National Council of Dentist Health Programs

2025 Report on State Dental Society Well-being Initiatives

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Executive Summary

A national survey of State Dental Societies (SDSs) examined how peer support, mental-health referral pathways, and wellbeing resources are structured and accessed. Findings show strong commitment across SDSs, with significant variation in program design, clinical integration, and accessibility.

Key Findings

Program structures vary widely.

SDSs organize their wellbeing resources in different ways, ranging from informal, volunteer-led efforts to more structured programs with defined processes and clearer roles.

Intake and triage models differ across states.

Some SDSs rely on staff or volunteer dentists to take initial calls and make early decisions, while others have licensed mental health professionals available to conduct clinical triage.

Access pathways are often unclear.

In several SDSs, contact information or instructions for initiating support are not easy to find, making it difficult for dentists to identify where to start.

Confidentiality policies and communication differ.

Respondents reported variation in how confidentiality is defined and explained across states, which influences dentists' willingness to seek support.

Substance use concerns and confidentiality-related stigma dominate help-seeking patterns.

Substance use was the most common reason dentists sought help, and concerns about stigma or breaches of confidentiality were the barriers cited most frequently.

Key Insight

These differences reflect the varying levels of organizational investment in infrastructure, access to licensed clinicians, and support systems. Without sustained investment, SDS wellbeing efforts risk being well-intentioned but unreliable at the moments dentists need support most. NCDHP has an opportunity, in collaboration with SDS leaders, to develop sustainable, confidential, and effective dentist health programs.

Purpose of the Survey

The survey aimed to:

- Identify peer support and professional mental health resources offered by SDSs
- Understand how dentists locate and access these resources
- Highlight gaps, challenges, and inconsistencies in program structure and delivery
- Inform practical, scalable, evidence-based guidance for SDSs nationwide

Findings are intended to support learning and guide improvements within state programs.

Survey Administration and Respondents

The survey was distributed electronically to all State Dental Societies (SDSs). Participation was voluntary. Twenty-four states submitted responses, provided by SDS executives and volunteer leaders involved in wellbeing-related activities. Not all respondents completed every question.

Responses indicated variability in how respondents understood and described wellbeing-related programs and terms. To address this, responses were interpreted based on how each SDS characterized its own system, rather than applying uniform external definitions.

To provide additional context, a limited review of SDS websites was conducted to assess the visibility and accessibility of wellbeing-related resources. This review was constrained by the fact that some information is available only behind member-only firewalls and therefore may not be fully reflected in publicly accessible materials.

Overview of SDS Programs and Resources

Almost all SDSs offer at least one wellbeing resource, and many provide multiple options to address different types of concerns. These efforts range from informal, peer-led programs to more structured models that incorporate defined processes and, in some cases, access to licensed mental health professionals.

Access and Entry Points

SDSs use a range of approaches to make wellbeing information available to their members. Some take a purely passive approach by only placing resources on their websites, which requires dentists to seek information on their own. Those online resources range from re-posting ADA resources to a mix of internal and external state-level options, with differing levels of detail and visibility.

Other SDSs use more proactive methods, such as offering continuing education or training to raise awareness of wellbeing issues and available support.

Help Requests and Barriers to Seeking Support

Respondents reported that substance use concerns were the most common reason dentists sought assistance through SDS wellbeing resources. Across states, fear of stigma and concerns about confidentiality were cited as the primary barriers that deter dentists from reaching out. These patterns suggest ongoing reluctance to seek help early, even when support options are available.

Triage and Clinical Integration

Survey responses showed that SDSs differ in how they handle intake and triage. In some states, peer volunteers or SDS staff take the initial calls and make early decisions about next steps. In others, licensed mental health professionals are available to assess concerns and provide clinical triage.

Volunteer Dependence and Sustainability

Most SDS wellbeing programs rely heavily on volunteer dentists. Respondents identified challenges related to recruiting new volunteers, variability in training and preparation, burnout among long-serving volunteers, and limited administrative support.

Overreliance on volunteers can affect program capacity and sustainability, particularly with respect to consistent availability, timely follow-up, and continuity of support.

The Role and Significance of Peer Support

Peer support emerged from the survey as a central mechanism through which many SDS wellbeing programs connect dentists to help. Across states, trained peer volunteers play a key role in reducing stigma, clarifying confidentiality expectations, and encouraging early outreach—especially when concerns involve substance use, the most common reason dentists sought help.

Respondents noted that dentists often feel more comfortable speaking with a colleague before engaging with a mental health professional or navigating a formal referral pathway. When peers provide supportive early contact and structured warm hand-offs, programs demonstrate smoother transitions into clinical triage where available. In contrast, states without organized peer engagement reported more variability in early response, uncertainty around boundaries, and inconsistent follow-through.

Peer support complements—rather than replaces—licensed clinical involvement. It functions most effectively when peer roles, expectations, and training are clearly defined, and when volunteers are supported by reliable referral structures. Given the persistent influence of stigma and confidentiality concerns, structured peer engagement represents a practical, low-cost strategy for increasing trust, improving access, and reinforcing the overall reliability of SDS wellbeing efforts.

Confidentiality and Trust

Confidentiality is critical to dentists' willingness to seek support. Survey responses indicate variation in how confidentiality policies are defined and communicated across SDSs. Some respondents reported the absence of written confidentiality guidelines, while others noted concern that proximity to regulatory or disciplinary bodies may discourage early outreach.

Clear and consistent communication about confidentiality expectations can influence trust and members' willingness to engage with available resources.

Assistance SDSs Would Find Helpful

Respondents also identified several types of support that would help them strengthen their wellbeing activities. The most frequently mentioned needs were practical outreach and engagement tips, examples or model programs that could be adapted for local use, and guidance for improving existing efforts. These requests reflect SDSs' interest in resources that can enhance visibility, consistency, and effectiveness across their programs.

Interpretation of Findings

The findings point to meaningful differences in how SDS wellbeing efforts are structured and supported. SDSs demonstrate strong commitment to member wellbeing but differ substantially in resources, staffing models, and how formally their programs are organized. These differences appear rooted in underlying infrastructure rather than differences in intent.

States appear to be operating two fundamentally different triage models. When early decision-making is handled solely by peers or staff, programs have less capacity to respond promptly or appropriately to concerns that require clinical judgment. In contrast, programs with access to licensed mental health professionals are positioned to assess situations more quickly and with greater clinical reliability. This structural difference helps explain why triage processes

vary so widely across SDSs and highlights an important opportunity to strengthen consistency and safety in early response.

Programs also tend to function more predictably when entry points, roles, confidentiality expectations, and communication pathways are clearly defined. States with more cohesive structures are better positioned to respond reliably than those with multiple loosely connected activities.

Differences in how respondents interpreted key terms point to a broader need for shared language. Establishing clearer, more consistent terminology would make it easier for SDSs to communicate about wellbeing activities and to collaborate across states.

The survey also produced two findings that provide additional context for this interpretation. Substance use concerns were the most common reason dentists sought help, and stigma or confidentiality fears were the barriers cited most often. Respondents likewise described several types of assistance they would find useful, with the most frequent requests focused on outreach and engagement tips, examples or model programs, and guidance for strengthening existing efforts.

Acknowledgments

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Limitations

1. Responses were self-reported and influenced by interpretation.
2. Not all respondents answered every question.
3. Findings reflect a moment in time and do not capture longitudinal trends.

Non-responding SDSs may differ from those represented here.

Conclusions and Next Steps

The survey findings show that SDSs are committed to supporting dentists, but they operate with markedly different levels of structure, staffing, and clinical involvement. These differences shape how consistently wellbeing resources are delivered and how effectively dentists can be connected to appropriate support. Strengthening the clarity of program roles, improving the visibility of access points, and increasing access to timely clinical triage would help SDSs respond more reliably when dentists seek help.

To support this, SDSs may benefit from clearer guidance and shared tools. Developing practical, evidence-informed guidelines could help states organize their programs more consistently, define roles and expectations, and communicate confidentiality in ways that build trust. Increasing access to licensed clinicians—whether through direct involvement or reliable referral pathways—would also help SDSs address concerns that require clinical judgment.

Greater visibility of resources is another opportunity for improvement. Publishing and regularly promoting clear access points would help ensure that dentists know where to start. Providing training, orientation, and administrative support could reduce the strain on volunteers and strengthen program continuity. Standardizing confidentiality communication across states would also help dentists feel more comfortable seeking help earlier.

Ongoing collaboration remains essential. SDSs are encouraged to review these findings in the context of their own program structures, share successful approaches with peer states, and participate in the development of shared guidelines and resources. Collective effort offers the clearest path toward improving wellbeing support systems nationwide.