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Gender, Recovery and Contemporary UK Drug Policy

Purpose

The article provides a gendered reading of the 2010 UK drug strategy and draws out the implications of the new recovery paradigm for female drug users.

Design

The article explores the concept of recovery at a theoretical level, uncovering the taken-for-granted assumptions in the three overarching principles: freedom from dependence; well-being and citizenship. It also analyses the available quantitative and qualitative evidence on women's access to recovery capital to explore the role gender might play in the journey to recovery.

Findings

Strategic thinking around recovery in the UK is largely silent on gender. However, close scrutiny of the available, albeit limited, evidence base on female drug users and feminist scholarship on the principles of well-being and citizenship suggests the need to understand recovery against a backdrop of the social and normative context of women's lives.

Originality/value

Recent analyses of contemporary UK drug policy have focused on the conflation of recovery with abstinence and the displacement of the harm reduction agenda. They have failed to draw out the implications for particular groups of drug users such as women.

The pursuit of recovery-based drug policy is not peculiar to the UK so the article offers a case study of its gendered application in a particular national context.

Introduction

Over the past five years there has been a paradigm shift in UK drug policy (McKeganey, 2014). Shortly after it came to power in May 2010, the Conservative-Liberal Democrat Coalition Government replaced a drug strategy still in its infancy (HM Government, 2008) with *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life* (HM Government, 2010). The new strategy emphasised the need for enhanced support 'for people who choose recovery as an achievable way out of dependency' (HM Government, 2010, p. 2). It displaced the prominence of the drug-crime connection (Duke, 2013; Monaghan, 2012) and rather than focusing solely on drugs looked at a broader range of substances including alcohol and new psychoactive substances. Recovery is best described as a contested concept, but there is some consensus that it refers to 'a lived experience of improved life quality and a sense of empowerment' (Best and Laudet, 2010, p.2). The new strategy promoted abstinence over harm reduction approaches. Whilst recovery is not synonymous with abstinence the politicised nature of debates about drug treatment (McKeganey, 2014) has conflated the two, and harm reduction has been inappropriately characterised as the antithesis of recovery (Best *et al.*, 2010). The strategy is now over five years old yet despite a change of government (to a Conservative majority in May 2015), it remains the overarching strategic document which frames drug policy-making. The Conservative Party manifesto (Conservatives, 2015, p.58) suggests continuity rather than change; underlining the

commitment to abstinence by defining 'full recovery' as becoming drug-free rather than 'routine maintenance of people's addictions with substitute drugs'.

Although the 2010 strategy is reasonably lengthy document (25 pages), surprisingly there is no reference to gender despite well-documented evidence from the UK and elsewhere that gender is a key factor in understanding patterns of drug use and drug careers (including experiences of treatment), and that female and male drug users have overlapping but distinctive needs (Neale, 2004). Arguably this is a retrograde step given that its predecessor at least made reference to gender through the inclusion of an appendix on equality and diversity (HM Government, 2008). All that the 2010 drug strategy offers is an indirect discussion of gender through reference to pregnancy and the need for midwives to identify women dependent on drugs and alcohol at a stage when they are most willing to accept help (HM Government, 2010; p.22). Other than this, there are only fleeting references to black and ethnic minorities and lesbian, gay, bisexual and transgender users when describing patterns of drug use (p.6). None of the annual reviews (HM Government, 2012, 2013a and 2015) or the evaluation framework (HM Government, 2013b) make reference to gender.

This article provides a gendered reading of the 2010 drug strategy and draws out the implications of the new policy paradigm for female drug users. The consequences for female alcohol users are beyond the scope of this short article but the literature on women's use of alcohol (for example, (Staddon, 2015) suggests a parallel exercise would be fruitful and is likely to reach similar conclusions. Following a short section outlining the salience of gender for understanding women's journeys into and out of drug use, the remainder of the article is divided into two main sections. The first deconstructs the concept of recovery as deployed in the 2010 drug strategy. In this influential policy document, recovery is underpinned by three overarching principles: freedom from dependence, well-being and citizenship. These are profoundly gendered concepts which have been extensively discussed by feminist scholars and we will draw upon this work to argue that whilst strategic thinking is silent on the role of gender, we need to understand recovery against the backdrop of contemporary gender politics. The second section develops this line of argument through drawing upon the small literature which compares the characteristics of female and male drug users and their experiences of drug treatment to consider how gender might shape their recovery experience. Here we will focus on the four components of recovery capital (see Best and Laudet (2010) for an overview of the concept) – social, physical, human and cultural - and reflect upon the significance of gender to understand the resources that recovering drug users can draw upon.

Before moving on to analyse the strategy in the way described above, we need to consider the theoretical and methodological approaches which underpin the article. It is influenced by developments in feminist drug scholarship and also in policy analysis. Feminist scholars have been influential in making female drug users visible and contributing via theoretical and empirical work to the development of gender-sensitive approaches to tackling drug use. The starting point in developing gender-sensitive drug policy must be to recognise points of similarity and difference between and the lives of female and male drug users. Intersectional approaches are useful here which do not assume that gender is the most important factor in shaping the experiences of drug users and provide space to consider the role of other factors - individual, social and cultural - which may be related to drug use. The latter involves recognition that drug users' experiences are shaped, but crucially are not determined by, structured inequalities. The links between drug use and

inequality have been documented elsewhere (see Stevens, 2011). It is acknowledged that whilst drug use cuts across social divisions, drug-related harms are experienced most sharply by those living in deprived communities characterised by poverty, unemployment and poor housing. This has implications for recovery (as defined in the 2010 drug strategy) due to a lack of recovery capital. Consequently, the term 'discovery' rather than 'recovery' has been favoured by the founders of the UK Recovery Academy to argue that many individuals need not to restore their previous life rather to aspire to a quite different one (Best and Bamber, 2009). Thom (2010) suggests that this may be particularly true for women, yet emphasises the heterogeneity of their experiences.

The article comprises a focused analysis of the latest UK drug strategy (HM Government, 2010). To clarify, UK in this context predominantly refers to England as other parts of the UK have separate drug strategies but the strategy is an overarching one in the sense that the devolved administrations (Wales, Scotland and Northern Ireland) do not have full responsibility for all the policy areas which are relevant to tackling drugs. The UK in this instance is used as a case study to reflect upon the gendered implications of the pursuit of a recovery-based drug policy. Such policies are not peculiar to the UK; rather the concept of recovery has become a central concept in the international drug field (Lancaster *et al*., 2015; McKeganey, 2014; Neale *et al.*, 2014). In addition, the need to take into account the rights of female drug users is of global concern as evidenced by its inclusion among the issues to be considered at the 2016 United Nations General Assembly on the World Drug Problem (see http://www.unodc.org/ungass2016/en/background.html). The work of Bacchi (2009) has influenced the approach to policy analysis. Placing an emphasis on 'problematisation', she argues for the need to critically interrogate the taken-for-granted assumptions and the conceptual underpinnings found within representations of 'problems' which are use to justify particular policy interventions. Of especial importance here is uncovering the gendered nature of these. We start this process by considering the available evidence on patterns of drug use among females and males.

Gender, drug use and the journey to recovery

Patterns of drug use appear to be gendered. The latest data available from the Crime Survey for England and Wales (CSEW) (Home Office, 2014) provides evidence for this. The large household-based survey asked adults aged 16 – 59 about their drug use and found higher levels of drug use among men, and this was particularly pronounced in the category of frequent users (categorised as use of any illicit drug more than once a month on average), with three times as men fitting these criteria as women (4.8% and 1.5% respectively). These gendered patterns of drug use are replicated across other parts of the UK (Toner and Freel, 2010; Robertson and Bates, 2014). Whilst the CSEW provides an insight into gender differences with respect to drug experimentation and what is typically referred to as 'recreational' (i.e. non-dependent) drug use, it offers little valid or reliable data to aid understanding of dependent drug use. However, estimates of opiate and/or crack cocaine use (for England for 2010-11) shed light on this issue and suggest that just under one-quarter (23%) of this drug-using population are female (Hay *et al.*, 2013).

A similar proportion of females access drug treatment services. The most recent National Drug Treatment Monitoring System (NDTMS) data on the gender breakdown of individuals (aged 18 and over) accessing drug treatment collected via GPs and drug treatment services (excluding those operating in prisons) reveal that females make up 26% of those in drug treatment In England (Public Health England, 2014). This proportion has remained more or less constant since the strategy was

published, although the number of female drug users accessing treatment has declined considerably: from 55,538 in 09/10 to 50,854 in 13/14 (NDTMS, 2010; NDTMS, 2014). In Scotland (Information Services Division Scotland, 2014) and Northern Ireland (Corrigan, 2014), males similarly outnumber females among the treatment population, although the proportion of females is slightly higher (31% in Scotland and 34% in Northern Ireland). Women participating in drug treatment programmes are, of course, not representative of all drug users and there has been considerable debate about whether women are reluctant to access drug treatment because the available services do not accommodate their specific experiences and complex needs (see Becker and Duffy, 2002; National Treatment Agency, 2010). The NDTMS for 2013/14 (NDTMS, 2014) paints a picture of the typical client as a White British (83%) opiate user (79%) with a mean age of 36. When broken down by gender (using 2012/13 data as 2013/14 is not available in this way), we can see some slight differences in the profiles of female and male drug users accessing drug treatment (NDTMS, 2015). The mean age is slightly lower at 35 with proportionately more young (i.e. aged under 30) female clients (27% c.f. 21%) and a marginally higher percentage of opiate users (83% c.f. 79%). No recent data on the ethnic breakdown of female and male treatment clients have been published. The 2013/14 data also suggest that whilst the main source of referral for both women and men is self-referral (44%) but just over one-quarter (27%) access drug treatment via criminal justice processes. The latest data are not broken down by gender but a National Treatment Agency for Substance Misuse report using 2008-9 data found that criminal justice referrals accounted for 18% of female referrals but 30% of male referrals. This is unsurprising given women's lesser involvement in crime in comparison to men (Heidensohn and Silvestri, 2012). The available quantitative evidence suggests that policy and practice should be informed by an understanding of how gender shapes drug use and recovery.

Problematising recovery as a high level policy concept

In the 2010 Drug Strategy, recovery is described as an 'individual person-centred journey' and viewed it as a process rather than an 'end-state' which 'will mean different things to different people' (HM Government, 2010, p.18). The extent to which this is realised in practice will be explored throughout the remainder of the article. Here it is worth flagging up the need for qualitative research with drug users which will unmask multiple interpretations of recovery, and the extent to which they might differ between sub-populations of drug users; for example, females and males. As we have already identified, in the 2010 drug strategy recovery is described as involving three overarching principles. The first - freedom from dependence - refers to freedom from drug dependence but for female drug users may have other connotations. For example, it may involve leaving a partner who is violent towards them or who plays a key role in maintaining their drug use.

The second principle is well-being. Like recovery, well-being is a contested concept which, as Taylor (2015) notes, has been dominated in recent times by positive psychological and behavioural economics perspectives which focus on individual experience and behaviour. Enhancing individual well-being as a basis for improving national well-being has become a political priority in the UK since 2010 (Taylor, 2015). Whilst the term 'well-being' is not defined in the drug strategy, shortly after its publication the Coalition government tasked the Office for National Statistics (ONS) with measuring well-being and a multidimensional approach has been adopted which looks initially at individual subjective well-being and moves on to look at factors which might affect it (health, relationships, personal finance, education and skills, what we do, where we live) and finally contextual domains

(governance, economy and natural environment) (ONS, 2015). The second set of measures capture different aspects of recovery capital which we will explore in the next section. In terms of the 2010 drug strategy, becoming drug-free is central to enhancing well-being. However, feminist work on women's use of substance suggests the need for more nuanced analysis. It describes how women sometimes resort to substances – illegal drugs, alcohol, tobacco, prescribed medication and food – to manage their lives. This is not to suggest that these approaches are helpful; instead, they are often counter-productive with negative implications for health. Nonetheless we should recognise that sometimes substances, both licit and illicit, might be used as mechanism to enhance well-being (Wincup, 2001). Defining pleasure as a 'deep sense of personal and social satisfaction based on emotional and physical well-being', Ettorre (1992, p. 146) argues that women use substances as a means to search for pleasure and manage 'patriarchial pain' (p.153). This has rarely been acknowledged at policy level, and the contemporary preoccupation with abstinence at the level of policy continues a trend to render pleasure absent from official discourse on substance use (O'Malley and Valverde, 2004). The women participating in du Rose's study 2015, p.201) saw themselves as 'responsible, self-medicating governors of their pain' caused by trauma, abuse, violence and illness. Yet within contemporary policy discourse, such behaviour is perceived as 'irrational', justifying measures to 'responsibilise' drug users by steering, and sometimes coerceing, them towards abstinence. Feminists have been influential in drawing attention to the political economy of health arguing that improving women's well-being is not simply about improvements in medicine and health care or through requiring women to actively manage their own health but through broader social change which reduces inequality (see for example, Doyal, 1995). Looking specifically at female drug users, we can see that enhancing well-being is not simply about treating their drug use and related problems but addressing a broader range of issues; for example, their relationships with men.

The final principle is citizenship. The 2010 drug strategy is similarly vague in terms of what the term 'citizenship' means. A useful starting point is Lister's (1997) distinction between citizenship as 'status' with associated civil, political and social rights and as 'practice', that often involves responsibilities and duties. Feminist scholars have been highly critical of the ways in which citizenship has been conceived and argue that it is a gendered concept that reflects the wider patriarchal oppression of women. Traditionally, citizenship has been defined according to gendered notions of what men should be or do (i.e. the public citizen), relegating women to the private sphere and excluded from full citizenship. A feminist approach to citizenship involves recognition of the structural constraints which continue to diminish and undermine women's citizenship whilst not reducing them to the status of passive victims (Lister, 1997). The strategy focuses implicitly on citizenship as practice. Successive governments - of all colours – have focused more on the obligations or responsibilities of citizens than on their rights. In this way they construct a particular model of citizenship; that of the 'responsibilised' citizen who actively manages their behaviour, making appropriate choices to ensure they are healthy, law-abiding and financially secure. There is increasingly an expectation that almost all individuals should engage in paid work, or at least take steps to secure it, and this underpins the provision of welfare. Consequently, some women (i.e. those who are financially dependent on the state) are expected to be public as well as private citizens. Drug users are not exempt from job-seeking requirements and associated responsibilities (for example, to engage in training) unless they are engaged in residential treatment, have been assessed as incapable of work or are parents of children under 5. Since 2008, there have been

proposals – yet to fully materialise – to channel drug users into paid employment. This approach is underpinned by three beliefs: paid work sustains recovery, has a transformative potential and should be the primary duty of the responsible citizen (Monaghan and Wincup, 2013). Work, as we will see below, is one form of recovery capital.

Problematising the construct of 'recovery capital'

As the concept of recovery has gained currency so too has the concept of recovery capital. Drawing upon the work of the sociologist, Pierre Bourdieu (1980), it refers to the 'sum of resources necessary to initiate and sustain recovery from substance misuse' (Best and Laudet, 2010, p.2). The work of Cloud and Granfield (2009) has been influential in identifying four components of recovery capital (social, physical, human and cultural) which comprise of internal and external resources. The latter can include parents, families, partners, friends and neighbours. However, given that some drug users may not have these resources or those they do have may help to sustain their drug use, successful recovery requires community level activity; for example, through the development of recovery communities or mentoring schemes. Recovery capital can be both positive and negative, and consequently the aim of treatment (viewed in a holistic way) is to enhance the former whilst reducing the latter.

This section draws upon data gathered from the Drug Treatment Outcomes Research Study (DTORS) (Jones *et al*., 2007), a large-scale national empirical study of 1796 individuals who entered drug treatment over a three year period. Whilst dated, DTORS remains an important source of information about gender and drug treatment because data routinely collected via NDTMS do not provide the same level of detail on the characteristics and recovery capital of drug users. Moreover, the data which are available in the public domain are not always broken down by gender. It is important to acknowledge that the timing of the DTORS study coincided with the policy emphasis of using all stages of the criminal justice process to channel drug users into treatment (Hucklesby and Wincup, 2010). This resulted in a rapid expansion of drug treatment services to accommodate growing number of referrals via this route, particularly male drug users. Treatment data, as we have already noted, by its very nature does not capture those who are unable or do not wish to access treatment. This group is likely to be diverse in terms of their levels of recovery capital since it may include groups as diverse as occasional drug users through to those who are heavily dependent. Quantitative data are supplemented by using qualitative studies from the UK but as Thom (2010) notes there is a dearth of evidence on the needs of drug-using women and how their life situations and social contexts shape their pathways into and out of drug use.

Social capital

Social capital refers to the sum of resources that each person has as a result of their relationships with either family and friends or broader social networks (Cloud and Granfield, 2009). It is important to recognise that relationships offer a source of support but also entail commitments and obligations. Moreover, whilst relationships can aid recovery they are sometimes a source of negative recovery capital; for example, helping to sustain drug use and associated behaviours. Whilst only so much can be gleaned from the available research evidence, it provides some indication of the gendered nature of social capital among drug users.

The available data from DTORS suggest that women are more likely than men to have a partner (51% c.f. 33%) but are less likely than men to describe them as supportive (Jones *et al*., 2007). Qualitative research evidence provides some explanation for this, supplementing the DTORS finding that three-quarters of women have drug-using partners whilst only two-fifths of men do. Neale *et al*. (2014) found that women were more likely than men to describe their partner as someone involved in 'initiating, maintaining or escalating their drug use' (p.6) and that domestic violence was a problem for a number of women.

The majority of women who enter drug treatment are parents but do not always have day-to-day parental responsibility for them (National Treatment Agency for Substance Misuse, 2010; Jones *et al*., 2007). Women are more likely that men to be parents (Jones *et al.*, 2007*)* but a complex picture emerges that whilst men were more likely than women to live apart from some or all of their children (85% c.f. 62%), women were more likely than men to have children living 'in care' (15% c.f. 4%). The most obvious explanation of this is that the children of male drug users were more likely to be looked after by their mother. Rather than relying on a partner – who were often also drug users - female drug users were more likely to use family members to care for their children, and this happened in one-third of cases (c.f. one-eighth of men). Being a parent is associated with positive treatment outcomes (National Treatment Agency for Substance Misuse, 2010). This can be explained in terms of a desire to become a better parent or because there are external drivers which impact upon motivation. These drivers might be defensive (for example, avoiding a child going into 'care') or proactive (for example, resuming contact with a child). There has been extensive debate about whether being a parent deters women from accessing treatment in the first instance. It has been suggested that drug use conflicts with traditional images of mothering and caring, and the fear of losing children acts as a powerful disincentive to access drug treatment (Becker and Duffy, 2002). Lack of child care provision acts as a further barrier (Simpson and McNulty, 2008).

Physical capital

Physical capital refers to tangible assets such as property and money that many increase recovery options; for example, through purchasing treatment or providing the opportunity to move away from drug-using networks. To elaborate this might include income, savings and accommodation with some security of tenure. It is more likely that drug users will have negative physical capital; for example, debt or illicit sources of income (Neale *et al.*, 2014). On a number of dimensions, it appears that there are importance differences in the physical capital enjoyed by female and male drug users. Looking first at accommodation, the DTORS study (Jones *et al.*, 2007) found that a higher proportion of female drug users (68% c.f. 57%) had access to stable accommodation, although they did define it broadly to include living in hostel. Fewer women than men lived in unstable accommodation which included rough sleeping, living in temporary accommodation (e.g. caravans, squats, night shelters) and institutions (ranging from prison to hospitals and residential treatment). These data need to be interpreted against the backdrop of research which has drawn attention to 'hidden homelessness' amongst women (Crisis, 2008). This form of homeless refers to individuals living in highly precarious situations, which are insecure (for example, sleeping on a friends' sofa) and/or risky. This is of particular importance given that we have already noted that female drug users are often in problematic relationships and may choose to remain with a violent partner or one that makes it difficult for them to desist from drug use and/or offending rather than risk becoming homeless..

The DTORS data reveal that whilst similar numbers of females and males (11% and 12%) were in employment, education and training, the vast majority were not. The same proportion of females and males described themselves as unable to work due to long-term sickness and disability (25%) but males were more likely to describe themselves as unemployed but looking for work (32% c.f. 30%). The valorisation of paid work referred to in our discussion of citizenship has specific implications for drug users, downplaying the value of other forms of work such as caring and volunteering in the recovery process (Monaghan and Wincup, 2013). This is likely to impact on women and men differently given the gendered nature of caring responsibilities, reflected in the drug treatment population.

Overall, a picture emerges of high levels of worklessness, lack of financial autonomy and lack of access to appropriate accommodation among drug users in treatment but with some differentiation between females and males in their ability to acquire positive physical capital and move toward self-sufficiency and financial security. The quantitative data hint at a complex picture which a recent qualitative study by Neale *et al.*, (2014) sheds some light on. There were noticeable differences in how women and men sought to 'get by', although social security benefits were the main source of income for both groups. Males were more likely than females to declare overtly criminal activities, whilst women reported greater reliance on state benefits, prostitution, family assistance and legal/quasi-legal income sources. The same study found that that typically drug users were living in insecure and inappropriate accommodation, that none of the interviewees owned their own homes and that those living in relatively secure social housing were predominantly women.

Human and cultural capital

Human capital refers to skills, positive health, aspirations, hopes, and personal resources that permit individuals to prosper (Cloud and Granfield, 2009). Human capital can be both tangible and abstract. Research evidence provides more detail on the former, pointing to significant gender differences, but the latter is important because hopes and aspirations are heavily gendered. Despite moves towards greater equality, expectations of the roles women and men might undertake in both the public and the private spheres remain influential.

The available research evidence does not suggest there are significant gender differences in terms of skills (Neale *et al*., 2014); rather that lack of education and skills is a significant problem for many drug users and serve as significant barriers to employment (Bauld *et al*., 2010). It is in terms of health – both physical and mental – that we see some of the most striking gender differences with far higher rates of chronic health conditions and mental health problems among female drug users. DTORS data (Jones *et al.*, 2007) found that slightly fewer women rated their health as 'excellent' or 'very good' (21% c.f. 18%) and that slightly more women than men described their general health as 'poor' (20% c.f. 16%). This hides a more complex picture of women experiencing injuries related to domestic violence, reproductive and sexual health problems and poor mental health resulting in self-harm, suicidal thoughts and suicide attempts (Becker and Duffy, 2002; Neale *et al.*, 2014).

Like aspects of human capital, cultural capital is not tangible. It refers to values, beliefs and attitudes that link to social conformity and ability to fit into dominant social behaviours (Cloud and Granfield, 2009). This aspect of recovery capital is deeply gendered, manifesting itself in different notions of appropriate female and male behaviour. Women engage in self-regulation because of the powerful nature of these values, beliefs and attitudes but are also subject to greater levels of social control in

both the private and public spheres. As Ericsson and Jon (2006) argue, the social control of women is 'immeasurably *tighter* . . . and qualitatively *different*' (p. 126; emphasis in original) from that of men. It forms part of the patriarchal structures of society and serves to reproduce them by defining acceptable female behaviour, in part through punishing and stigmatising those who deviate beyond these boundaries. Female drug users are often perceived as those who have deviated from the norms of acceptable and respectable womanhood.

Concluding comments

The work of Bacchi (2009), introduced at the beginning of this article, argues that it is important to consider 'What it left unproblematic in this problem representation? What are the silences? Can the problem by thought about differently?' (p.2). We have noted that the 2010 drug strategy is largely silent on the issue of gender. Despite the rhetoric of the individual person-centred journey, the design and implementation of the current recovery agenda provides little space to explore what recovery might mean for individuals and how this might differ for females and males. It glosses over the gendered nature of the underpinning principles of recovery; namely, freedom from dependence, citizenship and well-being. It constructs a particular vision of a 'recovered' citizen who is abstinent, engaged in paid work (or at least not dependent upon state welfare without good reason), and actively managing their own health. Consequently, we are left with a strategy that fails to recognise the social and normative contexts of women's and men's lives alongside notable yet complex differences in the recovery capital of female and male drug users.

In examining the available evidence, it has become evident that we know too little about the lives of female drug users (and arguably male drug users too) and further research is needed to explore what 'recovery' (or 'discovery') means for women and how much recovery capital – positive and negative – they 'possess'. There is an inherent danger in this project of polarising female and male drug users and in some of the recent discussions of women and recovery (Neale *et al*., 2014; Thom, 2010), there has been a strong emphasis placed on the need to recognise the unique experiences of women whilst avoid glossing over similarities with male drug users. Developing this nuanced understanding through academic research is important because this has the potential to influence dialogue at policy and practice levels by offering a 'broad assessment of the vulnerabilities, opportunities and inequalities specific to each gender' (OECD, 2013; p.16) whilst recognising the shared experiences of many drug users, regardless of gender. This, in turn, can make a difference 'on the ground' to recovering drug users. It has been argued that attempts to tackle drug use reproduce the gendered nature of social control. Historically, approaches to tackling women's drug use have become a further tool for social regulation (Seddon, 2008). This leads us to consider Bacchi's question as to what we could do differently. There have been calls for a 'revisioning' of our approach to women's use of drugs (Ettorre, 2004), referring to the need to let go of damaging, outdated images and ideas of female drug users, and to establish more progressive perceptions that open up new opportunities to avoid reinforcing gender control and repression (Neale *et al.*, 2014). A greater empirical understanding of the lives of female drug users coupled with a gender-sensitive policy framework would support this 'revisioning'.

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