The impact of a legislative amendment on administration burden in Dutch Mental Healthcare.

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Abstract: The need for mental healthcare professionals in the Netherlands is increasing caused by the growth of patient complexity. The administration burden causes outflow of professionals and therefor they become increasingly scares. Improvement initiatives are aimed as the intended strategy and starts with (re)-structuring organizations through legislation and regulations. They entail both experienced and measured administration burden for healthcare professionals working in Long-Term Care (LTC). However, most studies only provide insight into the current administration burden or the impact of legislation and regulations on the administration burden from a broad perspective. These insights are useful to LTC managers, but more in-depth research is needed to implement laws and regulations to reduce the administration burden for LTC professionals in the future.
The Compulsory Mental Healthcare Act (CMHA) was implemented in the Dutch mental healthcare and replaced the Special Admissions Act in Psychiatric Hospitals (SAAPH) on January 1, 2020. The aim of this study is to investigate the effect of the legislative transition and to determine the effect on the administration burden of Dutch mental healthcare professionals.
A survey concerning the administration burden for especially psychiatrists before and after the transition was distributed to an addiction institute with a diversity of different mental healthcare professionals and a psychiatric institute that has been led by psychiatrists. Also some interviews with the lead professionals where held.
The results show that the administration burden among psychiatrists has increased due to the contact with external healthcare providers and contact with the patient, family and their loved ones (a consequence of the amendment of the law). This effect was significant and in line with the results of the interviews.
Therefor we conclude that the administration burden has increased as a result of the legislative amendment.

Keywords: Dutch Mental Healthcare, Administration burden, Legislative amendment, Public governance, Information Management

1. Introduction

Politicians translate current care needs into policy, taking into account current and desired policies according to its stakeholders (Ranchordas and Roznai, 2019). The administrative impact for stakeholders has been the focus for years that is taken into account when making changes to a law (Harlow and Rawlings, 2006, European Commission, 2007). Nevertheless, healthcare professionals still complain about the increasing amount of rules and regulations that need to be accounted for and thus the administration burden (Rao et al., 2017).
Stakeholders of care, such as the patient, their family and loved ones, the legislator, insurer and the Health Care Inspectorate demand thorough accountability for the care provided. The growing possibilities of information systems raise the expectation among these stakeholders that these requirements can be easily met. As a result, more and more reporting is done, even when it is not useful or necessary according to the professionals, resulting in an increasing administrative burden.
The highest administration burden is experienced within the mental health sector (Hanekamp et al., 2019). Accordingly, mental health professionals scored the highest on the lack of functionality and the compliance burden (Bronkhorst, 2019). Nowadays, healthcare professionals in mental health spend about 40% of their time on administration, while it is important for healthcare providers to spend as much time as possible with their patients (Hanekamp et al., 2019). This is important for healthcare and greater job satisfaction (Van Ark, 2020). Psychiatrists indicate that they see mandatory administration as the main cause of the extreme workload they experience in their routine clinical practice (Joldersma, 2019). Maris et al. (2020) shows that legislation has impacted the administration burden within healthcare. However this study did not show the impact of a change of legislation on the administration burden.

On January 1st, 2020, the CMHA was implemented in the Dutch mental healthcare. This act replaced the SAAPH, an admission law, in which a citizen may be admitted to a psychiatric hospital against their will when there is an emergency (IGJ, 2019). This emergency implies that a person may be a danger to themselves or the environment caused by a mental disorder, whether acute or not, and for which an admission is the last solution (Hulpgids, 2001).
The CMHA regulates the rights of citizens who receive compulsory care due to a mental illness and forms a serious disadvantage to themselves or surroundings. The CMHA is a treatment law, in which care for the citizen is central and an admission is no longer compulsory. The CMHA strives to allow the patient to participate in the society and to involve family and immediate loved ones as much as possible (VWS, 2019).
This study focuses on the administration burden in the transition from the SAAPH to the CMHA. To provide a more in-depth insight the aim of this study is to determine whether the administration burden in mental healthcare has changed as a result of this legislative transition. Therefore, the research question is: *To what extent does the legislative amendment from the SAAPH to the CMHA affect the administration burden of healthcare professionals, e.g. psychiatrists, within Dutch mental healthcare?*
Based on the research question, the next section describes the concepts of this research: administrative burden, visualization legislative amendment and the Dutch mental healthcare sector. Followed by the section which describes our research approach. The results are presented in the results section and finally the discussion and conclusion, as well as limitations and recommendations are described.

2. Theoretical perspective

This section describes the concepts of this research: administration burden, amendment of the law and the Dutch mental healthcare sector.

2.1 Administration burden

Administration is *'the most obvious part of government; it is government in action; it is executive; the operative, the most visible side of government'* (Wilson, 1887). It is *'The systematic collection, recording and processing of data aimed at providing information for the benefit of the management sector, function and control of a household and for the accountability that must be accounted for it'* (Blommaert and Blommaert, 2016). Two types of administration are distinguished: patient-related administration and non-patient-related administration. Patient-related administration is, for example, writing reports, writing a care plan, or completing checklists. Non-patient administration is, for example, recording hours worked or recording reports of incidents (De Veer et al., 2017).
Administrative burdens can be seen as 'the costs of administrative activities that organizations have to perform in order to comply with the information obligations' (Ecoryse, 2018). Allers (1994) defines it as 'the costs of a specific sector to comply with regulations'. Nijsen (2003) talks about 'the integral costs of activities that companies must carry out in order to comply with specific obligations to transfer information to the government and on top of which the costs are incurred to meet the general accounting requirements'. The scope of administration burden can be calculated through three costs variables (Boog, Suyver & Tom, 2004).
Although the term costs has not been defined, it is an option to view this part purely financially. But healthcare professionals experience an administrative burden. This administrative burden includes the perceived burden for an individual to comply with information obligations arising from legislation and regulations (Boog, Suyver & Tom, 2004). The individual perceives administrative obligations as a burden (Burden et al., 2012).
Only a financial perspective on administrative burdens therefore does not justify the feeling that a care provider might feel when performing administrative work. Therefore, in this study costs are also seen as an effort and even a sacrifice.
So the perceived administration burden consists not only of the time spent by a healthcare professional, but also of the possible frustration in the lack of usefulness and necessity of these record-keeping tasks.

2.2 Visualization legislative amendment

The government works on the principle that legislation and regulations are drawn up to achieve public value (Van der Steen, 2019). One of these values is public health. Healthcare is therefore largely funded by the public authorities. In order to account for where the public money has gone, the public government has established through legislation what must be accounted for.
Dutch LTC organizations and therefore also Dutch mental health care must comply with various laws and regulations, each with its own flow of funds. For example nursing home organizations have to deal with more than 451 external rules (Hanekamp et al., 2020).

To this end, they carry out administrative activities that are embedded in the primary and supportive processes (Maris et al., 2020). A primary healthcare process is initiated from outside the organization, for example by the patient. A supporting process creates the conditions for carrying out the primary process (Aguilar-Saven, 2004). When the legislation changes, so do these processes. A process is a "*set of partially ordered activities intended to reach a goal" (*Hammer and Champy, 1993).
To compare processes of departments or organizations, a common description or model needs to be developed. For this purpose the Business Process Modeling Notation (BPMN) is used because it visualizes the activity flow and the stakeholders involved. The primary goal of BPMN is to design visualizations which are understandable for all stakeholders of the process (White, 2004).

2.3 Dutch Mental healthcare

The context of this study is Dutch mental health care because this part of the healthcare sector experiences the highest administrative burden (Hanekamp et al., 2019) and a legislative amendment with a direct impact on primary healthcare has been implemented. According to the European Commission (2007), an amendment to the law should also aim to reduce the administrative burden.
About 89,000 professionals work in Dutch mental health care, spread over about 100 organizational units. Within Dutch mental health care, the level of care a person needs determines where and which care a person receives. There are three different lines (Dutch mental healthcare, 2020):

- Basic mental health care (BMHC). A general practitioner provides care and psychologists provide BMHC. This care is quickly and easily accessible. Healthcare providers within BMHC may seek advice from specialized mental health care institutions;
- Specialized mental health care (SMHC). If an individual requires more specialized treatment, the family physician or a medical specialist will refer that individual to the second line, to SMHC. Mental health institutions provide this specialized care;
- Highly specialized mental health care. This care is for patients with complex, severe and/or rare mental illnesses. For these patients, basic care or a specialized treatment is not enough. Often the patient suffers from multimorbidity.

3. Method

This research focuses on mapping the change in the administrative burden among healthcare professionals in Dutch long-term care (e.g. psychiatrists) in the context of a change in the law. An explanatory mixed method study fits this perspective (Yin, 2014; Zegers et al., 2020). This study at two healthcare organizations was conducted from September 2019 to June 2021.
The research started with a desk research and four interviews to understand what the impact of the legislative amendment could be for stakeholders within a healthcare organization. Two interviews were held with healthcare professionals who were responsible for the implementation of the activities in the context of the new legislation within their healthcare organization and two with research professionals in the field of process innovation in healthcare. Based on the results, a survey (available in Dutch upon request by the authors) and two process descriptions were drawn up and validated by these respondents (appendix A - SAAPH and appendix B - CMHA).
The survey consists of three parts. The first part contains questions to be able to categorize the respondent. The second part focuses on the average time (cost) that the respondent estimates to spend on administrative tasks during an eight-hour working day. And the third part focuses on the perceived burden (perception) of these administrative actions.

After these phases of preparation two studies were conducted:

1. The first study was conducted in a mental health institute for addiction-psychiatry. About 800 employees work at this healthcare organization. Two surveys were executed among healthcare personnel. One survey was carried out before the amendment of the law and the other a year after the legislative amendment. In case of the last survey, the number of psychiatrists was scarce. For that reason, three interviews and a focus group session with outpatient assistances were also conducted;
2. The second study was conducted in a mental health facility where the psychiatrists were the leading professionals. This organization employs approximately 1800 employees. In this case too, two surveys were conducted among the psychiatrists. The first was about the situation before the amendment of the law. The second focused on the situation under the CMHA.

The context of the second case was chosen because, according to the outcomes first study, it appears that the CMHA has had a particular effect on the work of psychiatrists. For example, they have been given more responsibilities, act as independent professionals and they are also the professional in the lead in the clinic.

The surveys were set up using Qualtrics. In order to obtain the highest possible response and to place a minimum burden on the primary services, the invitations were sent by the management of the organization to a random selection of 50 employees affected by the change in the law.
Due to the chance that respondents would give politically desirable answers if they could be linked to their answers, the survey was sent out completely anonymously. Anonymity is guaranteed because a general link to the survey has been used, the data was directly collected by the research group without management intervention and no personal data is requested in the survey.
The results of the studies were quantitatively analyzed in SPSS version 25 and discussed with two healthcare professionals directly involved in the implementation of the new legislation.

4. Results and discussion

4.1 Desk research

4.1.1 SAAPH

The SAAPH officially entered into force in 1994 (Hulpgids, 2001). It is an admission law, which means that a citizen may be admitted to a psychiatric hospital against their will when there is an psychiatric emergency (IGJ, 2019). This emergency implies that a person may be a danger to themselves or the environment caused by a mental disorder, whether acute or not, and for which an admission in a mental care facility is the last solution (Hulpgids, 2001). This is assessed by the independent psychiatrist. Appendix A shows the process of the SAAPH. In addition to the patient, a total of at least 4 organizations and 6 functions are involved in the execution of the SAAPH. There are two types of registrations within the SAAPH process that form the basis of communication between the various stakeholders:

I. In case of immediate danger the (independent) psychiatrist can request a Detention Order (IBS) written and approved by the mayor. This requires a medical certificate. If this is the case, a patient will be admitted immediately to a mental health care facility (Amaris care group, 2017). Within three days, a judge decides whether the patient should remain in the clinic or not. The patient is admitted for up to six weeks.
II. If there is no immediate danger, but there is a societal deterioration, the (independent) psychiatrist may request a court order (RM). When the judge issues this court order, the patient must be admitted within two weeks. The court order is valid for a maximum of six months, one, two or rarely five years.

4.1.2 CMHA

On January 1, 2020, the CMHA was implemented in the Dutch mental healthcare. The CMHA regulates the rights of citizens who receive compulsory care due to a mental illness and forms a serious disadvantage to themselves or their environment. It is a treatment law, in which the care for the citizen is central and an admission is no longer a condition for compulsory care. The CMHA strives to allow the patient to participate in the society and to involve the family and other immediate loved ones as much as possible (VWS, 2019). Appendix B shows the process of the CMHA.
In addition to the patient, a total of at least 4 organizations and 10 functions are involved in the execution of the CMHA. There are four types of registrations within the CMHA process that form the basis of communication between the various stakeholders:

I. When the serious harm is imminent and there is no time for a procedure, the mayor can issue a crisis order (CM) (GGZ Centraal, 2020). In this case the (independent) psychiatrist examines the patient and writes a medical statement. For the examination the environment will have a maximum of 6 hours for transportation. During this time, the patient may already have mandatory care imposed. After this, the psychiatrist has 12 hours for psychiatric examination and prepare the procedure for issuing by the mayor. The mayor decides whether a CM is needed or not. When it is issued, the patient immediately receives mandatory care for a maximum of 3 weeks in a clinical facility.
II. When there is no acute danger, but mandatory care is needed, the medical director (MD) of a Psychiatric Institute will be asked to start a request for an authorization of care. A plan of action is needed. Patients are given the opportunity to write their own plan of action (PoA).

III. If the PoA is not provided by the patient within 14 days, the MD will ask an independent psychiatrist to write a medical statement (MV) and the patient to create a care map (ZK) and a care plan (ZP) under the supervision of the psychiatrist responsible for the treatment.
IV. The MD reviews both documents and sends the conclusion to the prosecutor. The prosecutor submits a request for an authorization for care (ZM) based on the input of the MD to the judge. The judge ultimately decides within three weeks whether compulsory care is needed. Compulsory care lasts a maximum of six months or more if needed.

4.1.3 Differences between SAAPH and CMHA

SAAPH and CMHA differ on the following points:

- The SAAPH is an admission law, which means that a citizen may be admitted to a psychiatric hospital against their will when there is an (psychiatric) emergency (IGJ, 2019). The CMHA is a treatment law, in which the care for the citizen is central and an admission is no longer a condition for compulsory care.
- The CMHA has more treatment options and different forms of compulsory care, such as behavioral influences, administering medication and compulsory care in an outpatient setting.
- Compared to the SAAPH, the legal position of the patient is improved at the time of the CMHA. An admission is no longer a condition of compulsory care, allowing the patient to receive outpatient care as well. The patient is given more of a say throughout the process and is allowed to create a care map and their own PoA.
- As a result of the amendment of the law, healthcare professionals must register in a different way. Instead of an RM application, an MV, ZK and ZP must be provided. In addition to this change in registration, the tasks, responsibilities and the number of stakeholders have changed, such as the role of the mayor and public prosecutor. All stakeholders have been given tighter deadlines.

4.2 Results studies

All surveys are conducted among healthcare professionals between the ages of 18 and 67. The respondents are 1. psychologists (mental health psychologists, clinical psychologists and psychologists in training), 2. psychiatrists (in training), and 3. others (addiction specialists (in training), nurse specialists and other primary healthcare professionals).
Not all respondents completed the survey completely or provided reliable answers. In order to be able to do a reliable analysis, the respondents who had not answered substantive questions were not included. In addition, respondents who spent extremely long hours on administrative tasks were also excluded. We have set the limit for a maximum of eight hours of administrative tasks per working day. Table 1 shows the response per group per survey before and after filtering the non-response.

		Before filter		**Filtered**	
	Respondent	**SAAPH**	**CMHA**	**SAAPH**	**CMHA**
Case 1	Psychologists	15	18	15	15
	Psychiatrists	11	3	11	3
	Other	8	11	8	7
	Total	***34***	***32***	***34***	***25***
Case 2	Psychiatrists	15	22	11	12
	Other	1	0	1	0
	Total	***16***	***22***	***12***	***12***

Table 1: Response per study

The next step was to look at the significant differences between the situation before and after the legislative change. An independent sampling T-test was performed for this. The administrative burden (measured on a 5-point Likert scale) and the estimated total time spent on registration tasks were used as test variables. The grouping variable was the legislation (act). The results are shown in Table 2.

	Function		Act	Mean	Std. Deviation	Sig. (2-tailed)
Case 1	Psychologists	Administration burden	SAAPH	3.3636	1.02691	0.606
			CMHA	3.5455	0.52223	
		Time spent on administration	SAAPH	2.7467	1.65256	0.465
			CMHA	2.3233	1.47379	
	Psychiatrists	Administration burden	SAAPH	3.6364	1.02691	0.639
			CMHA	3.3333	0.57735	
		Time spent on administration	SAAPH	2.7924	1.72229	0.271
			CMHA	4.0389	1.29146	
	Other	Administration burden	SAAPH	3.2857	1.11270	0.875
			CMHA	3.2000	0.44721	
		Time spent on administration	SAAPH	2.3479	1.71208	0.758
			CMHA	2.6429	1.91913	
Case 2	Psychiatrists	Administration burden	SAAPH	2.3333	0.51640	0.017
			CMHA	3.1000	0.56765	
		Time spent on administration	SAAPH	3.3788	2.14822	0.121
			CMHA	2.1875	1.32255	
	Other	Administration burden	SAAPH	3.0000	.	.
			CMHA	.	.	.
		Time spent on administration	SAAPH	2.5000	.	.
			CMHA	.	.	.

Table 2: T-test for Equality of Means per study

Table 2 shows no significant differences on all parts ('administrative burden' and 'time use') of case 1. In the case of the psychiatrists, the first survey was completed by 11 respondents and the second by only 3. This was because more than 50% of the psychiatrists had resigned before the second survey took place. Case 2 shows a difference of 1 point on the 5-point scale for 'administrative burden' before and after the amendment of the law, while the average estimated time spent on administration is less. On average, psychiatrists experienced a lower registration pressure before the legislative amendment (average = 2.333; SD = 0.516) than after the legislative amendment (average = 3.100; SD = .568). This difference, p = 0.017, is significant. The difference in time spent is not significant.

The interview results of case 1 confirm these results, making it clear that the registration pressure for psychiatrists increased at the time of the amendment of the law. The main reason appears to be the increased communication between a greater diversity of stakeholders.

5. Discussion and Conclusion

In the last decades mental health care has changed. Also different administrations have worked on the new law for patients that needed care in difficult situations. During the process of development the impact of the administrations have a huge impact on the development of the law. In the first phase under leadership of the secretary of Justice Hirsch Ballint a commission was envisioned to monitor the process of treatment and see if the patient was making any progress (House of Representatives, 2017). Thereafter his successor envisioned a different strategy and because of the murder of secretary of health care Els Borst, the criterium of safety has been added to the three criteria under which the MD operates: subsidiarity, proportionality and efficiency. Also the legal part of the law was turned in a stronger and more compelling way. The Netherlands Association for Psychiatry has warned the ministry of health care for incompetents of the law as for example the administration burden (Joldersma, 2019).

A year and a half after the transition, the number of medical directors and the number of forced admissions has increased instead of decreasing (Broadcasting Zeeland, 2020), and the work process for a request for an authorization for care (ZM) lasts 10 weeks on average an increase of more than 30% in time to process. There

after the administration burden has increased and the dissatisfaction under psychiatrist increased significantly as the preliminary results of this study indicated.
To answer our main question our research was conducted into two mental health care institutions, one for addiction psychiatry and a psychiatric service. They had a different staffing concerning their mental health professionals. The first institute had only a few psychiatrists. The second is psychiatrists driven. Because psychiatrists are thé professionals with the most knowledge of this specific care procedures to be provided and its associated administration. They are the most affected by the change in legislation.
The results of the desk research show that the procedure of the CMHA is more complicated than that of the SAAPH. The CMHA has a longer process, more tasks, tighter deadlines and more parties involved. This makes consultation necessary and the parties are dependent on each other. The psychiatrists in particular seem to have to register much more under the new legislation.
The two mixed method studies also point to an increase in administrative burdens among psychiatrists. In the first case, the psychiatrists' score has fallen, but the interviews show that the administrative burden has increased considerably. This is corroborated by the fact that more than 50% of psychiatrists had resigned before the second survey could be completed. The second study shows that the administrative burden on psychiatrists has increased by almost one point, a significant difference.
Our conclusion therefore is that the administration burden has increased as a result of the legislative amendment.

6. Limitations and next steps

This study is a first exercise to get an idea of the real administration burden among psychiatrists. The advantage of this law is that the patient is at the center of the universe, but in addition to the letters they receive when an emergency occurs, it also gives them and psychiatrists a headache. More investigation is needed to give back the results of the law in clinical practice on administration and job satisfaction among psychiatrists.
We have to be aware that psychiatrists are scarce and that we do not want to burden them to much with a law harness. If this harness is to tight more psychiatrists will leave the job what will harm mental health care in general and decreases the quality of care for patients. That cannot be the intent of the law and therefore a review of the law is a necessity.
Despite the fact that the research results indicate that the administrative burden among psychiatrists has increased, further research is needed. The total response is too small to generalize the results to the entire sector in a statistically substantiated manner. It is therefore recommended to conduct a third (national) survey among psychiatrists to confirm the results of the first and second pilot.
Before a bigger study, it is important to improve the survey. A number of respondents did not complete the survey, because in their opinion it did not fit well with their practice. This was especially the case in the second study. To avoid this non-response in the future, it is important to use their comments (already collected by interviewing them) to improve the survey.

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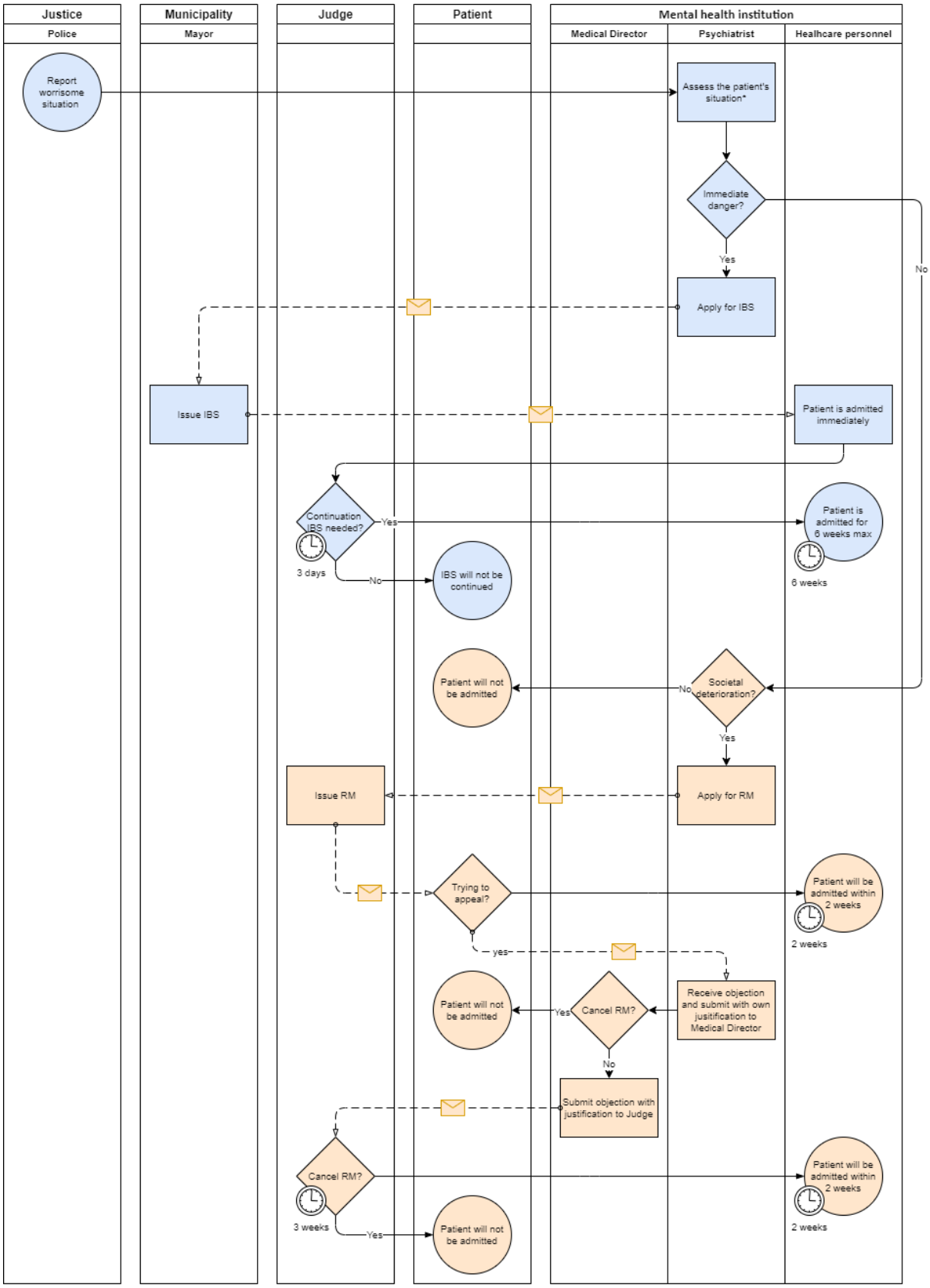
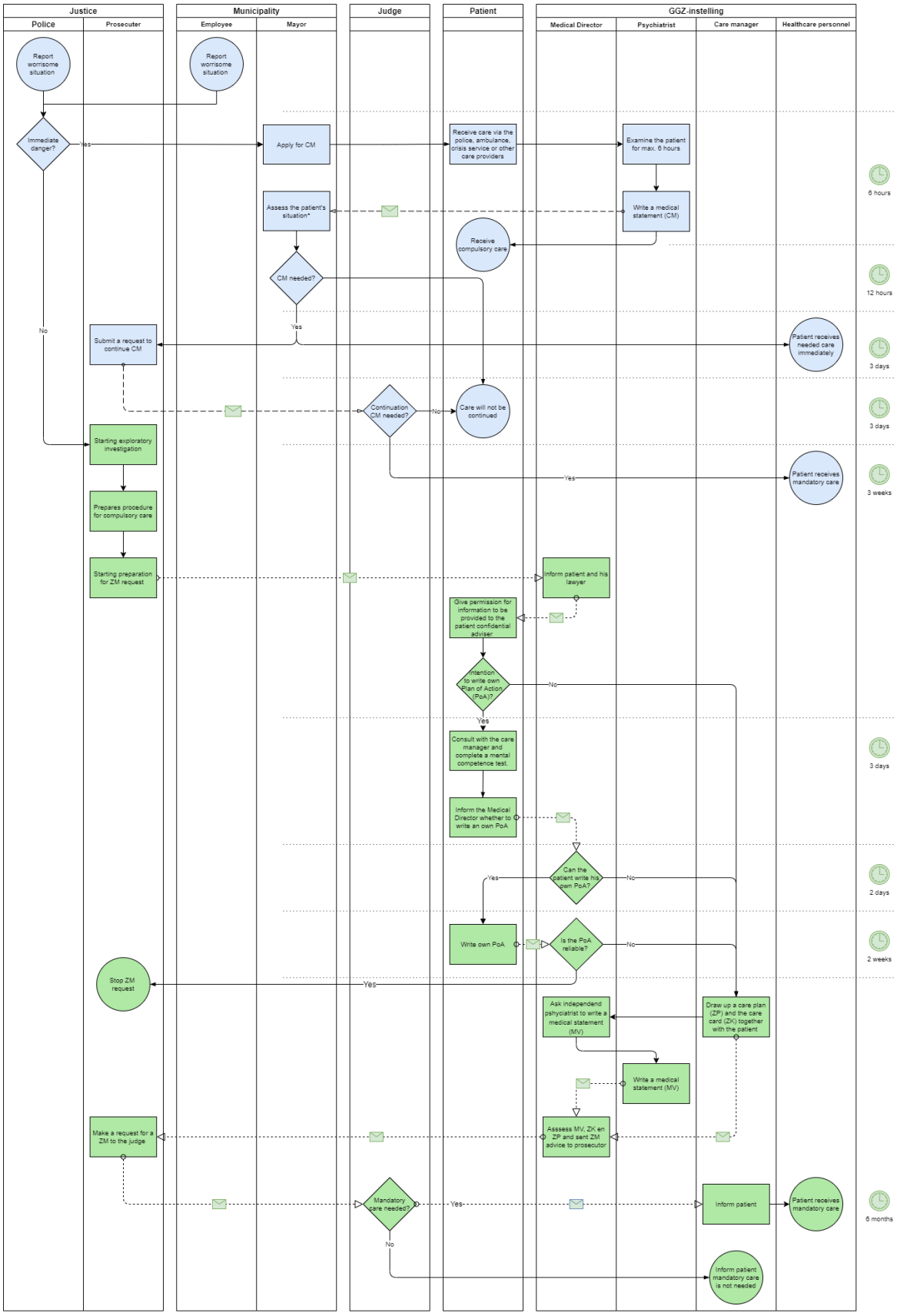
Appendix A



* situation is assessed based on:

1. Psychiatric disorder
2. Danger to self or environment
3. The situation can only be solved by admission
4. The patient resists admission

Appendix B



The mayor views the situation on the basis of 5 criteria:
1. There is imminent serious harm
2. Serious harm is caused by a mental disorder
3. The patient is in resistance
4. There is an 'MV'
5. The patient has had the opportunity to be heard