



Chapter 7

Improving Mental Health to Mitigate Pandemic Burnout

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A. Introduction

The Corona Virus Disease 2019 (COVID-19) pandemic affects socio-economic, physical, and mental health (Wiguna et al., 2020). Before 2020, mental disorders were the driving causes of the health-related burden worldwide, whereas anxiety and depressive problems were the top contributors to this burden (Santomauro et al., 2021). Anxiety and depression prevalence are growing and even doubled in some countries (Organisation for Economic Co-operation and Development, 2021). The rise of the COVID-19 pandemic has created an environment in which numerous determinants of destitute mental well-being are exacerbated (Santomauro et al., 2021). The COVID-19 episode has sparked an open and worldwide mental well-being

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Rahmah, L., Melianto, Y., & Mardiah, A. (2022). Improving mental health to mitigate pandemic burnout. In A. P. Sunjaya, Y. B. Wang, R. Sagita, & D. Sugiharti (Eds.), *Indonesia post-pandemic outlook: Rethinking health and economics post-COVID-19* (141–168). BRIN Publishing. DOI: 10.55981/brin.537. c523 ISBN: 978-623-7425-91-5 E-ISBN: 978-623-7425-92-2

ISBN: 978-623-7425-92-2

emergency and massive psychosocial problem. Across countries in the general population, unemployed people and those experiencing financial insecurity have the worst mental health status (Organisation for Economic Co-operation and Development, 2021). Government, non-governmental organizations (NGOs), and mental health providers (MHPs) worldwide, especially in Indonesia, can play a treasured part in supporting the well-being of COVID-19 patients and their families, society, and healthcare specialists (Jakovljevic et al., 2020).

The novel COVID-19 pandemic has been under intense pressure on the world in the past two years. Indonesia is the fourth most populous nation in the world and, compared to other less crowded countries, is anticipated to endure tremendous loss (lives, economic loss, educational loss, etc.) over an extended period (Djalante et al., 2020). In Indonesia, the pandemic has affected many determinants of mental health. As a result, the Indonesian government is shifting priorities to control the COVID-19 outbreak, applying measures like social distancing, social quarantine, lockdowns, schooling, and working from home (WFH). It results in a decline in economic activity, loss of livelihoods, reduced access to physical exercise, and a dramatic loss of daily routines that can considerably influence the mental well-being of the population (Santomauro et al., 2021; Wiguna et al., 2020).

Changes in daily routines and adaptations needed to survive a pandemic cause many people to feel uncomfortable, triggering burnout (Anindyajati et al., 2021). As the Indonesian government implemented a WFH program to limit virus transmission during the outbreak, employees' work-life balance was disturbed, directly and indirectly leading to job burnout. Furthermore, burnout is a mediator between work demand and intention to leave (Faaroek, 2020). Limited IT assistance, social isolation, and no defined working hours (Irawanto et al., 2021) contribute to stress and work-life balance, influencing job satisfaction.

Among the mental health problems triggered by the pandemic, burnout is among the most prevalent; some of its causes are extreme changes in daily routines, such as social distancing, social quarantine,

lockdowns, schooling, working from home, etc. (Faaroek, 2020). Referring to World Health Organization (2019), burnout is a disorder caused by stress in a work environment that is still not well-managed. Three dimensions characterize burnout, including feelings of lack of energy or fatigue, increased mental distance from one's work, feelings of cynicism or unfavourability about one's work, and reduced professionalism. As a result of the COVID-19 pandemic, burnout may be experienced by a majority of people, including Health Care Providers (HCPs), the most prominent, and people from other backgrounds like parents, workers, and young people.

Mental health literacy is crucial in dealing with burnout to control this problem. One of five Indonesians experienced burnout and mental health problems during the COVID-19 pandemic (Anindyajati et al., 2021). However, compared to mental health, the affected countries like Indonesia mainly focused on physical health impacts (Ifdil et al., 2020; Nasir, 2020). Accessible information to improve mental health care, health literacy, social connections, a supportive environment, and mental health surveillance is essential to prevent more significant post-pandemic psychiatric problems and build a resilient and future-ready society (Anindyajati et al., 2021).

This chapter can be seen as an evaluation as it gives insights for all stakeholders to improve mental health in Indonesia and adjust existing policies that affect people's mental health. There are four objectives of this chapter. The first is to highlight the pandemic burnout experienced by people in Indonesia. The second is to share awareness about mental health literacy and how to improve it. The third is to analyze the gaps and challenges in available mental health resources in Indonesia. Fourth, to put forward suggestions toward fast, comprehensive, and more precise approaches within the brief- and longer-term related to mental health to build a resilient and future-ready society.

B. Pandemic Burnout

Burnout is being physically, cognitively, and emotionally spent due to excessive and sustained demands (Queen & Harding, 2020). There

are three types of burnout symptoms such as physical (e.g., sleep disturbances), psychological (e.g., helplessness), and social burnout (e.g., conflict with others). Burnout may be experienced by most people from various social backgrounds worldwide due to the COVID-19 pandemic. While healthcare practitioners (HCPs) are among the most prominent, burnout affects other groups such as parents and the general population.

Most pandemic burnout sources in HCPs are from the working environment and household responsibilities, affecting job performance. A survey from sixty countries with more than two thousand HCPs shows that more than half of all participants suffer from burnout, with the main sources being work-related household issues (e.g., childcare), exposure to a contagious work environment (e.g., patients with COVID-19 symptoms), job stress (e.g., deciding patients' lives), and a lack of organizational support (e.g., personal protective equipment (PPE) availability) (Morgantini et al., 2020). Similarly, a cross-sectional study that included twenty-one provinces in Indonesia discovered that direct interaction with patients with COVID-19 symptoms could lead to burnout among HCPs (Sunjaya et al., 2021). Furthermore, a systematic review found other contributing factors to burnout in HCPs: young age, inadequate clinical experience and training, low social support, long working hours and increased workload, PPE, and personnel scarcity. These are all risk factors for nursing burnout. HCPs who are burnt out at work are affected by the pandemic (Galanis et al., 2021). In the same study, the authors concluded three detrimental consequences of burnout during pandemics in HCPs: emotional tiredness, depersonalization or negative attitude toward job and co-workers, and a sense of a loss of personal accomplishments.

Parental burnout is not new, but increasing during the pandemic could detriment children's well-being. Parental burnout is chronic stress-related to fulfilling parenting tasks that manifest as physical and emotional exhaustion (Mikolajczak et al., 2019). Both external and internal factors contribute to parental fatigue during COVID-19.

External factors include uncertainty about the financial situation due to the high unemployment rate and lack of social support and contact from extended family (e.g., grandparents) due to COVID-19 restrictions (Griffith, 2020). Meanwhile, internal factors include parental profiles and perspectives. Upadyaya & Salmela-Aro (2021), who conducted a longitudinal study on 1314 parents in Finland, found that parental profiles, attitudes, and children's ability contribute to parental burnout throughout COVID-19. The same study concluded that latent profiles of parental burnout are associated with different burnouts (Upadyaya & Salmela-Aro, 2021). The three types of latent parental burnout profiles are low parental burnout, high parental burnout, and emotionally distant. High parental burnout has the most significant effect on fatigue and frustration compared to the other profiles. In contrast, emotionally distant parents significantly impact distance from their children during the pandemic. However, parental burnout is low in cases involving parents with a growth mindset and children with academic strength (Upadyaya & Salmela-Aro, 2021).

Similarly, the relationship between parents' mental health conditions because of COVID-19 could affect children's positive behavior and stress. This impact varies based on the parent's income, and it is most prominent in families with low socioeconomic status (Kerr et al., 2021). In the context of Indonesians, the relationship between the impact of COVID-19, parental burnout, and children's well-being is slightly complex. This complexity could be seen in an online survey study (Riany & Morawska, 2021), revealing that financial and work burdens can influence parents' psychosocial functions and directly affect children's adjustment and competencies. Results from mediation analysis show that parents' psychosocial situations could also have indirect effects through family interaction. This analysis means that fewer psychosocial function problems for the parents would lead to more enjoyment during family interaction, reducing adverse outcomes on children's adjustment and increasing children's competencies.

Furthermore, according to a study by Susilowati and Azzasyofia (2020), online learning from home may increase parental burnout,

particularly among parents of children in kindergarten and primary school who require greater supervision. Financial concerns, family health, lack of technology expertise, balancing work from home (WFH), domestic tasks, and teaching the children all contribute to parental stress (Susilowati & Azzasyofia, 2020). Learning from home also affects students' academic deficit, reading, and mathematical issues (Panagouli et al., 2021). From the data above, it can be seen that external and internal factors affect parental burnout and children's psychosocial issues.

Lastly, in a larger population, the pandemic has caused mental health problems as most people feel exhaustion related to online access. On the one hand, the internet makes it easier to access information associated with COVID-19 and interact with others during COVID-19 restrictions. On the other hand, it could affect one's well-being due to excessive internet use. A systematic review study (Xiong et al., 2020) argues that uncontrolled use of social media platforms could expose one to disinformation, leading to amplified anxiety and unnecessary fear. In line with that, a survey study in eight developed countries with a total number of 8,806 participants claims that in comparison to persons who access traditional media such as television and health professionals; exposure to internet media, politicians, and personal contacts is associated with disinformation and conspiracy theories (Susilowati & Azzasyofia, 2020). In Indonesia, "infodemic" tends to misguide people's health behavior. A study from Prawira et al. (2021) shows that conspiracy theory and pseudoscientific cures are inversely correlated with social distancing behavior. Cross-sectional research in Bali found that beliefs in conspiracy theories, conventional media, and authoritative sources deeply affect vaccine acceptance (Wirawan et al., 2021).

Pandemic burnout could affect one's well-being and mental health on the personal, professional, and community levels. Thus, it indicates a need to deeply involve mental health management services by improving mental health literacy among the community to mitigate

the impact of COVID-19 pandemic crises related to mental health disorders.

C. Mental Health Literacy

Mental health literacy (MHL) arose from health literacy, which was introduced and defined as “a knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al., 1997). MHL consists of several components: knowledge and beliefs against the risk factors and causes of mental health disorders, the ability to recognize specific conditions, knowledge of how to seek mental health information, knowledge and beliefs against self-treatments and professional help available, and attitudes that encourage recognition and appropriate help-seeking (Jorm et al., 1997). However, MHL was later redefined as an understanding of how to gain and maintain positive mental health, knowledge of mental disorders and their treatment, stigma related to mental disorders, and enhancing help-seeking efficacy—knowing when and where to seek help, and developing competencies designed to improve mental healthcare and self-management abilities (Kutcher et al., 2016).

Adopting good MHL is appropriate for managing mental health. According to Jorm (2012), people with a high level of MHL were more likely to recognize their mental disorders and identify appropriate sources of healthcare than those with a low level of MHL, who tended to use inappropriate coping strategies such as the use of alcohol and other drugs. Therefore, increasing MHL will also increase knowledge of dealing with mental disorders, both for oneself and providing first aid to others (Idham et al., 2019). Nevertheless, Jorm (2012) reported that MHL still did not get the same attention as physical health literacy. Moreover, the research about intervention efforts and improving the lack of MHL among the community, especially the young adult group, were also limited and poorly evaluated (Kelly et al., 2007).

In Indonesia, the information on the current state of MHL among the general population is still limited. However, a study demonstrated that a condition that reflected the low level of MHL among people in

Indonesia was an existing high level of stigma that developed in the community about mental disorders patients (Center for Public Mental Health, 2020). This stigma encourages reluctance to access mental health services in many people (Center for Public Mental Health, 2020). Another evidence that reflects the low level of MHL in Indonesia is the reliance on traditional and informal treatments in many communities, such as visiting religious practitioners and traditional healers as the first aid upon any signs and symptoms related to mental health disorders (Novianty & Hadjam, 2017). Moreover, a study also reported a lower level of MHL in non-mental health practitioners than in mental health practitioners (Praharsu et al., 2020). These findings suggested that the level of MHL in the community has remained persistently low. This indication was also suitable with a study that stated that the concept of MHL tended to conflict with traditional folk beliefs, especially in developing countries that assumed the idea only represented Western scientific conceptualizations (Jorm, 2012).

Additionally, Petersen et al. (2011) also revealed that traditional explanatory models and some of the conventional healing models of mental disorders were significantly attributed to the emergence of stigma, discrimination, and human rights abuses in the community. It further led to the delayed decision and their practice to seek any help for mental health care from formal health providers. Therefore, cultural diversity is an essential factor that needs to be considered in approaching the whole community to improve their mental health literacy (Jorm, 2012).

Furthermore, this low level of MHL might be worsened by Indonesia's low prioritization of mental health services (Nasir, 2020). Several studies have revealed that the priority of mental health services in Indonesia remains significantly low and unintegrated in primary health care services (Makkasau, 2013; Marchira, 2011). This low level of priority and attention against mental health services in Indonesia reflects how relevant stakeholders failed to meet the standards for mental health management set by WHO for developing countries (Marchira, 2011). This led to a lack of resources to address mental

health-related cases and stigma against mental health issues according to existing standards (Afifah et al., 2016; Marchira, 2011; Mawarpury et al., 2017).

In Indonesia, several organizations, including the Medical Doctors Association, the Association of Psychiatrists, Indonesian Psychological Association (HIMPESI), the Public Health Association, the Association of Nurses, Into Light Indonesia, Get Happy, Komunitas Peduli Skizofrenia Indonesia, Indonesia Mental Healthcare Foundation, and ISMILE4YOU had provided and delivered education and care to improve health literacy to the general public (Fanada, 2017; Nasir, 2020). Nevertheless, many of the population remain unaware of MHL and these organizations providing mental health services (Jorm, 2000; Syafitri & Wijayanti, 2017). In addition, religious organizations in Indonesia still play little in strengthening health literacy among the general population, either in the COVID-19 crisis or in the future (Nasir, 2020). Thus, this situation indicates the need for immediate action by relevant stakeholders and organizations to develop and apply appropriate planning, strategy, and effort to trigger an increase in MHL in the population (Grace et al., 2020). Moreover, the mental health services must be scaled up and given more resources to do this vital work (Nasir, 2020). Several interventions might be considered to be adopted to improve the MHL of the community potentially, and it includes whole-community campaigns; community campaigns aimed at specific groups as audiences; interventions based in an educational setting through teaching about help-seeking skills, the resilience of mental health, and MHL; mental health first aid training; and web-based interventions through providing of the validated information by mental health experts and relevant organizations regarding MHL and mental disorders management (Jorm, 2012; Kelly et al., 2007).

D. Available Resources for Mental Health

Accessing mental health resources is a crucial step in recovering from pandemic burnout. However, the delivery of mental health resources has to be rapidly modified from in-person, face-to-face formats to

remote delivery through online access (Murphy et al., 2021). These services are still facing challenges and adapting to the pandemic's effect on MHP, and the patients are still being felt. Various mental health resources are currently accessible worldwide, both in-person and online, especially in Indonesia; they are provided by the government, NGOs, and online industries - as listed in Table 7.1.

Table 7.1 List of Mental Health Resources Provided by Government and NGOs

Type of Resources	Name of Services	(G/N)	In-Per-son	On-line	Ac-cess
In-Person - Con-ventional Resource (Ifdil et al., 2020; Morin, 2021; Tala, 2020)	Psychotherapist	G/N	+	+	Glob-ally
	Psychiatrists	G/N			
	Psychologists	G/N			
	Psychoanalysts	G/N			
	Clinical counselors	G/N			
	Peer specialist	G/N			
	Social worker	G/N			
Online Therapy (Bali Bersama Bisa, 2021; Biro Hukum dan Humas Ke-men PPPA, 2021; Philipp, 2020)	Layanan Kesehatan Jiwa (SEJIWA)	G	-	+	Indo-nesia
	<i>Sehat Pedia</i>	G			
	LISA Suicide Prevention Helpline (Love Inside Suicide Awareness)	N			
	The Center for Indonesian Medical Students' Activities (CISMA) and UNICEF	N			
Telemedicine (Rokom, 2021)	Free consultation and prescription: Alodokter, GetWell, Good Doctor and GrabHealth, Halodoc, Klik-Dokter, and KlinikGo. Then Link Sehat, Milvik Doctor, ProSehat, SehatQ, and YesDok	G/OI	-	+	Indo-nesia
Self-Management Mobile App (Morin, 2021)	Free: Mood fit, eMoods (BV), Depres-sion CBT Self-Help Guide, Bearable (BV), PTSD Coach, Todoist (BV)	OI	-	+	Glob-ally
	Commercial: MoodMission, Shine, Calm, Talkspace, Happify, Sanvello,				

Note:G: Government, N: Non-Government Organization, OI: Online Industry, BV: Basic Ver-sion

In-person therapy is any conventional therapy in which the practitioner and the client meet directly in the same room simultaneously in an offline situation (Cruz-Cunha et al., 2010). Traditional mental health resources encompass HCPs who diagnose and treat mental illness, usually provided by the government or NGOs (Tala, 2020). Data on mental health facilities for in-person services other than mental hospitals and general hospitals with mental services are almost entirely unavailable. Until now, psychiatric beds are only available in mental hospitals and a small number of public hospitals. Other service facilities such as shelters, community care homes, daycare treatments, and so on do not yet exist in Indonesia. The psychiatrists per 100,000 population ratio were 0.01 in 2011 and 0.3 in 2014. Human resources in the mental health field other than psychiatrists include nurses as much as 2.67 per 100,000 population, psychologists 0.18 per 100,000 population, and social workers 0.05 per 100,000 population. Data on general practitioners, occupational therapists, and other health workers are unavailable (Idaiani and Riyadi, 2018).

Before the incidence of COVID-19, people suspected of mental health conditions or needing counseling had to make a hospital/clinic appointment with their mental health provider for diagnosis or treatment (Ifdil et al., 2020; Tala, 2020). This face-to-face counseling reduced cortisol levels, the 'stress hormone,' and raised dopamine, the 'happy hormone' (Hart, 2008). In addition, therapeutic presence enables a relationship attachment to grow, as it involves MHP being in the moment entirely on many levels, including relationally and physically (Geller & Greenberg, 2002).

However, in-person therapy during the pandemic was no longer relevant due to increasing challenges and limitations, even as mental health problems among patients and HCPs became more prevalent during the spread of the virus (Ojha & Syed, 2020). Currently, there is insufficient medical staff in Indonesia to bear with elevating demands for taking care of COVID-19 cases due to an unequal geographical distribution of physicians and a low physician-to-population ratio (Mahendradhata et al., 2021). In addition, with the high levels of

mental and physical stress, the psychological and physical well-being of HCPs adds another challenge (Tyssen, 2019). Patients understandably feared contracting the virus and refused to attend the few services that remained open (Murphy et al., 2021). This overall condition causes the number of untreated mental disorder patients to increase, even as the number of HCPs remains relatively limited and going away from the ideal ratio by WHO 1 doctor per 2,500 population. Significant changes in lifestyle that have become very restricted due to the lockdown have rendered face-to-face impossible (Pfefferbaum & North, 2020). Therefore, web-based intervention like online therapy can quickly solve this problem by continuing consultations without having to meet face-to-face and helps to stop the spreading of the virus in this pandemic.

Online therapy for psychological problems is a treatment (evident-base) for anxiety and depression. It is progressively being offered through various mediums of long-distance communication, including telephone, video conferencing, email, text, and web-based messaging between patients and their HCPs (Hasselfeld, 2021; Hyder & Razzak, 2020; Irvine et al., 2020; Tatum, 2021). These various methods are sometimes collectively referred to as ‘telepsychology’ or ‘mental telemedicine’ (Irvine et al., 2020). Before the onset of COVID-19, most therapists had concerns about mental telemedicine and only cared for patients face-to-face. However, during the COVID-19 lockdown, patients still need therapy, but face-to-face therapy sessions have become unsafe (Sampaio et al., 2021). Several Internet startups have been developed and tested for common mental disorders. Evidence suggests that these treatments often produce the same results as face-to-face psychotherapy and are relatively cost-effective (Andersson & Titov, 2014).

These days, mental telemedicine has spread beyond developed countries and entered prevalent use in developing countries, including Indonesia (Koh, 2019). In Indonesia, the government and NGOs own their mental telemedicine platform, as shown in Table 7.1. In addition, the Indonesian Ministry of Health is collaborating with

11 telemedicine service platforms as the government's response to monitor self-isolating patients and ensure the fulfillment of people's mental health rights during the COVID-19 pandemic. In contrast, it also improves public MHL; education, consultation, and psychological assistance are free (Biro Hukum dan Humas Kemen PPPA, 2021; Koh, 2019; Philipp, 2020).

Although the government, NGOs, and healthcare industry are rapidly combining new ways of treating people with mental health conditions with advances in technology (Ojha & Syed, 2020), these technologies cannot be applied equally in the nation due to the different distribution of healthcare resources (Wiseman et al., 2018). Especially in Indonesia, there are gaps in the district's public health system, resulting in a wider gap between those who receive adequate care for mental illness and those who do not. Therefore, it is necessary to evaluate the country's healthcare system's capacity to assimilate and suit the shifting healthcare requests (Mahendradhata et al., 2021). Most mental health patients (98.3%) were internet users, but there remains a substantial gap in high-quality internet access among urban and rural households (Allain-Dupré et al., 2021). Unfortunately, telemedicine options that require high-quality internet access, especially for video and audio services, are not as helpful. Only 60 % of people in rural areas have a good quality of internet, compared to over 95 % of people in the urban area (Anderson & Singh, 2021).

Online-based treatment and self-management for mental health have expanded the scope of treatment supply. The beneficial effects of self-management of mental health include improving well-being and lowering mortality, morbidity, and costs of medical care. In addition, there is a developing acknowledgment of the need for individuals with unremitting mental well-being conditions to expect duty for their well-being and be actively involved in self-management (Riegel et al., 2021). The ever-wider availability of mental health related-self management mobile applications, as listed in Table 7.1, permits clients to get to their feature at any time, seek specialists and medication while remaining anonymous, and offer a few ways to stay engaged,

like regular updates, sentiments to trackers, and inexhaustible learning material (Morin, 2021).

Still, although these mobile apps can be incredible tools to assist patients in self-manage their well-being concerns and medication, they are ideally meant to supplement a licensed therapist (Ifdil et al., 2020). Mental telemedicine inevitably still faces some limitations regarding the missing non-verbal communication. Research shows that 55% of communication on feelings and demeanor is passed on through facial expressions (7% passed on vocally, and the rest 38% by how things are said) (Hart, 2008). In this manner, much of what is communicated by a patient, both in the evaluation and within continuous treatment, will be misplaced in online counseling, as clinicians would have picked up critical information from the client not only through words but also through gestures, eye contact, and bodily movements. Without such information, the recovery rate will be impacted due to decreased quality of treatment (Geller & Greenberg, 2002).

There also exists a discrepancy in age, as data shows that younger patients search for information about diseases psychiatrists and communicate with other patients more frequently than older patients. Due to the lack of MHL, only a small percentage of individuals have previously used online self-management interventions. In the future, more people have communicated interest in utilizing online self-management interventions, especially for the younger patient. A study showed that 59.2% of patients with college degrees, 52.3% with high school degrees, and patients with mandatory degrees had expressed interest in using self-management intervention (Bali Bersama Bisa, 2021; Biro Hukum dan Humas Kemen PPPA, 2021; Philipp, 2020). Prove appears that improved MHL creates better mindfulness of looking for assistance and medication and advances early recognizable proof of mental disorders. Therefore, MHL is essential to improve mental health outcomes and increase health services in person or online (Wei et al., 2015).

E. Conclusion

COVID-19 pandemic affects not only socioeconomic and physical health but also mental health. Mental disorders were the driving causes of the health-related burden around the world. Indonesia is the fourth most populous nation in the world and, compared to other less crowded countries, is anticipated to endure massive losses over a more extended period. Among the mental health problems triggered by the pandemic, burnout is the most prevalent, caused by extreme changes in daily routines (such as social distancing, social quarantine, lockdowns, schooling and working from home, etc.). Due to the COVID-19 pandemic, burnout may be experienced by a majority of people, including HCPs as the most prominent and people from other various backgrounds like parents, workers, and young people.

Adopting good MHL is expected to be an appropriate option to manage mental health and improve stress from burnout. Accessible information to improve mental health literacy, health care, social connections, a supportive environment, and mental health surveillance is essential to prevent more significant post-pandemic psychiatric problems. In Indonesia, various mental health resources are currently provided by the government and NGOs and are accessible both in-person and online. Unfortunately, personal services are still remarkably lacking, with small psychiatric beds available in mental and general hospitals. Conversely, the ratio of HCP in Indonesia for mental health is still less at 2 per 100,000 population. The government should be concerned about this number and put some measures to increase it because generally, this number remains relatively low and goes away from the ideal ratio by WHO 1 doctor per 2,500. On the other hand, for online services to improve mental health, the Indonesian Ministry of Health is collaborating with 11 telemedicine service platforms as the government's response to monitor self-isolating patients and ensure the fulfillment of people's mental health rights during the COVID-19 pandemic. It also aimed to improve public MHL with free education, consultation, and psychological assistance.

It is essential to improve the mental health system in various countries due to the emergence of the COVID-19 pandemic. Prevention strategies can consolidate ways to make strides in mental health and target the clincher of the low mental health level and activities to care for those with a mental disorder. Therefore, this chapter can be seen as an evaluation as it gives insights for all stakeholders to improve mental health in Indonesia and adjust existing policies that affect people's mental health. The authors have suggested fast, comprehensive, and more precise approaches within the brief and longer-term mental health to build a resilient and future-ready society, especially for workers, young people, and HCPs.

F. Recommendations for Improving Mental Health

It is essential to improve the mental health system in various countries due to the emergence of the COVID-19 pandemic. Prevention strategies can consolidate ways to improve mental health and target the clincher of low mental health levels and activities to care for those with a mental disorder. It is not an option to not take action to overcome the burnout caused by the COVID-19 pandemic. There is no option not to take action to overcome the burnout caused by the COVID-19 pandemic. The rise of the COVID-19 pandemic in 2020 has increased numerous questions concerning its rapid psychological effects and long-term financial and social concern (Santomauro et al., 2021).

Indonesia still has a massive gap between the reality (<2 per 100,000 population) and the ideal (1 per 2,500 population) ratio for HCP in mental health (Pfefferbaum & North, 2020). For accessing online mental health services, there also remains a substantial gap in high-quality internet access among urban (90%) and rural households (60%) (Anderson & Singh, 2021). Moreover, a discrepancy in patient age and educational background exists in to search for information about mental health problems (Wei et al., 2015). Therefore, due to these gaps, we recommend the government (Adit, 2020):

1. Prevent mental health crises during and after the pandemic by facilitating the results of surveillance of mental health problems

and health resources and providing support for access to reliable information and technology.

2. Provide mental health and psychosocial support for productive and vulnerable age groups by facilitating adaptation to work and study from home, strengthening interactions within the family, social security, and health.
3. Expand the reach of mental health services in the community by facilitating access (including self-checking technology and teleconsultation), integrated physical health services, standardized service guidelines, and active outreach in the community.
4. Ensure continuity of mental health services for people with mental disorders through the development of telemedicine, drug access policies, and prevention of physical health risks.

According to OECD (2021), people between 15 to 24 years old have mental health that deteriorates significantly by 2020–2021. Their mental health support is severely compromised, notably in schools, college, and the workplace (Xu & Banks, 2020). The protective factors that help maintain good mental health, such as social interaction and daily routines, are weakened by the closure of educational institutions at all levels, especially in underprivileged backgrounds (UNESCO, 2021). In addition, the impact of COVID-19 on the labor market disproportionately affects youth, reduces work-based learning for students and part-time job opportunities, and exposes prospective and recent graduates to the daunting task of finding and keeping jobs, placing them at high risk of developing health problems. Mentally throughout life (Churchill, 2021). Therefore, to protect the mental health of young people, it is necessary to build a resilient and future-ready society; an integrated policy response is needed, both short and long term, including:

1. Prioritizing support through information dissemination for mental health, through telephone, web-based services, and face-to-face services that can be accessed quickly (OECD, 2021) because the foundation to promote mental health in young people is the need to gain MHL (Jorm, et al., 2012). Alternatives must

be sought immediately in case mental health support services in educational institutions cannot continue;

2. Supporting young students at risk of dropping out of school early, including those with mental health problems, should be prioritized. COVID-19 has disproportionately impacted labor market outcomes leaving young graduates to experience an uphill challenge to seek, retain and stay in work (OECD, 2021). This is to maintain socio-economic aspect and prevent long-term problems as unemployment has been shown to hurt self-esteem and increase depression (Churchill, 2021);
3. Ensuring managers and staff in the workplace and school have a good MHL and contributing factors for well-being is essential to promote better mental health among young adults and to achieve high performing workplace and school (OECD, 2021; Idham et al., 2019).

HCPs role in the pandemic caused them to experience noticeable challenges and stressors that may negatively affect their physical, mental, and emotional well-being (Svold et al., 2021). Front-line healthcare providers and those who worked in low-resource settings were the most vulnerable. Due to HCP's mental health being directly related to health service quality, more attention has been paid to improve their mental well-being (Hayashino et al., 2012; Khanal et al., 2020; Muller et al., 2020). We offer some recommendations to improve mental health in HCPs and to build a resilient and future-ready society:

1. Increase the MHL of health workers by creating a national knowledge base containing essential information, tools, and resources to improve workers' resilience and welfare in times of crisis and rebuilding. Digital technology and other innovative approaches can ensure access to ongoing support, guidance, and training, especially for frontline workers (Thatrimontrichai et al., 2021).
2. Adequate staffing, appropriate work shift, and regular breaks must be ensured, as long shifts and high demand can pressure health care staff. Indirectly, this may cause staff shortages as workers

- get sick or stay home because of stress and anxiety or for other reasons (Thatrimontrichai et al., 2021).
3. Clear communication with healthcare workers is critical to identify and acknowledge the most common concerns of healthcare workers. Struggling providers must be encouraged to seek support and help, and the availability of appropriate support resources must be ensured. (Knaak et al., 2017; Thatrimontrichai et al., 2021).
 4. The stigmatization of healthcare workers must be condemned and reduced by educating the community about mental health stigma and negative stigma on healthcare workers. Any workplace culture that does not support mental well-being must also be revised. (Knaak et al., 2017).

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