Psycho-Social/Mental Health Care
in the Occupied Palestinian Territories:

The Embryonic System

Rita Giacaman

Institute of Community and Public Health
in cooperation with
the Center for Continuing Education / Birzeit University

Birzeit University Logo

Institute of Community and Public Health
2004

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EXECUTIVE SUMMARY AND RECOMMENDATIONS

EXECUTIVE SUMMARY

1.1   This report presents the findings of a base line survey on the nature and extent of current provision of counseling and therapeutic services in the West Bank and Gaza Strip. It represents the beginning of a process related to an ongoing assessment of the terrain of psycho-social/ mental health care in the Palestinian Occupied Territory.

1.2   The aims of the baseline survey were:

- To map the extent of institutional provision of psycho-social/ mental health services
- To gain a picture of the type of work being undertaken by psycho-social/ mental health personnel and the approaches and methods used
- To identify the main obstacles that are encountered in the provision of psycho-social/ mental health services
- To identify what employers and staff see as their principal learning and development needs

1.3   Birzeit University hopes that this survey will contribute to a gradual system building process that is compatible with local needs, appropriate for the local context, is cost effective and will meet the highest professional standards and/or guidelines.   It is hoped that the findings of this study will stimulate an active discourse on the development of psycho-social/ mental health services in Palestine.

1.4   **Methodology**

The survey concepts and instruments were developed between February and March of 2002 with fieldwork commencing two months later and ending in January 2003 in the West Bank. Fieldwork once again commenced in September of 2003 and ended early February 2004 in the Gaza Strip. Due to differences in the timing of both the West Bank and Gaza surveys, UNRWA counseling services within primary health care

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were excluded from this study. Data processing, analysis and report writing were completed by the end of April 2004.

One of the selection criteria used in this study was that institutions were required to employ at least two staff members involved in psycho-social/ mental health care. A list of over 70 institutions providing psycho-social/ mental health services was generated. This was narrowed to 34 institution in the West Bank and 23 in Gaza following telephone contact to determine if they had more than one employee providing psycho-social care. There was some indication that a number of smaller institutions had folded possibly due to war-like conditions and changes in donor priorities.

Data Collection: Questionnaires that were sent to directors focused on institutional infra-structure, systems of worker supervision and support and views on training needs of their personnel. Questionnaires sent to the psycho-social/ mental health workers attempted to elicit views on cases dealt with and approaches taken. Counsellors were asked to identify the most significant problems encountered at work and what they considered to be their learning and development needs. Follow-up interviews were conducted with respondents to clarify results provided in the questionnaires. Considerable ingenuity was required to distribute and collect questionnaires at a time of closure and war. Some questionnaires were finally completed by telephone.

Response Rate: All 57 institutions identified responded at director/coordinator level. Out of seven hundred and seven psycho-social workers, 453 workers (64%) from the West Bank identified by the directors as working in these institutions at the time of the survey and 312 out of 365 persons (85%) employed in the Gaza institutions at the time of the Gaza survey responded and were included in the study. A representative sample of personnel in each of the three types of institutional provider (see below), and a reasonable geographical spread (38% Central West Bank, 43% North area of the West Bank, 19% in South area of the West Bank) was achieved.

1.5   **What Institutions are Providing Psycho-social/ mental health Services on the West Bank and Gaza?**

The fifty seven institutions included in this study operate programs with at least two psycho-social staff members on board. These include:

* Government Institutions
- The Ministry of Education which has the largest pool of counselors all working in schools
- The Ministry of Health
- The Ministry of Social Affairs' Youth with Special Problems Program

* The United Nations Relief and Works Agency's (UNRWA) school counseling program

* A range of **Non-Governmental Organizations** (NGOs) which specialize in service delivery to specific groups within the population such as women, children, disabled and young people. These institutions generally employ up to 28 personnel. Some also use volunteers.

Many of these institutions have their main centers located in the central area of the West Bank or Gaza city and are primarily urban based. Some of these institutions are well established dating back to the 1980's with some even earlier. Others, particularly those institutions providing a school counseling program (Ministry of Education/ UNRWA) have evolved and expanded rapidly in recent years (since 1994) and are in the process of developing their structural and managerial systems to support psycho-social/ mental health interventions. It is within this group that capacity building needs at structural, managerial and human resource levels were most strongly identified.

Two different but inter-related systems of psycho-social/ mental health care were found:

a) The largest provision of services is offered in schools through the Ministry of Education and UNRWA. The counselors provide basic counseling and guidance to students. Schools counselors are first level service providers and are well placed to offer preventive services and promote healthy lifestyles and positive behaviors among children and young people. These counselors are also in a position to provide initial screening of those who may need more specialist help and to refer them to appropriate secondary level care providers. School counselors are also well placed to extend their services to include families and communities.

b) A small group of specialist institutions (mainly NGO institutions) provide specific care for specific groups within the population while the Ministry of Health provides services for the general population. Of the total institutions, nine West Bank and 5 Gaza institutions reported that medication provision is part of the services they offer. Eleven West Bank and 3 Gaza institutions reported dealing with substance abuse. Six institutions in the West Bank and 3 in Gaza reported the availability of beds for the mentally ill largely provided by the Ministry of Health. None of the institutions reported the availability of beds for the mentally ill in general hospitals. No private mental hospital exists in either the West Bank or Gaza.

The findings suggest there is some level of co-operation between the two systems in providing services but there is a further need for referral systems to be more formally developed which can provide secondary level support to primary counselors. This requires co-ordination and collaboration within and between the various service providers and is a major area for policy development at both inter-sectoral and intra-sectoral levels, and at a governmental level.

Psycho-social service provision in the West Bank is in the process of development. This mapping exercise represents a snapshot view of the nascent system at a particular moment in time. The specific results obtained

from this study can only be seen as estimates reflecting the timing of the survey rather than a reflection of factors pertaining to specific conditions within the responding institutions.

1.6 **Who is Providing Psycho-Social / mental health Care?**

Of the total number of psycho-social/ mental health workers included in this study, 46% were men and 54% were women, reflecting the important presence of men who have joined this profession. Local imperatives seem to be offsetting other local, perhaps even universal tendencies towards the feminization of care. With male counselors employed in male schools and female counselors in female schools as a matter of cultural necessity, the de-feminization of this caring profession is emerging as an unintended consequence.

Respondents reported having been employed in their current job for an average of 3.98 years per worker (4.01 years for the West Bank and 3.95 years for Gaza). For a significant number, this was the first job they have been holding since graduation. This reflects the relative inexperience of not only the personnel but also the relative youthfulness of the psycho-social system of care especially in the schools.

The majority of these psycho-social/ mental health workers are Bachelors degree holders (92%), mainly in psychology, social sciences or education obtained from mostly local universities (73%). Whilst these are relevant initial qualifications for those working in this field, these undergraduate courses of study were never intended to prepare these graduates to work in psycho-social/ mental health care in a full professional capacity. These results draw attention to the need to re-examine undergraduate curricula in order to make them as relevant as possible to the employment needs of these graduates.

Nearly all the respondents have undertaken additional training whilst in their current post (an average of 1.2

continuing education scheme per worker). Virtually all counselors and their directors consider further training to be a crucial need.

1.7 Work Undertaken by Psycho-social/ mental health Personnel

Over ninety percent of the respondents stated that anxiety, stress and fear were the most frequent presenting problems in their case loads. Other main problems dealt with included phobias, sources of distress that are war related, child abuse, and grief and loss. Respondents also reported that they worked with cases related to domestic violence. Those working in the specialist NGO sector stated that they worked with women and girls who have been sexually abused. When asked about the type of cases they dealt with at the time of the survey, the reports of directors and counselors were generally compatible.

Directors and staff perceived their case loads have risen since the beginning of the 2nd Intifada (from September 2000), with an average of double the case loads reported per organization. However, caution must be exercised in interpreting this result. There was a high rate of non-response to the case load questions due in part to the lack of development of an adequate recording and information system.

The respondents revealed not only quantitative but also qualitative changes in the type of cases encountered since the beginning of the 2nd Intifada in September 2000. Respondents perceived that prior to the start of the 2nd Intifada, emotional problems were the most common problems dealt with (31%) followed by behavioral problems (28%), learning difficulties (26%), social problems (19%) and abuse problems (12%).

Since the beginning of the 2nd Intifada, there has been a perceptible shift to a higher reporting of emotional problems constituting the most common cases being dealt with (74%) followed by behavioral problems (35%), somatization (20%) and diagnosable psychiatric

disorders (17%). Great caution should be used in interpreting these results. They do not represent an epidemiological picture of what is happening in mental health in the West Bank and Gaza but rather the perceptions of counselors and directors as to the type of cases they handle. An adequate diagnostic base and/or information system has not been established to confirm these results. These results are nonetheless, interesting in that, based on the respondents' perceptions, the conditions and consequences of the 2nd Intifada have led to a necessary change from what they have dealt in the past towards interventions for cases related to the extreme political turmoil that characterize this period. Because of the increase in crisis related cases, ongoing problems such as social problems, abuse and learning difficulties which would have most likely intensified due to the current escalation of violence and spiraling poverty appear to have been relegated to a secondary position in terms of priority attention.

1.8 **Methods of Intervention Used by Psycho-social/ mental health Workers**

An eclectic range of intervention approaches were cited by the respondents. Virtually all stated that they used both individual and group counseling. A high proportion of respondents stated they used cognitive behavioral and behavioral approaches, with a smaller proportion also citing psychodynamic approaches. Eighty eight percent of counsellors cited using crisis debriefing techniques and 12% reported using EMDR (Eye Movement Desensitization Re-processing). The latter appears to be a training effect in that short courses have been provided by international bodies in these techniques. Perhaps these results represent in part the desire of psycho-social/ mental health workers who feel unacknowledged to legitimize their professional standing by citing the use of therapies and techniques.

There is no evidence of a coherent approach to assessment and intervention. There is also insufficient evidence of the effectiveness of these approaches within a Palestinian context.

1.9 Obstacles to Professional Development

Sixty two percent of the respondents reported that they faced obstacles that impede their professional development, with higher reports of obstacles for West Bank workers at 70% compared to 50% for Gaza. Twenty nine percent stated that the political situation was the main impediment, again with important differences between the West Bank reports (43%) and those from Gaza (8%) reflecting perhaps the differences in contexts, political realities and the timing of the survey in the two regions. The situation affecting the country since September 2000 have pushed many institutions to deal with crisis situations at a time when they were neither necessarily nor adequately prepared structurally or managerially. Respondents cited obstacles in the general delivery of services. School counseling services seemed to face particularly tough challenges leading at times to a strong sense of worker frustration, resentment and isolation

Other obstacles reported by psycho-social/ mental health workers included bureaucratic management problems (19%); absence or insufficiency of training schemes (16%); lack of acceptance of counseling by teachers, principals, students and families (14%); lack of space, privacy, equipment and materials needed to complete the tasks at hand (11%); and financial constraints (9%). Some also mentioned difficulties in referring cases on for more specialist intervention.

1.10 Learning and Development Needs of Psycho-social/ mental health Workers

Nearly all the respondents identified learning and development needs and showed commitment to continuing professional development. A wide range of training courses was requested including managerial skills, counseling skills, therapeutic skills, preventive therapeutic approaches; general topics related to women and their needs, general child related topics, and general social topics including health and disability rehabilitation. However, the training courses requested are very similar

to, if not exactly the same as, previous training courses undertaken by counselors. This raises the question as to whether and the extent to which trainees have consolidated the knowledge and practice gained from their training. One of the issues identified is that having completed training courses, staff were not supported in practice to consolidate, develop and extend what they have learned in the training programs. It may also be that the training undertaken was neither relevant to the work they were doing at the time nor perhaps culturally appropriate.

Developmental and supportive clinical supervision is rarely provided (except in selected specialist NGOs). Supervision when provided appears to be bureaucratic with a focus on administrative matters rather than enabling counselors to deal with the impact of their work and to develop their knowledge and skills.

Professional development is more than simply attending training workshops. A serious commitment to continuing professional development necessitates 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. Organizations also need to develop systems to support and appraise personnel development.

RECOMMENDATIONS

1.11 **Coordinated Policy Development**

- There is a need to further develop coordinated policy regarding the nature and scope of psycho-social/ mental health care within the Palestinian context. Key service providers including both governmental and non-governmental organizations need to formulate shared and appropriate policies for Palestine in order that resources may be used more effectively. A sector wide approach is needed in the provision of psycho-social/ mental health care.

- The role of psycho-social/ mental health workers should be more clearly defined. This should include both promotion of psycho-social well being through individual and family support, community participation as well as preventive therapeutic interventions for those experiencing problems.

- The location of psycho-social/ mental health workers within a wider framework of mental health provision needs to be clarified. Referral systems between primary and secondary (specialist) level services need to be developed including links with primary health care established. This requires (a) co-ordination and collaboration within and between the various service providers and system development, and (b) increased access to secondary (specialist) level services in the community.

1.12 **Accreditation, Training and Development of Psycho-social/ mental Health Workers**

- The responsibilities of psycho-social/ mental health workers need to be more clearly defined. Consensus needs to be reached on the eventual professional accreditation of psycho-social/ mental health personnel at different levels. A Code of Practice needs to be developed and implemented.

- There is a need to develop a recognized national core curriculum for basic grade counselors that includes training and assessment in practice.

- A recognized national continuing professional development scheme for psycho-social/ mental health personnel should be devised to enable established workers to build on existing knowledge and to provide training in more specialist areas of work

- Universities should review their undergraduate curricula in psychology and social work to assess their relevance to the work needs of psycho-social/ mental health personnel. Such courses should incorporate placements and work practice based learning.

1.13 Organizational Development

- Institutions providing psycho-social/ mental health services need to review their policies and strategies for managing and supporting psycho-social/ mental health services.

- Systems to support and appraise personnel development and to provide counselors with clinical supervision need to be developed.

- Case management systems need to be put in place to promote effective management of information.

1.14 Developing Evidence Based Practice in Psycho-social/ mental Health Care

There is a need for research into the effectiveness of psycho-social/ mental health interventions in Palestine. A monitoring and evaluation programme needs to be developed, the results of which can inform both policy and professional practice. "Model building" before scaling up operations is desirable.

INTRODUCTION

INTRODUCTION

Concern for the psycho-social health of Palestinians is a relatively new phenomenon and probably dates back to the late 1980's and the beginnings of the 1990's. This was a period characterized throughout the world by a growing realization and understanding of the possible negative impact of acute periods of conflict. In the Palestinian Occupied Territories, concern focused especially on the psycho-social health of Palestinian youth. During the first Uprising which began in December 1987, schools closed down for several years, economic activity almost came to a halt and public life was transformed to accommodate this state of emergency. In addition, the period was marred by much violence including the death, injury and permanent disablement of many, primarily young people. These were trying conditions that prompted communal action leading eventually to the creation and development of a Palestinian disability movement. This movement used the opportunity to advance the cause of not only those who were injured by Israeli army violence but the disabled at large.

Concerted initiatives in the area of psycho-social/ mental health care came at a later date with certain notable exceptions particularly among local non-governmental organizations. Several reasons are partially responsible for this delay. These include: (a) the fact that stigma attached to mental health is even stronger than the stigma associated with disability - the elevated social status of disabled heroes of the Uprising contributed towards ameliorating the problem; (b) the fact that some forms of violence have always existed as an accepted social phenomenon in society. Rather than being acknowledged as a social problem, these forms of violence have been used as instruments of social control especially in dealing with women and children and towards maintaining the status quo in a patriarchal society with seniority of age as a key element in determining power relations. One of the consequences has been to hinder the efforts of those attempting to place the issue of violence against women and children on the national agenda; and (c) the distortions generated largely, but not solely, by outsiders in focusing on youth as a source of violence that needs to be restrained or even controlled.

Rather than understanding that Palestinian youth themselves have been cumulatively violated not only by the Israeli army

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but also by and within their own families, and by educators at school, these two contradictory notions have become conflated. On the one hand, there is the notion that the youth of the first Uprising have grown up in political and social chaos. They require serious attention because they are seen as a source of violence within society. On the other, the response of youth to political violence through political participation was seen as their legitimate right in resisting occupation even though they were themselves violated in the process. These two opposing if not reductionist categorizations of Palestinian youth have locked the local debate on youth psycho-social/ mental health into a corner leading to eventual silence.

However, Occupied Palestine of the 1980's had witnessed the development of a strong nationalist social action movement and within this framework, a strong women's movement as well. This movement has been instrumental in promoting the issue of dealing with violence against women and children. It has also gradually opened a space in which relevant questions can be raised regarding the development of psycho-social/ mental health programs as a legitimate endeavor. Other than a very limited and strictly biomedical-psychiatric model of care that existed within the governmental health system and controlled by the Israeli military, very few models of psycho-social/ mental health care existed and were operational in the 1980's. Nevertheless, that was a time of model building with the beginnings of new initiatives by non-governmental organizations such as the Gaza Community Mental Health Project and the Palestinian Counseling Center in Jerusalem.

Over time, these organizations that were involved in a gradual process of institution building and through trial and error accumulated a good amount of knowledge and experience based on local need. Others also began to follow suit either by developing psycho-social/ mental health programs within their existing institutions or by establishing institutions to deal exclusively with specific groups, notably women. All these projects operating within the framework of a nationalist movement were resolved in the building of Palestinian systems of care outside those controlled by the Israeli military. Just as importantly, they took care of the basic needs of the population as a matter of national survival. Yet, despite this, tension continued between national imperatives on the one hand and the need to address internal social issues on the other, issues

that were seen by some as 'rocking the boat' in the process of national liberation.

The Oslo Accords of 1993 marked the beginning of a new phase characterized by the emergence of Palestinian quasi-state structures and the gradual handing over of various spheres to the Palestinian Authority. By 1996 the Ministry of Education had launched its counseling program in all the public schools, an initiative given impetus by the Minister and legitimized by felt need and demand. However, probably through a combination of donor pressure and the starvation of funds as well as other internal considerations, all these factors contributed to the over-rapid launching of the school counseling program with minimal consideration given to model building. At the same time, little consideration was given to the conceptualization of details to ensure programmatic success such as those related to the purpose of counseling in the Palestinian context, its components, the human resources needed to implement the project, the management system needed for implementation, structural changes within the school system to accommodate this new project and the human resources needed, and the development of instruments needed for the monitoring and evaluation of this program. Within UNRWA, a mixture of mental health and counseling programs within the health program and the school system were implemented at different times, with programs growing and shrinking it seems, based on the availability of funds.

By the year 2000, it was becoming clear that the Palestinian Authority was facing a systemic crisis, a combination of internally generated problems, serious external political impediments as well as a reduction in donor aid. In September 2000, population disillusionment with the peace process exploded in the form of the second Uprising which continues up to the present day. Since that time, the Israeli military onslaught against a largely civilian population, closures, curfews and siege policies, the death and injury of mostly young men, shelling and bombardment of civilian areas, and re-occupation combined with spiraling poverty have all produced conditions precipitating a state of generalized and/or acute psychological distress amongst the population. Particularly for some children living in fear, these conditions have contributed to diagnosable medical cases.

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This inevitably led to a communal response followed by an initial flurry of activities in the field of psycho-social/ mental health care. However, by the end of 2003 and the beginning of 2004, at the time of this report writing, the area of psycho-social/ mental health care provision has begun to stabilize somewhat. By 2004, some groups that had initially responded to the crisis by moving into this particular area of service provision have ceased to operate. Groups that managed to survive and continued to exist have stabilized into institutional systems and programs that we hope will last.

This investigation represents the beginning of a much needed ongoing assessment of the terrain of psycho-social/ mental health care in Palestine. The research was initiated by a group of researchers and trainers at Birzeit University who was concerned with both youth and communal aspects. This study aims to identify the most pressing communal needs especially in the area of training and continuing education for psycho-social/ mental health workers within a framework of gradual appropriateness for context system building. The responsibility of program development and implementation was assigned to the Center for Continuing Education while the investigation was conducted by the Institute of Community and Public Health, both belonging to the Birzeit University structure. This study followed an initial investigation carried out in 2001 on the condition and views of Birzeit undergraduate students. The findings revealed a high level of psychological distress, and more importantly perhaps, what seemed to be a generalized sense of loss of hope or vision for a better future among the study participants.

Faced with a mission statement linking academic and scientific endeavors to societal development, the initial group conceptualized the University's role primarily in terms of model building and the provision of training and continuing education schemes. The group also took into consideration the rising if not pressing need for care and perhaps more importantly, for rational and culturally appropriate programming and system development. Given the confusing landscape, the project necessitated a thorough investigation of what was available at the time since it was unclear who was doing what, when and where, both in terms of care provision and training.

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Moreover, the needs appeared to be mounting and changing at the same time as violence against civilians rose to previously unimaginable proportions. As the invasions of March of 2002 turned into a milestone, they began to shape matters of life and psychosocial care in new ways leading to a focus on survival issues and coping with extreme challenges. These considerations were emphasized by the findings of a study completed by the Institute of Community and Public Health in April-May of 2002 immediately after the town invasion. The findings showed that between 70-90% of respondents in a representative sample of all five invaded towns in the West Bank reported mental health problems as important problems affecting their households.

There is an evident need for psycho-social/ mental health system building in the Occupied Palestinian Territory, as is suggested in the 'Plan on the Organization of the Mental health Services in the occupied Palestinian Territory' by the Palestinian Steering Committee on Mental Health (2004). The mix of institutions involved in the caring of emotional problems in the Occupied Palestinian Territory is complex and fragmented. There is a lack of overview on what mental health resources (institutions and professionals) currently exist in the area. As recommended in the 'World Health Report 2001: Mental Health New Understanding New Hope' (WHO, 2001) and as shown by the WHO Project Atlas (2001) that provides an overview of mental health resources in 185 countries, the mapping of mental health resources is an essential first step in the process of building a mental health system. In this document, we report on an extensive mapping exercise of psycho-social/ mental health resources in the government and non-governmental sectors in the Occupied Palestinian Territory.

METHODOLOGY

METHODOLOGY

This study is primarily a mapping and initial needs assessment exercise intended to distinguish the main established institutions operating psycho-social/ mental health care programs in the West Bank and Gaza. Individual counselors working in smaller level projects such as individual counselors working in private schools, charitable societies and other small non-governmental organizations were not included. It sought to obtain basic institutional information, the views and perceptions of those responsible for program operation (institutional directors or main supervisors) as well as the workers themselves in order to identify the following: contours of the institutional structural set up; the number of employees; their qualifications and previous training experience; average case loads; type of cases handled; methods of psycho-social/ mental health care used; problems encountered in operating projects; obstacles to further systemic development, and setting the stage for the identification of training needs within these institutions.

The Institutional Maze of Who is Doing What

We began by building a basic roster of the main institutions operating psycho-social/ mental health projects. An initial list of over seventy institutions was developed once it was ascertained that they were operating programs with more than one employee on board. However, the list soon diminished to a total of thirty four institutions on the West Bank and 23 in Gaza as we began the phone contact process to ensure the projects were still operational. Those can be categorized as follows: governmental institutions including the Ministry of Education that employs the largest group of counselors all within the schools; the Ministry of Health; the Ministry of Social Affairs' special program for youth with special problems; UNRWA employing counselors working in schools; and, a host of non-governmental organizations focusing on the provision of services to specific categories within the population (women, children, the disabled, youth, the sick, the elderly etc.). Although the types and nature of institutional activities in these categories differ substantially at times, common structural features allowed for the completion of a comparative analysis of these groups in part. For the regional analysis, comparisons of the type of work and the gender of workers were completed whenever possible.

The Research Instruments

The research instruments included two questionnaires. The first was specifically geared towards the main supervisors/directors, focusing on identifying the institutional infrastructure and structure, systems of supervision and referral, and views regarding the training needs of workers. This instrument included specific questions focusing on medical mental health institutional identification as well. The second questionnaire concentrated on the views of the employees themselves, containing many of the same questions that were raised in the supervisors' questionnaire. This second questionnaire also included questions that pertained to specifics related to each worker (such as previous training, where trained, how long working on the job etc.). The workers' questionnaire also attempted to solicit views on the most pressing problems encountered at work and their possible solution. Both were semi-structured questionnaires yielding a considerable amount of coding and recoding work. Nonetheless, they provided a very rich base of field discourse that allowed us to better understand the different dynamics and problems of psycho-social/ mental health care in these institutions. Throughout, a process of informal contact and interviews with informants in the three systems assisted in the completion of the study and helped to make sense of the results of the statistical analysis. This was a key process that proved to enrich the analysis in ways that could not have been possible had there been no contact as such.

On How it was Done in Siege, Closures and Curfew

Given the conditions that prevailed in the country during the past three years (closures, siege, frequent curfew, and more recently, the erection of the 'Separation Wall') we opted to send the questionnaires by commercial courier service to the main supervisors based in the different locales within districts and regions. Permission was obtained from the main directors of each of the institutions to complete the field work and contact was made with a focus person for one and up to several locales in each region who was willing to cooperate. The Gaza office of the Birzeit University Center for Continuing Education facilitated the process. Surprisingly, there was always someone within these institutions who was willing to help. At times, it

felt as if some of those who understood our initiative were also acting out of a wish to help implement the work within their own extremely deprived if not neglected locales. The mere fact that we were asking seemed to make a bit of difference.

The reader needs to be reminded that during this period, two thirds of the country's families fell below the poverty line and many locales in the West Bank were constantly under curfew for extended periods of time. Curfews were only lifted for two to three hours every few days to allow for the management of essential needs. In Gaza, in addition to severe violent episodes affecting innocent civilians, the population has been facing unimaginable hardships with thousands of home razed to the ground, destruction of agricultural land, uprooting of trees and mounting poverty.

Some of the institutions we were seeking information from were not even operational at the time of our field work in the West Bank. This meant that we had to reach those helpful persons at home for coordination of activities, often via mobile phones. Thus the sending off and the return of questionnaires took rather longer than expected. In time, this logistics exercise actually became even more complicated due to the fact that the curfew was only lifted at different times and in different areas in the West Bank, or that the crossing junctions between Gaza and the West Bank and within the Gaza Strip itself were closed. Given the state of chaos, questionnaires could only be sent to the workers whenever it was deemed possible. When the curfew was lifted in one area, the helpful person had to take the questionnaires from one area to another where there was no curfew. The questionnaires then waited in that second locale until as such time when the curfew was lifted at the same time, both in that locale and in Ramallah (where our office is located) or when the checkpoint was opened, and so on.

Some of the target groups could not be reached by courier service notably in villages where such services do not operate. Otherwise they were under strict and constant siege as in some parts of Nablus city which has suffered probably the most severe and continual state of curfew. Rather than simply omit these locales, especially if we thought that they needed the most assistance, we opted to conduct the interviews by phone. We succeeded to a good extent. However, despite these attempts, we could not reach everybody either because they

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had no phones or because their landline phone lines were cut. Other non-responders, we were told, were so demoralized or so burned out they had no inclination to fill out our questionnaire. In some cases, others had left the institutions or even traveled abroad.

By February 2003, we decided to end the field work in the West Bank that had taken nearly the whole of 2002 to complete. Field work for Gaza which began in September 2003 ended in February of 2004. Overall, we managed a considerable feat by capturing responses from all 34 West Bank and 23 Gaza Strip institutional directors/supervisors and the majority of the workers. Of 707 persons employed in West Bank institutions during the period from May 2002 till early February 2003, 453 individuals or 64% provided responses that were included in this study. A reasonable West Bank geographic spread (38% of Central, 43% of Northern and 19% of Southern West Bank psycho-social workers) was achieved. Of 365 persons employed in the Gaza institutions during the period September 2003-February 2004, 312 or 85% provided responses that were included in this study as well. Of the total, 39% of West Bank and 23% of Gaza respondents were interviewed by phone.

It should be noted here that the UNRWA counseling in schools initiative was included in this analysis. However, UNRWA's counseling within health care was excluded although it was acknowledged as operational at the time of this report writing. UNRWA's school counseling program began in 2001 with the employment of counselors in schools and it is still in existence. This program was covered by our survey of UNRWA West Bank services in 2002. In the meantime, UNRWA's program of counseling within health care appeared to follow a pattern of fluctuation. After a period of implementation, it ceased to operate and was revived again in the latter part of 2002 and 2003. By then, we had already completed surveying UNRWA's West Bank programs. The Gaza survey took place during 2003 and early 2004 and thus captured the operation of the counseling in health care program. However, it was not possible to include UNRWA's Gaza-based counselors in health care program in this study as this would have biased our results in the absence of similar data from UNRWA West Bank. It was therefore decided to acknowledge the existence of this program, and to proceed with the analysis contained in this report without including this specific program. Indeed, this may well

demonstrate the instability of psycho-social/ mental health care programs and their funding base in the area, calling for special care in interpreting the results. Even as we write this final report, it is evident that systemic and operational changes are taking their own courses.

Time Frame

The investigation itself was conceptualized in February-March 2002 when we began the process of questionnaire development. Fieldwork in the West Bank began in May of the same year and was ended in early February of 2003. Fieldwork in Gaza began in September of 2003 and ended in February 2004. Coding and data feeding into computers, utilizing the SPSS package (Statistical Package for the Social Sciences) were completed during this period. Computer coding and the recoding variables, data analysis and report writing began in February of 2003 and were completed in May of 2004.

DIRECTORS' REPORTS

DIRECTORS' REPORTS

The Institutions Providing Care

In this study, we found thirty four institutions (the Ministry of Health, West Bank with two structures, primary mental health services and the Mental Hospital in Bethlehem, dealt with separately in this report, and increasing the total number of institutions in the West Bank to 35) providing psycho-social/ mental health care in the various regions of the West Bank (including Jerusalem), and 23 in the Gaza Strip (the Ministry of Health Gaza with two structures, primary mental health services and the Governmental Mental Hospital, again dealt with separately in this report, and adding up to 24 institutions included in this analysis).

These figures do not include smaller level operations of less than two counselors and one director each, nor individual counselors operating here and there in institutions that limit their care to a small group of people on locale (such as free lance counselors acting as private practitioners, clinical psychologists and psychiatrists, those working in private schools that do not form part of a larger system of schools or non-governmental organizations that offer counseling services to their beneficiaries by employing one person for the job, again without links to others and/or in a limited capacity in just one locale).

Of those, by far the largest operation at the times of the surveys was that of the Ministry of Education employing 382 responding workers (Chart 1), followed by UNRWA with 55 employees for the West Bank and 150 employees for the Ministry of Education and 85 for UNRWA in the Gaza Strip.

Chart 1: Distribution of Respondents - West Bank and Gaza

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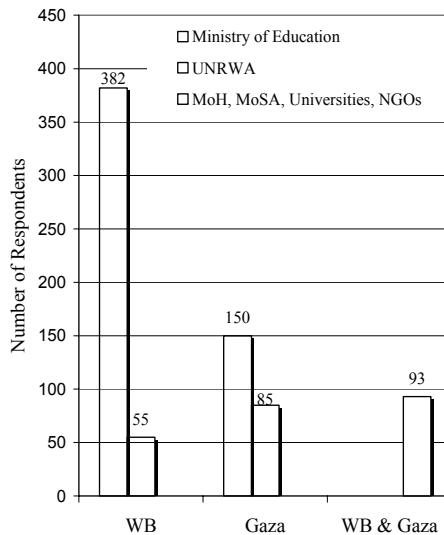
The Ministry of Health, the Ministry of Social Affairs, universities and a variety of non-governmental organizations are also involved in the provision of such care.

In total, for the West Bank, 5 were governmental institutions (14%), 29 were NGOs (83%) and UNRWA. In the Gaza Strip, 3 (13%) were governmental institutions, 20 (83%) were NGO operations and UNRWA (Chart 2).

Chart 2: Institutions Providing Services - West Bank and Gaza
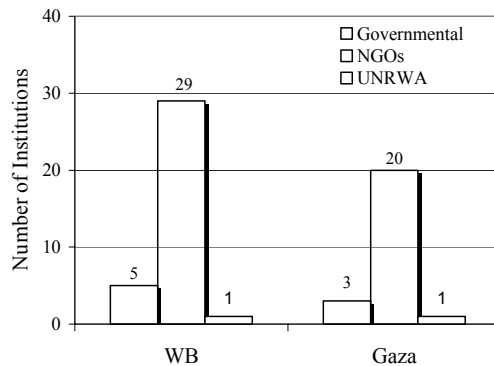
Our data indicated that there were 707 persons employed in these institutions during the period May 2002 till early February 2003 for the West Bank, of which 453 or 64% provided responses that were included in this study. In Gaza, 365 persons were employed, of which 312 or 84% with responses were included in this study for the period from September till February 2004, all dealing with psycho-social/ mental health issues.

What we found striking was the finding that one relief-focused international aid agency had turned operational on its own with little linking of its work with local partners. Why an international aid agency would want to operate services on its own in a context where local initiatives are already ongoing, and where system building and sustainability of operations are paramount is a question that needs further investigation.

Generally speaking, we see the role of international aid as support to local partners, as opposed to 'doers' in a field of operation that is heavily reliant on the understanding of culture and society. It is difficult to comprehend how internationals can engage in a process of sustained, culturally appropriate system building on their own as their efforts will always be hampered by the length of time they spend in the country. Since they often only stay for a limited period of time, such initiatives end

up training no one. With rapid staff turnover, work cannot proceed properly and the lack of familiarity with culture and language raises all sorts of questions related to the longer-term system building impact of their work. In addition, other initiatives oftentimes end up hiring local psychologists and other skilled local personnel, luring them away from local structures with better salaries and contributing to the weakening of local infrastructures.

Otherwise, the range of local NGOs that are operating psycho-social/ mental health services is wide including women's support organizations, health care services, educational and community services, human rights and democracy groups, universities, disability rehabilitation services, legal aid centers and agricultural projects. The range of services provided by NGOs is not necessarily a problem. In fact, the range may well provide us with a template of institutions that allows us to reach different sectors of the population more effectively.

Regional Distribution

West Bank institutions tended to be clustered around the central area of the West Bank. Of the total, 32 of these institutions operated mainly out of urban areas (81%) with some extending services to different geographic locations. The remaining institutions (3, 9%) are housed in towns. As one would expect, mother institutions are located mainly in the center of the West Bank as well. These results tell us what we already know: the need to support, develop and strengthen institutions in the north and the south of the West Bank in a diversity of ways so that they will be in a position to provide services within their own regions. This is especially important in view of closures, siege and curfews which seem to have no end in sight. Of the total institutions, 16 (46%) operate branches in areas and in regions other than where the mother institution is located, and the rest, 19, operate only on locale. In addition, 16 institutions are exclusively urban based. Some of these institutions have branched out considerably with some operating in all the governorates of the West Bank. The branches are, in the main, urban based as well.

A similar pattern was observed for the Gaza Strip institutions, with 19 (79%) of the institutions together with the main mother institution located in the urban area, 2 in villages and 3 in camps. All 19 institutions with urban-based mother institutions also reported operating branches that appear to cover the different regions of the Gaza Strip. The number of branches ranged from one and up to 16, with some reporting that they cover all of the Gaza Strip and others in specific locales, urban, camp and rural.

Year of Institutional Establishment, Project Mission and Written Documentation

The majority (68%) of West Bank institutions that responded to the question were established before 1995 when many of the Palestinian Authority structures became operational. All institutions were established before the year 2000, that is, before the beginning of this current Uprising. One institution dates back to 1922 with about half having been established before 1992. Nevertheless, since the advent of the Palestinian Authority period, about one third have been established including, of course, the three Ministries that existed as structures prior to the period of the Palestinian Authority but were controlled by the Israeli military. This is understandable in view of the system building imperative of those times as well as the initial hopes for peace, prompting many institutions to pay attention to the impact of the first Uprising especially on youth.

We found similar results for the Gaza Strip, with 14 (58%) reporting that their institutions were established before 1995 and all but one before September 2000 when the current Uprising began. Gaza Strip institutions are younger than those on the West Bank with the oldest institution (other than UNRWA) established in 1978. These results should dispel the notion among some who conclude that institutions operating psycho-social/ mental health projects arose out of the availability of money during the current Uprising rather than attributing other dynamics at work following the first Uprising period. Thus, the majority of institutions included in this study was already well established and had been operating for considerable and extended periods of time.

Of West Bank institutions, 22 (63%) reported that the institution has developed a written statement detailing vision, mission and goals for psycho-social/ mental health. Of these, 2 were able to provide this statement at the time of this report writing, 13 (62%) promised to send our team a copy as soon as feasible, 3 (14%) reported that it is posted on the institution's website and the rest either did not know or hesitated to provide us with a copy. For the Gaza Strip, 12 institutions (50%) reported having developed the written statement, with 2 providing a copy, and 2 others requesting that we obtain them from the mother institution as this required permission (Chart 3).

Chart 3: Percentage of Institutions with Written Mission Statements - West Bank and Gaza

63%   50%

West Bank   Gaza

In the local context, the necessity of drawing up a written, as opposed to an otherwise declared mission, may not be a high priority on the institutional agenda. It may or may not even be relevant to the local framework within which these institutions operate. Whether a written statement does or does not exist should then be interpreted in light of these observations as some of the better institutions may be providing quality services without necessarily giving much thought to formalizing their mission in writing. The presence or absence of a written statement may well reflect the 'exposure' of local groups to outside institutions, their workings and expectations rather than a reflection of sound structures and quality operations.

Likewise, when we asked the directors whether they included psycho-social/ mental health problems in their annual reports, 26 (74%) of West Bank institutions and 15 (63%) in Gaza Strip responded in the affirmative. However, when we asked for a copy of the last annual report, some maintained that the report is stored centrally and hence not available to them. Others reported that such reports are confidential and not for distribution or that sending the report requires higher level approval. For others, the reports were not ready while some promised to send us the annual reports some time in the future.

Within the local context, the wide dissemination of annual reports is not a common phenomenon. Usually, they are given to institutional boards and funding sources but are not distributed widely except in selected instances. Requests for annual reports are sometimes seen as an intrusion, thus corroborating our view that while adequate documentation may not be a feature of local operations and may well require strengthening, the production of written material for dissemination is not necessarily an adequate gauge for assessing quality of operations although perhaps important for transparency purposes.

Services Provided

Respondents were asked to report on when they began operating psycho-social/ mental health services. We found that among West Bank institutions that responded to the question with 30 on the West Bank, 5 institutions reported operating such services before 1987, 14 before 1995, 9 between 1995 and 1999, and 7 during the years 2000 and 2001. In Gaza, one of the 21 responding institutions reported that it has been operating services before 1987, 6 before 1995, 11 between 1995 and 1999, two additional ones during 2000-2001 and two more during 2002-2003. That is, institutional attention to psycho-social/ mental health care provision appears to be partially a longer term tradition and partially a new response to prevailing conditions. However, a change in the focus of activities to deal with 'crisis intervention' in war like conditions may well have begun only recently. It is questionable whether these institutions were prepared to handle such a shift given the availability of human resources and managerial structures.

Another question that needs further investigation concerns institutions where counseling programs were instituted without the requisite human resource development in relation to needs and tasks. Without model building and experimentation before scaling up operations, how were these institutions prepared to handle large counselor pools and structures? When asked why they began operating psycho-social/ mental health projects, almost all the institutions reported communal need as the principal reason. Secondary reasons included the need to empower women, to assist children, to improve the health of Palestinian society and the necessity of incorporating such programs into the educational process.

Table 1 and Chart 4 reveal that eighteen (51%) of the West Bank and 11 (46%) of the Gaza institutions reported that they provide health care services as part of their operations; 16 (46%) in the West Bank and 22 (92%) in Gaza in educational services, 27 (77%) in the West Bank and 22 (92%) in Gaza in community oriented ones, 13 (37%) in the West Bank and 11 (46%) in Gaza with a democracy and non-violence focus, 15 (43%) in the West Bank and 15 (63%) in Gaza with a focus on research, 16 (46%) in the West Bank and 14 (58%) in Gaza in rehabilitation, 5 (14%) in the West Bank and 2 (8%) in Gaza in geriatric care, 29 (83%) in the West Bank and 21 (88%) in Gaza in various forms of training, 13 (37%) in the West Bank and 14 (58%) in Gaza in women oriented projects, 28 (80%) in the West Bank and 14 (58%) in Gaza in advocacy, in addition to or intertwined with psycho-social/ mental health care provision.

The results show that these institutions provide a wide range of services in addition to basic psycho-social/ mental health service provision. Of the total, 26 (74%) of West Bank institutions and 20 (83%) of Gaza ones reported that their institutions provide health promotion and 31 (87%) of West Bank and 20 (83%) of Gaza ones offer preventive services. Overall, 23 (66%) of West Bank and 17 (71%) of Gaza institutions reported that they provide treatment of various kinds to their clients. Given our knowledge of the field and our observations that the differences between prevention and promotion are not always clear to local care providers, these results should be interpreted with caution.

Table 2: Type of Services Provided by Region- Percentage of Regional Group

Type of Service	West Bank	Gaza
Health care	51	46
Educational	46	92
Community	77	92
Democracy non-violence	37	46
Research	43	63
Rehabilitation	46	58
Geriatric care	14	8
Various training	83	88
Women	37	58
Advocacy	80	58
Health Promotion	74	83
Preventive Services	87	83
Treatment	66	71

Chart 4: Type of Services Provided by Region Percentage of Regional Group
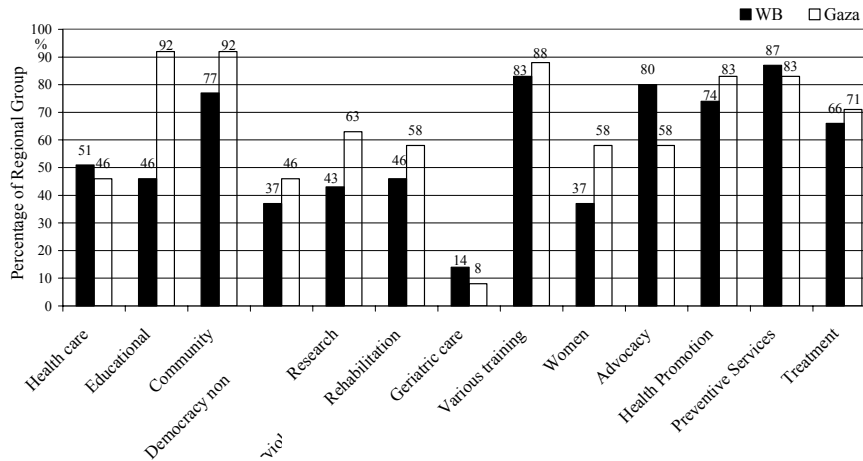
It is also interesting to note that 16 (46%) of the West Bank and 11 (46%) of Gaza institutions reported that they provide primary health care services along with psycho-social/ mental health care ones. These include the Ministry of Health, UNRWA Gaza, larger NGOs providing mainly primary health care services as well as smaller level NGO service providers focusing on children, the disabled and women. Fifteen West Bank (43%) and 11 (46%) Gaza institutions reported that psycho-social/ mental health services are provided at the site of developmental activities, 23 (66%) in the West Bank and 16 (67%) in Gaza within the school system, and 32 (91%) in the West Bank and 19 (79%) as freestanding services.

Of the total, 6 institutions in the West Bank and 3 in Gaza reported the availability of beds for the mentally ill with the large majority of beds provided by the Ministry of Health in both regions.   Reports indicated that the total number of beds available for the mentally ill is 323 in the West Bank and 41 in Gaza. None reported the availability of beds for the mentally ill in general hospitals. No private mental hospital exists in either region.

When we asked specifically about medication provision, 9 (26%) West Bank and 5 (21%) Gaza institutions reported that medication provision is part of the service, the Ministry of

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Health and selected non-governmental organizations. Of those using drugs, 6 West Bank and 4 Gaza institutions reported having developed an essential drug list. Table 2 and Chart 5 outline responses to questions pertaining to specific medications that are used in dealing with mental health problems:

**Table 2: Number of Institutions Reporting Using Medications
by Type and Name of Medication**

Type and Name of Medication	West Bank	Gaza
Antiepileptic drugs		
Carbamazepine	9	4
Ethosuximide	4	1
Phenobarbital	6	3
Diphenylhydantoin	7	4
Sodium valproate	5	3
Psychotropic drugs		
Amitriptyline	9	3
Chlorpromazine	7	4
Diazepam	7	4
Fluphenazine	5	3
Haloperidol	9	4
Lithium carbonate	5	3
Antiparkinson drugs		
Biperiden	4	1
Carbidopa	6	2
Levodopa	6	4

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**Chart 5: Number of Institutions Reporting Using Medications
by Type and Name of Medication**
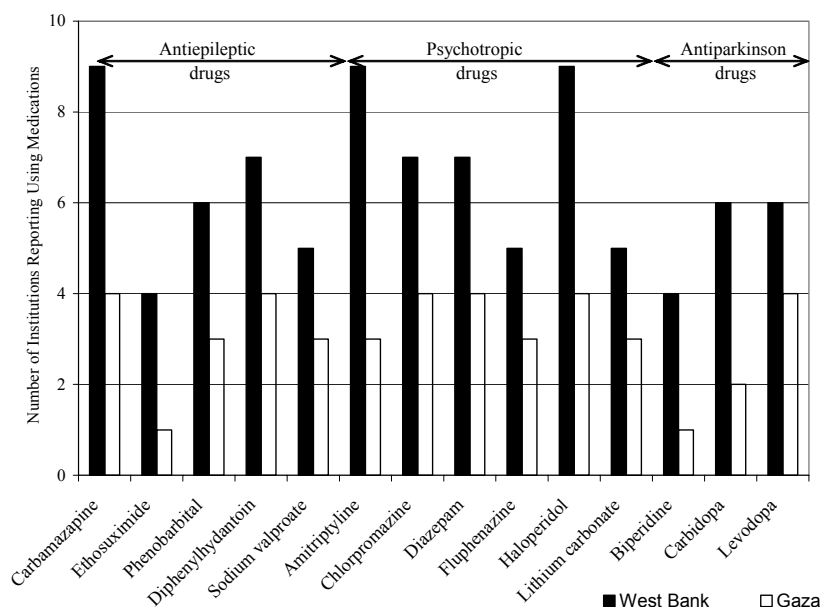
Type of Cases

The directors were asked to report on the type of cases that they generally dealt with. Table 3 and Chart 6a summarize the perception reports of the directors, divided in categories related to Intifada conditions versus what was seen as non-Intifada related cases (ordinary cases seen without the extra traumatizing factors of current conditions). Of course, as is common in the field of mental health, it is often difficult to link problems to specific causes and pre-existing and current stressors may well have interacted to produce or exacerbate problems within a population. Given the lack of standardized methods for case diagnosis as well, these results should be read with caution.

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Table 3: Percentage of Directors Reporting Dealing with Specific Problems.

Problem Type	Intifada Related		Non-Intifada Related		Both	
	WB	Gaza	WB	Gaza	WB	Gaza
Depression	17%	21%	11%	8%	60%	63%
Anxiety	14%	8%	9%	0	71%	83%
Phobias	12%	17%	6%	0	69%	67%
Physical disability counseling	9%	13%	6%	4%	43%	54%
Chronic disease counseling	9%	8%	11%	8%	31%	25%
Grief counseling	23%	13%	3%	8%	57%	67%
Acts of war counseling	83%	75%	9%	0	0	0
Stress management	20%	13%	9%	0	69%	75%
Psycho-somatic disorders	20%	8%	3%	0	60%	75%

Chart 6a: Percentage of Directors Reporting Dealing with Specific Problems

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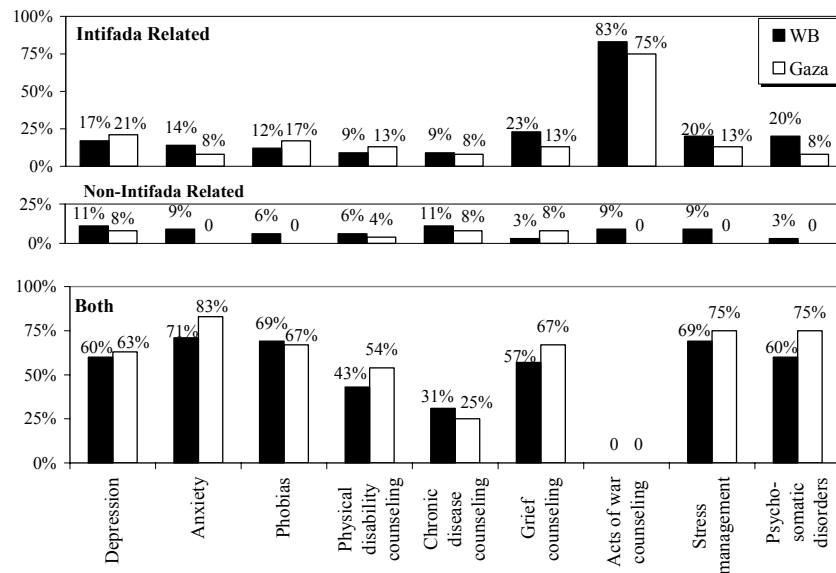
In addition, directors also reported on cases that have existed all along in society (Chart 6b):

Chart 6b: Percentage of Directors Reporting Dealing with Specific Problems

	Rape	Spouse abuse	Child abuse	Schizophrenia	Psychosis	Substance abuse
■ WB	54%	66%	71%	31%	60%	31%
☐ Gaza	33%	71%	83%	25%	33%	13%
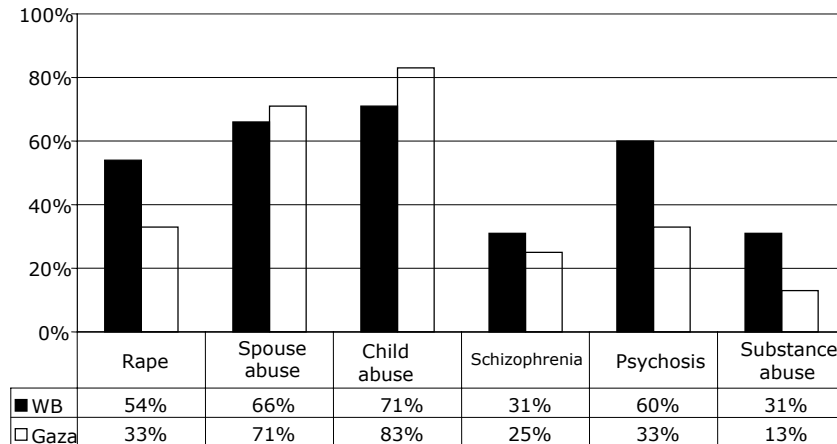
We found a range of other cases that were also noted as important by the directors of these institutions. These include paranoia, personality disorders, enuresis, conduct disorder, autism, Post Traumatic Stress Disorder (PTSD), unspecified trauma management, rehabilitation of disabled people, rehabilitation of drug addicts, student and teacher relations, aggression, loss of confidence, maladjustment, hysterical disorders, collective counseling, physical abuse, crisis interventions of various sorts, learning difficulties, youth leadership training and other such schemes. In a nutshell, it appears the range of cases is so wide it is difficult to identify priorities for both training and action based solely on case types presented by the directors.

In the area of substance abuse services, 11 (31%) West Bank and 3 (13%) Gaza institutions reported dealing with such cases. However, only one West Bank institution was able to furnish written documentation on its operational program. Of these, 6 West Bank and one Gaza institutions reported providing treatment in this area, 8 West Bank and one Gaza in advocacy, health promotion and prevention each, and 3 West Bank institutions and one Gaza institution in the rehabilitation of substance abusers.

Case Load

Based on reports from institutional directors, we found that the range of individual case load is very wide, with a minimum of 5 cases served per month in the West bank and 3 in Gaza, to a maximum of 500 in the West Bank and 300 in Gaza before the Uprising. Since the beginning of the Uprising, a minimum of one in the West Bank and 8 in Gaza and a maximum of 1200 cases in the West Bank and 1500 in Gaza per month were reported. Assuming that the reported statistics are valid, we found that, out of the 19 institutions in the West Bank and 13 in Gaza that were able to provide some figures for pre-Intifada times, each served an average of 105 cases in the West Bank and 71 in Gaza per month. These figures do not include group work and other activities related to the field that were reported by the directors.

Reports on case load from 21 institutions in the West Bank and 18 in Gaza revealed that case loads have more than doubled since the beginning of the Uprising, averaging 248 cases in the West Bank and 186 in Gaza per institution other than group work, indicating an observed rise in cases dealing with psychological distress during the Uprising period. These figures represent an under-estimate of the actual figures as many of these institutions reported engaging in group work while others also participated in psycho-social/ mental health care in various capacities. However, these were not eligible for inclusion in this study due to the absence or insufficiency of information systems to allow us to obtain definitive results. In addition, problems related to accessibility and stigma associated with seeking psycho-social/ mental health services do not allow us to yield conclusive results. It is impossible to estimate from our survey the numbers within the population that are involved in group activities. Given the retrospective nature of this study, the data on cases before the Uprising may be subject to some bias and therefore need to be interpreted with care. It is also possible that rising case loads may be partially but not entirely related to an increase in service availability and in case identification during the Intifada period.

Practiced techniques and methods

We investigated the techniques, methods and practices most commonly reported in these institutions. According to the directors, the following techniques and methods were being used at their institutions (Chart 7):

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Chart 7: Percentage of Directors Reporting Dealing with Specific Techniques

Method/ Technique used	Individual counseling	Group counseling	Educational interventions within community	Social work activities within community	Behavioral therapy	Cognitive therapy	Cognitive behavioral therapy	Debriefing/ defusing	EMDR	Psychoanalysis	Drug therapy
West Bank	91%	91%	94%	100%	54%	40%	46%	89%	23%	34%	26%
Gaza	100%	92%	79%	92%	71%	42%	50%	92%	8%	46%	21%
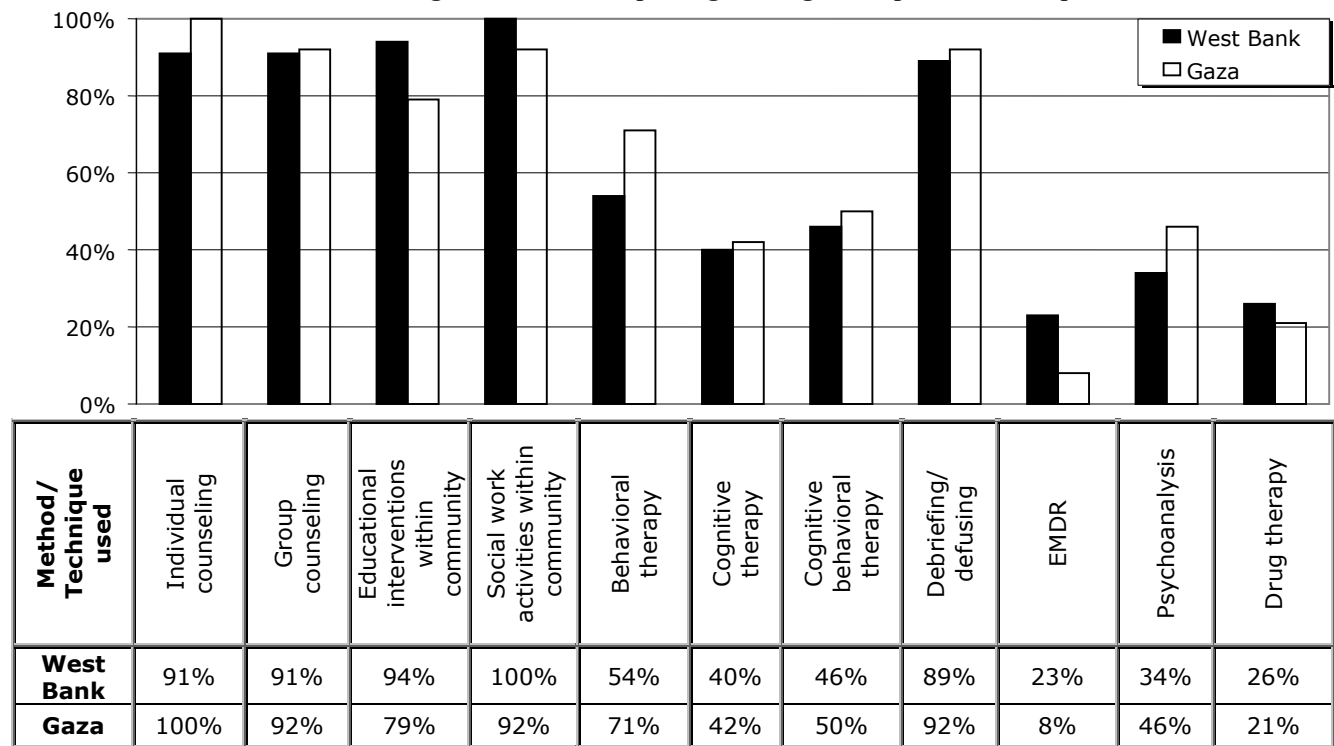
Other methods of trauma/ psycho-social/ mental health management were reported as being used by one institution each. The many techniques that were used at these institutions include family counseling, conflict resolution training, art therapy (drawing), counseling through play, drama therapy, music therapy, medication use, dynamic therapy, gestalt and insight therapy and even 'electrical sessions' (perhaps referring to ECT). Evidently, this nascent system is quite eclectic in nature and it is not clear if the methods used achieve the desired effects, as in the main, an evaluation system is absent.

It is also important to note that the standardizing of methods is not the issue at stake here mainly because different methods of management are required to deal with different types of situations. Rather, the issue forces us to examine questions related to the need to practice these methods or perhaps even alternative ones, the qualification and supervision of those practicing them and evidence for their effectiveness. A further question to be raised is whether other more effective forms of support can be utilized. As an alternative form of support, existing communal structures and relations can be strengthened to help individuals cope rather than relying on individual-oriented 'techniques and therapy'. As an offshoot of a biomedical model, this modality can divorce humans from their context. Nonetheless, it seems to attract the attention of a seemingly sizeable proportion of care providers.

While there is little doubt some psychologically distressed persons do benefit from individual or other forms of therapies, it is equally true that many distressed individuals exposed to traumatic events will recover at some point without therapeutic services. In such cases, support from the family and the community can do much to enhance natural recovery. The efforts of counselors to enrich and build this already existing network of support appear to be worthwhile treatment interventions particularly within the context of a Palestinian society. A community-based approach to help individuals 'get back on track' is worth further exploration.

Rather than expose individuals to multiple sessions of therapy that may contribute to an 'inducing' of disease, efforts should be made to reinforce an existing support structure. We should also be careful not to inadvertently place subjects in a passive and helpless mode that can come with the territory of clinical

diagnosis and therapies. They can exacerbate distress and raise expectations that therapies are always necessary or that techniques will invariably lead to the 'disappearing' of traumatic events. Objectively, within the Palestinian context, traumatic events have persisted for generations and are not likely to disappear in the near future.

It is impossible to evaluate the outcome/success resulting from the use of such techniques since record keeping, supervision, referral and re-referral, and follow up elements are either deficient or lacking altogether, among other considerations. Having said that, it does seem important to work with these institutions to develop tailor-made evaluation systems geared towards assessing the efficacy of their activities. The development of such systems will help to avoid the waste of unnecessary resources while putting the appropriate emphasis on 'activities and techniques' without at the same time claiming undue success in assisting the population. Through carefully designed evaluations, institutions will be in a better position to identify what practices work and what do not, when and how. This formalized procedure is critical especially within a Palestinian context where the chronic nature of conflict and psychological distress seem to have no end in sight.

Such evaluation mechanisms will need to incorporate qualitative aspects and not merely the quantitative reports that institutional bureaucracies and aid agencies have come to expect; they need to be continuous and consistent focusing not just on outcomes but also on the counselors themselves. They should take into account the dynamics of interaction, cooperation and learning created within the organization as well as between the organization and other organizations working in a similar field. In other words, although this form of evaluation is not easy to implement and does not lend itself to ready acceptance by either bureaucracies or aid agencies, it nevertheless remains essential and a necessity.

THE CAREGIVERS' REPORTS

THE CAREGIVERS' REPORTS

General Characteristics

Chart 8: Distribution of Caregivers by Type of Institution

UNRWA
15%

Non-Governmental
35%
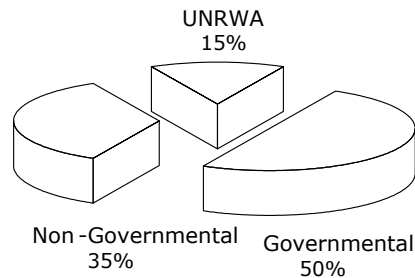
Governmental
50%

Fifty percent of respondents reported they were working within governmental institutions, 35% with NGOs and 15% with UNRWA at the times of the survey (Chart 8). Of the total number of workers, 59% of respondents from the West Bank and 57% from Gaza worked as counselors in schools, at governmental and UNRWA facilities, while the remainder were employed in other specialist organizations which include both NGOs as well as Ministry of Health facilities and the Ministry of Social Affairs' program for Youth with special problems. Overall, 46% of our respondents were men and 54% women (Chart 9).

Chart 9: Overall Distribution of Caregivers by Sex

Women
54%

Men
46%
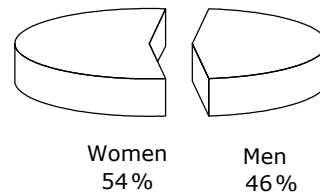
Of the counselors, 48% in the West Bank and 49% in Gaza were men, leaving women to occupy the remainder of the positions. Women seem to be better represented in the specialized psycho-social/ mental health service in the West Bank, with 68% of women working in these institutions compared to 32% for men. The sex distribution of workers included in this study and working in specialist institutions in Gaza seems to take the opposite pattern with 41% of the workers there being women compared to 59% men (Chart 10).

One cannot ascertain the male/female employee ratio in these institutions because not all the workers participated in the study. Nonetheless, it is important to stress here that the care-taking counseling role is in keeping with society's expectation of women and their role as family caretakers. In addition, the way students are streamed at the beginning of high school and into

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university education tend to push more women into the social sciences/ psychology streams than men. What is interesting here is that despite these constraints, counseling, especially in schools, has inadvertently offset the local, perhaps even universal tendency towards the feminization of 'care'. As a matter of local cultural necessity, by employing male counselors in male schools and female counselors in female schools, an unintended positive consequence has been the de-feminization of the counseling profession.

**Chart 10: Distribution of Caregivers
by Sex, by Type of Work, and by Region**
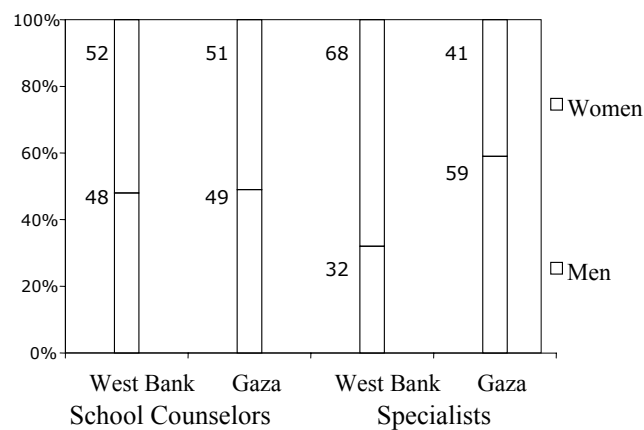
Qualifications of Caregivers

The majority of these caregivers are holders of Bachelors degrees (92% for the West Bank and Gaza each), mostly in psychology and social science/ social work. We found that 6 of the West Bank and 11 of the Gaza respondents were psychiatrists, 5% for the West Bank and 3.5% for Gaza Masters degree holders, with 9 West Bankers and 10 Gazans reporting they were Masters level trained clinical psychologists. The rest obtained their post graduate degree in a variety of fields including education, counseling, educational counseling, educational administration and social work. We also found 7 in the West Bank and 3 in Gaza who have received only post high school level diploma training. The majority of school counselors (98% for the West Bank and Gaza each) were Bachelors degree

holders compared to 84% among the specialized workers each for the two regions.

Drawing on the directors' report, we found that 10 institutions in the West Bank and 3 in Gaza employed psychiatrists; 16 in the West Bank and 9 in Gaza employed clinical psychologists; none of the institutions in either the West Bank or Gaza reported employing neurosurgeons (it is doubtful that one is available in the country); one institution in the West Bank and 3 in Gaza employed neurologists; and, 2 institutions in the West Bank and 5 in Gaza employed psychiatric nurses. It is impossible to determine the number of specialized mental health professionals working in the country since an adequate registration system for these professionals is still absent. An agreed upon accreditation of specializations is also lacking and given the scarcity of this category of human resource, these specialists tend to work in more than one institution. Because of their simultaneous employment in more than one institution, the task of keeping track how many specialists work where becomes an impossible if not ultimately futile exercise.

There were no significant differences in the level of education by sex for the West Bank workers. However, differences were noted for Gaza, with 6% of the males reporting being Masters degree holders compared to 1% for females, and with 88% of males reporting being Bachelors degree holders compared to 96% for females (x^2=8.307, p=0.029). Women workers reported having graduated with their Bachelors degrees significantly more recently than the males, with a high of 69% of women reporting having graduated since 1995 or later compared to 57% for males in both regions together (x^2=11.156, p=0.004). However, breaking down the data by region, the significance remained for the West Bank but disappeared for Gaza.

These data suggest a pattern observed elsewhere of the rising educational level of women over time, and more recently, with many more opportunities to study locally. The increasing incorporation of women into the labor force which comes as a consequence of their higher education is another observed pattern. The results on where these workers completed their higher education corroborates our observations in that a high of 79% of women reported having completed their higher education in West Bank or Gaza universities compared to 68%

for men (x^2=13.547, p=0.001). Thus access to local education taking into account how travel abroad poses difficulties for women because of the moral code, is partially determinant of these results.

The workers' pool seems to demonstrate limited work experience. Of the total, 19% earned their Bachelors degree between 1969 and 1987, 17% between 1988 and 1994, and a high of 64% between 1995 and 2002 (Chart 11). We also found that 9 of the 14 Masters Degree holders had earned their degrees between 2000-2003. The space created for job placement in the psycho-social/ mental health field in the latter part of the 1990's may well have influenced the streaming of students to the social sciences/ psychology post graduate specialties. The opening up of degree programs in these specialties in different universities of the West Bank beginning in the middle and latter 1990's may also have been of influence.

Chart 11: Year of Earning Bachelors Degree - Workers in West Bank and Gaza

1969 -1987
19%

1995-2002
64%

1988 - 1994
17%
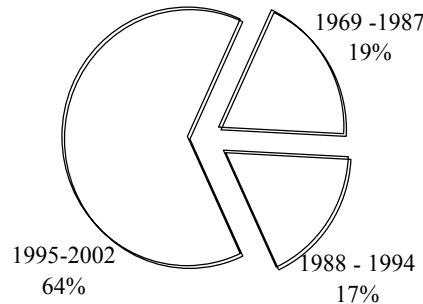
As expected, a sizeable proportion of these workers have graduated from local Universities (Chart 12). Al-Najah University alone boasts a high of 25% of these workers or 39% of the West Bank graduates and 3% of Gaza's; followed by 9% for al-Azhar University; 8% for

Chart 12: University of Graduation – Workers in West Bank and Gaza

Foreign Universities , 27%

Al-Najah University, 25%

Islamic University Of Gaza, 6%

Al- Azhar University,9%

Birzeit University, 7%

Al-Quds Open University, 8%

Al-Quds University, 3%

Bethlehem University, 8%

Hebron University, 7%

Bethlehem University and al-Quds Open University each; 7% for Hebron University and Birzeit University each; 6% for the Islamic University of Gaza and, 3% for al-Quds university thus bringing the total to 73% of the total staff having been trained locally. These results can only reinforce the need to carefully examine the curricula offered at local universities for their approach, content and suitability for local needs as well as for their orientation towards equipping these workers with the fundamental concepts, culturally relevant approaches and skills required to handle their practices upon graduation.

When asked how long they have been working in the institution at the time of our survey, the majority indicated they have been there only recently with an average of 3.98 years per worker, with 4.01 years for the West Bank and 3.95 for Gaza, (4.32 years for men and 3.61 for women), and with 47% having worked in their institution for 2 years or less, and 84% 6 years or less (Chart 13).

Chart 13: Years Working with the Current Institute

2 Years or less, 47%

More than 2 and up to 6, 37%

More than 6, 16%

When asked if they had held previous jobs, 59% responded positively for each of the West Bank and Gaza. Of those with previous jobs, many had held jobs unrelated to the type of work they were currently doing at the time of the survey ranging from working with the Jawwal Company (Palestine cellular phone, private company) all the way to the Ministry of Planning. These results confirmed that this body of workers tended to be not only younger but also pointed to their limited experience in handling psycho-social/ mental health work in 'normal' circumstances, let alone in these exceptional times. These results also highlighted the need to support them in every way possible to deal with the sometimes very difficult tasks at hand.

Type of Cases Caregiver Handle

In comparing the results obtained from the perceptions of directors and workers (and we stress, perceptions since the absence or insufficiency of information system and adequate diagnosis gets in the way of making concrete statements here) as to the type of cases that the workers handle, we found that, even with variations in reports, overall, the perceptions of directors and workers as to the type of cases dealt with do not differ dramatically (Table 4a and Chart 14a):

Table 4a: Percentage of Directors and Workers Reporting Dealing with Specific Problems -Total West Bank and Gaza

Problem Type	Intifada		Non-Intifada		Both		No		Missing*	
	Directors	*Workers*	*Directors*	*Workers*	*Directors*	*Workers*	*Directors*	*Workers*	*Directors*	*Workers*
Depression	16%	12%	9%	11%	67%	52%	5%	18%	3%	7%
Anxiety	12%	18%	4%	9%	80%	66%	3%	4%	1%	3%
Phobias	14%	23%	2%	8%	72%	61%	8%	5%	4%	3%
Physical disability counseling	7%	5%	5%	29%	59%	40%	22%	20%	7%	6%
Chronic disease counseling	6%	2%	9%	31%	37%	25%	39%	33%	9%	9%
Grief counseling	16%	16%	3%	10%	69%	55%	6%	14%	6%	5%
Stress management	15%	15%	3%	7%	77%	70%	5%	4%	0	4%
Psycho-somatic disorders	15%	14%	1%	9%	71%	57%	8%	15%	5%	5%

*: missing cases pertain to questions that were skipped by directors and workers, probably but not definitively because the institutions do not deal with such cases.

Chart 14a: Percentage of Directors and Workers Reporting Dealing with Specific Problems - Total West Bank and Gaza
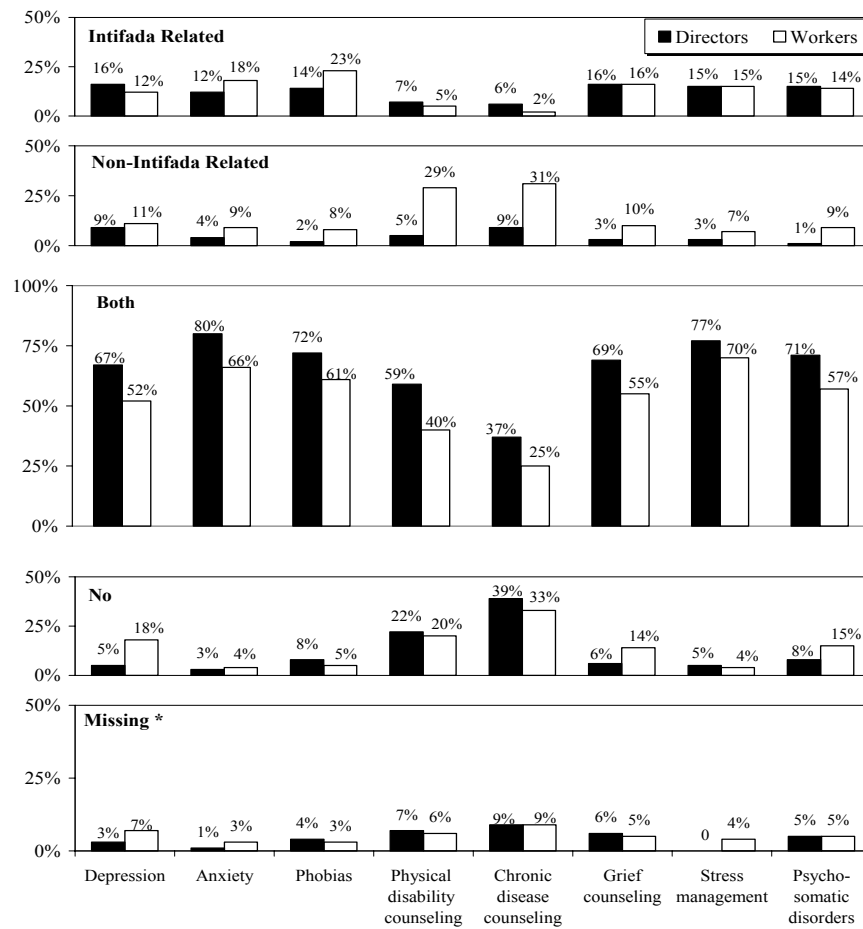
*: missing cases pertain to questions that were skipped by directors and workers, probably but not definitively because the institutions do not deal with such cases.

However, these results should be interpreted with great caution for the following reasons: distinctions between war related and non-war related pathologies are very difficult to identify, as many if not most mental health problems are related to interacting war and non war effects with varying proportions for each individual case. In addition, our psycho-social/ mental health workers are not necessarily that well trained to respond adequately to such a distinction. Hence, again, caution should be exercised in interpreting these results. What is interesting here though is the recognition by both directors and workers that mental health problems occur not merely because of

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external political causes but that they are also inherent within society itself and are internally generated as well.

Comparing directors and workers responses in relation to other conditions, we found the following (Table 4b and Chart 14b):

Table 4b: Percentage of Directors and Workers Reporting Dealing with Specific Problems-Total West Bank and Gaza

Problem Type	Yes		No		Missing*	
	Directors	Workers	Directors	Workers	Directors	Workers
Rape	51%	27%	34%	53%	15%	20%
Spouse abuse	57%	37%	23%	43%	20%	20%
Child abuse	80%	76%	9%	14%	11%	10%
Schizophrenia	29%	19%	51%	59%	20%	22%

* Missing cases pertain to questions that were skipped by directors and workers, probably but not definitively because the Institutions do not deal with such cases

Chart 14b: Percentage of Directors and Workers Reporting Dealing with Specific Problems - Total West Bank and Gaza

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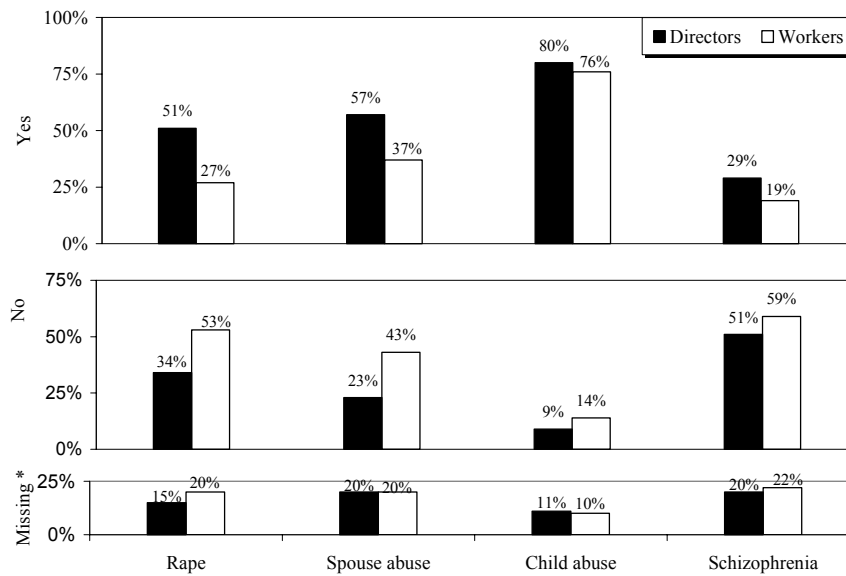
Generally speaking then, there seems to be a level of compatibility between the reports of directors and workers, given the variation in cases that one would expect by worker and by locale. However, this level of compatibility was not found in cases of rape, spousal abuse and schizophrenia where directors reported higher levels of engagement with such cases compared to workers' reports. This may be due to the fact that while some workers within the system deal with such cases, others do not. There may also be problems of confidentiality making it difficult to disclose certain case notes that may seem sensitive and constrained by cultural taboos**.**

Recoding these variables and excluding the missing cases, we found that, overall, the highest levels of reported cases that were perceived to be common and dealt with by workers, are related to anxiety and stress at 96% each being reported by workers, phobias at 95%, acts of war related cases at 86%, grief and child abuse at 85% each, psychosomatic disorders at 84%, depression at 80%, and disability counseling at 79%. Chronic disease counseling stood at 64%, spousal abuse at 46%, rape at 34% with schizophrenia at 24% (Chart 15).

Chart 15: Percentage of Directors and Workers Reporting Dealing with Combined Specific Problems - Total West Bank and Gaza

	Anxiety	Stress	Phobias	Acts of war related	Grief	Child abuse	Psychosomatic disorders	Depression	Disability counseling	Chronic disease counseling	Spouse abuse	Rape	Schizophrenia
	96%	96%	95%	86%	85%	85%	84%	80%	79%	64%	46%	34%	24%
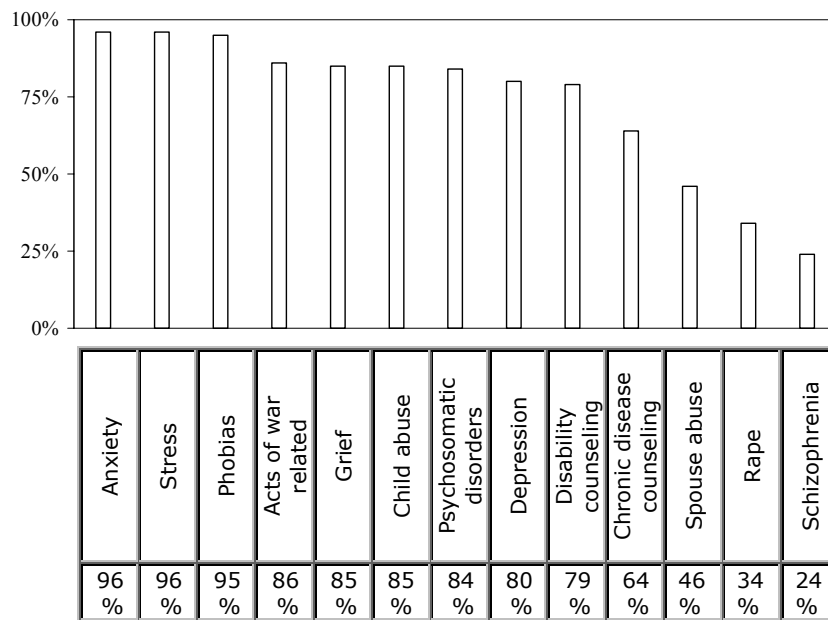
Although the results obtained above do not necessarily 'quantify' cases in terms of absolute numbers, they nevertheless, provide a general idea of the most commonly seen cases by type. These results do suggest that anxiety, stress and somatization of psychological distress, due perhaps to acts of war, as well as child abuse are important priorities for attention and action.

What may be of interest here is that we found that West Bank and Gaza workers reported dealing with anxiety, phobia, grief, stress, acts of war, schizophrenia and child abuse at almost similar levels. However, significant differences in reporting were observed for physical disability counseling, with 84% of Gaza workers reporting dealing with such cases compared to 75% for the West Bank ($x^2=8.573$, p=0.002); with chronic disease counseling, again with a higher of 73% for Gaza workers reporting dealing with such cases compared to 58% for the West Bank ones ($x^2=17.067$, p<0.00005); with psychosomatic cases where 88% of Gaza workers reported dealing with such cases compared to 81% for the West Bank ($x^2=6.322$, p=0.007); with depression where 85% of Gaza workers reported dealing with such cases compared to 77% for the West Bank ($x^2=5.884$, p=0.015); and, with spousal abuse where 55% of Gaza workers reported dealing with such cases compared to 42% for the West Bank ($x^2=9.566$, p=0.001).

For all such cases, a higher percentage of Gazan workers reported dealing with these cases compared to the West Bank workers. However, the picture reverses itself with rape where a high of 37% of West Bank workers reported dealing with such cases compared to a lower 27% for Gaza ($x^2=6.752$, p=0.006). These results are interesting in two ways. Firstly, they may be suggestive of the general orientation of institutions in Gaza compared to the West Bank in not picking up specific cases. Secondly, institutions in Gaza may not be in a position to directly confront certain sensitive social issues such as cases of rape where family members are usually the perpetrators and responsible for the offences. Robust epidemiological data on rape in the West Bank and Gaza is yet to be found and there is no reason to suspect that rape as a phenomenon is more prevalent in the West Bank compared to Gaza. Nonetheless, these results may suggest an increased willingness on the part of West Bank workers to disclose sensitive information and,

perhaps an increased willingness or capacity on the part of their institutions to address such a socially delicate issue as well.

In examining whether there were differences in response to type of cases seen by the institution where the worker is employed, important patterns were observable:

Table 5: Type of Case by Institutional Affiliation- Percentage of Affiliation Group - West Bank and Gaza*.

Case Type	Institutional Affiliation of Worker					
	Governmental		Non-Governmental		UNRWA	
	WB	Gaza	WB	Gaza	WB	Gaza
Physical disability	79		65		85	
Chronic disease	65	86	37	60	74	71
Stress management	97		96		90	
Psychosomatic cases	77		85		91	
Anxiety		98		91		97
Depression	76		85		61	
Grief		91		80		94
Acts of war	87		87		72	
Schizophrenia	26	19	29	39	5	0
Rape	32	25	52	42	21	6
Spouse abuse	29	42	69	80	29	29
Child abuse	88		83		57	

* All listed differences among institutions found to be statistically significant

Table 5 and Chart 16 are interesting in more than one respect. For the West Bank, UNRWA personnel reported working with physical disability and chronic disease counseling management in significantly higher levels, at 85% and 74% respectively than governmental and non-governmental organization workers, with the lowest rate for non-governmental organization at 65% and 37% respectively. For stress, psychosomatic cases, depression and acts of war, the pattern is conflicting with each of the three institutional groups showing the highest rates for one of the seen symptoms. With spousal abuse, rape and schizophrenia cases, non-governmental organizations consistently reported the highest levels at dealing with such cases, while perhaps understandably, child abuse is reported at the highest levels (88%) for governmental workers, mostly within the school system.

As for Gaza, the table indicates an element of specialization as well with the highest reports of schizophrenia case management emerging from NGO workers at 39% compared to 19% for

governmental workers and none for UNRWA. A similar pattern can be found in the West Bank for rape cases, with 42% of the NGO workers reporting dealing with such cases compared to 25% for governmental workers and 6% for UNRWA. Likewise with spousal abuse where non-governmental institutions seemed to report the highest levels of dealing with such cases at 80% compared to 42% for governmental and 29% for UNRWA workers.

Chart 16: Type of Case by Institutional Affiliation- Percentage of Affiliation Group - West Bank and Gaza
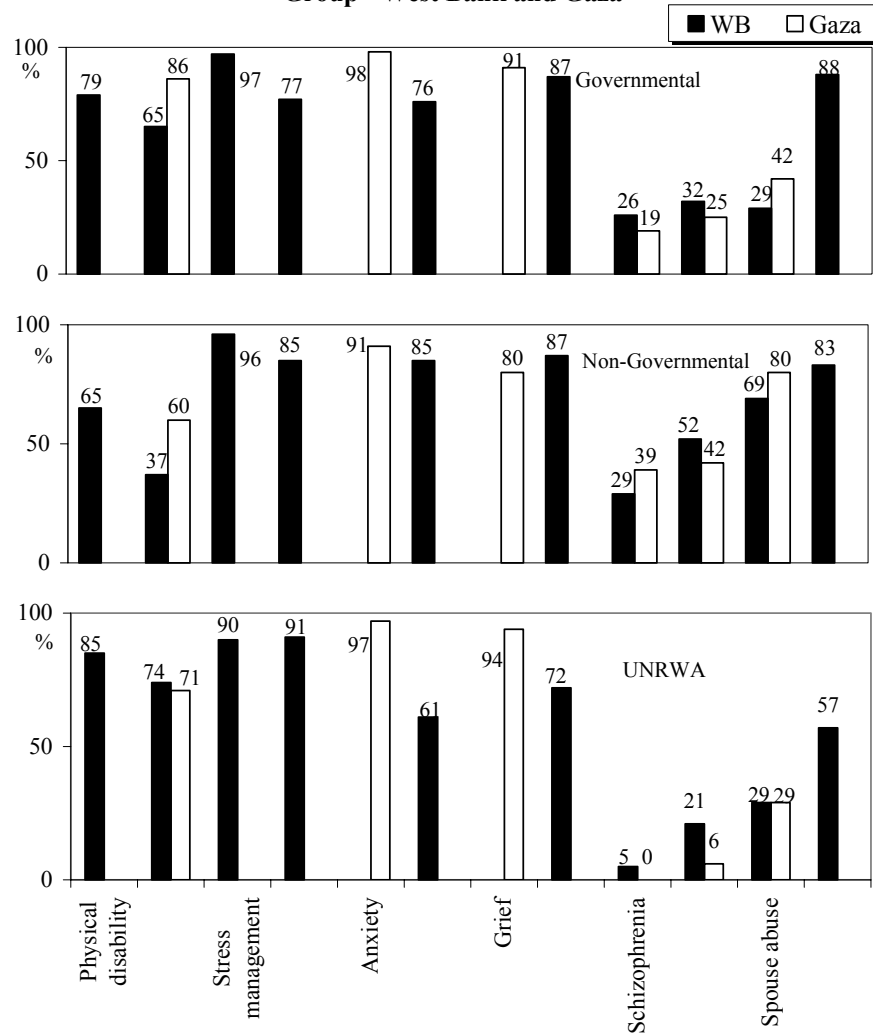
These results may be suggestive of tendencies towards some form of specialization, based on the institution, with non-governmental organizations apparently focusing especially on the abuse of women.   All seemed to focus on general psychological distress probably due in large part to the consequences of war that have affected the country since September of 2000.   How one can benefit from this perceived higher level of experience found in one institutional group and not the other, is a question that bears some consideration.   At the very least, one can reformulate ways of developing referral and re-referral cooperation systems between these institutional structures especially when confronted with difficult to handle cases

Most Common Cases before and since the Uprising began

Without prompting, we also asked the workers about the most common type of cases they dealt with before and since the beginning of the Uprising. We regrouped their responses into several categories: **emotional problems** (such as fears of all sorts, anxieties, grief, nightmares, anger and stress); **behavioral problems** (such as aggressive behavior, hyperactivity, use of illicit drugs, loss of appetite, jealousy, rebelliousness, attempted suicide, destruction of property of others and lying [in one case, we had a report of fingernail biting specifically noted as a behavioral problem, and in another, thumb sucking - we excluded these and other such cases from the analysis]); **somatic problems** (such as enuresis, encopresis, and other symptoms related to the belief that one is sick where there is no evidence of physical disease); **social problems** (such as divorce, marital discord, early marriage, social instability and problematic relations with others); **sources of stress that are war related** (such as torture, fear of checkpoints, guns and shelling, caring for the family of martyrs, and caring for the injured of the Uprising); **general abuse cases** (such as beating or being beaten by others, family violence, violence against women, violence against the elderly, violence of teachers against students, killings in the name of family honor protection, and denial of women their legal inheritance rights); **health problems** (such as dealing with cerebro-vascular accident cases, epilepsy, reproductive health and other health problems); **mental and psychiatric cases** (such as schizophrenia, acute stress reaction disorder, chronic stress conditions, nervous breakdowns, psychosis, mania, personality disorders and other such nervous disorders); **sexual abuse cases** (such as rape, incest, sexual problems, relations between the sexes and sexual deviance); **learning difficulties** (such as inability to concentrate, forgetfulness, difficulties at school in learning, language learning problems, stuttering and other educational problem cases); **disability cases** (such as physical disability, disability at birth, accident disabilities, hemiplegias and paraplegias and congenital malformations); and, **adjustment problems** (such as social maladjustment, difficulties in dealing with family, family maladjustment, school and other forms of maladjustment).

As Table 6 and Chart 17 below demonstrate, it appears that the workers perceptions support initial circumstantial evidence that an important change has taken place in the type of cases being seen by these workers before and since the beginning of the current Uprising. Once again, these results are not absolute results but only indicative of the most and least common cases

before and since the Uprising. As such, they provide a gauge rather than quantitative evidence of how case type has shifted as a result of war like conditions:

Table 6: Percentage Distribution of Most Common Case Reports in Groups - West Bank and Gaza and Total

Most Common Case Type	Before Uprising			Since Uprising		
	WB	Gaza	Total	WB	Gaza	Total
Emotional	30	32	31	75	74	74
Behavioral	28	27	28	34	37	35
Somatization#	3	6	4	17	25	20
Social*#	22	14	19	17	11	14
War related#	1	0.3	1	16	4	11
Abuse*	14	7	12	4	4	4
Health#	4	5	4	1	3	2
Mental psychiatric#	8	10	9	15	21	17
Sexual abuse*#	8	4	7	2	0	1
Learning difficulties*#	31	20	26	29	18	24
Physical disability*	7	3	5	5	6	6
Adjustment*	5	1	3	2	1	2

- *differences between the West Bank and Gaza in *pre* uprising rates were statistically significant.
- #differences between the West Bank and Gaza *since* uprising rates were statistically significant.

Chart 17: Percentage Distribution of Commonest Case Reports in Groups - West Bank and Gaza and Total
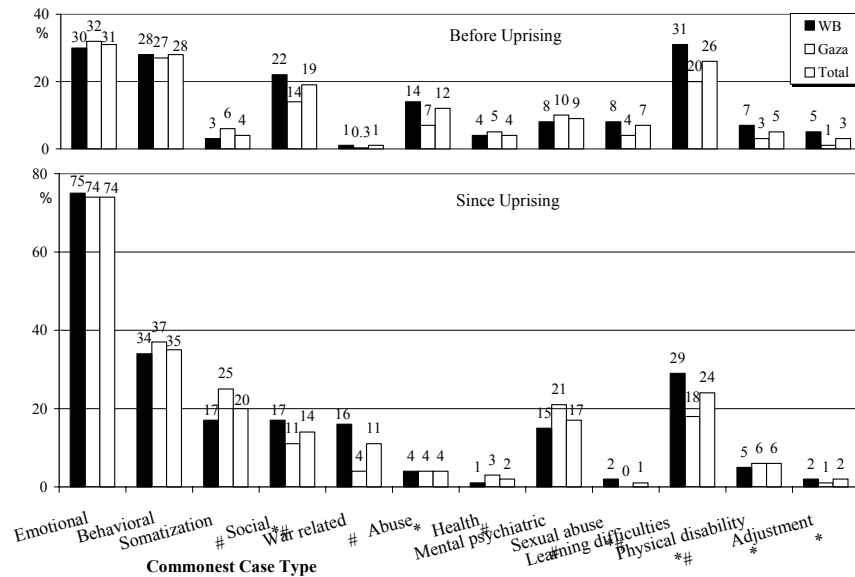
• *differences between the West Bank and Gaza in pre uprising rates were statistically significant.
• #differences between the West Bank and Gaza since uprising rates were statistically significant.

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The previous table demonstrates a generally similar pattern of change in the most common type of cases seen by workers before and since the beginning of the U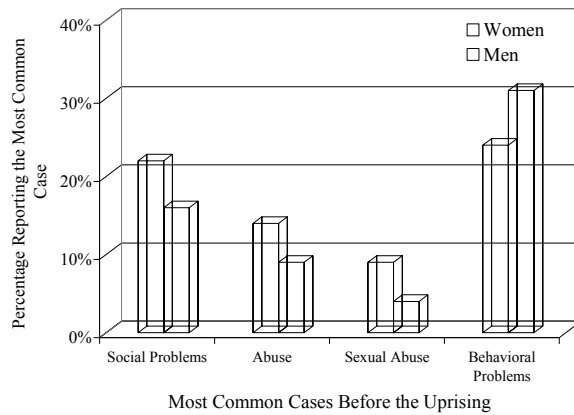prising for both the West Bank and Gaza. It should be noted that emotional problems were perceived by workers to be the most common problems since the beginning of the current Uprising, from 31% reporting that these were the most commonly encountered problems at least once before the Uprising to a high of 74% for the West Bank and Gaza combined. Diagnosable psychiatric problems appeared to have become more common since the Uprising began as well, from 9% reporting them as the most common at least once before to 17% since the beginning of the Uprising. This is likewise with somatization with reports ranging from 4% before and up to 20% since the beginning of the Uprising. Evidently, the most common cases encountered since the beginning of the Uprising appeared to be related to emergency conditions and probably a shift in case load towards crisis intervention.

According to workers' perception, some categories of problems that appeared to be on the rise have taken over other types of work including learning difficulties, social problems, abuse, sexual abuse, adjustment and health problems. Clearly, this does not imply that workers are only dealing with cases from the groups that have increased in levels nor does it mean that cases of behavioral and social problems, and learning difficulties have decreased. The results instead, demonstrate that based on the perception of workers, the major portion of their work has perhaps now shifted to dealing with the new emergency situation. With such an increase in work volume, other types of interventions have assumed less importance and priority. Given our findings in part one of this report suggesting an increase in the number of cases per worker to more than double the case load since the Uprising years began, it may well be that the size of this increase is related to handling people in crisis. The Uprising conditions have created a sizeable number of certain types of cases and thus marginalizing other types of cases that these workers have to handle.

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We found some differences in responses to the question of most common cases dealt with before the Uprising by sex of respondent, but not since the beginning of the Uprising. Again this may be an indication of a general crisis intervention mode affecting everyone. For reports related to the most common cases before the

Chart 18: Percentage of Respondents Reporting Commonest Cases (Before Uprising) - By Sex

Uprising, Chart 18 demonstrates that 22% of the women reported social problems as problems that were most common in their work compared to 16% for men (x^2= 3.566, p=0.036); 14% reported abuse as most common cases compared to 9% for men (x^2=3.543, p=0.038); 9% reported sexual abuse problems as most common compared to 4% for men (x^2= 7.171, p=0.005). Interestingly, the picture reverses itself for behavioral problems, where a high of 31% of men reported this to be the most common problem before the Uprising compared to 24% among women (x^2=5.083, p=0.015). It is likely that these differences relate to the fact that women workers worked primarily with girls and women while men dealt with boys and men, influencing perceptions as to what cases are most common in the context of their practice and consequently, with higher behavioral problems reported for males compared to females.

Variations in responses in relation to the work setting (school counseling versus specialized services) were also noted for common problems *before and since* the beginning of the uprising (Chart 19). Differences in pre-Uprising responses were noted for behavioral problems at higher levels, as one would expect, among the school counselors (37%) compared to 18% among the specialized workers (x^2=43.875, p<0.00005); in learning difficulties, at 40% of the school counselors compared to 7% among the specialized workers (x^2=108.710,

p<0.00005); in social problems at 22% of school counselors compared to a lesser 15% for specialized workers (x^2=6.173, p=0.008); in adjustment problems at 5% for school counselors compared to 1% for specialized workers (x^2=7.597, p=0.004); and the contrast between abuse at 9% for school counselors with 15% for specialized workers (x^2=6.894, p=0.006); in counseling the disabled at 1% for school counselors compared to 11% for the specialized workers (x^2=43.557, p<0.0005); in psychiatric ones at 3% of school counselors compared to 18% for specialized workers (x^2=56.370, p<0.00005); and, sexual abuse at 5% of school counselors and 10% for specialized workers (x^2=8.307, p=0.003).

Since Uprising reports yield similar results indicating differences in case type by setting, with a high of 79% of school counselors reporting emotional problems as common compared to 68% among the specialists (x^2=11.383, p=0.001); 43% of school counselors reporting behavioral problems compared to 24% for the specialist workers (x^2=27.363, p<0.00005); with 13% of school counselors reporting dealing with mental psychiatric problems compared to 23% among the specialists (x^2=11.673, p<0.00005); with 36% of school counselors reporting learning difficulties as a common problem compared to 7% for the specialists (x^2=84.283, p<0.00005); and, with 10% of the specialists reporting dealing with physical disability cases compared to 2% for school counselors (x^2=21.931, p<0.00005). Clearly then, the most common cases reported are ultimately determined by the setting in which the caregivers operate, with behavioral problems, learning difficulties, social and adjustment problems occupying the attention of school counselors while the other more specific cases are relegated to more specialized institutions. These results point to differing work contexts dictating differing training needs, structures and processes in order to address needs more adequately.

Chart 19: Percentage Distribution of Commonest Case Reports in Groups - School Counseling versus Specialized Services [Pre and Since Uprising]
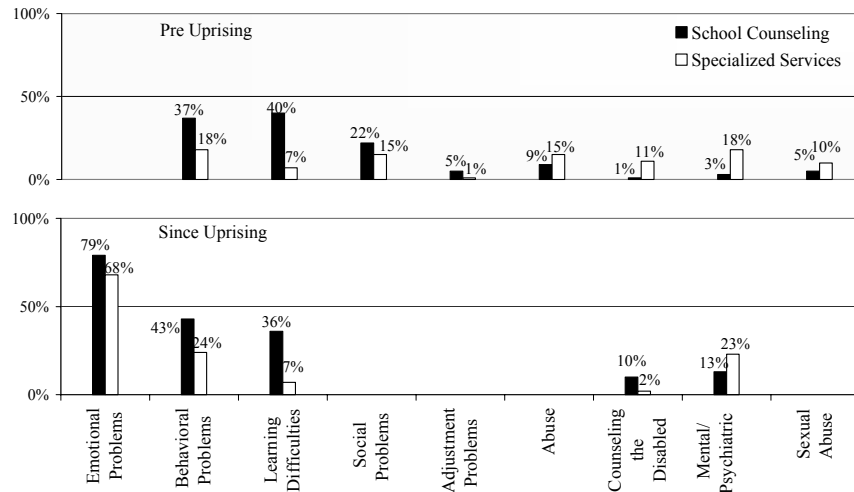
Overall, the results so far indicate:

1. That case loads since the beginning of the Uprising seemed to have increased substantially. Case loads have also shifted more towards crisis intervention with an important rise in somatization, emotional, psychiatric and other such indicative groups of problems. According to the workers, these constitute the most common type of cases that they are currently handling. This over-emphasis has led to the marginalizing of other types of work related to behavioral and adjustment problems, learning difficulties, social and abuse problems. This is understandable given the rapid deteoriation of political and daily life context in which people live and increasing levels of economic and material deprivation. Ironically, the collateral damage resulting from the so called 'targeted attacks' has, in the main, affected civilians.

2. That the structure within which workers operate (especially the distinction between school counselors and the specialized workers but also the distinction existing among the different specialist institutions), their assigned functions and type of cases they manage in real life determine not only their views of the most common cases that they encounter. More importantly perhaps,

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they partly help to elucidate the type of approaches and skills that they need for case management. These results point to the importance of developing training and upgrading schemes to respond to specific needs arising out of practice. Not only should they be tailor made to suit field requirements, they should directly relate to the structure and functions of specific programs. What is clearly less useful though, are training models (and not only therapies) of the wholesale-variety type imported from the outside without an evaluation for relevance or adaptability. There seems to be substantial and understandable differences in the functions of a school counselor compared with for instance, workers from non-governmental organization specializing in abuse. These different functions would require perhaps entirely different approaches to training, supervision and field work practices.

3. With a sizeable body of counselors located in schools while others work in the field of psycho-social/ mental health care (whether within the NGO structures or the Ministry of Health) with special focus on specific sectors of the population seeking help, the results of this investigation emphasize the need for inter and intra sectoral collaborative links to be created, developed, maintained and supervised. This perspective takes into account different specializations with what appears to be an NGO specialization of handling 'more difficult' cases as opposed to school counseling with its emphasis on a variety of tasks needing less specialization and a broader approach to support. Collaborative links should include and involve the Public Health Care (PHC) system in areas where these institutions operate. It is important to ensure the creation and development of PHC links because counselors need to rule out physiological problems through adequate physical screening before seeking other appropriate solutions to existing problems. At the same time, PHC centers are often good entry points for persons seeking help. Not only can they provide biomedical help, they can assist in the screening and referral to appropriate psycho-social/ mental health care institutions in their area and possibly specialized ones elsewhere.

On Case Load

There was a relatively high level of non response on monthly case load, indicating the presence of a deficient information system. However, those who provided responses divided their work load into cases that took time to deal with (long term cases) and others that took a relatively short period of time (short term cases). This was relevant to West Bank workers but not to Gaza ones. The average long term case load per employee that we found on the West Bank was 22 cases monthly per worker, similar to the average of 20 cases monthly obtained from directors' reports **(**non-response at 25%). For Gaza, the average was 29 long term cases per month, again with non response at 25%. The explanations provided for the non response included difficulty of predicting, too many or not available. The overall mean for both regions was 25 cases per worker per month. For short term cases, the level of non-response was very high for the West Bank, with only 29% of workers providing responses to this question. This question was thus omitted for Gaza, taking into consideration that it would have been very difficult if not impossible for workers to estimate the monthly case load given the realities of the information system on locale.

When workers were asked about whether this case load is too high or too low (Chart 20)**,** 55% thought the case load was adequate, 27% reported it was too high and 18% too low. Differences in responses were observed by region, with a higher 61% of Gazan workers reporting their case load as being adequate compared to 50% for West Bankers, 29% of West Bankers reporting a high case load compared to 24% for Gazans, and 21% of West Bankers reporting a low case load compared to 15% for Gazans (x^2=8.319, p=.016). That is, West Bankers seemed to perceive their work load in more extreme terms compared to the Gazans. Women tended to report adequate case loads, at 57% compared to 52% among the men, while 23% of the women thought their case load was too high compared to 31% among men, and with women reporting low case loads at 19% compared to 17% among men. While these results are of borderline statistical significance, it is still amusing to note this observed difference that is consistent with the insight held by some here regarding the division of labor between the sexes during these exceptional conditions

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contributing to the expression 'men complaining about conditions and women absorbing the jolts'.

Chart 20: Case Load Type - by Region, by Sex, and in Total
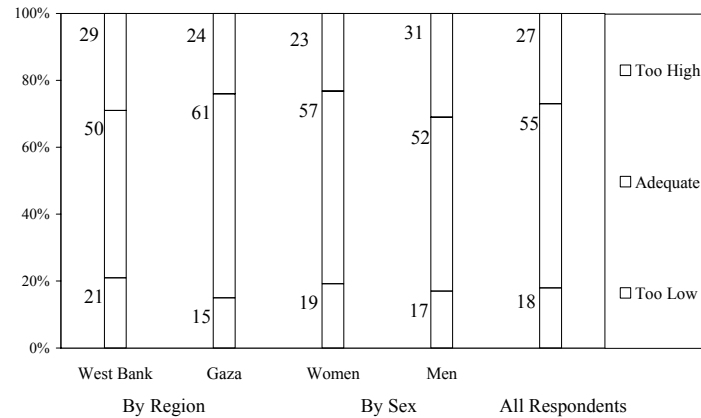
What may be interesting is the finding that those who reported the highest levels of emotional problems as the most common problems they encountered at the time of the survey, or in the period since the Uprising but not before, also reported that their case load is too high, at 29% of those reporting them also reporting the case load as too high. This is in comparison to those who did not report these as the most common, at 23% while 26% of those not reporting emotional problems were also those who reported low case loads compared to 16% among those reporting emotional problems as most important in their work (x^2=9.652, p=0.008). The tendency was similar for most other groups of problems encountered, with those reporting specific problems also reporting that their case load was high. What these data suggest then, is a link between the perception of the worker as to the most common type of problem and complaints about work load being too high, and that the problem of the most common reports may not only relate to actual cases at hand but also to the work load/overload that they have to deal with on a regular basis.

Practiced Techniques and Methods

Chart 21: Practiced Methods / Techniques, Percentage of Total Institutions – West Bank, Gaza and Total
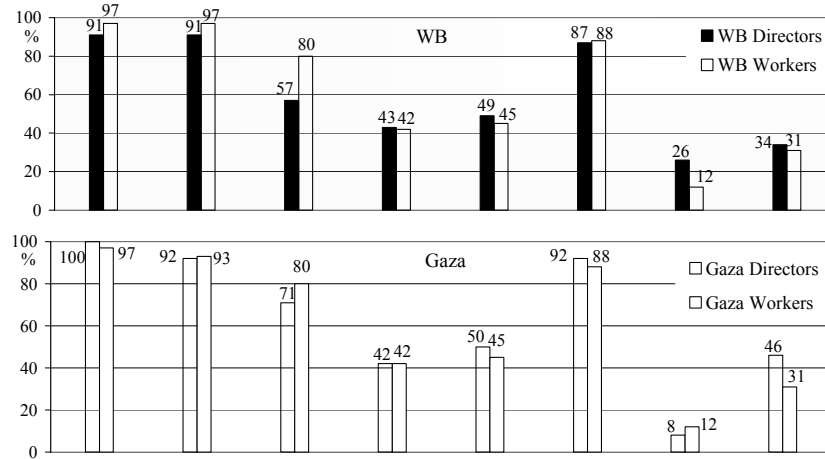
		Individual counseling	Group counseling	Behavioral therapy	Cognitive therapy	Cognitive behavioral therapy	Debriefing/ defusing	EMDR	Psychoanalysis
WB	D	91	91	57	43	49	87	26	34
	W	97	97	80	42	45	88	12	31
Gaza	D	100	92	71	42	50	92	8	46
	W	97	93	80	42	45	88	12	31

Chart 21 reveals a general comparability between directors' and workers' report, with high rates of using such methods as individual and group counseling, and debriefing (probably because these are simpler to learn by the generalist, and perhaps more appropriate particularly for the schools system) and lower rates for more 'sophisticated' techniques and therapies such as cognitive therapy, psychoanalysis and EMDR. Still, we found it remarkable that specialized techniques requiring higher skills and specialized education, training, and field supervision were reportedly used at the levels noted by

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both directors and caregivers. So, who then practices these techniques?

More male caregivers use group counseling techniques at 98% compared to 93% for females in the West Bank but not in Gaza where the results are similar by sex (x^2=4.619, p=0.024). More males reported using cognitive therapy techniques in Gaza at 70% compared to 54% for females (x^2=5.257, p=0.016); cognitive behavioral therapy is used more by men compared to women in Gaza, with 71% of men reporting using this method compared to 56% for women (x^2=5,357, p=0.015); and psychoanalysis as well is used at higher levels among men in Gaza at 54% of the men compared to 41% of the women (x^2=3.126, p=0.05), all once again suggesting a higher level of specialization among men in Gaza but not in the West Bank.

Group counseling seemed to be used considerably more by Bachelors degree holders, at 96% compared to 86% for Masters degree holders (x^2=7.493, p=0.05) but with similar levels for these two types of degree holders in Gaza. All responding psychiatrists, 67% of Masters degree holders and 53% of the Bachelors degree holders use cognitive therapy in their practice in the West Bank (x^2 =5.618, p=0.044), while 9 out of 11 psychiatrists, all Masters degree holders and 62% of Bachelors degree holders do so in Gaza (x^2=7.284, p=0.034). All responding psychiatrists, 71% of Masters degree holders and 53% of Bachelor degree holders use cognitive behavioral therapy in the West Bank (x^2=6.161, p=0.029), while 9 psychiatrists, 89% of Masters degree holders and 62% of Bachelors degree holders do so in Gaza (x^2=6.006, p=0.02). There were no significant differences by degree obtained in the other responses even for psychoanalysis and other techniques that may be quite difficult to practice. This again raises serious questions regarding the quality and effectiveness of these techniques that the workers report to be practicing, whether these techniques were in fact used or not, and whether indeed there were justifiable reasons for such techniques to be used given the type of work that school counselors especially are expected to perform.

We noted important differences in the use of specific techniques by type of work the respondent held, specifically whether holding counseling positions in schools or working in specialty institutions (Chart 22). All school counselors in the West Bank

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reported using individual counseling compared to 94% for specialized workers (x^2=15.349, p<0.00005) with no difference by specialty group for Gazans. Ninety nine percent of Gaza counselors reported using group counseling compared to 93% among the specialized workers (x^2=10.708, p=0.001) with no differences observed for West Bank workers. With no differences for West Bank workers, 96% of Gaza counselors reported using debriefing and defusing techniques compared to a lower 89% for the specialists (x^2=5.397, p=0.019). In contrast, 39% of school counselors reported using cognitive therapy compared to 79% among specialists in the West Bank (x^2=56.402, p<0.00005) with a similar pattern found for Gaza with 56% of school counselors reporting using this method compared to 71% among the specialists (x^2=5.047, p=0.017), 41% of counselors reported using cognitive behavioral therapy compared to 77% among the specialized in the West Bank (x^2=46.429, p<0.00005) again with similar results for Gaza with 58% of counselors reporting using this method compared to 71% among the specialists (x^2=4.069,p=0.03), and 13% reported using EMDR compared to 24% among the specialists in the West Bank (x^2=7.727, p=0.005) with no differences found among these two groups in Gaza and finally, 58% of the specialists in Gaza reporting using psychoanalysis compared 41% for the counselors (x^2=5.825, p=0.011) with no differences found for West Bank workers.

**Chart 22: Practiced Methods/Techniques, by Type of Work –
West Bank and Gaza**
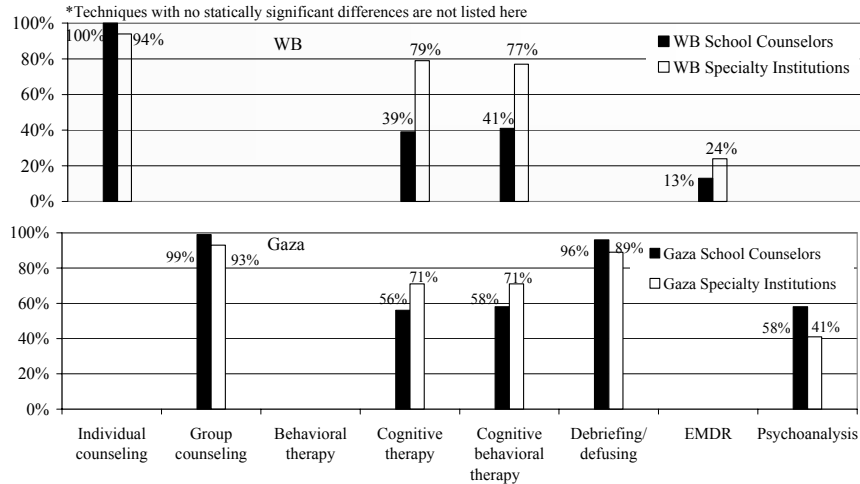
Non-governmental organization workers in the West Bank tended to report significantly less use of individual counseling at 93% compared to 100% for both governmental and UNRWA workers each (x^2=20.536, p<0.00005) with no differences observed for Gaza; all UNRWA workers in the West Bank and Gaza each reported using group counseling techniques compared to 97% for non-governmental organization workers in the West Bank and 93% for Gaza; curiously, the highest reports for behavioral therapy use came from governmental workers in the West Bank at 91% compared to 85% for non-governmental organization workers and 72% for UNRWA (x^2=12.112, p=0.002) with no observable differences among workers in Gaza and raising questions as to what exactly West Bank governmental workers mean by behavioral therapy. A high of 77% of non-governmental organization workers in the West Bank reported using cognitive therapy techniques compared to 46% for governmental and 35% for UNRWA workers (x^2=39.035, p<0.00005) with no observable differences for Gaza. Cognitive behavioral therapy again was most highly reported by non-governmental organization workers in the West Bank, at 74% compared to 49% for governmental ones and 30% for UNRWA's staff (x^2=31.052, p<0.00005) again with no noted differences for Gaza. In contrast, higher levels of debriefing use were noted for UNRWA and governmental Gaza

workers, at 96% each, compared to a lower 88% for non-governmental organizations (x^2=6.358, p=0.042). No other differences in institution type were noted.

Overall then, and although the above analysis demonstrates that specialists (non-governmental organizations to a large extent and the Ministry of Health) seemed to focus more on specialized techniques compared to counselors working in the school system, one nevertheless finds it astonishing that techniques entailing such a strong background with strict training and supervision should be used by generalists especially school counselors. These results raise concerns as to the meaning of these reports, the possible influence of the 'questionnaire effect', and the need for further in depth investigations focusing on how the methods are being used, why and with what type of outcomes. In addition, the results call for the development of monitoring and evaluation instruments that can assist in answering such questions as well as ascertain that the activities completed are relevant, culturally appropriate and effective.

In-Service Training and Continuing Education of Staff

Chart 23: In-Service Training and Continuing Education of Staff - West Bank & Gaza and Total
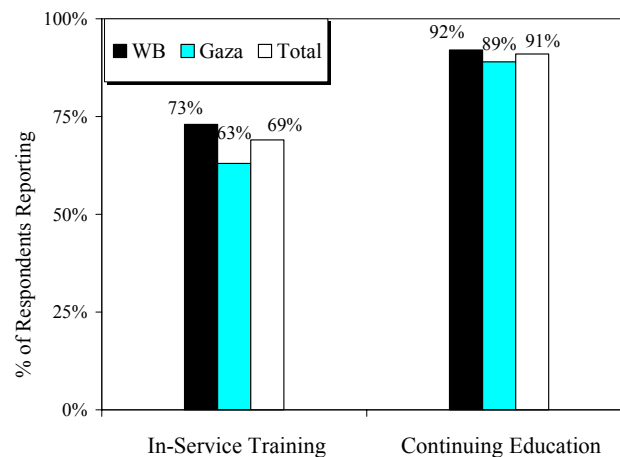
Of the workers who responded to this question (97%) in this study, 73% of West Bank workers and 63% of Gaza ones reported that they have had in-service training at their institutions, with an overall country rate of 69%, and with the differences between the West Bank and Gaza found to be statistically significant (x^2=8.646, p=0.002), indicating that in service training is a more frequent practice in the West Bank compared

to Gaza. For continuing education, the majority reported that they have attended such training while on the job, with 92% for the West Bank and 89% for Gaza and an overall rate of 91% (Chart 23).

When asked about the nature and content of in service training, workers reported a very wide range of training schemes. This range is partly understandable in view of the different aims and structural make up of institutions even though all work in psycho-social health. The range span human rights groups and conflict resolution ones, agricultural, cultural, developmental, women's and child rights groups, as well as providers of services to families, victims of violence, the disabled, drug addict, the elderly, as well as personnel working in health and in education, among other interests. However, the data also show the abundance of continuing education/upgrading schemes that have yet to be assessed in relation to utility, relevance and impact on practice in a real life and work setting.

Reports indicate that both men and women received the same level of in-service training, at 68% and 69% respectively each (Chart 24). Differences by type of institution were strong, with a high of 79% of non-governmental organization employees reporting having had in service training at the time of their employment compared to 69% for governmental workers with a low of 62% for UNRWA ones (x^2=18.242, p=<0.00005). Significantly more specialized workers reported attending in
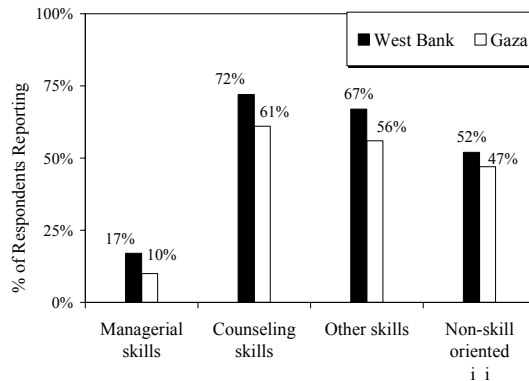
**Chart 24: In-Service Training
by Sex, by Type of Institution, and by Type of Work**

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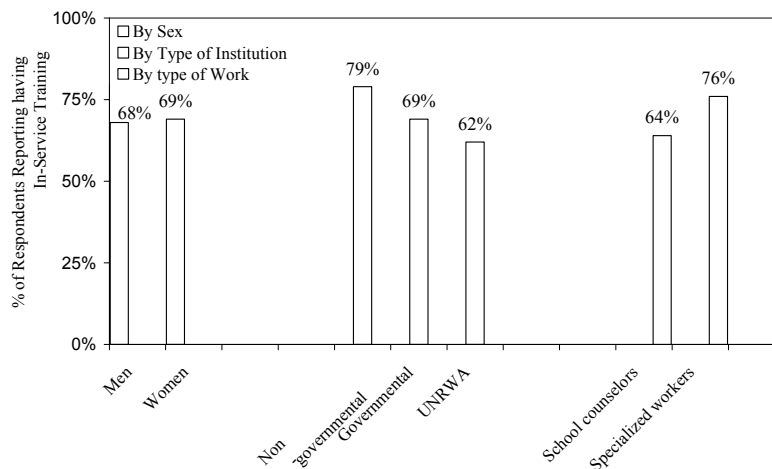
service training at 76% compared to 64% among the school counselors (x^2=12.689, p=0.004).

To make more sense out of the data, we regrouped the type of in service training/continuing education the workers reported having received into four groups: **managerial skills** (covering a range of skills from computer use to time management, planning, proposal writing, small project management, media and program development, workshop management, monitoring and evaluation, understanding internal bylaws among other such skills); **counseling skills** (including methods of group and individual counseling, hot-line counseling, the counseling of children, women, the disabled, the elderly, drug addicts, educational counseling as well as communication skills); **other skills oriented training** (ranging from therapeutic ones such as EMDR, Reiki, psychodynamic therapy, hypnosis, cognitive therapy and the like, as well as preventive ones such as drama and art work, CISM, stress management, field psychological support, trauma prevention, burnout prevention, trauma prevention, psychological imaginative techniques, teachers' training, learning through play, health record development, Palestinian sign language, psychometric testing, clinical psychology, family management and various forms of art skills); and, finally the last group pertaining to seemingly **non-technical skill oriented training (**including workshops on a wide range of topics such as psychological problems among children, the concept of death, psychology and disease, depression, fear, thumb sucking, the psychology of bereavement, despair, family development, violence against women, women's empowerment, motherhood, gender, women's and children's rights, the happy child, child protection, early marriage, teacher performance, facilitation, training methodologies, hospital management, culture, epidemiology, civil society, old people's care, voluntary work, democracy, first aid, maternal and child health care, health education, school health, modern education, problems at school, rape and violence, disability needs, scientific inquiry, jealousy among many other topics).

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Chart 25: In-Service Training of Workers by Type of Service - West Bank and Gaza

In all, Chart 25 demonstrates that 17% of West Bank and 10% of Gaza workers have had at least one managerial skill in service training scheme; 72% of West Bank and 61% of Gaza workers at least one type of counseling skill; 67% of West Bank and 56% of Gaza workers at least one type of other skill oriented in service training, and 52% of West Bank and 47% of Gaza workers other non skill oriented training. This brings the average to almost 2 in service training schemes per worker.

For continuing education, the majority reported that they have attended such training while on the job, with 92% for the West Bank and 89% for Gaza and an overall rate of 91%. Not only did a high of 92% reported that they have had continuing education but the more interesting finding is that 14% have had that chance once in the West Bank and 17% in Gaza, 18% twice for the West Bank and 26% for Gaza, 11% three times for the West Bank and 14% for Gaza, 12% four times for the West Bank and 10% for Gaza, 14% five times for the West Bank and 9% for Gaza, and 31% 6 and up to 20 sessions for the West Bank and 24 for Gaza! If we remember that the average working years for these employees is 4 years on the job, we find the average number of continuing education courses per person is 4.7 courses per person or 1.2 courses per person per year working in the current job.

The range of topics for which continuing education was attended was very wide, necessitating, once again, that we re-group responses into 4 categories, as noted in Chart 26 below:

Chart 26: Percentage of Workers who Attended Continuing Education Sessions at Least Once by Grouped Topics- West Bank, Gaza and Total

	Managerial skills	Counselling skills	Other skills	Other non skill general
■ West Bank	21	59	45	50
■ Gaza	12	46	34	63
□ Total	17	54	41	55

Grouped topic
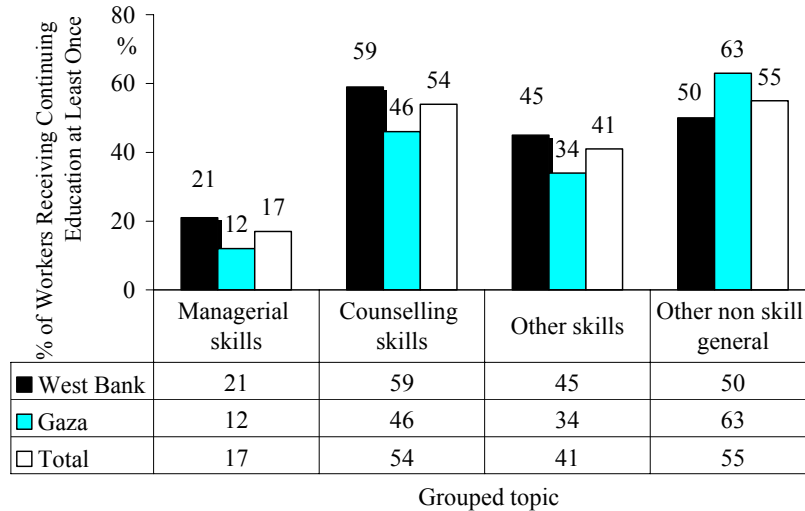
Overall, 17% have had from one and up to five continuing education management skill training, 54% from one and up to seven counseling skill training, 41% from one and up to six other skill training, and 55% from one and up to seven other non-skill oriented training (Chart 27). This is a very high rate of contact raising questions as to the utility, effectiveness and outcome of such training in the field, which we gather have not been evaluated seriously enough by all parties involved.

Chart 27: Percentage of Workers with Continuing Education Sessions at Least Once by Grouped Topics - Total West Bank and Gaza

1 to 7 Other non-skill oriented training 55%

1 to 6 Other skill 41%

1 to 7 Counseling skill training 54%

1 to 5 Continuing education management skill training 17%

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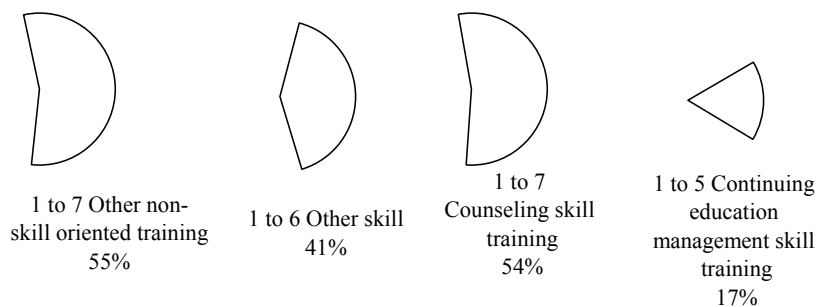
We found no differences in the frequency of continuing education overall received by these workers and by sex of employee, with higher levels of continuing education attendance at least once yearly among school counselors at 94% compared to 87% for the specialists (x^2=11.133, p=0.001). Non governmental organization employees had the lowest levels of continuing education schemes at 86% compared to 92% for UNRWA and 94% for governmental employees (x^2=11.539, p=0.003). This result confirms suggestions that school counselors appeared to be the most exposed to this apparent training flurry with the general conclusion that the availability of 'training' may be too high for all workers, perhaps too high for system building needs.

Training Needs

The surprising aspect is that, when the workers were asked if they thought they needed additional training, an overwhelming 90% responded positively, with 95% for the West Bank and 84% for Gaza. These results once again raise questions as to why they perceived training to be such a strong need. Given their reports of relatively abundant training at both the in service and continuing education levels, they raise serious concerns that the workers may be thinking that a solution to their problems at work (whether structural, managerial or otherwise) would lie with receiving more training. Questions also need to be asked as to the effectiveness of the previous training they have had.

One psychologist with substantial experience in the field of counseling in the West Bank and the Gaza Strip also indicated that the counselors were often aware of their limitations but that 'counselors often wait for the perfect trainer that will give them the secrets of the job, the key to success or the recipe books'. She adds 'they are not convinced that the solution to their problems at work is not adding short training sessions to make a real difference, but long term training, reading, with access to another language. So they continue to ask for more short term sessions'.

These observations may offer additional explanations to these findings that prove compatible with our previous experience in working with disability rehabilitation workers who deal with the disabled and their families. At the time of initiating this scheme (the late 1980's), it was striking to observe that everybody expected 'the magical cure of disability' from the nascent project as opposed to what we were actually offering that included: working on improving the possibilities of managing activities of daily living, working towards the social integration of the disabled, a gradual process of learning on the job after an initial classroom training period and, with problem solving in the field as a key approach. It took much effort to bring about the realization that disabilities were not going to disappear, and that what was needed was to deal with disabilities rationally and realistically. It also took years for some workers to come to terms with this disappointing reality, and even then, others continued to search for the instant if not magic answer.
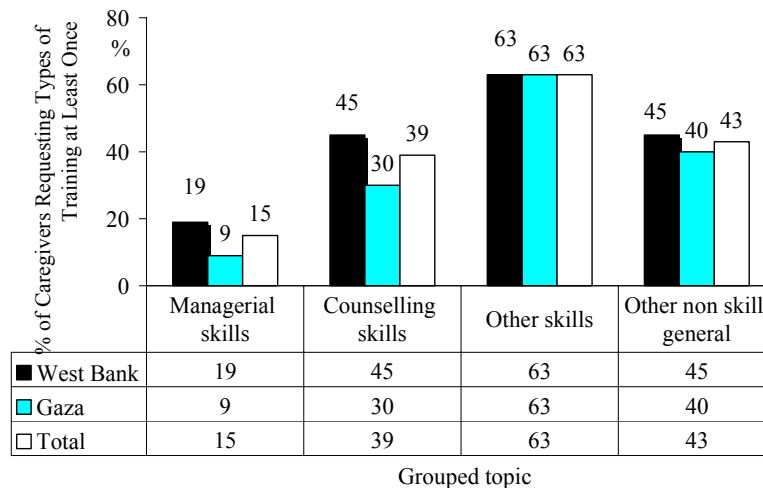
When asked about the type of training the workers thought were needed, once again, the range of responses appeared to be so wide it was difficult to determine whether these needs arose out of the imperatives of work (through associating training needs with service requirements and the type of institution the caregiver was employed in, for instance) or whether they represented a 'wish list' derived from other consideration reflecting more personal interests which may not correspond with need.

Categorization was again necessary. The list comprised of: **managerial skills** including aspects such as computer use and data entry, institutional administration, school administration, library administration, report and proposal writing, documentation and archive training, time management, planning and general administration, and, interestingly, administrative problem solving with teaching staff; **counseling skills** included the usual such as hot line counseling, school counseling, career counseling, family, women and child counseling, and wartime counseling; **therapeutic skills** including EMDR, psycho-analysis, cognitive behavioral therapy, drug therapy, play therapy, cognitive therapy, behavioral modification, and hypnosis among others; **preventive skills** such as containment strategies, relaxation methods, crisis intervention, stress management, and pressure reduction in moments of difficulties; **general psychological training less skill based but more theoretically oriented** such as understanding split personalities, general mental health, trauma, depression, psychological needs, grief, even neuro-psychology; **general topics related to women and their needs** such as abuse and sexual abuse, helping women solve their problems, dealing with the consequences of the Intifada on women and women's physical and mental health; **general child related topics**, as previously, with child growth and development, the rights of children, aggressions against children, child behavior, children and adolescence, counseling adolescents, how to deal with child mental health and early childhood; **general social topics** such as early marriage, sex education, how to help mothers deal with adolescent girls, social adjustment, social empowerment, dealing with the law, dealing with poverty and the like; **health and disability rehabilitation** such as reproductive health, principles of public health, principles of mental health and its relation to rehabilitation, first aid, managing the families of disabled

people, mental disabilities, and managing difficult disability cases; **general school related** such as academic achievement, how to manage exams during crises, student activity development, activities in class, managing teachers in schools, managing students in schools, educational topics and how to manage pressures in the classroom; and finally, **other topics, also general in nature** such as drawing, physical education, dance, psychodrama, research, data analysis, field work, questionnaire development, statistics, English language training, basic requirements to operationalize activities, networks of communication with other professionals to exchange experiences and even attendance at international conferences as a way of learning.

The final recodes revealed the following (Chart 28): 15% requested managerial skill training at least once, 19% on the West Bank and 9% in Gaza; 39% counseling skills, 45% in the West Bank and 30% in Gaza; 63% other skill oriented training for the West Bank and Gaza each; and, 43% other non-skill types of training needs, 45% in the West Bank and 40% in Gaza.

Chart 28: Percentage of Caregivers Requesting Types of Training, at Least Once for Each Training Skill.

|	Managerial skills	Counselling skills	Other skills	Other non skill general
■ West Bank	19	45	63	45
■ Gaza	9	30	63	40
□ Total	15	39	63	43

Grouped topic

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On having been trainers

We asked respondents to inform us if they have been participating as trainers in any training schemes. We were surprised to note that a high of 36%, 40% on the West Bank and 30% in Gaza, were engaged in training others (Chart 29). This was surprising especially in view of findings from this report indicating that the workers themselves felt the need for more training to manage the cases they deal with. Interestingly, significantly more male employees reported having participated in training others at 42% compared to females at 31% ($x^2=$ 8.301, p=0.004). Understandably, a high of 80% of Masters or higher level degree holders reported having been trainers compared to 31% for those with Bachelors degrees or less (x^2=46.059, p<0.00005). More employees from specialist institutions reported having been trainers at 43% compared to 31% for school counselors (x^2=9.996, p=0.001) and more non-governmental organization employees reported training others at 43% compared to 39% for governmental workers and 12% for UNRWA (x^2=33.866, p<0.00005).

While transferring skills and knowledge to others in an environment with a limited number of well established trainers may explain these findings, nonetheless these results remain worrisome. They raise serious concerns regarding the quality, relevance, effectiveness, utility and outcome of such training. Altogether they call for further investigation of training schemes, who does them, why, their qualifications and rationale, given the potential harm that can emerge from involvement in training with insufficient knowledge and experience, and the absence of relevant support and good supervision schemes.

Chart 29: Percentage of Caregivers who Participated as Trainers, by Region, by Sex, by Type of Work, by Type of Institution, and in Total
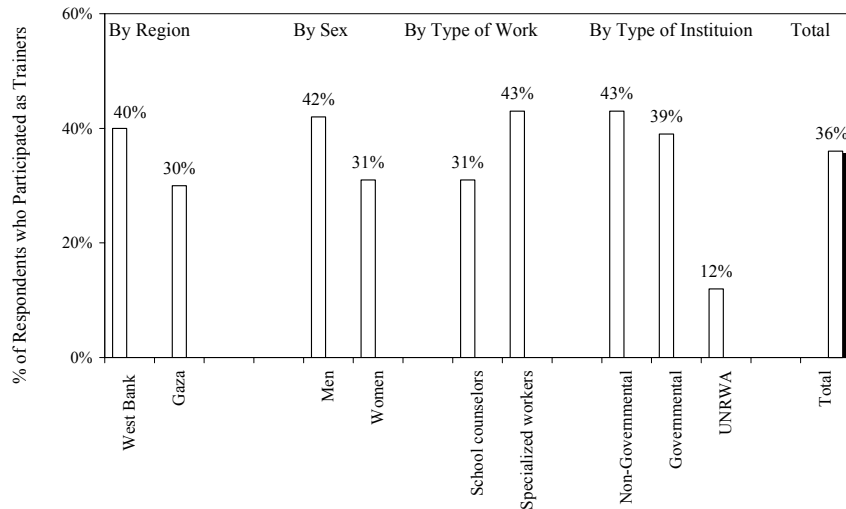

Obstacles to knowledge and performance improvement

We asked the caregivers to offer their opinions regarding the obstacles that they think get in the way of an improvement in their knowledge and performance at work. Overall, a high of 62% responded that they faced obstacles (Chart 30), with 70% for the West Bank and a significantly lower 50% for Gaza ($x^2 = 31.451$, p<0.00005). More school counselors reported obstacles at 65% compared to 58% among the specialists ($x^2 = 4.430$, p=0.035); 14 out of the 17 psychiatrists reported obstacles with similar results to other degree holders; with significantly more workers with degrees obtained from local universities reporting obstacles at 65% compared to 55% among those who received their education abroad ($x^2 = 30.009$, p<0.00005); and with a high of 70% of UNRWA workers reporting obstacles compared to 66% in governmental institutions and a low of 54% among non-governmental workers ($x^2 = 12.032$, p<0.002).

Controlling for region, we found that the highest levels of obstacle reports came from UNRWA West Bank workers at 96%, compared to 53% for UNRWA Gaza workers. This finding partially reflects a level of dissatisfaction related to what we understood as a problem of 'daily employment' as opposed to

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regular contracts that these workers were offered by UNRWA at the time, a situation that apparently reflects the instability of funding. Interestingly, there was also a significantly higher level of dissatisfaction among West Bank governmental workers at 74% compared to 49% for Gaza but no substantial

Chart 30: Percentage of Caregivers Reported Facing Obstacles, by Sex, by Type of Institution, by Type of Work, and by University of First Degree.
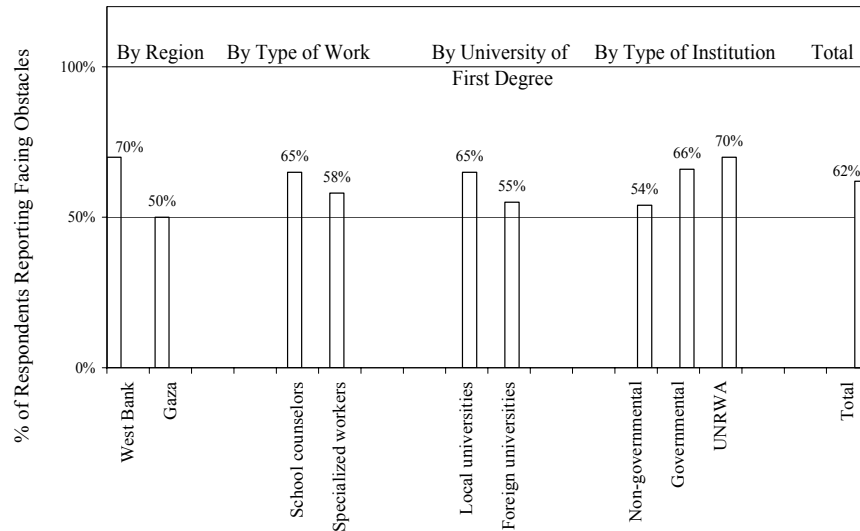
differences for NGO workers in the two regions. These results may reflect the overall conditions that the West Bank workers were facing during 2002, a period marred by invasions, curfews for long periods and intensified siege and closures, making work and life difficult if not impossible at times.

Obstacles were varied and included **political problems** such as closures, siege, inability to reach training far away because of conditions, serious school interruptions because of conditions, inability to reach students because of political conditions, having to deal with checkpoints, inability to reach students when an incident occurs, and not living close to work making it difficult to reach students; **economic/financial** such as cannot afford training or upgrading, salary too low to allow for improvement, having to work another job to make ends meet making it difficult to improve oneself and performance, lack of special budget at work for learning and improvement, and absence of job security; **lack of training possibilities** such as the absence of training institutions, the absence of good

trainers, too much work and only one specialist who is unable to train the workers, the repeat of the same training schemes over and over again, lack of local experience in individual counseling, unavailability of training schemes in the required subjects, insufficient reading materials especially in Arabic especially and no internal institutional training; **management problems** such as management sending seniors for training and not juniors, jobs entail too much and is not focused on particular issues, multiple roles make it difficult to learn and perform better, lack of interest on part of management in helping workers develop, *wasta* (connections as opposed to meritocracy) determines who goes on training and who does not, no job description for counselors and no authority either, no incentives, chaos at school, lack of communication channels, time management problems, absence of team work or meetings among counselors, not allowed to home visit students as part of my job, job in more than one school, cannot work properly this way, bureaucracy, too much paper work does not allow better performance, cannot get students who need help out of class, inability to maintain links between parents and school, unclear role for counselor, ineffectiveness of periodic and limited meetings of counselors, and morning and afternoon school schedules make it difficult to operate; **counselors are not accepted by school principal, teachers, parents or students** such as unwillingness of family to accept the role of the counselor, teachers unwilling to accept the counselor or accept dealing with them, school principals not willing to cooperate, principals intervening in bureaucratic ways, administrative routine gets in the way, students' lack of acceptance of counselors, Ministry of Education does not understand the role of the counselor and debases their status which in turn blocks student willingness to take their role seriously, lack of belief in the work of counselors, no interest in counseling in our institution and the negative general view of mental health locally; **lack or insufficient space, equipment and materials to allow for adequate work** such as lack of private room for the purposes, lack of special desk, lack of basic equipment, lack of budget to use for 'scientific' methods of counseling, lack of educational materials, lack of references to use when needed and lack of privacy for the purpose of work; **lack or insufficient supervision/referral** such as absence of specialized people to go back to deal with cases, no technical supervision in our system with the managerial and technical seen as one, no psychoanalysts, psychotherapists or other such

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specialists available in the country to refer cases to, no communication mechanisms to allow for referral to mental health and other referral institutions, no links between one level and another within the same institution, and no courts of law or police to refer cases to; and finally, **other constraints** such as the conditions of international aid these days are negatively affecting institutions, absence of a unionized movement for counselors, conditions of work not conducive, social impediments, personal family reasons do not allow for improvement and insufficient information on mental health in the country.

Overall, 29% of the total workers, with a high of 43% for the West Bank and a low of 8% for Gaza reported political problems as main impediments at least once (Chart 31). This corroborates our suggestion above that different periods and contexts make for differing zones of political realities that get in the way of work performance; 9%, with 10% for the West Bank and 8% for Gaza financial ones; 16%, with 18% for the West Bank and 13% for Gaza absence or insufficiency of training schemes, trainers and specialists; 19%, with 21% for the West Bank and 17% for Gaza bureaucratic management problems; 14%, with 17% for the West Bank and 11% for Gaza the lack of acceptance of counseling by teachers, principals, students and families; 11%, with 15% for the West Bank and 11 for Gaza lack of space, privacy and equipment and material needs; 2%, with 2% for the West Bank and 1% for Gaza absence of referrals and supervision; and 8%, with 7% on the West Bank and 10% Gaza other problems, all mentioned at least once and up to three times.

Chart 31: Percentage of Caregivers Reported Facing Obstacles, by Type of Obstacle - West Bank, Gaza and in Total
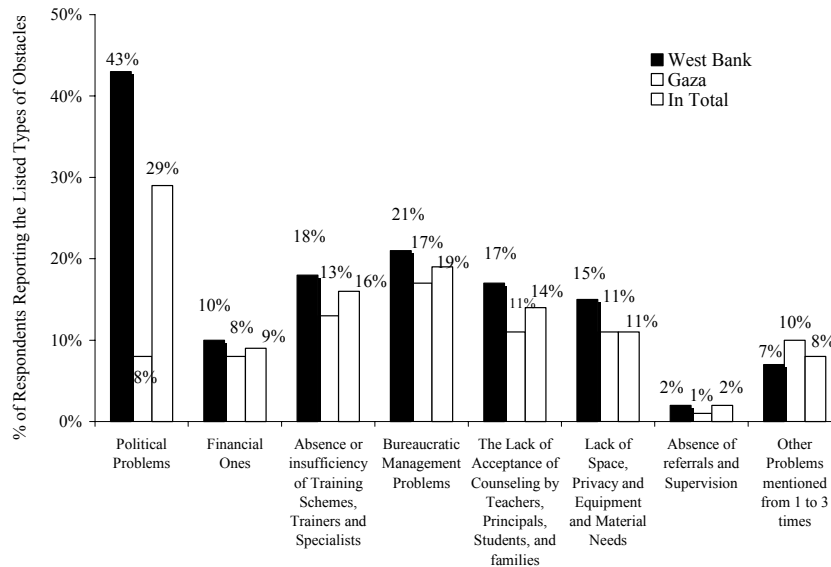

What is remarkable is that the above represents a summary of what many specialists here have repeatedly noted in relation to structural impediments getting in the way of system building and not only in the area of psychosocial/ mental health care. These workers responded in relation to the burning issues that they face, and seemed to have in fact, pin pointed the main elements: insufficient experience/training of counselors. Despite the many training schemes, they do not appear to respond to needs within the local context. For example, in view of the stigma associated with mental health, why is there such a strong focus on individual therapies rather than group activities or the reinforcement of already existing social support systems.

Other shortcomings within the system include the absence of supportive transformative supervision, a model of supervision that can help counselors not only with problem identification but also encourage a sense of creativity and develop problem solving skills on a case by case basis. Furthermore, managerial bureaucracy can get in the way of time management and access to individuals who need help. In addition to political and financial considerations, obstacles that impede work performance include the absence of effective linkages to referral services for both physical health and specialized psycho-social/

mental health care, the isolation of counselors from the main institutional framework, the devaluation of their role and lack of attention to their needs. Now that the problems are becoming clearer, the next question has to look at how to address these real issues and reform the systems in ways that can allow for transformative system building and the fulfillment of needs in a culturally and contextually appropriate manner.

Political obstacles seemed to affect women more than men at 34% compared to 24% among the men (borderline significance). This is perhaps an indication of the cultural constraints on women in traveling long distances and confrontations with checkpoints, closures, difficult road conditions and uncertainties making the trip home after work. Significantly more men reported financial problems as obstacles at 12% compared to 7% for women ((x^2=6.551, p=0.010) suggesting that these problem are gendered while others may have more structural constraints instead, affecting both males and females.

Chart 32: Percentage of Caregivers Reported Facing Obstacles, by Type of Work
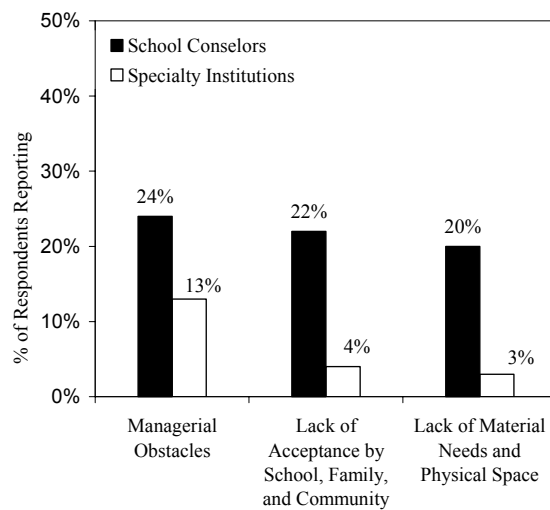
Differences by type of work were important (Chart 32) with more school counselors reporting managerial obstacles that get in the way of their work at 24% compared to 13% among the specialists (x^2=13.512 p<0.00005). More school counselors reported lack of acceptance by school, family and community as an obstacle to their work at 22% compared to 4% among the specialists (x^2=40.138 p<0.00005). With more school counselors reporting the lack of material needs and physical space as a problem at 20% compared to a much lower 3% for

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the specialists (x^2=52.503 p<0.0005), these results all point to the fact that the school counseling sector may well be a priority for further investigation and action.

Institutional differences were also notable (Chart 33) with an interesting 31% of governmental, 30% of non-governmental workers reporting political problems as impediments compared to 15% among UNRWA workers (x^2=11.149, p=0.004). These results prompted us to speculate that perhaps more of UNRWA personnel worked closer to their place of domicile than others, that is, within or in the immediate vicinity of camps. These workers may then have less checkpoints to cross and closures to contend with especially in the West Bank. More governmental staff pointed to the absence of trainers and training schemes as impediments, at 17% compared to 16% for non-governmental organizations and 9% for UNRWA staff (x^2=5.051, p=0.05). Management related impediments were highest among governmental staff, at 27%, compared to 12% for UNRWA and 11% for non-governmental organization workers (x^2=28.886, p<0.00005).

Interestingly, lack of acceptance by principal, teachers, students and family was highest among UNRWA workers at 35%, compared to 14% for governmental workers and 4% for non-governmental organizations (x^2=64.568, p<0.00005); and again, UNRWA workers reported the highest levels of lack of basic space and equipment to work with at 41%, compared to 12% for governmental workers and 2% for non-governmental ones (x^2=110.928, p<0.00005). It appears then, that overall, workers' perceptions as to the impediments for personal advancement and work performance improvement relate more to the way they perceived types of problem created by the institutional framework rather than problems generated by other external, social or personal factors. These findings call for a concerted effort on the part of the institutions in question to investigate these problems in order to facilitate the process of psycho-social/ mental health care provision as well as system building within their institutions.

Chart 33: Percentage of Caregivers Reported Facing Obstacles, by Type of Institution
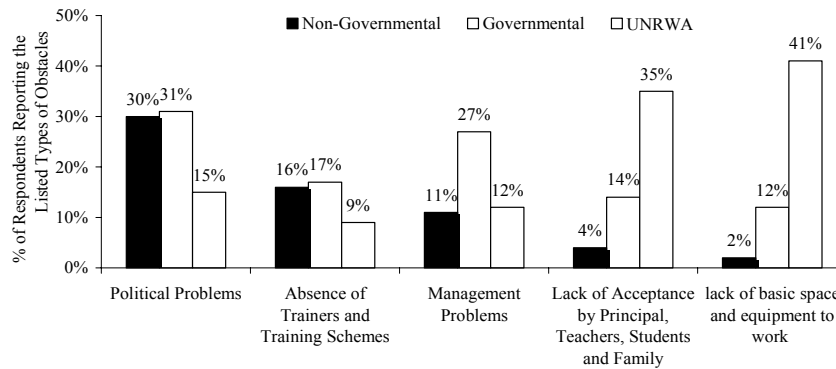
We also asked the caregivers to offer us their views as to how these problems can be solved but only 52% (396 persons) responded to the question, perhaps an indication of a sense of loss or despair over possible changes in their settings. Of those, only 6% (7% for the West Bank and 4% for Gaza) indicated that change can take place through personal initiative such as personal resolve, personal initiative in studying, personal time management, using the internet for personal development, planning to complete a Masters degree, personal development through reading, and working to prove to school and community the importance of counseling (Chart 34). These responses raised questions as to why personal initiative responses should be so low and why some believe that personal initiative is possible and others not. An additional 11% (7% on the West Bank and 39% in Gaza) thought that solutions rested with the intervention of outside specialist institutions (not their own) and an increase in the number of specialists to help them learn at the regional or country level, with the establishment of special institutions to deal with work needs, employing more specialists at work, calling on universities to train counselor trainers who are well equipped to train others, specialist institutions providing training in the different regions of the West Bank, setting up and operating teaching programs at universities with different needed specialties, organizing consultants institutionally to assist in training and seeking training in other local institutions.

A high of 57% (56% in the West Bank and 58% in Gaza) reported that the solution to this problem rests with structural managerial changes within their institutions that have to do with less bureaucratic management, better in-service training, better managerial support of counselors, human resource development within institutions, job descriptions, clarification of roles, building up a strategy for dealing with psycho-social health within the institution, budget allocation for counseling, follow up and evaluation after having completed training courses, better time management, organizing schools better, allowing home visiting to take place, the establishment of merit based appointment systems, administrative assistance to counselors, facilitating movement and setting up an incentive system to improve work.

Twenty four percent (25% on the West bank and 21% in Gaza) reported that the problems can be solved with various types of awareness raising and educational schemes directed towards principals, teachers, students, family and community to assist in increasing appreciation of the role of caregivers, decreasing isolation, and decreasing the stigma associated with psycho-social/ mental health care (such as helping teachers in understanding and appreciating the role of the counselor, ongoing training for principals and teachers on the importance of the counselor, family and parent council meetings to increase awareness in this area, working to build confidence in the counselor, working to help administration realize the importance of human resource development in psycho-social/ mental health care, and increasing the importance of psycho-social/ mental health care within the institution).

Eight percent (8% on the West Bank and 7% in Gaza) reported that bringing in technical supervision and improving contacts and communications with others can assist them in increasing their knowledge and improving their performance. This would include professional supervision, more meetings with those responsible for counseling at the institutional level, separating administrative from technical supervision, instituting appropriate communication channels with others within their institutions, implementing joint training schemes with others from other regions, instituting a system of visits and exchanges with other institutions doing similar work, supporting the development of a union for those working in psycho-social/ mental health care, producing a special periodical for psycho-

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social/ mental health care, instituting a program of regular meetings among counselors, and facilitating travel abroad for exposure.

Ten percent (10% on the West bank and 2% in Gaza) appeared to have been desperate enough to report that nothing can be done; and finally, 16% (16% for the West bank and 15% for Gaza) reported alternative solutions to these problems such as media awareness campaigns to expose the problems, working to protect counselors from burn out, conducting studies to investigate the counselors needs, obtaining money for scholarships of training, improvements in the general environment including the political one and finally, time , as time will solve the problems!

Chart 34: Percentage of Caregivers Suggesting Solutions - West Bank, Gaza and in Total
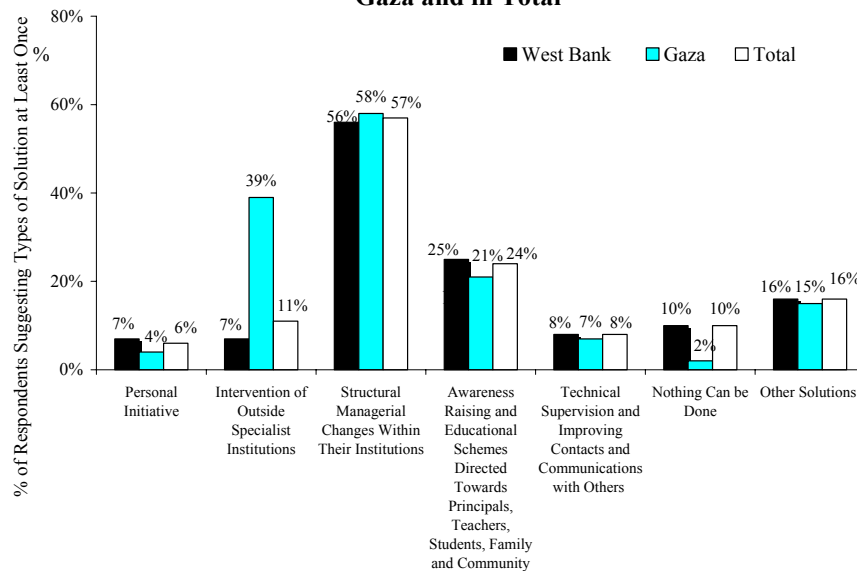
With no differences in responses noted by sex, school counselors placed change in the arena of managerial changes at 60% compared to 49% among the specialists (x^2=28.958, p<0.030), and understandably in the area of educating community, teachers, parents, principals and students about the role of the counselor at 32% compared to 8% among the specialists. These results indicate that the first steps needed to

upgrade and manage the school counseling programs is a further investigation into these findings in order to corroborate and to understand the reasons, and to work towards changing and reforming these impediments.

On Supervision

Of the total workers included in this survey, 93% (96% on the West Bank and a significantly lower 90% in Gaza) reported that they were being supervised in some form.   However, as noted in part one of this report dealing with the responses of directors, the concept of supervision varied greatly although there seemed to be an over-emphasis on bureaucratic/administrative aspects and quantitative report writing.   What is called for is greater attention to technical/clinical supervision that focuses on a previously identified need to raise awareness on the different aspects of supervision and to re-define what is required to meet the needs of different operational systems.   All of these components should work together to establish and operate such systems with a transformative, supporting and problem solving approach in mind

SUMMARY AND CONCLUSIONS

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This investigation represents the beginning of a process of an ongoing assessment of the terrain of psycho-social/ mental health care in Palestine. This mapping exercise locates and identifies the main institutional providers of psycho-social/ mental health services in the West Bank and Gaza Strip, the type of cases they encounter, their principal training needs and main obstacles to project operations (that is, the big gaps). In collating the results of this research with other studies being generated locally, we hope to contribute to a gradual, contextual-appropriate system building process that is responsive to local needs, is cost effective and meets the highest professional guidelines. Furthermore, we hope that the findings of this study will stimulate the different parties involved in an active exploration of a common discourse on psycho-social/ mental health. Through such a collaborative effort, future action will become based on field evaluation, model building before scaling up operations, in addition to transformative and culturally appropriate human resource and institutional development. It is hoped that such measures will eventually lead to the formulation and adoption of psycho-social/ mental health policies that emphasizes a bottom up rather than a top down approach. Clearly, this will take years to implement in contrast to the 'services in a moment' approach that has come to characterize and mar our system building initiatives in recent years.

Fifty seven institutions were included in this study, 34 in the West Bank and 23 in Gaza, primarily those that operate stable programs with at least two counseling staff. These include the Ministry of Education with the largest pool of counselors all working in schools at the time of the survey in 2002 for the West Bank and late 2003 for Gaza (382 on the West Bank and 150 in Gaza, a group with potentially a very significant impact not only within the schools but the community), the Ministry of Health, the Ministry of Social Affair's Youth with Special Problems Program, UNRWA's school counseling program employing 55 persons on the West Bank and 85 in Gaza, as well as a range of non-governmental organizations. These NGOs employ up to 28 persons to operate their projects and specialize

in service delivery to specific groups within the population such as women, children, the disabled and youth. Many of the institutions are primarily urban based with main centers located in the central area of the West Bank and Gaza City. Given the state of flux that have come to characterize the psycho-social/ mental health service provision system, with projects growing and folding over a short space of time, this mapping exercise represents a snapshot view of a nascent system at a particular moment in time. Thus, the results obtained from this study can only be seen as estimates and approximations reflecting the timing of the survey rather than an analysis of the workings of specific dynamics within institutions over time.

Some of these institutions dating back to the 1980's, with some even earlier, have evolved over time. Institutions with a history of model building have gradually 'scaled up' to establish a solid system of care thus forming the nucleus around which further system development can evolve. For others, over-hasty expansion has led to serious structural, managerial and human resource problems that have come to affect and compromise the level of quality care.

The survey concepts and instruments were developed between February and March of 2002. Field work commenced in May 2002 immediately following the Invasion Period and ended by the end of January 2003 on the West Bank. The Gaza survey began in September 2003 and ended in February 2004. Data processing, analysis and report writing were completed at the end of April 2004.

The Caregivers

Of the total number of workers included in this study, 46% were men and 54% were women, reflecting the important presence of men who have joined this profession. Local imperatives seem to be offsetting other local, perhaps even universal tendencies towards the feminization of care. As a matter of cultural necessity, by employing male counselors in male schools and female counselors in female schools, the defeminization of the profession has emerged as an unintended

consequence. The majority of these caregivers are Bachelors degree holders (92%) obtained from primarily local universities (73%). The workers reported having been placed in their current job for an average of 4 years per worker. For a significant number, this was the first job they have been holding since graduation which reflects not only the relative inexperience of workers but also the youthfulness of the psychosocial/ mental health care system, especially in schools.

Cases

Case load per institution appeared to have risen considerably since the beginning of the Uprising, with an average of double the case load reported per organization. The high rate of non-response to the case load questions, particularly by workers, points to a critical problem in the area of information system development that is crucial for monitoring, evaluation and planning. When asked about the type of cases they dealt with on the job at the time of the survey, the responses of directors and workers were generally compatible. No major contradictions were located in the survey results, a general indication that directors are 'in tune with the field'. Ninety six percent of workers, school counselors and specialist organization workers perceived anxiety and stress each to be a frequent presenting problem; phobias/fears at 95%; sources of stress that are war related at 86%; child abuse, grief and loss at 85%; psychosomatic cases at 84%; and depression at 80%. When asked if they dealt with rape and spousal abuse, 51% of workers reported that they work with rape cases and 57% for spouse abuse. The majority of reports on rape and domestic violence came from the specialized NGO sector.

The workers also revealed not just quantitative but also what seemed to be qualitative changes in the type of cases encountered since the beginning of the Intifada in September 2000. Before the uprising, the perception was that emotional problems, behavioral problems, learning difficulties, and social problems constituted the most common problems, with 31%, 28%, 26% and 19% of workers responding positively for each respectively. With the beginning of the Uprising, there has

been a dramatic shift in worker reporting on the most common problems encountered, with a high of 74% reporting emotional problems as the most common problem, 35% behavioral problems, 20% somatization, and 17% diagnosable psychiatric disorders.

Caution, however, should be exercised in interpreting all the results based on the cases since they do not represent the basis of an epidemiological picture of what is happening in mental health in the West Bank and Gaza. Rather, they reflect the perceptions of the workers and directors surveyed as to the type of cases they handle but in the absence of an adequate diagnostic base and information system to confirm these results. Nonetheless, these results are interesting in themselves. Based on workers' perception, Uprising conditions and the consequences of Israeli army violence on civilians have led to a necessary shift in activities towards crisis intervention at the expense of attention for such ongoing problems as social problems and learning difficulties. We are only too aware that these problems which have been overshadowed by the onslaught of crisis related cases continue to exist. In fact, the severity of these problems has probably intensified due to the current escalation of violence and the increasing economic deprivation that have gripped the country since September of 2000.

When asked about the methods of intervention used to deal with these sometimes very difficult cases, the workers cited an eclectic range of therapies and techniques ranging from a psycho-dynamic approach, behavioral and cognitive approaches and specific interventions such as EMDR. Questions must be raised as to the basis of assessment used by these workers to inform their choice of intervention methods. Perhaps these reports reflect in part, the need by workers who feel a lack of professional acknowledgement to legitimize their professional standing by citing the use of therapies and treatment methods. A coherent approach to assessment and intervention appears to be lacking along with the tools for evaluating these disparate approaches to care. There is an urgent need for evidence-based practice. The results indicate that these workers have been exposed to inconsistent, perhaps even irrelevant and

ineffective training schemes. Although these schemes were intended to address local problems they were in fact, generated outside the country for implementation here without due regard for evidence of effectiveness in any culture or more critically, appropriateness in the local culture.

Obstacles to professional development

Overall, a high of 62% of the workers reported that they faced important obstacles that impede their professional development. Significantly more workers with degrees obtained from local universities reported such obstacles compared to those with degrees obtained from abroad. Of the total: 29% reported political problems as main impediments; 19% bureaucratic management problems; 16% absence or insufficiency of training schemes; 14% lack of acceptance of counseling by teachers, principals, students and families, trainers and specialists; 11% lack of space, privacy, equipment and materials needed to complete the tasks at hand; 9% financial constraints; and, 2% absence of referrals and supervision.

The workers' responses represent a summary of what many specialists on the West Bank have repeatedly noted and just not in the area of psycho-social/ mental health care. Despite the many training schemes, the workers continue to report a need for further training and support. What is of interest here is that in general the training requested mirrors the training they have already received. This raises the serious question as to whether the trainees have consolidated the knowledge and practice gained from their trainings. The insufficiency/absence of effective technical/clinical supervision may be a factor inhibiting the ability of workers to consolidate, develop and extend what they have learned in the training programs. Furthermore, in many cases, this is compounded by managerial bureaucracy with oftentimes a narrow understanding of what constitutes supervision. The problem of limited supervision that is sometimes reduced to fax contact only is exacerbated by an overemphasis on the number of cases seen or the punctuality of staff and people checking into work on time.

Other main integrated findings include the following*:*

These institutions represents two different but inter-related systems of care: the generalist counseling system found in schools (Ministry of Education and UNRWA) and specialist institutions that provide specific care for specific groups within the population (Ministry of Health, Ministry of Social Affairs and the NGO institutions). While some of the main findings are relevant to all, many, if not most of the important findings pertain to the specificities of these two differing systems and their functions, seen here in terms of levels of care. Schools may be conceptualized primarily as a first level main catchment area for the prevention, promotion of healthy lifestyles and behaviors, and for the initial screening of those children and young people who may require further specialized help. With the relevant referrals, perhaps even extending to cope with communal needs, we can visualize the specialist system operating as a secondary level referral network for further action, if and when as is needed. As such, structural, systemic, managerial and human resource requirements for each of these two systems emerge separately. At the same time, they are inter-related in a system of referral and re-referral between the school and community but functioning with different goals, objectives, structural requirements, and indeed, training, management, supervision and evaluation needs.

Since September 2000 and persisting till now, conditions that have been gripping the country, particularly in terms of the psychological and emotional impact on civilians from Israeli military targeted attacks (its major collateral damage) seemed to have pushed many of these institutions into crisis intervention mode. The shift has come about at a time when they were neither adequately equipped nor prepared necessarily to deal with such changes. The lack of structural and managerial capacity, the availability of human resources, abilities and skills highlight the issue of crisis within the provision of care itself. These were indicated as serious obstacles faced by workers in the delivery of services, especially in the school counseling areas, obstacles that serve to increase at times the workers' sense of frustration, resentment and even isolation.

In this initial survey, the most important problem that has been identified pertains to the area of human resources in these institutions and points to the seemingly inappropriate preparation of probably most, if not all, these Bachelors degree holders. Despite obtaining degrees in psychology/ social sciences from local universities, these graduates were nonetheless, professionally under-prepared and ill-equipped to manage the needed operations. This is understandable in view of the fact that these undergraduate courses were never intended to prepare their graduates to work in the psycho-social/ mental health care area in a professional capacity. These results however, draw attention to the increasing need to review and re-examine undergraduate curricula in order to make them relevant to the work needs of these professionals. We need to emphasize here the important element of incorporating placement and work practice-based learning into future undergraduate curricula.

At another level, although nearly all the workers have received some form of in service training or continuing education while on the job, reaching to the level of an average of 1.2 continuing education scheme per worker overall, both reports from directors and workers indicate a demand for more training, training that was revealed to be very similar if not exactly the same as training received in the past. Past training programs and current demands for more present a disturbing picture, the picture of wholesale demand for mostly therapeutic interventions that may not necessarily be compatible with the systemic and functional needs of organizations providing counseling in Palestine.

It is not entirely clear to us that workers and directors realize that systemic and human resource development require far more than simply attending training workshops, the magic fix. Instead, what is required is a serious commitment to continuing professional development. We are however, convinced that change entails a gradual process of relevant learning with serious effort expended on self and system development alike. There should be a balance of class contact and theoretical knowledge with field training and strong supportive supervision

and evaluation that can often take years to produce results. This model of change also calls for gradual structural and operational reform that can produce the environment and processes within which better and more effective practices can be produced. This is reminiscent of our previous findings from the late 1980's when we were confronted with the problem of the disabled. In this instance, the disabled, their families and disability rehabilitation workers were all expecting the magical cure for disability rather than accepting the new status, the adaptation to daily life, physical infrastructural changes, skill acquisition and the social integration imperatives that we were offering as part of our model building in this area.

Another area that deserves attention is the absence/insufficiency of a workable referral system that allows secondary level support and back-up for primary care workers. Several impediments seem to stand in the way of the development of such a care system. Firstly, the number of specialists practicing in the country and access to specialist care in the community is minimal. As a result, establishing and maintaining such a referral system to secondary care becomes very difficult, if not impossible. In addition, the available if limited human resources are stretching their services so wide, working sometimes in several institutions at the same time, that it can only raise questions as to the quality and effectiveness of their technical supervision of personnel in these institutions. At this stage, a system of referral-re-referral is difficult to envisage in the face of seemingly insular systems with unyielding problems of inter and intra-sectoral collaboration. Within our framework, one of the most difficult areas to affect change is precisely in this domain, the fostering of an effective collaboration of referral and re-referral between governmental and UNRWA school counseling schemes, and both ministerial and non-governmental organizational structures.

On the whole then, the results of this study call for: a) a re-definition of the concept and components of school counseling, and the concept and components of specialized service delivery to particularly vulnerable groups within the population, and b) the availability of specialist care within the community to accept referrals for the treatment of people with complex mental health

problems that cannot be easily treated within the school system or primary health care. The development of services should take place within the context of what is appropriate and realizable for a Palestinian setting. The identification of concepts and components for specific sectors should be based on realistic goals. It is imperative then, that training should proceed in keeping with these goals and not necessarily with the kinds of training that are available.

There must be recognition that the provision of care takes place within a range of settings that include health, education, community and development. While there is a need to develop a core curriculum for basic grade counselors, the gradual introduction of the concept of continuing professional development scheme is equally important. Through these schemes, established counselors can build on existing knowledge and pursue further training in more specialist areas of work. Structural and managerial changes have to be made to encourage the growth of an environment that is conducive to self learning and development as well as the delivery of effective practice. Finally and just as critically, these broad recommendations should be supported by ongoing research focusing on both needs assessment and effective practices.