

Insights into the effective management of support groups for Aboriginal Australian women with substance use disorders

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Abstract

Aboriginal women with substance use disorders are a vulnerable population. This study examines approaches used to deliver support to Aboriginal women in an outpatient alcohol and other drug treatment service in Australia. A descriptive qualitative study was undertaken using structured interviews to explore staff and client perceptions of current and optimal processes for the management of an Aboriginal women's group. The findings show that approaches to the management of the support group involved personal skills development and therapeutic strategies that were all grounded in the women's social and cultural context. A framework is proposed for the management of support groups that may be transferrable to other culturally distinct and marginalised populations.

Keywords: *Aboriginal Australian; women; substance use; group support; empowerment*

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Alcohol and other drug (AOD) issues among Aboriginal and Torres Strait Islander (Aboriginal¹) Australians are of serious concern and linked to poor health and social outcomes for these individuals, their families and whole communities (Gray, Stearne, Wilson, & Doyle, 2010; Ministerial Council on Drug Strategy, 2006). These are issues that are shared with other groups around

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the world who have experienced exclusion and disadvantage, including First Nations populations in Canada, New Zealand, and the USA (Pulver et al., 2010).

Aboriginal women seeking treatment for AOD dependence and related issues can be particularly marginalised due to stigma and a range of complex health and social issues (Lee, Dawson, & Conigrave, 2013; Lee et al., 2012). There can be barriers for women with children engaging with treatment services, including a fear of notification to child protection services (Goodyer, 2014). It is important to find approaches for treatment services to engage such populations in ways that empower the client (World Health Organization, 1978). One approach that has been described for Aboriginal Australians is through women's groups (Lee et al., 2013).

In non-Aboriginal populations, therapeutic, educational, or social support groups are offered in a range of AOD treatment settings (Borkman, Kaskutas, & Owen, 2007; New South Wales Health, 2008; Pectorius, 2006). Many groups use therapeutic models to assist with bringing about or maintaining change in substance use and relationships, and use approaches such as cognitive behaviour therapy (CBT; Horvarth & Yeterian, 2012), mindfulness approaches including dialectical behaviour therapy (DBT; Baer, 2006), or 12-step mutual help programs founded on principles of Alcoholics Anonymous (Emrick, 1987). Other groups provide opportunities for health education (Moos, 2008), for example, to increase a client's understanding of the addictive process, reduce the risks of ongoing substance use (Tross et al., 2008), build life skills (Arria et al., 2013),

or enhance confidence and self-efficacy (Stevens, Jason, Ferrari, & Hunter, 2010).

Social and cultural group support is widely offered among both non-indigenous (Hurdle, 2001; Jackson & Cook, 2005) and indigenous² populations (Brady, 1995; Dell et al., 2011; Gray, Mays, Wolf, & Jirsak, 2010; Niccols, Dell, & Clarke, 2010; Robertson, Demosthenous, & Demosthenous, 2005) to help individuals with disrupted relationships that often result from substance use disorders (SUD). In a residential rehabilitation setting, groups provide valuable opportunities for individuals to come together to address the challenges of substance use dependence (Chenhall, 2007; Gray, Stearne, et al., 2010). However, available reports are descriptive and there is a paucity of methodologically rigorous evaluations in this area. In North America, healing circles and sweat lodges provide group support to address a range of issues (e.g. addictions, identity and family issues) and an opportunity to learn from elders in a culturally safe environment (Stevenson, 1999; Vick, Smith, & Herrera, 1998).

Other efforts have adapted programs developed for a non-Aboriginal population to an Aboriginal context such as SMART Recovery[®] (Australian Indigenous HealthInfoNet, 2012). However, it is not yet clear how well these existing mainstream models for group therapy or support can be adapted and applied in Aboriginal contexts (McCormick, 2000; Taylor, Thompson, & Davis, 2010). In particular, it is not clear how best to facilitate such a group in the context of an indigenous culture and in a way that assists indigenous participants to build the skills, knowledge and self-efficacy required to exert control over their

decisions that affect their lives. To address this knowledge gap, this paper aims to identify appropriate ways to deliver and manage a support group for Aboriginal Australian women with SUD in an outpatient AOD treatment setting, based on suggestions from clients and staff.

ABOUT THE ABORIGINAL WOMEN'S GROUP

In Sydney (Australia), Aboriginal women who attended an outpatient AOD treatment service attached to a large hospital asked for an Aboriginal women's support group to be established (Teasdale et al., 2008). This group was then developed by Aboriginal and non-Aboriginal staff of the service. It includes opportunities for socialisation and comprehensive care delivered in a safe and relaxed environment, and encourages user-friendly pathways to access treatment (Lee et al., 2013). An evaluation of the group in 2012 showed that women and staff perceived it to be beneficial (Lee et al., 2013). However, a number of challenges were identified in how the group is facilitated.

As previously described (Lee et al., 2013), this Aboriginal women's group has been offered since September 2004, one morning a week to Aboriginal female clients and to a smaller number of non-Aboriginal female clients who have children of Aboriginal descent. At the time of this research, two female staff members facilitated the group—a senior Aboriginal woman with many years of experience in Aboriginal AOD work and a non-Aboriginal counsellor/occupational therapist. Aboriginal and non-Aboriginal staff employed by the same health district periodically attended the

group as support staff, drop-in to greet the group, or to lead a discussion on a specified topic. These visiting staff members included: experienced nurse-midwife, addiction medicine specialist, social worker, Aboriginal health promotion or mental health professionals, and AOD researcher. Group format can change depending on group size and demand with typically 5–10 women at each session and an estimated 35 women attending over a 12-month period. Women who attend have either been referred by other women who attend or by staff. Characteristics of attendees have been described elsewhere (Lee et al., 2013). Attendance is entirely voluntary and women can stay as long as they like within the designated hours of 10 am to 1 pm and are free to attend as many meetings as they wish even upon recovery. The group includes informal conversation, art and craft, or educational activities (e.g. on treatment options, parenting, first aid, or financial management). Women themselves direct what issues are to be discussed and make plans to undertake activities with the support of staff. Attendance is typically fluid with some weeks where none or few women may attend (e.g. 0–3) while in other sessions up to 10 women may participate. Accordingly, group facilitators are prepared with a range of possible discussion topics and activities. Children are welcome and lunch is provided. Initially, no clearly defined rules were established for the running of the group, and an incident relating to the vandalism of the meeting room (outside of group times) revealed a need to develop policies and procedures related to the provision of groups for clients. One of the resulting procedures was for group attendees to be

escorted to and from the activity room by clinic staff, instead of being able to move freely through the treatment area. This was identified as an important change as the group room is located alongside a range of other clinical services (including counselling and medication dosing).

METHODS

This paper reports on qualitative data collected as part of a larger mixed methods study (Lee et al., 2013). A previous paper documented the high needs of clients that attend this Aboriginal women's group and considered perceived usefulness of the group, and practical ways to improve its operation as suggested by women and staff (Lee et al., 2013). The current paper reports findings on the management of group processes and facilitation that have not been described elsewhere.

Setting

The outpatient AOD treatment service is attached to a large teaching hospital. A multidisciplinary team including doctors, nurses, and counsellors treats clients with a range of SUDs. A shared care arrangement with the local Aboriginal Community Controlled Health Service (ACCHS) is offered. At the time of this research, one in eight of the service's 215 female clients was Aboriginal ($n = 27$, 12.6%) and, of these, four in five ($n = 22/27$, 81.5%) received opioid substitution treatment program dosing at the service (Lee et al., 2013).

Data collection

An advisory group comprising staff from the outpatient service and local ACCHS

guided the study methods. Three female interviewers conducted interviews (including KSKL). No interviewers were involved in group delivery or treatment.

Interview schedule

Forty-five structured face-to-face interviews were conducted, 24 with Aboriginal female clients and 21 with staff (at the outpatient service: 17 females, 2 males, 5 Aboriginal; ACCHS: 2 males, non-Aboriginal) to examine their perceptions of the usefulness of the Aboriginal women's group and to make suggestions for its improvement, including on group facilitation processes.

Recruitment

Clients were recruited for interview by the Aboriginal case worker, nursing staff, and women's group facilitators. Clients sought for interview included those who: never attend, regularly attend (nearly every week, when possible depending on other appointments or family commitments), or used to but no longer attend the group (approximately equal numbers from each group). Women who have never or used to attend the group were also selected to acquire a full range of potential views on the group from all women who attend the drug and alcohol treatment service. Clients were given a \$20 supermarket chain voucher as reimbursement for participation.

Interviews

Interviews (20–90 min) were conducted individually in a private room at the treatment service over three consecutive weeks (June–July 2012). For practical reasons, five staff interviews were conducted by telephone, Skype, or email.

Data analysis

Interview transcripts were imported into the qualitative analysis software NVivo (NVivo Version 10, QSR International, Doncaster, Australia) and analysed thematically. Two researchers (KSKL and AD) independently coded the data using a process of constant comparison (Morse & Field, 1995). This involved inductive category coding to describe and tabulate the data as per study aims alongside a simultaneous comparison of experiences across all the transcripts (Glaser & Strauss, 1967). The researchers met to discuss category coding and to compare and refine categories until consensus was reached on key themes and subthemes.

For this paper, qualitative data that were coded under the theme of managing group processes were selected for detailed examination. Models were generated to map patterns across the emergent subthemes. Differences between clients and staff were noted.

The study was approved by the Human Research Ethics Committees of Sydney Local Health District and of the Aboriginal Health and Medical Research Council of New South Wales.

RESULTS

Three themes emerged from the qualitative data analysis coded under the theme of managing group process: (1) the group approaches used to address client needs, (2) the required role and characteristics of group facilitators, and (3) the requisite processes for developing a common understanding of group process. These are discussed in detail below.

Group approaches used to address client needs

Key suggestions emerged that provided insight into the expectations and needs of women regarding the approaches used to deliver or facilitate the group. These three approaches are: (1) personal skills building, (2) therapeutic processes, and (3) providing a setting for social and cultural opportunities.

Personal skills building

Clients and staff discussed how the group facilitator provided opportunities for personal skills development in ways that were formal (e.g. education sessions on different topics such as parenting and budgeting) and informal (e.g. positive staff role modelling in relation to dealing with conflicts with each other and with children). Clients who had never attended the group also supported the use of such an approach based on their experience of attending other support groups.

The facilitators were also seen to offer practical and useful support to enhance clients' skills to accomplish necessary tasks. The group: "Helps you organise things like with court or community services. Gives more practical support compared with just talking one-on-one that happens in counselling" (client).

In addition, the group was regarded as providing a venue to address stigma that may serve to encourage treatment with women who have shared experience and culture: "[The group] is a social activity that helps reduce the stigma of being in treatment ... opportunity for socialisation with other ladies going through similar issues" (staff).

Further opportunities for enhancing client skills were suggested:

... participant [in the Aboriginal women's group] felt that it would be good to learn lobbying skills from an experienced person ... so that they know they don't have to accept things the way they are, that they can help to make changes through lobbying. (staff)

This indicates the motivation of women to learn skills to empower themselves and bring about change.

Therapeutic processes

Clients and staff discussed how the relaxed and safe group environment provided opportunities to directly address participants' SUD and related medical and psychological issues: "A safe place where they can access support and assistance and build resilience for themselves and their families" (staff).

The group environment appeared to help facilitators to identify client issues earlier and to offer user-friendly pathways for women to access treatment: "[The group] Offers female clients a sense of stability—they can unwind, vent and start to change behaviours" (staff).

The group can give an opportunity for ladies to learn new ways to relate to each other ... This includes emotional learning too, as some women have not had the opportunity in life to understand and identify what they are feeling, let alone know how to cope with this feeling and to address it. (staff)

As well as helping establish a relaxed environment and by providing food and sometimes a recreational activity, the facilitators provided opportunistic counselling

or other assistance. However, some clients felt that counselling that occurred spontaneously in the group should be conducted in one-on-one sessions instead:

Women should talk about their problems in [one-on-one] counselling, not bring them to the group. They [the facilitators and clients] need to separate when you talk about things and to separate what are their wants and what are needs. (client)

Providing social and cultural opportunities

Clients and staff stressed the importance of socialisation opportunities provided by the group in a culturally respectful and safe setting. Clients and staff saw the social and Aboriginal cultural context as the foundation upon which the group operates. This socio-cultural approach was described as being able to help participants take charge of their lives as Aboriginal women. The informal setting of the group and the fact that the members were all Aboriginal women with shared AOD issues were viewed as a highly appropriate and unique environment and one that provided opportunities for social and cultural support that were not received elsewhere: "[The group offers a] chance to sit and talk in relaxed environment and with others who have similar background and kids, etc. There is nowhere else for this kind of relaxed support" (client).

Women saw themselves as being part of a family and belonging: "Friendship and support. It is different to other services—it is more like a family. You can get a hug, people will say that things will be ok, I like this support" (client).

The women also identified the importance of other Aboriginal women's

stories in this shared space: “I find hearing about other people’s personal experiences very inspiring” (client).

Optimal facilitator approach and characteristics

Three suggestions emerged in relation to how group process should best be facilitated. Some clients and staff suggested that the group should continue in its current form, being led by two staff members. Having two facilitators was useful as it allowed for one staff member to step out of the group if the need arises, for example, if a client is acutely distressed or to discuss a sensitive issue with a client.

All respondents stressed that the involvement of an Aboriginal leader was imperative: “Have an [Aboriginal staff member] run the group who is more there just to make sure nothing bad happens and is able to talk about things with language that [clients are] more likely to understand” (staff).

Some clients suggested that the group should be client-led because personal insight into alcohol or other drugs dependence was important to understanding the needs of the women and the most appropriate approaches to group management. However, this view was not held by most study participants who were concerned that client leaders may have difficulties resolving conflicts between clients and as a result safety may be compromised. A client-led group was also not seen by clients and staff as appropriate in the context of a hospital-based treatment service: “Things could get out of control [if a client were to run the group]. Staff have got what is needed to help all women realise their problems

and what to do [to fix these]” (client). A staff member also commented on the ability of clients to cope with the role: “You need to be assertive and I don’t know if a client would be able to wear it all [the challenging behaviour and stress]” (staff).

The majority of clients and staff suggested that the group should build on its current form with strong support provided by professional staff, but that greater opportunities should be made for clients to partner with staff in the group’s delivery. Interviewees stated that the group should be delivered in a spirit of partnership involving active collaboration between staff and clients that works towards building the women’s self-efficacy and confidence.

Clients and staff described a number of desirable attributes of an ideal group leader (Table 1). Professional knowledge about AOD use and related issues were key, along with strong communication and group facilitation skills. Many clients talked about the need for creativity to ensure group activities are appealing and based on client interest. Nearly, all clients and staff were unwilling to be too prescriptive in their description of the optimal attributes of a group leader, noting the influence of individual personalities and group dynamics.

Importance of developing a common understanding of group process

The Aboriginal women’s group offered different things to each client (e.g. to learn about health issues or other skills; for support, socialisation, or relaxation). The majority of clients and staff suggested that a shared understanding of the group’s purpose was needed to better

Table 1. Positive attributes seen as desirable for a group facilitator of an Aboriginal women's group, reported by female clients ($n = 24$) and staff ($n = 21$) in an inner city outpatient alcohol and other drug treatment service in Sydney, Australia.

Reported by clients	Reported by staff
Life experience about drug and alcohol use and related issues	
"Street knowledge, knows about different dugs, using, how it makes you feel, when you try to get help"	"Some users find life experience very inspirational"
Professional knowledge about drug and alcohol use and related issues	
Including knowledge about treatment approaches	
Understanding and respect for Aboriginal culture and lifestyle	
	"Aboriginality is not mandatory, but they need to be part of the community in some way. Connected to the community" "Aboriginal person as a co-leader is a must"
Skill and training as a group facilitator	Able to work with challenging behaviours in stressful environments, promote positive group conduct, and ensure confidentiality. "Staff should be able to coordinate and give direction. Know when to step back and allow women to take the lead" "Clear boundaries about how the group works and have group rules (for workers and clients) . . . to help make things clear about purpose and expectation of the group" "Firm boundaries, be laid back, not pressured by time, keep confidence from ladies who attend"
Communication skills	
"Good with people and kids, relate to women and people from a range of interests, good working with communities"	"Clients are very vulnerable, so need to be choosy about facilitator, should be able to build relationships with ladies"
"Respectful, understanding of where everyone comes from and what the group is about, non-judgmental"	
"Should be strong, open-minded, say what they need to but in the right way, like to be careful with how they say it"	
	Clients as the priority
	"Allow women the space to say what is important" "Listen to what clients want out of the group, i.e. What do they want to achieve [from the group]?"
Original and creative ideas	
"Puts more things in place for group, more strategies and thought in topics . . . something more original"	

meet the expectations of its participants' and to help reinforce group boundaries. This common understanding of group process could then be explained to all clients, whether they attend regularly or on a "drop-in" basis: "Clear boundaries [are needed] about how the group works and have group rules [for workers and clients] . . . to help make things clear about purpose and expectation of the group" (staff). A client was cautious about the adoption of rules and felt that others should rather be respectful and encouraging. "[We don't need] . . . more rules or guidelines, but to pick words carefully, to run the group so ladies feel ok to talk about it [their personal problems] in counselling [rather than in the group]" (client).

The majority of clients and staff stressed the importance of clear boundaries to ensure that confidentiality is maintained when personal issues are discussed in the group. Many clients described worries related to reported breaches of confidentiality by other clients who attend, and some said they ceased attending the group due to such concerns. In addition, personal issues with other clients were said to affect attendance: "A lot [of clients were] worried about confidentiality, [they] don't want people to know where they are at. Some do come regardless, but some came and dropped out" (staff).

The majority of interviewees suggested that group boundaries should be more clearly defined and routinely reinforced: "Gently but repeatedly remind the ladies about 'no gossiping' and not using information spoken about in the group [outside of the group]" (staff).

DISCUSSION

To our knowledge, this is the first published report that examines the processes used to manage and deliver group support for Aboriginal Australian clients seeking help for SUDs in an AOD outpatient treatment setting. Clients and staff described three distinct approaches (personal skill building; therapeutic processes; and social and cultural opportunities) used to facilitate this Aboriginal women's group. Figure 1 summarises this as a model that helps to articulate these approaches as a first step towards planning for group processes in a treatment setting.

The circle at the top "Personal skill building" was linked by the women to the socio-cultural context (in the centre) of the group, in particular, their Aboriginal culture and experiences as women with AOD issues. For example, women noted that their shared background facilitated mutual support and inspiration while staff identified that the unique socio-cultural context enabled women to address stigma indicating the building of confidence and self-efficacy. The socio-cultural context was also related to the therapeutic process (as seen in the bottom circle) by both women and staff. The space provided social-cultural safety to engage in treatment, seek counselling, and assist staff to identify early interventions. For some women, the socio-cultural setting in which the group operated enabled them an opportunity to address personal skill building. For example, learning about budgeting, parenting, or other relevant skills that they otherwise may not have engaged in had it

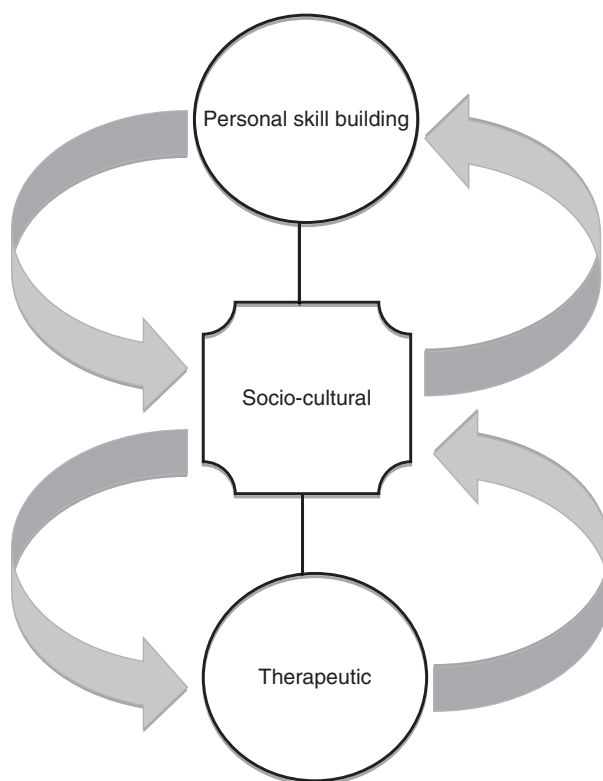


Figure 1. Proposed model for understanding and planning group process in a support group for Aboriginal Australian women with substance use disorders in an inner city outpatient treatment service.

not been for the safe environment provided by the group. Similarly, the therapeutic process provided by the group was enhanced by the socio-cultural foundation upon which the group was based. It also provided an additional safety net, which assisted some women to feel more comfortable to explore issues important to them. There is no arrow directly linking “Personal skill building” (top circle) and the “Therapeutic” process offered by the group (bottom circle), as both women and staff felt strongly that the socio-cultural context was the key link in understanding how this group process worked.

The importance of social and cultural opportunities at the centre of group processes concurs with other evidence. Access to social support is a strong determinant of good health (Richmond, Ross, & Egeland, 2007), and the unique value of indigenous-specific group support for individuals to address substance misuse and related harms has been described (Evans, Achara-Abrahams, Lamb, & White, 2012). Similar to other initiatives for indigenous individuals with SUDs (Chenhall, 2007; Stevenson, 1999; Vick et al., 1998), the women’s group of this study draws on Aboriginal culture and storytelling to bring about positive change.

However, few programs that are embedded in a socio-cultural approach have been systematically evaluated (McCalman et al., 2010). Our study is unique in its analysis of current and optimal approaches to facilitate such an approach. This analysis drew on client and staff feedback on a group support program offered in an outpatient treatment setting since 2004. This research documented particular challenges providing group support in an outpatient treatment setting, for example, meeting the changing needs of a varying mix of individuals whether they regularly attend or “drop-in” occasionally. The flexibility in delivery of treatment services, whether outpatient or residential, has been called for as essential to ensure “greater quality and diversity” in activities that are offered to assist with client motivation and participation (Brady, 2002).

The women’s group described in this study embraces a mixture of approaches as it moves between facilitating personal skills building and therapeutic outcomes (Pestorius, 2006). Most importantly, the women and staff interviewed see the group as being grounded in a distinctly socio-cultural context belonging to the women themselves. This is similar to group approaches used with indigenous individuals in residential rehabilitation in Australia (Berry, 2013; Chenhall, 2007) or in healing circles or sweat lodges in North America (Garrett et al., 2011; Stevenson, 1999; Vick et al., 1998). In the present study, this mixture of approaches appears to have enabled opportunities for learning in the group to be extended to cultural concepts, health facts, behaviour change, and getting earlier help for participants (e.g. with

improved access to addiction specialists, psychologists, and hospital admission). In this manner, the approaches employed in the group appear to have maximised opportunities for help available for these vulnerable individuals.

Group empowerment approaches (Tsey et al., 2005) that value client participation over didactic approaches were highlighted by respondents as an important part of group process. The women brought life experiences to the group, and staff brought their professional AOD knowledge and cultural expertise (for Aboriginal staff). However, being located in a treatment setting, with clients with substance dependence and mental health comorbidity poses particular challenges (Lee et al., 2013; Swift, Copeland, & Hall, 1996). These were encountered when trying to conceive a fully client-led model (e.g. pressure on clients to “lead” a group while addressing their substance use issues, managing personality differences, and conflicts between clients). Instead, the majority of clients and staff suggested that clients should have a supported role in guiding group direction (including organisation of activities). This would have the added benefit of encouraging their learning and self-development. Clear boundaries of group expectations would need to be reinforced and reviewed (Haswell et al., 2010) to ensure that the clients’ needs are met regardless of whether they attend regularly or on a “drop-in” basis.

Respondents in this study recommended that clients be continually reminded of the need to maintain the confidentiality and privacy (Lee et al., 2012; Stevenson, 1999) of what is discussed in each group. Some clients and

staff were aware of concerns that what is discussed in the group may be discussed “on the street.” However, it is important to acknowledge that confidentiality can never be absolutely guaranteed in a group setting, no matter how often it is emphasised to clients (Yalom & Leszcz, 2005). From a practical perspective, having two facilitators appeared useful in maintaining privacy, as one could step out of the group if the need arises for a client to discuss a sensitive issue, or if a client is acutely distressed.

Facilitators of support groups in the treatment of AOD dependence bring intangible qualities to the group. This is similar to one-on-one therapy, where in a large follow-up study of clients with alcohol dependence, a client’s relationship with staff was found to be a significant variable in predicting positive outcomes (Project MATCH Research Group, 1998). The particular importance of relationships and trust in working in Aboriginal health is well established (Lee et al., 2012; Taylor, Bessarab, Hunter, & Thompson, 2013). Furthermore, Aboriginal women’s groups offer a unique opportunity for new clients to gauge the suitability of the staff and of the service in an informal manner.

Respondents reported the importance of an Aboriginal facilitator or co-facilitator. It should be noted that immense pressures are experienced by Aboriginal Australian AOD and other health workers in this challenging field (Ella, 2013; Roche et al., 2010), with workers reporting poorer access to job support and other relevant resources (Roche, Duraisingam, Trifonoff, & Tovell, 2013). Not all Aboriginal or non-Aboriginal staff have specific training in group work. Given

the challenges of managing clients in such a group, increased workforce development opportunities (Ministerial Council on Drug Strategy, 2011) may be needed to raise awareness and skills for both Aboriginal and non-Aboriginal AOD workers in the approaches that can be used to deliver and manage support groups for Aboriginal clients with SUDs.

Limitations

Only a small number of Aboriginal female clients were interviewed ($n = 24$). However, this represented the majority (89%) of Aboriginal women attending the service at the time. Social desirability bias may have influenced client responses, though no interviewers were involved in delivering the group or treatment at the service. None of the interviewers were from an Aboriginal Australian heritage, which may have affected responses. However, every effort was made to help respondents feel at ease during interviews, and for stigmatized issues related to substance use, clients sometimes desire the anonymity of talking to an “outsider” not of their community (Teasdale et al., 2008). The group’s location in a mainstream treatment service will present different challenges to groups run in community settings or in ACCHS or other clinical care services. However, it is likely that similar issues will arise and the findings should have relevance to other Aboriginal groups (women’s and men’s) and other disadvantaged or marginalised groups around the world.

CONCLUSION

This paper provides an opportunity to better understand the components and

processes required to manage and deliver group support to Aboriginal women in an AOD treatment setting. Further research is needed to map the design and outcomes achieved by existing groups offered to indigenous individuals, which target AOD issues. This research could also explore the role of cultural adaptations of mainstream therapeutic or support models (e.g. CBT, DBT, or 12-step) as well as of other uniquely developed approaches. This Aboriginal women's group incorporates approaches which facilitate personal skills building and deliver therapeutic strategies. However, it appears firmly rooted in a social and cultural context that belongs to the women themselves. The latter element is likely to be particularly important for indigenous or other marginalised populations.

CONFLICT OF INTEREST AND FUNDING

The authors declare none.

Notes

1. The term "Aboriginal" is used to denote both groups.
2. The term "indigenous" is used to denote populations of first-nation origin in an international context (including Australia).

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