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Stress, shift work and substance use among nurses: A single-centre experimental study

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Summary

■ **Introduction:** ***Burnout is a form of chronic work-related stress characterised by emotional exhaustion, detachment and reduced fulfilment. It can lead to dysfunctional coping mechanisms, such as self-medication for stress, anxiety and insomnia. In the healthcare sector, access to medication can contribute to addiction, posing risks to both healthcare professionals and patients. This study investigates coping mechanisms and addiction among healthcare professionals.***
Materials and methods: ***This cross-sectional study was conducted from 12 January to 13 March 2026 at the Local Health Authority (AST) in Ascoli Piceno. The survey involved a sample of 174 nurses using a questionnaire comprising a sociodemographic section and the ASSIST test, ensuring their privacy.***
Results: ***The sample was predominantly female (75%), with high heterogeneity (90%) in the reasons for leaving the profession. Although 80% reported strong family support, 59% experienced critical environmental stress and 20% had difficulty separating their private life from work. This is associated with smoking habits: daily use in 37% and cravings in 28%, with moderate risk.***
Discussions: ***Significant gender differences emerged, in line with the Glass Escalator Theory and the biological-hormonal component.***
Conclusions: ***The ASSIST test identifies tobacco as the most prevalent substance, followed by sedatives, with moderate risk. The study highlights the need for prevention, organisational support and the reduction of stigma.*** ■

Keywords: ***Nurses, Burnout, ASSIST tool, Coping, Mental health, Patient safety.***
Parole chiave: ***Infermieri, Burnout, Strumento ASSIST, Strategie di coping, Salute mentale, Sicurezza del paziente.***

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Background

In recent years, the shift in healthcare systems towards management models focused on extreme efficiency, coupled with a chronic shortage of staff, has radically transformed the working environment, exposing professionals to unprecedented levels of occupational stress. Against this backdrop, burnout no longer appears as an isolated phenomenon or one linked to individual vulnerability, but rather as a genuine structural crisis threatening the very integrity of the healthcare workforce and patient safety. The phenomenon of burnout within the nursing profession reveals an extremely multifaceted reality that goes far beyond a simple feeling of professional fatigue and constitutes a genuine structural crisis in modern healthcare systems. Burnout can be defined as the pathological outcome of a stress-inducing process affecting those in 'helping professions' and personal care roles, where they fail to respond adequately to the excessive stress loads their work imposes on them (Favretto, 1994). 59% of nurses working in Italian hospitals are highly stressed, and 36% feel they have no control over their workload. 47.3% feel 'devoid of energy', and 40.2% show signs of severe emotional exhaustion. 45.4% believe that their professional commitments do not leave enough time for their personal and family lives. In

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a recent national survey, when asked whether they might leave the hospital within the next year due to job dissatisfaction, almost half of nurses answered in the affirmative (45.2%) (FNOPI, 2023). The main aetiological driver lies in the multidimensional workload, often defined by the concept of care intensity. This variable is not limited to the mere sum of technical services provided, but includes the density of care and the complexity of patients' needs, which demand a expenditure of cognitive and emotional energy that frequently exceeds the practitioner's capacity for physiological recovery. In settings characterised by chronic staff shortages and inadequate nursing staffing ratios, there is a reduction in the time available for relational care, which generates a profound sense of ethical and professional frustration in nurses, acting as a catalyst for emotional exhaustion. Alongside purely operational factors, the quality of leadership and the organisational climate play a decisive role in shaping work-related stress. No less significant is the impact of environmental factors linked to the very structure of shift work and the fragmentation of life outside work. The disruption of circadian rhythms and the chronic difficulty in balancing professional and personal demands fuel a vicious circle of physical and mental fatigue that progressively erodes individual resilience. In this scenario, reduced personal fulfilment does not stem from a lack of technical competence, but from the realisation that it is impossible to carry out one's caregiving role to high standards, thus leading to a collapse in professional motivation and an increase in intentions to leave the profession. On the contrary, it is essential to adopt a systemic and paradigmatic view of the workplace, in which the professional's distress is interpreted as a symptom of a structural dysfunction within the entire care ecosystem. From this perspective, burnout ceases to be a matter of 'personal fault' or a weakness of character, and is instead seen as a maladaptive response triggered by a work organisation that has eroded the psychological resilience of those involved (Maslach & Leiter, 2016). The focus must therefore shift towards analysing "contextual variables", such as the intensity of care and the quality of organisational support, recognising that the professional's well-being is inextricably linked to the well-being of the institution in which they work. This systemic view suggests that preventive intervention should not aim merely to 'repair' the individual through coping techniques, but must prioritise the reconfiguration of workplace dynamics. At the national level, various studies confirm that burnout among healthcare professionals in Italy is closely linked to the quality of the working environment (Bagnasco *et al.*, 2020). As highlighted in the INAIL guidelines, this is not a matter of personal vulnerability, but rather a psychosocial risk arising from a work organisation that fails to balance high care demands with adequate support resources (INAIL, 2022). Chronic stress and burnout are among the main triggers that drive individuals towards substance use as a coping mechanism to manage unsustainably difficult emotional and work-related burdens. According to the World Health Organisation (WHO), pathological addiction is defined as a condition, sometimes purely psychological, sometimes also physical, which develops from the interaction between a living organism and a toxic substance. It manifests itself through behavioural responses and other reactions, notably a compulsive need to consume the substance (WHO, 1992). This behaviour is aimed both at experiencing the psychological effects of the substance and, in some cases, at avoiding the discomfort caused by withdrawal. Addiction and substance misuse affect adolescents and adults, all ethnic groups and all socioeconomic levels. More than 132,000 people with substance use disorders are receiving treatment in Italy through the Public Services for Addiction (Ser.D.), with 85% of all patients being male (Ministry of Health, 2024). The percentage of women with substance dependence, however, is on the rise: they accounted for around 15% of the drug-dependent population until the early 1980s, whilst more recent surveys show an increase to 30% (Istituto Superiore di Sanità, 2003). It is believed that the prevalence of alcohol and drug abuse among the nursing population is similar to that of the general population (Dunn, 2005). Current estimates of rates of substance abuse, misuse and dependence among nurses range from 10% to 16%, and 6% experience difficulties severe enough to interfere with their ability to practise their profession. Impaired nursing practice is defined as a nurse's inability to perform essential job functions due to chemical dependency on drugs or alcohol, or mental illness. Substance misuse among healthcare professionals is a topic which, although still considered taboo, has recently emerged as a subject of study. This phenomenon has been linked to multiple risk factors. The first is family background. Individuals with a complex family history resulting in emotional distress tend to show a propensity to develop disorders linked to alcoholism, drug use or emotional abuse, which manifests as low self-esteem and hyperactivity. Living in an environment with addicted family members can lead to enabling behaviour, often described as 'helping' behaviour. People who fall into this category may be drawn to the nursing profession because of the opportunity to continue in a caring role. Another factor contributing to substance abuse among healthcare workers is work-related stress. With significant staff shortages, increased workloads and a rise in the severity of conditions among hospitalised patients, shift work, overtime and rotation between different wards contribute to stress, fatigue and alienation; substance use may be seen as a coping mechanism to alleviate this stress. Nurses tend to be described as 'workaholics' and may be unable to cope with the considerable strain that the job entails. The availability and accessibility of medicines have also been linked to substance misuse among nurses. Every day, they administer medicines to relieve pain, fight infections, reduce anxiety and depression, and treat conditions such as cancer. Professionals' easy access to medicines can lead to misuse, fuelled by the mistaken belief that they can manage such use thanks to their familiarity with administration and knowledge of the associated risks. Nurses can access medicines through various illicit means. These include the option of requesting a prescription from a colleague or forging one themselves. Another deviant method involves appropriating medicines originally intended for patients. Analysis of the most frequently abused substances reveals a varied picture, with a key distinction that must first be made between so-called legal drugs – which are legally permissible for adults to purchase and consume, such as alcohol and tobacco – and illicit drugs. In terms of prevalence, the data show that alcohol and tobacco dependence statistically affects mortality and morbidity to a greater extent, but that the abuse of illicit substances such as cannabis, cocaine and opiates has highly critical social and criminal impacts.

Aim

The aim of this study is to investigate the coping strategies employed by nursing professionals to maintain their mental and physical well-being. In particular, the study seeks to understand the extent to which these strategies are effective in reducing the

risk of burnout and in fostering a positive organisational climate, thereby contributing to a better quality of working life and the care provided.

Materials and methods

This paper is a descriptive, cross-sectional observational study. The study was conducted from 12 January 2026 to 13 March 2026 at the 'C.&G. Mazzoni' Hospital in Ascoli Piceno, part of the Ascoli Piceno Local Health Authority (AST), using a non-probabilistic convenience sampling technique. The study sample consisted of 174 nurses employed at the "C.&G. Mazzoni" Hospital in Ascoli Piceno, part of the Ascoli Piceno Local Health Authority (AST). Nurses who met the following criteria were included in the study: Holding a qualification to practise the nursing profession; Be in service at the "Mazzoni" Hospital in Ascoli Piceno at the time of data collection; Work in one of the care settings; Have at least one year's service, in order to ensure sufficient experience of the work environment; Have provided informed consent to participate in the study. The following professionals were excluded from the study: nursing staff in training (student nurses); nurses with exclusively administrative or managerial roles, not directly involved in patient care within the clinical unit; nurses absent from duty during the data collection period for reasons such as long-term illness, maternity leave or leave of absence; non-nursing healthcare staff; Failure to sign the informed consent form. Data collection was carried out using a questionnaire based on the World Health Organisation's Alcohol, Smoking and Substance Involvement Screening Test (WHO, ASSIST). The tool was supplemented with an additional section specifically designed to assess psychosocial determinants, such as the relational and social context, psychological well-being and identity, stress management (coping), burnout and stress. This integration allowed for a broader analysis, whilst maintaining the structure and objectives of the original tool. The tool was disseminated digitally, initially involving Nursing Coordinators as facilitators for its distribution. This method involves the initial participants (operational unit coordinators) in the study distributing the questionnaire to other potential participants from the same target population, thereby facilitating a gradual expansion of the sample. The choice of this sampling method was driven by the need to facilitate access to the nursing population and increase the study's response rate, in a context characterised by heavy workloads and limited availability of time. Furthermore, snowball sampling proved particularly suitable for the dissemination of an online data collection tool. In order to encourage participation and counteract non-response, periodic reminders were scheduled and sent out, reiterating the scientific importance of the research and the guarantee of confidentiality, serving as a reminder for professionals who had not yet completed the survey. Monitoring: Automated collection of responses into a database. The survey tool used is a structured research protocol, implemented digitally via the Google Forms platform. It consists of macro-sections designed with items to identify personal details, psychological well-being and substance use patterns:

I. Personal and Professional Profile
   The first section aims to define the characteristics of the sample in order to identify any risk clusters, including: Gender, Age, Educational Background and Employment Profile.
II. Relational and Social Context, which examines the professional's quality of life through perception scales and targeted questions on a 5-point Likert scale (strongly agree, agree, neither agree nor disagree, disagree and strongly disagree): Question 1: "I feel that the people I care about (family/partner) support me emotionally." Question 2: "I spend time with people who regularly use substances." Question 3: "I feel pressured by others to use substances so as not to feel excluded." Question 4: "There are unresolved conflicts or constant tensions within my family."
III. Psychological Well-being and Identity: explores the professional's intrapsychic resources and relational vulnerabilities, which are key factors in coping with work-related stress. Question 1: "I feel uncomfortable or inadequate when I am among others." Question 2: "I have a positive view of myself, regardless of my achievements." Question 3: "I find it difficult to manage my emotions (anger, sadness, anxiety) without external help." Question 4: "I feel optimistic about my professional future."
IV. Stress Management (Coping) and Environment, which examines the causal link between the external environment (work and private life) and the individual's response (coping or avoidance strategies). In short, it aims to understand whether the nurse uses substances as a 'solution to problems they are unable to manage in any other way. Question 1: "I use substances to 'switch off' from a reality that is too much to bear." Question 2: "My work/study environment causes me a great deal of stress." Question 3: "I have experienced recent events (bereavements, separations, redundancies) that I cannot get over." Question 4: "I have hobbies or interests that make me feel fulfilled and at peace."
V. Burnout and Occupational Stress, which encompasses the psychosocial risks associated with the profession. The aim is to map the deterioration of organisational and individual health, correlating chronic stress with the clinical symptoms of burnout. Question 1: "I feel emotionally drained and empty right from the start of the working day." Question 2: "I have become more cynical or detached towards colleagues or clients/users." Question 3: "I feel that my work no longer has any real value or positive impact." Question 4: "I use substances to stay awake/alert or to improve my performance." Question 5: "I find it difficult to separate my private life from work-related concerns."
VI. ASSIST Test – Alcohol, Smoking and Substance Involvement Screening Test to investigate the use of ten categories of substances (Tobacco, Alcohol, Cannabis, Cocaine, Amphetamine-type stimulants, Inhalants, Sedatives/Sleeping pills, Hallucinogens, Opiates and "Other"). For each substance, the participant answers eight questions that measure: Question 1: "Which of the following substances (tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants, sedatives, hallucinogens, opioids) have you ever used in your lifetime? (FOR NON-MEDICAL USE ONLY)"; Yes (3 points) and No (0 points). Question 2: "How often have you used the substances mentioned in the last 3 months?"; never (0 points), 1 or 2 times (2 points), monthly (3 points), weekly (4 points) and daily or almost daily (6 points). Question 3: "In the last three months, how often have you had a strong desire or craving?"; never (0 points), 1 or 2 times (3 points), monthly (4 points), weekly (5 points) and daily or almost daily (6 points). Question 4: "In the last three months, how often has your substance use caused you health, social, legal or financial problems?"; never (0 points), 1 or 2 times (4 points), monthly (5 points), weekly (6 points), daily or almost daily (7 points). Question 5: "In

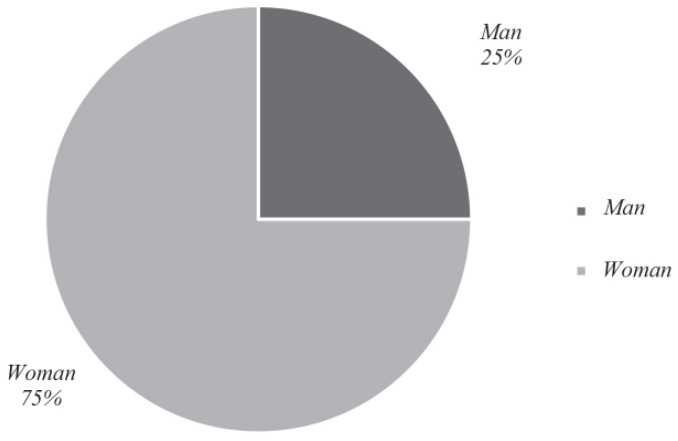
the last three months, how often have you been unable to do what you normally do because of your substance use?"; never (0 points), 1 or 2 times (5 points), monthly (6 points), weekly (7 points), daily or almost daily (8 points) Question 6: "Has your substance use caused concern to any friends, relatives or others?"; No, never (0 points), Yes in the last 3 months (6 points), Yes but not in the last 3 months (3 points). Question 7: "Have you ever tried to cut down on or stop using substances without success?"; No, never (0 points), Yes in the last 3 months (6 points), Yes but not in the last 3 months (3 points). Question 8: "Have you ever injected substances? (Non-medical use only)"; No, never (0 points), Yes in the last 3 months (2 points), Yes but not in the last 3 months (1 point).

The statistical analysis of the collected data was divided into two main phases: a descriptive analysis and an inferential analysis. In the first phase, a descriptive analysis of the variables under consideration was carried out using absolute frequencies (n) and percentages (%), providing a clear representation of the distribution of the categories within the sample. With regard to quantitative variables, measures of central tendency and dispersion were calculated, specifically the mean (μ) and standard deviation (SD). Differences between groups were analysed using t-tests and ANOVA, whilst associations between categorical variables were assessed using Fisher's exact test ($p < 0.05$). The analyses were carried out using Microsoft Excel and Rstudio. The research was conducted in accordance with the fundamental ethical principles for clinical and social research (EU Regulation 679/2016 GDPR and current Italian legislation). Each participant was informed about the nature, aims and methods of the research via an introductory form. Participation was strictly voluntary, subject to digital acceptance of consent. Given the highly sensitive nature of the information processed, the anonymity of the sample was guaranteed by avoiding the collection of identifying data, such as IP addresses or email addresses. Furthermore, participants were guaranteed the option to stop completing the questionnaire at any time.

Results

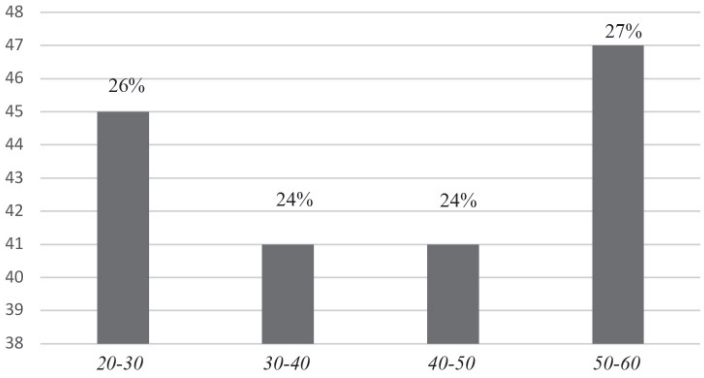
The study yielded 174 responses. These show that the majority of questionnaire respondents were women, accounting for 75% (131), whilst the remaining respondents were men, accounting for 25% (43) (Figure 1).

Fig. 1 - Genre



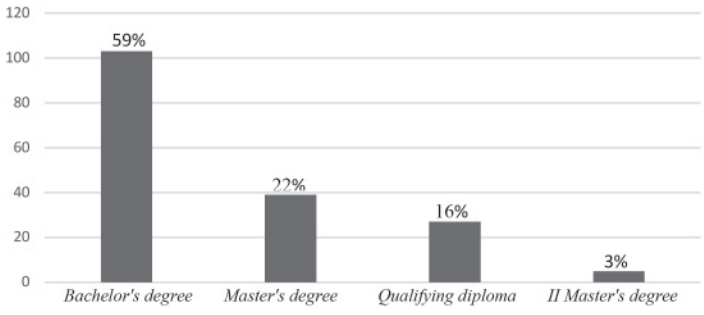
However, when considering the age of the respondents, there is considerable diversity, encompassing various age groups, resulting in a balanced sample across the different age brackets. The 50-60 age group accounts for 27% (n = 45), followed by 24% (n = 41) in the 40-50 age group, 24% (n = 41) in the 30-40 age group and, finally, 26% (n = 45) in the 20-30 age group (Figure 2).

Fig. 2 - Age



Years of work experience were also taken into account. Analysis of the data reveals a wide range, ranging from 1 year of service up to 39 years. The average is therefore 15.96 years (SD = 10.64). Another factor analysed is educational qualification, with the majority of respondents holding a three-year degree (59%, n = 103), followed by a master's degree (22%, n = 39), a vocational diploma (16%, n = 27) and, finally, a second-level master's degree (3%, n = 5) (Figure 3).

Fig. 3 - Qualification



With regard to employment history, the data collected allow for an assessment of work experience across different companies, with an average of 3.41 (SD = 1.69), and operational units, with an average of 5.22 (SD = 2.84). The reasons for leaving the setting were also investigated, revealing the following: interpersonal problems 4% (n = 7), care workload 3% (n = 6), lack of competence 3% (n = 5) and 'other' 90% (n = 156). After outlining the demographic and professional profile, Part II analyses the relational and social context with four questions, the answers to which are linked to a Likert scale designed to assess the level of risk of substance dependence. The analysis aims to investigate the areas set out in Table 1 and outlined below.

Question 1: "I feel that my loved ones (family/partner) support me emotionally", 47% (n = 81) of respondents answered that they completely agreed, 33% (n = 57) agreed, 10% (n = 18) were neutral, 7% (n = 13) disagreed and 3% (n = 5) completely disagreed.

Question 2: "I spend time with people who regularly use substances", 60% (n = 105) strongly disagreed, 17% (n = 30) disagreed, 9% (n = 21) agreed, 9% (n = 16) were neutral and 1% (n = 2) strongly agreed. Question 3: "I feel pressured by others to use substances so as not to feel excluded", 88% (n = 154) strongly disagree, 10% (n = 17) disagree and 2% (n = 3) strongly agree.
Question 4: "There are unresolved conflicts or constant tensions within my family", 59% (n = 102) strongly disagree, 16% (n = 28) disagree, 14% (n = 25) neutral, 7% (n = 13) agree and 3% (n = 6) strongly agree.
The results regarding risk levels are as follows: 95% (n = 166) low risk and 5% (n = 8) moderate risk.
Section III of the questionnaire examines and explores the area of individual well-being and comprises four items:
Question 1: "I feel uncomfortable or inadequate when I am among others", 67% (n=117) strongly disagree, 16% (n = 27) disagree, 14% (n = 24) neutral, 2% (n = 4) agree and 1% (n = 2) strongly agree.
Question 2: "I have a good opinion of myself, regardless of my achievements", 34% (n = 60) agree, 20% (n = 35) neutral, 19% (n = 33) strongly agree, 15% (n = 26) strongly disagree and 11% (n = 20) disagree.
Question 3: "I find it difficult to manage my emotions (anger, sadness, anxiety) without outside help", 48% (n = 84) strongly disagree, 26% (n = 46) disagree, 13% (n = 22) neutral, 10% (n = 18) agree and 2% (n = 4) strongly agree.
Question 4: "I feel optimistic about my professional or personal future", 34% (n = 60) agreed, 20% (n = 35) strongly agreed, 20% (n = 34) disagreed, 15% (n = 26) disagreed and 11% (n = 19) strongly disagreed.
The results regarding risk levels obtained in this section are: 81% (n = 141) low risk and 19% (n = 33) moderate risk.
Section IV, on the other hand, concerns coping strategies and occupational/personal stress, and also comprises four items:
Question 1: "I use substances to 'switch off' from a reality that is too overwhelming", 84% (n = 147) strongly disagree, 9% (n = 16) disagree, 4% (n = 7) agree, 2% (n = 3) are neutral and 1% (n = 1) strongly agree.
Question 2: "My work/study environment causes me a great deal of stress", 38% (n = 66) agree, 27% (n = 47) neutral, 21% (n=36) strongly agree, 7% (n = 13) strongly disagree and 7% (n = 12) disagree.
Question 3: "I have experienced recent events (bereavements, separations, redundancies) that I cannot get over", 56% (n = 97) strongly disagree, 21% (n = 36) disagree, 20% (n = 18) neutral, 20% (n = 18) agree and 3% (n = 5) strongly agree.
Question 4: "I have hobbies or interests that make me feel fulfilled and content", 82 respondents (47%) agreed, 42 (24%) were neutral, 35 (20%) strongly agreed, 8 (5%) disagreed and 7 (4%) strongly disagreed.
The risk level results for this section are as follows: 86% (n = 150) low risk and 14% (n = 24) moderate risk
Section V, on the other hand, comprises five items assessing emotional exhaustion, depersonalisation, dysfunctional coping and work-life spillover:
Question 1: "I feel emotionally exhausted and drained right from the start of the working day", 39% (n = 68) strongly disagree, 23% (n = 40) neutral, 17% (n = 30) disagree, 13% (n = 23) agree and 7% (n = 13) strongly agree.
Question 2: "I have become more cynical or detached towards colleagues or clients/users", 39% (n = 67) strongly disagree, 21% (n = 36) neutral, 18% (n = 31) disagree, 16% (n = 28) agree and 7% (n = 12) strongly agree.
Question 3: "I feel that my work no longer has any real value or positive impact", 48% (n = 84) strongly disagree, 21% (n = 37) disagree, 13% (n = 22) neutral, 13% (n = 22) agree and 5% (n = 9) strongly agree.
Question 4: "I use substances to stay awake/alert or to improve my performance", 82% (n = 142) strongly disagree, 14% (n = 24) disagree, 3% (n = 6) agree, 1% (n = 1) strongly agree and 1% (n = 1) are neutral.
Question 5: "I find it difficult to separate my private life from work-related concerns", 51% (n = 88) strongly disagree, 16% (n = 28) disagree, 16% (n = 27) agree, 14% (n = 24) neutral and 4% (n = 7) strongly agree. The results for risk levels in Section V are as follows: 64% (n = 112) low risk, 31% (n = 54) moderate risk and 5% (n = 8) high risk.

Tab. 1 - Epidemiological Analysis of Psychosocial Determinants

Questions	*Answers*	*Absolute frequency N.*	*Percentage frequency %*
II section			
I feel that the people I care about (family/partner) support me emotionally	Strongly agree	81	47%
	Agree	57	33%
	Neutral	18	10%
	Disagree	13	7%
	Strongly disagree	5	3%
I spend time with people who regularly use drugs	Strongly agree	2	1%
	Agree	21	12%
	Neutral	16	9%
	Disagree	30	17%
	Strongly disagree	105	60%
I feel pressured by others to take drugs so that I don't feel left out	Strongly agree	3	2%
	Agree	0	0%
	Neutral	0	0%
	Disagree	17	10%
	Strongly disagree	154	89%
There are unresolved conflicts or constant tensions within my family	Strongly agree	6	3%
	Agree	13	7%
	Neutral	25	14%
	Disagree	28	16%
	Strongly disagree	102	59%
Risk level	Low risk	166	95%
	Moderate risk	8	5%
	High risk	0	0%

Questions	*Answers*	*Absolute frequency N.*	*Percentage frequency %*
III section			
I feel uncomfortable or out of place when I'm around other people	Strongly agree	2	1%
	Agree	4	2%
	Neutral	24	14%
	Disagree	27	16%
	Strongly disagree	117	67%
I have a positive view of myself, regardless of my achievements	Strongly agree	33	19%
	Agree	60	34%
	Neutral	35	20%
	Disagree	20	11%
	Strongly disagree	26	15%
I find it difficult to manage my emotions (anger, sadness, anxiety) without outside help	Strongly agree	4	2%
	Agree	18	10%
	Neutral	22	13%
	Disagree	46	26%
	Strongly disagree	84	48%
I feel optimistic about my professional and personal future	Strongly agree	35	20%
	Agree	60	34%
	Neutral	34	20%
	Disagree	26	15%
	Strongly disagree	19	11%
Risk level	Low risk	141	81%
	Moderate risk	33	19%
	High risk	0	0%
IV section			
I use drugs to "switch off" from a reality that's too much to bear	Strongly agree	1	1%
	Agree	7	4%
	Neutral	3	2%
	Disagree	16	9%
	Strongly disagree	147	84%
My work/study environment causes me a great deal of stress	Strongly agree	36	21%
	Agree	66	38%
	Neutral	47	27%
	Disagree	12	7%
	Strongly disagree	13	7%
I have recently been through some difficult times (bereavements, break-ups, redundancies) that I am struggling to get over	Strongly agree	5	3%
	Agree	18	10%
	Neutral	18	10%
	Disagree	36	21%
	Strongly disagree	97	56%
I have hobbies or interests that make me feel fulfilled and content.	Strongly agree	35	20%
	Agree	82	47%
	Neutral	42	24%
	Disagree	8	5%
	Strongly disagree	7	4%
Risk level	Low risk	150	86%
	Moderate risk	24	14%
	High risk	0	0%
V section			
I feel emotionally drained and hollow right from the start of the working day	Strongly agree	13	7%
	Agree	23	13%
	Neutral	40	23%
	Disagree	30	17%
	Strongly disagree	68	39%
I have become more cynical or detached towards my colleagues or clients/users	Strongly agree	12	7%
	Agree	28	16%
	Neutral	36	21%
	Disagree	31	18%
	Strongly disagree	67	39%
I feel that my work no longer has any real value or positive impact	Strongly agree	9	5%
	Agree	22	13%
	Neutral	22	13%
	Disagree	37	21%
	Strongly disagree	84	48%
I use substances to stay awake or alert, or to improve my performance	Strongly agree	1	1%
	Agree	6	3%
	Neutral	1	1%
	Disagree	24	14%
	Strongly disagree	142	82%
I find it hard to separate my private life from my work concerns	Strongly agree	7	4%
	Agree	27	16%
	Neutral	24	14%
	Disagree	28	16%
	Strongly disagree	88	51%
Risk level	Low risk	112	64%
	Moderate risk	54	31%
	High risk	8	5%

Section VI, on the other hand, begins with an analysis of the results of the ASSIST test (Alcohol, Smoking and Substance Involvement Screening Test), which assesses the levels of risk associated with substance use (Table 2).

Tab. 2 - Test ASSIST

Substances	*Answers*	*Absolute frequency N.*	*Percentage frequency %*
Which of the following substances have you ever used in your life? (For non-medical use)			
Tobacco	Yes	92	53%
	No	82	47%
Alcohol	Yes	89	51%
	No	85	49%
Cannabis	Yes	136	78%
	No	38	22%
Opioids	Yes	6	3%
	No	168	97%
Amphetamines	Yes	11	6%
	No	163	94%
Sedatives/Sleeping pills	Yes	31	18%
	No	143	82%
Cocaine	Yes	5	3%
	No	169	97%
Hallucinogens	Yes	15	9%
	No	159	91%
How often have you used the substances listed below in the last three months?			
Tobacco	Every day or almost every day	64	37%
	Once a week	5	3%
	Once a month	3	2%
	Once or twice	10	6%
	Never	92	53%
Alcohol	Every day or almost every day	12	7%
	Once a week	46	26%
	Once a month	20	11%
	Once or twice	27	16%
	Never	69	40%
Cannabis	Every day or almost every day	13	7%
	Once a week	3	2%
	Once a month	1	1%
	Once or twice	12	7%
	Never	145	83%
Opioids	Every day or almost every day	1	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	1	1%
	Never	170	98%
Cocaine	Every day or almost every day	2	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	0	0%
	Never	171	98%
Hallucinogens	Every day or almost every day	1	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	9	5%
	Never	163	94%
Over the last three months, how often have you had a strong craving?			
Tobacco	Every day or almost every day	48	28%
	Once a week	4	2%
	Once a month	3	2%
	Once or twice	9	5%
	Never	110	63%

Substances	*Answers*	*Absolute frequency N.*	*Percentage frequency %*
Alcohol	Every day or almost every day	3	2%
	Once a week	3	2%
	Once a month	2	1%
	Once or twice	6	3%
	Never	160	92%
Cannabis	Every day or almost every day	12	7%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	3	2%
	Never	158	91%
Opioids	Every day or almost every day	2	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	0	0%
	Never	171	98%
Amphetamines	Every day or almost every day	2	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	1	1%
	Never	170	97%
Sedatives/Sleeping pills	Every day or almost every day	5	3%
	Once a week	2	1%
	Once a month	0	0%
	Once or twice	2	1%
	Never	165	95%
Cocaine	Every day or almost every day	2	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	0	0%
	Never	171	98%
Hallucinogens	Every day or almost every day	1	1%
	Once a week	2	1%
	Once a month	0	0%
	Once or twice	0	0%
	Never	171	98%
Over the last three months, how often has your substance use caused you health, social, legal or financial problems?			
Tobacco	Every day or almost every day	5	3%
	Once a week	2	1%
	Once a month	0	0%
	Once or twice	4	1%
	Never	163	94%
Alcohol	Every day or almost every day	1	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	2	1%
	Never	170	97%
Cannabis	Every day or almost every day	2	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	1	1%
	Never	170	97%
Opioids	Every day or almost every day	2	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	1	1%
	Never	170	97%
Amphetamines	Every day or almost every day	2	1%
	Once a week	2	1%
	Once a month	0	0%
	Once or twice	1	1%
	Never	169	97%

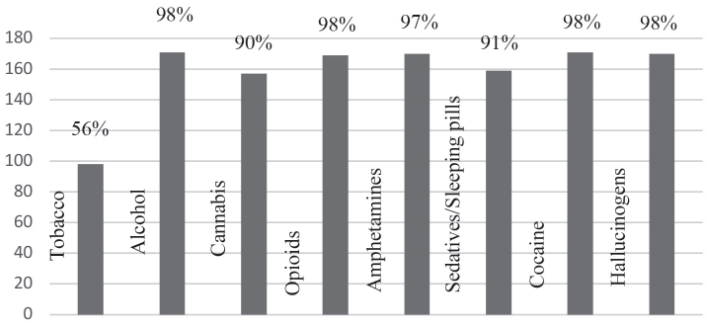
Substances	*Answers*	*Absolute frequency N.*	*Percentage frequency %*
Sedatives/Sleeping pills	Every day or almost every day	2	1%
	Once a week	2	1%
	Once a month	0	0%
	Once or twice	1	1%
	Never	169	97%
Cocaine	Every day or almost every day	2	1 %
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	0	0%
	Never	171	98%
Hallucinogens	Every day or almost every day	1	1%
	Once a week	2%	1%
	Once a month	0	0%
	Once or twice	0	0%
	Never	171	98%
Over the last three months, how often have you been unable to do what you normally do because of your substance use?			
Alcohol	Every day or almost every day	0	0%
	Once a week	2	1%
	Once a month	1	1%
	Once or twice	1	1%
	Never	170	98%
Cannabis	Every day or almost every day	2	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	1	1%
	Never	170	98%
Opioids	Every day or almost every day	2	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	0	0%
	Never	171	98%
Amphetamines	Every day or almost every day	2	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	0	0%
	Never	171	98%
Sedatives/Sleeping pills	Every day or almost every day	1	1%
	Once a week	2	1%
	Once a month	0	0%
	Once or twice	0	0%
	Never	171	98%
Cocaine	Every day or almost every day	2	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	0	0%
	Never	171	98%
Hallucinogens	Every day or almost every day	2	1%
	Once a week	1	1%
	Once a month	0	0%
	Once or twice	0	0%
	Never	171	98%
Has your use of substances caused concern among any of your friends, relatives or others?			
Tobacco	Never	158	91%
	Yes, in the last 3 months	9	5%
	Yes, but not in the last 3 months	7	4%
Alcohol	Never	170	98%
	Yes, in the last 3 months	2	1%
	Yes, but not in the last 3 months	2	1%

Substances	*Answers*	*Absolute frequency N.*	*Percentage frequency %*
Cannabis	Never	169	97%
	Yes, in the last 3 months	2	1%
	Yes, but not in the last 3 months	3	2%
Opioids	Never	171	98%
	Yes, in the last 3 months	1	1%
	Yes, but not in the last 3 months	2	1%
Amphetamines	Never	171	98%
	Yes, in the last 3 months	0	0%
	Yes, but not in the last 3 months	3	2%
Sedatives/Sleeping pills	Never	170	98%
	Yes, in the last 3 months	1	1%
	Yes, but not in the last 3 months	3	2%
Cocaine	Never	171	98%
	Yes, in the last 3 months	1	1%
	Yes, but not in the last 3 months	2	1%
Hallucinogens	Never	170	97%
	Yes, in the last 3 months	1	1%
	Yes, but not in the last 3 months	3	2%
Have you ever tried to cut down on or stop using substances without success?			
Tobacco	Never	135	78%
	Yes, in the last 3 months	20	11%
	Yes, but not in the last 3 months	19	11%
Alcohol	Never	168	97%
	Yes, in the last 3 months	3	2%
	Yes, but not in the last 3 months	3	2%
Cannabis	Never	168	97%
	Yes, in the last 3 months	4	2%
	Yes, but not in the last 3 months	2	1%
Opioids	Never	170	98%
	Yes, in the last 3 months	2	1%
	Yes, but not in the last 3 months	2	1%
Amphetamines	Never	169	97%
	Yes, in the last 3 months	1	1%
	Yes, but not in the last 3 months	2	2%
Sedatives/Sleeping pills	Never	169	97%
	Yes, in the last 3 months	0	0%
	Yes, but not in the last 3 months	5	3%
Cocaine	Never	170	98%
	Yes, in the last 3 months	2	1%
	Yes, but not in the last 3 months	2	1%
Hallucinogens	Never	171	98%
	Yes, in the last 3 months	0	0%
	Yes, but not in the last 3 months	3	2%
Risk level			
Tobacco	Low risk	98	56%
	Moderate risk	74	43%
	High risk	2	1%
Alcohol	Low risk	171	98%
	Moderate risk	1	1%
	High risk	2	1%
Cannabis	Low risk	157	90%
	Moderate risk	15	9%
	High risk	3	1%

Substances	*Answers*	*Absolute frequency N.*	*Percentage frequency %*
Opioids	Low risk	170	98%
	Moderate risk	1	0,5%
	High risk	3	1,5%
Amphetamines	Low risk	169	97%
	Moderate risk	4	2%
	High risk	1	1%
Sedatives/Sleeping pills	Low risk	159	91%
	Moderate risk	12	7%
	High risk	3	2%
Cocaine	Low risk	171	98%
	Moderate risk	0	0%
	High risk	3	2%
Hallucinogens	Low risk	170	98%
	Moderate risk	3	1%
	High risk	1	1%
Have you ever injected substances for non-medical purposes?			
Never	167	96%	
Yes, in the last 3 months	0	0%	
Yes, but not in the last 3 months	7	4%	

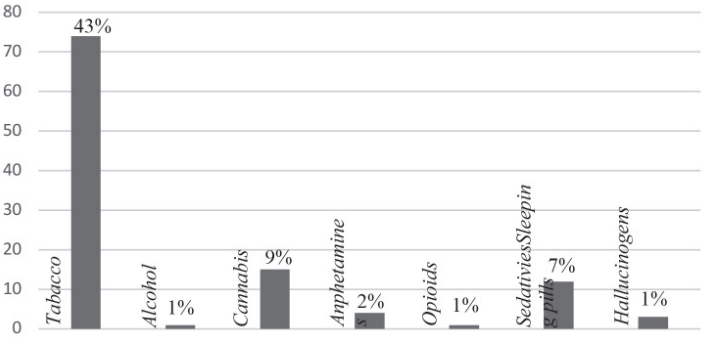
Analysis of the results shows that the low-risk category accounts for 56% (n = 98) for tobacco, 90% (n = 157) for cannabis, 91% (n = 159) for sedatives/sleeping pills, 97% (n = 169) for amphetamines, and 98% for alcohol (n = 171), opioids (n = 170), cocaine (n = 171) and hallucinogens (n = 170) (Figure 4).

Fig. 4 - Low Risk



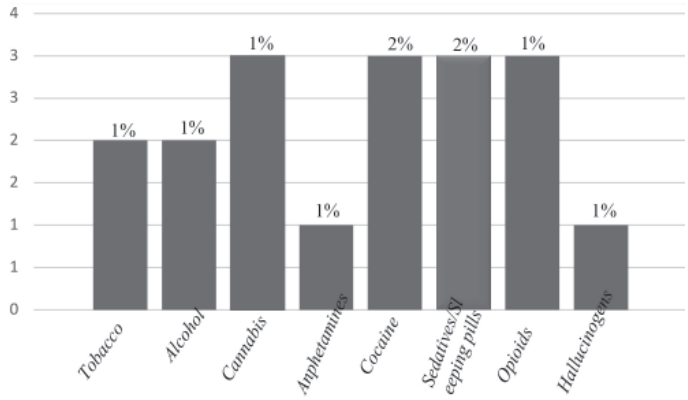
For moderate risk, the figures are 43% (74 cases) for tobacco, 1% (1 case) for alcohol, 9% (15 cases) for cannabis, 2% (4 cases) for amphetamines, 1% (1 case) for opioids, 7% (n = 12) for sedatives/sleeping pills and 1% (n = 3) for hallucinogens (Figure 5).

Fig. 5 - Moderate risk



Taking into account the high-risk category, tobacco accounts for 1% (2 cases), alcohol for 1% (2 cases), cannabis for 1% (3 cases), amphetamines for 1% (1 case), opioids for 1% (3 cases), 2% (n = 3) for sedatives/sleeping pills, 2% (n = 3) for cocaine and 1% (n = 1) for hallucinogens (Figure 6).

Fig. 6 - High Risk



A preliminary analysis was conducted to test the assumption of homogeneity of variances using Levene's test, which was found to be violated, F (1, 172) = 11.43, p < .001. Consequently, the t-test for independent samples with Welch's correction was used. The test results revealed a statistically significant difference in the number of companies in which participants had worked during their careers between men and women, t (56.71) = –2.47, p = .016. Specifically, men (M = 4.05) reported having worked in a greater number of companies than women (M = 3.20). The 95% confidence interval for the difference between the means is [–1.53, –0.16], suggesting that the observed difference is substantial and not attributable to chance. The effect size, calculated using Cohen's d, was found to be –0.66, indicating a moderate effect (Figure 7).

To assess whether there were differences in the number of settings changed between participants who reported never having used substances by injection and those who had used them, but not in the last 3 months, a two-sample Welch's t-test (un-

equal variances) was conducted. Thus, the experience of never having used substances is associated with higher values for this indicator. Levene's test did not detect any violations of the homogeneity of variances, F (1,172) = 3.03, p = 0.083 F (1,172) =3.03, p = 0.083. Welch's t-test revealed a significant difference between the two groups, t (8.99) = 4.23, p = 0.002, p = 0.002, with participants who had never used substances by injection showing higher mean values for changed settings (mean = 6.29) compared to those who had used them in the past, but not in the last three months (mean = 4.14). The 95% confidence interval for the difference between the means was between 1.00 and 3.30, confirming the significant effect.

Fig. 7 - Box plot Number of companies surveyed by gender

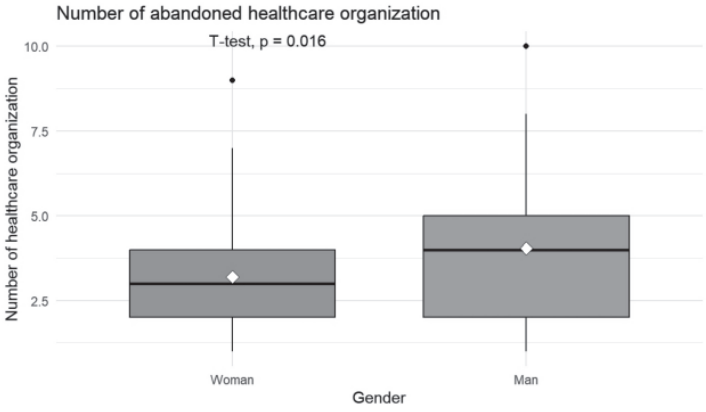
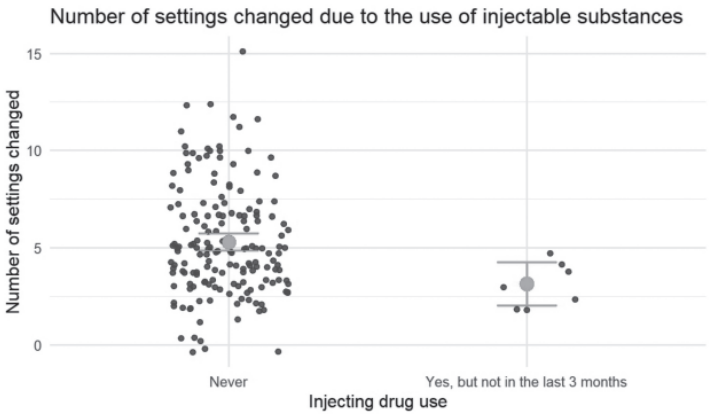
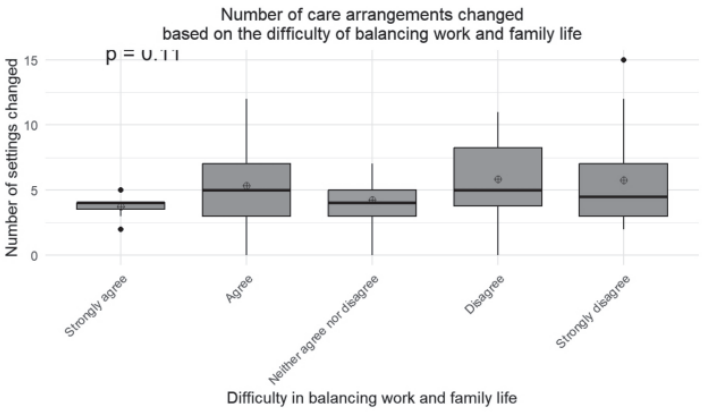


Fig. 8 - Scatter plot showing the number of settings changed according to the use of injectable substances



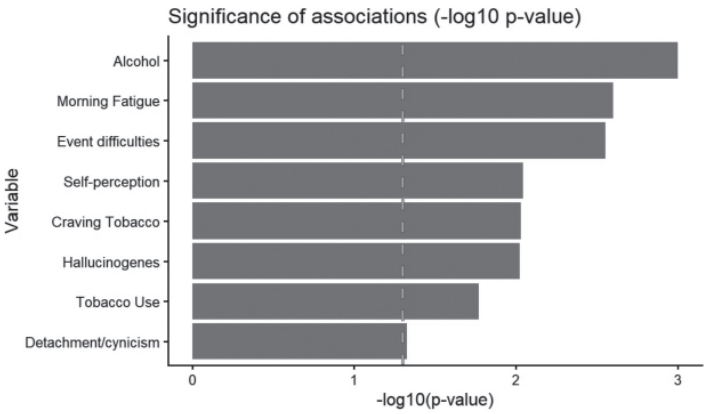
A Welch's ANOVA was conducted to examine differences in the number of care settings changed according to the perceived difficulty in balancing work and family life. Levene's test revealed a violation of the assumption of homogeneity of variances, F (4, 169) = 3.34, p = .012; therefore, Welch's correction was applied. The results showed a statistically significant difference between the groups, F (4, 42.18) = 4.68, p = .003. Post-hoc analyses, conducted using t-tests for independent samples with Bonferroni correction and without assuming homogeneity of variances, revealed significant differences between the 'Strongly agree' group and the 'Agree' (p = .037) and 'Disagree' (p = .037) groups. No further statistically significant differences emerged between the other pairs of groups (p > .05).

Fig. 9 - Boxplot ANOVA Care settings modified due to family circumstances



A statistically significant association emerged between gender and the perception of having a positive self-image (Fisher's Exact Test, p = 0.009). In particular, females exhibited a more heterogeneous distribution of responses, with a greater presence even in the most extreme categories (e.g. 'Strongly disagree'), whilst males tended to cluster predominantly in the intermediate categories, such as 'Neutral'. This result highlights gender differences in self-representation. A significant association was also found between gender and the perception of difficulty in overcoming critical events (Fisher's Exact Test, p = 0.0028). Females more frequently report high levels of difficulty, with responses concentrated in the negative categories ("Disagree" and "Strongly disagree"), whilst males show a more balanced distribution, also leaning towards more positive categories. This suggests a different perception of the ability to cope with stressful situations. With regard to feelings of tiredness upon waking, the analysis revealed a significant difference between the genders (Fisher's Exact Test, p = 0.0025). Females more often report high levels of morning fatigue, whilst males tend to report more moderate or favourable conditions, indicating a different subjective experience of rest. A significant difference was also observed in the level of cynicism and detachment in professional relationships (Fisher's Exact Test, p = 0.047). In this case, females showed a greater polarisation of responses, whilst males were predominantly concentrated in the central categories, suggesting different ways of perceiving and experiencing working relationships. With regard to substance use over the past three months, the results indicate a significant variation by gender (Fisher's Exact Test, p < 0.001). Males report high-frequency use more frequently, with a greater presence in the 'Daily or almost daily' category, whilst females are more represented in the 'Never' category and also distributed across the intermediate frequencies. This highlights different patterns of use between the groups. Similarly, significant differences emerged in the frequency of craving (Fisher's Exact Test, p = 0.0093). Females show greater variability in their responses, alternating between the absence and presence of craving – including frequent craving – whilst males tend to cluster more at the extremes of the distribution, indicating a more defined pattern. Finally, a further significant association was found for the frequency of recent substance use (Fisher's Exact Test, p = 0.0095). Females were predominantly in the 'Never' category, whilst males were more frequently found in the categories of occasional use, suggesting a more pronounced tendency towards sporadic use among males (Figure 10).

Fig. 10 - Fisher's significance test



Discussions

Analysis of the data from the questionnaire shows that the majority of respondents are women, accounting for 75% (131), whilst the remaining respondents are men, accounting for 25% (43). According to the National Federation of Nursing Associations, the profession is predominantly female, with women accounting for 76% (339,470) of those registered with the associations; this statistic also holds true at European level (FNOPI, 2024). The ANOVA analysis confirms that there is a significant correlation (p-value = 0.012) between the number of settings and the difficulty professionals face in balancing private life and work; the results show that the perception of certain difficulties leads to compensatory behaviour adopted to cope with work-related or personal challenges, such as changing department or operational unit. Post-hoc analyses revealed significant differences between the 'Strongly agree' group and the 'Agree' and 'Disagree' groups. This ambivalence is consistent with the literature, specifically the study conducted by Dr Söderberg, who states that, compared to women, men experience greater job mobility when exposed to high demands or a significant effort-reward imbalance (Söderberg *et al.*, 2014). Deng *et al.* also state that men working in the healthcare sector tend to leave the sector due to a lower tolerance for environments that are not meritocratic or are excessively routine, seeking out more dynamic settings that offer greater decision-making autonomy (Deng *et al.*, 2024). This phenomenon can be interpreted through the 'Glass Escalator' theory, which suggests that, in predominantly female environments, men tend to change jobs more frequently in order to reach leadership or better-paid positions more quickly (Williams, 1992).

Using the Fisher Test, the respondents' self-perception and self-assessment were examined. The results show that women tend to place themselves more at the extremes of the response scales (e.g. 'Strongly disagree'), whilst men show a greater propensity for neutral responses. These data highlight gender differences in self-representation and confirm the findings of numerous studies: on average, men exhibit higher self-esteem, whilst women tend to underestimate their own abilities. The gap is particularly pronounced in affluent Western societies, where cross-gender comparisons subject women to typically male standards. In such a context, women often start out with a 'perception deficit' regarding their own skills, which they must compensate for with a double psychological effort. In the long term, this situation can contribute to a gradual erosion of self-esteem, negatively affecting self-perception and confidence in one's abilities (Bleidorn *et al.*, 2015). The scientific literature suggests that gender differences in self-esteem and self-perception are the result of complex processes of socialisation and the internalisation of cultural models. The gap emerges strongly during adolescence and tends to persist into adulthood, also influencing approaches and working styles (Kling, 1999). This phenomenon ties in perfectly with 'Impostor Syndrome', which explains how cultural contexts that reward humility and modesty convey the message that professional women's achievement of their goals is solely linked to luck or misjudgements. Consequently, women are more prone to perfectionism and harbour a fear of not being up to the task, which drives them to live in a constant state of alert, reducing their propensity for risk-taking and negotiation (Young, 2011).

Another aspect analysed concerns the difficulty in coping with stressful events and the perception of tiredness upon waking. The data show that women report greater difficulty in managing stressful situations ($p = 0.0028$), with responses concentrated in the negative categories ('Disagree' and 'Strongly disagree'), whilst men tend to fall more into the positive categories. At the same time, it emerges that women report a greater sense of fatigue upon waking ($p = 0.0025$), whilst men report more favourable conditions. Overall, these results suggest a consistent picture: women, compared to men, perceive greater limitations in managing daily stress and a higher level of physical fatigue, with possible repercussions on general well-being and resilience. A significant difference was also found in the level of cynicism and detachment in professional relationships ($p = 0.047$); indeed, women show a greater polarisation of responses, whilst men are predominantly concentrated in the central categories, suggesting different ways of perceiving and experiencing work relationships. Substance use emerges as a coping mechanism to alleviate these conditions, facilitated by the constant availability and accessibility of medicines, which may lead healthcare professionals to misuse them based on the belief that they can manage the risks thanks to their knowledge and technical expertise. Data from the ASSIST test reveal widespread tobacco use (53%), with daily use (37%), often accompanied by cravings reported by users (28%). Noteworthy is the figure relating to sedatives and sleeping pills, used by 18% of the sample, with daily use (5%), highlighting a self-medication strategy to cope with symptoms such as anxiety or insomnia. Although the majority of the sample falls into a low-risk category, 43% of participants are nevertheless at moderate risk for tobacco use and 7% for sedatives. Alcohol consumption, whilst presenting a low risk in 98% of cases, nevertheless shows weekly use in 26% of participants. These figures further illustrate that the risk of addiction is not only linked to the availability of the substance, but is also interlinked with organisational health and the professional's perception of competence, making it necessary to adopt an approach that integrates health surveillance with psychological support to promote professional well-being.

The survey also confirms that nurses are vulnerable to developing addictions, a phenomenon which the literature links to a prevalence of substance misuse ranging from 10% to 16%

(Dunn, 2005). This risk stems from increased workloads, as also demonstrated by the fact that 59% of the sample report critical levels of stress due to their work or study environment.

With regard to substance use, the data show significant gender differences. Men are more frequently exposed to high levels of use, characterised mainly by sporadic but recurrent use, suggesting the presence of a problem linked both to frequency and to the development of a habit. Women, on the other hand, are predominantly in the 'Never' category and experience intermittent cravings, indicating that the main difficulty lies in managing the urge to use rather than the actual frequency. These gender differences in addiction can also be explained at a biological level: gonadal hormones directly influence brain plasticity and modulate the way neurons communicate in the presence of substances of abuse. Consequently, the brain's response to stimuli associated with drug use or cravings differs between men and women, contributing to distinct behavioural patterns and different prevention and treatment strategies (Becker & Chartoff, 2018). Another study, using positron emission tomography (PET), demonstrated that men release a greater amount of dopamine in response to pharmacological stimuli than women. This demonstrates and supports the idea that male drug use is driven by more pronounced pleasure/euphoria, whilst female drug use is more closely linked to the management of negative states or cravings (Munro, 2006). Furthermore, male substance use is often viewed as an extension of 'masculinity', exhibitionism and strength, which encourages sporadic yet recurrent use linked to socialising. Conversely, substance use among women is burdened by a deep-seated social stigma. Since substance abuse is perceived as a violation of the caregiver role, in a traditionally matriarchal society, women are driven to conceal their addiction to avoid external judgement. The need to hide their condition confines their distress and significantly hinders their ability to seek help and access support services (Ettorre, 1992).

This study has certain limitations, despite the significant results obtained and the insights provided into the phenomenon under analysis. First and foremost, the cross-sectional nature of the research design must be taken into account; whilst this allows data to be collected over a defined period, it does not permit the establishment of definitive causal links between burnout and the onset of addictive behaviours. A further limitation concerns the sample, which was selected using a non-probabilistic convenience sampling method and restricted to 174 nurses at the 'Mazzoni' Hospital in Ascoli Piceno. This choice limits the analysis to a single healthcare setting, making it difficult to generalise the results to other healthcare facilities or organisations. Furthermore, the risk of bias linked to 'social desirability' must be considered: given the sensitive nature of the issues, participants may have underestimated their own behaviours, despite the measures taken to ensure confidentiality. Finally, the study excluded staff absent due to long-term illness or on leave, potentially excluding those who might have exhibited more acute forms of burnout or issues related to substance abuse, thereby limiting the overall representativeness of the data.

Conclusions

The issue of substance use and medication misuse among nurses is a complex problem that is still considered taboo within the community. The literature shows that chronic stress and burnout are not merely signs of individual vulnerability, but rather the root of an organisational and structural crisis that threatens the well-being of staff and patient safety. The study presented here, conducted at the Local Health Authority at the 'C&G Mazzoni' Hospital in Ascoli Piceno, aims to examine these dynamics and identify the psychosocial determinants that drive individuals to resort to dysfunctional coping mechanisms. The results obtained confirm a heterogeneous reality; whilst, on the one hand, professionals report strong family support, on the other, a significant proportion of the sample reports critical levels of stress. The survey, carried out using the ASSIST (Alcohol, Smoking and Substance Screening Test), highlighted that tobacco is the most commonly used substance, followed by a concerning use of sedatives and sleeping pills, placing the sample in a moderate-risk category. The inferential analysis also revealed statistically significant gender differences, with men exhibiting greater mobility and a tendency towards sporadic consumption, whilst women reported higher levels of fatigue upon waking and greater difficulty in coping with critical events, suggesting the need for preventive interventions. The study highlights the central role of nurses in the care relationship, emphasising the importance of promoting a support-oriented culture, combating stigma and developing prevention strategies based on scientific evidence. From this perspective, the request for help should increasingly be recognised not as a sign of weakness, but as an expression of responsibility and professional awareness. It is therefore hoped that future research will explore the effectiveness of interventions aimed at organisational well-being and psychological support programmes, with the aim of ensuring the safe and sustainable management of healthcare professionals' mental and physical well-being. The findings suggest the need to introduce counselling and psychotherapeutic programmes aimed at strengthening self-esteem, particularly during the most critical stages of a professional career or whilst recovering from debilitating illnesses. In this context, the establishment of mutual support groups could prove to be an effective tool for encouraging the sharing of work experiences and personal stories, helping to normalise the phenomenon and reduce levels of anxiety and feelings of inadequacy. From a human resources management perspective, it is essential to adopt strategies aimed at preventing pathological staff turnover. In this regard, the creation of mentorship programmes, in which senior professionals support new recruits, can foster the development of trust, a sense of belonging and professional skills. It is also important to promote organisational policies based on flexibility and the recognition not only of results but also of personal growth processes. Finally, healthcare organisations that invest in the mental health of their staff not only improve the quality of care provided but also reap benefits in terms of reducing the costs associated with staff turnover and replacement. In this context, the National Action Plan for Mental Health (PANSM) provides a fundamental framework for guiding structured and sustainable interventions, promoting an integrated approach that takes into account the needs of both service users and staff. In light of the findings, it is clear that we need to move beyond a still-limited view of organisational wellbeing – often confined to one-off interventions – and instead adopt systemic and ongoing strategies. Although the PANSM focuses

primarily on the general population, it can also be effectively applied in the healthcare workplace, promoting the adoption of organisational models that place greater emphasis on the prevention of psychological distress, the promotion of resilience and support in situations of heightened vulnerability. A crucial aspect concerns overcoming the stigma associated with seeking help, which remains widespread among healthcare professionals. In this regard, integrating the recommendations of the PANSM with organisational policies aimed at safeguarding mental health can help to create safer and more inclusive working environments, in which psychological well-being is recognised as an integral part of professional practice. In conclusion, investing in the mental health of healthcare workers is not only an ethical duty, but also a strategic choice to ensure the sustainability of the healthcare system. The alignment between scientific evidence and the PANSM guidelines therefore presents a concrete opportunity to develop effective interventions capable of improving both the working conditions of professionals and overall care outcomes.

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