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Women as Vulnerable Subjects:
A Gendered Reading of the English and Irish Drug Strategies

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Women as vulnerable subjects: a gendered reading of English and Irish drug strategies

1. Introduction

It is well-documented that women are less likely than men to engage in drug use, particularly in its most harmful forms. Data for England and Ireland paint a remarkably similar picture. Self-report studies reveal that men are at least twice as likely as women to disclose using drugs in the last year (Health Research Board, 2017, Home Office, 2018a), they are three times more likely than women to become opiate users (Hay et al., 2017; Hay et al., 2018) and they comprise approximately three-quarters of the drug treatment population (EMCDDA, 2017; Public Health England, 2017). Women are often described as a vulnerable group. In recent years, vulnerability discourses have been deployed across a range of policy fields and critical analysis has highlighted the contested nature of the term (Brown et al., 2017). When invoked to describe women who use drugs, the concept draws attention to the distinctive needs of women who comprise a minority of a male-dominated population. Typically, these needs are not recognised in drug policy (Hamilton and Eastwood, 2017; Stengel and Fleetwood, 2014).

On 14th July 2017, the *2017 Drug Strategy* was published (HM Government, 2017a). The strategy represents a re-engagement with the concept of vulnerability, using it to refer to specific sub-populations of people (for example, young people, offenders and children of drug-using parents) who are most at risk of drug-related harm in order to justify targeted preventative measures and tailored interventions to recovery. (see Brown and Wincup, forthcoming). For the most part, the strategy presents itself as gender-neutral. Like the drug strategy it replaced (HM Government, 2010), references to women's experiences were notably absent (see Wincup, 2016). Women were mentioned only eight times in the entire strategy. Three days after the English drug strategy was launched, Ireland published its new drug strategy: *Reducing Harm Supporting Recovery* (Department of Health, 2017a). The Irish strategy devotes greater attention to women: one, albeit small, section is devoted exclusively to women and two of the fifty-two identified strategic actions explicitly refer to women. Like it English counterpart, the discourse of vulnerability is used to emphasise the need for bespoke measures in response to the diverse needs of the drug-using population; for example, relating to socio-demographic factors such as age, gender and ethnicity or individual circumstances such as health, involvement in crime and housing status.

This paper provides a gendered reading of recent strategic thinking on drug use and its control in England and Ireland with a particular focus on gendered representations of vulnerability and their effects. After providing a brief overview of the literature on women, drug use and vulnerability and outlining the analytical approach adopted, the English and Irish strategies are considered in turn. Both strategies, in different ways, construct women – or at least some groups of women – as vulnerable subjects. The English strategy considers women's vulnerability in relation to the presence of risk factors which increase the likelihood of

involvement in drug use. The Irish strategy adopts a different understanding of women's vulnerability, highlighting the barriers women face engaging in or sustaining involvement with treatment and rehabilitation services, which are intensified when women have children or become pregnant. The final section draws out more fully the implications of both approaches. It is not my intention to determine whether the English or the Irish drug strategy offers the best approach to tackling women's drug use. Indeed, both fall short of demonstrating gender-responsive strategic thinking by attempting to add women and stir to strategies which are largely gender-blind. Instead, I use the insights form the comparative policy analysis to outline how to develop more gender-responsive policies to enhance support for women who use drugs.

2. Women, drug use and vulnerability

Women who use drugs are typically constructed as a special population through comparing them with a male norm. A starting point is often to emphasise differences in the nature and extent of women's and men's use of drugs. Women are in the minority when drug use becomes regular and damaging and this is reflected in male-dominated treatment populations (ECMDDA 2016; UNODC, 2016). Alongside noting qualitative and quantitative differences between women's and men's use of drugs, research has also drawn attention to emphasising the ways in which the experiences of women who use drugs are distinct from men. This has involved highlighted both sex differences, in particular recognising women's greater susceptibility to rapid dependence and the negative impact of dependent drug use on reproductive health (Hankins, 2008), and gender differences. Evidence – often derived from treatment populations which arguably are not representative of all women who use drugs – points to poorer levels of mental health, higher levels of physical and sexual abuse within childhood and adulthood and involvement in sex work (Becker and Duffy, 2002; Neale et al., 2014; Simpson and Nulty, 2008). These factors may explain pathways into drug use but also why drug-using careers are sustained.

Compared to women's use of drugs, relatively little is known about their experiences of recovery (Thom, 2010; ACMD, 2013). Over the past decade there has been considerable emphasis on analysis how access to recovery capital impacts upon defined as 'the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery' (White and Cloud, 2008: 22)). The concept of recovery capital has been largely generated from studies of men and constitutes an example of what Campbell and Ettorre (2011) refer to as epistemologies of ignorance (2011). The available evidence suggests that women's access to recovery resources appears to be shaped by a complex mix of intrapersonal, interpersonal and structural factors. It suggests that gender differences are most apparent in relation to human capital which incorporates health and wellbeing and social capital which includes relationships. Women not only have lower levels of recovery capital but appear to be exposed to higher rates of negative recovery capital (defined as

factors which 'actually impede one's ability to successfully terminate substance misuse and keep people trapped in the world of addiction' (Cloud and Granfield, 2009: 1977).

Grella et al. (2008) have helped to understand the role gender plays as individuals progress through the treatment, relapse and recovery cycle. They argue that whilst the broad contours of the recovery cycle are similar for women and men, gender is a moderator of outcomes following treatment in the same way that it influences the course of substance use initiation, addiction onset and treatment participation. Neale et al. (2014) reached similar conclusion from qualitative interviews with 40 current or former heroin users. They found that gender was an important factor in structuring participants' experiences but there was no essential recovery experience among women. In keeping with this, Neale et al. (2014: 4) call for an intersectional understanding of women's use of drugs which explores 'interactions between different aspects of social identity, the impact of subsystems and processes of oppression and domination and the multiplicity of lives experiences. Whilst there is plentiful evidence of commonality of need among the female drug-using population, there is a growing awareness of the need to recognise heterogeneity within their experiences. Campbell and Ettorre (2011) emphasise the important of examining the gendered, classed and racialized power differentials that structure women's lives, otherwise women's specific needs will not be rendered visible in knowledge-making practices.

Research on stigma – an example of negative recovery capital– further emphasises the need for an intersectional perspective. A review of the literature on stigmatisation of drug users revealed that being female was one of the most commonly experienced stigmas (Lloyd, 2010). The review noted that often the stigma of being a female drug user is compounded by belonging to other stigmatised groups (being Black, homeless, a sex worker or an offender). In particular, being a mother or pregnant led to greater stigma. Similarly, feminist research has highlighted gendered responses to drug use and the construction of women's use of drugs as a greater problem than men's. It has drawn attention to the stigmatisation of women who use drugs, perceiving them to be bad mothers, psychopathological and emotionally disturbed, polluted and polluting (Du Rose, 2015). A number of studies have explored the clash between idealised images of motherhood and stereotypical images of women who use drugs (Radcliffe, 2011; Stengel, 2014).

3. Approach

This paper draws on the insights of feminist (post) critical policy analysis (Lather, 2010). This approach has a number of distinguishing features. First, it emphasises the importance of an embodied policy analysis which recognises how social power differentially positions women's bodies and the pervasive epistemologies of ignorance that structure knowledge practices in drugs research, policy and practice (see Ettorre, 2018). This form of policy analysis elucidates the relevance of gender in how policy problems are shaped discursively and can result in

unintended consequences and uneven effects (see Allan et al. 2009). This is especially important in the context of gender and drug policy. For example, research has highlighted the disproportionate impact of the 'war on drugs' on women across the globe (Kensey et al., 2012; Malinowska-Sempruch and Rychkova, 2015; United Nations Office on Drugs and Crime, 2014). Second, it questions what is presented as problematic, thus providing a critique of the tendency of policy to engage in a process of 'othering' (see Lather, 2010: 74). Again, this is particularly pertinent to drug policy analysis. As noted, above, this occurs when women, especially pregnant women and mothers, use drugs.

As Bacchi (1999: 63) notes, whilst an emphasis on the social construction of policy problems seems to offer a 'natural home' for feminist policy analysts, there have been dissenting voices. The first concern relates to a fear that political activism will be undermined by an (over) emphasis on discourse and its meaning. The emergence of a feminist critical discourse analysis has helped to allay this fear. As Lazar (2005) notes, this analytic approach adopts an overtly political stance, concerning itself with gender inequality and injustice. It operates as a form of political praxis, challenging the discursive strategies employed in different forms of oppression and arguing for social change. In keeping with this tradition, this paper ends by exploring alternative policy formulations to support women who use drugs. The second concern is the inclination to focus on articulated claims rather than exploring what is not included. For Bacchi (1999), both of these fears can be addressed through the adoption of the 'What's the problem represented to be' (WPR) approach to policy analysis.

The WPR approach provides scope to explore both discursive and non-discursive factors and the relationship between them by asking a series of questions about policies.

1. What's the problem (in this case, of women, drug use and vulnerability) represented to be in a specific policy or policies?
2. What deep-seated presuppositions or assumptions (conceptual logics) underlie this representation of the 'problem'?
3. How has this representation of the 'problem' come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be conceptualised differently?
5. What effects (discursive, subjectification, lived) are produced by this representation of the 'problem'?
6. How and where has this representation of the 'problem' been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced?

For Bacchi (1999: 64) policies (as forms of discourse) are shaped by structural factors, including the power of institutions and individuals, and these concerns are particularly important for feminists as women are not well-represented among 'political claims-makers'.

Moreover, policies have material effects which can 'limit or enable access to material resources, or cause or relieve emotional distress' (Goodwin, 2012: 33). The WPR approach also highlights the importance of reflecting upon silences (Question 4). This is particularly important for feminist work on drug use since, as previously noted, women are often neglected in drug policy.

This analytical strategy has been used extensively in the drugs field with a number of authors deploying it specifically to look at gendered representations in different discourses. For example, Martin and Aston (2014) used the WPR approach to render visible thinking about women's alcohol and other drug use in academic studies, concluding that it reifies women as a unique population and paradoxically may limit the range of services and support available for women. Focusing on policy discourses, Wincup (2016) used the same analytical approach to provide a gendered reading of the (UK) 2010 drug strategy, uncovering the taken-for-granted assumptions within the three overarching principles of recovery articulated in the strategy (freedom from dependence, well-being and citizenship). After rendering visible the gendered effects of the seemingly gender-neutral recovery agenda, she argued for the need to understand recovery against a backdrop of the social and normative context of women's lives.

This paper focuses solely on the most recent English and Irish drug strategies. Since both are in their infancy no follow up documentation; for example, annual reviews, was available for analysis. The Irish drug strategy was accompanied by an extensive consultation, described in Section 5, and its portrayal of women who use drugs was also analysed. Publication of the English strategy was accompanied by a long overdue evaluation of the previous strategy (HM Government, 2017b) and a letter to the Advisory Council on the Misuse of Drugs[1] from the Minister for Crime. Safeguarding and Vulnerability (Newton, 2017). Neither made reference to women.

Each strategy was read carefully on three occasions. The first reading involved a quantitative and qualitative content analysis to explore the extent and positioning of women in each strategy alongside the ways in which women who use drugs are problematized (questions 1 and 2 of the WPR approach). The WPR approach encourages researchers to move beyond discourse analysis to consider the potential effects of these problematisations. Consequently, both strategies were re-read with the three types of effects described by Bacchi and Goodwin (2016) in mind (Question 5 of the WPR approach).

[1] The Advisory Council on the Misuse of Drugs is an advisory non-departmental public body, sponsored by the Home Office as the lead government department for drug policy. It makes recommendation to government on drug control.

1. *Discursive effects*: the silencing of alternatives through the adoption of particular problem representations and the discourses which frame them. For example, the framing of women who use drugs as vulnerable limits possibilities to recognise how some women might make choose to use drugs.
2. *Subjectification effects*: the impact of establishing particular social relationships within discourse, which often involves pitching groups in opposition to one another and attributing responsibility for the 'problem' to particular groups. For example, the construction of 'bad' mothers who use drugs and 'good' mothers who are abstinent.
3. *Lived effects*: the material consequences of problem representation. For example, how the construction of women as vulnerable impacts upon their access to drug treatment.

The final reading focused on revealing examples of gender-blindness (WPR Question 4), noting places where gender differences might have explored. This involved reflecting upon whether particular parts of the strategy which were presented as gender-neutral should have explicitly acknowledged the importance of gender. These examples serve to facilitate an analysis of why gender is made evident only in certain contexts. In common with other drug policy analyses informed by the WPR approach (see for example, Lancaster et al., 2015), the analysis emphasised some aspects of the WPR approach more than others.

4. A gendered reading of the 2017 Drug Strategy

The English strategy is a slender document, comprising of 47 pages of well-spaced out text. It has been described as a 'refreshed' rather a new strategy (see Easton, 2016). Like its predecessor (HM Government, 2010), its key themes included reducing demand, restricting supply and building recovery. The 2017 version added an additional theme – global impact – described as taking 'a leading role in driving international action' (p. 7).

There are few references in the strategy to women and when they are mentioned the discussion surrounding them is brief. The 'Reducing Demand' theme lists nine groups deemed to be vulnerable because of their heightened risk of 'misusing' (p.10) drugs. Consequently, in addition to universal attempts to prevent drug use, the strategy outlines the need for 'a targeted approach for high priority groups' (p.10). Women are not identified as a vulnerable group but they comprise the majority of two of the identified vulnerable groups (victims of intimate partner violence and abuse and sex workers). Women are explicitly referred in the discussion of victims of intimate partner violence and abuse, defined in terms of 'extensive physical and sexual violence' (p.12) which appears narrow in comparison with other official definitions (see Office for National Statistics, 2016). It notes that this group are 'more likely to have an alcohol problem or be dependent on drugs' (p.12). This bold claim is supported by only one reference to a study published by Agenda (Scott and McManus, 2016) on women 's experiences of violence and abuse. The strategy fails to acknowledge that the study explored

violence and abuse against the backdrop of multiple disadvantage. Consequently, substance use was considered alongside adverse circumstances in women's lives such as poor mental and physical health, disability, poverty, debt, poor housing and homelessness. Whilst many of these forms of disadvantage are discussed elsewhere in the strategy, they were not acknowledged alongside the discussion of intimate personal violence abuse. Men are not referred to explicitly in the discussion of intimate partner violence and abuse: they are neither acknowledged as victims of intimate partner violence and abuse nor is the over-representation of men among perpetrators acknowledged. Findings from the UK Life in Recovery survey suggest that 29 per cent of men experience family violence during their substance use careers (Best et al., 2015). It can be reasonably assumed - based upon general population surveys - that these men are more likely to be perpetrators than victims (ONS, 2018).

There is a more indirect reference to women in the section on sex workers (p.12). It is noted that the Violence Against Women and Girls Strategy (HM Government, 2016) includes measures to address the heightened vulnerability of women engaged in sex work, particularly victims of child sexual exploitation and modern slavery. However, a footnote clarifies the need for action to cover all individuals, regardless of gender, implicitly recognising diversity within the sex worker population (Balfour with Allan, 2014). There is a further reference to women under the 'Building Recovery' theme where the rapidly rising number of drug-related deaths (ACMD, 2016) is attributed, in part, to increases in the number of drug-related deaths among women. There is no analysis of possible explanations for the increase. Research commissioned by the Scottish Government has identified a range of possible explanations including the growing prevalence of physical and mental health problems among women who use drugs and the disproportionate impact of welfare reform and public sector austerity measures, particularly cuts to drug treatment budgets (Tweed et al., 2018).

The 'problems' raised are significant ones. There is a growing body of evidence drawing attention to disproportionate levels of drug use among women who have experienced intimate partner violence (Atkinson et al., 2009; Simonelli et al., 2014), and similarly women who are engaged in sex work (Cuisick and Hickman, 2005; May and Hunter, 2006;). Moreover, there have been mounting concerns about sharp increases in drug-related deaths among women. Whilst men account for most drug-related deaths, women now comprise an increasing proportion of drug-related deaths, which has increased consistently year-on-year (ACMD, 2016; Sacks-Jones and Hamilton, 2018). It is not my intention to deny that such 'problems' exist but instead to unpack their underpinning presuppositions and assumptions before moving on to look at examples of gendered 'problems' which the strategy failed to acknowledge.

The discussion of sex work and drug use provides some insight into possible explanations for drug use in a group comprising predominantly of women (Balfour with Allan, 2014). First, it

suggests that in some instances individuals may be coerced into drug use and prostitution but there is no recognition of the strong likelihood that this involves women being coerced by men. Neither is it appreciated that whilst women may not be coerced, involvement with drugs and sex work can result in disempowerment and dependence in the overall form of gendered domination (Miller, 1995). Second, it is proposed that drug use may 'be a way of coping with what they have to do' (p.12) but without recognition of the circumstances which may have resulted in women having to do 'what they have to do'; for example, socio-economic factors (Balfour with Allen, 2014). Finally, it is acknowledged that drug use may precede involvement in sex work, re-emphasising the drug-crime nexus which has featured so heavily in previous drug policies despite over-simplifying the connections between drug use and crime (Duke, 2013; MacGregor 2000; Monaghan, 2012). There is no appreciation that women might actively decide to engage in sex work or drug use or that the link between the two is not a direct causal one (Cuisick and Hickman, 2005). Other than noting the overlap between drug policy and the Violence against Women and Girls strategy, the links between sex work and interpersonal violence are not fully recognised, reflecting a broader problem that vulnerable groups are largely viewed as discrete populations rather than acknowledging the intersecting nature of vulnerabilities (Brown and Wincup, forthcoming). Overall, the strategy fails to recognise the complexities of vulnerable women's lives. It deploys an overly simplistic victim discourse, which has been heavily criticised in feminist work on prostitution since it ignores the complexities of power and resistance that define female sex workers' experiences (see Sanders et al. 2009).

What is striking about the strategy is that women's experiences are only acknowledged when discussing two vulnerable groups. These are highly specific contexts in which it is possible to 'excuse' but not condone women's drug use as a consequence of their difficult personal circumstances (experiencing violence and abuse or involvement in sex work). This serves to maintain the overriding narrative in the strategy that drug use needs to be censured. The underpinning assumption is that women would not choose to use drugs under different circumstances. In this context, vulnerability is constructed in terms of lack of agency, justifying paternalistic responses to 'protect' women who are unable to exercise control over their own lives. Brown et al. (2017) draw attention to the use of normative vulnerability narratives in other policy contexts (for example, work with disadvantaged young people) which serve as controlling force under the guise of support and protection. They highlight how forms of social control justified via vulnerability rationales in policy and practice might be gendered when deployed in unequal societies.

There are other points in the strategy at which women's vulnerability may have been noted. Whilst women make up a small proportion of two of the other vulnerable groups (offenders and veterans) and their distinct experiences have been noted (Grace, 2017; Jones and Hanley, 2017). This is particularly surprising in relation to women who appear before the criminal courts as the lens of vulnerability was used by Baroness Corston (2007) to argue for a woman-

centred approach to criminal justice. Women's vulnerability in these instances similarly relates to the problem of being 'too few to count' (Heidensohn, 1993: 62). Rather than benefitting from their exclusivity through specialist provision, women's needs are typically glossed over in favour of the male majority. The lack of consideration of the distinctiveness of women's experiences applies to other vulnerable groups included in the strategy. A pertinent example here is discussion of vulnerability among the homeless population. As Reeve (2018: 172) argues homelessness is inherently gendered: it 'interacts with and is informed by gender roles and expectations, institutions and power structures'. However, these gender differentials are not fully appreciated and homeless women who use drugs remain invisible. By concentrating on the rough sleeping population, the focus shifts predominantly towards men who comprise the majority of rough sleepers (Homeless Link, 2019) who are seen as vulnerable because of their use of new psychoactive substances (Home Office, 2018b). Women's distinct experiences of homelessness are overlooked. For example, Bretherton (2017) explores how gender is consistently linked with distinctive pathways through homelessness including close links to domestic violence; a greater reliance on informal support rather than accessing services, and enhanced access to housing when responsible for dependent children.

The third strand of the English drug strategy focuses on building recovery. It emphasises the need to:

> 'raise our ambition for recovery by enhancing treatment quality and improving outcomes through tailored interventions for different user groups . . . to ensure the right interventions are given to people according to their needs' (HM Government, 2017a: 28).

The treatment of individuals in recovery as gender-neutral is surprising, given that there have been repeated calls for bespoke treatment for women (Becker and Duffy, 2002; Simpson and McNulty, 2008) and a gendered perspective on recovery (Neale et al., 2014; Wincup, 2016). Moreover, prior to the publication of the strategy, the Advisory Council for the Misuse of Drugs (ACMD) – a government-appointed independent expert advisory body – recommended that the UK government should commission research to establish how best to maximise recovery outcomes among different genders (ACMD, 2014). Much of the content of the Recovery section refers to issues which are profoundly gendered (including homelessness, discussed above) yet this not acknowledged. For example, post-release support for prisoners is considered without acknowledgement that 95% of then are men (Ministry of Justice, 2018). McIvor (2018) argues that women released from prison face different challenges to men and are disproportionally disadvantaged by wider economic and social conditions.

5. Looking at *Reducing Harm Supporting Recovery* through a gendered lens

The Irish strategy is a far more substantial document than its English counterpart, not least because its remit covers alcohol in addition to drugs. It is almost twice as long as its English equivalent, outlining a far more detailed strategic approach. There are five goals with the discussion of women appearing in the second one: to 'minimise the harms caused by the use and misuse of substances and rehabilitation and recovery' (p.1). To achieve these goals, over 50 strategic actions are outlined, each with considerable detail offered about the how they will be delivered and by whom. A strategic plan for the first three years of the strategy is also included.

The Irish strategy explicitly describes itself as a health-led response and notes in the Foreword the need for 'substance abuse and drug addiction' to be treated 'as a public health issue, rather than a criminal justice issue' (p.3). The strategy was developed by the Department of Health, contrasting starkly with the English strategy which is Home Office led. Unlike its English counterpart, the Irish strategy describes the process of developing the strategy which involved establishing a steering group in 2015 and a well-publicised public consultation with responses from nearly 3,000 individuals and organisations (Department of Health, 2017b). A detailed report of the latter process was published alongside the strategy (Department of Health, 2017b). The lack of adequate service provision for women was a recurring theme. Women are mentioned almost 50 times in the final report and there are 25 references to pregnancy. The overriding theme was the need for improved service provision for women which recognises the particular experiences of women in relation to pregnancy, responsibility for children and domestic violence.

There is clear evidence that the consultative process informed the strategy. Unlike its predecessor which referred to women on only even occasions and solely in relation to alcohol use (Department of Health, 2017b), the new strategy includes an entire page focused on women. First, the strategy draws attention to the particular needs of women. It refers to experiences of domestic violence in childhood and/or adulthood, associated trauma and the negative impact on mental health. Whilst not detailed, it recognises a wider range of issues which may shape women's pathways to drug use than its English equivalent. These are important. There is emerging evidence of the links between women's adverse childhood experiences and drug use (see for example, Covington, 2008; Friestad, 2014) and as noted in Section 4 growing recognition of the relationship between women's drug use and experiences of interpersonal violence. The discussion of women's pathways into drug use focuses largely on individual risk factors rather than acknowledging the role played by social determinants. For example, economic inequality is not acknowledged until later in the strategy.

> Poverty, deprivation and inequality contribute to the vulnerability that may lead to dependency and harm and act as barriers to recovery and leading a fulfilling, safe and healthy life (Department of Health, 2017a: 40)

However, there is no recognition of the links between economic inequality and gender, despite an abundance of research evidence highlighting the feminisation of poverty and the disproportionate impact of austerity measure on women (Bennett, 2015; Bennett and Daly, 2014).

The Irish strategy focuses on finding 'solutions' to the 'problem' of women's lack of access to treatment. It explores women's drug use and its control alongside children and young people, and arguably as a result, the bulk of the discussion draws attention to women's roles as child-bearers and mothers with a particular focus on pregnant and post-natal women. Seven proposals (listed under one strategic action) focus specifically on 'expanding addiction services for pregnant and postnatal women' (p.43). They relate to more effective partnership working between addiction and maternity services, enhanced service provision including residential treatment and expanding what is portrayed as existing good practice (for example, specialist midwives). A further two proposals support a broader strategic action to 'respond to the needs of women who are using drugs, and/or alcohol in a harmful manner' (p.44). They include increasing the range of treatment options for women, emphasising the importance of childcare, alongside addressing 'gender and cultural specific risk factors for not taking up treatment' (p.44). Later in the strategy there is a call for appropriate housing provision for women and their children after discharge from residential treatment (p.89). The policy emphasis is unsurprising: feminist drug scholarship has drawn attention to gendered nature of the governance of drug use, which as previously noted falls disproportionately on pregnant women and mothers (Du Rose, 2015; Whittaker et al., 2018).

In the Irish strategy, women are considered alongside other groups judged to be in need of improved services access due to 'more complex needs' (p.44). In addition to children and young people, these groups include long-term substance users, people with co-morbid mental health and substance use problems, member of the traveller community and other minority ethnic communities, homeless people, people in prison, sex workers and LGBTI communities. Like the English strategy, there is no discussion of the gender composition of these groups nor how women's and men's experiences may differ. Apart from the one exception noted above, the discussion of women's use of drugs is confined to the dedicated section despite gender differences between important to considerations of how to obtain other goals, for example, in relation to health and well-being (Goal 1).

6. Discussion and conclusion

By comparing the English and Irish drug strategies we have witnessed two distinct attempts to construct women – or at least some sub-groups of women – as vulnerable subjects. The English strategy depicts women as vulnerable in highly-specific contexts, focusing on the enhanced likelihood of sex workers and victims of interpersonal violence and abuse engaging in drug use, particularly in its most harmful forms. This arguably overly selective approach to understanding women's vulnerability neglects some of the distinctive aspect of women's experiences as users of drugs and the interconnections between gender, drug use and the other sources of vulnerability recognised in the strategy. Consequently, for the most part the strategy can be considered as gender-blind. Women are only explicitly constructed as vulnerable when they can be portrayed as passive victims lacking in agency. Feminist scholarship in the drugs field has repeatedly drawn attention to the tendency to deny women who use drugs a sense of agency (Taylor, 1993; Ettorre, 2007). It has tried to steer a course between recognising the ways in which the lives of women who use drugs are shaped and constrained by structural inequalities (including gender alongside racial and economic inequalities) and their 'choices' to use drugs (see Neale et al., 2014). It has argued that a concern with pleasure – albeit mediated by structural context as well as physical and mental well-being – can challenge the tendency to see women who use drugs as 'helpless victims' and drawn attention to the paradox that women's use of some substance are condoned (for example, illicit drugs and alcohol) whilst others are accepted (for example, prescribed medication (Ettorre, 1992: 149)). The English drug strategy recirculates the dated image of women who use drugs as victims, rendering them passive and incapable of self-advocacy. Whilst constructing particular groups of women as vulnerable in this way has the potential to secure additional resources for women in need, the cost is the perpetuation of stereotypes and assumptions surrounding women's drug use which feminist drug scholarship has been at pains to challenge.

The Irish strategy designates all women as inherently vulnerable, engaging in further 'thin-slicing' of vulnerability (see Brown and Wincup, forthcoming) by proposing that some groups of women (i.e. pregnant women and mothers) are more vulnerable than others. The heavy emphasis placed on women's reproductive and caring roles is not unusual in drug policy. It constructs parental drug use as a woman's 'problem', glossing over the harms caused by fathers and their potential support needs. This is a recurring theme within analyses of drug policy (Flacks, 2018). Moore et al. (2015) make similar observations based upon their analysis of Australian and Swedish drug strategies. They note the willingness to repeatedly specify gender in relation to maternal drug use whilst typically treating people who use drugs as de-gendered.

Despite the apparent need for improved service access for women – as the response to the Irish strategy consultation illustrates (Department of Health, 2017b) – advocating for women

to be treated as a 'special population' needs to be approached judiciously. This call for bespoke treatment is repeated expressed in the academic literature (see Martin and Aston, 2014) yet there are several risks with this approach. It tends to exaggerate differences between women and men whilst constructing an image of the 'essential woman' (Spelman, 1990) who uses drugs, which over-emphasises the similarities between women. As noted in Section 2, there is increasing support for intersectional approaches to drug use which recognise the significance of gender as a structural form whilst appreciating its cultural variability and other sources of power and subordination (see Neale et al., 2014).

In many respects, neither the English or Irish approach to addressing women's drug use is satisfactory. Both fail to connect women's dependency of 'the addiction kind' with women's dependency of 'the subordinate kind' (Ettorre, 1992: back cover) and locate women's use of substances in their socio-political context. Gender, as other analyses of drug policies have revealed, is only made evident 'when it appears palatable to do so – that is, when it fits cultural conventions regarding the gendering of blame' (Moore et al., 2015: 427). On these occasions, gender is only articulated in relation to women. For the most part gender is ignored in the drug strategies and there is a veneer of gender-neutrality which tends to reinstate the masculine as the norm (Moore et al., 2015). Closer analysis is likely to reveal tacit gender norms and the impact on women and men may be far from gender-neutral. Moreover, there is also a risk that those women who use drugs who are not identified as sufficiently vulnerable will not able to access the support they need, particularly in an era of scarce resources (ACMD 2017, Butler and Hope, 2015) (see Brown and Wincup (forthcoming) for a discussion of the potential lived effects of the adoption of the 'vulnerability zeitgeist' in English drug policy). For example, a policy emphasis on pregnant women and new mothers may divert attention away from other groups such as women beyond child-bearing age; a group increasingly seen as vulnerable (Atkinson, 2016).

There is a growing body of literature which outlines the key elements of gender-responsive drug treatment with a focus on enhancing access to, and effectiveness of, treatment for women (Covington, 2002; Grella, 2013). Less attention has been paid to developing gender-responsive drug policies which recognise the vulnerabilities, opportunities and inequalities specific to each gender. Moving from critique to outlining the ingredients of a gender-responsive policy is challenging but the comparative analysis presented in this paper elucidates some of the key features of a 'woman-wise' drug policy. It suggests the need to recognise commonality within the experiences of women who use drugs whilst appreciating how gender interacts with other structured inequalities. In so doing, drug policies can recognise the social determinants of women's use of drugs so that recommendations extend beyond 'responsibilising' and regulating women who engage in drug use, and look to address sources of gender inequality. For example, given the close connections between women's use of drugs and problematic relationships with men, drug policy might usefully advocate specific support for women who use drugs who might otherwise be excluded from refuges to allow

them to leave abusive partners. This take us beyond drug policy to consider the (gendered) impacts of policy in other areas which contribute to the vulnerability of women who use drugs. A 'women-wise' drug policy would also need to guard against the tendency for vulnerability discourses to result in undue paternalism, subjecting women who use drugs to further levels of regulation thus reinforcing the gendered nature of social control.

As a starting point gender mainstreaming should feature routinely in the development, implementation and evaluation of drug policies. This is not an end in itself rather a strategic approach which involves including a gender perspective and a commitment to addressing gender inequality in policy development (European Institute for Gender Equality, 2017; UN Women, 2018). This involves policy-makers being alert to equality issues from the earliest stages of policy development through to preparing for implementation and monitoring its short-, medium- and long-term impacts, being alert to unintended consequences and uneven effects. A WPR approach can support this work by considering how typical representations of gender and drug use can be disrupted and replaced (Question 6) and through subjecting drafts to critical analysis of their problematisations of women who use drugs and their effects (Questions 1, 2, 4 and 5). Inclusion of the voices of women who use drugs and those who support them could play a key role in the policy- making process. Their voices are often marginalised in drug policy-making (see Monaghan et al., 2018). Incorporating their experiences could help to ensure that drug policies adequately address the lived realties of women who use drugs rather than assuming they are the same as men's or resorting to stereotypes of gender difference which fail to recognise the diversity of women's experiences. Including women who use drugs in a meaningful rather than tokenistic way in the policy process could also challenge the tendency to 'other' women who use drugs.

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