Best Practices in Teaching and Learning

Polish Institute of Open Dialogue

1. What is your definition of experienced-based learning?

The distinguishing feature of **experience-based learning i**s that the experience of the learner occupies central place in all considerations of teaching and learning. This experience may comprise earlier events in the life of the learner, current life events, or those arising from the learner's participation in activities implemented by teachers and facilitators. **A key element** of **experience-based learning** (henceforth referred to as EBL) is that learners analyse their experience by reflecting, evaluating and reconstructing it in order to draw meaning from it in the light of prior experience. This review of their experience may lead to further action.[1]

EBL is based on **a set of assumptions** about learning from experience. These have been identified by Boud, Cohen and Walker (1993)[2] as:

- experience is the foundation of, and the stimulus for, learning
- learners actively construct their own experience
- learning is a holistic process
- learning is socially and culturally constructed
- learning is influenced by the socio-emotional context in which it occurs.

2. What do / would you call your best practice?

Before I answer the question: what do we call our best practice? - let us look how Andresen, Boud and Cohen define the characteristics of Experienced-based Learning.

EBL does not lend itself to being reduced to a set of strategies, methods, formulas or recipes. It is possible, however, to recognise within it some features which characterise and distinguish it from other approaches:

EBL appears to demand that **three factors,** each be operating, at some level. These are:

i. Involvement of the whole person—intellect, feelings and senses. For example, In learning through role-plays and games, the process of playing or acting in these typically involves the intellect, some or other of the senses and a variety of feelings. Learning takes place through all of these.

ii. Recognition and active use of all the learner's relevant life experiences and learning experiences. Where new learning can be related to personal experiences, the 2 meaning thus

[1] Lee Andresen, David Boud and Ruth Cohen, Experience-based Learning, Chapter published in Foley, G. (Ed.). Understanding Adult Education and Training. Second Edition. Sydney: Allen & Unwin, 225-239.

[2] Boud, D., Cohen, R. & Walker, D. (eds) Using Experience for Learning Buckingham: SRHE and Open University Press

derived is likely to be more effectively integrated into the learner's values and understanding.

iii.Continued reflection upon earlier experiences in order to add to and transform them into deeper understanding. This process lasts as long as the learner lives and has access to memory. The quality of reflective thought brought by the learner is of greater significance to the eventual learning outcomes than the nature of the experience itself. `Learning is the process whereby knowledge is created through the transformation of experience.' (Kolb 1984:38)[3]

However, EBL varies in practice according to **three possibilities** which represent factors that may or not be applicable in a particular instance. These are:

iv. Intentionality of design. Deliberately designed learning events are often referred to as `structured' activities and include simulations, games, role play, visualisations, focus group discussions, sociodrama and hypotheticals.

v. Facilitation. This is the involvement of some other person(s) (teachers, leaders, coaches, therapists). When such persons are involved, the outcomes may be influenced by the degree of skill with which they operate. EBL often assumes relatively equal relationships between facilitator and learner, involves the possibility of negotiation, and gives the learner considerable control and autonomy.

vi. Assessment of learning outcomes; and in the event that assessment takes place, much depends upon by what means, by whom, and for what purpose it is carried out. EBL is often as much concerned with the process as the outcomes of learning, and assessment procedures should accord with this. Assessment tasks congruent with EBL include individual or group projects, critical essays located in the learner's own experience, reading logs, learning journals, negotiated learning contracts, peer assessment and self-assessment. They might include a range of presentation modes other than writing, so as to enable the holism, context and complexity of the learning to be evidenced.

Summarizing, Andresen, Boud and Cohen say that "**At the personal leve**l EBL draws on learners' previous life experience, engages the whole person and stimulates reflection on experience and openness towards new experience and, thence, continuous learning. **At the societal level** it emphasises critical social action and a stance embodying moral accountability and socio-political responsibility.

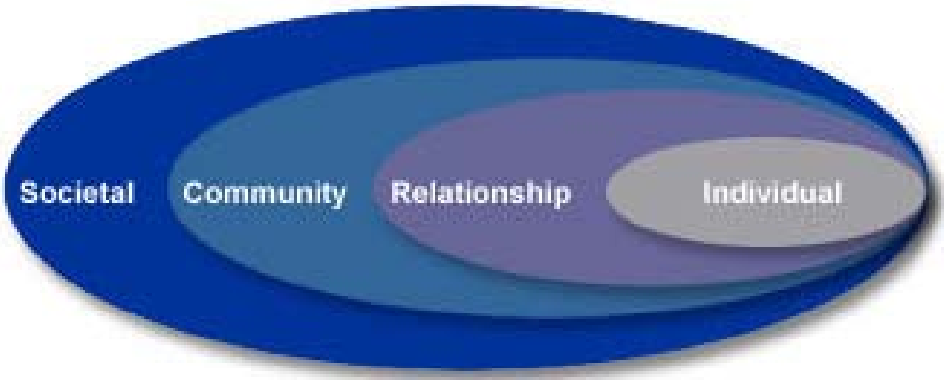
Now we can come back to the initial question: what do we call our best practice?

From Poland we will introduce a process called: **"Change the thinking. Change the practice. Change the system".**

[3] Kolb, D. 1984 Experiential Learning: Experience as the Source of Learning and Development Englewood Cliffs, NJ: Prentice Hall

This practice is derived from **personal experience** of one person (the mother) who did not agree on the status quo of mental health treatment applied for her son. The mother was convinced, out of her former life experiences, that "whatever you vividly imagine, ardently desire, sincerely believe, and enthusiastically act upon... must inevitably come to pass![4]. This attitude let her start thinking that in XXI century there must be a better mental health treatment somewhere in Poland or even in Europe. She and her husband ware ready to learn and to act upon finding "better world" for their son. As they found **Open Dialogue[5]** approach in Western Lapland, with unheard so far results of recovery process (one of them was decrease by 90% of schizophrenia[6]), they decided **to build relationships** with professionals from mental health institutions, and other partners, first i**n local community** and later in the **whole country**, who will be willing to change their thinking and their practice, from illness oriented to recovery oriented one. The key element of this process was dissemination of the Open Dialogue **knowledge**, **experiences and results** of the treatment meetings with the person in mental crisis, their family and social network.

As the process came to **societal level** it appeared that it is very difficult to implement from one country to another an effective mental health practice (for example Open Dialogue), if there is not inadequate mental health system in this country. So, the mentioned above family realized that they must rise the need for the **system change** through waking up the moral accountability and



socio-political responsibility the Parliament members and the Government itself.

Experienced -based Learning: from personal experience to system change requirement

3. Brief description / goal of your best practice

The goal of our best practice called **"Change the thinking. Change the practice. Change the system"** might be defined on different levels:

- Individual: instead complaining on the life circumstances - start looking for solution and undertake action to implement this solution in life

[4] Meyer P.J. and Slechta R., 2012, "5 Pillars of Leadership. How to Bridge the Leadership Gap"
[5] Seikkula J., Arnkil T.A., 2005, "Dialogical Meetings in in Social Networks".
[6] Whitaker R. 2011, "Anatomy of an epidemic".

- Societal (generally): develop leadership skills, undertake personal learning process, build relationships with others, be-proactive in local community and, if needed, influence the politicians to make the world a better place to live
- Mental Health: influence changes in the system, through promotion and implementation of **Open Dialogue,** as the heart of community based, integrated services.

Implementing Open Dialogue in Poland and achieved so far results might be an example how **"Change the thinking. Change the practice. Change the system"** might work.

4. When did you start it?

° **What were the reasons / motives to introduce and continue your best practice?**

Context

In Poland, the number of people treated for various mental disorders and illnesses is growing systematically.[7] 1,3 million persons benefit from care in mental health outpatient treatment facilities. At the same time, **mental health problems affect**, directly or indirectly, **about 8 million Poles**! What is more, due to the rise of social risks for mental health, such as unemployment, poverty, violence, loneliness and loosening of social bonds, the further worsening of mental condition is expected to occur in the Polish society.

The occurring mental disorders not only degrade the emotional and mental balance of a person, but also impede relationships with family members, community and the closest social environment. A bad mental condition very often results in **losing job** by a person, which deteriorates his/her quality of life and leads to a sense of exclusion and helplessness, intensifying mental disorder.

The aforementioned problems mostly affect **young people**, causing their social isolation and economic non-existence. Why is it so? Mental disorders most often occur in the puberty period. The lack of early intervention leads to an acute crisis and hospitalization. After hospitalization, it is difficult to come back to education and, what is even harder, to get a job. The study shows that as many as 73% of employees lose their jobs when an employer finds out about their illness.[8] As a result, many people claim for benefits, sickness or disability benefits or similar benefits, which represent a multi-million burden for the national budget. The same study presents that only on benefits going to the persons suffering from schizophrenia **the Polish Social Insurance Institution (ZUS) spends 940 million zlotys annually**![9]

As far as the reintegration into the labour market of those persons is concerned, it appears that a low self-esteem, fear of taking up employment, social stigmatization, but also a lack of experience and appropriate qualifications, make their situation on the labour market extremely difficult. What is more, the consequences of the illness of a family member affect the whole family and, thus, further costs are generated. According to the Ministry of Health, the **annual costs of mental**

[7] The report of the team appointed by the Minister of Health to develop a project of the National Health Protection Programme for 2016-2020, (2015).

[8] Andrzej Kiejna prof., MD, PhD, the report "Schizophrenia. Social perspective. Situation in Poland", (2014).

[9] Ibidem.

illness are estimated at 5 billion zlotys[10], being two times bigger than the NHS budget for psychiatric care![11]

° **What was your starting situation?**

The starting point was the year 2010 when my son was three times hospitalised without his will, and he spend together 7 months in one year at three asylums. So, we (me and my husband) raised to ourselves a few question:

To start: Why do we have such situation in our family? How does other families experience mental illness of their relatives? How does mental health institutions in other regions of Poland operate?

The answers were overwhelming! The organisation of mental health system in our country **reflects the way of thinking,** which has been perpetuated over decades, about the mentally ill and **mental** illness. It's a type of thinking based on the following assumptions:

1. A mental illness is incurable and a person diagnosed as "mentally ill" will remain ill through the rest of his/her life.

2. The best place for the treatment of persons with a mental health problem is a psychiatric hospital because mentally ill persons can be dangerous for themselves and for the society, that is why they should be subjected to treatment in an isolated place.

Actual facts:

At the end of 2014, there were **49 psychiatric hospitals** in Poland, offering **17,7 thousands beds** (which represented 1,3%, i.e. 231 beds, more than at the end of 2013). 201,6 thousands patients were treated there, which was 3,1% (6 thousands) more than a year ago. [12]

3. Due to the long-term course of illness, many persons lose their ability to live independently in the society and, then, in the case of no support from a family, they should be placed in a social care centre (Dom Pomocy Społecznej, abbreviated as DPS in Polish) or in a residential medical care facility (Zakład Opiekuńczo-Leczniczy, abbreviated as ZOL in Polish).

Facts:

In 2015, as many as **18 679 persons were residents of social care centres** (DPS) for persons with mental health problems and **4 956 persons were placed in residential medical care facilities** (ZOL).[13]

4. The system of psychiatric care has to be directly linked to the judicial system to be able to issue decisions on:

[10] The Regulation of the Council of Ministers on the National Health Programme for 2016-2020, (2015).

[11] The NHS Financial Plan for 2016.

[12] Data of the Central Statistical Office of Poland (GUS): Health and its Protection, Warsaw, 2014.

[13] Data of the Central Statistical Office of Poland (GUS): Health and its Protection, Warsaw, 2014.

- ➢ a compulsory treatment in a psychiatric hospital of a person experiencing mental health crisis;
- ➢ a compulsory treatment of a long-term patient in a social care centre;
- ➢ a use of safeguard measure in a form of the compulsory placement of a mentally ill person in a forensic unit of a psychiatric hospital.

Facts:

In 2014, there were **2360 persons** placed in national and regional forensic psychiatry centres, and an average time of detention of a person in a forensic unit was 4,5 years.[14]

5. Financing the activity of 24/7 inpatient psychiatric wards is based on the rule „**we pay for each hospital bed occupied"** and not for the effect of treatment.

A few months later (in 2011) we raised another questions: How do mental health systems function in Europe? What are their basic principles? What effects do they bring in the health and wellbeing of people?

At that time we discovered a sensation (it was for us): For more than 50 years, the countries of Western Europe have been in a process of profound changes of the system of mental health care. As the European experiences show, the process begins with **the change of paradigms** in three spheres:

1. the way of thinking about a person and recovery;
2. the way of providing health care services;
3. the way of integrating health care services and social support in one system

ad 1. **The most important is a person** – his/her rights as a human being, life history, individual needs and also family and social network support, which all constitute resources for recovery. Thus, the change in the way of thinking occurs, from orientation to the "process of being ill" to concentration on the "process of recovery", from "isolation" to "integration", from a "fear of the future" to "hope for recovery".

ad 2. **The system of health care services is oriented to an early contact with a person in need of help,** which gives a possibility to detect an illness in its early phase, to create a therapeutic relationship, to respond to individual needs of a person and to include a family and social network in the process of recovery. The hospitalization in psychiatric units (created in general hospitals) is a final form of help, a sort of last resort used in the situation when the other forms are ineffective.

ad 3. **Health care and social services are integrated and provided to inhabitants of a given catchment area** (a powiat/region or a district of a big city), which favours taking responsibility for a specific group of patients by the system, their social inclusion and reintegration into the labour market. As a result, these persons take control over their lives and move from the role of a "*passive service user*" to that of an "*active participant of the recovery process*"

[14] Ibidem.

Two regions in Europe - Western Lapland (Finland) and Triest (Italy) are the worth to learn examples of the effectiveness of mental health system change.

5. Please describe your best practice:

- **Which learning goal/targets does your best practice have?**
- **Which (learning or teaching) methods are used?**
- **Which themes are addressed?**
- **Which resources are used?**
- **What requirements do the participants have to fulfil?**
- **What standards does your best practice have?**

As stated above, the objective of our best practice **"Change the thinking. Change the practice. Change the system"** is "influence changes in the mental health system, through promotion and implementation of **Open Dialogue,** as the heart of community based, integrated services".

To reach this goal we have undertaken in years 2011 - 2016 following activities:

1. Conferences and seminars to build in the society new understanding of mental health and need of change from institutional to community oriented system, in which "The person" is in the middle of the recovery process.

   Result: about 5000 participants of 12 conferences and 15 seminars

2. Trainings for professionals, who are providing mental health and social services, is the Open Dialogue Approach, to open new thinking and develop new practices in their daily operation Result: 250 persons were graduated after 1-year course

3. Empowerment of people with lived experience, mainly through Ex-In workshops, to become experts who know best how to help others with mental illness and advocate for changes in Poland.

   Result: 100 people participated in Ex-In workshops organised in Wroclaw, Cracow, Gdynia, Katowice

4. Improving peoples live by organising in their local community integrated services: Prevention - Treatment - Social support

   Result: we have started these activities in 2014 from small scale - 20 families from one municipality, 1 year project and now we are close to start country based project, financed by EU funds (15 000 families from 25 municipalities, 3 year project, 20 partners in the whole country)

5. Advocacy towards reform of Polish mental health system on the governmental level.

   Result: we have been invited since 2014 to Polish Parliament, National Advisory Board for President of Poland, Ministry of Health, Ministry of Development, Ministry of Family.

6. Multinational projects, study visits, bilateral cooperation with foreign organisations to take advantage in European heritage in Mental Health.

   Results:

   a. We and our partners organised 15 study-visits to 7 countries, in which participated

about 150 people

b. Open Dialogue is well known in the whole country and will become “The heart“ of 25 Community Mental Health Centers which will be founded within 3-years EU project; this project will be the **pilot for the reform of Polish Mental Health system**.

We think, that It is high time to see that not only the countries of Western Europe, **but also those of Middle-East Europe, have exceeded Poland** in fostering the basic human rights, in changing the way of thinking about mental illnesses and in creating the mental health care system with the **human being at its centre**. The time has come in Poland to move away from the system based on isolation, forced treatment and oppression, because, as Italians put it, “*this is the oppressive system that induces aggression in people experiencing a mental health crisis*.”

Due to the urgent need of change, **the vision of the future of Polish mental health system** was defined on the basis of good European practices and recommendations of the World Health Organization. The following principles depict this vision:

41 **Mental illnesses are curable,** and a person experiencing mental disorders is the one who needs help and not the one who poses danger. #

51 **Prevention - Treatment – Social Support -** constitute three pillars of the system, representing a holistic approach to the human being and ensuring the integration of activities and therapeutic continuity, which has influence on **the efficiency of the system** both in health and economic dimensions.#

61 **The system is pro-active,** which means that through prevention we build the social awareness, making it possible to provide the right professional care in the first episodes of mental disorders. Nowadays, we have a reactive system, which means that we wait until the acute symptoms of illness occur, and then we react in placing a person in a psychiatric hospital (mostly without his/her permission).#

71 **The system covers children and youth**, because mental disorders mostly begin in adolescence; the early intervention is a necessary condition of success of all actions taken up.#

81 **Primary mental health care services** are community-based through a network of **Community Mental Health Centres** (with special importance of mobile teams), which gives a possibility of early intervention and includes family and social network as resources for recovery. Now, there is a network of outpatient mental health care institutions and Community Treatment Teams, but they have small contracts, which leads to long waiting periods and the lack of comprehensiveness of the services provided.#

91 T**reatment is individualized** – what is important is a person, his/her life history, individual problems and needs, and that where he/she lives, studies or works.#

:1 The Community Mental Health Centre **coordinates health care services**, providing **an effective cooperation with a 24/7 psychiatric ward** in a local general hospital (or in a local psychiatric hospital).#

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;1The Community Mental Health Centre **coordinates health care and social services,** covering also the needs in terms of housing and employment, as this is a prerequisite for regaining independence and taking control over one's life. The coordination of the aforementioned services can only be possible thanks to a local partnership.#

<1The Community Mental Health Centre **cooperates with GPs** on a given area.#

10. The Community Mental Health Centre **is responsible for providing care to the inhabitants of a given area** (a powiat/region or a district of a big city), which favours the social inclusion of the patients (the clients of the system) and their reintegration into the labour market and, consequently, leads them to take control over their lives and fosters their independence. These persons move from the role of a "*passive service user*" to that of an "*active participant of the recovery process*."

11. The system is based on **an effective model of financing of the primary psychiatric care**, provided by the Community Mental Health Centres, which takes a form of "global budget" calculated on the basis of the "per capita rate". Today, the NHS pays for individual medical services.

12. Persons affected by a mental illness, the clients of the system, are partners for mental health institutions, because they know best what helps them recover; they are "experts by experience" and bring hope for recovery to those in crisis.

13. The family and social network members of the mental health system user are involved in every phase of recovery, i.e. starting from prevention efforts, through treatment, to social rehabilitation.

6. What did you learn from your experiences with your best practice?

- **What are the outcomes of your best practice?**

During last 6 years, since we have met first time **Open Dialogue** - it serves us as an inspiration, indication and a practical tool in the process of **changing our thinking and our practices**. The first basic training in Poland started in 2013, and soon was followed by another nine in different cities. These actions created a breeding ground for further actions and practice. Altogether there is now over 250 trained people – mostly among professionals of mental health field – psychologists, psychiatrists, nurses, but also social workers and people with experience of psychological crisis.

This group of 250 people is as well **group of advocates of changes** in the mental health system.

They have build 'Open Dialogue islands' on the map of Poland and seem to create a growing web of good practices. Discrepancies between places concerns f.eg. types of financing. In Poland neither National Health Found nor insurance companies pay for treatment shaped around Open Dialogue**.** It is mostly a mash of private, charity or short-term EU or departmental projects funds. Needless to say that such a situation challenges professionals to search for sources of financing that could give their work basic sense of stability.

Also institutions involved in Open Dialogue movement vary – from psychiatric hospitals and psychiatric inwards in general hospitals, through daily care units, community help-care centres, family support centres, finishing on social welfare centres. In such a wide range of institutions

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there are professionals pioneering in Open Dialogue, searching for their own way of implementing their ideas, creating their own projects and dealing with institution-specific obstacles – such as hierarchical structure, housing conditions limitations, colleagues. Nevertheless, fruits of good practices pays back with growing work and personal satisfaction and promising outcomes.

The most important outcome of our best practice **"Change the thinking. Change the practice. Change the system"** is the decision of Ministry of Development to dedicate 60 mln Euro for 20 municipalities for 3-years innovative project called "Deinstitutionalization of health and social services for people with mental health problems"[15]. In 10 out of these 20 regions there are "islands of Open Dialogue". The project is based on **the vision of the future of Polish mental health system**, described above.

7. How might these experiences be useful to the Empowerment College?

Our best practice might be **inspiration for the courses** provided by Empowerment College.

Why?

In each country, independently of the level of society development, we need people who:

- instead of complaining on the life circumstances - start looking for solution and undertake action to implement this solution in their life
- develop leadership and professional skills, undertake long-life personal learning process
- build effective relationships with others
- are pro-active in local community and, if needed,
- influence the politicians to make the world a better place to live.

Implementation of Open Dialogue in Poland and its role in influencing the change in Polish mental health system is an example that the best practice called **"Change the thinking. Change the practice. Change the system"** is worth to be promoted.

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[15] https://www.power.gov.pl/nabory/1-22/