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Article

Study of Impact of COVID-19 on Mental Health and Wellbeing of Staff Working in a Forensic Mental Health Service

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Abstract: This study explored the impact of COVID-19 on the mental health and wellbeing and trust support of Tees Esk and Wear Valleys (TEWV) NHS forensic staff using an online google survey during the second wave of the pandemic. Survey respondents were a voluntary cross-sectional sample of 246 TEWV staff working in the forensic directorate staff; this included males ($n = 60$, 24.5%); with the majority of staff aged between 36–50 years ($n = 99$, 40.2%) and 50 years or older ($n = 80$, 32.5%). The results showed that staff working at home and on the front line were both affected by depression, stress and anxiety. Those most at risk were younger staff members. We concluded that the mental health and well-being of staff working should be a priority. It is important to consider targeted support that should be aimed at younger staff members to provide an open culture enabling for those who want support to have readily available signposted resources. Staff working in different settings may have experienced a different impact of COVID-19 on their mental health and wellbeing, and whilst some interventions might be successfully applied across the service, it would be beneficial to understand the unique needs of staff working in specific settings.

Keywords: COVID-19; frontline mental health workers; survey; mental health; well-being



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1. Introduction

Since 2020 the COVID-19 pandemic has been a worldwide major life event. It has affected the way most people work, especially those that provide healthcare to others [1]. To the authors' knowledge, this is one of the first studies to examine the experiences of forensic mental health care staff in the UK during the COVID-19 pandemic. The survey data were collected towards the end of the second wave when the government began the 4-step roadmap and national lockdown restrictions began easing. Previous literature evidences the substantial psychosocial impact of the pandemic on the healthcare workforce [2]. The annual NHS staff survey reported 44% of all staff being ill from work-related stress, a significant increase on the previous year. Approximately one third of NHS staff working on COVID-19 wards in the last year, reported feeling unwell due to work-related stress [3]. More specifically, this finding was shown in a comparable mental healthcare sector study which demonstrated moderate levels of burnout and mild to moderate levels of anxiety and depression in staff working in learning disability service in Ireland during the pandemic [4]. A systematic review found similar results worldwide in Italy [5], Spain [6], Norway [7] and Switzerland [8].

Depression is an affective state characterised by low mood or reduced interest in activities which may be associated with low energy levels, poor concentration and disturbed sleep. Anxiety symptoms include excessive worry, impaired concentration, restlessness and increased heart rate [9]. Stress symptoms may include mental or physical tension, feelings of pressure and negative emotions [10].

Within the Directorate the forensic mental health, learning disability and autism services provide inpatient, prison and community care and treatment to vulnerable, high-risk patients, often with physical health co-morbidities, living in the Northeast of England

and North Cumbria. These patients often have treatment resistant conditions and are susceptible to worse outcomes from COVID-19 infection [11]. Staff worked in a range of setting including in a secure mental health hospital with 187 beds for adults with a mental disorder, learning disability or autism and non-secure wards with 11 beds for adults with a learning disability. Some participants worked in community teams where healthcare was provided in outpatient clinics, in the homes of patients, care/nursing homes, in police stations and in the Courts. Other participants worked as part of a mental health in-reach team located in each of the region's eleven prisons.

The COVID-19 pandemic has challenged the delivery of mental health care as many staff were encouraged to work from home and the amount of usual face-to-face appointments were reduced and/or changed to phone or video calls. Front line staff working in mental health services have had to quickly adapt to find new ways of working that attempt to reduce transmission of infection, whilst also trying to minimize disruption for patients [12].

The aim of this study was to find out the Impact of COVID-19 on the mental health and wellbeing of staff working in Forensic Mental Health Services in Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) in the UK. The Foundation Trust employs overall 7500 (79% female and 21% male) staff.

2. Materials and Methods

Data were provided by a cross sectional group of staff ($n = 246$) who worked in within the Forensic Directorate of Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). High levels of staff sick leave were reported during this time frame with 216 and 234 absent during February and March respectively.

Survey respondents were broadly representative of the wider staff group: female ($n = 180$, 73.4%) male ($n = 60$, 24.5%). Most staff were aged between 36–50 years ($n = 99$, 40.2%) and 50 years or older ($n = 80$, 32.5%). Respondents represented a range of professional groups. Eighty-four were nurses (34%), thirty-two were psychologists (13%), thirty-two were health care assistants (13%), thirty-two were managers (13%), twenty-three were administrators (9%), twelve were medical doctors (5%), twelve were allied health professionals (5%), two were social workers (1%), and thirteen were in other roles (5.3%). Many staff were working in a patient facing role most ($n = 153$, 62.7%), or some of the time ($n = 61$, 25%) during the pandemic.

2.1. Measures

Participants completed a survey comprising of three main sections: (i) exposure to COVID-19, (ii) impact on wellbeing, including self-report anxiety, depression, stress, sleep and alcohol intake and, (iii) support provided by the Trust (TEWV). There were 26 questions in total, 9 in section (i), 7 in section (ii), 6 in section (iii), and the remaining 4 questions were related to COVID-19 tests and vaccinations. All questions were multiple choice and responses included "yes", "no", "to some extent", "to a large extent". Demographic data were collected on gender, profession, and age. The survey did not use standardized measures of depression, anxiety, stress or alcohol intake; instead, self-report items were used. This was deemed more appropriate in a group of NHS staff working within the mental health directorate and with whom are very familiar with their own mental health and well-being. Additionally, the survey was not aimed at diagnosing staff with their own mental health condition but was interested in staff self-perception of their own well-being.

2.2. Procedure

The bespoke survey was developed in collaboration with TEWV forensic clinical staff (led by SG) and a researcher from the University of York (AP). The survey was reviewed by the COVID-19 senior clinical management team and key staff members (e.g., AA). The survey was facilitated electronically by an online google link and circulated to all senior managers in the Forensic Directorate via email between 3 February 2021 and 31 March 2021.

Managers were responsible for sending the email to their colleagues to ensure full coverage of the service workforce. The survey was promoted widely to all forensic staff to gain the maximum responses. Promotional channels included: staff meetings, research champions (members of staff who encouraged uptake of the survey), forensic directorate management meetings, emails sent to team managers, and the weekly forensic directorate staff briefing. The final sample of respondents was a non-random volunteer self-selecting group of staff who were willing to complete the survey.

It is worth noting that during this time the patient population in TEWV forensic services was almost static, new admissions, discharges and leave of absence were postponed for most patients. Consequently, the chance of staff becoming infected with COVID-19 from patients was minimal and the foremost concern was to protect the patients from becoming infected by staff.

2.3. Ethics Approval and Consent

The final version of the survey was approved by TEWV audit and clinical effectiveness team, where it was deemed a service evaluation (ref: 6380FOR20). Information on participation was included at the start of the online survey to gain informed consent. By starting the survey, participants agreed that they had read and understood this information. All survey responses were anonymous.

2.4. Analysis

Descriptive information from each item was summarized by categorical response; this included the frequency count for each item, percentage, mean age, and range. The distribution of the data was assessed for each item to identify whether it was normally distributed, and appropriate statistical tests were applied (e.g., Fishers Exact Test) depending upon the distribution (parametric/non-parametric) and Chi-squared tests. All analyses were conducted using Social Science Statistics (<https://www.socscistatistics.com/tests/chisquare2/default2.aspx>, accessed on 22 September 2022). Analysis was considered at $p < 0.05$ to identify differences between patient, and non-patient facing roles, impact of working at home or on the wards, gender, age and alcohol intake.

3. Results

3.1. Mental Health (Impact on Anxiety, Depression, Sleep)

3.1.1. Patient Facing vs. Non-Patient Facing Roles

Those in patient facing roles were most affected by the pandemic. Data from Table 1 were collapsed into a dichotomous variable (patient facing yes, most of the time vs. none of the time). Using this categorical variable staff in patient facing roles demonstrated significantly higher levels of self-reported anxiety and stress compared to non-patient facing roles 35% vs. 23% ($p = 0.004$), and depression 16% vs. 13% ($p = 0.000$).

Table 1. The effect of Covid-19 on stress & anxiety, depression, and sleep in forensic staff by sample characteristics.

	<i>Increase in Stress & Anxiety Levels</i>					<i>Increase in Depression Levels</i>					<i>Difficulty Sleeping</i>				
	Not at All (%)	Yes, Some (%)	Yes, a Lot (%)	n/a (%) *	χ^2 p-Value	Not at All (%)	Yes, Some (%)	Yes, a Lot (%)	n/a (%) *	χ^2 p-Value	Not at All (%)	Yes, Some (%)	Yes, a Lot (%)	n/a (%) *	χ^2 p-Value
Gender															
Male (n = 59)	5 (8)	34 (58)	16 (27)	4 (7)	1.00 > 0.05	17 (29)	28 (48)	9 (15)	5 (8)	0.19 > 0.05	20 (34)	25 (42)	10 (17)	4 (7)	0.32 > 0.05
Female (n = 177)	22 (12)	96 (54)	58 (33)	1 (1)		57 (32)	81 (46)	26 (15)	13 (7)		62 (35)	86 (49)	27 (15)	2 (1)	
Age (years)															
18–25 (n = 10)	0	7 (70)	3 (30)	0	6.51 > 0.05	0	6 (60)	3 (30)	1 (10)	6.30 > 0.05	0	9 (90)	1 (10)	0	11.31 > 0.05
26–35 (n = 57)	3 (5)	32 (56)	22 (39)	0		19 (33)	28 (49)	9 (16)	1 (2)		17 (30)	34 (60)	6 (10)	0	
36–50 (n = 99)	12 (12)	60 (61)	27 (27)	0		32 (32)	49 (49)	10 (10)	8 (9)		40 (40)	42 (42)	16 (16)	1 (2)	
50+ (n = 80)	12 (15)	36 (45)	27 (34)	5 (6)		23 (29)	32 (40)	15 (19)	10 (12)		26 (33)	32 (40)	16 (20)	6 (7)	
Patient facing															
No (n = 30)	5 (17)	18 (60)	7 (23)	0	2.73 > 0.05	8 (27)	13 (43)	4 (13)	5 (17)	4.24 > 0.05	11 (37)	12 (40)	6 (20)	1 (3)	1.67 > 0.05
Yes, some of the time (n = 61)	7 (11)	35 (57)	18 (30)	1 (2)		25 (41)	25 (41)	7 (11)	4 (7)		22 (36)	27 (44)	11 (18)	1 (2)	
Yes, most of the time (n = 153)	15 (10)	80 (52)	54 (35)	4 (3)		41 (27)	76 (50)	25 (16)	11 (7)		50 (33)	77 (50)	22 (14)	4 (3)	
Home working															
No (n = 94)	12 (13)	51 (54)	31 (33)	0	0.78 > 0.05	23 (24)	48 (51)	18 (19)	5 (6)	4.32 > 0.05	32 (34)	46 (49)	15 (16)	1 (1)	1.75 > 0.05
Yes, some of the time (n = 122)	13 (11)	65 (53)	39 (32)	5 (4)		42 (34)	51 (42)	16 (13)	13 (11)		40 (33)	59 (48)	18 (15)	5 (4)	
Yes, most of the time (n = 28)	2 (7)	17 (61)	9 (32)	0		9 (32)	14 (50)	3 (11)	2 (7)		11 (39)	10 (36)	6 (21)	1 (4)	

* Statistical testing did not involve the NA category across any aspect of the table.

3.1.2. Home Working

Regardless of whether staff were mandated to work at home or as usual in the hospital setting, levels of self-reported anxiety and stress and difficulty sleeping were not statistically significantly different. The categorical responses of 'no' vs. 'yes, most of the time' were compared to show that levels of self-reported depression increased most in those that did not work from home with 19% ($n = 18$) stating their levels had increased to a greater extent and 51% ($n = 48$) to some extent.

3.1.3. Age and Gender Differences

Those aged between 26–35 years experienced the greatest impact of anxiety and stress during the pandemic with 39% ($n = 22$) of this group stating it was increased to a large extent. Levels of depression were greatest in those that were youngest and least experienced in their roles and aged between 18–25 years of age 30% ($n = 3$), although the numbers were too small to draw any conclusions (Table 1). Those aged 50 years and older were least likely to sleep well with 20% ($n = 16$) saying their ability to sleep was impacted to a large extent.

3.2. Variations in Substance Use

Alcohol consumption increased most in those that did not work from home with 15% ($n = 14$) reporting drinking more alcohol, compared to those that worked from home some days 11% ($n = 14$) and most days 11% ($n = 3$). Increase in smoking activity was similar in both those that did not work from home 12% ($n = 11$) and those that were home working most days 11% ($n = 3$) (Table 2). The age group who reported the largest increase in alcohol use was 26–35 years with 18% ($n = 10$) saying they had increased alcohol consumption due to stress related to the pandemic and 23% ($n = 13$) that it had increased to some extent. This age group also reporting the greatest increase in stress and anxiety. The data showed marginal differences between the age groups in terms of increased smoking due to the stress of the pandemic. Similar levels of increase in alcohol consumption due to the stress of the pandemic were seen in both males 15% ($n = 9$) and females 11% ($n = 20$). Overall, age appeared to have the largest impact on increase consumption of alcohol and smoking due to the stress of the pandemic with the biggest increase in the age group aged 26–35 years. Gender and working at home or not had minimal impact on substance use habits.

Table 2. Substance use of forensic staff during the COVID-19 pandemic by sample characteristics.

	<i>Increase in Alcohol Consumption</i>					<i>Increase in Smoking</i>				
	No	To Some Extent	Yes	n/a	χ^2 p-Value	No	To Some Extent	Yes	n/a	χ^2 p-Value
Gender										
Male (n = 59)	31 (53)	10 (17)	9 (15)	9 (15)	1.31 > 0.05	10 (17)	1 (2)	5 (8)	43 (73)	2.58 > 0.05
Female (n = 177)	115 (65)	33 (19)	20 (11)	9 (5)		64 (36)	6 (3)	12 (7)	95 (54)	
Age (years)										
18–25 (n = 10)	7 (70)	2 (20)	1 (10)	0	3.16 > 0.05	3 (30)	0	0	7 (70)	Insufficient data to test
26–35 (n = 57)	31 (54)	13 (23)	10 (18)	3 (5)		22 (39)	2 (3)	5 (9)	28 (49)	
36–50 (n = 99)	64 (64)	19 (19)	10 (10)	6 (7)		24 (24)	3 (3)	8 (8)	64 (65)	
50+ (n = 80)	48 (60)	12 (14)	10 (13)	10 (13)		29 (36)	2 (3)	6 (7)	43 (54)	
Patient facing										
No (n = 30)	19 (63)	7 (23)	3 (10)	1 (4)	2.77 > 0.05	5 (17)	1 (3)	1 (3)	23 (77)	1.53 > 0.05
Yes, some of the time (n = 61)	40 (66)	8 (13)	10 (16)	3 (5)		20 (33)	2 (3)	3 (5)	36 (59)	
Yes, most of the time (n = 153)	90 (59)	31 (20)	17 (11)	15 (10)		53 (35)	4 (2)	14 (9)	82 (54)	
Home working										
No (n = 94)	55 (59)	19 (20)	14 (15)	6 (6)	4.28 > 0.05	31 (33)	1 (1)	11 (12)	51 (54)	8.99 > 0.05
Yes, some days (n = 122)	71 (59)	25 (20)	14 (11)	12 (10)		41 (34)	4 (3)	5 (4)	72 (59)	
Yes, most days (n = 28)	22 (79)	2 (7)	3 (11)	1 (3)		5 (18)	2 (7)	3 (11)	18 (64)	

3.3. Support from the Trust

Most staff felt well supported by the Trust (Table 3). Most respondents found the Trust management supportive throughout the pandemic with only 14% ($n = 35$) answering 'no'. Most respondents were satisfied with the provision of PPE 77% ($n = 190$) and COVID-19 tests from the Trust 77.6% ($n = 191$). A small number of staff said the provision of PPE and COVID-19 tests was not adequate (6%; $n = 15$ and 6.5%; $n = 16$ respectively). The response to the daily COVID-19 email briefings was largely positive with 56% ($n = 137$) saying they found them helpful and 32% ($n = 79$) saying they were helpful to some extent. Two areas of staff dissatisfaction focused on the provision of free uniforms with 22.4% ($n = 55$) saying they were not helpful, and the adequacy of IT systems with 16% ($n = 40$) stating 'no'. Overall, most staff appeared satisfied with the Trusts' efforts to support them throughout the pandemic.

Table 3. Forensic staff perception of support by TEWV during the COVID-19 pandemic.

	No (%)	To Some Extent (%)	Yes (%)	n/a (%)
Do you feel that the Trust management has been supportive during COVID-19 pandemic	35 (14)	100 (41)	111 (45)	0
Do you feel that the Trust's IT systems have been adequate to meet your needs?	40 (16)	81 (33)	125 (51)	0
Do you feel that the COVID-19 briefings have been helpful?	29 (11.6)	79 (32)	137 (56)	1 (0.4)
Do you feel the provision of free uniforms has been helpful?	55 (22.4)	0	141 (57.3)	49 (20)
Do you feel that the provision of PPE has been adequate to meet your needs?	15 (6)	41 (17)	190 (77)	0
Do you feel that the provision of COVID-19 testing by the Trust has been adequate to meet your needs?	16 (6.5)	37 (15.1)	191 (77.6)	2 (0.8)

4. Discussion

One of the main findings of this paper is those in patient facing roles reported significantly higher levels of self-reported anxiety, stress and depression during the pandemic. This is perhaps not surprising given that most of those in these roles, such as nurses and health care assistants, typically involved close contact with patients and therefore higher risk of transmission of COVID-19.

Similar to our study findings other research has shown that several factors contributed to the adverse effect on wellbeing in mental healthcare staff. These included, risk of infection, staffing pressures, longer working hours, moral injury, increased responsibility, patient frustration, feelings of uncertainty, and feelings of guilt among others [13]. Our research also concurred with the same major finding from this paper reporting similar increases in self-reported anxiety, stress, depression, and sleep difficulties in both those working as usual and those working from home. Interestingly, the reverse was true of sleep with 20% ($n = 6$) of those in non-patient facing roles reporting that their ability to sleep was affected to a large extent in comparison to only 14% ($n = 22$) of patient facing staff, (categorical response 'yes a lot') but this was not found to be statistically significantly different ($p = 0.36$). Working from home has some acknowledged benefits (e.g., greater flexibility), there were also several negative aspects noted elsewhere (7.8). There was no significant difference between those who work from home some days and those that were home working most days. Other research found that the average length of a workday has increased by 48.5 min, and the number of meetings per person had increased 12.9% since working from home was introduced [14]. Furthermore, home working was found to increase screen time resulting in feelings of fatigue, headaches, and increased eye strain [15]. The term 'zoom fatigue' has even been coined describing the emotional and physical drain of constant video conferencing [16]. There have also been reports of back-to-back virtual meetings as no travel time is required [17] and the expectation of constant connectivity [18]. The necessary rapid introduction of remote working also meant that some staff had to learn to use new technologies too quickly and/or without sufficient training and support [19];

this will have an impact on how people work in the future and new policies are required to support staff regardless of whether they work at home or continue with some element of hybrid working following the pandemic.

Not all staff may have had adequate physical space and required facilities to work from home effectively, such as good internet connection or a desk. Indeed, the results from this survey showed dissatisfaction with IT systems as one of the main issues for staff [17]. One study in mental health staff found that some experienced digital connectivity issues when communicating with vulnerable service users, which impacted the ability to build a trusting relationship [20]. Although virtual health care has been available for several years, it had not been widely adopted by health care providers. The pandemic prompted urgent implementation of “tele mental health” as a delivery option in order to reduce transmission of COVID-19 [21]. It is important to note the digitization of mental health care has some benefits including improved time efficiency, more flexibility in working hours, reduced waiting times and reduction in non-attendance [22], these benefits have been demonstrated globally across mental health services [23].

Our research found that those in the two younger age groups [18–34] appeared most negatively affected by the pandemic. This finding is consistent with the growing body of evidence that shows although least likely to be physically ill from COVID-19, young adults are experiencing the largest adverse effect on mental health [24,25]. It has been suggested that this may be because they are at a critical point in their careers, education, and social life so their mental health is most affected [26,27]. It is also generally accepted that younger adults are more anxious and worry more compared to older adults who can regulate their emotions more effectively [28].

More specifically, a study examining the psychosocial and psychopathological impact of the pandemic on mental health and addiction staff found that the younger age group (20–35 years) had significantly more burnout scores than their older peers [29]. In addition, a large-scale UK study found that younger staff tended to have poorer outcomes in terms of probable anxiety, depression, and post-traumatic stress disorder than their older peers [30]. Shorter work experience has also been found to correlate with higher prevalence of anxiety and depressive symptoms in healthcare workers during the pandemic [7,8,31].

Those in the younger age groups (26–35 years) also reported the largest increase in reported alcohol use, this was comparable to their reporting of stress and anxiety. We did not find any significant difference in relation to smoking with 7% ($n = 12$) females and 8% ($n = 5$) males reporting an increase in their smoking due to the stress of the pandemic. The relationship between mental disorders, particularly mood disorders, has been studied widely in the literature [32]. The connection between stress and alcohol use was established early in alcohol research with Tension Reduction Theory [33]. This theory suggests that alcohol is consumed as a mechanism to reduce a state of tension or high arousal. Several studies demonstrated increased alcohol consumption in the general population during the pandemic [34]. A cross-sectional study in the UK found more than one in six adults increased their alcohol consumption during lockdown. Furthermore, increased alcohol use was independently associated with increased depressive symptoms and lower mental wellbeing [35]. Another study showed an increase in binge-drinking from 10.8% to 16.2% [36]. One study involving healthcare professionals found that alcohol consumption increased during the pandemic and was correlated with greater time spent at work [37].

We found no effect of gender on any of the variables explored, which contradicts most of the existing literature. Male and female employees seemed to experience the impact of COVID-19 in a comparable way. The categorical responses to anxiety and stress were combined: 87% ($n = 154$) of females reported an increase in anxiety and stress to some, or a great extent, as did 85% ($n = 50$) of males. Likewise, both males 63% ($n = 37$) and females 61% ($n = 107$) reported similar levels of depression (combined responses of yes some and yes a lot) and an inability to sleep with 15% ($n = 27$) of females saying their sleep was affected to a large extent compared to 17% ($n = 10$) of males. It is well established

in previous studies that women have almost twice the risk of developing depression, most anxiety [38,39] and post-traumatic stress disorder [40]. This gender difference also appeared to carry over into the way males and females experienced the pandemic, with a study in China demonstrating significantly higher scores in measures for anxiety, stress, depression and insomnia in females compared to males [41]. Similarly, a longitudinal UK study documented a decline in mental well-being during the pandemic twice as large in women than in men [42].

This study has some limitations that should be considered during the interpretation of the results. The first is that the data collected was self-reported and is therefore subjective, however the purpose of this study was to gauge the wellbeing of staff rather than diagnose any potential illnesses. Staff working in this environment are trained to support, diagnose, and manage mental health and therefore arguably have a good insight into their own mental health. It should also be acknowledged that the study had a relatively small sample size and was cross-sectional in nature so cannot show change over time; nor can we claim that the sample was truly representative of all staff members within the Trust. Additionally, the survey was online meaning that it is prone to self-selection bias, all of which limit the generalizability of findings. It also could have been beneficial if there were items included asking what was done well or positives of the new ways of working. Finally; there were no qualitative data collected, elaboration on some of the answers may have helped to provide wider contextual findings. The survey did not focus on the patient needs and their experiences of what it was like to be living in a secure hospital facility whilst experiencing the pandemic.

5. Conclusions

Mental wellbeing of staff should be a priority for the Trust, especially important given the new variant strains that continue to develop and risk of reinfection. Mental health care staff are at particular risk of mental health illness, largely due to work-related stress and anxiety, together with the unpredictability of COVID-19 [43]. Added to this, the demand for mental health care is increasing because of the pandemic [44], producing significant pressure for mental health care staff. Staff working in different settings may have experienced a different impact of COVID-19 on their mental health and wellbeing, and whilst some interventions might be successfully applied across the service, it would be beneficial to understand the unique needs of staff working in specific settings. We also know that the institutional responses in hospitals (patient face-to-face contact continued) differed from that in other settings (face-to-face often replaced by virtual contact). Successful management of the COVID-19 pandemic is dependent on the effective functioning of the healthcare workforce, and therefore maintaining workers' psychological health is vital. Targeted support should be collaborative focusing on younger staff members.

Author Contributions: S.S.G., A.E.P. and A.A. were involved in the planning and conduct of the original study from which these results were obtained. Initial presentation of the findings was led by S.K. who in staff meetings engaged with staff to help them interpret the results. S.S.G. led on the report findings internally for the Trust. H.B led on the drafting of the manuscript and the statistical analyze were conducted by A.E.P., S.S.G. and H.B. All authors were involved in discussions about the drafting of the manuscript and all authors approved the final version for submission. All authors have read and agreed to the published version of the manuscript.

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Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Data is contained within the article.

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Conflicts of Interest: The authors declare no conflict of interest.

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