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How has the mental health of junior staff been negatively affected by the current COVID-19 climate?

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ARTICLE INFO

Keywords:
Mental health
COVID
Trainees
Support
OMFS

ABSTRACT

While pandemics are widely recognised and remembered for their devastating physical effects on human and/or animal life, previously a less talked about but recognised effect is that on mental health. This audit aimed to measure the negative effects COVID-19 has had on the mental wellbeing of junior staff working in hospitals, specifically the Dental Core Trainees (DCT) throughout the Thames Valley and Wessex (TVW) Deanery.

40% of the respondents used the intervention, with meditation and mindfulness found most useful. The overall mental health of the DCT improved with increased scores seen in all areas of personal life. Leisure activity/hobbies increased as well as positive behaviours which resulted in anxiety levels decreasing significantly. There was an overall reduction in all stressors except ‘workload/responsibilities’, which increased from 40 to 80%. Dissatisfaction with senior support which was not in line with what the DCT wanted or needed. Responses still showed that ‘family/friends health’ continues to be of higher importance than ‘personal health’.

The intervention was partly successful, with increased satisfaction levels and improved mental wellbeing. A lack of perceived internal support from Trusts and poor communication from senior colleagues with no specific guidance on how their role was changing despite the second intervention.

1. Introduction

Pandemics are widely recognised and remembered for their devastating physical effects on human and/or animal life. However, their effect on mental health both at the time and subsequently is also important [1,2].

The majority of dental core trainees (DCT) are recently qualified dentists, many of whom move into Oral and Maxillofacial Surgery (OMFS) jobs within hospitals around the country. Challenges not only include introducing unfamiliar medical based knowledge but the likelihood of re-locating away from family and friends [3]. Prior to COVID-19, a recent study showed almost half of dentists saying stress in their job is exceeding their ability to cope and 17% of these admit they had seriously thought about taking their own lives [4]. The current evidence suggests that working conditions and nature of dentistry contribute heavily to this stress and affects patient care [5,6]. However, there is limited research specifically assessing the mental health of those undergoing dental training pathways in the UK. With the COVID-19 pandemic occurring alongside this, it has brought a unique and difficult environment.

The dental regulator, General Dental Council (GDC) has nine principles which dentists must follow throughout their professional and private lives, however none of these promote self-care in order to work more effectively for our patients. This research aimed to identify the mental health status, potential stressors and relievers for DCT, with the hope of improving mental health and support provisions.

2. Method

This research encompassed a two-cycle questionnaire with a tailored intervention separating the two. An online questionnaire (Appendix 1) was emailed to all DCT in the TVW deanery and anonymised, with a further three reminders being sent out over a three-week period.

The questionnaire included 25 questions covering many aspects of life that may have been affected by the pandemic, habits that could impact mental wellbeing as well as how the respondents perceive their own mental wellbeing. A large variety of questioning styles were utilised in order to develop a deeper understanding of satisfaction levels, for more detailed answers and for individuals to express specific feelings more clearly.

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Three weeks after the first cycle an intervention consisting of a wellbeing resource was emailed to all DCT and consultants, during which time the COVID-19 pandemic would have developed and changed lifestyle and surroundings further. The resource (Appendix 2) was created to enable DCT to reflect more on their mental wellbeing and acted as a pool of information that they could easily access. The following topics were included:

- Meditation and Mindfulness
- Positive attitudes
- Exercise
- Acute stress relieving techniques
- Food/healthy eating

A second cycle of the questionnaire was distributed 3–4 weeks after the wellbeing resource and two further reminders were sent. The second questionnaire was the same as the first to allow direct comparison, however an additional five questions based on the wellbeing resource were included:

1. Did you use the wellbeing resource sent to you over the last 3 weeks?
2. Which of the sections of the wellbeing resource did you find most useful?
3. How many different sections did you use?
4. How many times a week did you use the resource?
5. Do you have any comments about the wellbeing resource, or think anything else would be a useful addition?

These aimed to demonstrate the frequency the resource was utilised and its level of impact upon the results when comparing both cycles. These additional questions were also created to receive feedback on how it could be improved and used in the future for new junior staff.

3. Results cycle 1

All respondents were either DCT 1 or 2, aged between 25 and 28. Of the initial questionnaire, there were 12 responses out of a possible 29, giving a 41% response rate.

The pandemic resulted in a large range in differing mental health statuses amongst the DCT (Question 2, Fig. 1), with scores varying from 3/10 to 10/10, showing that whilst some were thriving, others were significantly struggling to cope. Nearly all, however, were abstaining from behaviours which could potentially negatively impact on mental health or be a symptom of poor mental health, with only inactive lifestyle being the behaviour that increased (Question 3 and 6). Conversely, questions 4, 6 and 24 assessed positive behaviours and how these may have been affected, with exercise/fitness routine being the one aspect that has been stopped for some respondents. Whilst 83% were undertaking hobby/leisure activity as a coping strategy, hobbies have been affected with only 1/3 of DCT being able to continue them in the same way prior to COVID-19.

DCT were asked to rank causes of high stress experienced over the previous three months (Question 5, Fig. 3). Unsurprisingly, 41% identified their workload/responsibilities and furthermore 33% identified moving from home and family member health as their significant stressors, showing a large proportion of the DCT were under considerable strain not only due to work commitments but also due to lifestyle and personal factors.

When it came to support networks, sadly, only 50% of DCT felt their network was somewhat available to them, with 50% again stating they did not know where to go for support within their Trust (Questions 15 and 16). There was a mixed response with regards to senior support, and whilst the majority were satisfied and scored 7–9/10, 1/3 still scored 4–5/10 (Question 17, Fig. 4). This means that at a time of heightened stress, many were receiving less support both from work and personal life.

Generally, people were worried about the pandemic (Questions 19 and 20, Fig. 5), with scores ranging from 6/10 to 10/10, with 41% scoring 7/10. Interestingly, the majority were concerned of that of their family/friend’s health over their own. When assessing other potential worries the DCT may have, including: “Increased work responsibilities, completion of training post, personal health and family/friend’s health”, despite wide ranging results, the majority of responses were skewed towards the higher scores (Fig. 6).

4. Cycle 2 results and comparison

The second questionnaire sent out included 5 further questions, as mentioned above, related to the use of the intervention. Out of the 12 who responded to the first questionnaire only 5 responded in the second cycle creating a response rate of 41%. The following statements represent the responses to the extra 5 questions included:

- 40% of the respondents used the resource
- DCT found ‘Meditation and Mindfulness’ to be the most useful section
- 60% used 1–3 out of the 5 sections
- 20% used the resource every day, 20% used it 4 times per week and 60% did not use it every week

The responses to the second cycle showed a more positive outlook, with an increase in satisfaction in all areas of personal life for the DCT including mental wellbeing, with the score range reducing and skewing towards the higher end (7–10/10, Question 2, Figs. 1 and 2).

There was minimal change in negative behaviours with most abstaining from them and positively, no one responded ‘increased’ to inactive lifestyle (Question 3). Although hobby/leisure activity remained reduced, this time all respondents felt that they could do their hobbies in some way, which was an improvement from the responses taken at the start of COVID-19 (Question 24). Whilst there was a boost in healthy eating, it was prayer and dedicated time for rest which significantly increased from 40 to 60%. An overall reduction in all stress management habits in questions 4 and 6 was also noted.

We can see an overall reduction in all stressors with the exception of ‘Workload/responsibilities’ which increased from 40% to 80% (Question 5, Fig. 3). The respondents from question 15 stated a great improvement in the perception of their support network with 80% feeling that it was still available to them just as before COVID-19. The remainder still had a support network in a reduced form and there was been an elimination of ‘No’ responses. Question 16 showed a pronounced improvement from 50% to 80% of DCT stating they were informed of where to go for help and support within their Trusts, however it seems additional effort is still required to raise this awareness further.

Contrastingly, Question 17 showed a greater dissatisfaction from the DCT with regards to senior support, with results decreasing down to 3/10 alongside the mode response falling from 7/10 to 5/10 (Fig. 4). This indicates that the second part of the intervention was not successful or that the type of support received from seniors was not in line with what the DCT wanted or needed.

There has been a significant improvement in anxiety levels amongst the DCT regarding the pandemic (Question 19, Fig. 5) with all scores of 8, 9 and 10 being eliminated and 60% scoring 6/10. Responses still show that ‘family/friends health’ continues to be of higher importance than ‘personal health’, with the ranges decreasing and an eradication of the highest and lowest responses (Question 20, Fig. 6).

5. Discussion

Stress is a physiological reaction to feeling under threat and it is widely documented that it influences our mood, behaviour, health and well-being [7]. While there is a relationship between the nature,
quantity and frequency of stress on the factors outlined above, it is also affected by genetics and resources available which aid coping strategies [7–9].

Our results have evaluated DCT mental wellbeing during a very unique period which has not been previously experienced. Although the sample pool was small, with 59% of the cohort not responding to the first cycle questionnaire there was still a wide range of responses, some of which helped highlighted effects potentially caused by COVID-19, lifestyle alterations during quarantine and an indication of the need for further support. One of the drawbacks of the questionnaire was that it wasn’t clear what state the mental wellbeing of the DCT was prior to COVID and therefore difficult to measure its effects.

Some of the results show that generally the DCT of Thames Valley and Wessex have many positive habits and limited in their negative ones. However, there was a large variation in how they perceive important aspects of their lives regarding family, friends and their own mental health. This could be indicating that some found it more difficult to deal with recent changes caused by COVID or have had to endure far greater changes than others, due to the variation in job roles. In the second cycle, it was noted that workload and responsibilities increased significantly. This was likely affected by those DCT who were redeployed to a new area or team within the hospital, or those working in the new Urgent Dental Centres, as they were placed in new environments with very little time to prepare. A change/increased workload is a specific change that can negatively impact mental wellbeing, but this will come alongside other environmental stressors. This gives an indication that some intervention needs to be targeted at the changes caused by coronavirus but also how to deal with other stressors with a more general intervention.

A large area where improvements are needed is in support and isolation. Many junior doctors and dentists live alone or in hospital accommodation. While they would have previously sought social contact from friends and family, this was taken away during lockdowns and will have caused colleagues to start requiring additional support. Only 50% knowing where they could go for support in their trust is not suitable during this time. This support would come from various areas at work; on a daily basis from within individual teams but also from occupational health, should stressors exceed local coping strategies. Support from senior colleagues did not score highly and was backed up by emails sent into our regarding a perceived lack of support. Changing daily guidance due to an evolving situation can make keeping teams informed difficult and staff can quickly feel lost or uninformed if information isn’t shared in a timely manner from senior colleagues.

The pandemic has created new worries and exaggerated other normal stressors. DCT would usually have some sort of worry about whether they would complete their training posts, being able to complete projects and targets before their final competency review. This is definitely an area that has been exacerbated due to a reduction in patient contact, reduced time in work, reduced procedures allowed and at the second intervention aimed to address this, the results showed this was not effective, although this was difficult to measure with only one question addressing it.

Declarations of competing interest

None.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.jadoms.2021.100143.

Ethics statement/confirmation of patient permission

None required.

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