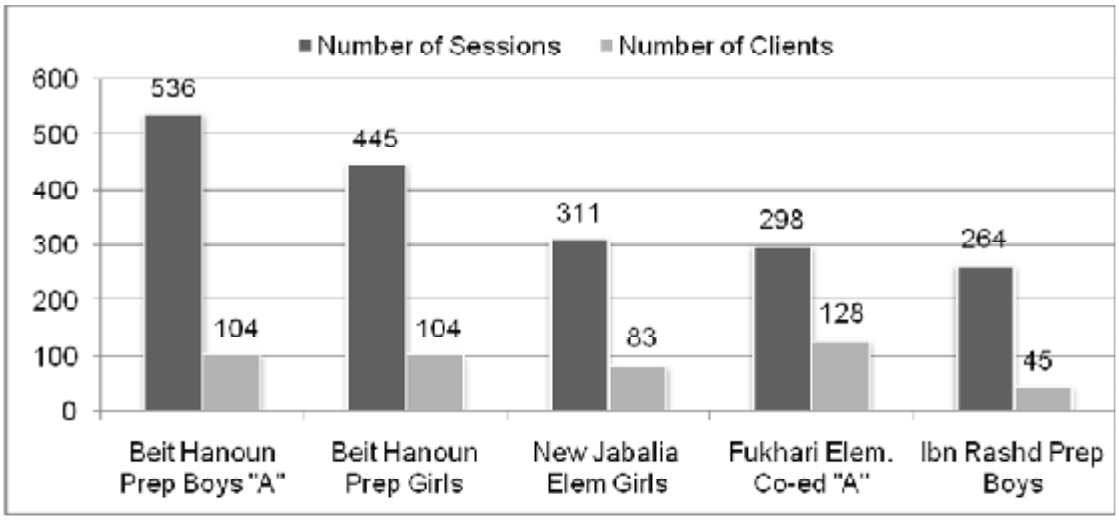
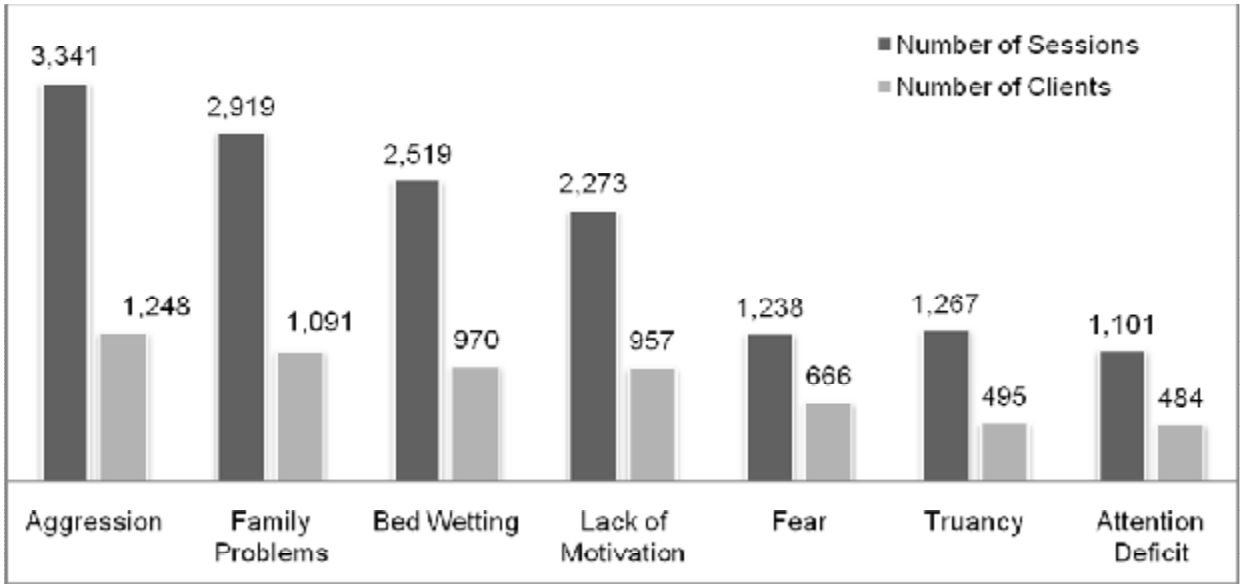


Figure 4.28 compares the total number of sessions with client numbers for the most-reported problems during the year at both UNRWA health centers and schools:

Figure 4.28: Comparison of Most-Reported Problems by Numbers of Sessions and Clients



4.2.14 Calculating the Number of Sessions per Client

Each CMHP database record included the field "Number of Session" to indicate the ordinal rank of a particular counseling session among all other sessions with a given client. For example, the number "2" would indicate data for a specific counselor's 2nd counseling session with a specific client. The researcher analyzed the data in this field to calculate the number of sessions per client.

4.2.14.1 Session Number Duplicates among Client Records

The ordinal numbers in this field are assumed to be unique (e.g., there could only be one 1st session for any one client). However, in the CMHP database there were multiple entries (duplicates) of a session number among records for a number of clients.

An example of such duplicates is shown in Table 4.11 below. For instance, Client No.1 had 6 records for their 1st counseling session with CMHP counselor No.1; since the client could only have had one 1st counseling session, for the sake of data validity 5 of the 6 records must be considered duplicates.

These duplications were most likely due to either data-entry errors by CMHP clerks or mistakes in counselors' reports.

Table 4.11: An Example of Duplicates among Client Records

MHC ID No.	Client No.	1st Session	2nd Session	3rd Session	Grand Total	Actual No. of Sessions	Duplicates
1	*1*	6	3	1	10	3	**7**
	2	9	3	1	14	4	**10**
	3	2	3	1	6	3	**3**
	4	5	2	0	7	2	**5**
	5	4	1	1	6	3	**3**
	6	6	2	0	8	2	**6**
	7	3	1	0	4	2	**2**
	8	3	2	0	5	2	**3**
	9	4	0	1	5	2	**3**
	10	1	1	2	4	3	**1**
	12	0	1	1	2	2	**0**

Out of 8,541 clients, 2,109 (25%) had at least 1 duplicate session number in the CMHP database.

- 4,298 records (17% of the total) had duplicate session numbers.

- The highest number of duplicate numbers for any one particular session was 17 records.

- The highest number of duplicate session numbers among all the client's records was 36 duplicates among all their sessions (12 records for their 2nd session, 12 records for their 3rd sessions, 8 records for their 4th session, and 8 records for their 5th session, totaling 40 sessions).

- Duplicates were highest among 1st session records; of 8,714 "1st" sessions reported, 1,792 records (21%) had duplicate session numbers. The second highest number of duplicates was among "2nd" session records, with 1,089 duplicates among 1,877 records (17%)

- After factoring out duplicate session numbers, the total number of clients reported per session decreased by 47% by the 3rd session and 68% by the 4th session.

4.2.14.2 Missing and Extreme Session Numbers among Clients' Records

Session numbers per client should be sequential and consecutive, beginning with the 1st session, followed by the 2nd session, and so on. However, several clients had missing session numbers among their records (e.g., a client would have records for their 1st and 4th counseling sessions but not for their 2nd and 3rd sessions).

Table 4.12 shows some examples of missing session numbers among clients' records, where missing records are highlighted in gray. Similar to the duplicate session numbers, these gaps in the data were most likely due to either data-entry errors by CMHP clerks or mistakes in counselors' reports.

Table 4.12: Examples of Missing Session Numbers among Client Records

MHC ID No.	*Client No.*	1st Session	2nd Session	3rd Session	4th Session	5th Session	6th Session
2	60311			1	1		
	62302						1
	70206	1	1	1		1	
	70207	1	1	1		1	
	70208	1	2		1		

- 1,619 clients (19% of all clients) were missing records for their 1st session.
- Obvious data-entry errors were also among session numbers, such as 20th counseling sessions and up to as high as the 146th session. 78 clients had records of session numbers over their 20th session.

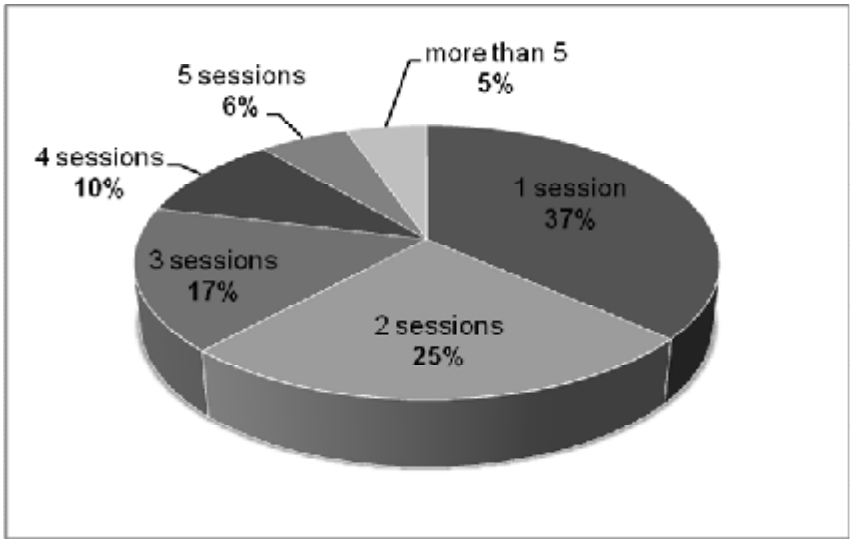
Regardless of the ordinal rank of the reported sessions, the researcher determined the number of session records per client by tallying all unique session numbers in each client's records. The results are illustrated in Figure 4.30:

- Of the 8,541 clients, 5,283 (62%) had a total of 1-2 individual counseling sessions; 3,126 clients (37%) had one reported session, while 2,157 clients (25%) had a total of 2 sessions.

- 1,364 clients (16% of all clients) had a total of 4-5 sessions with their CMHP counselor.

- Only 452 clients (5%) had records for more than 5 sessions with their counselor.

Figure 4.29: Total Number of Sessions per Client



4.2.14.3 Average Number of Client Sessions per Problem

Session numbers were also utilized to calculate the average number of sessions a client would have with a CMHP counselor, according to reported problems:

- 3 of the 69 problems listed in the CMHP database, *"Mood Disorder"*, *"Perfectionism"and "Substance Misuse"*, were not listed among any of the records.

- **Regardless of the type of problem reported, the average client had a total of 1-3 sessions with the CMHP counselor**.

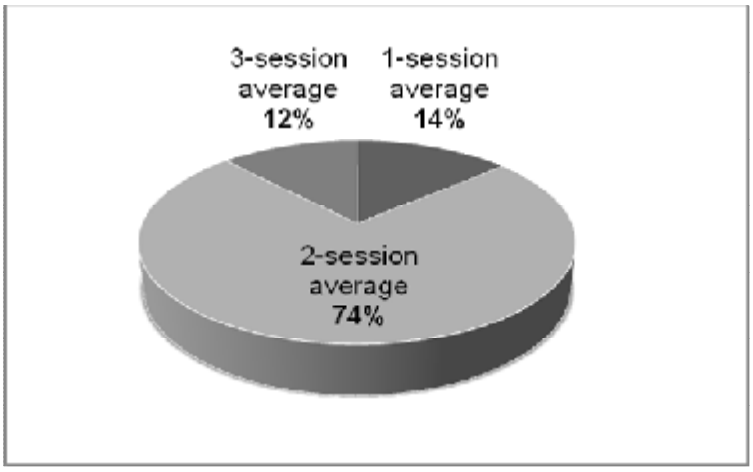
- 49 of 66 reported problems (74%) reported in the database averaged 2 sessions per client. "*Aggression*", the most-reported problem by CMHP counselors, averaged 2.2 sessions per client. "*Family Problems*" also averaged 2.2 sessions per client. "*Bedwetting*" averaged 2.0 sessions per client. Other chronic problems such as "*Learning Disability*" (averaging 1.8 sessions per client) and "*Mental Retardation*" (averaging 1.9) were also included in this group.

- 9 of 66 problems (14%) averaged only 1 session per client, and 8 problems (12%) averaged 3 sessions per client.

- The two problems with the highest average for client sessions (2.8 sessions) were "PTSD" and "*Inappropriate Sexual Behavior*".

- Problems averaging one counseling session per client included serious clinical diagnoses such as "*Bipolar Disorder*" and "*Schizophrenia*", as well as less specialized problems (e.g., "*Eating Problems*", "*Prejudice*" and "*Fire Setting*").

Figure 4.30: Average Total Number of Sessions per Problem



4.2.15 Analysis of Database Problem Categories

4.2.15.1 Translation Issues with Problem Terminology

Since data collection and data entry were in Arabic but CMHP monthly reports were in English, the next issue to be examined was cross-translation problems. How certain terms are interpreted and utilized may differ significantly between cultures, and how a term is translated between languages can have a significant impact. Below are two issues of translation discrepancies that may have influenced data collection results and therefore data presentation.

4.2.15.2 Comparison of CMHP Database Problems and Shaefer & Millman Book

44 of the 69 problem categories listed in the CMHP database seem to come directly from a book called *How to Help Children with Common Problems*, by Charles E. Shaefer and Howard L. Millman (Shaefer & Millman, 1983). As illustrated in Annex 6, the first 44 terms in the CMHP database show remarkable similarity to the 44 problems listed in this book, even in order of appearance.

Discrepancies in terminology possibly occurred because CMHP used an Arabic version of this book, translated by Nasimeh Dawoud and Nazih Hamdi, published by the University of Jordan(Dawoud & Hamdi, 1989). Some differences in terminology were relatively minor, such as "*Time Misuse*" (No.7 on CMHP's list) and "Time Used Poorly" (Schaefer-Millman) and "*Sensitivity to Critics*" (No.14) and "Hypersensitivity to Criticism" (Schaefer-Millman), but other discrepancies may cause confusion in usage and interpretation:

- "***Compulsivity*"** – (No. 2 on CMHP's list of problems)
  The Schaefer-Millman term is "Impulsive". In the Random House Dictionary, "impulsive" is defined as "actuated or swayed by emotional or involuntary impulses", whereas "compulsive" is defined as "pertaining to, characterized by, or involving

compulsion [a strong, usually irresistible impulse to perform an act, especially one that is irrational or contrary to one's will" (Random House, 2005). Although the two terms bear some similarity, compulsivity implies a more serious psychological state.

- **"*Attention Deficit*"** – (No. 3 on CMHP's list) The Schaefer-Millman term for this is "Short Attention Span – Distractible", which indicates a milder, more common problem presented by children, whereas "*attention-deficit*" is most-often used professionally as an official term for a psychological disorder (as in Attention Deficit Disorder).

- **"*Substance Misuse*"** – (No.41 on CMHP's list)
  The Schaefer-Millman term for this is "Drug Abuse", whereas "*Substance Misuse*" can also include a range of interpretations such as accidental overdosing, using prescribed medication to cure other ailments without doctor consultation, etc.

- **"*Lack of Motivation*"** (No.43 on CMHP's list)
  The Schaefer-Millman term for this is "Unmotivated in School", which more clearly defines the problem behavior and specifies the behavior to a particular setting.

- "***Joking*"** – (No.4 on CMHP's list)
  The Schaefer-Millman term for this is "Silly – Clowning", which more clearly defines the problem behavior.

4.2.15.3 Comparison of Original Arabic Version of Database Problems and English Version

Comparing the two versions of the client problems listed in CMHP database (both versions provided by CMHP and included as Annex 7), there were also a number of discrepancies in translation:

- **"*Compulsivity*"** and **"*Perfectionism*"** (No.2 and No.16 in the CMHP list, respectively), are the English translation for the same Arabic word ("Al-qahriya") in the Arabic version, meaning "compelling".

- "***Autism***" (No.49 in CMHP's list), is "id'dtira-b ad-dawa-ni" in the Arabic version. However, the English-Arabic dictionary translates autism as "ash-sharu-d". "Id'dtrira-b ad-dawa-ni" (literally, twin disorder) seems closer in meaning to "Bipolar Disorder".

- "***General Anxiety Disorder***" (No.56) is the English translation for the CMHP problem category "al-qalaq an'nafsi al-am" (literally, general anxiety", without the word disorder included).

- **"*Dissociation Disorder***" (No.59), which is actually "Dissociative Disorder" in psychological terms, is in the Arabic version "ad'dtira-b ad-dikra", literally "Memory Disorder", leaving open to conjecture what symptoms this "disorder" would entail (e.g., being forgetful? Short-term amnesia?)

- "***Schizophrenia***" and "***Bipolar Disorder***" (No.58 and 67, respectively) both are translated in the Arabic version "Al-fasa-m".

- "***Conduct Disorder***" (No.68) is translated in the Arabic version as "Ad-dtira-b maza-ji", literally "Mood Disorder".

(It should be reiterated that the researcher's first language is not Arabic, and so these observations are based on literal translation with the use of dictionaries. This section may need to be revised by a native Arabic-speaker with a background in psychology.)

4.2.16 Pre-August 2007 Database Entries for Problems

Examination of all database records from March 2007 to July 2008 revealed that problem categories were solidified around August 2007. Prior to this time, data entries for client problems were done manually instead of using predetermined terms set in the database, meaning counselors had more flexibility as to how they chose to define their clients' problems.

To get a better sense of the types of client problems CMHP counselors reported prior to August 2007, the researcher analyzed 2,484 records from March to July 2007 and grouped the entries under the following categories:

- *Academic or Learning-Related Problems*
- *Behavioral Problems (including Relational Problems)*
- *Emotional Problems*
- *Family Problems*
- *Clinical Problems*
- *Other Problems*

The various data were divided according to category below, then further grouped into "very general", "general" and "more specific" problems within the category.

Of the 1,914 records reported under "schools" between March and July 2008, 1,391 records (73%) were attributed to referral sources within the school (teachers, head teachers, etc.). The high percentage of referrals by school staff suggests that school clients were often sent to CMHP counselors because they were seen by school staff as problems (behavioral) or as having problems (academic or emotional).

The problems reported by the CMHP counselors were far-ranging. They included:

- *learning difficulties* ("problems doing homework", "inability to write")
- *classroom issues* ("no respect for the teacher", "disturbing the lesson", "leaving class without permission)
- *miscellaneous behaviors* ("cynicism", "vanity", "lack of personal hygiene")
- Interestingly, one record listed the client's problem as "skipping out of a counseling session".
- *Other general problems* (health problems, economic problems)

Tables 4.13 to 4.18 illustrate the variety of problems reported by the CMHP counselors between March and July 2007. All terms listed below were actual entries in the database. Phrases marked in bold are terms listed among the 69 problems in the post-July 2007 CMHP database.

4.2.16.1 Academic or Learning-Related Problems

Table 4.13: Pre-August 2007 Database Entries for Academic Problems

Very General	General	More Specific
Academic Underachievement Academically Behind Academic Decline Academic Problems	**Bad Study Habits** **Time Misuse** Bad time management **Lack of Motivation**	Not doing Homework Unwillingness to study Lack of interest in school Academic indifference Not bringing books to school Neglect of Studies
Study Problems	Learning Problems Academic Difficulties	Weak writing skills Inability to write Problem doing Homework (completing) Problems understanding (comprehension)
Attention-related	Lack of concentration Inattention Absentmindedness Forgetfulness **Daydreaming** **Attention-Deficit**	
		Truancy Wanting to drop out Drop out Refusal of school Skipping out of class early Lateness Leaving class without permission Skipping out of a counseling session
		Stammering Pronunciation Problems

4.2.16.2 Behavioral Problems

Table 4.14: Pre-August 2007 Database Entries for Behavioral Problems

Very General	General	More Specific
- Inappropriate Behavior - Bizarre Behavior - Lack of Discipline - Behavioral Problems - Classroom Problems - Discipline Problems - Deviation - Unwanted Behavior - Problems during roll call	- **Aggression** - Serious aggression	- verbal aggression - physical aggression
	- **Cruelty**	
	- **Destructiveness**	- Fire-setting
	- **Disobedience** - Acting out - Troublemaking - Bad manners	- non-compliance - no respect for the teacher - lack of respect for the school rules - breaking school rules - **Joking** (clowning around) - terrorism - a finger in the eye
		- disturbing the lesson - mocking the teacher
		- bringing a dangerous object to school
	- **Inappropriate Language**	- using obscene words - blasphemy - cursing the teacher
		- **Hyperactivity** - excitability
		- constant crying - short temper - **Temper Tantrums** - rudeness - stubbornness - cynicism - disdain - **Selfishness** - arrogance - excessive pride - possessiveness - being spoiled - vanity
		- **Cheating** - **Telling Lies** - **Theft** - Smoking - begging - gossiping
- Adolescent Problems		- getting to know boys - romantic involvement through the Internet
		- **Tics** - **Thumb Sucking** - **Nail Biting** - **Bedwetting** - **Bed Soiling**
	- Eating Problems	- Eating strange things
	- **Messiness** - self-neglect	- lack of personal hygiene

Table 4.15: Pre-August 2007 Database Entries for Relational Problems

Very General	General	More Specific
- social problems - relationship problems - problems with friends / classmates - (lack of) psychological support - differences		- bullying - teasing - **bad company**
	- over-dependency	- clinging to mother
	- inability to adjust to school - social maladjustment	
	- **shyness** - **social isolation**	- selective mutism - inability to participate - inability to read in front of others

4.2.16.3 Emotional Problems

Table 4.16: Pre-August 2007 Database Entries for Emotional Problems

Very General	General	More Specific
- Emotional Problems - Psychological Problems - Emotional Relationships - School Problems	- **fear**	- not feeling safe
	- anger	
	- **anxiety**	- tension - exam anxiety - social anxiety
	- psychological pressure	
	- **depression**	- somber
	- **low self-esteem**	- self-criticism - feelings of inferiority - Non-acceptance of self - Non-acceptance of own body image - low self-esteem due to father's killing - feeling hated by others - feeling neglected by teacher
	- frustration	- feeling stifled
	- personal loss	
	- jealousy	
	- over-sensitivity	- **sensitivity to critics**

4.2.16.4 Family Problems

Table 4.17: Pre-August 2007 Database Entries for Family-Related Problems

Very General	General	More Specific
- **Family Problems**	- marital problems	- marital anxiety - divorce - spouse's addiction - marital differences - separation - abandonment by spouse
	- family disputes - family neglect - emotional neglect - emotional deprivation	- bad relationship with mother / father - problems dealing with father - hatred of mother - separation from mother - personal loss (loss of mother / father)
	- family aggression - domestic violence	- parental neglect & ill-treatment - harrassment by father - sexual abuse by brother - verbal abuse - physical abuse

Clinical diagnoses <u>unmentioned</u> in the CMHP database until August 2007 included:

- Night (Sleep) Terror Disorder
- Nightmare Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Personality Disorder
- PTSD
- Schizophrenia
- Sexual Disorder
- Somatization Disorder
- Substance use disorder

4.2.16.5 Other Reported Problems

Table 4.18: Pre-August 2007 Database Entries for Other Problems

Very General	General	More Specific
	- Health Problems	- kidney failure - iron deficiency - Epilepsy - psychosomatic symptoms - physical (somatic) symptoms
	- Economic Problems	
- with special needs - handicap	- physical handicap	
	- **Prejudice** (bias) - **Compulsivity** - Obsession	- false beliefs
	- selective mutism	- refusal to talk
	- **Trauma**	
- sexual problems	- sexual deviation	
		- sexual assault - sexual harassment

4.2.17 Problem Combinations (Co-morbidity)

Among the Pre-August 2007 database records, there were many records that listed more than one client problem, as illustrated in Table 23 below. Miscellaneous problem combinations mentioned in the database that did not fit under Table 23 include:

- Adolescent problems & inappropriate sexual behavior
- Acting out & lack of acceptance of own body
- Neglect & lack of cleanliness
- Suspicious & lacking self-confidence
- Severe neglect & the need for family planning
- Poor sexual response & emotional neglect
- Poor psychological [state] & [bad] physical treatment
- Poor control over stool & being spoiled

Table 4.19: Pre-August 2007 Problem Combinations Reported in CMHP Database

Academic underachievement	& **aggression** & **anxiety** & **fear** & forgetfulness & **inappropriate sexual behavior** & indifference to school & low intelligence & neglect of homework & **theft** from fear
Aggression	& jealousy & academic underachievement & **hyperactivity** & ill-treatment of others & **inappropriate language** & **low self-esteem** & **telling lies** & tension (**anxiety**) & **theft**
Anxiety	& personal loss & academic underachievement & frustration & sadness & shyness
Fear	& anxiety & bedwetting & jealousy & nightmares
Attention Deficit	& forgetfulness & hyperactivity & visual disability
Hyperactivity	& lack of acceptance of body image & academic underachievement & acting out & carelessness & **low self-esteem** & self-harm & selfishness & stammering
Family Problems	& emotional neglect & frustration & **low self-esteem** & theft
Low Self-Esteem	& **aggression** & **family problems** & forgetfulness & **hyperactivity** & **shyness**

4.3 Results of Part One of the Questionnaire Survey of CMHP Counselors

For Part One of the questionnaire, CMHP counselors were asked to read 79 statements related to their work and select their degree of agreement with each statement from among 5 choices: (1) Strongly Disagree, (2) Disagree, (3) Neither Disagree nor Agree, (4) Agree, or (5) Strongly Agree.

To facilitate analysis, the researcher merged counselors' responses (1)-(3) under "agree" and (4)-(5) under "disagree". The basis of this decision was on the social research theory of central tendency: studies have shown that respondents usually avoid ends of scales (extremes) in their answers and instead tend to try to be conservative and wish to be in the middle. In other words, respondents are more likely to check "Agree" or "Disagree" than "Strongly Agree" or "Strongly Disagree" (Foddy, 1993).

It can be inferred that the higher the percentage of positive responses among the statements, the higher the counselor's level of satisfaction in the area being focused upon. Therefore, counselors were divided into three groups:

(1) *Less than satisfied* (i.e., those who responded positively to less than 35% of all related statements)

(2) *Moderately satisfied* (i.e., those who answered positively to 35-64% of the statements)

(3) *Satisfied* (i.e., those who responded positively to more than 65% of the statements).

4.3.1 CMHP Counselors' Overall Satisfaction Level

Figure 4.32 illustrates the overall trend of counselors' responses to Part One of the questionnaire. The results were as follows:

- **Overall:** Taking Part One as a whole, CMHP counselors were divided between being moderately satisfied (82 counselors, or 48%) and satisfied (73 counselors, or 43%). 15 counselors (9%) indicated that, overall, they were less than satisfied.

- **Training:** 69 counselors (41%) were less than satisfied, 45 counselors (26%) were moderately satisfied, and 56 counselors (33%) were satisfied with their training.

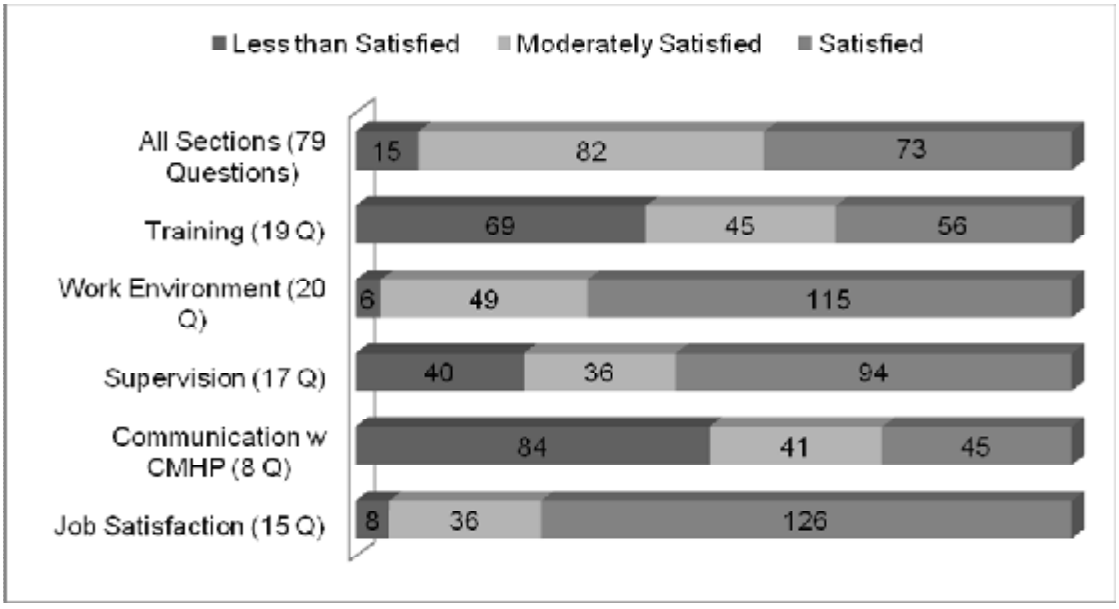
- **Work Environment**: Satisfaction was significantly high among counselors in this section. 115 counselors (68%) indicated that they were satisfied, while 49 counselors (29%) were moderately satisfied and 6 counselors (4%) were less than satisfied with their work environment.

- **Supervision**: 94 counselors (55%) indicated that they were satisfied with the supervision they were receiving. 36 counselors (21%) were moderately satisfied, and 40 counselors (24%) were less than satisfied.

- **Communication with CMHP Management**: Satisfaction among counselors was also comparatively low in this section. 84 counselors (49%) indicated that they were less than satisfied with communication with CMHP management. 41 counselors (24%) were moderately satisfied, and 45 counselors (26%) were satisfied.

- **Job Satisfaction**: Satisfaction among counselors was the highest in this section. 126 counselors (74%) indicated job satisfaction. 36 counselors (21%) had moderate satisfaction, and only 8 counselors (5%) were less than satisfied.

Figure 4.31: CMHP Counselors' Satisfaction Level (Positive Responses to Questionnaire), by Section



Figures 4.33 and 4.34 examine counselors' responses according to their work venue (UNRWA health centers and schools). Since health center counselors only numbered 11, percentages of their responses cannot be blindly compared to those of school counselors (numbering 159). However, it is interesting to note that in all sections of Part One, health center counselors as a whole showed higher levels of satisfaction than school counselors. Health center counselors showed an especially high number of positive responses in areas of work environment (9 out of 11 counselors), supervision (10 out of 11 counselors), and job satisfaction (all 11 health center counselors).

Figure 4.32 School Counselor Satisfaction Level (159 Respondents)

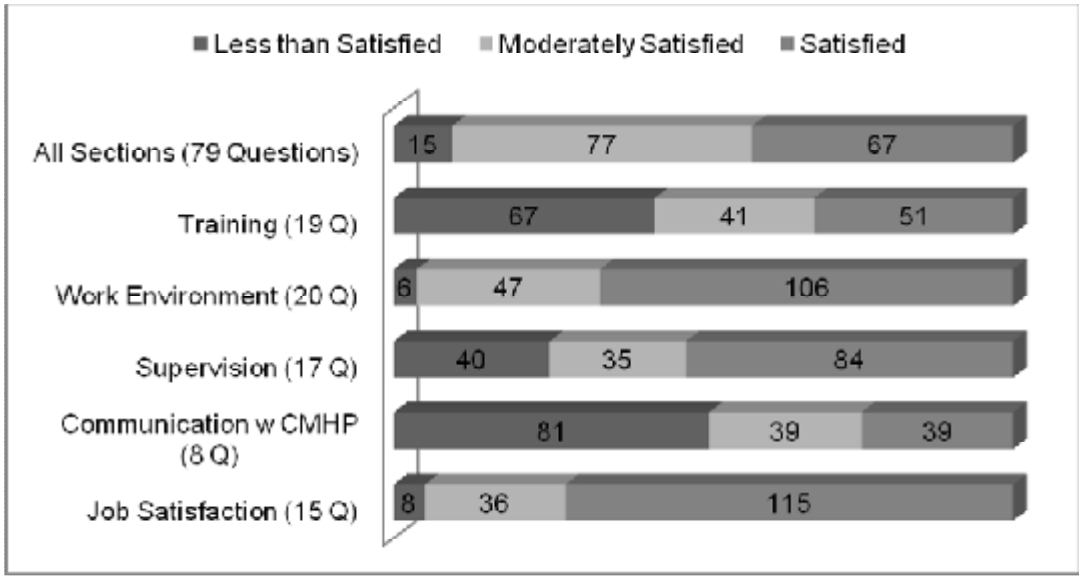
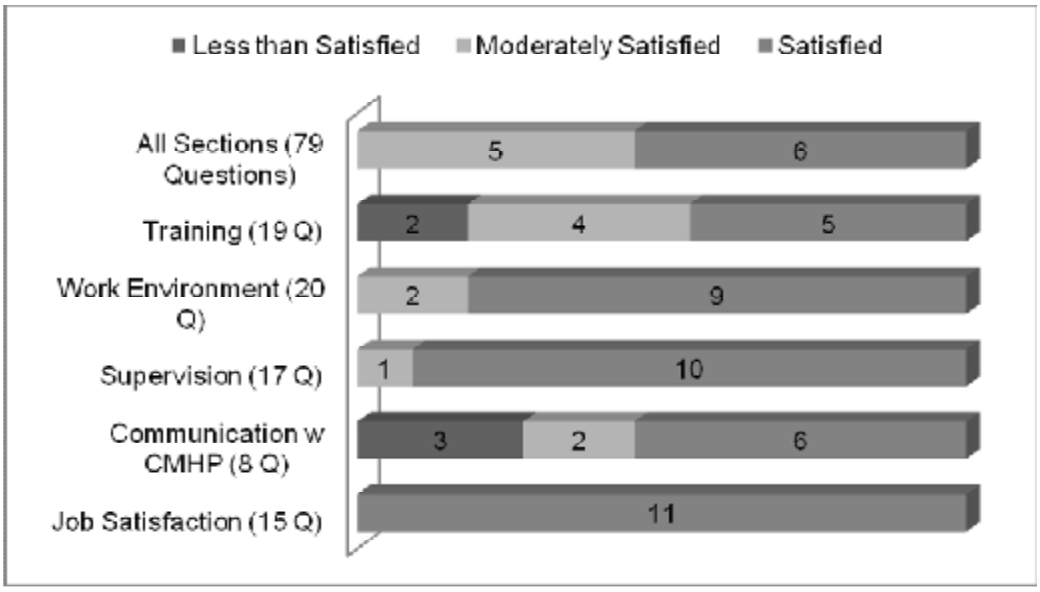


Figure 4.33: Health Center Counselors' Satisfaction Level (11 Respondents)



4.3.2 CMHP Counselors' Views on Training

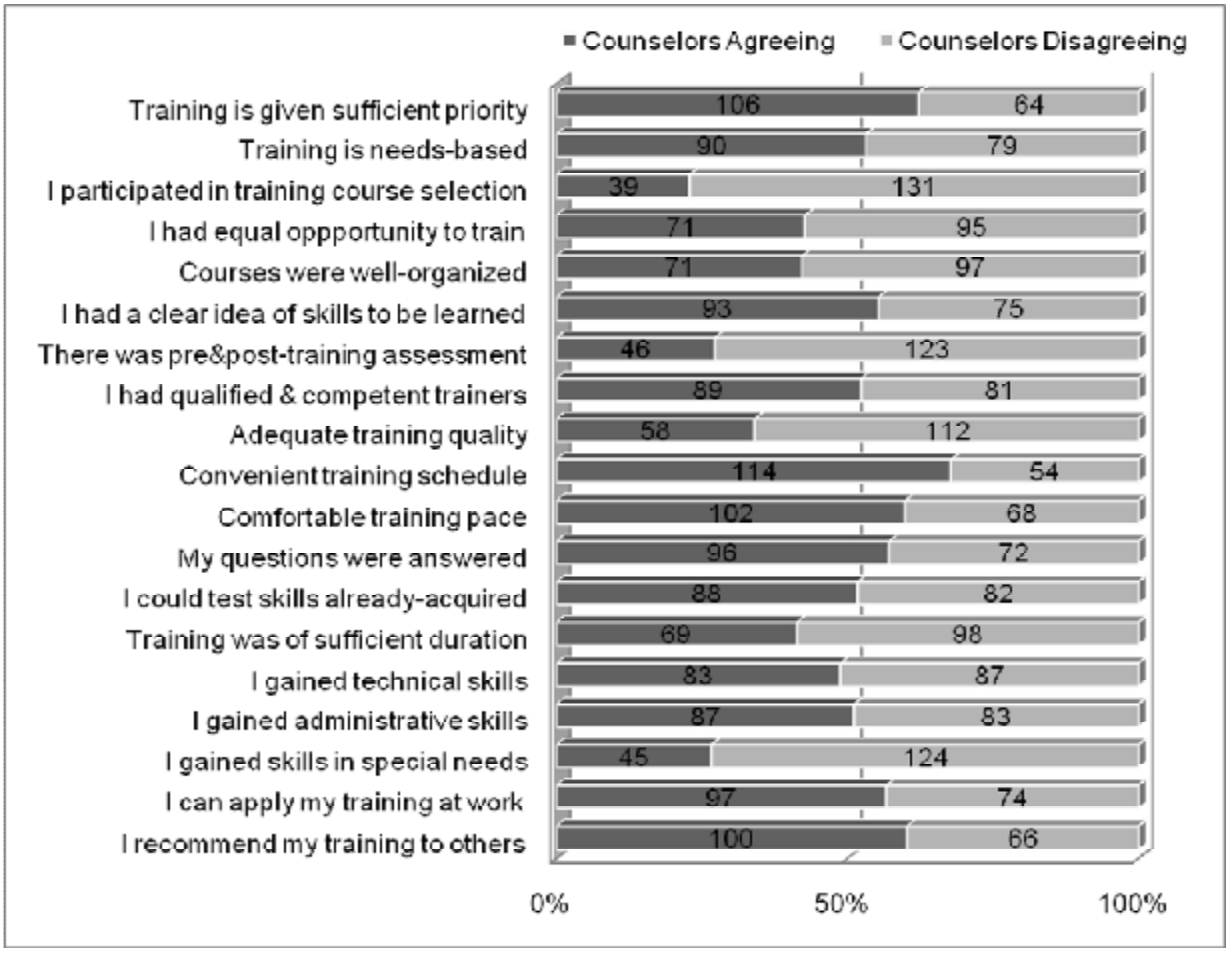
Figure 4.34 shows the number of counselors who agreed or disagreed with each of the 19 statements related to training:

- For the majority of the statements in this section, the percentage of counselors was nearly evenly split between agreement and disagreement. In 13 out of 19 statements, the total number of counselors who agreed was from 69 to 102 counselors or from 41% to 60% of the total.

- The highest percentage of agreement for a single statement was 67% (for "Training was offered at a time that made it easy for me to attend"), while the lowest was 23% (for "I participated in determining the training courses I needed.")

- Other statements with significantly low agreement were for pre and post-training assessment (6 of the counselors, or 27%, agreed that there had been any), adequate training quality (58 counselors, or 34%) and gaining skills in special needs (45 counselors, or 26%).

Figure 4.34: CMHP Counselors' Views on Training (Questions 1 - 19)



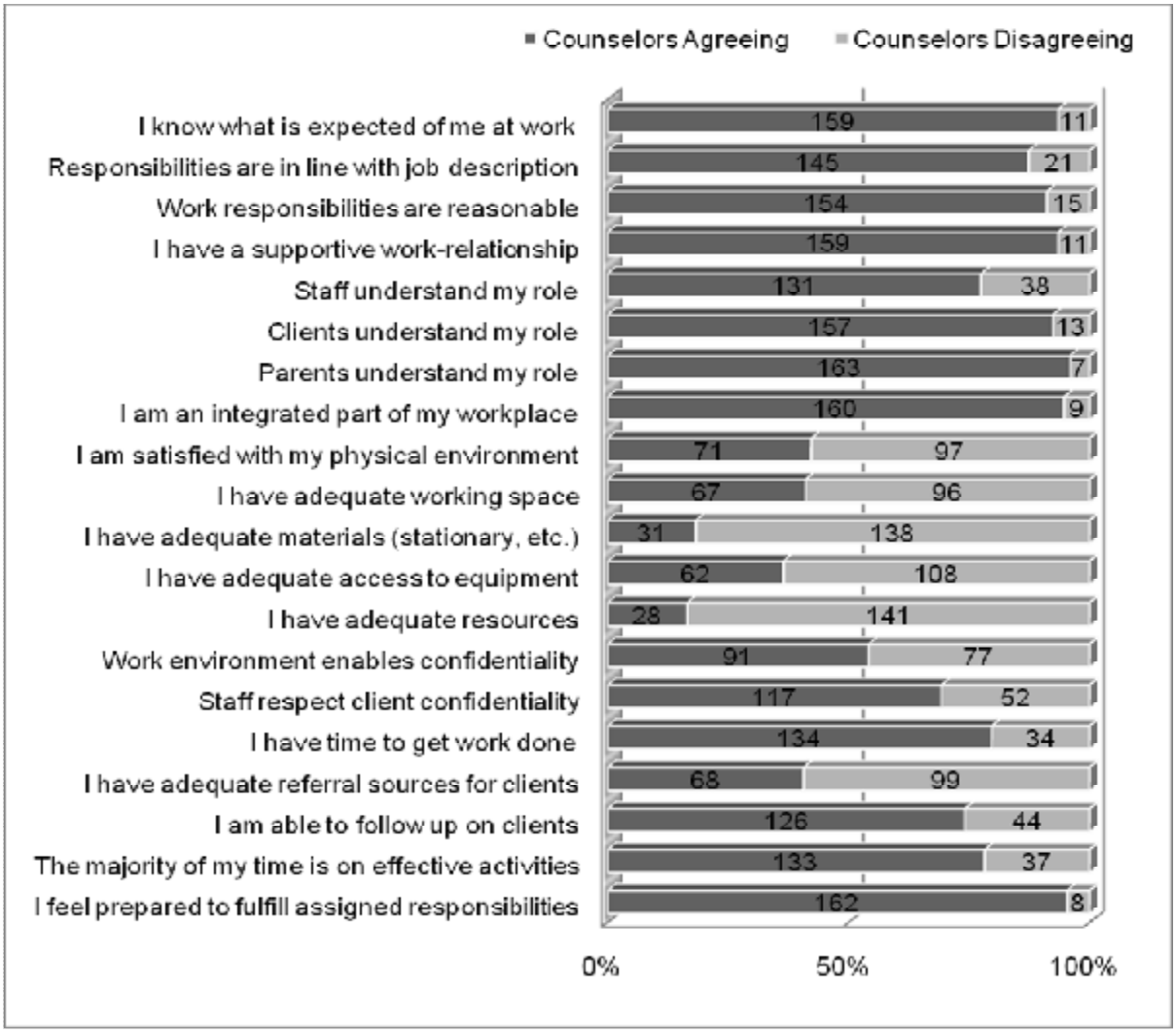
4.3.3 CMHP Counselors' Views on Work Environment

Figure 4.35 shows the number of counselors who agreed or disagreed with each of the 20 statements related to their work environment, available resources, and support:

- For 12 out of 20 statements, more than 74% of all counselors responded positively; for 8 of those 12, more than 90% of the counselors agreed with the statement. **Agreement was particularly high among counselors in statements related to level of comfort in work duties, work relationships, and understanding by others of their roles within the workplace**.

- For 6 out of 20 statements, less than 43% of the counselors agreed. **Agreement was principally low among counselors in statements related to availability of physical resources**. Only 28 counselors (16%) agreed that they had adequate resources, and 31 counselors (18%) agreed that they had adequate material.

Figure 4.35: CMHP Counselors' Satisfaction in Their Work Environment, Resources and Support (Q20-39)



4.3.4 CMHP Counselors' Views on Supervision

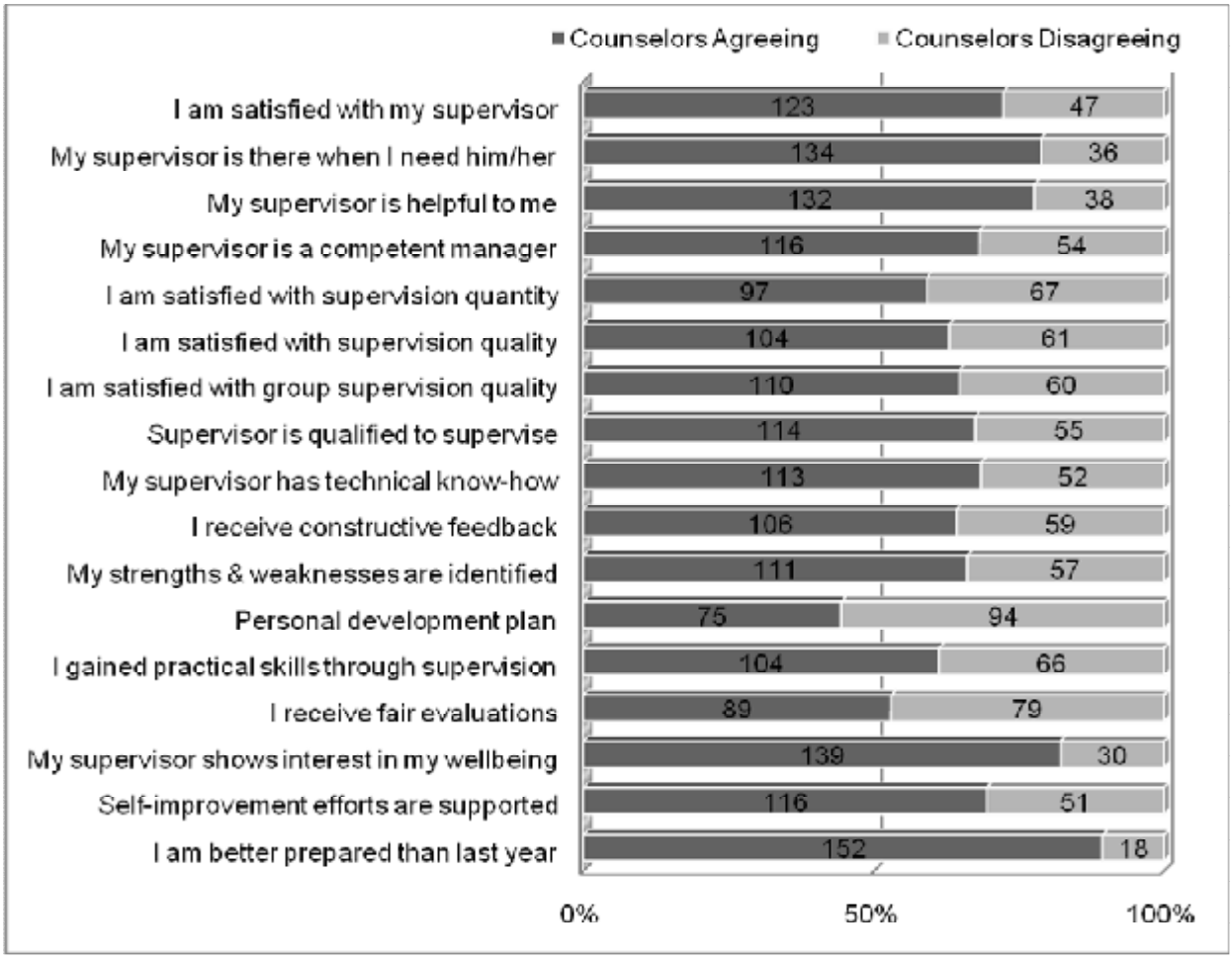
Figure 4.36 shows the numbers of counselors who agreed or disagreed with each of the 17 statements related to the supervision they receive in CMHP:

- More than half of the counselors responded positively for 16 out of 17 statements. Percentages of agreement among counselors ranged between 52% and 89%.

- Satisfaction was relatively high among counselors for statements related to the emotional availability of supervisors. 132 counselors (78%) agreed that their supervisor was helpful for them; 139 counselors (82%) agreed that their supervisor showed interest in their wellbeing).

- In comparison, agreement among counselors tended to decrease for statements related to supervision quality. 104 counselors (61%) were satisfied with supervision quality; 89 counselors (52%) agreed that they received fair evaluations by the supervisor.

Figure 4.36: CMHP Counselors' Views on Supervision (Q40-56)



4.3.5 CMHP Counselors' Views on Communication with CMHP Management

Figure 4.37 shows the number of counselors who agreed or disagreed with each of the 8 statements related to communication with CMHP management:

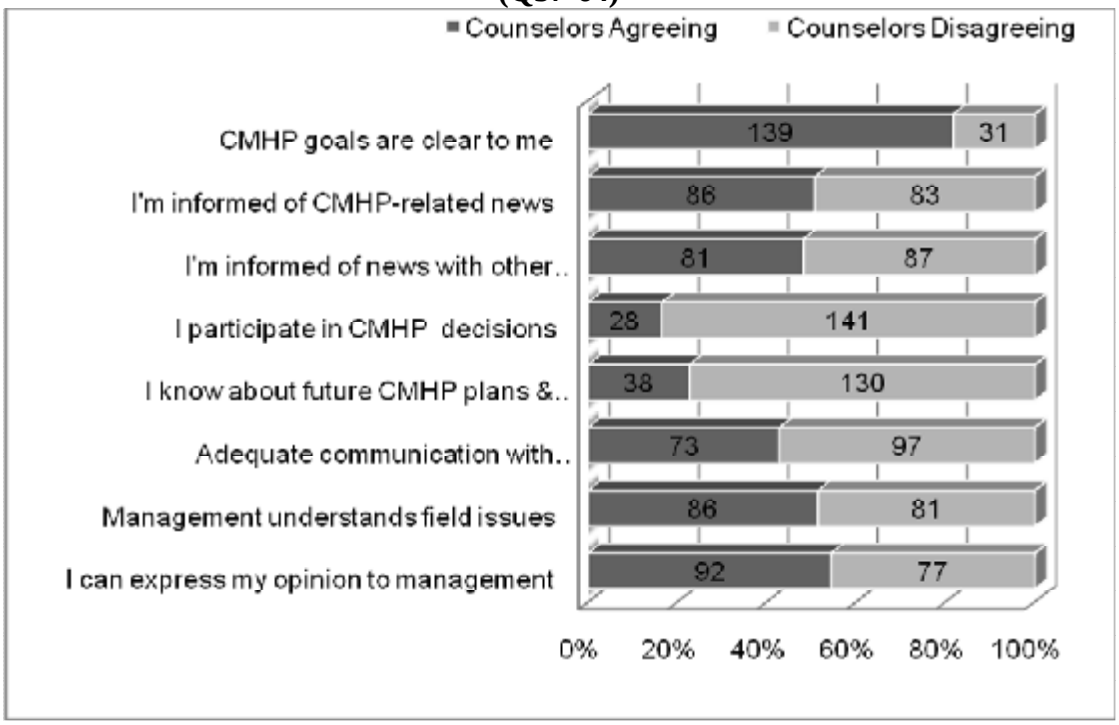
- Agreement was relatively low among counselors for 7 out of 8 statements concerning communication with their management, ranging from 16 to 54%.

- The only statement that generated a high percentage of agreement (82%) among counselors was regarding the clarity of CMHP goals.

- 28 counselors, (16%) agreed that they participated in decisions within CMHP, and 38 counselors (22%) felt informed about the direction and future plans of CMHP.

- 73 counselors (43%) felt there was adequate communication between counselors and CMHP management; 86 counselors (48%) felt informed about news between CMHP and other departments; 86 counselors (51%) felt updated about CMHP-related news and felt CMHP management understood issues that counselors faced in the field; and 92 counselors (54%) felt they could express their opinions to management.

Figure 4.37: CMHP Counselors' Views on Communication with CMHP Management (Q57-64)

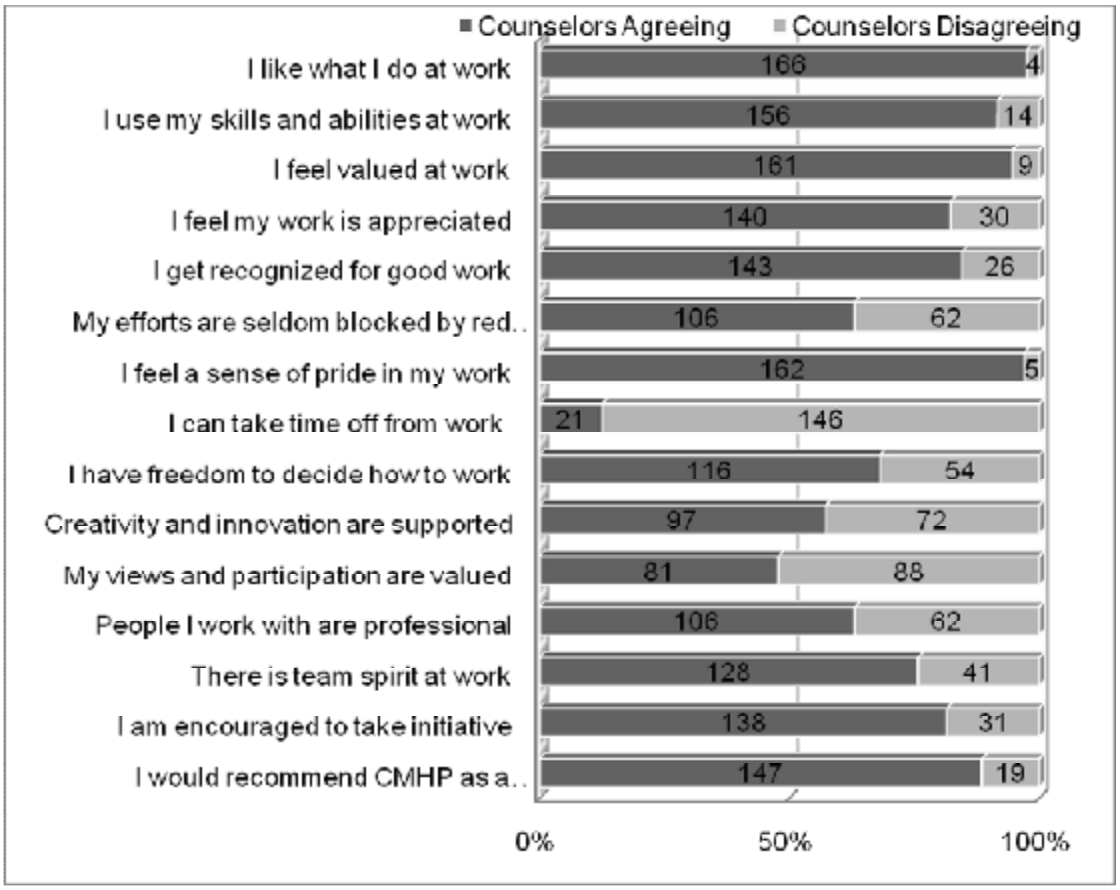


4.3.6 CMHP Counselors' Views on Job Satisfaction

Figure 4.38 shows the number of counselors who agreed or disagreed with each of the 15 statements related to their job satisfaction in CMHP:

- Agreement was significantly high among counselors for most statements concerning job satisfaction. Over 75% of the counselors responded positively for 9 out of 15 statements.
- 156 counselors (92%) agreed that their jobs allow them to use their skills and abilities; 161 counselors (95%) took pride in their work and felt valued at work; 166 counselors (98%) liked what they did at work.
- Only 21 counselors (12%) felt free to take time off from work to tend to personal affairs.

Figure 4.38: CMHP Counselors' Views on Job Satisfaction (Q65-79)



4.4 Results of Part Two of the Questionnaire

4.4.1 Counselors' Perception on CMHP Training

4.4.1.1 Types of training

Counselors were asked to list the different types of training they underwent through CMHP from March 2007 until present time (the day they participated in the questionnaire survey for this study).

All responses were categorized into the following three groups:

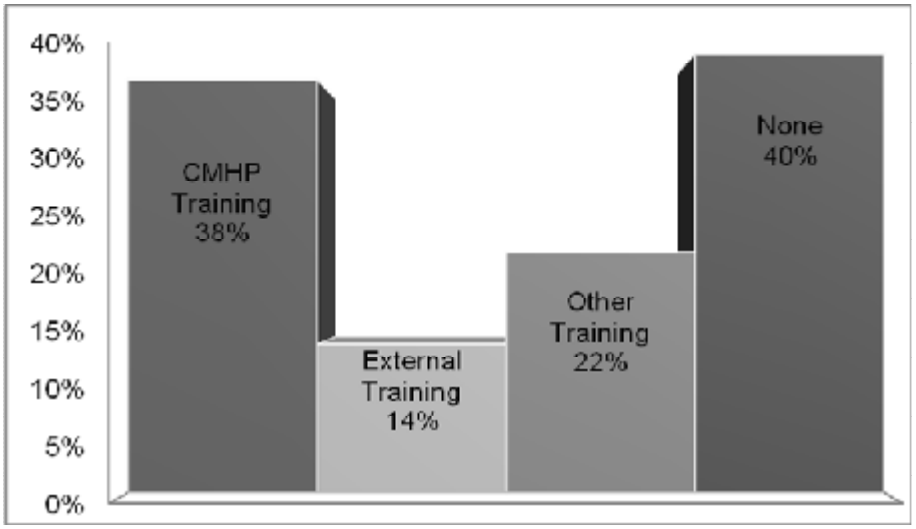
- **CMHP Training:** Training conducted by CMHP staff
  Summer Intensive Course (Individual Counseling, Mental Illness, Mental Health, Cognitive-Behavioral Therapy, Behavioral Counseling, Development Stages, Communication Skills); Life Skills

- **External Training:** CMHP Training by another organization outside of UNRWA
  Mind & Body; WHO; Drama (Theater Day Productions)

- **Other Training:** Training that did not fit into the above groups
  1-day workshop on how to conduct questionnaires; Data-entry; Computer; English; Group Supervision.

Figure 4.39 illustrates the percentage of counselors who cited having undertaken each type of training. 82 counselors (48%) listed only one type of training; 18 counselors (11%) listed 2 types; 2 counselors (1%) listed all 3 training types.

Figure 4.39: CMHP Counselors' Recollection of Training Courses



- The only exclusive group was "None", where the counselors left the question blank. In other words, 68 respondents (40% of the total) listed no training courses, while the remaining 108 respondents (60% of the total) listed one, two, or three types of training.

- 65 counselors (38%) listed some form of training done by CMHP staff; 24 counselors (14%) listed external training; 37 counselors (22%) listed miscellaneous training.

- **CMHP training**: 51 out of 170 counselors (30%) mentioned Summer Intensive training; 18 counselors (11%) mentioned Life-Skills.

- **External Training**: 18 counselors (11%) mentioned training in drama (Theater Day Productions).

- **Other training**: 30 counselors (18%) mentioned English courses; 3 counselors (2%) mentioned their biweekly group supervision sessions with their supervisors as part of their training.

- 6 of the 11 health center counselors mentioned keywords related to the Summer Course of 2007 (*individual counseling, cognitive-behavioral therapy, mental illnesses*); 3 health center counselors mentioned external training by the WHO.

4.4.1.2 Effective training

- 142 counselors (84%) responded that they benefited from either some or all of the training they had listed; 28 counselors (16%) responded that none of their training was useful in their work.

- **CMHP training**: Among training by CMHP staff, 43 counselors (25%) mentioned benefiting from Behavioral Counseling courses; 34 counselors (20%) mentioned benefiting from a course in Communication Skills.

- **Other Training**: 25 counselors (15%) mentioned benefiting from English courses; 6 counselors (4%) mentioned benefiting from biweekly group supervision. 6 counselors mentioned benefiting from courses undertaken in CMHP prior to March 2007.

4.4.1.3 Training needs

Training needs listed by counselors were divided into 4 groups:

- **General Activities:** *Psychotherapy; individual counseling; group counseling; group guidance; awareness meetings; counseling techniques*

- **Problems:** *Special needs; mental illness / psychological disorders; students' behavioral problems; Learning Disabilities; learning disabilities, handicapped children; hearing-*

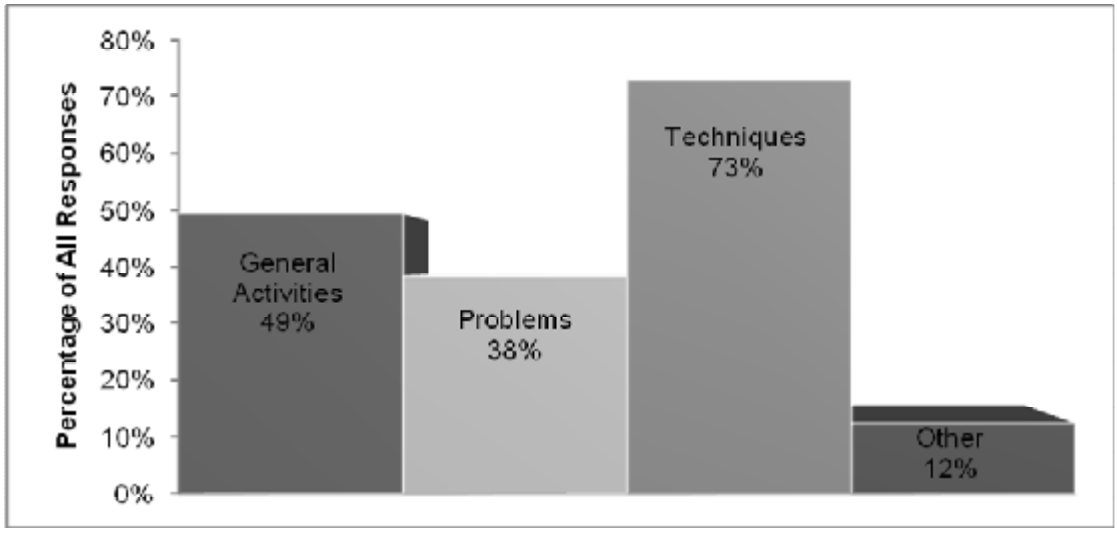
impairment; student failure; low academic achievement; speech problems; pronunciation problems; mutism; psychological trauma

- **Techniques:** *Drama; drawing; games; cognitive-behavioral therapy; relaxation; communication skills; scientific research; emotional release; behavioral therapy; behavior modification; testing (IQ, personality, psychological); activation; crisis & working under pressure.*

- **Other:** *Computer (including PowerPoint and SPSS); Internet; English*

Figure 4.40 illustrates the percentage of counselors who requested each type of training. 82 counselors (48%) listed requests for two types of training. 20 counselors (12%) listed 3 types, 66 counselors (39%) listed only one type, and only 1 counselor listed all 4 types.

Figure 4.40: CMHP Counselors' Training Requests



- In general, the majority of the counselors' requests were for practical training (e.g., the requests included the phrase "how to…").

- **Training in Techniques:** 124 counselors (73%) cited that they needed more training in various techniques, making this group the most-common among all requests.

- 22 counselors (13%) requested training in behavioral therapy; 14 counselors (8%) requested training in general psychotherapy. 24 counselors (14%) requested training in drama; 6 counselors (4%) requested training in interpreting children's drawings.

- **95 counselors (56%) requested training in psychological testing**. 60 counselors (35%) requested training in IQ testing. This phenomenon is suggestive of the relatively new focus in UNRWA schools on special needs and learning disabilities among students.

- **Training in Problems**: 46 counselors (27%) requested more training on mental illnesses, particularly in diagnosis and assessment. 11 counselors (6%) requested training in special needs; 8 counselors (5%), in learning disabilities and disorders

- **Training in Activities**: 35 counselors (21%) requested training in group counseling; 22 counselors (13%) in individual counseling; 7 counselors (4%) in group guidance.

4.4.2 Counselors' Perception of their Work Environment

4.3.2.1 Additional Material / Resources

Counselors' requests for additional material and resources were grouped into 5 categories:

- **Room & Furniture:** *private room, suitable room, playroom for clients; desk; chairs; carpeting; curtains; relaxation bed; fan; heater*

- **Equipment:** *computer; copy machine; camera; LCD; phone/Jawwal (including pre-paid cards); video player; TV*

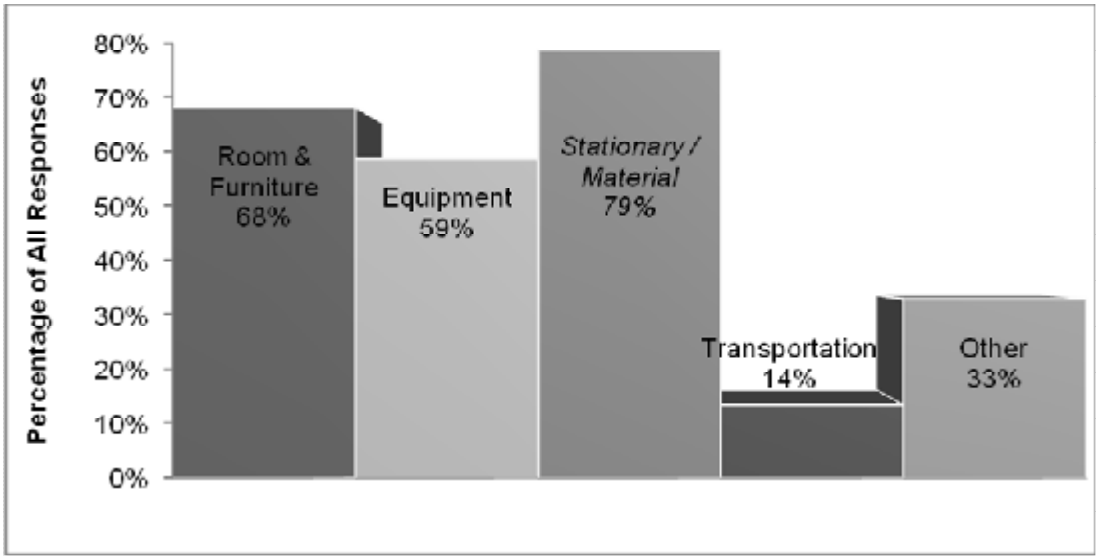
- **Stationary / Material:** *stationary (including pens, photocopier paper; files); office materials; technical books [related to counseling]; videos and CDs on counseling; IQ tests; psychological tests*

- **Transportation:** *transportation for home visits*

- **Other:** *gifts, rewards, financial incentives for clients; recreational material; games; psycho-educational cassettes/CDs; bulletins; posters; petty cash*

Figure 4.42 illustrates the percentage of counselors who requested each type of resource. 62 counselors (36%) listed two types of material support they needed. 20 counselors (12%) listed only one type. 54 counselors 32%) listed 3 types; 27 counselors (16%) listed 4 types; only 3 counselors (2%) listed all 5 types.

Figure 4.41: CMHP Counselors' Requests for Materials/Resources



- **Stationary / Material: Lack of stationary and material was the most-commonly mentioned category among respondents (134 counselors, or 79% of the total).** 114 counselors (67%) requested a sufficient supply of stationary.

- Interestingly, 10 of the 30 counselors (33%) who agreed in Part I of the questionnaire that they have the material (e.g. stationary) they need to do their work effectively listed stationary among their requests in this section.

- **Room & Furniture**: The second most-commonly requested resource was related to physical space; 116 counselors (68%) cited unavailable or inadequate rooms and furniture. 95 counselors (56%) mentioned needing rooms; 67 counselors (39%) specified "private rooms".

- **Equipment**: 100 counselors (59%) cited lack of access to equipment. 91 counselors (54%) requested computers; 20 counselors (12%) requested copy machines; 4 counselors (2%) requested printers

- **Transportation**: 23 counselors (14%) complained of lack of transportation to visit homes of clients.

- **Other**: 56 counselors (33%) listed other requests for material support that did not fit into any of the other categories. 32 counselors (19%) requested incentives for students such as gifts and rewards; 42 counselors (25%) requested games.

4.3.2.2 Other kinds of support

Non-material support cited by the counselors was grouped into 4 categories:

- **Administrative / Emotional Support from CMHP Management:** *encouragement from supervisors / managers for successful work; respect for counselors' work; financial incentives for the counselors; "symbolic" support; more vacation days; freedom to take days-off by choice; regular communication between supervisors and counselors;*

debriefing sessions with supervisors; protection of counselors from abusive parents; involvement of supervisors in difficult cases; psychological support for counselors to relieve work pressure

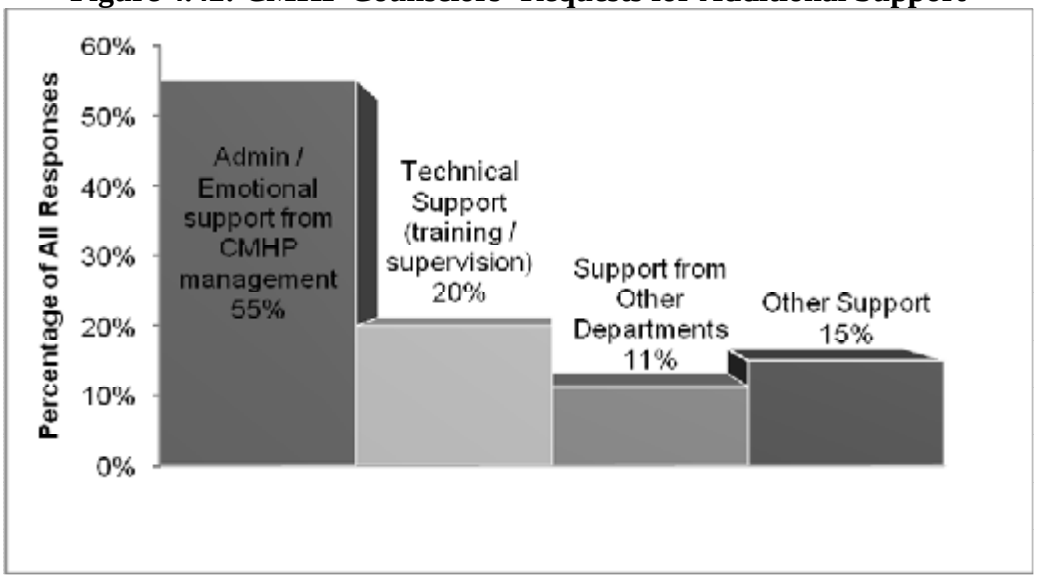
- **Technical Support (CMHP Training / Supervision):** *special courses in general diagnosis; intensive courses in mental illnesses; high-level courses overseas; training in psychological testing; updates on developments in the counseling field; more supervision; professional supervision; training by specialists; training in fundamental skills in guidance and counseling; training in English and computers*

- **Support from other UNRWA Departments:** *team support and cooperation from the Education Department (ED); coordination between CMHP and ED; coordination with UNRWA's Relief Department; cooperation with other UNRWA programs; more support from UNRWA management; appreciation by UNRWA management*

- **Other Support:** *assistance for financially-needy cases; protection of clients during home visits; moving CMHP under UNRWA's General Fund (job security); salary increase; recreational trips; more promotion of CMHP (including distributing brochures to increase awareness of counselors' role in schools and health centers, expanding school library to include magazines and books related to psychology; posters to promote the importance of CMHP counselors)*

Figure 4.42 illustrates the percentage of counselors who requested each type of additional support. 93 counselors (55%) cited needing only one type of additional support; 37 counselors (22%) cited two types; only 2 counselors listed 3 types.

Figure 4.42: CMHP Counselors' Requests for Additional Support



- **Over half of all counselors cited needing more administrative or emotional support from CMHP management (94 counselors, or 55%)**.

- 34 counselors (20%) asked for more technical support including more/better-quality training and supervision.

- 19 counselors (11%) asked for more support from other UNRWA departments, particularly from the Education, Health, and Relief Services Departments.

- 26 counselors (15%) cited support needs not fitting into the previous 3 categories.

4.4.3 Client Privacy and Confidentiality

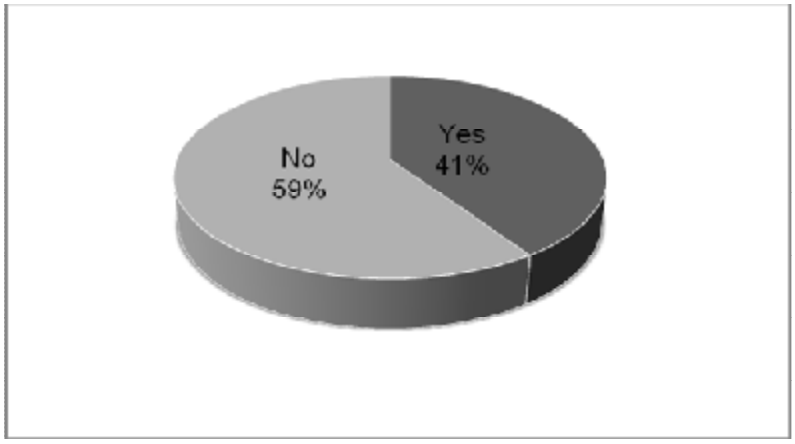
4.4.3.1 Private Rooms

- 101 counselors (59%) reported that they did not have a private room.

- 10 (91%) out of 11 Health Center counselors responded that they had private rooms, while only 59 (37%) out of 159 School counselors similarly responded.

- Interestingly, among the 91 counselors who responded in Part One of the questionnaire that their work environment enables privacy and confidentiality, 31 counselors (43%) responded that they did not have a private room at their workplace, suggesting that not all counselors need to have a private room to maintain privacy and confidentiality.

Figure 4.43: CMHP Counselors with Private Rooms

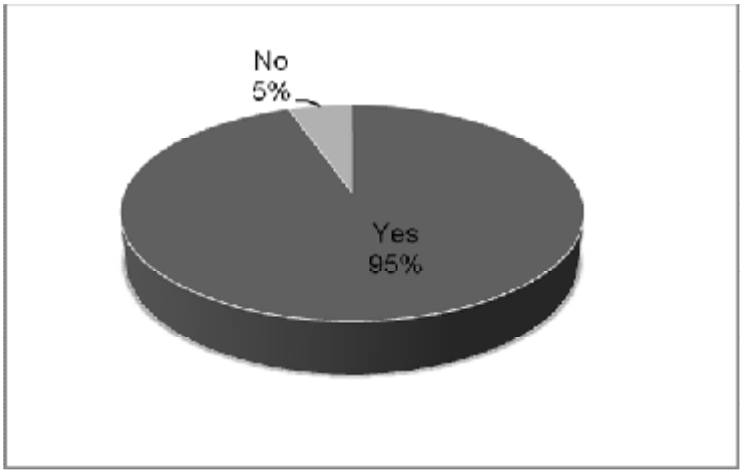


4.4.3.2 Locked Cabinets

- The vast majority of counselors (161 counselors or 95%) reported that they had locked cabinets in which to store their confidential files.

- 10 (91%) of 11 Health Center counselors and 151 (95%) of 159 School counselors reported that they had locked cabinets.

Figure 4.44: CMHP Counselors with Locked Cabinets



4.4.3.3 Obstacles to Maintaining Client Privacy and Confidentiality

Obstacles to maintaining client privacy and confidentiality, listed by the counselors, were divided into 2 categories:

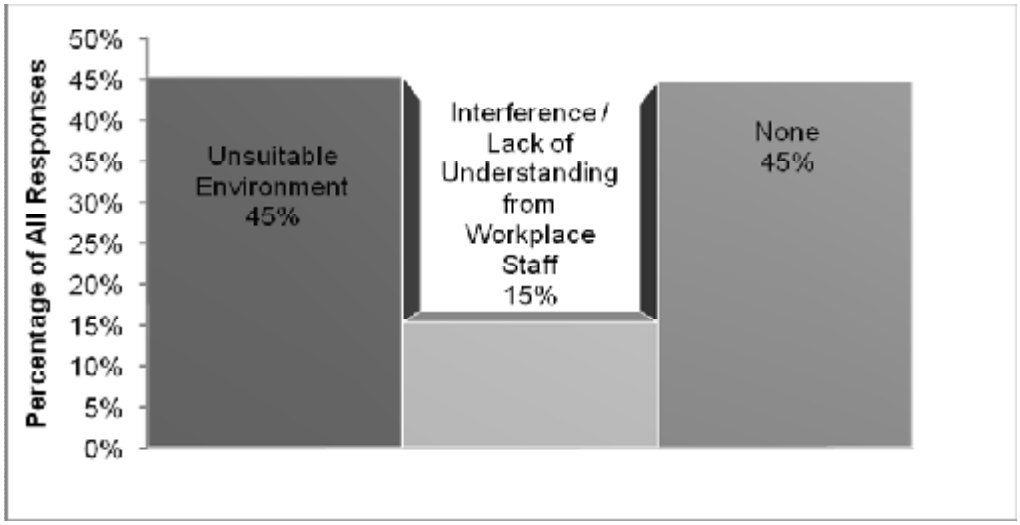
- **Unsuitable Environment:** *no private room; unsuitable room (including no curtain, no key to room, people coming in and out)*
- **Interference / Lack of Understanding from Workplace Staff:** *prying teachers; prying Head Teacher; interference by teachers and school management; teachers and school management need lectures about the importance of client confidentiality (lack of*

understanding); parents speak about their children's problems in front of Head Teachers and teachers

- **None**

Figure 4.45 illustrates the percentage of counselors who cited either or both of two types of obstacles or those who listed no obstacles at all.

Figure 4.45: Obstacles to Privacy and Confidentiality, As Reported by CMHP Counselors



- 76 counselors (45%) reported that they faced no obstacles to maintaining client privacy and confidentiality.

- 94 counselors (55%) responded that they faced obstacles to maintaining privacy and confidentiality of their clients. 85 counselors (50%) reported only one type of obstacle, while 9 counselors of the above 103 (9%) mentioned having obstacles in both an unsuitable working environment and from interference / lack of understanding from workplace staff.

- Of the 117 respondents who in Part One of the questionnaire that their workplace staff respect their need to maintain client privacy and confidentiality, 7 counselors (6%) mentioned staff interference as an obstacle.

4.4.4 Counselors' Perception on Presenting Problems

4.4.4.1 Most-Frequently Presenting Client Problems

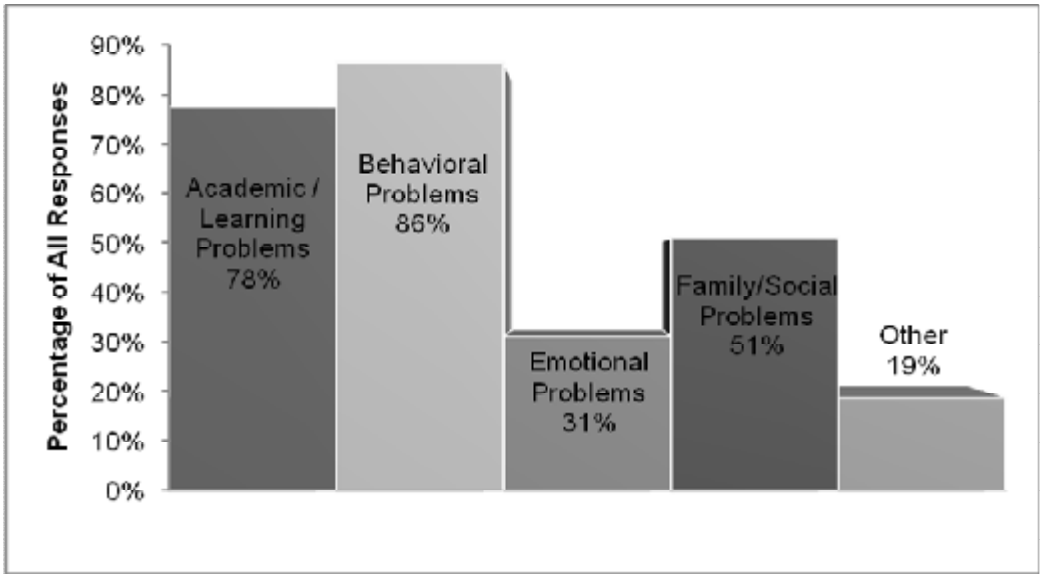
Client problems mentioned by counselors ranged from the specific (e.g., not doing homework) to the very general (e.g., *psychological problems*). Most-frequently seen client problems, as listed by counselors, were divided into 5 categories:

- **Academic / Learning-Related Problems**
- **Behavioral Problems**
- **Emotional Problems**
- **Family / Social Problems**
- **Other Problems** *(including unspecific problems & non-psychological problems)*

As the specific problems mentioned by counselors tended to differ according to the counselors' venue, detailed descriptions of each problem category are listed separately below.

Figure 4.46 illustrates the percentage of counselors who cited each type of problem as most-frequently seen at their workplaces. The highest number of counselors (68 counselors, or 40%) listed 3 types of problems. 57 counselors (34%) listed 2 types; 23 counselors (14%) listed 4 types; 6 counselors (4%) listed all 5 types of problems. 11 counselors (6%) listed only one of the 5 categories.

Figure 4.46: CMHP Counselors' Perception of Most-Frequently Presenting Problems



- **Behavioral problems** were cited by the most number of counselors (147 counselors, or 86% of the total). "*Aggression*" & "*aggressive behavior*" were listed by 112 counselors (66%)."*Violence*" was listed by 30 counselors (18%). 19% of the counselors listed "*Bedwetting*" among the non-disciplinary behavioral problems frequently seen in their work.

- **Academic / learning problems** were the second most-cited among counselors: 132 counselors (78%) mentioned some form of this problem. 96 counselors (56%) specifically mentioned "*low academic achievement*".

- 117 counselors (69%) mentioned frequently dealing with both academic/learning problems and behavioral problems among clients.

- 87 counselors (51%) listed family problems; 53 counselors (31%) listed various emotional problems; 32 counselors (19%) listed other problems that did not fit into the other 4 groups.

4.4.4.2 Client Problems Listed by Counselors, According to Venue

For each problem category, school counselors mentioned one or more of the following keywords:

- **Academic / Learning-Related Problems:** *lack of motivation; attention-deficit; daydreaming; lack of concentration; forgetfulness; neglect of studies; not doing homework; school failure; low academic achievement; lack of organization; truancy; tardiness; drop-out; learning difficulties; learning disabilities; illiteracy; mental retardation*

- **Behavioral Problems:** disciplinary (including *aggression, violence, hitting, hyperactivity, trouble-making, stealing, lying, cheating, inappropriate language, disobedience, stubbornness, running away from home (staying out), lack of discipline in the classroom, destructiveness, sexual misconduct);* non-disciplinary (including *bedwetting, shyness, isolation, oversensitivity, maladjustment*)

- **Emotional Problems:** *fear; depression; frustration; trauma; low self-esteem; low self-confidence; psychological pressure; anxiety* (including *anxiety at night*)

- **Family / Social Problems:** *problems related to childrearing; death of parent(s); separation from mother; divorce; [a child's] bad treatment by family; domestic violence; neglect; lack of attention of parents for child's academic success*

- **Other:** *economic problems; poverty; adolescent problems (including love relationships, fantasizing); communication problems; bad dreams; addiction to TV / computer / internet; emotional relationships; general psychological problems*

Health Center Counselors mentioned the following keywords:

- **Academic Problems:** *bad study habits*

- **Behavioral Problems**: *bedwetting; aggression; stubbornness; general behavioral disorders; children's behavioral problems; thumb-sucking*

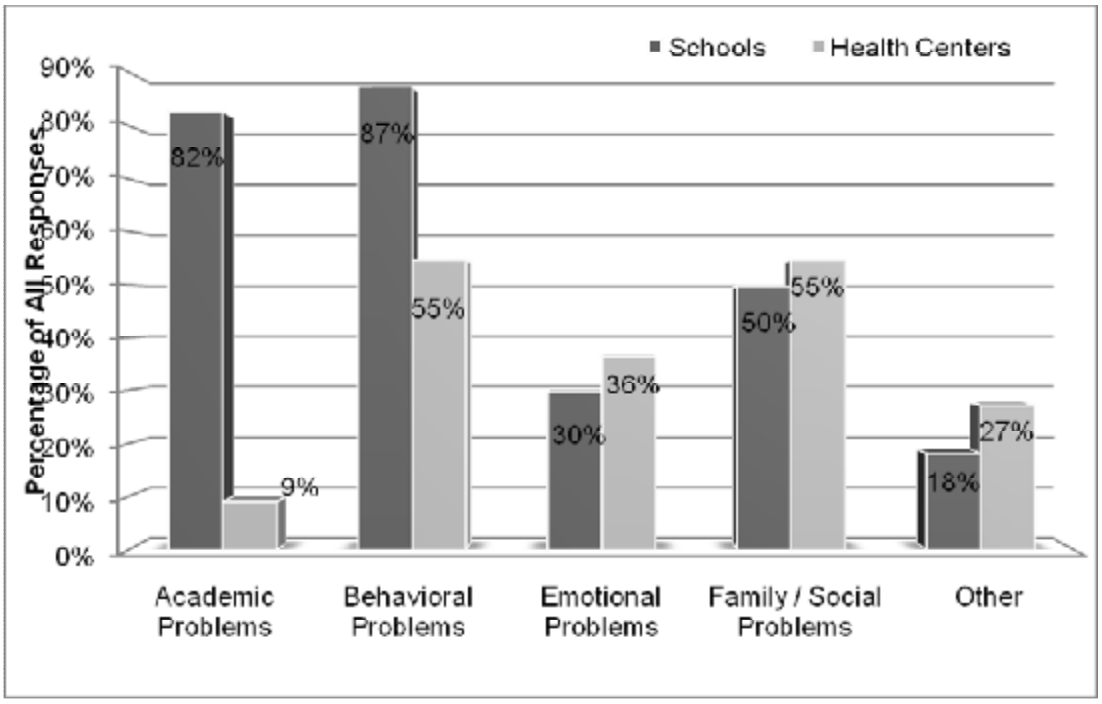
- **Emotional Problems:** *psychological stress; psychological pressure; depression (including post-partum depression and depression during pregnancy); fear; anxiety*

- **Family / Social Problems:** *family problems; social problems; domestic violence; marital problems; sexual harassment; illiteracy in the family*

- **Other:** *mental illnesses; somatoform disorders; psychosomatic pain; psychological problems; economic problems (clients' poor financial situation); youth problems*

As demonstrated in Figure 4.47, the total number of counselors reporting certain types of problems differed according to the counselors' workplace.

Figure 4.47: CMHP Counselors' Perception of Most Frequently Presenting Problems, by Venue



- **Academic Problems**: As expected, academic problems were reported by a much higher percentage of school counselors than health center counselors. 131 out of 159 school counselors (82%) mentioned some form of academic or learning problem, while only 1 out of 11 health counselors mentioned an academic problem.

- **Behavioral Problems**: Reports of behavioral problems were also comparatively higher among school counselors: 139 school counselors (87%) listed some behavioral problem, while 6 health center counselors (55%) did the same. Behavioral problems listed by school counselors were also very specific and detailed, including many of a disciplinary nature.

- **Emotional Problems**: 47 school counselors (30%) and 4 health center counselors (36%) mentioned emotional problems among the most-frequently handled at work.

- **Family / Social Problems**: 79 school counselors (50%) and 6 health center counselors (55%) listed family or social problems among the most-frequently handled at work.

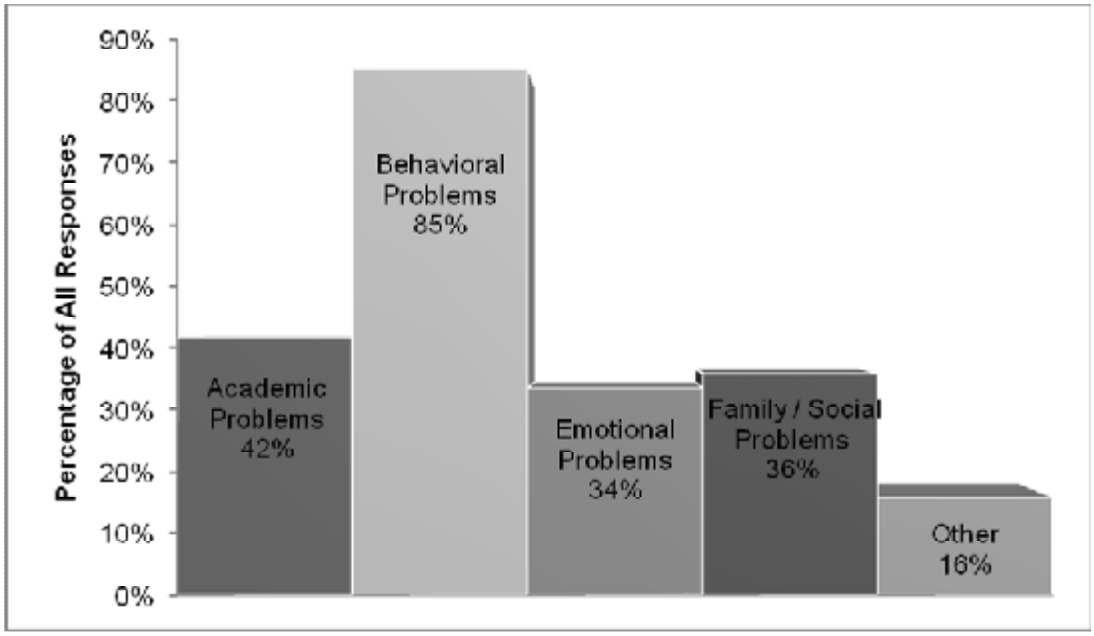
- **Other Problems**: 29 school counselors (18%) and 3 health center counselors (27%) mentioned other problems not fitting into any of the other categories.

- **None of the school counselors mentioned any kind of mental illness or serious psychological (clinical) disorder**.

4.4.4.3 Client Problems Counselors Feel Most Able to Handle

Figure 4.48 illustrates the types of problems counselors reported feeling most able to handle. (The majority of problems listed here would likely be from among the problems counselors mentioned among their most-frequently seen problems, with a few exceptions)

Figure 4.48 Types of Problems CMHP Counselors Feel Most Able to Handle



- 145 counselors (85%) reportedly felt able to handle behavioral problems, either a particular problem or in general. 71 counselors (42%) felt comfortable handling academic / learning problems; 61 counselors (36%) listed family / social problems; 57 counselors (34%) listed emotional problems; 27 counselors (16%) listed other problems not fitting into any of the previous categories.

School Counselors mentioned the following keywords:

- **Academic / Learning-Related Problems:** *attention-deficit; lack of motivation; slow learning; truancy; poor concentration; forgetfulness; bad study habits; not doing homework; daydreaming; neglect of studies; learning difficulties; lack of organization; punctuality*

- **Behavioral Problems:** disciplinary (including *aggression, violence, hyperactivity, stubbornness, stealing, lying, trouble-making, sexual misconduct, classroom discipline,*

inappropriate language, cruelty; short temper); non-disciplinary (including *sleep-walking, bedwetting, shyness, isolation, nail-biting)*

- **Emotional Problems:** *fear; trauma; tension; psychological tension; self-confidence; low self-esteem; anxiety (including exam anxiety)*

- **Family / Social Problems:** *family problems; problems related to childrearing; family neglect; bad relationship with mother; family disputes; domestic violence; maladjustment*

- **Other Problems:** general (including *psychological problems; adolescent problems; health problems; special groups; children's problems); pronunciation problems; providing support during crises; memorizing the Koran; scheduling plans for students; cleanliness; helping to regain loss of trust & hope with others; lack of cooperation; bad dreams; maladjustment; personality disorders*

Health Center Counselors mentioned the following keywords:

- **Academic Problems:** *slow learning*

- **Behavioral Problems**: *bedwetting; aggression*

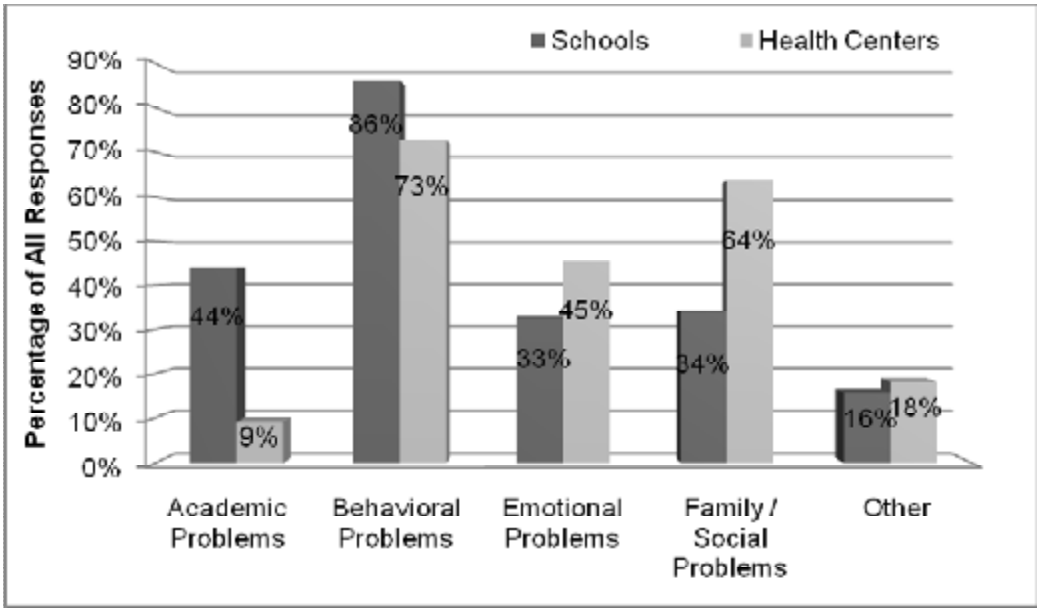
- **Emotional Problems:** *depression*

- **Family / Social Problems:** *family problems; social relationships; marital conflict*

- **Other:** *relaxation techniques; children's psychological problems*

Figure 4.49 compares, by venue, the total number of counselors reporting feeling most able to handle certain types of problems.

Figure 4.49: Types of Problems Counselors Feel Most Able to Handle, by Venue



- **Academic Problems:** While 131 school counselors (82%) reported frequently seeing academic / learning problems among their clients, about half that number (70 school counselors, 44%) reported feeling most able to handle some form of this problem.

- **Behavioral Problems**: 137 school counselors (86%) reportedly felt most able to handle behavioral problems, nearly equal to the number of those who reported frequently dealing with such problems. While 6 health center counselors mentioned behavioral problems among frequently-seen problems, 8 (73%) felt most able to handle such problems.

- **Emotional Problems**: 52 school counselors (33%) and 5 health center counselors (45%) felt most able to handle emotional problems.

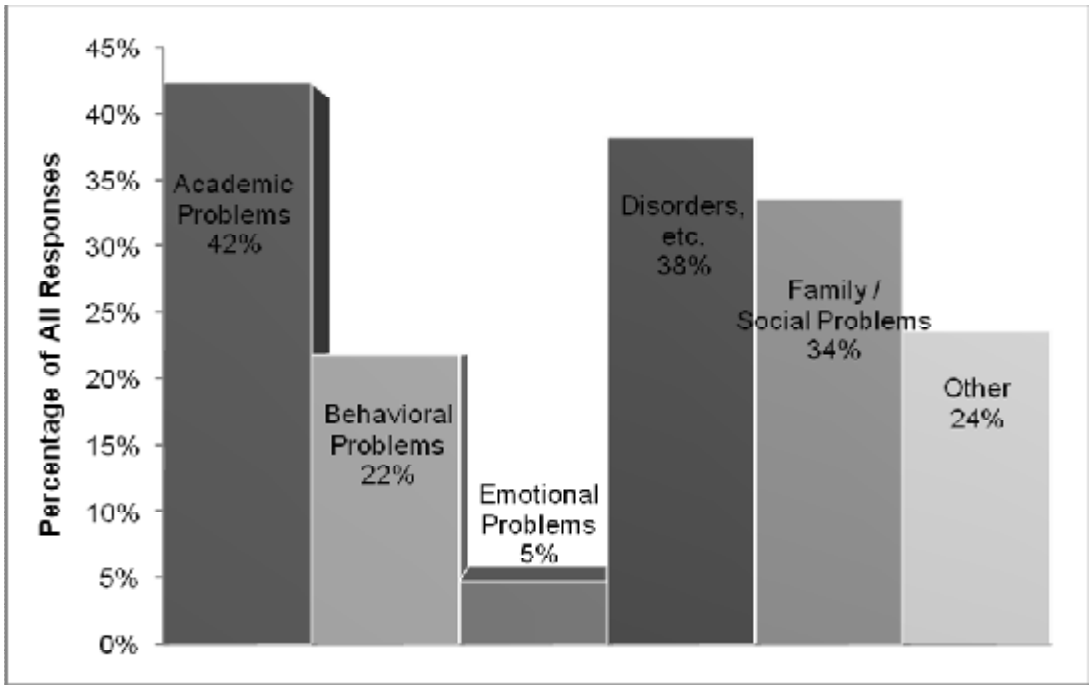
- **Social / Family Problems**: 54 school counselors (34%) and 7 health center counselors (64%) felt most able to handle social/family problems.

- **Other Problems**: 25 school counselors (16%) and 2 health center counselors mentioned feeling most able to handle miscellaneous problems or activities that did not fit under any of the other categories.

4.4.4.4 Client Problems Counselors Feel Least Able to Handle

As a significant number of counselors mentioned mental illnesses and psychological disorders among the problems they felt least able to handle, an additional category "Disorders, etc." was added to the previous 5 types of problems, as illustrated in Figure 4.50.

Figure 4.50: Client Problems CMHP Counselors Feel Least Able to Handle



- 72 counselors (42%) felt least able to handle academic problems. 65 counselors (38%) listed psychological disorders or other serious clinical problems; 57 counselors listed social/family problems; 37 counselors (22%) listed behavioral problems; 9 counselors (5%) listed emotional problems. 40 counselors (24%) listed problems that did not fit under any of the other categories.

- It cannot be assumed that those who did not mention certain types of problems feel confident in dealing with them (e.g., that 38% of counselors reportedly felt least able to deal with disorders does not suggest that the remaining 62% of counselors feel able to handle such disorders; instead, it is possible that these counselors do not deal with this problem to a wide extent).

School counselors mentioned:

- **Academic Problems:** *learning disorders; learning difficulties; low academic achievement; lack of motivation; academic failure; attention-deficit; daydreaming; tardiness*

- **Behavioral Problems**: disciplinary *(including discipline, stubbornness, inappropriate sexual behavior, lying, short-temper);* non-disciplinary *(isolation; bedwetting; horrible nightmares, sleep problems, sleep-walking, sexual problems)*

- **Emotional Problems:** *severe depression; obsession; trauma; exam anxiety*

- **Disorders, etc:** *mental retardation; psychological problems needing special treatment; mental problems; epilepsy; mental illnesses; personality disorders; Obsessive-Compulsive Disorder; IQ measurement; low mental abilities; psychological trauma lasting a long time*

- **Family / Social Problems:** *family problems; domestic violence; family neglect; family member's addiction; father's short-temper; illiteracy in the family; lack of understanding by families on how to deal with children; unresponsive families; divorce; separation of mother; remarriage of father; clan disputes; father's absence from the home; marital problems; parents' psychological problems; sexual abuse; refusal to participate in counseling*

- **Other:** *Cleanliness; pronunciation difficulties; stammering; issues related to manners and etiquette; fear of spirits; economic problems; poverty; handicapped children; mutism; special needs (including speech and hearing difficulties); family size; physical problems; health problems; adolescent problems; honor-related problems; political problems; problems related to sexuality*

Health Center counselors mentioned:

- **Academic Problems:** *low academic achievement; concentration problems*

- **Behavioral Problems:** *hyperactivity; stubbornness; sleepwalking; Obsessive-Compulsive Disorder; problems related to sexuality, honor, cultural traditions in the community, and sexual aggression*

- **Emotional Problems:** *depression; trauma*

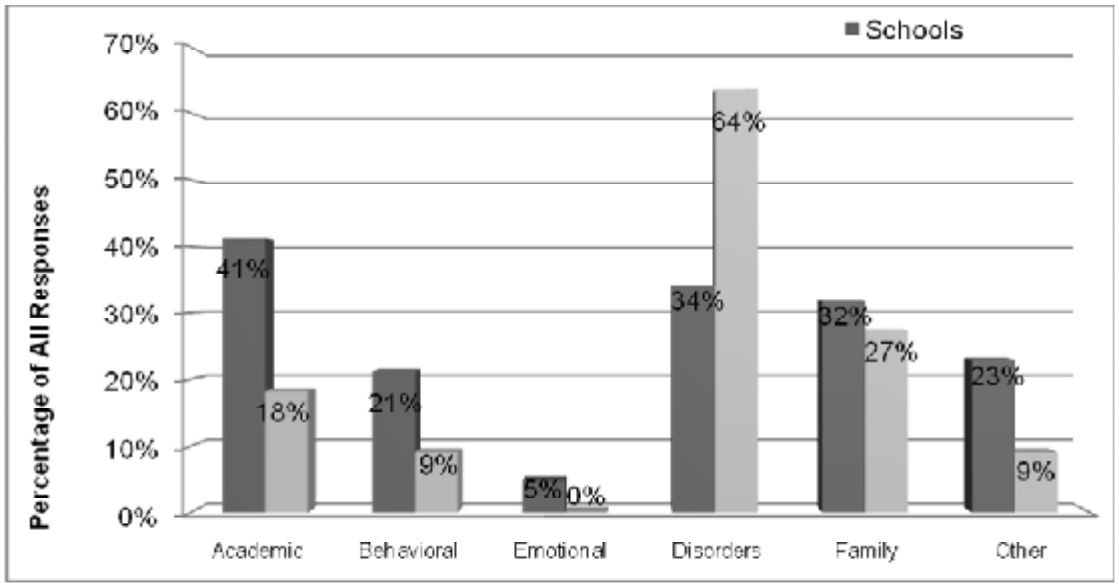
- **Disorders, etc:** *mental illnesses; personality disorders; psychological disorders; psychotherapy; [psychotropic] drugs; psychological testing; epilepsy*

- **Family / Social Problems:** *complicated family problems; economic problems*

- **Others:** *pronunciation disorder; memory*

Figure 4.51 compares, by venue, the total number of counselors reporting feeling least able to handle certain types of problems.

Figure 4.51: Client Problems CMHP Counselors Feel Least Able To Handle, by Venue



- 70 school counselors (41%) reported being least able to deal with academic problems, while only 2 health counselors did the same. As previously mentioned, this is most likely because academic problems were not reported among problems often seen by health center counselors.

- 58 school counselors (34%) and 7 health center counselors (64%) mentioned disorders among problems they felt least able to handle.

- 54 school counselors (32%) and 3 health center counselors listed family/social problems; 36 school counselors (21%) and 1 health center counselor mentioned behavioral problems; 9 school counselors (5%) and no health center counselor mentioned emotional problems. 39 school counselors (23%) and 1 health center counselor mentioned miscellaneous problems that did not fit under any of the other categories.

4.4.5 Counselors' Perception of Major Obstacles to work

Major obstacles to work listed by the counselors were divided into 5 categories:

- **Physical Work Environment:** *lack of equipment; insufficient material; lack of stationary; lack of rewards or other incentives for clients; lack of furniture (including desk, table, comfortable chairs); lack of privacy (including lack of private room / unsuitable room); transportation; no means to call parents (no phone);*

- **Problems with Workplace Management (ED or HD):** *interference by Head Teacher and/or teachers; poor relationship with school management; being given inappropriate tasks by school management; lack of understanding by school staff about counselors' work*

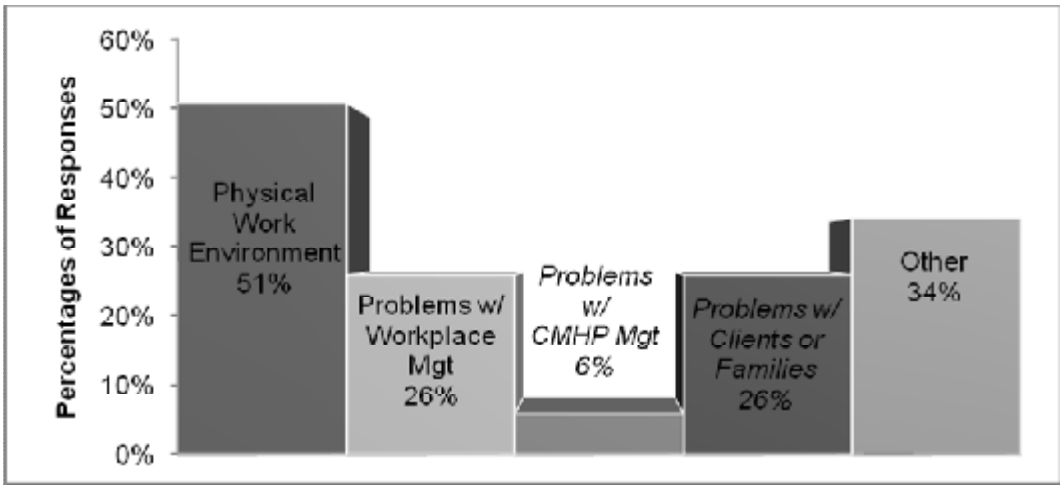
- **Problems with CMHP Management:** *relations between 2 managements (CMHP and school); supervisor visits less than twice a month; lack of communication with supervisors in schools*

- **Specific Problems with Clients or Families:** *lack of communication with families; lack of parental / familial cooperation; lack of appreciation of parents for the psychological state of their children; difficulty getting parents to come in to school for a consultation; students' refusal to accept home visits; parental neglect; lack of parental attention to children's academic performance; children's complicated problems;*

- **Other:** *high caseload; large school size; no scheduled time for group guidance; no time to work with students; lack of vacation days for counselors; having to work in 2 schools; low academic abilities of students; lack of counselor protection during home visits; transfers; lack of teacher's ability to maintain discipline in classrooms; lack of time to finish work; psychological stress*

Figure 4.52 illustrates the percentage of counselors who reported each type of obstacle. 84 counselors (49%) mentioned only one category of obstacle. 53 counselors (31%) mentioned 2 categories; 16 counselors (9%) mentioned 3 categories; 1 counselor mentioned all 4 categories.

Figure 4.52: CMHP Counselors' Perceptions of Obstacles to Work



- 86 counselors (51%) mentioned their physical work environment as being a major obstacle to their work.

- 44 counselors (26%) mentioned problems with their workplace management and specific problems with clients or families, respectively.

- 10 counselors (6%) mentioned problems with CMHP management.

- 58 counselors (34%) mentioned miscellaneous problems that did not fit under any other category. 7 counselors (4%) mentioned the large student population; 8 counselors (5%) mentioned their high caseload.

4.4.6 Counselors' Perception of Their Most Productive / Effective Work

Activities listed by counselors as their most productive / effective were grouped into 4 groups:

- **Work with Clients:** *individual counseling; group counseling; group guidance*

- **Work with Parents and Family:** *awareness meetings; family counseling / family intervention; home visits; meetings with parents; meetings with families; involving parents in treatment process; dealing with parents; relations with local community through home visits*

- **Work with Workplace Staff:** For school counselors, this refers to teachers and Head Teachers; for health center counselors, this refers to physicians, nurses, and other health center staff
  Cooperation between school and home; meetings with teachers; working with teachers to give low-achieving students more attention; teamwork with other counselors; teamwork with other health center staff

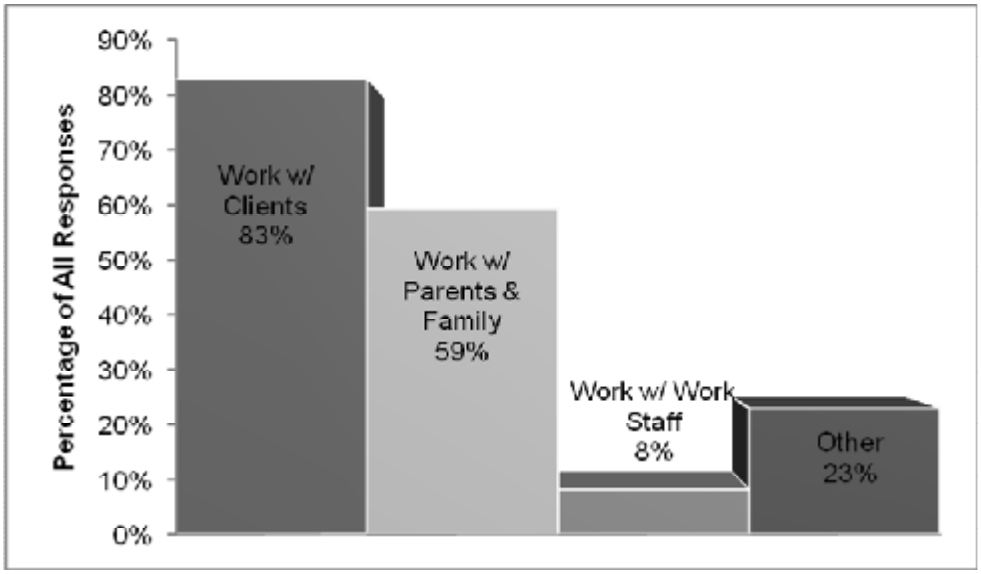
- **Other:** general *(consultation, counsel, dealing with cases, protection from disorders, protection from psychological problems, continual follow-up on cases, problems, negative behavior, giving clients a chance to debrief, listening to student's problems, helping clients ; helping clients achieve psychological wellbeing; solving clients' problems; emotional relief through games; involvement in problem situations; involvement in crises);* specific skills *(cognitive-behavioral therapy; behavioral counseling; games; drawing; Mind & Body skills [skills acquired from training by an NGO called Mind & Body]; GCMHP skills [skills acquired from training by an NGO called Gaza Community Mental Health Programme]; psychological awareness; activation; teaching teachers alternative discipline methods);* specific problems *(low academic achievement, students who fail; not doing homework, aggression, violence,*

hyperactivity, anxiety and tension; increasing self-esteem, increasing motivation, adolescent problems, truancy)

miscellaneous *(school announcements; distributing brochures; wall posters; promoting importance of children's psychological state to teachers)*

Figure 4.53 illustrates the percentage of counselors listing activities for each of the 4 categories above. 84 counselors (49%) listed 2 categories of activities; 21 counselors (12%) listed 3 categories; 1 counselor listed 4 categories; 4 counselors (2%) listed activities for all 5 categories. 60 counselors (35%) listed activities fitting in only one category.

Figure 4.53: CMHP Counselors' Perceptions of Their Most Productive / Effective Activities



- 141 counselors (83%) reported **direct work with clients** as being among their most productive activities. 117 counselors (69%) mentioned individual counseling; 47 counselors (28%) mentioned group counseling; 74 counselors (44%) mentioned group guidance; 52 counselors (31%) mentioned home visits; 45 counselors (26%) mentioned awareness meetings.

- 101 counselors (59%) mentioned work with parents and family; 14 counselors (8%) mentioned work with staff; 39 counselors (23%) mentioned miscellaneous activities that did not fit under any of the other categories.

4.4.7 Counselors' Recollection of CMHP Supervision Visits

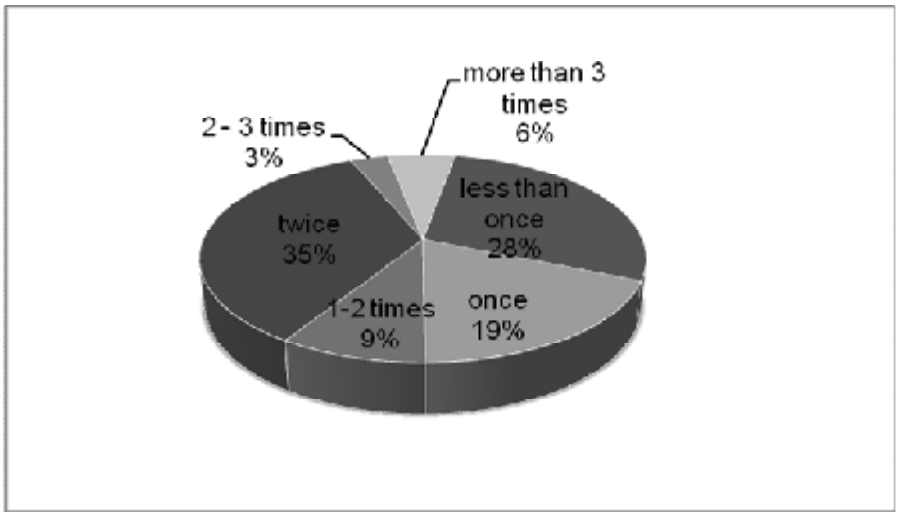
Counselors' responses to the average number of monthly visits by their supervisors differed significantly, as illustrated in Figure 4.54.

- 54 counselors (35%) reportedly received two monthly visits; 5 counselors (3%) reportedly received an average of 2-3 monthly visits; 9 counselors (6%) reportedly received more than 3 visits by their supervisors a month.

- 29 counselors (19%) responded that they received one monthly visit; 14 counselors (9%) cited that they received an average of 1-2 visits per month.

- 44 counselors (28%) responded that they received less than one monthly visit by their supervisor.

Figure 4.54: Average Number of Supervisor Visits per Month



4.4.8 Counselors' Suggestions to Improve CMHP

Counselors' suggestions on how to improve CMHP were divided into 7 categories:

- **Training / Resources:** *training by specialists; practical training; relevant updates on international developments in the field; IQ and psychological testing; special needs; learning disabilities; training for supervisors; travel outside for training; higher education; creating a research team within CMHP; educational material (including manuals, library, work-related information, internet access); IQ tests; questionnaire to determine students' problems; incentives for clients (gifts, rewards, financial incentives)*

- **Physical Environment:** *material; equipment (computer); room; furniture; transportation; phone*

- **Emotional support:** *psychological support (debriefing, recreational spaces); encouragement from supervisors; fair PERs (yearly evaluations); freedom to choose vacation days; same vacation days as school teachers; financial incentive; protection; support against pressure and stress*

- **PR (Promotion) for CMHP:** *brochures; special CMHP magazine; meetings to raise teacher awareness of counselor's role; special festivals; Open Day for CMHP at schools; extra-curricular activities run by CMHP; conferences*

- **CMHP Management:** *more involvement in decisions; more involvement in choosing training; updates on developments within CMHP; better communication with management; more opportunities for counselors; clearer annual plan*

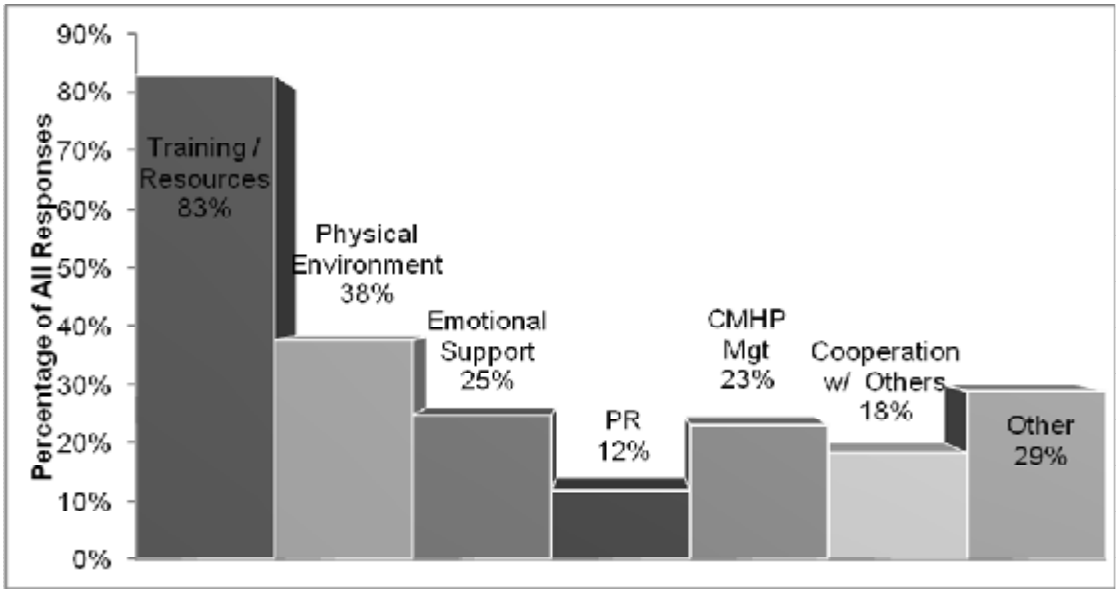
- **Cooperation with Others:** *more coordination and cooperation with other UNRWA departments; improved relations with Education Department / Health Department;*

meetings with other departments; introduction to local organizations; official coordination with other organizations; field visits to other organizations to share experiences and know-how; increased work in community;

- **Other:** *increase in number of counselors; more counselors in larger / more violent / lower-achieving schools; job security; stability; no transfers without counselor's consent; financial support to improve work; financial support for clients, especially for family wage-earner; field trips*

Figure 4.55 illustrates the percentage of counselors who cited suggestions fitting under each of the 7 categories listed above. 59 counselors (35%) listed suggestions fitting 2 categories. 43 counselors (25%) listed suggestion fitting one and 3 categories, respectively. 16 counselors (9%) listed suggestions fitting 4 categories, and 4 counselors (2%) mentioned suggestions fitting all 5 categories.

Figure 4.55: CMHP Counselor's Suggestions to Improve the Program



- 141 counselors (83%) requested more training and/or resources, of which 136 counselors (80%) specifically requested more training. 18 counselors (11%) requested that specialists in the mental health field assist them through training and research.

- 64 counselors (38%) requested a more suitable physical environment.

- 42 counselors (25%) listed some form of emotional support as key to program improvement. 39 counselors (23%) requested a better relationship with CMHP management; 31 counselors (18%) suggested more cooperation with others.

- 20 counselors (12%) suggested more public relations strategies to promote CMHP to the public

- 49 counselors (29%) mentioned miscellaneous suggestions that did not fit under any of the other categories.

- 18 counselors (11%) requested increasing the number of counselors in the program.

- 29 counselors (17%) requested more sufficient (e.g., longer and/or more flexible) vacation days

Chapter Five

Discussion and Recommendations

This final chapter will present an in-depth discussion of fundamental concerns related to the client problem categories as reported by UNRWA's CMHP counselors. The responses of the CMHP counselors to the mixed-methods questionnaire survey will also be discussed here, focusing on likely interpretations of the results. The chapter will end with a presentation of conclusions drawn from this study as a whole, as well as recommendations for improving both CMHP's database and CMHP's overall program.

5.1 Discussion on Problem Categories

With the exception of family and economic problems, the majority of client problems listed in the CMHP database seem to suggest that the clients' problems are caused by deficiencies or pathology within the individual, irrespective of the environment that they are in. This tendency seems to come precariously close to contributing towards "blaming the victim", in this case making client the cause of the problem, rather than thoroughly considering the environmental circumstances that may have caused the problem in the first place.

For instance, client referred by a teacher to the school's CMHP counselor as having "lack of motivation" may be highly-motivated in classes with another teacher (e.g., the child finds the teaching style of the latter teacher to be more suitable to their tastes). Similarly, a "hyperactive" child at school may be a quiet, obedient child at home. Because the majority of clients are children and referral sources are overwhelmingly of an authoritarian nature, it is all the more important for service providers to be careful how they label problems and thus clients.

Key questions regarding problem behavior that need to be taken into consideration include:

- Whether the behavior was intentional or unintentional on the part of the client
- If intentional, whether it was initiated by the client or the client was provoked (i.e., it was a reaction to something or someone)
- If reactive, whether it was a reaction to threats on the client's self-esteem, freedom, relationship with others, etc.
- If the behavior was initiated by the client, whether there were any benefits the client derived from the behavior (e.g., getting attention) that might have outweighed any negative consequences (e.g., punishment)

Compounding this problem are the diverse interpretations possible when utilizing the problem terminology. What exactly constitutes "disobedience"? The threshold for "acceptable" behavior tends to differ among people. What is excessively disruptive behavior for one teacher may be within the tolerable bounds for another. The same parent may have a higher tolerance for certain behavior from their child on one day than another.

Considering the demonstrably limited qualifications of CMHP counselors to diagnose clinical problems, the danger of CMHP counselors falsely labeling clients (of whom, in UNRWA's case, the vast majority is children) with clinical terms is a serious concern. As shown in Annex 8, clinical problems mentioned in the CMHP database between March and August 2007 averaged only 37 sessions a month for the entire Gaza Strip, with the vast majority of clinical problems presently listed among problems unmentioned. However, **after August 2007 (and after the predetermined 69 problem categories were introduced to the database), the average number of clinical problems reported by CMHP counselors multiplied by over 8 times**, to 307 sessions per month.

Diagnostic labels invoke strong images, at worst becoming harmful stereotypes for the clients. The results of data analysis as illustrated above indicate that closer scrutiny should be placed on defining specific criteria of problem categories, within the qualifications and capabilities of the caregivers (CMHP counselors) and also taking into account the clients' environment, to reduce the dangers of labeling.

5.2 Discussion on Survey Results

Counselors' responses seemed to suggest that a significant number of CMHP counselors felt isolated, misunderstood, and perhaps even undervalued in their workplaces and within UNRWA. Indications of this tendency included requests by counselors to implement more ways to help others to understand the counselor's role and suggestions to increase awareness about CMHP through brochures and specially-organized activities hosted by CMHP.

This feeling of isolation can also be understood in the context of counselors' work environment, as CMHP counselors are the only staff members stationed in venues managed by other UNRWA departments. While counselors are ultimately under the responsibility of one department (CMHP), for all practical purposes they have to answer to two separate managements that may not always have the same agenda. This can imaginably create feelings of discomfort for counselors, as evidenced by counselors' suggestions to improve relations between CMHP and other departments, specifically with the Education and Health Departments.

Counselors also requested more official coordination with local organizations working in their field. Some counselors asked for regular updates on international development within the psychology field and asked for "*field visits to other organizations to learn about how other organizations do their work*". This trend seems to suggest that counselors wanted to feel more connected and develop stronger ties with others within their field.

A high percentage of counselors reported not having suitable workspace or material, which must be frustrating for counselors given the nature of the work CMHP assigns them to do, especially individual and group counseling. School counselors cited having difficulty getting students out of classes for counseling sessions, and others mentioned being unable to conduct group guidance sessions because there was no scheduled times for such sessions. Such difficulties would likely heighten any given counselor's sense of being an "outsider" in their own workplace, increasing their need for personal support and affirmation, especially from their own department.

A significant number of counselors asked for psychological support and encouragement from CMHP management through more encouragement from supervisors, regular debriefing, and recreational activities for the counselors themselves. As a form of emotional support, increasing vacation days and/or more freedom to choose their own days-off was a particularly common request. Another poignant request by counselors was for more "*protection*" in their work (e.g., "*from abusive parents*" and "*during home visits*"). Among the problems they felt least able to handle, a few counselors mentioned "*honor-related problems*" and "*problems dealing with sexuality*", shedding light on the particular sensitive nature of some of the work counselors are asked to do.

The extensive client problems listed by the counselors seemed to indicate the range of functions they were being asked to play in their workplaces, especially in the schools. Counselors asked for more practical training that was relevant to their work, but requested training included the likes of pronunciation problems, hearing-impairment, learning disabilities, psychological testing and scientific research, which ultimately begs the question of what exactly counselors expect themselves to be able to handle in their workplace, what is expected of them, and whether these are truly reasonable expectations.

5.3 Conclusion and Recommendations

The review of documented information provided by UNRWA's Community Mental Health Programme, in particular CMHP's database records, revealed data issues that hampered CMHP's ability to inform on the psychosocial/mental health needs of the client population it serves and the effectiveness of services it provided.

- **Unanalyzed Data:** Much of the data collected by counselors and entered into CMHP's database remained unanalyzed.

- **Imprecise Data Presentation**: What data were analyzed by CMHP consisted of simple aggregations that lacked denominators to put them into context or that were inaccurate.

- **Poor Database Design**: The database was actually composed of separate files for each month, independent from each other. In its original form, no data comparison could be made across time periods. Data records were also based on counselor names and individual sessions, making it difficult to compile data based on individual clients.

- **Poor Data Quality**: The database files contained a significant portion of missing data fields and data-entry errors. Definitions of terminology were unclear, especially in client problem and intervention names. Indicators for variables were likewise undeterminable, suggesting data were based on the purely subjective judgment of individual counselors and not on standardized conventions.

- **Lack of Practical Information Distribution**: The CMHP information system seemed to be designed primarily to report to UNRWA senior management and not for use by the counselors and supervisors at the recording and reporting level. Staff did not seem to receive any feedback on data collection results or to be informed as to why they were required to gather data and how it would be used.

5.3.1 Data Recommendations

Improvements on CMHP's database and reporting system should be based on the World Health Organization's 5 stages of a mental health information system:

- **Collection**: *What data can be feasibly gathered?*
- **Processing**: *How are the data transmitted, collated, and prepared?*
- **Analysis:** *How are the data examined and analyzed?*
- **Dissemination**: *How are the results of the analysis communicated?*
- **Use:** *How are the data applied to making decisions?*

- **There needs to be a thorough assessment of what kinds of data are necessary** and practical for CMHP counselors to gather. Variables that are superfluous, that cannot be credibly gathered due to existing resource constraints, or that do not have clear and measurable indicators need to be filtered out from the collection process.

- **The criteria for terminology used by counselors for data collection need to be clearly defined**, starting with the basics. For example, what constitutes an individual counseling session? How long is a counseling session? If a student is sent to the counselor's office by a teacher for misbehavior, would this compulsory visit warrant being considered as an individual counseling session?

- **Terminology needs to be simplified**. Terms utilized should be of the same level / rank / classification (e.g., in client problem, it is illogical to place a general category such as "*family problems*" alongside a very specific category such as "*thumb-sucking*", etc). Clinical terminology in particular should be removed, considering the lack of qualification of counselors to diagnose such problems. Merging problems into more-easily identifiable categories is recommended.

- As improving data and information quality is a collaborative effort, **more effort should be made to include counselors and supervisors in the process and to clarify any**

misunderstandings that may arise during data collection. For example, educational sessions could be provided to counselors on precise criteria of database terminology and data quality issues. A guideline defining the terminology should also be distributed among all staff. Staff should also receive regular feedback on the results of their data collection, including how the results will translate into their work focus.

- **Data should be cross-checked at various stages to ensure data quality**. Measures to check data quality should be integrated into the data collection process. Supervisors should make regular random checks whether data match (e.g., client ID numbers match with the client). Safety measures should also be included in database design to prevent extreme data-entry errors or missing data.

- **Database files for all months should be merged into one to facilitate data analysis of trends over time.**

- Considering the differences in clientele seen at health centers and at schools, it would make sense to have **separate databases for the two venues**, including different problem categories (e.g., the list of client problems utilized by health center counselors would include some specific clinical terms that the list for school counselors may not need). The two separate databases could potentially be linked to databases in the respective departments in which counselors work (i.e., for health center counselors, to complement the Health Department's database; for school counselors, to complement the Education Department's database)

- Given the richness of detailed information that can be gleaned using database records, **much more specific and context-oriented analysis should be done by CMHP,** utilizing all available data fields.

- In the absence of specific, objective indicators to assess the efficiency and effectiveness of CMHP interventions, **methods to measure client satisfaction should also be implemented to balance the present subjective judgment of counselors**.

- **Analysis results should be more utilized for practical changes to improve program.** For instance, since the database records show that clients for "aggression" were the most-frequently seen by CMHP counselors, CMHP could put special focus on this specific problem, analyzing specific incidents of aggression, running focus group with referral sources to specify actions, identifying environments that tend to heighten the risk of aggression, and researching the effectiveness of specific forms of intervention for this problem.

5.3.2 Overall Program Recommendations

- **Proper assessment to identify the problems and support mechanisms of the population is necessary to plan mental health and psychosocial interventions appropriately**: they should cover factors such as the population's resiliency and risk factors, vulnerable groups' social and psychological health problems, as well as an overview of available psychosocial and mental health resources. Psychosocial factors that could potentially be measured include perceived stress, anxiety, depressive symptoms, sleep disturbances, internal locus of control, and self-esteem.

- Since both database analysis and results of the questionnaire survey of CMHP counselors indicated that counselors were either being asked to or took it upon themselves to handle an amazingly broad variety of problems, **clarification of counselors' role, capacity and limitations is imperative for all stakeholders.**

- **Every effort should be made to provide counselors with sufficient materials, equipment, and resources they need to facilitate their work**.

- The responsibility of CMHP to demonstrate that the interventions undertaken are suitable and feasible in its particular venues, that they will lead to increased productivity of clients, and that they are cost-effective, cannot be overstated.

- **Programmatic planning should balance existing strengths and limitations of CMHP staff, their work environment, and the community.** For example, there is great potential for interventions within schools, such as training teachers to recognize distress in children, provide initial interventions, and refer those who require specialized attention. The school setting also provides an excellent opportunity for breaking the cycle of violence by integrating peace and reconciliation in the curricula. To more effectively utilize its counselors to serve a greater number of the population, CMHP may have to shift its emphasis away from interventions such as individual counseling and focus more on local empowerment, engagement, and capacity-building in their workplaces and community.

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Annexes

Annex 1.

Sample of Statistics from a UNRWA CMHP Monthly Report, March 2008

(a) Breakdown of Types of Mental Health Interventions

MARCH 2008	Individual Counseling Sessions	Group Counseling Sessions	Group Guidance (Awareness)	Public Awareness Meetings	Home Visits	Other Activities
Interventions						
Month	**2,614**	**1,117**	**1,949**	**272**	**308**	**961**
Year Cumulative	5,735	2,192	4,439	681	894	2,255
Beneficiaries						
Month	**235**	**1,054**	**43,572**	**6,180**	**843**	**55,749**
Year Cumulative	557	2,285	128,746	15,306	2,560	175,023

(b) Breakdown of Intervention Statistics

	No. of Sessions	*No. of Beneficiaries*	*No. of Beneficiaries*	*Beneficiaries According Gender*		*Beneficiaries According Place*			*Counseling Coefficient*	*Percentage Rate*		
				Male	*Female*	*School*	*Clinic*	*Assoc*		*Improvement*	*Recovery*	*No Change*
Individual Counseling	**2,614**	**235**	**18**	**128**	**107**	**216**	**19**	**0**	**11.12**	**28.94**	**0**	**71.06**
Group Counseling	**1,117**	**1,054**	**0**	**577**	**477**	**1,045**	**9**	**0**		**44.85**	**0**	**55.15**
Group Guidance	**1,949**	**43,572**	**3,135**	**23,704**	**19,868**	**42,625**	**947**	**0**				
Home Visits	**308**	**843**										
Other activities	**961**	**5,5749**	**10,563**	**35,883**	**19,866**	**53,956**	**515**	**1,278**				
Awareness Meetings	**272**	**6,180**	**6,143**	**1,451**	**4,729**	**3,302**	**2,809**	**69**				

(c) Breakdown of Cases per Diagnosis for Individual Counseling

Breakdown of cases per diagnosis for individual counseling		
Problem Behavior	**# of cases**	**Percentage**
Peer Violence	323	12.36
Family Problems	238	9.10
Lack of Motivation	217	8.30
Bed Wetting	209	8.00
Fear	161	6.16
Truancy	148	5.66
Theft	105	4.02
Trauma	92	3.52
Attention Deficit	81	3.10
Hyperactivity	78	2.98

Sample Database Record from UNRWA CMHP Database

(d) Example of an Individual Counseling Session Record

	Field Name	Data	Details	Manual* Entry vs Selection
1	*Counselor's Name*	Mahmoud Ahmad	First name (and father's name) and family name	*Manual*
2	*Date of Entry*	9/15/2007	date of report	*Manual*
3	*From*	9/1/2007	starting date of reporting period	*Manual*
4	*To*	9/15/2007	end date of reporting period	*Manual*
5	Workplace	Khan Younis Elem Co-ed "B"	name of school, health center, etc	*Manual*
6	*Area*	South	unspecified	*Manual*
7	*Session Number*	1	Ordinal number (e.g., 1st session, 2nd session, etc)	*Manual*
8	*Client Number*	51	Client's ID number assigned by the counselor to maintain the client's confidentiality	*Manual*
9	*Problem*	Aggression	One of 69 choices	*Selection*
10	*Target Group*	Child	One of 4 choices	*Selection*
11	*Age*	9	Age of client	*Manual*
12	*Gender*	Male	One of 2 choices	*Selection*
13	*Referral Source*	Peer	One of 8 choices	*Selection*
14	*Case Type*	New	One of 3 choices	*Selection*
15	*Intervention*	Behavioral Counseling	One of 14 choices	*Selection*
16	*Venue*	School	One of choices	*Selection*
17	*Outcome*	Improvement	One of 6 choices	*Selection*

*For "Manual Entry" data, the clerk must type each letter or number of the data into the database, while for "Selection" data the clerk chooses the appropriate data from a pull-down menu already programmed into the database.

Annex 2. Individual Counseling Sessions Reported in CMHP Monthly Reports, *March 2007 – August 2008*

Year	Month	No. of Sessions	No. of Beneficiaries	No. of Beneficiaries >18	Beneficiaries According to Gender		Beneficiaries According to Place			Counseling Coefficient	Percentage Rate		
					Male	Female	School	Clinic	Association		Improvement	Recovery	No Change
2007	March	4,161	1,741	101	910	831	1,447	249	45	2.4	45.3	9.8	44.4
	April	2,581	884	47	462	422	742	112	30	2.9	67.2	0.2	31.9
	May	1,929	243	25	127	116	201	33	9	3.0	54.9	0.4	44.6
	June	182	35	20	11	24	0	31	4	5.2	48.2	0.9	50.9
	July	188	13	3	6	7	1	12	0	2.2	28.7	0.0	71.3
	August	172	17	10	5	12	1	17	0	2.2	17.9	3.2	78.9
	September	2,645	615	29	351	264	578	37	0	4.3	40.5	0.8	58.1
	October	2,724	486	33	256	230	458	28	0	5.6	40.9	0.3	57.3
	November	2,950	442	43	251	191	419	23	0	6.7	37.6	0.0	61.9
	December	2,967	317	30	158	159	289	28	0	9.4	33.6	0.0	58.3
2008	January	918	96	7	53	43	84	12	0	9.6	33.8	1.4	64.8
	February	2,203	226	20	138	88	206	20	0	9.7	29.2	0.1	68.5
	March	2,614	235	18	128	107	216	19	0	11.1	28.9	0.0	71.1
	April	2,272	257	26	112	145	229	28	0	8.8	37.7	0.1	61.3
	May	1,992	221	25	112	109	196	25	0	9.0	48.2	0.0	51.6
	June	353	27	18	4	23	0	27	0	13.1	25.7	0.0	73.2
	July	2,393	340	43	146	194	298	42	0	7.0	29.9	0.3	62.9
	August	1,062	58	27	23	35	19	39	0	18.31	12.55	0	78.35
	TOTAL	**34,306**	**6,253**	**525**	**3,253**	**3,000**	**5,384**	**782**	**88**				
	AVERAGE	*1,906*	*347*	*29*	*181*	*167*	*299*	*43*	*5*	*7*	*36.7*	*1.0*	*60.5*

Annex 3. Revised Version of Reported Problems for Individual Counseling Sessions in CMHP Monthly Reports, *March 2007 – August 2008*

		2007										2008										
	Listed Problem Categories	March	April	May	June	July	August	September	October	November	December	January	February	March	April	May	June	July	August	**Total**	Average of All Months	Average of Regular School Months
	total number of listed problem categories	45	45	44	44	44	*34*	64	65	61	60	53	59	63	58	60	36	57	58		52.8	57.8
1	Aggression	221	196	55	10	1	4	420	444	440	391	83	290	323	297	262	2	105	42	**3,586**	199.2	321.4
2	Family Problems	88	31	13	0	2	29	288	287	343	325	82	248	238	210	201	56	258	159	**2,858**	158.8	214.9
3	Bed Wetting	153	88	13	0	2	61	180	234	315	345	177	197	209	119	117	86	179	190	**2,665**	148.1	179.1
4	Lack of Motivation	114	20	2	0	0	1	143	164	179	154	42	143	217	186	110		712	161	**2,348**	138.1	141.8
5	Fear	171	106	49	3	0	7	151	128	150	144	42	92	161	132	89	10	36	25	**1,496**	83.1	131.1
6	Truancy	33	8	2	0	0		201	166	133	122	30	113	148	122	70		52	4	**1,204**	75.3	110.4
7	Attention Deficit	53	28	5	0	0	0	106	116	100	107	37	77	81	67	80	15	203	55	**1,130**	62.8	78.7
8	Hyperactivity	57	32	4	0	0	2	112	124	109	122	16	76	78	67	50	12	65	29	**955**	53.1	78.3
9	Theft						1	69	76	94	137	29	99	105	115	84	1	13	2	**825**	63.5	91.7
10	Trauma						14	56	62	73	72	20	75	92	108	111	5	39	17	**744**	57.2	82.4
11	Anxiety	45	20	2	2	0	4	83	54	44	74	58	38	48	42	65	21	36	29	**665**	36.9	48.8
12	Messiness	35	10	6	0	0		55	68	56	82	16	38	50	44	48		35	9	**552**	34.5	44.9
13	Inappropriate Language	61	36	8	0	0	1	48	48	65	69	13	32	44	74	44	1	3	1	**548**	30.4	50.2
14	Social Isolation	45	20	2	2	0		68	79	60	58	8	21	40	42	36		19	5	**505**	31.6	45.7
15	Telling Lies	135	85	25	4	1		35	34	36	33	7	13	29	25	19	1	8	7	**497**	29.2	45.7
16	Shyness	41	16	0	0	0		58	52	52	51	10	41	43	41	41	5	15	3	**469**	27.6	42.8
17	Low Self -Esteem	45	20	2	0	0	1	26	41	51	57	19	48	55	20	36	2	15	5	**443**	24.6	38.0
18	Bad Studying Habits	94						18	42	47	63	18	19	34	20	32		49	5	**441**	36.8	38.3
19	Depression & Self Harm	56	31	13	0	0	7	27	25	29	26	30	45	33	30	22	16	13	17	**420**	23.3	33.1
20	Inappropriate Sexual Behavior	27	0	0	0	0	2	31	31	34	48	17	40	59	55	59	2	7	7	**419**	23.3	37.3
21	Learning Disability						1	6	16	35	14	4	8	20	15	13		214	63	**409**	34.1	16.1
22	Disobedience	55	30	7	2	1	1	21	23	43	47	18	52	29	26	15	2	21	6	**399**	22.2	32.7

23	Generalized Anxiety Disorder						4	10	17	17	16	22	24	40	44	53	43	26	29	**345**	26.5	29.3
24	Bad Company	2	2	2	2	0	1	39	33	46	39	8	37	43	33	40		13	3	**343**	20.2	30.6
25	Stammering	21	2	1	0	0	5	48	29	24	31	11	23	26	23	10	5	30	19	**308**	17.1	22.9
26	Temper Tantrums	31	6	2	0	0	1	16	25	38	19	6	37	18	22	17	6	9	7	**260**	14.4	23.3
27	PTSD						1	22	20	25	23	6	29	48	33	42		1	3	**253**	21.1	31.3
28	Thumb sucking	38	13	1	1	1	6	30	24	25	16	3	11	14	5	18	12	12	19	**249**	13.8	19.8
29	Destructiveness	13	12	2	0	0		12	21	31	24	4	17	32	24	18		3	1	**214**	13.4	20.0
30	Sensitivity to Critics	0	0	1	0	0		35	18	14	18	3	20	22	28	20	1	4	5	**189**	11.1	17.4
31	Cruelty	4	4	1	3	0	1	5	15	20	23	14	20	16	12	19	7	12	6	**182**	10.1	12.8
32	Compulsivity	41	16	3	0	0		8	20	13	13	7	17	10	5	8	4	10	5	**180**	10.6	15.3
33	Nail Biting	27	2	2	2	1		16	14	18	21	2	9	12	15	18	1	2	4	**166**	9.8	14.6
34	Joking	17	3	2	0	0	1	27	12	12	16	7	11	21	18	10		3	3	**163**	9.6	14.6
35	Over-Dependency	19	17	2	0	0		23	8	4	7	3	7	30	20	14		4	2	**160**	10.0	15.8
36	Sleep Problems	30	5	2	2	2		16	17	10	11	3	10	12	13	5				**138**	9.9	13.1
37	Time Misuse	0	0	0	0	0		15	17	13	11	5	15	12	8	11	2	15	2	**126**	7.4	10.1
38	Mental Retardation						1	2	3	5	6		4	2	1	6		61	16	**107**	9.7	3.3
39	Daydreaming	21	2	2	0	0		7	12	9	14	4	10	9	13	1		1	1	**106**	6.6	9.3
40	Somatization Disorder							2	2	1	4	3	6	2	2	6	7	28	35	**98**	8.2	3.0
41	Selfishness							12	13	10	13	3	11	6	8	13		4	4	**97**	8.8	10.4
42	Rivalry	0	0	0	0	0		1	5	12	11	1	10	11	13	6		9	5	**84**	5.3	6.4
43	Nightmare Disorder						1	13	10	6	4	2	19	18		1		4	3	**81**	7.4	11.2
44	Bed Soiling	14	3	3	0	1	1	4	7	7	5	6	5	4	2	4	2	2	3	**73**	4.1	5.6
45	Running Away	0	0	0	0	0		1	6	11	7	2	6	11	10	7		5		**66**	4.4	5.8
46	Dissociation Disorder								6	13	18		3	6	10	4		1		**61**	7.6	7.0
47	Obsessive-Compulsive Disorder						4	6	3	12	6	1	2	3	4	1		3	1	**46**	3.8	4.4
48	Personality Disorder						2	7	1	4	3	3		5	3	5	4	3	3	**43**	3.6	4.2
49	Sleep Walking						1	4	3	9	6	2	6	2	1	2		4	2	**42**	3.5	3.9
50	Social Phobia						1	16	2		4		4	8				2	4	**41**	5.1	7.5
51	Autism							2	1	1		1	3	7	8	5	7	5		**40**	4.0	3.9
52	Perfectionism	0	20	2	0	0	1	2	2	3	3		1	1	2	2		1		**40**	2.7	3.7
53	Cheating	0	0	0	1	0		6	3	3	6	2	4	3	5	5		1		**39**	2.6	3.2
54	Egocentricity	18	16	4	0	0														**38**	7.6	17.0
55	Substance Misuse	0	0	0	0	0	2	3	4	1				3	5	4	1	5	10	**38**	2.5	2.5
56	Tics	0	0	0	0	0	1	3	6	12	2				5		2		2	**33**	2.5	4.3
57	Fire Setting	0	0	0	0	0		1	6	6	4		1	8		2		3		**31**	2.4	3.0
58	Night Terror								2	11	6			3	7					**29**	5.8	5.8

	Disorder																						
59	Sexual Disorder							3	3	4	7	4	5	1			1		1	**29**	3.2	3.2
60	Substance Use Disorder							2	2				3	1	2		6	6	6	**28**	3.5	2.0
61	Eating Problems	10	4	3	1	1		2				1		1	3	1				**27**	2.7	3.5
62	Simple Phobia							3	10	5	4					1				**23**	4.6	4.8
63	Eating Disorder							8	2			2				2	3	3	2	**22**	3.1	4.0
64	Prejudice	0	0	0	0	0		3	2	4	2		1	1	5	1			2	**21**	1.5	1.9
65	Sleep Disorder								2		2	1	3	3	3	3	1		1	**19**	2.1	2.8
66	Panic Disorder						1	5	1		1		2	2		3			1	**16**	2.0	2.6
67	Schizophrenia							2	1	1							1		1	**6**	1.2	1.3
68	Bipolar Disorder							1					2	1					1	**5**	1.3	1.3
69	Conduct Disorder									2								1	1	**4**	1.3	2.0
	Total number of cases	1,835	904	243	35	13	172	2,645	2,724	2,950	2,967	918	2,203	2,614	2,272	1,992	353	2,393	1,054	**28,287**	1,572	2,238
	Total no of sessions	4,161	2,581	1,929	182	188	172	2,645	2,724	2,950	2,967	918	2,203	2,614	2,272	1,992	353	2,393	1,062	**34,306**	1,906	2,682
	Total no of beneficiaries	1,741	884	243	35	13	17	615	486	442	317	96	226	235	257	221	27	340	58	**6,253**	347	567
	Referred Cases				2	4	2	8	8	3	9	0	7	18	10	4	3	10	3	91		

Annex 4. Monthly Individual Counseling Sessions per Counselor, *September 2007 – August 2008*

	Workplace	Mental Health Counselor ID No. (coded by reviewer)	*Sep-07*	*Oct-07*	*Nov-07*	*Dec-07*	*Jan-08*	*Feb-08*	*Mar-08*	*Apr-08*	*May-08*	*Jun-08*	*Jul-08*	*Aug-08*	***Grand Total***	**Avg # of months w/o sessions**	**Avg # of Sessions**
1	Maan Health Center	63	64	4	63	63	60	62	65	64	64	63	63	64	**699**	*0*	58.3
2	Beit Hanoun Health Center	76	92	46	55	58	50	54	53	52	19	56	52	24	**611**	*0*	50.9
3	Beit Hanoun Prep Boys "A"	61	36	31	51	86	28	31	58	77	50		75	13	**536**	*1*	48.7
4	Beit Hanoun Prep Girls	43	101	46	50	45	11	28	28	42	46		39	9	**445**	*1*	40.5
5	Bureij Health Center	62	6	13	7	10	4		8			176	78	70	**372**	*3*	41.3
6	Nuseirat Health Center	163	15	10	26	27	12	26				111	96	48	**371**	*3*	41.2
7	Rafah Health Center	64	24	48	50	39	32	40	18	18	14	29	16	19	**347**	*0*	28.9
8	Jabalia Health Center	9	15	41	26	25	42	33	25	15	26	25	19	21	**313**	*0*	26.1
9	New Jabalia Elem Girls	105	20	26	31	34	4	28	52	15	25		55	21	**311**	*1*	28.3
10	Fukhari Elem. Co-ed "A"	52	40	32	38	26	4	29	42	43	25		19		**298**	*2*	29.8
11	Daraj (Gaza Town) Health Center	120	10	12	45	21	32	31	30	16	19	25	11	15	**267**	*0*	22.3
12	Ibn Rushd Prep. Boys	179	2	16	24	32	12	43	64	18	20		23	10	**264**	*1*	24.0
13	Beach prep girls "C"	180	10	27	30	29	11	23	58	14	22		24	12	**260**	*1*	23.6
14	Zeitoun Health Center	113	15	21	16	22	44	14	47	9	10	14	18	26	**256**	*0*	21.3
15	Rafah Prep Boys "D"	2	20	24	26	17	8	23	38	16	15		66		**253**	*2*	25.3
16	Rimal Health Center	107	35	35	35	31	10				22	30	30	25	**253**	*3*	28.1
17	Jabalia Elem. Boys "A"	74	5	32	27	30		30	56		27		30	15	**252**	*3*	28.0
18	Maghazi Health Center	78	23	14	12		11	12	15		15		90	60	**252**	*3*	28.0
19	Jabalia Prep. Girls "C"	151	6	22	24	32	4	30	68		21		37	8	**252**	*2*	25.2
20	Kh/Younis Prep Boys "B"	171	23	36	33	29	12	31	25	27	17		19		**252**	*2*	25.2
21	Jabalia Elem. Boys "E"	90	24	30	32	29		16	64	14	13		23	6	**251**	*2*	25.1
22	Izbet B/Hanoun Prep. Boys	57	53	12	28	21	9	12	21	21	30		25	12	**244**	*1*	22.2
23	Der El Balah Women Activity Ctr	162			4	4	3	3	4			118	72	32	**240**	*4*	30.0
24	Der Balah Health Center	26	12	13	11	12	6					60	72	52	**238**	*4*	29.8
25	Jabalia Prep. Girls "B"	83			14	34	10	36	76		25		30	13	**238**	*4*	29.8
26	Kh/Younis Prep. Girls "B"	125	17	26	29	30	2	25	25	25	23		33		**235**	*2*	23.5
27	Fukhari Elem. Co-ed "B"	38	25	19	37	28	2	23	37	26	20		17		**234**	*2*	23.4
28	Beach Elem. Co-ed "E"	25	22	27	23	28	1	19	60	13	27		6		**226**	*2*	22.6
29	Khalil Uweida Elem. Co-ed	134		16	32	37		29	16	32	30		24	7	**223**	*3*	24.8
30	B/Hanoun Prep. Boys "B"	174	24	18	24	30	2	26	24	15	14		24	16	**217**	*1*	19.7
31	Rimal Prep. Girls	36	20	28	37	20		5	79	11	16				**216**	*4*	27.0

32	Shouka Prep. Girls	127	29	26	30	20	7	24	24	28	10		12		**210**	*2*	21.0
33	Gaza Elem. Co-ed "A"	155	33	24	25	18		22	20	33	18		10	3	**206**	*2*	20.6
34	Khan Younis Health Center	183	19	20	23	12	8	16	20	12	30	25		16	**201**	*1*	18.3
35	Ma'en Elem. Co-ed "A"	14	19	20	20	27	5	20	39	26	18		4		**198**	*2*	19.8
36	B/Hanoun Elem. Co-ed "B"	160	23	25	21	23	4	9	32	13	15		27	6	**198**	*1*	18.0
37	B/Hanoun Elem. Co-ed "C"	122	30	27	25	25	7		9	18	18		28	9	**196**	*2*	19.6
38	B/Lahiya Prep. Girls	161	13	25	17	18	3	18	42	9	16		28	7	**196**	*1*	17.8
39	Shaja'iya Prep. Boys B	75	16	37	29	25		18	24	16	13		9	7	**194**	*2*	19.4
40	Falah Prep. Boys "B"	59	17	31	25	21		20	24	26	15		12		**191**	*3*	21.2
41	B/Suhaila Prep. Girls	104	26	23	28	14	9	12	17	20	22		16		**187**	*2*	18.7
42	Rafah Prep. Boys "B"	11	25	28	27	24	8	30	28		11				**181**	*4*	22.6
43	Asam' Elem. Co-ed B	137		22	16	23		25	52	9	17		10	5	**179**	*3*	19.9
44	Jabalia Prep. Boys "A"	6	11	28	20	21	3	13	11	15	12		26	18	**178**	*1*	16.2
45	Hafsa Elem. Girls	123	8	24	17	21	2	8	17	26	24		21	8	**176**	*1*	16.0
46	Jabalia Prep. Boys "B"	8	7	9	16	19	6	20	18	11	19		24	25	**174**	*1*	15.8
47	Makka Al Mukarama Prep. Boys	67	20	12	18	21	5	18	20	16	8		36		**174**	*2*	17.4
48	Ayyoubiya Elem. Boys	92	13	18	19	29		8	8	10	22		27	20	**174**	*2*	17.4
49	Rafah Prep. Girls "D"	139	18	20	19	18	2	19	29	31	13		5		**174**	*2*	17.4
50	B/Lahiya Elem. Boys	95	2	19	20	16	1	19	20	23	18		30	4	**172**	*1*	15.6
51	Jabalia Elem. Girls "C"	10			21	29		20	34	10	20		31	6	**171**	*4*	21.4
52	Khan. Elem. Boys B & D	130	22	14	22	15	5	21	9	23	19		18		**168**	*2*	16.8
53	Must. Hafez Elem. Boys "B"	145	21	17	24	17	8	14	21	22	11		12		**167**	*2*	16.7
54	B/Hanoun Prep. Boys "C"	88	14	26	13	23	4	8	3	17	16		27	15	**166**	*1*	15.1
55	Rafah Prep. Girls "A"	124	6	30	21	18		26	19	17	19		10		**166**	*3*	18.4
56	Kh/Younis Prep. Girls "C"	140	12	19	19	19	5	19	19	20	16		16		**164**	*2*	16.4
57	B/Hanoun Elem. Co-ed "A"	146	20	14	15	27	9	10	9	19	10		19	11	**163**	*1*	14.8
58	Farabi Elem. Co-ed	178	18	16	28	15		15	20	25	13		11		**161**	*3*	17.9
59	Rimal Prep. Boys A	72	10	28	33	8		11	27	31	12				**160**	*4*	20.0
60	B/Suhaila Elem. Co-ed	84	13	23	19	12	4	13	16	19	11		29		**159**	*2*	15.9
61	Beach Elem. Co-ed "G"	15	19	18	15	25		11	19	20	16		15		**158**	*3*	17.6
62	Zaitun Prep. Girls	39	24	19	21	24			30	17	23				**158**	*5*	22.6
63	Daraj Elem. Co-ed "B"	68	18	18	14	15		17	41	7	12		11	5	**158**	*2*	15.8
64	Kh/Younis Prep. Boys "C"	102	10	20	21	14	7	19	20	20	16		10		**157**	*2*	15.7
65	Nuseirat Prep.Girls "C"	135	18	21	19	18	4	14	13	13	17		20		**157**	*2*	15.7
66	Rafah Prep. Boys "E"	110	9	8	15	12	7	24	30	27	10		12		**154**	*2*	15.4
67	Beach Elem. Boys "A"	28	24	25	20	17		19	28	5	15				**153**	*4*	19.1
68	Zaitoun Prep. Boys B	58	10	19	17	11	3	15	16	25	15		15	7	**153**	*1*	13.9
69	Beach Elem. Boys "D"	86	10	12	23	31	9	10	10	20	20		8		**153**	*2*	15.3
70	Rafah Prep. Boys "A"	31	26	22	15	6	5	11	20	17	4		24		**150**	*2*	15.0
71	Kh/Younis Prep. Boys "A"	91	20	29	24	18	7	13	16	14	7				**148**	*3*	16.4
72	Must. Hafez Elem. Boys "A"	32	12	20	20	15	3	17	17	18	11		14		**147**	*2*	14.7

73	Umariya Prep. Boys	56	17	20	18	12	3	12	15	15	7		27		**146**	*2*	14.6
74	Ibn Sina Elem. Boys	93	17	17	24	18	6	12	14	17	8		13		**146**	*2*	14.6
75	Jabalia Prep. Boys "D"	46	8	17	7	18	3	5	5	25	18		19	20	**145**	*1*	13.2
76	Qarara Prep. Co-ed	173	17	6	23	19		17	19	18	14		12		**145**	*3*	16.1
77	Beach Health Center	3	25	21	7	17	19	20	17					17	**143**	*4*	17.9
78	Rafah Elem. Boys "E"	40	16	31	15	7	5	13	17	19	4		16		**143**	*2*	14.3
79	Rafah Elem. Co-ed "B"	69	24	19	10			6	17	27	8		29		**140**	*4*	17.5
80	Jabalia Prep. Boys "C"	41	13	17	24	8	6	7	12	6	15		20	9	**137**	*1*	12.5
81	Mustafa Hafez Elem. Co-ed	108	13	15	20	18	4	18	16	20	8		5		**137**	*2*	13.7
82	B/Hanoun Elem. Boys	60	9	13	10	8		14	10	18	19		16	19	**136**	*2*	13.6
83	Jabalia Elem. Girls "E"	168	23	6	14	17				12	16		37	11	**136**	*4*	17.0
84	Jabalia Elem. Girls "C"	16	6	22	23	20				7	16		23	16	**133**	*4*	16.6
85	Kh/Younis Elem. Co-ed "B"	55	14	18	24	19	5			6	17		30		**133**	*4*	16.6
86	Rafah Prep. Girls "C"	79	13		25	24	6	14	17	13	13		8		**133**	*3*	14.8
87	Jabalia Elem. Boys "C"	77	20	24	26	14	2			8	14		16	8	**132**	*3*	14.7
88	Kh/Younis Elem. Girls "B"	37	15	10	22	19	5	16	9	8	13		14		**131**	*2*	13.1
89	B/Hanoun Elem. Co-ed "D"	48				19	10	37	34	20	8				**128**	*6*	21.3
90	Kh/Younis Prep. "A" Girls	170	11	17	15	7	2	10	20	21	8		17		**128**	*2*	12.8
91	B/Lahiya Elem. Girls	106				11		20	48	9	10		21	8	**127**	*5*	18.1
92	A/A/Aziz Prep. Boys B	142	13	9	16	19	6	13	16	12	5		16		**125**	*2*	12.5
93	Jabalia Prep. Girls "A"	159	13		18	15	3	9	10	5	13		30	9	**125**	*2*	12.5
94	Beach Elem. Boys "C"	20	26	17	16	15	4	5	4	10	12		13		**122**	*2*	12.2
95	New Kh/Younis Prep. Girls	121	16	15	16	14	4	9	10	15	10		11		**120**	*2*	12.0
96	Rimal Prep. Boys B	141	10	20	17	14	4	8	6		18		19	4	**120**	*2*	12.0
97	Jabalia Elem. Girls "A"	29	10	28	13	15	3	16	13	20					**118**	*4*	14.8
98	Rafah Prep. Boys "F" & "G"	111	4	17	7	6	5	9	14	15	5		32		**114**	*2*	11.4
99	Beach Prep. Girls "A"	166	4	17	16	7		13	30	6	13		7		**113**	*3*	12.6
100	Kh/Younis Elem. Boys "C"	115	8		16	13	4	15	16	17	11		12		**112**	*3*	12.4
101	Razi Elem. Co-ed	53	20	13	14	12			9	24	1		17		**110**	*4*	13.8
102	Tal Sultan Health Center	117	4	6	5	12				5	8	14	27	29	**110**	*3*	12.2
103	Beach Elem. Co-ed "G"	175	10	15	10	11		14	20	8	16		4		**108**	*3*	12.0
104	Rafah Prep. Girls "E"	138		21		19		15	17	20	4		11		**107**	*5*	15.3
105	Kh/Younis Elem. Boys "A"	5	9	30	11	12	2	4	4	11	12		10		**105**	*2*	10.5
106	Rafah Elem. Boys "B"	87	8	12	11	7	1	9	6	8	4		36		**102**	*2*	10.2
107	Khawla Elem. Co-ed	136	23	18	6	13	3	7	9	14	9				**102**	*3*	11.3
108	Umariya Elem. Boys	50	4	9	11	12	8	6	6	18	7		18		**99**	*2*	9.9
109	Asama' Elem. Co-ed B	148	22	18	15	13	3	6	16		5				**98**	*4*	12.3
110	Kh/Younis Elem. Co-ed "C"	19	13	15	11	10	2	4	10	19	4		7		**95**	*2*	9.5
111	Gaza Prep. Girls "B"	71	29	14	9	22	7		13						**94**	*6*	15.7
112	D/Balah Prep. Girls	12	8	15	11	16	3	18	22						**93**	*5*	13.3
113	New Nuseirat El. Coed	54	24		17	26	3		19		2				**91**	*6*	15.2

114	Abasan Elem. Co-ed "A" & "B"	73	20	14	9	7		9	7	4	6		15		**91**	*3*	10.1
115	Zahra Elem. Co-ed	164	13	15	12	20	4	2	11	8	6				**91**	*3*	10.1
116	B/Suhaila Prep. Boys "B"	66	13	3	14	10	2	11	12	11	8		5		**89**	*2*	8.9
117	Zaitoun Prep. Boys A	152	6	8	10	10	5	9	7	4	10		12	7	**88**	*1*	8.0
118	Abu Tu'ema Prep. Co-ed	129	21	8				11	18	8	13		8		**87**	*5*	12.4
119	Nusierat Prep. Boys "C"	156	17	9	8	20	2	5	13		10				**84**	*4*	10.5
120	Gaza Prep. Girls "A"	30		17	15	18	2	14	17						**83**	*6*	13.8
121	Rafah Prep. Boys "C"	181	4	8	11	7	5	9	10	10	5		13		**82**	*2*	8.2
122	Zaitun Elem. Co-ed "A"	144	24	16	11		4		13		13				**81**	*6*	13.5
123	B/Suhaila Prep. Co-ed	147			15	21	4	13	10	3	8		7		**81**	*4*	10.1
124	Nusierat Elem. Boys "B"	109	11	10	10	11	7	11	10		10				**80**	*4*	10.0
125	Beach Elem. Co-ed "A"	116				14		19	9	23	13				**78**	*7*	15.6
126	Gaza Elem. Co-ed "C"	34	13					17		24	13		8		**75**	*7*	15.0
127	Nuseirat Prep. Girls "B"	17	10		11	13	7	21	12						**74**	*6*	12.3
128	D/Balah Prep. Boys A	101	16	7	17		6	9	10		9				**74**	*5*	10.6
129	Rafah Elem. Co-ed "A"	49				6		11	19	18	7		12		**73**	*6*	12.2
130	Zaitun Elem. Co-ed "C"	1	9	10	10	7		7	9	8	5		7		**72**	*3*	8.0
131	B/Suhaila Prep. Boys "A"	27	8	12	27	16	4		4						**71**	*6*	11.8
132	Falah Prep. Boys "A"	98	21	1	15	19			14						**70**	*7*	14.0
133	Jabalia Elem. Boys "B"	157				13		11	19	12			10	4	**69**	*6*	11.5
134	Maghazi Prep. Boys A	169		29	15	15	8		1						**68**	*7*	13.6
135	Rafah Prep. Girls "B"	149	6	28	6	4	2	8	7				6		**67**	*4*	8.4
136	D/Balah Prep. Boys B	13	13	8	9	9	7	9	11						**66**	*5*	9.4
137	Jeddah Elem. Co-ed	23				11	8	10	14	8	5		9		**65**	*5*	9.3
138	Bureij Prep. Girls	24	14		12	16	6	15							**63**	*7*	12.6
139	Maghazi Prep. Boys B	97	6		8	12	2	11	12		12				**63**	*5*	9.0
140	Tal Sultan Prep. Co-ed	143	4	6	10				9	22			12		**63**	*6*	10.5
141	D/Balah Elem. Boys "A"	94	12	10	9	8		6	8		8				**61**	*5*	8.7
142	Bureij Prep. Boys B	153	14	17	9	8	5		8						**61**	*6*	10.2
143	Al Amal Prep. Co-ed	44		1	8	13	10		14		14				**60**	*6*	10.0
144	Beach Prep. Girls "B"	65	19	8		10	4	7	6		6				**60**	*5*	8.6
145	Razi Elem. Girls	158			5	12		14	10	10	5		3		**59**	*5*	8.4
146	D/Balah Elem. Co-ed "D"	172	9		13	9		9	9		9				**58**	*6*	9.7
147	Nuseirat Elem. Co-ed "F"	177	17		13	14		13							**57**	*8*	14.3
148	Shaja'iya Elem. Co-ed "A"	35	17	9		18			11						**55**	*8*	13.8
149	Nuseirat Elem. Co-ed "B"	182	16	10	4	9		9	7						**55**	*6*	9.2
150	Nuseirat Elem. Co-ed "A"	81	12	6	8	8			9		9				**52**	*6*	8.7
151	Maghazi Elem. Co-ed "B"	150	6	12	8	9	5	7	5						**52**	*5*	7.4
152	Nusierat Elem. Boys "A"	22	8	12	11	15	5								**51**	*7*	10.2
153	Maghazi Prep. Girls	51		6	7	8	5		12		12				**50**	*6*	8.3
154	Nusierat Prep. Boys "D"	96	4	6	9	9	3	4	7		7				**49**	*4*	6.1

155	Khalil Uweida Elem. Co-ed	133	19	10			3		14						**46**	*8*	11.5
156	Shaja'iya Prep. Boys A	7	5		8	8	6		9		9				**45**	*6*	7.5
157	Bureij Elem. Co-ed "A"	89	17		5	4	11		4		4				**45**	*6*	7.5
158	Bureij Elem. Boys "B"	118	14		6	6	3	7	9						**45**	*6*	7.5
159	Nuseirat Elem. Co-ed "E"	4	6	8		6		8	8		8				**44**	*6*	7.3
160	Der Balah Elem Co-ed "A"	114	20		9	15									**44**	*9*	14.7
161	Qarara Elem.. Co-ed	21	10	3	8	12	3				7				**43**	*6*	7.2
162	Bureij Prep. Boys A	103	6	7	6	8	2	5	7						**41**	*5*	5.9
163	D/Balah Elem. Boys "B"	167	5		6	12			9		9				**41**	*7*	8.2
164	Maghazi Elem. Boys "B"	42		7	6	7	3	6	6		5				**40**	*5*	5.7
165	Maghazi Elem. Boys "A"	100	6		5	6	5	6	6		6				**40**	*5*	5.7
166	Nuseirat Elem. Co-ed "G"	128	8	7	8	9	3		5						**40**	*6*	6.7
167	D/Balah Elem. Co-ed "B"	80	25				9		4						**38**	*9*	12.7
168	Nuseirat Prep. Girls "A"	119		9	8	10	3		8						**38**	*7*	7.6
169	Nuseirat Elem. Co-ed "C"	154	8		11	7	1	11							**38**	*7*	7.6
170	Zaitun Elem. Co-ed "B"	85	7	6	4	4	5	3	4		4				**37**	*4*	4.6
171	Maghazi Elem. Co-ed "A"	131	2		6	13	4		6		6				**37**	*6*	6.2
172	Daraj Elem. Co-ed "C"	132			6	11	5	5	5		5				**37**	*6*	6.2
173	Bureij Elem. Co-ed "C"	70	4		13	5	2	3	4		4				**35**	*5*	5.0
174	Nusierat Prep. Boys "A"	33	5	4	6	7			5		5				**32**	*6*	5.3
175	Hashem Elem. Boys "B"	99	6	5	6	9	1	5							**32**	*6*	5.3
176	Bureij Elem. Co-ed "B"	18	11			10			5		5				**31**	*8*	7.8
177	D/Balah Elem. Co-ed "C"	45		2	7	14		7							**30**	*8*	7.5
178	Nusierat Prep. Boys "B"	165	3	4	5	7	3	6							**28**	*6*	4.7
179	Daraj Elem. Co-ed "A"	126	12	6					9						**27**	*9*	9.0
180	Imam Shafi Elem. Boys "A"	176		1	6	14									**21**	*9*	7.0
181	Bureij Elem. Co-ed "D"	112	4			7			5		3				**19**	*8*	4.8
182	Hashem Elem. Boys "A"	47	8						5		5				**18**	*9*	6.0
183	Nuseirat Elem. Girls "D"	82	6					4	4		4				**18**	*8*	4.5
Total Number of Sessions Reported			**2,583**	**2,558**	**2,871**	**2,946**	**911**	**2,205**	**3,122**	**2,000**	**1,974**	**746**	**2,533**	**931**	**25,380**		
Average Number of Sessions per Month			*16.0*	*17.3*	*17.5*	*17.1*	*7.1*	*15.4*	*19.0*	*17.9*	*13.5*	*57.4*	*22.6*	*17.2*			
Total Number of Counselors without any Sessions			23	36	19	12	55	40	19	71	37	170	71	129			

example of unusually high number of sessions

counselors with reported sessions every month

Annex 5. Client Session Numbers by Problem

Rank No.	Problem	DB code	Client Tally	Avg S#	*Sessions*									
					1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
1	Aggression	*25*	1,248	2.2	570	275	190	102	64	27	12	4	0	2
2	Family Problems	*46*	1,091	2.2	540	220	139	90	48	23	13	9	7	1
3	Bedwetting	*19*	970	2.0	532	225	83	59	27	18	16	3	2	0
4	Lack of Motivation	*43*	957	2.1	432	222	172	81	31	10	4	2	1	0
5	Attention Deficit	*3*	666	2.0	330	166	80	53	18	8	7	1	1	0
6	Truancy	*39*	495	2.1	243	101	63	48	22	8	9	0	1	0
7	Fear	*11*	484	2.2	232	103	67	37	30	10	2	0	1	1
8	Hyperactivity	*1*	392	2.0	207	76	48	37	9	12	2	0	0	0
9	Theft	*31*	356	2.1	176	71	50	29	17	10	1	1	0	1
10	Trauma	*45*	278	2.3	137	53	35	21	17	5	5	3	0	0
11	Anxiety	*10*	257	2.0	135	55	32	16	9	6	2	0	1	0
12	Inappropriate Language	*35*	223	1.8	134	45	15	15	11	2	1	0	0	0
13	Learning Disability	*48*	217	1.8	82	102	24	6	3	0	0	0	0	0
14	Messiness	*6*	201	2.2	85	58	26	16	9	4	1	1	1	0
15	Social Isolation	*29*	181	2.2	86	42	24	7	11	6	2	2	1	0
16	Shyness	*15*	177	2.1	92	32	24	14	8	3	2	1	0	0
17	Low Self-Esteem	*12*	163	2.1	86	30	21	10	9	5	1	0	0	1
18	Bad Studying Habits	*44*	155	2.0	84	30	14	13	11	2	0	1	0	0
19	Bad Company	*27*	150	2.1	71	32	25	12	6	1	2	0	0	0
20	Disobedience	*30*	134	2.0	68	32	11	12	7	3	1	0	0	0
21	Generalized Anxiety Disorder	*56*	133	2.4	54	28	24	22	0	1	1	1	0	1
22	Inappropriate Sexual Behavior	*42*	129	2.8	49	25	16	16	13	4	2	1	1	0
23	Stammering	*23*	126	2.0	66	32	8	10	5	4	1	0	0	0
24	Depression & Self-Harm	*13*	113	2.4	61	20	11	6	4	5	1	0	1	0
25	Telling Lies	*50*	105	2.2	51	21	14	8	7	4	0	0	0	0
26	Temper Tantrums	*33*	87	2.3	44	17	11	4	6	0	1	3	0	0
27	Thumb Sucking	*32*	84	1.7	55	16	4	4	3	1	0	0	0	1
28	PTSD	*55*	83	2.8	30	14	13	12	7	4	1	1	0	1
29	Sensitivity to Critics	*14*	82	1.9	49	15	6	5	3	2	2	0	0	0
30	Time Misuse	*7*	72	1.6	45	16	6	4	1	0	0	0	0	0
31	Compulsivity	*2*	69	1.7	46	11	5	3	3	0	0	0	1	0
32	Destructiveness	*37*	68	2.3	32	14	9	5	3	2	0	3	0	0
33	Joking	*4*	68	1.9	39	10	12	3	3	1	0	0	0	0
34	Nail Biting	*18*	59	2.1	29	13	6	6	4	1	0	0	0	0
35	Cruelty	*28*	56	2.4	23	17	3	5	6	0	0	0	1	0
36	Over-Dependency	*9*	53	2.0	28	9	8	5	0	3	0	0	0	0
37	Mental Retardation	*47*	51	1.9	21	17	3	0	0	0	0	0	0	0
38	Somatization Disorder	*57*	40	1.4	27	9	4	0	0	0	0	0	0	0
39	Sleep Problems	*21*	39	2.3	20	6	6	2	3	1	0	0	0	0
40	Daydreaming	*5*	38	1.8	26	4	2	3	1	1	1	0	0	0
41	Selfishness	*8*	38	2.2	15	11	4	6	1	1	0	0	0	0
42	Conduct Disorder	*69*	37	1.8	21	9	4	2	0	0	1	0	0	0
43	(Sibling) Rivalry	*26*	36	2.0	23	4	3	3	0	1	1	1	0	0
44	Running Away (from Home)	*38*	30	2.1	17	3	4	4	0	1	1	0	0	0
45	Nightmare Disorder	*64*	29	2.7	10	4	7	3	3	1	1	0	0	0
46	Substance Use Disorder	*41*	29	1.4	21	4	4	0	0	0	0	0	0	0
47	Dissociation Disorder	*59*	27	2.3	8	10	6	1	1	1	0	0	0	0
48	Obsessive Compulsive Disorder	*54*	25	1.5	18	4	1	2	0	0	0	0	0	0
49	Cheating	*34*	24	1.5	18	4	1	0	0	0	1	0	0	0
50	Bed Soiling	*20*	22	1.9	12	6	2	0	1	0	1	0	0	0
51	Fire Setting	*36*	20	1.4	17	1	1	0	0	1	0	0	0	0
52	Social Phobia	*53*	19	1.9	12	2	2	2	0	0	1	0	0	0
53	Autism	*49*	17	2.2	10	0	3	2	2	0	0	0	0	0
54	Personality Disorder	*61*	17	2.2	7	3	4	3	0	0	0	0	0	0
55	Sleep Walking	*66*	15	2.5	5	4	3	2	0	0	0	1	0	0
56	Prejudice (bias)	*40*	14	1.3	10	4	0	0	0	0	0	0	0	0
57	Sexual Disorder	*60*	11	2.5	6	1	1	0	2	0	1	0	0	0
58	Tics	*24*	11	2.6	5	2	1	0	2	2	1	0	0	0
59	Schizophrenia	*58*	10	1.1	9	1	0	0	0	0	0	0	0	0
60	Night (Sleep) Terror Disorder	*65*	9	2.3	4	2	1	0	2	0	0	0	0	0
61	Panic Disorder	*51*	9	1.4	6	2	1	0	0	0	0	0	0	0
62	Sleep Disorder	*63*	9	2.0	4	1	4	0	0	0	0	0	0	0
63	Eating Disorder	*62*	8	2.6	4	1	1	1	0	0	0	1	0	0
64	Simple Phobia	*52*	7	2.7	4	1	0	0	1	0	0	1	0	0
65	Eating Problems	*22*	5	1.0	5									
66	Bipolar Disorder	*67*	3	1.0	3									

Annex 6. Comparison Between CMHP Database Terminology and Problems Listed in "How to Help Children with Common Problems", by Charles E. Shaefer and Howard L. Millman[1]

CMHP Database Key

	Problem
1	Hyperactivity
2	Compulsivity
3	Attention Deficit
4	Joking
5	Day Dreaming
6	Messiness
7	Time Misuse
8	Selfishness
9	Over Dependency
10	Anxiety
11	Fear
12	Low Self esteem
13	Depression & Self harm
14	Sensitivity to Critics
15	Shyness
16	Perfectionism
17	Thumb Sucking
18	Nail Biting
19	Bed Wetting
20	Bed Soiling
21	Sleep Problems
22	Eating Problems
23	Stammering
24	Tics
25	Aggression
26	Rivalry
27	Bad Company
28	Cruelty
29	Social Isolation
30	Disobedience
31	Temper Tantrums
32	Theft
33	Telling Lies
34	Cheating
35	Inappropriate Language
36	Fire Setting
37	Destructiveness
38	Running Away
39	Truancy
40	Prejudice
41	Substance Misuse
42	Inappropriate Sexual Behavior
43	Lack of Motivation
44	Bad Studying Habits

Schaefer & Millman, 1994.

#	Immature Behaviors
1	Hyperactive
2	Impulsive
3	Short Attention Span – Distractable
4	Silly – Clowning
5	Daydreaming
6	Messy – Sloppy
7	Time Used Poorly
8	Selfish – Self-Centered
9	Overdependent
	Insecure Behaviors
10	Anxious – Worrier
11	Fearful
12	Low Self-Esteem
13	Depressed – Self-Injurious
14	Hypersensitive to Criticism
15	Shy
16	Compulsive – Perfectionistic
	Habit Disorders
17	Thumbsucking
18	Nailbiting
19	Bedwetting
20	Soiling
21	Sleep Disturbances
22	Eating Problems
23	Stuttering
24	Tics
	Peer Problems
25	Aggression
26	Sibling Rivalry
27	Bad Companions
28	Cruelty
29	Social Isolate
	Antisocial Behaviors
30	Disobedience
31	Temper Tantrums
32	Dishonesty: Stealing
33	Dishonesty: Lying
34	Dishonesty: Cheating
35	Bad Language
36	Firesetting
37	Destructiveness
38	Running Away
39	Truancy
40	Prejudice
	Other Problems
41	Drug Abuse
42	Sexual Misbehaviors
42	Unmotivated in School
44	Poor Study Habits

[1] Charles E. Schaeffer & Howard L, Millman. *How to Help Children with Common Problems.* Aronson. New Jersey: 1994.

Annex 7. Comparison of English and Arabic Versions of Problem Categories in CMHP Database

DB Key	***Database Categories, Alphabetically Listed***	Arabic (CMHP glossary)
1	Hyperactivity	النشاط الزائد
2	Compulsivity	القهرية
3	Attention Deficit	ضعف الانتباه - التشتت
4	Joking	التهريج
5	Day Dreaming	احلام اليقظة
6	Messiness	الفوضوية و عدم الترتيب
7	Time Misuse	سوء استخدام الوقت
8	Selfishness	الانانية - التمركز حول الذات
9	Over Dependency	الاعتمادية الزائدة
10	Anxiety	القلق
11	Fear	الخوف
12	Low Self Esteem	تدني اعتبار الذات
13	Depression & Self Harm	الاكتئاب و ايذاء الذات
14	Sensitivity to Critics	الحساسية الزائدة للنقد
15	Shyness	الخجل
16	Perfectionism	القهرية - الكمال الزائد
17	Thumb Sucking	مص الابهام
18	Nail Biting	قضم الاظافر
19	Bed Wetting	التبول اللاارادي
20	Bed Soiling	التبرز اللاارادي
21	Sleep Problems	اضطرابات النوم
22	Eating Problems	مشكلات الأكل
23	Stammering	التلعثم
24	Tics	**اللازمات**
25	Aggression	العدوانية
26	Rivalry	تنافس الأشقاء
27	Bad Company	الصحبة السيئة
28	Cruelty	القسوة
29	Social Isolation	العزلة الاجتماعية
30	Disobedience	العصيان
31	Temper Tantrums	نوبات الغضب
32	Theft	السرقة
33	Telling Lies	الكذب
34	Cheating	الغش
35	Inappropriate Language	الكلام البذىء
36	Fire Setting	اشعال الحرائق
37	Destructiveness	التخريب
38	Running Away	الهرب من البيت
39	Truancy	الهرب من المدرسة
40	Prejudice	التحيز
41	Substance Misuse	سوء استخدام العقاقير
42	Inappropriate Sexual Behavior	السلوك الجنسي غير المناسب
43	Lack of Motivation	ضعف الدافعية للدراسة
44	Bad Studying Habits	عادات الدراسة الخاطئة
45	Trauma	صدمة نفسية
46	Family Problems	مشاكل أسرية
47	Mental Retardation	التخلف العقلي
48	Learning Disability	**اضطراب التعلم**
49	**Autism**	**اضطراب الذواتي**
50	Substance Use Disorder	اضطراب متعلق بالعقاقير
51	Punic Disorder (typo)	اضطراب الهلع

52	Simple Phobia	الرهاب البسيط
53	Social Phobia	الرهاب الاجتماعي
54	Obsessive Compulsive Disorder	الوسواس القهري
55	PTSD	اضطراب ما بعد الصدمة
56	Generalized Anxiety **Disorder**	القلق النفسي العام
57	Somatization Disorder	جسدنة الاضطراب النفسي
58	**Schizophrenia**	**الفصام العقلي**
59	**Dissociation Disorder**	**اضطراب الذاكرة**
60	Sexual Disorder	الاضطراب الجنسي
61	Personality Disorder	اضطراب الشخصية
62	Eating Disorder	اضطراب الأكل
63	Sleep Disorder	اضطراب صعوبة النوم
64	Nightmare Disorder	اضطراب الكابوس الليلي
65	Night Terror Disorder	اضطراب الفزع أثناء النوم
66	Sleep Walking	اضطراب المشي أثناء النوم
67	**Bipolar Disorder**	**الفصام**
68	**Conduct Disorder**	**اضطراب مزاجي (و جداني) ذو قطبين**
69	**(blank)**	**اضطراب التضرف**

Annex 8. Clinical Disorders Reported by CMHP Counselors, Ranked by Most-Reported ***March 2007 – August 2008***

	Problems	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Grand Total
1	Attention Deficit	7	42	19	1	1		105	116	99	106	36	77	99	55	80	15	203	56	**1,117**
2	Trauma	10	50	23	1	17	17	53	59	73	70	20	75	107	93	111	11	37	17	**844**
3	Learning Disability					1	1	6	16	35	13	4	8	26	15	11		214	65	**415**
4	Generalized Anxiety Disorder					2	4	10	17	17	16	22	24	40	41	52	43	30	27	**345**
5	PTSD		1				1	22	22	23	23	6	29	73	31	41		3	4	**279**
6	Somatization Disorder							2	2	1	4	3	6	2	2	6	46	39	20	**133**
7	Mental Retardation					1	1	2	3	5	6		4	2	1	6		61	16	**108**
8	Nightmare Disorder					2	1	11	10	6	4	2	19	28	6	1		8	2	**100**
9	Conduct Disorder							10	8	5	6	2	10	8	10	10	12	13		**94**
10	Substance Use Disorder						2	5	6	1			3	4	7	4	31	7	8	**78**
11	Dissociation Disorder								6	13	18		3	6	10	4		1		**61**
12	Personality Disorder					2	2	7	1	4	3	3		7	3	5	4	3	3	**47**
13	Obsessive Compulsive Disorder						6	4	3	12	6	1	2	3	4	1		3	1	**46**
14	Social Phobia						1	16	2		4		4	13				2	4	**46**
15	Autism							2	1	1		1	3	7	7	5	7	5		**39**
16	Sexual Disorder					1		3	3	4	7	4	5	1			1		1	**30**
17	Eating Disorder					1		8	2			2				2	3	3	2	**23**
18	Night (Sleep) Terror Disorder								3	10	6			3						**22**

19	Simple Phobia							3	9	5	4					1				**22**
20	Sleep Disorder								2		2	1	3	3	3	3	1		1	**19**
21	Panic Disorder						1	5	1		1		2	2		3			1	**16**
22	Schizophrenia							3	1	1			2	1			1		2	**11**
23	Bipolar Disorder									2							3			**5**
	Grand Total	**17**	**93**	**42**	**2**	**28**	**37**	**277**	**293**	**317**	**299**	**107**	**279**	**435**	**288**	**346**	**178**	**632**	**230**	**3,900**

Annex 9. CMHP Counselor Survey Questionnaire

CMHP Counselor Questionnaire

December-08

This questionnaire is intended to assess the training, work environment, and job satisfaction level of the CMHP field staff. Please read the questions carefully and answer them honestly. All survey responses will be kept COMPLETELY CONFIDENTIAL and will only be used in statistical formats without the use of any identifiable characteristics. Your responses will be compiled with the responses of other staff members for the purpose of analyzing the program and making improvements in services. Your supervisor(s) will neither see nor have access to the completed form at any time.

CMHP Counselor Questionnaire

December-08

	Please circle the number based on the scale that most accurately reflects your opinion.	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*
		1	2	3	4	5
	On CMHP Training					
1	Training is given sufficient importance in the Community Mental Health Programme.	1	2	3	4	5
2	The training courses I was given were based on my developmental needs.	1	2	3	4	5
3	I participated in determining the training courses I needed.	1	2	3	4	5
4	I had equal opportunity to participate in the training courses.	1	2	3	4	5
5	Overall, training courses were well-planned and organized.	1	2	3	4	5
6	I was given a clear understanding of the skills and knowledge I was expected to acquire from the training.	1	2	3	4	5
7	My skills were adequately assessed before and after the training to determine the effectiveness of the training.	1	2	3	4	5
8	Training courses were given by qualified, competent people.	1	2	3	4	5
9	The overall quality of training was adequate.	1	2	3	4	5
10	<u>Overall, the training(s) I have received so far:</u> … was offered at a time that made it easy for me to attend.	1	2	3	4	5
11	… was delivered at a comfortable pace so I could understand the content.	1	2	3	4	5
12	… gave me a chance to have my questions answered.	1	2	3	4	5
13	… allowed me to test out the skills I already had.	1	2	3	4	5
14	… was of sufficient duration.	1	2	3	4	5
15	… helped me to acquire the technical knowledge and skills I need to fulfill my responsibilities.	1	2	3	4	5

16	… helped me to acquire the administrative knowledge and skills I need to fulfill my responsibilities.	1	2	3	4	5
17	…helped me to develop skills in interacting with individuals with special needs (learning disabilities, etc)	1	2	3	4	5
18	I was given opportunities at work to try out what I have learned through training courses.	1	2	3	4	5
19	I would recommend the training I have received so far to new employees.	1	2	3	4	5
	On Work Environment, Resources & Support					
20	I know exactly what is expected of me at my job.	1	2	3	4	5
21	My present responsibilities are in line with my job description.	1	2	3	4	5
22	My work responsibilities are reasonable (i.e., what is expected of me is on par with my capabilities)	1	2	3	4	5
23	I have a supportive working relationship with the staff at my workplace.	1	2	3	4	5
24	The staff at my workplace understand what my role is.	1	2	3	4	5
25	Clients understand what my role is at my workplace.	1	2	3	4	5
26	Parents understand what my role is at my workplace.	1	2	3	4	5
27	I feel I am an integrated part of my workplace.	1	2	3	4	5
28	I am satisfied with my physical working environment.	1	2	3	4	5
29	I have the working space I need in order to do my work effectively.	1	2	3	4	5
30	I have the materials (e.g. stationary, etc.) I need in order to do my work effectively.	1	2	3	4	5
31	I have access to the equipment (e.g. copy machine, computer, etc) I need to do my work effectively.	1	2	3	4	5
32	I have the resources (e.g., assessment tools) I need to do my work effectively.	1	2	3	4	5
33	My work environment enables me to maintain the privacy and confidentiality of my clients.	1	2	3	4	5
34	The staff at my workplace respect my need to maintain the privacy and confidentiality of my clients.	1	2	3	4	5
35	I have enough time to get my work done	1	2	3	4	5

36	I have the referral resources I need to refer clients to specialized care.	1	2	3	4	5
37	I am able to adequately follow up on my clients.	1	2	3	4	5
38	The majority of my time is spent on activities most effective to promoting mental health and psychosocial wellbeing at my workplace.	1	2	3	4	5
39	I feel I am adequately prepared to fulfill the responsibilities assigned to me by CMHP.	1	2	3	4	5

	On Supervision					
40	I am satisfied with my direct supervisor.	1	2	3	4	5
41	My supervisor is there for me when I need him/her.	1	2	3	4	5
42	My supervisor is helpful to me in getting the job done	1	2	3	4	5
43	My supervisor is a competent manager.	1	2	3	4	5
44	I am satisfied with the amount of supervision I receive.	1	2	3	4	5
45	I am satisfied with the quality of individual supervision I receive.	1	2	3	4	5
46	I am satisfied with the quality of my group supervision sessions.	1	2	3	4	5
47	I feel my supervisor is qualified to supervise my work.	1	2	3	4	5
48	I am satisfied with the technical know-how of my supervisor.	1	2	3	4	5
49	I receive constructive feedback from my supervisor.	1	2	3	4	5
50	My supervisor has worked with me to identify my strengths and development areas.	1	2	3	4	5
51	My supervisor has worked with me to create a personal development plan.	1	2	3	4	5
52	I feel I have gained practical skills through my supervisor's supervision.	1	2	3	4	5
53	I receive fair and honest performance evaluations from my supervisor.	1	2	3	4	5
54	My supervisor shows interest in my wellbeing.	1	2	3	4	5
55	My efforts to improve myself are supported by my manager	1	2	3	4	5
56	I feel better prepared to fulfill my duties effectively than I was last year.	1	2	3	4	5

	On Communication with CMHP Management					
57	The goals of CMHP are clear to me.	1	2	3	4	5
58	I feel informed about what is going on in CMHP.	1	2	3	4	5

59	I feel informed about what is going on between CMHP and other departments within UNRWA.	1	2	3	4	5
60	I feel involved in decisions that affect CMHP.	1	2	3	4	5
61	I feel informed about the direction and future plans of CMHP.	1	2	3	4	5
62	I feel communication between me and CMHP management is sufficient.	1	2	3	4	5
63	I feel CMHP management understands the issues being faced by me in the field.	1	2	3	4	5
64	I am comfortable expressing or discussing my opinions/feelings with CMHP management.	1	2	3	4	5

	On Job Satisfaction					
65	I like doing the things I do at work.	1	2	3	4	5
66	My job lets me use my skills and abilities	1	2	3	4	5
67	I feel valued and affirmed at work.	1	2	3	4	5
68	I feel that the work I do is appreciated.	1	2	3	4	5
69	When I do a good job, I receive the recognition for it that I should receive.	1	2	3	4	5
70	My efforts to do a good job is seldom blocked by red tape.	1	2	3	4	5
71	I feel a sense of pride in doing my job.	1	2	3	4	5
72	It is possible to take time off from work to take care of personal or family matters.	1	2	3	4	5
73	I am given enough freedom to decide how to do my own work	1	2	3	4	5
74	Creativity and innovation are supported in CMHP.	1	2	3	4	5
75	I am satisfied that my views and participation are valued by CMHP.	1	2	3	4	5
76	I am satisfied with the professionalism of the people I work with.	1	2	3	4	5
77	I am satisfied with the team spirit in my work environment	1	2	3	4	5
78	I am encouraged to take initiative and do things on my own without having to wait for instructions from my supervisor.	1	2	3	4	5
79	I would recommend CMHP as a place to work.	1	2	3	4	5

80. What kind of training have you received since March 2007? Please specify in the space below, along with the time period (e.g., Jan – Mar 08) and the total number of hours for each training course (e.g., 10 hours).

Name of Training	Approx Time Period	Approx Total # of Training Hours

81. What training did you find most useful to you in your work? Please specify.

_____

_____

_____

_____

82. What other kind of training do you need in relation to your work? Please specify.

_____

_____

_____

83. What kind of additional material / resources do you need to do your work effectively? Please specify.

84. What other kinds of support do you need to do your work effectively? Please specify.

85. Do you have a private room at your workplace?

Yes ☐ No ☐

86. Do you have a locked cabinet or other kind of furniture in which to keep confidential files?

Yes ☐ No ☐

87. Do you have any other obstacles to maintaining the privacy and confidentiality of your clients? If so, please specify.

88. What are the most frequently presenting problems of your clients (what kinds of problems do the majority of clients come in with)? Please specify.

89. What kind of client problems do you feel you are MOST ABLE to deal with? Please specify.

90. What kind of client problems do you feel you are LEAST ABLE to deal with? Please specify.

91. What are the major obstacles to you in your work? Please specify.

92. What part of your work do you find the most productive / effective in promoting mental health?

93. On average, how often does your direct supervisor come and visit you at your workplace?

94. On average, how many hours of individual supervision do you get per month?

95. What other suggestions /comments do you have to improve CMHP so that we can provide the best quality service to our beneficiaries?

Thank you for your cooperation.