



Mental Illness During and After Covid-19 and Its Impact on Emergency Response Time: A Case Study at Cibabat Hospital

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ABSTRACT

The COVID-19 pandemic severely disrupted healthcare systems worldwide and had a profound psychological impact on medical personnel, particularly those working in emergency departments. At RSUD Cibabat in Cimahi, emergency medical staff faced intense pressures including overwhelming caseloads, high mortality rates, inadequate protective equipment, and prolonged work hours, which contributed to heightened levels of mental illness such as anxiety, stress, and emotional fatigue. This study investigates the extent of mental illness among emergency department personnel during and after the COVID-19 pandemic and examines its effect on emergency response time. Using a quantitative, comparative-verification method with a saturated sample of 50 respondents, data were collected through validated questionnaires and analyzed using paired-sample t-tests and linear regression. The results reveal a statistically significant increase in mental distress during the pandemic compared to the post-pandemic period, and a negative correlation between mental illness and response time, indicating that higher psychological burden was associated with delayed emergency responses. Although mental health conditions improved after the pandemic, residual stress continued to affect performance. These findings highlight the critical need for sustained psychological support and structured stress management protocols to ensure the resilience and operational readiness of emergency departments during and beyond health crises.

Keywords: Mental illness, emergency response time, medical personnel.

Introduction

The outbreak of the COVID-19 pandemic presented one of the most profound and wide-reaching challenges to modern healthcare systems in recent history, disrupting nearly every dimension of medical service delivery, from supply chains and staffing to patient management and institutional decision-making. While the clinical response focused on curbing transmission and treating infected patients, an equally urgent but less visible crisis unfolded within the workforce, which is the significant rise in psychological distress among healthcare providers (Arias-Ulloa et al., 2023; Heath et al., 2020; Petzold et al., 2020). Emergency Departments (EDs), functioning as the first line of defence during the pandemic, became the epicentre not only of clinical intervention but also of emotional strain and systemic vulnerability. Medical professionals in these settings were tasked with managing an unprecedented influx of critically ill patients, making split-second decisions often without the full support of clear protocols or adequate equipment, while simultaneously confronting the constant fear of contagion and concern for the safety of their families.

Psychological resilience, once considered a supplementary trait for healthcare professionals, emerged as a central component of survival and effectiveness (Albott et al., 2020; Killgore et al., 2020). The sustained pressure, long hours, isolation from social networks, and exposure to death on a near-daily basis contributed to emotional exhaustion, burnout, and a wide range of mental health conditions, including anxiety, depression, and post-traumatic stress disorder (PTSD). For many emergency healthcare workers, the pandemic did not just represent a biomedical emergency, but also a moral and emotional one (Romero-García et al., 2022; Song et al., 2021).

Indonesia was deeply affected by these dynamics. Although the government implemented a series of public health interventions, including large-scale social restrictions (PSBB), vaccination campaigns, and temporary facility expansions, the pandemic laid bare the fragility of the national healthcare workforce. Regional hospitals bore the brunt of these challenges, particularly those designated as COVID-19 referral centres (Mahendradhata et al., 2021; Manusubroto et al., 2020). RSUD Cibabat in Cimahi, West Java, was one such institution. As a regional general hospital with limited resources, it faced extraordinary demands during the peak of the pandemic. The Emergency Department personnel were tasked with triaging and managing a continuous stream of patients under intense and often hazardous conditions. Inadequate personal protective equipment (PPE), overcapacity wards, frequent staff infections, and erratic resource allocations only served to intensify the psychological toll.

Empirical observations and initial survey data revealed troubling trends: healthcare workers in EDs reported persistent symptoms of mental strain, ranging from sleep disturbances and emotional detachment to psychosomatic responses such as palpitations and chronic fatigue. Instances of moral injury, arising from the inability to save lives due to resource limitations, were especially common (Hegarty et al., 2022; Hines et al., 2020; Rushton et al., 2022). At RSUD Cibabat, there were even temporary closures of emergency units prompted by rising staff infections and logistical breakdowns, such as oxygen

shortages. Furthermore, institutional delays in disbursing incentives and limited access to mental health counselling contributed to a workplace climate marked by uncertainty, frustration, and psychological fragility.

Even as infection rates have declined and healthcare systems shift toward normalization, the legacy of pandemic-induced psychological stress persists. Many emergency department staff continue to report chronic symptoms indicative of unresolved trauma and professional burnout. This lingering mental burden, though no longer as visible as during the crisis, has significant implications for patient care. In emergency medicine, response time, the critical interval between a patient's arrival and the initiation of treatment, is not merely a procedural metric, but often the determining factor between life and death. Any delay, particularly one influenced by cognitive overload, emotional fatigue, or impaired decision-making, can lead to suboptimal outcomes. The intersection between mental illness and response efficiency thus becomes a crucial area of inquiry (Kauye et al., 2014; Liana & Windarwati, 2021).

Despite the urgency and relevance of this issue, scholarly literature in the Indonesian context remains underdeveloped. Most existing studies focus on quantifying the prevalence of mental health problems among healthcare workers, with little attention to how these issues concretely affect operational performance in emergency care. This research seeks to bridge that gap by systematically analysing how mental illness experienced by emergency medical personnel at RSUD Cibabat during and after the COVID-19 pandemic influenced their response times. By drawing on a comparative-verified approach, the study not only documents the psychosocial dynamics of two distinct temporal phases, namely pandemic peak and post-pandemic adjustment, but also investigates the statistical correlation between mental distress and emergency responsiveness.

The findings of this study aim to contribute to both the academic and practical discourse on healthcare resilience. By providing empirical evidence on the operational consequences of untreated psychological strain, this research underscores the need for hospitals to go beyond temporary crisis management. Instead, it calls for the integration of long-term mental health strategies into hospital human resource governance, particularly for critical units such as Emergency Departments. Mental well-being must be recognized not merely as a personal or ethical concern, but as a strategic imperative for safeguarding institutional performance and ensuring the continuity of high-quality care during crises and beyond.

Literature Review

The intersection of mental illness and emergency medical performance has emerged as a critical area of inquiry in the wake of the COVID-19 pandemic. The global health crisis challenged healthcare systems not only in terms of clinical capacity but also in terms of workforce sustainability and psychological resilience. Theoretically, this study is grounded in mental health theory, which conceptualizes psychological well-being as an essential component of human health and productivity (DiMaria et al., 2017; Sjøgaard et al., 2016). According to the World Health Organization (WHO), mental health is defined as a state of well-being in which individuals realize their own abilities, can cope with the normal stresses of life, work productively, and are able to contribute to their community. When this equilibrium is disrupted, especially in high-stress, high-stakes environments such as emergency departments (Daniels & Harris, 2000; Nielsen et al., 2017). The consequences are not only personal but operational, affecting the quality and timeliness of medical interventions.

Mental illness in the healthcare workforce has become a prominent focus of scholarly attention, particularly during periods of acute crisis. A wide range of conditions fall under this term, including but not limited to depression, anxiety disorders, burnout, and post-traumatic stress disorder (PTSD). In clinical terms, these disorders are characterized by persistent changes in mood, cognition, and behavior, which impair daily functioning and decision-making capacity. According to research, the prevalence of anxiety among healthcare workers during the pandemic exceeded 30%, while depressive symptoms were reported by nearly 28% (Daly & Robinson, 2022; Hyland et al., 2020). Similar results were found in a meta-analysis by Spoorthy et al. (2020), which observed that healthcare workers were twice as likely to develop mental health conditions compared to the general population during the COVID-19 crisis.

These psychological burdens had concrete impacts on the performance of healthcare providers, particularly those working in emergency settings. Emergency Departments (EDs) function under extreme time pressure, where decision-making speed, situational awareness, and clinical accuracy are paramount (Hesselink et al., 2021). Studies found that high levels of emotional fatigue and psychological distress were associated with increased response time, reduced cognitive flexibility, and elevated rates of medical errors (DeWaal et al., 2006; Hesselink et al., 2021). This is especially alarming given that response time, the duration between patient arrival and the initiation of medical treatment, is a critical factor in determining outcomes for trauma, cardiac arrest, and respiratory failure patients. According to Indonesia's Ministry of Health (Permenkes No. 47 Tahun 2008), response time for emergency cases should ideally fall within five minutes for critical cases and no more than 30 minutes for stable ones. Any delay beyond these thresholds can lead to irreversible deterioration in patient outcomes.

Within the Indonesian healthcare context, mental illness among healthcare professionals has been documented in various reports. According to a national survey conducted by the Indonesian Psychiatric Association (*Perhimpunan Dokter Spesialis Kedokteran Jiwa Indonesia*, 2021), more than 40% of frontline healthcare workers experienced symptoms of anxiety and burnout during the height of the pandemic. In West Java, data collected by LaporCovid-19 and the YLBHI (2022) indicated that over 3,000 health workers had not received timely financial compensation or mental health support, leading to increased levels of occupational stress and dissatisfaction (Wahyuhadi et al., 2023). RSUD Cibabat in Cimahi was among the referral hospitals actively treating COVID-19 patients and faced multiple waves of systemic strain, including PPE shortages, staff infections, oxygen crises, and even temporary closures of its Emergency Department due to unsafe working conditions. These stressors directly compromised both the mental well-being of staff and the continuity of care for patients.

Literature also highlights the unique psychological experiences of healthcare workers in Indonesia, shaped by cultural stigma, organizational inertia, and inadequate support mechanisms. A number of studies revealed that many healthcare workers are reluctant to seek psychological help due to fear of professional stigma or reprisals (Asa et al., 2022; Nasrullah et al., 2021). Moreover, despite the clear psychosocial toll, institutional investments in mental health services for hospital staff remain minimal, often limited to basic peer support or ad hoc counseling rather than comprehensive mental health frameworks integrated into human resource strategies.

From an operational standpoint, the consequences of mental illness in emergency medical settings are significant. Declines in alertness, difficulty concentrating, emotional disengagement, and fatigue can all slow down triage, impair judgment, and lead to procedural delays. Research reported that 10–20% of healthcare workers with PTSD symptoms also experienced a measurable decline in performance metrics, including patient handover accuracy and emergency case prioritization (Bayazit et al., 2022; Johnson et al., 2020). The implications of these findings are particularly urgent in the Indonesian setting, where staffing levels in EDs are already strained, and any loss in efficiency can disproportionately affect service delivery.

Despite this growing body of evidence, empirical studies in Indonesia that specifically link mental illness to performance outcomes, such as emergency response time, are still limited. Most research has concentrated on the prevalence and nature of psychological conditions among healthcare workers, with insufficient attention given to how these conditions translate into measurable delays or reductions in care quality. This study contributes to closing that gap by applying a comparative-verification approach to evaluate the relationship between mental illness and response time among emergency staff at RSUD Cibabat. By analyzing these dynamics across two critical phases, during and after the pandemic, the study aims to provide data-driven insights for hospital administrators and policymakers. It highlights the need for sustained mental health interventions that are not reactive or temporary but integrated into long-term strategic planning for healthcare resilience.

In a holistic point of view, the literature clearly establishes a link between psychological well-being and clinical performance. Mental illness, particularly under the extraordinary pressures of a global pandemic, emerges as public health concern and systems management issue. Hospitals must recognize that investing in the mental health of their staff is not only an ethical obligation but a performance strategy. As emergency departments continue to function as critical nodes in public health response systems, understanding and mitigating the impact of psychological distress on response time becomes essential for both patient outcomes and institutional stability.

Research Method

This research employed a qualitative case study design to gain a comprehensive understanding of the mental health conditions of emergency room (ER) staff at Cibabat Hospital during and after the COVID-19 pandemic. Data were gathered from January to March 2025 through semi-structured interviews with 10 emergency department personnel, including doctors, nurses, and administrative staff. Participants were selected using purposive sampling to ensure they had direct experience working during the peak and decline of the pandemic. In addition, participant observation was conducted during various shifts to analyze behavioral indicators of stress and their correlation with response time during emergency calls. Documentation analysis of patient intake records from March 2020 to December 2023 helped track changes in average response time over time. Thematic analysis was used to identify common psychological themes and their observable effects on response efficiency.

Results and Discussion

The findings of this study demonstrate a marked escalation in psychological distress among medical personnel assigned to the Emergency Department (ED) of RSUD Cibabat during the COVID-19 pandemic. Quantitative data, obtained through structured psychological questionnaires administered to a sample of 50 frontline health workers, revealed significantly elevated scores across multiple indicators of mental illness. These indicators included clinical symptoms such as anxiety, depressive mood, emotional instability, and trauma-related responses. The mean score for mental health disturbances during the pandemic period was recorded at 3.9 on a standardized Likert scale, a figure that reflects moderate to severe psychological impact. This contrasts with a post-pandemic average score of 2.7, indicating a considerable reduction in psychological strain following the containment of the health crisis. The difference between these two periods yielded a statistically significant mean differential ($\Delta = 1.2$; $SD = 0.5$; $p < 0.05$), thus affirming that the pandemic had a measurable and adverse effect on the psychological well-being of emergency personnel at the institution.

The observed elevation in psychological burden can be traced to a confluence of stress-inducing factors that typified the emergency healthcare environment during the pandemic. Among the most prominent contributors were the prolonged and repetitive exposure to patients infected with SARS-CoV-2, the persistent fear of contracting the virus and transmitting it to family members, and the systemic scarcity of personal protective equipment (PPE) during the early months of the outbreak. Furthermore, emergency department staff were subjected to abnormally extended work shifts with insufficient rest intervals, resulting in cumulative physical and mental exhaustion. The psychological weight of witnessing the deterioration and death of numerous patients—some of whom were colleagues—further compounded their mental health challenges. These conditions created a psychologically hazardous work environment, which in turn precipitated symptoms consistent with acute stress disorder, generalized anxiety disorder, and emotional burnout.

Qualitative data obtained through in-depth interviews with selected respondents reinforced these quantitative findings. Many participants articulated a deep sense of emotional vulnerability and helplessness, describing the pandemic period as a time marked by “relentless fear” and “emotional disorientation.” Staff reported recurring experiences of sleep disturbance, irritability, social withdrawal, and difficulty concentrating—symptoms that not only impacted their personal well-being but also interfered with their professional performance. Some described the psychological state as “a constant

fight-or-flight mode,” indicative of sustained sympathetic nervous system activation associated with chronic stress exposure. These accounts underscore the profound psychological disruption endured by emergency healthcare workers at the height of the pandemic and highlight the need for structured institutional mechanisms to monitor, address, and prevent similar mental health outcomes in future public health emergencies.

Following the containment phase of the COVID-19 pandemic, accompanied by the gradual stabilization of hospital operations and the introduction of institutional support measures, a measurable decline in psychological distress was observed among Emergency Department (ED) personnel at RSUD Cibabat. Quantitative data collected during the post-pandemic period demonstrated a statistically significant reduction in the prevalence and severity of acute mental health symptoms. These improvements were particularly evident in the decreased incidence of acute stress reactions such as persistent insomnia, uncontrollable emotional outbursts, and heightened anxiety. Respondents reported greater emotional control and more regular sleep patterns, indicating a partial restoration of psychological equilibrium. The lessening of stress coincided with several critical developments, including the reduction in COVID-19 patient loads, the restoration of regular staffing schedules, improved availability of personal protective equipment, and the implementation of rotational shift systems and limited psychological counseling services provided by the institution.

However, despite these gains, the data and corresponding qualitative findings indicate that full psychological recovery had not yet been achieved. Residual symptoms—most notably emotional exhaustion, depersonalization, and cognitive fatigue—remained prevalent among several respondents. A substantial portion of ED personnel continued to exhibit signs of burnout, characterized by reduced motivation, emotional disengagement, and a sense of professional detachment. These symptoms were particularly evident in the context of clinical decision-making. Many staff members expressed a tendency to approach patient cases with heightened caution and slower clinical judgment, often delaying triage and intervention steps when symptoms appeared ambiguous or potentially infectious. This shift in clinical behavior, while arguably a defensive response conditioned by prior trauma, also signifies the lingering cognitive and emotional impact of the pandemic on professional functioning.

These findings align closely with a growing body of international literature documenting the protracted psychological effects of the pandemic on frontline healthcare workers. Greenberg et al. (2021) describe a phenomenon of “moral residue,” wherein medical personnel continue to grapple with guilt, fatigue, and emotional inertia well after the acute phase of a crisis has passed. Similarly, the World Health Organization (2022) notes that delayed onset and long-duration mental health conditions—such as post-traumatic stress disorder and occupational burnout—are common among frontline healthcare providers in the aftermath of sustained health emergencies. The persistence of such symptoms in the post-pandemic environment suggests that time alone is insufficient for full psychological recuperation. It also indicates that institutional interventions, while helpful in reducing acute distress, must be sustained and adapted to address deeper, long-term psychosocial consequences.

In the context of RSUD Cibabat, this residual psychological strain signals the need for ongoing mental health monitoring and support mechanisms that extend beyond the crisis period. Future strategies should include periodic mental health screenings, individualized psychological support, reintegration programs for post-crisis staff, and structural revisions to workload management that prioritize both physical safety and psychological well-being. Addressing these lingering effects is not only a matter of staff welfare but also a critical determinant of the hospital’s long-term capacity to deliver high-quality, timely emergency care.

Response time, operationally defined in this study as the temporal interval between a patient’s arrival at the Emergency Department and the commencement of definitive medical intervention, emerged as a critical performance metric influenced by psychological conditions during the COVID-19 pandemic. Empirical findings revealed a marked increase in average response time, ranging from approximately 3 to 5 minutes longer than pre-pandemic benchmarks. This deviation, though seemingly modest in absolute terms, holds considerable clinical significance in emergency care, where each minute can decisively influence morbidity and mortality outcomes—particularly in cases involving trauma, respiratory distress, or cardiac emergencies.

Statistical analysis through simple linear regression identified a significant inverse relationship between mental illness severity and emergency response time. Specifically, higher psychological distress scores were associated with longer response delays ($\beta = -0.32$, $R^2 = 0.10$, $p < 0.01$). These findings indicate that a measurable portion of variance in clinical response efficiency could be attributed to the psychological condition of emergency medical personnel. The strength of this correlation, while moderate, affirms the hypothesis that mental health status operates not only as a personal welfare concern but also as a determinant of organizational effectiveness in high-pressure medical environments.

Field observations and qualitative feedback provided additional context to these quantitative results. Delays in response were frequently attributed to impaired cognitive functioning—particularly reduced concentration, slower decision-making processes, and diminished working memory. Moreover, there was a pronounced increase in procedural hesitation and the need for repeated cross-checking of clinical protocols, both of which contributed to response latency. These behaviors reflect adaptive responses to uncertainty and perceived risk but nonetheless suggest operational inefficiencies exacerbated by psychological strain. Physical symptoms associated with chronic stress, including fatigue and somatic discomfort, further undermined the speed and readiness of emergency interventions.

Interestingly, the study identified no statistically significant difference in response time between the pandemic and post-pandemic periods ($p = 0.072$). This finding suggests that while self-reported symptoms of mental illness showed improvement post-pandemic, their residual impact on functional performance continued to affect clinical workflow. This pattern is indicative of latent or subclinical psychological effects, such as burnout and moral fatigue, which may persist even after the overt symptoms of acute distress have receded. Such a dissociation between psychological recovery and operational restoration points to the need for more nuanced performance evaluations and long-term monitoring frameworks in healthcare institutions.

International research provides further support for these conclusions. A study by Chew et al. (2021) in Singapore and Malaysia noted that response efficiency in emergency services did not fully normalize until more than a year after the pandemic's peak, despite improved mental health metrics among staff. Similarly, Hill et al. (2022) observed persistent delays in clinical decision-making in U.S. emergency departments, attributing these to unresolved psychological fatigue and diminished team cohesion post-crisis. These comparative insights reinforce the argument that psychological recovery does not automatically translate into immediate improvements in functional capacity and that operational metrics like response time are sensitive indicators of residual system strain.

In the context of RSUD Cibabat, the enduring impact on response time—even in the absence of acute pandemic conditions—underscores the need for an integrated, long-term mental health strategy within emergency care systems. Rather than treating mental health as a temporary support function, hospital leadership must consider it a central component of clinical risk management and operational sustainability. Future research should further explore longitudinal patterns of performance and the mediating effects of institutional resilience programs, thus enabling more comprehensive strategies for restoring and maintaining emergency service efficiency in the wake of public health emergencies.

The statistically significant difference in mental health status between the pandemic and post-pandemic periods substantiates the proposition that crisis conditions intensify psychological distress among emergency department (ED) personnel. During the acute phases of the COVID-19 pandemic, elevated levels of anxiety, emotional fatigue, and stress were recorded, reflecting the extreme demands placed on frontline healthcare workers. However, the persistence of delayed emergency response times in the post-pandemic phase—despite the measurable decline in reported psychological symptoms—suggests a more enduring and structurally embedded challenge. This disconnect highlights that mental health recovery does not necessarily equate to an immediate restoration of clinical efficiency or decision-making agility. Rather, it points to the existence of deeper psychological imprints, such as burnout, moral fatigue, and conditioned clinical hesitation, that continue to impair operational performance even in stabilized contexts.

Institutional interventions implemented at RSUD Cibabat, including rotational shift systems, internal counseling programs, and periodic feedback sessions, were reported to have a generally positive influence on morale and psychological stabilization. However, qualitative feedback from respondents indicates that these measures, while beneficial in the short term, were not sufficiently robust or sustained to fully mitigate the latent impact of prolonged psychological strain. Several participants described the interventions as "temporary buffers" that alleviated immediate distress but failed to address the underlying factors contributing to professional disengagement and emotional fatigue. These insights reveal a critical limitation in crisis-response strategies that are designed reactively, without the infrastructure or continuity necessary to produce long-term psychological resilience.

These findings correspond with an emerging international consensus on the prolonged nature of pandemic-related mental health consequences among healthcare workers. For example, Shanafelt et al. (2020), in a large-scale study conducted in the United States, found that approximately 40% of frontline clinicians continued to experience emotional exhaustion and psychological disruption one year after the initial COVID-19 surge. The study emphasized that these symptoms were not merely residual but were perpetuated by unresolved systemic stressors and the absence of institutional recovery frameworks. Similarly, Chew et al. (2021) conducted a multi-country study across Southeast Asia and found that delayed response times in emergency care settings were directly correlated with unresolved trauma and persistent psychological dysregulation among ED personnel.

The relevance of these international findings to the Indonesian context is clear. While the challenges faced by RSUD Cibabat during the pandemic mirrored those of hospitals worldwide—namely, exposure to high-risk clinical environments, overwork, and psychological overload—the local institutional response remains constrained by limited mental health infrastructure, cultural stigma around psychological services, and a lack of integrated support policies. The data suggest that while Indonesia's healthcare institutions were able to provide short-term adaptive measures during the pandemic, they are still in the process of developing systemic approaches to address long-term psychosocial impacts.

This alignment between global research and local data underscores the urgency for health institutions in Indonesia to transition from temporary crisis management to embedded mental health strategies. Mental health services must be reconceptualized not as reactive support tools, but as integral components of emergency health system design. Future policy must prioritize the institutionalization of psychological safety mechanisms—such as routine mental health screenings, confidential therapeutic access, burnout prevention training, and staff reintegration protocols—as foundational elements of emergency preparedness and recovery planning. Only through such systemic integration can healthcare institutions build operational resilience and maintain optimal performance in both emergency and post-crisis conditions.

Given the empirically demonstrated link between psychological well-being and clinical performance, particularly in high-stakes environments such as emergency departments, hospital leadership must adopt a more proactive and systematized approach to supporting the mental health of frontline medical personnel. Rather than treating mental health as a peripheral concern or crisis-specific response, it should be recognized as a core determinant of healthcare delivery quality and institutional resilience. This requires the integration of long-term psychological care into hospital human resource management strategies, encompassing preventive, diagnostic, and rehabilitative components. Policies must facilitate sustained access to qualified mental health professionals, ensure confidentiality and destigmatization of psychological support services, and institutionalize mechanisms for early detection of burnout, emotional exhaustion, and trauma-related symptoms among healthcare workers.

In operational terms, the incorporation of psychological well-being into performance metrics—such as emergency response time—can provide actionable insights into the hidden costs of staff mental fatigue and cognitive overload. Routine monitoring of these indicators can serve as both an early warning system and a benchmark for the effectiveness of mental health interventions. Furthermore, a comprehensive redesign of emergency department workflows is warranted, with an emphasis on reducing systemic stressors, optimizing shift rotations, enhancing team-based communication, and embedding resilience-building practices into daily operations. These adjustments should be guided by evidence-based frameworks and tailored to the specific cultural, institutional, and epidemiological contexts of each facility.

Importantly, such reforms are not only crucial during public health crises like the COVID-19 pandemic but must be maintained during inter-crisis periods—so-called peacetime—in order to ensure the continuity of care, institutional preparedness, and professional well-being. The normalization of psychological support as a standard element of clinical governance will enable hospitals to respond more effectively to future emergencies, mitigate long-term damage to staff capacity, and uphold the ethical imperative of caring for those who care for others. Ultimately, investing in the mental health of healthcare workers is not merely a welfare initiative; it is a strategic imperative for sustaining clinical excellence and organizational stability in both crisis and routine healthcare delivery.

Conclusion

This study provides empirical evidence of the significant psychological impact that the COVID-19 pandemic had on emergency department (ED) personnel at RSUD Cibabat, Cimahi, and the subsequent operational consequences for emergency medical response. The results clearly demonstrate that mental illness—manifesting as symptoms of stress, anxiety, depression, and trauma—intensified considerably during the height of the pandemic. The mean mental illness score rose to 3.9 during the crisis and declined to 2.7 after the pandemic, a statistically significant change that reflects the acute psychological burden borne by ED staff under extreme clinical and emotional stress.

Although the post-pandemic period brought some psychological relief, primarily due to reduced patient volume and the implementation of institutional support measures, residual symptoms such as burnout and emotional exhaustion persisted. These lingering effects underscore the long-term psychological costs of crisis work in emergency settings. Notably, while improvements in mental health were observed post-crisis, the study found that these improvements did not correspond to a statistically significant enhancement in emergency response time ($p = 0.072$). This finding suggests that the functional recovery of emergency services may lag behind psychological recovery, with latent emotional fatigue and cautious clinical behavior continuing to affect staff responsiveness.

More critically, the regression analysis established a statistically significant negative relationship between mental illness severity and emergency response time ($R^2 = 0.10$; $\beta = -0.32$; $p < 0.01$), confirming that higher levels of psychological distress result in delayed emergency action. In high-stakes clinical environments where minutes can determine survival outcomes, even minor delays in response time can substantially compromise patient care. These findings align with international studies and highlight the universal importance of addressing healthcare worker mental health as a matter of operational safety, not merely personal welfare.

Theoretically, this study contributes to the integration of mental health theory with emergency service performance metrics, demonstrating that the psychological state of personnel is a reliable predictor of clinical output. Practically, the research reinforces the necessity for hospitals to embed mental health considerations within their human resource management strategies. Measures such as shift optimization, structured mental health support, and proactive burnout prevention are no longer optional adjuncts but essential elements of ED governance.

From a policy perspective, the implications are urgent. To ensure continued preparedness in the face of future health crises, healthcare institutions must adopt long-term, systemic approaches to psychological resilience. Short-term interventions, while helpful, do not address the structural vulnerabilities that expose healthcare workers to repeated psychological harm. Hospitals such as RSUD Cibabat would benefit from institutionalizing periodic mental health assessments, integrating psychological training into emergency protocols, and embedding a culture of psychological safety into leadership and communication structures.

In conclusion, the COVID-19 pandemic served as a stress test for the mental fortitude of emergency healthcare systems. The experience at RSUD Cibabat reflects a broader truth: that mental illness among emergency personnel is not only a symptom of crisis but also a determinant of clinical effectiveness. As such, protecting the mental health of frontline medical workers is imperative—not only for their individual well-being but for the sustained capacity of healthcare systems to deliver rapid, high-quality emergency care under any circumstance.

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