Problematic substance use: An assessment of workplace implications in midwifery

Abstract

Background: Problematic substance use (PSU) poses occupational, personal, and professional risks. As an occupational group, midwives have been under-represented in research on PSU.

Aims: To assess self-reported occurrences of PSU, help-seeking behaviours and barriers, and perceptions of impairment in United Kingdom (UK) based midwives.

Methods: Self-selecting registered midwives were anonymously surveyed using The Tobacco, Alcohol, Prescription Medications, and Substance Use/Misuse (TAPS) Tool, the Perceptions of Nursing Impairment Inventory (PNII) and open-ended/closed questions. Quantitative data was used to explore PSU, help-seeking, and attitudes to impairment. Qualitative responses were used to provide richer understandings.

Results: From 623 completed surveys, 28% (n=176) self-reported PSU in response to work-related stress and anxiety, bullying, traumatic clinical incidents, and the maintenance of overall functioning. PSU was related to alcohol and a range of restricted drugs. Whilst 11% of those affected indicated they had sought help, 27% felt they should seek help but did not. Reported barriers to help seeking included fear of repercussions, shame, stigma, practicalities, and a perceived lack of support either available or required. Perceptions of impairment were predominantly compassionate with a minority of stigmatising attitudes displayed.

Conclusion: Overall, 10% of the sample reported they had attended work under the influence of alcohol, and 6% under the influence of drugs other than tobacco or those as prescribed to them. Furthermore, 37% indicated concern about a colleague's substance use. As stigmatising attitudes and punitive actions can dissuade help-seeking, changed perceptions alongside compassionate interventions and policies as alternatives to discipline are suggested to reduce risk overall.

Keywords: Substance-Related Disorders; Occupational Health: Professional Impairment; Alcohol Drinking; Midwifery; Nurse Midwives; Delivery of Health Care; Fitness to practise; Attitude of Health Personnel; Perception; Social stigma

Introduction

In a key survey of 1997 midwives based in the United Kingdom (UK)(1), 1464 (83%) reported episodes of work-related stress and burnout. Evidence suggests that substance use may occur in healthcare professionals due to such episodes(2), leaving them depleted(3). Problematic substance use (PSU) in such populations may impact upon performance, relationships, attendance, reliability and the quality and safety of care given (3)(4). From a total of 1298 fitness to practise cases put before the Nursing and Midwifery Council (NMC) in the United Kingdom (UK) between 2014 and 2016, 16% (n=208) related to impairment due to alcohol and 10% (n=131) related to impairment through drug use(3). Whilst there is no definition of 'impairment' provided by the NMC's legislative framework, and there are some subtle and complex philosophical differences in how it is conceptualised, in this professional context, impairment may be generally referred to as the inability to practice with adequate professionalism, skill and/or safety due to the use of alcohol and/or drugs.

Whilst recent studies have focussed upon PSU in nursing populations(5), an integrative systematic review of the literature has revealed a paucity of evidence on PSU in midwifery populations(6). The increased risk to health and impaired functioning in healthcare workers with PSU(7) suggests that if PSU is a significant issue within midwifery it could be an additional factor to consider in addressing current midwifery workforce challenges(8). Midwives and nurses who become impaired through PSU may have conditions placed upon their practice, be suspended or removed from the NMC register(9). This, along with the stigma associated with a perceived 'failure to cope', leaves many reluctant to seek help(10)(4). This is concerning, because as is the case in other professional groups(4), delays in receiving treatment may prolong impairment, and thus any associated risks to both professionals and the public(11). With little evidence of the scale of self-reported occurrences of PSU in midwives based within the UK, other than from those referred to the NMC(3), it is not yet possible to assess its potential impact on both the profession, individual midwives and the public. Therefore, we distributed an anonymous self-selecting survey to UK midwifery networks to identify self-reported incidents of substance use in UK midwives, understand help-seeking behaviours and barriers to help seeking, and explore midwives' perceptions towards colleagues impaired by PSU.

Methods

We employed a confidential and anonymous self-administered mixed-method online survey, as these are evidenced to encourage participants to disclose potentially socially undesirable behaviours in relation to PSU(12). Recruitment began after ethical approval was granted from the appropriate ethical review committee. To be eligible, participants were required to be over the age of 18 years and registered as a midwife with the NMC. They self-selected to contribute by responding to an advert placed in an editorial of the British Journal of Midwifery and shared by the Royal College of Midwives, the research teams' professional networks and the 'Make Birth Better' network online.

Based on reported prevalence of PSU in a nursing population (4), we used a proportion estimate of 0.2 with 2% margin of error. With a population of 45,060 NMC registered midwives and dual nurse/midwives we calculated a sample size of 457 appropriate to estimate a simple proportion of PSU within UK midwives. However, due to the nature of the online survey an exact response rate is not possible to determine(13). Data collection began in January 2020 and ended on March 20th, 2020. Therefore, data were collected prior to the COVID-19 lockdown in the UK.

Demographic questions related to age, gender, education, and employment. Other variables included measures of substance use and perceptions of impairment. Two standardized instruments with established validity and reliability provided the foundation of the survey: Tobacco, Alcohol, Prescription Medications, and Substance Use/Misuse (TAPS) Tool(14) and The Perceptions of Nursing Impairment Inventory (PNII)(15). PNII statements were adapted for a midwifery cohort based in the UK. A subset of open questions were used to capture help-seeking behaviours, attending work under the influence of drugs and/or alcohol and concern for colleagues' PSU. Open-ended qualitative responses were invited to provide annotation to the answers given, including reasons for engagement in PSU. No timeframe restrictions were placed upon responses to open-ended questions; therefore, participants were able to share and recall incidents spanning their whole careers.

Responses to the 2-step TAPS tool were analysed in line with the benchmark for diagnosing PSU(16). Questions within TAPS-1 related to frequency of tobacco, alcohol above recommended daily limits (>5 drinks/day for men, >4 drinks/day for women), illicit drugs, and non-medical use of prescription medications (sedatives, opioids, and stimulants) use in the past 12 months. Any participant who indicated anything other than a negative response on the TAPS-1 screening tool was then assessed for problematic use via the TAPS-2 screening tool. Questions within TAPS-2 assessed use of tobacco, alcohol, 6 different classes of illicit drugs, and other drugs during the past 3 months. For tobacco and other regulated drugs, a score of 1+ was set as the cut-off. For alcohol, we equated a score of 1 to 'use', but not 'problematic use', thus a cut off of 2+ was used for diagnosis of PSU in line with current recommendations(14).

Responses to the PNII were analysed by the proportion of positive responses per item (agree or strongly agree), broadly in line with previous uses of the scale in a nursing population(17). We analysed the qualitative responses for each open-ended question using qualitative content analysis(18). Statements were classified into a number of categories which represented a similar sentiment. These categories were then assimilated into themes broadly representing an over-arching meaning. The number of statements related to each theme have been counted to provide an illustration of the salience of each theme within the sample (see table 5). We chose illustrative quotes which best represented the overall sentiment of the data within each theme. We were also unable to present some

of the qualitative data including descriptive accounts of particularly unique events as quotes because they posed risks to anonymity.

Results

All 623 completed returns were included in the analyses. To assess broad representativeness, the study sample demographics have been compared to the study population (table 1) The number of male respondents in the sample is broadly representative of the study population, but the low number (n=3) coupled with low numbers of male midwives in practice creates a risk to anonymity. Findings are therefore presented for the combined sample and all analyses conducted with the sample as a whole. The spread of age for the sample is younger than that in the overall population with a greater proportion of younger midwives responding to the survey which has the potential to introduce bias in the results. Overall, 64% (n=397) participants were in full-time employment, with 32% (n=200) in part-time employment. Only 2% (n=13) participants indicated that they were either agency/bank staff and 2% (n=13) indicated that they were not currently employed. No comparable data are freely available on employment status of the population as the NMC aggregates this data with nurses.

<<INSERT TABLE 1 ABOUT HERE>>

Self-reported PSU within the sample across all substances was 28% (n=176) with alcohol use disorders most common at 16% (n=101), and 6% (n=37) of respondents having a positive screen for multiple substances. Within this analysis, tobacco is analysed as a freely available substance distinct from regulated drugs, with 8% (n=50) reporting a dependence on smoking tobacco. Self-identified PSU by demographic variable is displayed in table 2.

<<INSERT TABLE 2 ABOUT HERE>>

Self-reported problematic drug use within the sample was 11% (n=67) with sedatives the most common drug used by 6% (n=68) of the total sample. A breakdown of the self-reported use of each drug type can be found in table 3. Within this sample, 72% (n=447) of respondents had a negative screen for PSU.

<<INSERT TABLE 3 ABOUT HERE>>

When asked about attending work under the influence, 10% (n=62) of respondents indicated they had "attended work under the influence of alcohol" and 6% (n=36) indicated they had "attended work under the influence of drugs other than tobacco or those as prescribed to them". Whilst there remains a lack of agreement on the operational definition of impairment in this context, PNII statements most widely agreed upon were that the regulator should provide midwives suspected of impairment information regarding their rights in any disciplinary process, and that employee assistance programmes should be a requirement for support (see table 4). Statements least agreed upon were the

suggestion that impairment in relation to alcohol and/or drugs is due to a personality weakness, and that impaired midwives could not be productive or trustworthy after treatment.

<<INSERT TABLE 4 ABOUT HERE>>

When participants were asked why they “typically use substances not as prescribed, illegally or that were not prescribed” for them, the statements offered (n=33) were categorised into themes of work-related stress and anxiety, bullying, traumatic clinical incidents, and the maintenance of overall functioning. Here, there were a particular spectrum of statements categorised into themes of work-related stress and anxiety, where some participants broadly described letting their hair down after a challenging shift, where others broadly described grappling with burnout. When asked whether they were “concerned about a colleague in relation to their use of substances”, 37% (n=229) of respondents indicated positively. Statements offered in relation to the nature of their concern and the substance, circumstances and outcomes associated with it (n=200) were categorised into themes of impairment through problematic alcohol use and addiction, problematic opioid use, lack of compassion toward problematic Nitrous Oxide (Entonox) use, functioning with cocaine, problematic pain medication use, problematic use of sleeping aids and problematic cannabis use.

Of those midwives who met the criteria for PSU, 11% (n=20) indicated they had sought help, and 27% (n=47) indicated they felt they should seek support but did not. When participants were asked why they had not sought help, statements offered in relation to this question (n=108) were categorised into themes relating to fear of repercussions, shame and stigma, support perceived to be unavailable, help not wanted or perceived as not required and perceived impracticalities. When participants were invited to offer any further information, some statements were categorised as stigmatising perceptions (n=7), yet the majority were categorised as compassionate (n=26). In respect of all open-ended questions, illustrative quotes are presented for each theme alongside the number of statements offered for each in table 5.

<<INSERT TABLE 5 ABOUT HERE>>

Discussion

Self-reported PSU across all substances was identified in just under a third of the midwives participating in this sample (28.3%); higher than that reported in nursing (8-20%)(5), and physician populations (8– 15%)(19). PSU within the present sample was reported in relation to alcohol, cannabis, nitrous oxide, cocaine, cannabis, amphetamines, pain medication, heroin, sedatives and/or ADHD medication. The percentage of midwives who met the criteria for alcohol use disorder (16%) is higher than percentages previously found for alcohol use disorders in nursing populations (6–10%)(20). The percentage of midwives within the present sample reporting cannabis use (5%) lies marginally higher than the global usage figure of 4%(21). These comparisons indicate that PSU may

be more prevalent among midwifery populations compared to allied professions. Our study sample of 623 NMC registered midwives met the criteria for estimating a simple proportion of PSU within the population. However, with a greater proportion of younger midwives responding to the survey than in the midwifery population and methodological decisions around limiting demographic questions to protect participants' identities, our ability to ensure full representativeness in our sample is inhibited. With the aim of the paper to address the lack of data on PSU in midwifery, we deemed threats to representativeness appropriate however results must be viewed with caution when attempting to identify prevalence.

Midwives within this sample reported substance use in response to work-related stress and anxiety, bullying, traumatic clinical incidents, and the maintenance of overall functioning. These findings are comparable with those in relation to paramedics, for whom PSU may also be linked to occupational and post-traumatic stress(22). Whilst 11% of this sample indicated they had sought help for PSU, 27% indicated that they did not seek help despite feeling they should. Within the responses, reported barriers to help-seeking included fear of repercussions, shame, stigma, practicalities, and a perceived lack of support available or required. A recent paper calls for the development of structural interventions to tackle bullying, work-related stress, and burnout currently endemic in the sector(10), and the Covid-19 pandemic, which escalated after these data were collected, may further psychologically deplete frontline healthcare workers(23). Such action will also be required in order to support those engaged with PSU, particularly as such cases may be exacerbated by the COVID-19 pandemic(24). Occupational health professionals have indicated that they do not feel adequately trained or resourced to support healthcare workers with PSU(25), and other gatekeepers to treatment may also be registered practitioners obliged to report impaired midwives to the NMC thus leaving midwives feeling unable to ask for support. Further training, education, and attention in this area of occupational health for midwives, and allied health professionals, is required to ensure a compassionate approach.

The majority of perceptions in relation to impairment were compassionate within our sample. Yet as evidenced by some of the illustrative quotes presented, punitive attitudes displayed towards impaired midwives can dissuade others from seeking help, and thus prolong risks to both professionals and the public (11). Broader naming, shaming and stigmatisation of PSU, as reported in our data, may result in breaches of health-related confidentiality, as well as cause occupational, personal, and professional harm, and should be challenged. Moreover, some acts reported here such as the theft of drugs may be behavioural symptoms of ill health rather than cognisant acts contrary to probity due to the loss of behavioural control over drug-seeking and drug-taking, which has long defined quintessential addiction(26). Thus, policies and actions which take a compassionate and non-punitive approach may

be most useful in recovery and the development of safer working environments as supported elsewhere for allied professions(17)(11).

The positive outcomes of the UK NHS Practitioner Health Programme (PHP) (27), established to support and treat doctors and other medical practitioners with PSU and addiction problems, as well as broader mental health problems, can provide a useful framework for the provision of a similar service for midwives. With doctors who had completed treatment though the PHP more likely to be in active employment at the end of the programme, a targeted employee assistance programme for midwives could help retain experienced and skilled midwives in the profession, as is needed to meet current workforce challenges (8). The size of the population registered with the NMC may make replicating the PHP for this group problematic due to the scale of the resources required. However, using a theory-driven online intervention as proposed for work-related stress (28), may provide an efficient and effective solution to balancing scarce physical resources.

Our study is an exploratory first step to understanding PSU in a UK midwifery population and contributes to the existing evidence of substance use within healthcare professions. Although the sample size is large, it only captures a small percentage of the UK midwifery population. This was expected due to the perceived risks associated with disclosure, alongside the decision to end data collection prematurely to prevent a distortion of results related to the COVID-19 pandemic. Additionally, the need to balance the risks associated with non-confidential disclosures compromises the generalisation of these results and the self-selection of the participants risks bias through a desire to share strong opinions and experiences. Substance use is more common in younger age groups (29); therefore, the greater proportion younger respondents may lead to an over-estimation of the scale of PSU within our data. However, survey respondents typically underreport socially undesirable activities and overreport socially desirable ones(30), indicating the potential for under-reporting of PSU in our results.

PSU in midwifery populations poses personal, professional, and occupational risks of harm. It is not conducive to occupational wellbeing, nor excellence in the midwifery profession. As well as addressing the underlying causes of PSU with regards to this population, future research could usefully assess the prevalence of PSU, challenge stigmatising perceptions with a view to increasing help-seeking behaviours and co-create effective bespoke interventions of support. Supporting occupational health providers, managers, and policy makers to assist midwives engaged in PSU compassionately, and with the assurance of confidentiality and anonymity, may augment help seeking behaviours thus resulting in a reduction of risk and the maintenance of a skilled midwifery workforce.

Key Learning Points

What is already known about this subject:

- Between 2014 and 2016,16% (n=208) fitness to practise cases brought before the Nursing and Midwifery Council (NMC) related to alcohol consumption and 10% (n=131) related to drug misuse.
- Stigma can act as a barrier to help seeking for this group and thus prolong risks to the midwifery profession, midwives, the public, and perinatal care.
- Whilst research has explored problematic substance use (PSU) in nurses and physicians, there is a paucity of evidence in relation to PSU in midwifery populations.

What this study adds:

- In the sample of 623 registered midwives, self-reported PSU was measured at 28% (n=176) with alcohol the most common substance indicated as being used followed by sedatives. Of those who indicated problematic use only 11% (n=20) reported seeking help, with 27% (n=47) feeling they should have asked for help but did not.
- Substance use was reported to have occurred in response to work related stress, bullying and trauma, as well as for the maintenance of functioning. Barriers to help seeking included fear of repercussions, shame, stigma, practicalities, and a perceived lack of support either available or required
- Perceptions towards impaired midwives were broadly compassionate with the most common attitudes being towards supporting midwives to return to practice following recovery. However, a minority of qualitative responses indicated stigmatising views which may perpetuate the risks of harm by posing as a further barrier to seeking help.

What impact this may have on practice or policy

- The occurrence of PSU within this sample indicates that midwives may experience a greater risk of substance use than other healthcare workers. This therefore points to the need for more in-depth studies to investigate the prevalence and nature of this issue.
- In addition to addressing the underlying causes of PSU in midwifery populations, the barriers to help seeking indicated by this sample points towards the development of compassionate and de-stigmatising policies and interventions to support midwives presenting with PSU.
- Management approaches, policies and actions which favour alternatives to discipline may be most useful in recovery and the development of a safer, more sustainable, and healthier midwifery workforce.

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Competing interests

The lead author acts as a panellist for the Nursing and Midwifery Council's Investigating Committee, presiding over cases brought before the council, including those related to problematic substance use.

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Table 1. Comparison of study population (NMC, 2018-19) with study sample

	POPULATION (%)	SAMPLE (%)
GENDER		
FEMALE	99.7	99.5
MALE	0.3	0.5
AGE		
< 30	19.2	25.2
31-40	26.7	32.3
41-50	22.7	23.6
> 51	31.3	18.9

Table 2. Self-identified problematic substance use by age and employment status (out of 623 responses)

	PROBLEMATIC SUBSTANCE USE	**PROBLEMATIC ALCOHOL USE**	**PROBLEMATIC TOBACCO USE**	**PROBLEMATIC DRUG* USE**
	***n* (%)**	***n* (%)**	***n* (%)**	***n* (%)**
TOTAL	176 (28)	101 (16)	50 (8)	67 (11)
AGE				
< 30	44 (28)	19 (12)	13 (8)	20 (13)
31-40	73 (36)	48 (24)	19 (10)	31 (15)
41-50	39 (27)	25 (17)	14 (10)	9 (6)
>51	20 (17)	9 (8)	4 (3)	7 (6)
EMPLOYMENT				
FULL TIME	119 (30)	68 (17)	33 (8)	46 (12)
PART TIME	51 (26)	28 (14)	17 (14)	20 (10)
AGENCY/BANK	3 (23)	3 (23)	0 (0)	0 (0)
NOT EMPLOYED	3 (23)	2 (15)	0 (0)	1 (8)

***Note: includes both prescribed and recreational drugs**

Table 3. Self-reported problematic usage by substance (out of 623 responses)

SUBSTANCE	N^{O}	%
ALCOHOL	101	16
SMOKING	50	8
CANNABIS	30	5
STIMULANTS	12	2
HEROIN	3	.5
OPIOIDS	14	2
SEDATIVES	68	6
ADHD MEDICATION (FOR EXAMPLE, ADDERALL OR RITALIN)	2	.3

Note: 36 respondents reported problematic use across multiple substances

(Problematic substance use was defined by a score of 1+ for drugs and tobacco and 2+ for alcohol in responses to the TAPS-2 screening tool)

Table 4. Perceptions of impairment ranked by percentage of positive responses (agree or strongly agree)

	Agree	
	N°	%
The Regulator's responsibility should include offering the impaired midwife referral to sources of assistance	596	95.7
Major health care agencies should be required to provide employee assistance programs which could serve the impaired midwife.	589	94.5
Midwives have an obligation to notify their manager when they suspect impairment in a co-worker	550	88.3
Public safety can be assured by placing a caution period on the registration of the impaired midwife	510	81.9
If an impaired midwife is receiving treatment, it is important for his/her manager and co-worker to be aware of the fact as they are usually able to offer assistance and /or help them to receive assistance	476	76.4
When a manager has concrete evidence that a midwife is impaired, the manager has a responsibility to suspend that individual pending investigation of the charges	433	69.5
Impaired midwives can best be understood as people who suffer from an illness.	365	58.6
When suspecting impairment in a co-worker, the midwife's first response should be to confront the individual	300	48.2
When a manager has concrete evidence that a midwife is impaired, the manager has a responsibility to dismiss that individual immediately and report the case to my regulatory body	151	24.2
In most cases, public safety should require that the impaired midwives' registration be revoked	100	16.1
For purposes of public protection, the regulator should publish the names of all midwives found to be impaired	46	7.4
Even after treatment it is unusual for an impaired midwife to be productive, trustworthy, and capable of working as a registered midwife.	42	6.7
Impairment is generally the result of a weakness in the midwife's personality.	23	3.7

Table 5. Qualitative Themes with illustrative quotes

Open-ended question	Theme	No. of statements	Illustrative quote(s)
"Why do you typically use substances not as prescribed, illegally or that we not prescribed for you?"	Work-related stress and anxiety	15	*"Social stigma means I have to walk around my block late at night and I fear for my safety. It [Cannabis] just helps me to relax and numbs my continuous worries and anxiety regarding the work we do" (P31)* *"I am also dealing with constant anxiety from work ... it's toxic" (P103) – [Nitrous Oxide]* *"To shut down from work... it is a living hell" (P253) [Nitrous Oxide, Cocaine, Smoking Heroine]* *Relief from work stress [Nitrous Oxide] (P323)* *"To let my hair down when I'm not on call." (P41) [Whip its', Mushrooms, Molly (MDMA), Ketamine and LSD]*
	Traumatic clinical incidents	6	*"I had a traumatic incident at work, I drink and take drugs [Nitrous Oxide and fentanyl] daily to block out the intrusive thoughts and panic attacks" – (P114)* *"Following traumatic incident at work a few years ago I started using weed and booze to cope... work is hard, triggers my anxiety... trapped" (P71)*
	Bullying	4	*"Escape from work stress [cannabis and cocaine], bullying and blame culture is rife in midwifery" – (P276)* *"My heavy drinking started when managers started to bully me... they kick me down at every opportunity" (P493)*
	Maintenance of functioning	8	*"Used coke and dexamphetamine to cope with hours of lack of sleep and having to function at work (P41)* *"I drink heavily after every shift just to survive. Hash helps me sleep." (P145)*
"Have you ever been concerned about a colleague in relation to their use of substances? If so, what was the nature of this concern and the substance, circumstances and outcomes associated with it?"	Impairment through problematic alcohol use and addiction	161	*"Midwives come on the early shift after heavy drinking the night before.., shaking, impaired... trying to get through the shift" (P118)* *"Several colleagues over time. Alcohol heavy drinking, smell on them at work, sickness, lateness, support treatment. Another continued denial support offered, eventually dismissed". (P70)* *"Excessive alcohol use and putting themselves in risky situations. Prostituting themselves for money and material items" (P582)* *"Smelt of alcohol, slurring words, unsteady on feet. Reported to supervisor who did nothing because they are friends" (P564)* *"Alcohol - senior colleague shaking at work - she retired" (P280)* *"Colleagues addicted to alcohol named and shamed by colleagues rather than helped and supported... bullied! Everyone else looking on learned from that…now nobody asks for help. It's dangerous" (P71)*
	Problematic opioid use	7	*"A colleague I knew regularly stole Fentanyl from work" (P393)*

			"Excessive opiate use" (P540)
	Lack of compassion toward problematic Nitrous Oxide (Entonox) use	8	*"A colleague was using Entonox as a way of dealing with PTSD suffered whilst at work and received no support from her Trust." (P587) "* *"She was dismissed for stealing and using Entonox" (P194)*
	Functioning with cocaine	12	*"Midwives take cocaine to get through shifts" (P498)* *"A colleague I knew used to take cocaine frequently before a night shift to keep herself awake" (P306)* *"She had been up all night and had come into work with no sleep and said she had taken cocaine. I told her to go home, and she did." (P349)*
	Problematic pain medication use	4	*"Colleague under strong pain relief, midwife had fallen asleep on the job whilst watching [Cardiotocograph] on [controlled drugs]. parents raised complaint. midwife under supervision" (P578)* *"Pain relief addiction" (P486)*
	Problematic use of sleeping aids	2	*"Colleague taking Non prescribed medications for sleeping due to stress at work from another colleague." (P49)*
	Problematic cannabis use	6	*"Missing shifts due to smoking weed." (P515)* *"Marijuana use - coming to work smelling of it." (P596)*
"Was there ever a time when you thought you should see a doctor, counsellor, or other health professional or seek any other help for your substance use, but you didn't go? If so, why did you not seek help?"	Fear of repercussions	71	*"I'm breaking the law and would lose everything if I opened up" – (P165)* *"Trapped. I have seen others named and shamed rather than helped when they reach out for support... I cannot afford to lose my job or my professional reputation. I struggle on" (P74)* *"I feared my managers would name and shame me, plus I would lose my job. I was right!" (P103)* *"Worried about NMC referral" (P237)* *"Getting reported because of my kids and profession" (P128)*
	Shame/stigma	15	*"Rather than helping her, she got sacked, named and shamed... this sends a very powerful message to others... we need help? We get destroyed! No wonder we soldier on in silence!" – (P21)* *"Stigma related to drug use" (P43)* *"Don't want to be judged … opinion of others thinking I can't cope or be fit for work" (P32)*
	Support perceived to be unavailable	5	*"There is no support, not even a phone call after caring for IUD's [intrauterine death's], or resuscitating babies" – (P11)* *"Nowhere to turn, the woman always comes first before the midwife" (P114)*
	Help not wanted or perceived as not required	9	*"I didn't think it was that bad for help "(P515)*

			"I would never be impaired by cannabis, as its only ever after work." (P31) *"Not ready to give it up" (P196)*
	Perceived impracticalities	8	*"Too much money privately, can't ask GP" (P614)* *"work pressures" (P544)* *"I needed the meds to keep me at work" (p24)*
Please offer any further information in relation to your perceptions	Stigmatising perceptions	7	*"There is never an excuse... midwives impaired by substances should be named and shamed, struck off and keep a low profile. We are a proud profession, as a senior midwife I believe there is no room for weakness! One colleague was stealing drugs from work. She was suspended and I made sure that I told as many people as possible about it... including local and national newspapers...!" (P381)* *"In my experience midwives who have misused substances always play the mental health card once they have been found out…. Just an excuse for their own mistakes in most cases." (P50)* *"Reluctance of colleagues to see it as symptoms of illness requiring clarity…supportive treatment, recognition" (P70)*
	Compassionate perceptions	26	*"I am really pleased that this kind of research is being carried out, there is far too much social stigma for midwives to feel empowered enough to address their issues/ask for help" (P9)* *"I believe abuse of alcohol is high. As nurses and midwives there are no specific treatment programmes aimed at them, unlike Drs and dentists who have, and they do not have to pay for. I applaud what you are doing." (P94)* *"More awareness is needed to all staff that these are real issues, more so than ever with the current pressures & working environment" (P45)* *"bust the myth that midwives are exempt from the pressures that make people self-medicate" (P116)* *"get people to understand that we are human!" – (P139)* *"no-one should be dismissed (lose their job) without help first and often many can continue work with the right help" (P41).*