



Whakaohoho manawa ora: Cognitive screening and support in alcohol and other drug services

Aotearoa New Zealand practice guidelines: September 2024

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Karakia

Mā te rā e kawē mai te āhuru ia rā ia rā

Mā te marama e whakaora ia koe i waenga pō

Mā te ua te horoi ōu māharahara

Mā te hau e pupuhi te pākahukahu ki roto i tō tinana

I roto i ōu hikoitanka i te kia whakaaro koe

Ki te hū marie hoki o ōu mō ake tonu atu

May the sun bring you energy every day.

May the moon softly restore you in the middle of the night.

May the rain wash away your worries.

May the wind blow new strength into your being.

In your travels on this earth may you contemplate its beautiful peaceful stillness all
of your days for ever and ever.

Kā mihi - Acknowledgements

These guidelines were developed by Te Pou on behalf of Health New Zealand | Te Whatu Ora in partnership with experts from clinical, cultural, whānau and lived experience perspectives.

We thank and acknowledge everyone who provided feedback and guidance. This has been a significant opportunity to refocus and update substance use practice guidance documents, with the overall goal of reducing the harm caused by alcohol and other drugs and improving equity.

The Te Pou project team includes:

- Selina Elkington (programme manager, addiction)
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- Maria Basabas and Meghan Mappedoram (research assistants) who assisted with the background literature review.

Expert technical advice and input was provided by the following members of the technical advisory group.

- Dr Jamie Berry (lead advisor: clinical associate professor, Macquarie University; senior clinical neuropsychologist, Advanced Neuropsychological Treatment Services, Australia)
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- Philip Patston (director, Diversity New Zealand)
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Dr Tai Kake gifted the te reo Māori name of these guidelines. Whakaohoho manawa ora encompasses the importance of inspiring hope when working with tāngata whai ora undertaking cognitive screening and assessment.

The practice examples were developed by Ashley Koning and reviewed by Dr Tai Kake, Dr Jamie Berry, and the Te Pou team.

Thanks to Whare Tukutuku who gifted the karakia and foreword for this document. Whare Tukutuku is the national addiction centre that sits within the korowai (cloak) of Te Rau Ora.

We acknowledge the Australian Turning Point Guidelines *Managing Cognitive Impairment in AOD Treatment* which informed the development and content of these guidelines.

He Kupu whakataki – Forward

E kā mana e kā reo rau rakatira ma. Kā mihi kia raḱinui me papatūānuku, Kā mihi kia Tāne mahuta, takaroa, me kā atua katoa. E ka huḱa mate kua wheturakitia, moe mai rā. E ki ana te Whakatauki.

Toitū te marae a Tāne-Mahuta, toitū te marae a Tangaroa, toitū te takata

If the land is well and the sea is well, the people will thrive.

No reira tēna koutou tēna koutou tēna tātou katoa.

This work is part of a suite of special projects commissioned by Te Whatu Ora and Te Aka Whai Ora from a range of providers, aimed at enabling improvements in the consistency, quality, cultural safety, and evidence-base of alcohol and drug services in Aotearoa. These projects serve as a wayfaring point (guiding compass) for national-level changes, aimed at promoting, protecting, and strengthening the wellbeing of people who use alcohol and other drugs - and the people who walk alongside them. Our overarching aspiration is to ensure that all people who use alcohol and other drugs have timely and equitable access to comprehensive care and treatment, including harm reduction services.

We need to go beyond providing isolated clinical support alone; we need to be inclusive of culture and cultural practices and be mindful of the connection between culture and wellbeing. Whānau seeking help deserve safe environments and opportunities for meaningful connection, the ability to determine their own aspirations for oranga (wellbeing), and the fundamental right to live free from racism, stigma, and discrimination.

The addiction sector, often referred to as a close-knit family, is committed to making a tangible difference in the lives of whānau presenting with alcohol and other drug challenges. These special projects stand as a testament to the unwavering dedication, compassion, and tireless efforts of the alcohol and other drug workforce in uplifting and supporting those dealing with addiction. Together, let us work towards the realisation of a society where every person, regardless of their circumstances, can access the care and support needed to overcome the challenges posed by addiction.

We extend our deepest appreciation to all those who have contributed to these special projects. Your feedback, insights, and contribution have not only guided this report, but will also lead to a deeper understanding of opioid substance treatment (OST), treatment in residential settings, approaches to continuing care, harm reduction in practice, and managing cognitive impairment. Together, let us continue to forge a path of compassion, understanding, and progress.

Nā Whare Tukutuku

Ōtepoti, 2023

Background

Aim, purpose and scope

These cognitive screening and support guidelines are for the alcohol and other drug (AOD) treatment workforce in Aotearoa. They are designed to help workers without previous training in the delivery of cognitive screening. The concepts will be useful across different settings.

These are the first guidelines developed in Aotearoa focused on screening and support for cognitive impairment in AOD settings. They aim to provide guidance to effectively recognise and support responding to tāngata whai ora and whānau experiencing cognitive impairment when accessing or seeking to access AOD services. They are intended to support culturally responsive engagement and positive outcomes by utilising tāngata whai ora and whānau strengths and supporting their values and aspirations.

The content includes an overview of screening for cognitive impairment and some insights into capacity assessment. It introduces the different cognitive domains and some practical ways to support tāngata, whānau and service delivery, while also being sensitive and responsive to the diverse needs of individuals within the community. Outside the scope of these guidelines is wider systemic and service implementation which requires consideration of broader issues. This includes resourcing for services (including kaupapa Māori¹ services) to enable effective cognitive screening, neuropsychological assessment, and support; adaptations to how substance use treatment and support is delivered; and workforce development. The guidelines also do not provide in-depth understanding or response to specific areas of practice, such as capacity assessment as required under the *Substance Addiction (Compulsory Assessment and Treatment) Act 2017* (SACAT Act), Fetal Alcohol Spectrum Disorder (FASD) or other neurodivergent conditions, and alcohol related brain injury (prevention or treatment). Other guidelines, or resources, can provide more specific information on these areas of practice.

These guidelines aim to guide practice but are not prescriptive. They should be used in conjunction with workplace policies. They should not replace sound clinical judgement or override the needs and preferences of tāngata whai ora.

¹ Services for Māori, by Māori, with Māori and under Māori control. A kaupapa Māori service does not preclude using knowledge systems and practices from other cultures when working with non-Māori.

Why these guidelines are needed

- Between 30 and 80 percent of tāngata whai ora accessing AOD services are estimated to experience cognitive impairment.¹⁻³
- When someone experiences cognitive impairment, treatment needs to be adjusted and tailored to support engagement and recovery. Therefore, understanding and identifying cognitive impairment in AOD settings is important to support best outcomes.
- Guidance is needed to ensure that identifying cognitive impairment is done in a way that avoids unnecessary harm and trauma and upholds people's mana.
- Failing to recognise cognitive impairment perpetuates and compounds stigma, discrimination, and inequities against tāngata whai ora accessing AOD services.
- Access to high quality health care is a human right in accordance with the *United Nations Convention on the Rights of Persons with Disabilities*.⁴ Proper application of the guidelines should result in more people who experience cognitive impairment receiving better support from AOD services. These guidelines should be applied in a way that does not present further barriers to tāngata whaikaha accessing mainstream AOD services.
- Cognitive impairment can impact anyone. It can often get missed in AOD services. Some groups of people appear more likely to experience cognitive impairment and/or problematic substance use.^{3,5-26} This includes:
 - Māori
 - Pacific peoples, and international Indigenous peoples
 - older people
 - people experiencing higher levels of socioeconomic deprivation
 - rainbow communities²
 - people who meet diagnostic criteria for a mental health condition, and/or with a history of psychological trauma
 - people experiencing homelessness, or in contact with the justice system (particularly younger people).

² Rainbow communities include lesbian, gay, bisexual, transgender, takatāpui, fa'afafine, queer, intersex, asexual, and other non-hetero-non-cis identities.

Development of the guidelines

These guidelines are informed by evidence, and cultural and clinical practice in Aotearoa. Te Pou completed a literature review in March 2023 then consulted with key technical advisors and wider sector representatives.

The rapid integrative literature review included journal publications, grey literature, and institutional websites.²⁷ Information from Aotearoa, review articles, and guidelines were prioritised. A range of literature gaps were identified.

In April 2023, a technical advisory group was set up to inform the development of the guidelines. The group guided and inputted into three guideline drafts. Wider sector input was sought from a range of perspectives including lived experience, whānau, disability, and cultural (including Māori, Pasifika, and Asian) perspectives.

Caseworker experiences informed the development of the practice examples. Situations and contexts have been changed for the purpose of these guidelines.


Aotearoa New Zealand context

AOD services should be guided by and demonstrate commitment to:

- tino rangatiratanga (self-determination) – providing for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services
- mana taurite (equity) – achieving equitable health outcomes for Māori
- whakamarumarutia (active protection) – acting to the fullest extent practicable to achieve equitable health outcomes for Māori and being well informed of the extent and nature of both Māori health outcomes and efforts to achieve Māori health equity
- kōwhiringa (options) – providing for and properly resourcing kaupapa Māori health services and ensuring all services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care

All publicly funded AOD services are obliged to embed Te Tiriti o Waitangi (Te Tiriti) throughout all aspects of service delivery, to achieve and improve outcomes for and with Māori. Te Tiriti recognises health as a taonga to be protected. Te Tiriti has three articles which are expressed through principles articulated by the courts and the Waitangi

Tribunal. Te Tiriti principles apply across the health and disability system as a whole and are reflected in *He Korowai Oranga: Māori Health Strategy* and *Whakamaua: Māori Health Action Plan 2020-2025*.^{28,29}



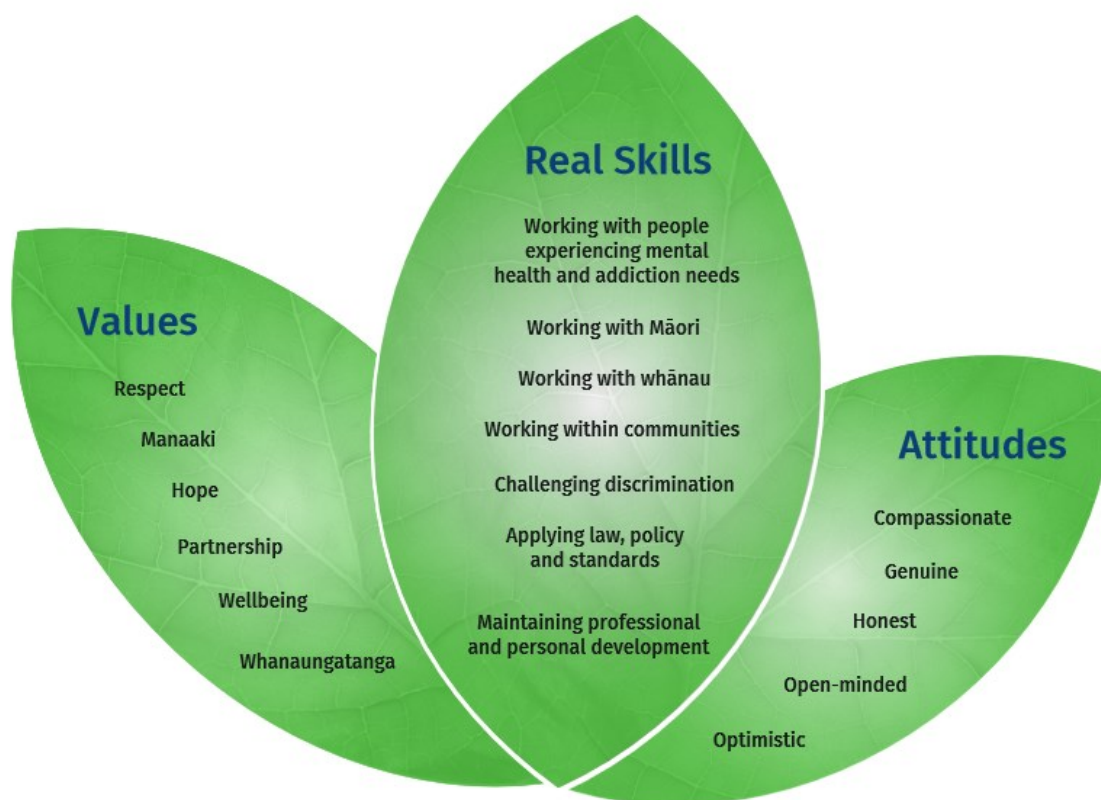
Te Tiriti underscores the importance of kaupapa Māori approaches and equitable funding, growing the Māori workforce and leadership throughout AOD services, ensuring the workforce is equipped to deliver culturally safe support, and monitoring outcomes to ensure equity for Māori.

While there is a lack of local prevalence data, older Māori appear to have higher rates of dementia³⁰ and Māori are exposed to more risk factors for cognitive impairment and problematic substance use.³¹ This is a result of Crown failure to provide equitable health services and successfully address the broader political, socioeconomic, and health conditions that contribute to problematic substance use among Māori.³¹ This includes colonisation, land loss, criminalisation, urbanisation, discrimination and racism, and trauma. It is imperative to work in a trauma-informed, strengths-based, and culturally safe manner to support tāngata whai ora Māori towards their vision of pae ora (healthy futures). This includes integrating into practice Māori concepts like wairuatanga (spirituality), whānau, te reo Māori, and considering common values, customs, and beliefs that underpin Te Ao Māori.

Workforce values and attitudes

The right values and attitudes are important to avoid harm when screening and providing support for cognitive impairment. The *Let's get real* values, attitudes, and Real Skills (Figure 1) apply across the health system and form the backbone of the dapaanz *Addiction Intervention Competency Framework* for AOD workers.^{32,33}

Figure 1. *Let's get real* values, attitudes, and Real Skills



Language

People experiencing cognitive impairment and using substances problematically have a diverse range of strengths, not defined or limited by their symptoms, diagnosis, or public perception. Where possible, we use and encourage strengths-based language which focuses on people’s strengths and support to live well. The right language (including words and imagery from diverse cultures) helps give hope to people, whānau, and workers. Key terms are included in the glossary on page 91.

Navigation

These guidelines have four key sections outlined below.

<p>Part 1: Cognitive impairment and its impacts</p>	<p>Part 2: Screening and support for cognitive impairment</p>
<ul style="list-style-type: none"> › Background information to enhance workers’ understanding of what cognitive impairment is and how it can impact people. › Includes a summary. The summary includes the focus of the section, key actions, and expected outcomes. 	<ul style="list-style-type: none"> › Practical information to support screening and effective support for tāngata whai ora and whānau. › Includes a summary - one for screening and one for support. The summary includes the focus of the section, key actions, and expected outcomes. › At the end of this section are three review quizzes – one about cognitive impairment and its impacts, one about screening, and one about support.
<p>Part 3: Practice examples</p>	<p>Part 4: Helpful resources</p>
<ul style="list-style-type: none"> › Four scenarios to help workers apply the information within the guideline. › Each scenario has a step-by-step plan to help guide workers’ thinking. › Quiz answers are included at the end of this section. 	<ul style="list-style-type: none"> › Helpful resources for the workforce, and community support resources for tāngata whai ora and whānau. › Following this section is a summary and the glossary.

Part 1: Cognitive impairment and its impact on tāngata whai ora and whānau

This section contains background information to enhance workers' understanding of what cognitive impairment is and how it can impact people.

Summary

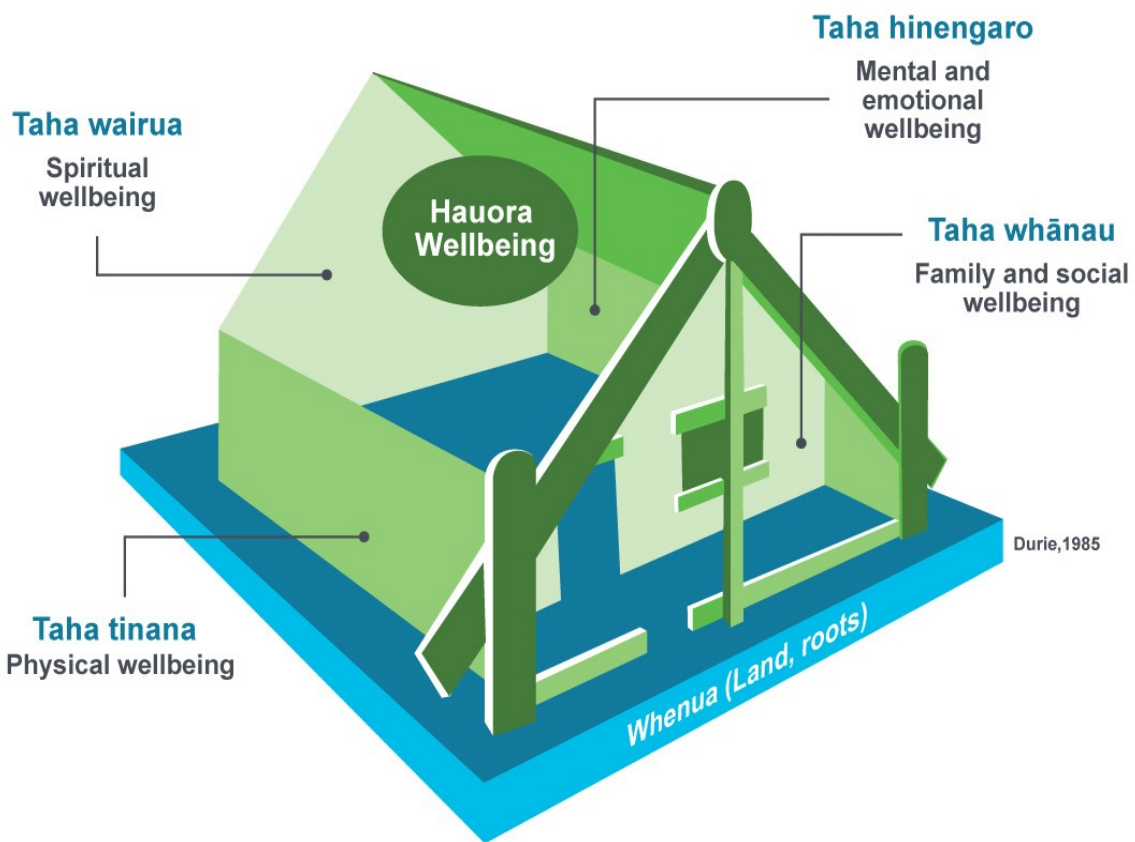
Focus	› Awareness and basic understanding of cognitive impairment.
Actions	<ul style="list-style-type: none"> › Enhance understanding of what cognitive impairment is, its causes, and impacts. › Understand how substances contribute to cognitive impairment, and where cognition fits in as part of holistic wellbeing. › Explore and use familiar terminology for each person. › Give tāngata whai ora hope for recovery.
Outcomes	<ul style="list-style-type: none"> › Cognitive impairment is better recognised in AOD settings. › Better outcomes for tāngata whai ora and whānau through improved awareness and understanding.

What is cognitive functioning and cognitive impairment?

- Cognitive functioning refers to functions of the brain such as attention, learning, memory, and problem-solving that allow people to process and respond to information in the environment in an adaptive and helpful manner.³
- Medical definitions of cognitive impairment refer to reduced functioning or difficulties in one or more cognitive domains that is noticeable and measurable.³ Cognitive impairment is considered amongst what is 'typical' for a person's context, including whānau, culture, social group(s), and age.
- Each individual tāngata whai ora is unique and has a diverse range of strengths which can be used to compensate for cognitive impairment. A strengths-based approach supports resilience, self-confidence, and a sense of hope.
- Cognitive function is just one part of a person's overall functioning. Therefore, it is important to take a holistic approach to cognitive impairment, especially when working with tāngata whai ora Māori.

- Within Te Whare Tapa Whā (illustrated in Figure 2) there are four interdependent dimensions contributing to wellbeing.³⁴ Cognitive functioning fits within the dimension of taha hinengaro (mental and emotional wellbeing), and thereby could also impact on te taha wairua (spiritual wellbeing), te taha tinana (physical wellbeing), and te taha whānau (family and social wellbeing).

Figure 2. Te Whare Tapa Whā



Cognitive impairment and disability are conceptualised differently across and within diverse cultures and worldviews. Therefore, it is helpful to explore each person’s individual beliefs within their own cultural context and practices.

Māori are diverse in their beliefs, interpretation of, and engagement with Te Ao Māori, and have varied views on cognitive impairment. Some examples of beliefs include it being viewed as a strength, a natural part of life, or as a result of colonisation (for example loss of land, traditional practices, and wairua).³⁵ Some other general ideas that may be helpful are included below.

Māori understandings of cognitive impairment

The head (upoko) is seen as 'the most tapu' of all body parts. The head is the distinguishing feature between each person and has a strong relationship to a person's mana. The brain is housed within the head and is an important part of what makes the person who they are. Thus, the head is generally considered a culturally and spiritually sacred part of the body ('he tapu te upoko') and is interconnected with all domains of wellbeing as well as identity and whakapapa.³⁶ An impairment or injury to the brain (roro) can impact multiple aspects of a person's life and wellbeing, especially wairua.^{35,36} Effectively supporting tāngata whai ora Māori and whānau requires not only excellent clinical skills but a holistic Māori-specific approach (for those who identify this is helpful) that heals wairua, including drawing from rongoā (traditional healing approaches) and whānau mātauranga.³⁶

Use of familiar terminology is important. For Māori who speak te reo Māori, some relatable terms may include hinengaro (mind, thought), tinana (physical body), hauā (disabled, disability), whaikaha (disabled – a strengths-based term meaning to have strength), and roro (the physical brain).^{37,38} There are also te reo Māori terms for specific causes of cognitive impairment, like dementia (mate wareware or korongenge) and autism spectrum disorder (takiwātanga).³⁷

*Te Reo Hāpai: The Language of Enrichment*³⁷ provides further guidance on terminology that may be appropriate for Māori.

Pasifika peoples have a holistic view on health and wellbeing, encompassing the physical, mental, spiritual, social, and economic wellbeing of the collective.³⁹ Wellbeing relies on balance or harmony between these factors.⁴⁰ Therefore, cognitive impairment may impact collective wellbeing and require a holistic approach.

Cognitive impairment can be frowned on and may not be accepted among Asian peoples. There may be beliefs such as having bad genetics, being seen as dysfunctional and a weakness by the entire family (including extended family), as well as religious or spiritual beliefs (like punishment from God for bad deeds or a family curse).⁴¹

Gain a good understanding of how tāngata whai ora make sense of and see themselves. Align terminology with the language people use to describe their own impairment and their self-identified access needs.

Table 1 covers six of the formally recognised cognitive domains in the DSM-5 (from higher to lower complexity),⁴² their definition, and what people, whānau, or workers might notice if these domains are impacted. While this acts as a guide, in practice it is challenging to separate specific domains affected as each cognitive domain impacts on others.³ Not everyone will experience these signs, and some of the signs listed below might be usual within a person's culture (such as thought processing, reasoning, or appearing to not respond appropriately to emotional cues due to beliefs around expressing emotions).

Table 1. Six of the formally recognised cognitive domains in the DSM-5, their function, and what people might notice if they are impacted^{3,43}

Domain	Definition	People might experience, or workers might notice these signs
Social cognition	The capacity to identify cues, detect emotions and intentions in others, recall relevant information, and navigate complex and ambiguous social situations.	<ul style="list-style-type: none"> • Misinterpreting emotional cues, others' thoughts, and intentions • Unhelpful or defensive behaviour • Social isolation and disrupted relationships • Negative impact on job opportunities, particularly those requiring a lot of contact with people
Executive function	A set of cognitively demanding processes that enable people to make adaptive responses to new, complex, or uncertain situations. Includes functions like planning, decision making, inhibition or restraint, concept formation, abstract	<ul style="list-style-type: none"> • Hard to multitask and complete tasks that require multiple steps • Hard to communicate in an organised or sequential way • Impulsive behaviour and lack of insight

	<p>thinking, and mental flexibility (like managing multiple bits of information).</p>	<ul style="list-style-type: none"> • Concrete or rigid thinking (such as forming habits or attitudes and not being able to change them) • Difficulty adapting to changing situations or environments • Difficulty problem solving and planning • Changes in thinking, behaviour, and sometimes personality • Unable to use devices like they used to
<p>Memory and learning</p>	<p>The ability to gain, hold, and retain information over time. There are various types of memory including sensory memory, working memory, and long-term memory.</p>	<ul style="list-style-type: none"> • Forgetting appointments, conversations, names, details, and objects • Vague or poor recall of events • Hard to learn or recall new information • Repeating questions or comments • Difficulty orientating to day, time, or place
<p>Language</p>	<p>The ability to communicate via speech, writing, or gesture, as well as the ability to understand and comprehend language.</p>	<ul style="list-style-type: none"> • Struggling to find words, especially common words • Problems communicating thoughts • Hard to understand information conveyed by others
<p>Visuospatial function</p>	<p>Making sense of sensory information and interpreting this in a spatial context (like depth or distance).</p>	<ul style="list-style-type: none"> • Getting lost easily • Bumping into or failing to see or identify distinct/obvious objects or areas in the environment

		<ul style="list-style-type: none"> • Changes in handwriting • Difficulty driving or unable to drive
Attention and concentration	The ability to focus attention on particular things or information and maintain that focus.	<ul style="list-style-type: none"> • Decreased alertness • Easily distracted • Easily misplaces items • Repeated requests to clarify or explain information

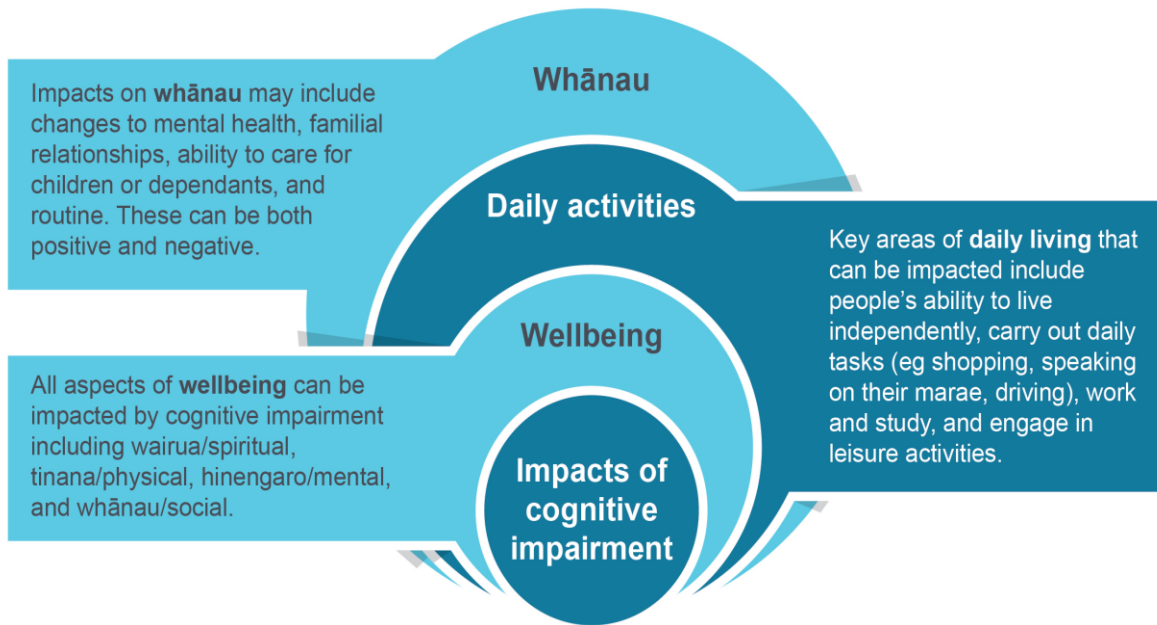
What are the impacts of cognitive impairment on tāngata whai ora and whānau?

People may experience mild, moderate, or severe cognitive impairment.⁴² However, not everyone experiences significant impact on their functioning. Factors that can lessen any negative impact of cognitive impairment include people's strengths and adaptation to daily functioning, the importance placed on particular aspects of their lives, and the support available around them.

The impacts of cognitive impairment depend on people's age, sex, gender identity, and level of health. For example, the impact of substances on cognition may be more significant for adolescents due to the developing brain; and substances can have differing effects in different sex and gender identities.^{44,45}

Cognitive impairment may impact a person's wellbeing, daily living, and whānau. When whānau support members with a cognitive impairment it may bring a sense of purpose and improved relationships, as well as feeling overwhelmed, anxious, a sense of grief, or burnout. There can also be conflict (including violence) and misunderstanding that impacts whānau relationships. Figure 3 summarises key potential impacts on people and whānau.⁴⁶⁻⁵³

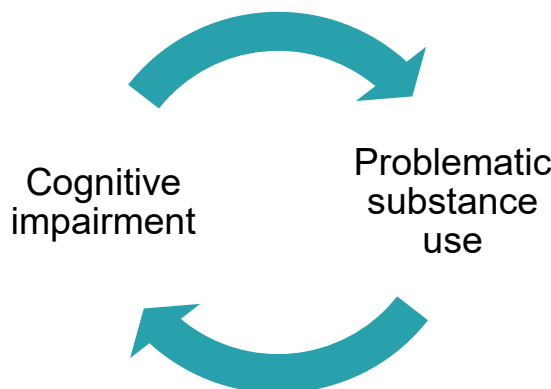
Figure 3. Cognitive impairment impacts on wellbeing, daily living, and whānau



What causes cognitive impairment?

There are a wide range of causes of cognitive impairment. Figure 4 highlights how problematic substance use can be both a cause and a consequence of cognitive impairment. It can also worsen existing cognitive impairment.³ For example, a prior traumatic brain injury (TBI) that hasn't been addressed can lead to using substances problematically, or can occur due to problematic substance use (such as from driving when intoxicated).⁵⁴

Figure 4. The cyclical nature of cognitive impairment and problematic substance use



There are three main causes of both short- and long-term cognitive impairment.

- **Neurodevelopmental** causes such as intellectual disability, autism spectrum disorder (ASD), attention deficit/hyperactivity disorder (ADHD), FASD, specific learning disabilities (like dyslexia), and epilepsy.^{3,55–59}
- **Neurocognitive** causes which are experience-based, acquired, or degenerative such as psychological trauma³, TBI, stroke, substance induced neurocognitive disorder, blood-borne viruses, encephalitis (brain inflammation), hypoxic brain injury (due to low oxygen in the brain such as from overdose), dementia, Parkinson's disease, Huntington's disease, brain tumours, meningitis or other infections, extreme stress and sleep deprivation, chronic medical conditions, and medication side effects.^{3,23–25,42,60–66}
- **Mental health challenges** such as schizophrenia or bipolar disorder, as well as depression or anxiety when these severely impact someone's life.^{67–70}

Neurodevelopmental conditions

Neurodevelopmental conditions like those listed above are common among people experiencing problematic substance use and can contribute to long-term cognitive impairment. For many people, a neurodevelopmental condition is seen as an essential part of who they are. Others may have learned to mask a disability due to stigma and discrimination, and previous issues with service access.

FASD in particular is often underdiagnosed and under recognised in Aotearoa New Zealand. It is a condition resulting from alcohol exposure during pregnancy, causing a range of complex physical, behavioural, learning, and intellectual challenges that can persist throughout life. [Read more about FASD on the Health New Zealand website.](#)

Short- and long-term cognitive impacts

Not all causes of cognitive impairment are permanent. Some types of cognitive impairment have long-term impacts on cognitive function, while some are short-term or transient and can be reduced or reversed over time.³

³ Including short- and long-term effects from traumatic events like COVID-19 rāhui or lockdowns, earthquakes, and flooding events.

Table 2 covers relevant long- and short-term causes of cognitive impairment in AOD services.^{3,71–84}

Table 2. Short- and long-term causes of cognitive impairment³

Long-term causes of cognitive impairment	Short-term or transient causes of cognitive impairment
TBI such as falls, car crash, or violence	Mental health challenges
Other acquired brain injuries such as stroke, hypoxic brain injury, or from substance use	Acute substance use/intoxication
Neurodegenerative conditions such as dementia	Acute medical conditions such as infection or hypoglycaemia (low blood sugar levels)
Chronic medical conditions like liver (such as from hepatitis C) or kidney disease	Extreme stress and/or sleep deprivation and insomnia
Neurodevelopmental conditions such as intellectual disability, FASD, ADHD, or ASD	Medication side effects

Some causes can have both short- and long-term impacts. For example, TBI may be long- or short-term depending on the degree of injury and rate of recovery, and acquired brain injury from substances can be reduced or reversed depending on substance use patterns and abstinence. Similarly, cognitive functioning can fluctuate based on peoples' wellbeing journey, like with mental health challenges. Cognitive impairment from medications may occur as a person adjusts to a new medication or for as long as a person takes a particular medication.

A neuropsychological assessment is required to differentiate between possible short- and long-term cognitive impairment. Where this isn't available, a clinician may be able to identify reversible or temporary factors impacting cognition and work towards addressing the practical impacts of cognitive impairment with the tangata whai ora. For example, providing support for anxiety may improve sleep patterns and lower stress levels resulting in improved cognitive functioning.

Common medications that can have cognitive effects include, but are not limited to: anticholinergics (like tricyclic antidepressants), anticonvulsants (like carbamazepine or sodium valproate), pain medications (like codeine or oxycodone), cardiac medications (like

beta blockers), and corticosteroids (like prednisone).^{85–93} However, it is not always clear if it is the medication itself impacting cognition or clinical factors like a specific medical condition.⁹¹ A doctor or addiction medicine specialist should be involved in identifying medications which may have cognitive effects.

Alcohol induced neurocognitive disorder (AINCD)

Alcohol induced neurocognitive disorder describes various conditions caused directly by alcohol. Wernicke-Korsakoff Syndrome is a type of AINCD caused by vitamin B1/thiamine deficiency, as alcohol use inhibits thiamine absorption.

Symptoms are usually significant and include memory impairment including jumbling or fabricating already formed memories, speech issues, and difficulty learning new information.

Wernicke-Korsakoff Syndrome is permanent and long-term but can be prevented with timely thiamine supplementation. The early form that can be treated is Wernicke's Encephalopathy. Signs of Wernicke's Encephalopathy include changes in walking patterns, coordination and balance, uncontrolled eye movements or double vision, agitation, and cognitive changes like confusion and difficulty holding attention. If these signs exist, prioritise referral to a medical or nursing practitioner for treatment.



Which substances contribute to cognitive impairment and is recovery possible?

This section refers to cognitive recovery directly related to substance use.

Recovery is possible. Share this with tāngata whai ora and whānau to give them hope.

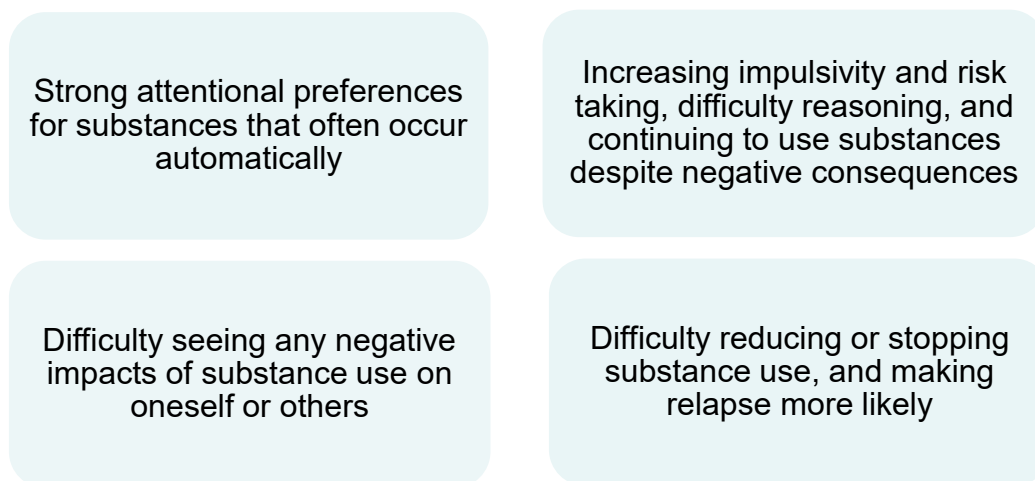
All substances can cause cognitive impairment – the effects largely depend on the type of substance, how often and how much is used, and over what time period.³

While any part of cognition can be affected, there is evidence that the cognitive domain most significantly impacted by problematic substance use is executive function.⁹⁴

Attention, processing speed, memory, and social cognition are also commonly affected.^{3,95}

Figure 5 highlights how cognitive impairment in these areas can influence or contribute to problematic substance use.^{95,96}

Figure 5. How cognitive impairment influences problematic substance use



At least partial recovery of cognitive function is possible for most substances – recovery depends on the level and frequency of use, periods of abstinence, and other health factors.³ From clinical experience the most rapid cognitive recovery is generally seen in the first 6 weeks after stopping substance use.

Substances tend to have a dose dependent effect, where higher levels of use are associated with more cognitive impacts.³

Alcohol is the most commonly used substance and is the substance most consistently associated with long-term cognitive impairment when used at high levels over a long period of time.³

Substance overdose is associated with cognitive impairment due to periods of low oxygen in the brain.^{97,98}

Table 3 summarises substance impacts on cognition and cognitive recovery. Interpreting information about substance effects can be difficult as many people use multiple substances so cognitive impacts might be more complex or compounded.^{3,99}

Table 3. Cognitive impact and recovery of different substances

Substance	Summary of effect and cognitive recovery⁴
Alcohol ^{1,3,45,66,100}	<p>Acute intoxication is associated with impulsivity, behaviour changes, difficulty focusing and recalling, slowed processing, and lack of insight.</p> <p>Long-term effects on executive functioning, visuospatial awareness, attention, processing speed, and short-term memory.</p> <p>Cognitive recovery begins just days after stopping use, but the time needed for full cognitive recovery is not clear.</p> <p>Associated with a range of conditions including FASD, TBI, stroke, nerve and organ damage, and AINCD.</p>
Cannabis ^{3,101}	<p>Short-term use is associated with altered psychomotor function (coordination and movement), lack of attention/concentration, and reduced processing speed, learning, and memory.</p> <p>Long-term effects are most consistently seen with verbal learning and memory.</p> <p>The tetrahydrocannabinol (THC) component causes the negative cognitive impacts.</p> <p>Cognitive recovery can occur within a few weeks of stopping use; however, this depends on the frequency and duration of use, age when use started, and length of abstinence.</p>
Stimulants ^{1,3} (eg ecstasy, amphetamines/ methamphetamine or cocaine)	<p>Short- and long-term impacts of heavy use include reduced attention, language, memory, learning, and executive function (like planning and inhibition). In low doses, acute use may enhance cognitive function.</p> <p>Cognitive recovery takes from a month to a year after which cognitive function often returns to a person's 'usual' level.</p>

⁴ Recovery is mostly based on abstinence. There is more limited evidence around the cognitive impacts and recovery of a harm reduction approach.

<p>Opioids^{1,3} (eg heroin, morphine or fentanyl)</p>	<p>Short-term use affects working memory and executive function (particularly flexibility and impulsivity).</p> <p>Long-term use is associated with attention, processing speed, memory, executive function (inhibition, decision making), and visuospatial issues.</p> <p>While some aspects recover, some cognitive impacts can remain even a year after stopping use.</p>
<p>Some medications associated with opioid substitution treatment (OST)^{3,102}</p>	<p>Can cause cognitive impairment (particularly in executive function, speed, attention, and memory), but to a lesser extent than opioids.</p> <p>People who switch from opioids to OST often experience improved cognitive function.</p>
<p>Benzodiazepines³ ^{103,104}</p>	<p>Short-term effects are sedative-like including decreased concentration.</p> <p>Commonly prescribed and used recreationally but can have lingering impacts for months or years after stopping use on memory, processing speed, language, visuospatial function, and attention.</p> <p>Careful consideration of risks and benefits in partnership with tāngata whai ora are required when prescribing.</p>
<p>Novel psychoactive substances^{3,105} (eg synthetic cannabinoids or cathinones)</p>	<p>Due to batch differences in content and potency, effects are varied and have a high potential for overdose.</p> <p>Synthetic cannabinoids have stronger negative effects than regular cannabis.</p> <p>Long-term effects on cognition are not known.</p>
<p>Hallucinogens¹⁰⁵⁻¹⁰⁷ (eg LSD or NBOme)</p>	<p>Short-term impacts on perception of reality, thinking rationally, and communication, with rapid shifts in mood.</p> <p>Long-term impacts are not clear.</p>

	<p>Cognitive function improves quickly with decreased use.</p>
<p>Inhalants or solvents^{3,108} (eg paint, petrol or glue)</p>	<p>Problematic toluene and petrol use can lead to short- and long-term impairments in language, processing speed, attention, learning, memory, coordination, and executive function.</p> <p>Memory and executive function may take months to years to fully recover.</p>
<p>Ketamine³</p>	<p>Frequent and high levels of use are associated with short-term effects on memory, planning, and visuospatial problems. Long-term use particularly affects visuospatial and memory domains.</p> <p>Cognitive function returns to a person's 'usual' level after stopping use though timing is unclear.</p>
<p>GHB³</p>	<p>GHB has a high likelihood of overdose and loss of consciousness which impacts cognitive function.</p> <p>There can be lasting cognitive impacts from repeated periods of overdose or unconsciousness.</p>
<p>Tobacco and vaping¹⁰⁹</p>	<p>Acute tobacco use can enhance cognitive function. However, using tobacco with other substances like alcohol can increase the negative cognitive effects compared to using the substance alone.</p> <p>Nicotine withdrawal is associated with decreased cognitive function which persists for several weeks.</p> <p>The cognitive effects of vaping are still emerging so long-term effects are unknown.</p>

Part 2: Cognitive screening and support for tangata whai ora and whānau

This section includes:

- an overview of an ideal cognitive screening and support pathway
- helpful information to guide practice in screening and providing support
- guidance on relevant questions to ask as part of a comprehensive assessment
- how to screen for cognitive impairment and referral considerations
- the support options available for people experiencing cognitive impairment.

Overview: Ideal cognitive screening and support pathway in AOD services

Clear service pathways are needed to guide the screening, assessment, and support process for cognitive impairment.¹¹⁰ Table 4 covers an ideal pathway that factors in cognitive screening and support. Culture should be considered at all points of the process.

Table 4. Ideal cognitive screening and support pathway

Phase	Actions
1	<p>Enter service</p> <ul style="list-style-type: none"> • For tangata whai ora who identify this as helpful, offer karakia or a way to open (like a daily affirmation or prayer they prefer) and the space for mihimihi, followed by whakawhanaungatanga. Ongoing whakawhanaungatanga is important to continue building relationships and trust to ensure tāngata whai ora and whānau feel safe and comfortable.¹¹¹ Relationships are fundamental for people from all cultures.
2	<p>Gather information as part of a comprehensive assessment</p> <ul style="list-style-type: none"> • Seek informed consent from tāngata whai ora to gather and access information such as from primary care, hospital records, or school reports. • Gather a range of information about a person's context. Take a conversational approach and allow time for storytelling. • Include cultural assessments to understand people's needs and use this to guide the screening and support process.

- Involve whānau if the tangata whai ora wishes and ask about their needs (including of dependent children).
- Provide manaaki (support, care) and reassurance along the way and offer breaks throughout steps 2 to 4 as needed.

3 Cognitive screening

- Trained workers in AOD services should use an appropriate cognitive screening tool. See the cognitive screening section for more detailed options.
- In some residential services it may be necessary or clinically indicated to screen for cognitive impairment prior to entering the service.
- Interpret screening results amongst all other contextual information. Seek supervision and support for interpretation if needed to ensure safety.
- Provide screening results back to tāngata whai ora and whānau in an understandable format using a trauma-informed and strengths-based approach.
- If required, discuss referral for a neuropsychological assessment.

4 Neuropsychological assessment (where indicated and resourcing permits)

- Gather previous assessment information.
- Refer for a neuropsychological assessment if needed and if the tangata whai ora wishes.
- Provide results of the neuropsychological assessment back to tāngata whai ora and whānau.

5 Integrated support plan

- Determine the most appropriate support plan based on tāngata whai ora wants, needs, worldviews, and strengths.
- Ensure whānau are connected with good quality information and support.
- Link in with and refer to other services as needed for integrated support.


6 Community support

- Needs assessment – determine eligibility for community support.
- Link tāngata whai ora and whānau with community and culturally relevant organisations.

While Table 4 presents an ideal pathway, in practice this isn't necessarily a linear pathway. For example, comprehensive assessment can occur alongside and as part of whakawhanaungatanga. Also, repeated cognitive screening may be necessary (for example due to substance use or other situational factors) before determining if a neuropsychological assessment is needed.

Information to guide practice across screening and support

Use a culturally safe approach when working with people from diverse cultures



Reflect on, acknowledge, and challenge your own biases and practices when working with people from diverse cultures and practice in a culturally safe manner. Resist deficit stereotypes that lead to bias in clinical decision-making. Work to actively recognise and eliminate racism from practice as this is a barrier for many tāngata whai ora, especially tāngata whai ora Māori.^{112,113} This is essential for a comfortable screening and support process.

A person's identity and culture should not be assumed. For example, due to historical trauma and colonisation not everyone who identifies as Māori will have an understanding of Te Ao Māori.¹¹⁴

Prioritise cultural assessments. Check how people identify and what processes they need to engage and feel safe. Ensure the correct processes are followed during cognitive screening and support.

Where possible, kaimahi (workers) from the person's own culture can assist with engagement and correct processes. Where this is not possible, seek cultural supervision or advice from specialist cultural organisations, especially when interpreting cognitive screening information.

Cultural frameworks can be helpful to guide assessment and screening processes. Examples for tāngata whai ora Māori are Te Whare Tapa Whā,³⁴ the Meihana model,¹¹⁵ the Hui process,¹¹⁵ or Te Waka Kuaka.¹¹⁶

The Hui process is a basic model, likened to the whakatau process, that includes karakia tīmatanga, mihi mihi (initial greeting engagement), whakawhanaungatanga (making a connection), kaupapa (the main purpose of the encounter), and karakia whakamutunga (closing the session).^{111,115} The kaupapa part of the Hui process is where comprehensive assessment, cognitive screening, or support sits. Te Whare Tapa Whā, the Meihana model, or Te Waka Kuaka can be used to gather information as part of this. Appendix A contains more information about the Meihana model and Te Waka Kuaka.

Appendix B contains frameworks that may be helpful for Pasifika peoples including the Fonofale and Fonua Ola model. While there is great diversity amongst Pasifika peoples, it is helpful to be aware of common values including family, collectivism, spirituality, reciprocity, love, consensus, and respect.^{117,118} Religion plays a central role in the identity of many Pasifika peoples.¹¹⁹

Check for and encourage the use of EPAs

An enduring power of attorney (EPA) is something all adults over 18 should have in place in case they can't make decisions about their personal affairs. There are two types of EPAs – one for finances and property, and the other for personal care and welfare.¹²⁰

As cognitive impairment can impact on people's decision-making capacity, it is very important to be aware if tāngata whai ora have an EPA.

An EPA can only be appointed if people have the capacity to understand what an EPA is and how they would choose their EPA.

An EPA only becomes 'active' when people are unable to make decisions for themselves. This is confirmed by a medical assessment.

Having an EPA means that the person's chosen 'attorney' makes decisions for them, depending on what instructions the person has for them. An attorney in this context does not need to be a lawyer but is someone the person trusts.

If people lose capacity and don't have an EPA in place, then an application can be made to the Court for a PPPR Act order(s). The Court will then appoint a property and/or welfare guardian for the person who reports back to the Court regularly.

If people regain capacity in the future (such as through treatment for problematic substance use and cognitive rehabilitation), the EPA can be deactivated with written notice.

The **Office for Seniors website has more information on EPAs and forms required to set up an EPA. There is also a webpage covering the requirements for changing or ending an EPA. The Public Trust website enables people to make their EPA online.**

Note: Some cultures may not be familiar with or comfortable using legal processes and whānau may have expectations around support and decision making. Ensure all legal processes are properly explained.

Creating an EPA requires legal advice and usually incurs a cost. People who don't have a lawyer or who need support with costs can enquire about options at their local Citizens Advice Bureau, Public Trust office, or Community Law Centre.

Adapt communication to people's needs

- Be flexible, tailor communication to the unique needs and style of the individual tangata whai ora and gauge what works for them. Encourage people to speak up about what help they need to engage. For example, telling other workers to speak slowly, or using more culturally relevant examples.
- Use interpreters if needed to support people to use their language of choice. If required and available, an interpreter with experience in AOD services is ideal. Where possible,



have resources available in various languages and formats like Easy Read, braille, or New Zealand Sign Language.

- Use concrete examples and words rather than abstract ideas.
- Use alternative media, for example writing down information, videos, and flash cards. When using visuals ensure these are culturally appropriate. Supplement verbal information with written information such as resources people can take away.
- Give people the time and space to respond without interrupting. This is especially important if there are language barriers.
- Check that people have understood what has been said or agreed.
- Keep information and sentences short and simple, avoid clinical jargon, and speak at a reasonable pace with a positive tone.
- Check in with tāngata whai ora regularly to see how they are coping and if they need a break. A good rule of thumb is to check in at least every 15 minutes.
- Where possible, use open rather than closed-ended questions within a conversational approach which can make the process more comfortable.
- When communicating with tāngata whai ora from rainbow communities, use gender neutral language like partner and parent, and use people's preferred pronouns.

Setting up the right environment supports communication

Consider environmental adaptations that will support tāngata whai ora. Factors to consider include lighting (dim or bright), space (cluttered or tidy, open plan or closed off), and noise (background noise or quiet spaces).

Use trauma-informed approaches

- Many people who use substances problematically have experienced psychological trauma.¹²¹ This is compounded by co-existing issues such as mental health challenges, or an intellectual, learning, developmental, and/or physical disability.^{26,122,123}
- Māori have experienced significant trauma from colonisation and the impacts are ongoing (intergenerational trauma).^{26,124,125} Pasifika peoples, refugees and migrants,

people in contact with the justice system, and people in rainbow communities (particularly rainbow youth) are also more likely to have experienced trauma.^{26,126–130}

A trauma-informed approach focuses on what has happened in a person's past and how this has impacted and shaped the person. It requires workers to recognise and understand that trauma manifests in many ways and to actively work to avoid retraumatising people.^{26,131}

Asking some tāngata whai ora about their history can potentially be retraumatising. Therefore, some people who have experienced trauma may have unexpected or negative reactions to cognitive screening or assessment questions. Clinical judgement should be used about whether cognitive screening or assessment should continue if tāngata whai ora and whānau appear distressed and people should be linked with appropriate support if needed.⁵⁴ The way results are shared can also be retraumatising; therefore, always share results back with people using a strengths-based approach.

Check if tāngata whai ora have had previous bad experiences with screening or assessment in health settings. This includes mistrust of clinical processes (like Māori may have due to colonisation) or people (like discrimination or abuse). Take the time to understand what happened for the person and how you can build trust and improve on previous experiences.

An example of approaching sensitive topics in a trauma-informed way is to prepare tāngata whai ora for what you might ask. For example, "In the second part of this session I'm going to ask questions about the trauma that happened to you during your teenage years. Is there anything I can do to help you prepare for this?"

Involve whānau in screening and assessment processes

- Whānau provide valuable contextual information and can help fill in gaps especially if the tangata whai ora has challenges with insight or determining the impacts on them. Therefore, if the tangata whai ora agrees, it is helpful to include whānau in the comprehensive assessment, cognitive screening, and neuropsychological assessment process.



- Whānau involvement may not be appropriate for everyone. It is up to the person to determine who their whānau is and if it is helpful for them to be involved. Discuss and agree on issues like confidentiality and sharing of information.
- Some tāngata whai ora may not have whānau with them but may have others for support. For example, people with a learning or intellectual disability may have support workers or meeting assistants present.
- In some cultures (like many Asian cultures), people may feel an obligation to include their whānau even if they do not want to. This can affect people's responses which might be changed to avoid upsetting whānau. Therefore, offer one-on-one sessions to the tangata whai ora alongside collective sessions.
- Consider the needs of parents and caregivers who may need support with childcare to be fully involved in screening and assessment processes.

If the tangata whai ora wants whānau involved, take the following steps to bring them safely into the process.

- Ask the chosen whānau member(s) if and how they would like to be involved in the process. Explain what the process involves.
- Explain the privacy rights of the person they are supporting and that you have been given consent to discuss their case with them.
- Offer an appointment kanohi ki te kanohi (in-person) if possible (especially for the initial meeting) or online if appropriate.
- Check with the tangata whai ora and whānau member(s) if they would like combined or separate sessions. If separate, explain that whānau feedback will be shared with the person they are supporting.

Safely support tāngata whai ora experiencing challenging behaviour

Tāngata whai ora experiencing cognitive impairment and/or problematic substance use may express their needs in diverse ways, which may sometimes come across as challenging behaviour. Impairment of executive function can lead to problems with impulsivity. Safety is paramount – follow organisation-specific guidelines for tāngata whai ora and workers' safety.³

- While it is sometimes appropriate to ignore a behaviour,³ allow time for tāngata whai ora to express their needs.¹³² Good relationships and rapport are important to support

this. Taking a trauma-informed approach can help to understand behaviours and ensure safe boundaries.

- As cognitive screening and neuropsychological assessment can be challenging for everyone, lookout for signs of increasing frustration and ask people what would help.
- De-escalate the situation and remove or avoid provoking situations where possible.³
- If challenging behaviour impacts on a person's daily functioning and ability to access services, consider and discuss referral to another specialist service if necessary.
- Debrief with other workers to support worker wellbeing.³

Information gathering as part of a comprehensive assessment

- Use your standard service information gathering checklist or tool to gather contextual information to understand a person's situation. This section is not a full guide to comprehensive assessments.

Presentation

To understand if the person is presenting with cognitive concerns, ask whether the person has experienced any changes or difficulties with any of the following:

remembering things, organising yourself, making decisions, planning ahead, interacting with others, focusing on tasks and maintaining focus, following directions or multiple steps, regulating behaviour, communicating ideas, or finding your way around.

Table 5 contains questions to ask as part of a comprehensive assessment that are important for understanding cognition and cognitive impairment.^{3,133}

- This information is helpful for interpreting information alongside cognitive screening tools, determining the need for a neuropsychological assessment or other referrals, and informing next steps. Cognitive screening can form part of the comprehensive assessment (towards the end of the process) or can happen afterwards.
- Where possible and if you have consent, access previous records (like medical records, school reports, and other historical information) to avoid tāngata whai ora having to repeat themselves. Check with the person if the records are still correct.
- For further guidance on comprehensive assessments refer to **Mental Health and Addiction: Screening and Assessment** and **Te Ariari o te Oranga**.^{133,134}

Comprehensive assessment questions

Presentation

To understand if the person is presenting with cognitive concerns, ask whether the person has experienced any changes or difficulties with any of the following:

remembering things, organising yourself, making decisions, planning ahead, interacting with others, focusing on tasks and maintaining focus, following directions or multiple steps, regulating behaviour, communicating ideas, or finding your way around.

Table 5. Relevant questions to ask as part of a comprehensive assessment

Substance use history

Explore with tāngata whai ora current and previous substance use including alcohol, cannabis, novel psychoactive substances (like synthetic cannabis), tobacco or vaping, stimulants, opioids, sedatives (like benzodiazepines), hallucinogens, and any others like inhalants, GHB, ketamine, kava, or over the counter medications. Explore how frequently and how much is used, and when use started (such as adolescence).

- Have you ever injected substances intravenously?
- Have you been through withdrawal? What was that experience like for you?
- Have you ever experienced an overdose? How did that affect your thinking?
- What is the longest period you have abstained from a particular substance? Did you notice any changes in your thinking?

Mood and emotions

- Have you experienced any trouble regulating your emotions?
- Do you feel well equipped to respond to everyday stressors?
- Have you experienced more intense or changeable emotions or thoughts?
- Do you get angry at things you wouldn't normally get angry about before?
- Do you feel overwhelmed more easily than in the past?
- Have you noticed your reactions to situations changing?

These are not mental health screening questions. Appendix C has information on mental health screening tools.

Physical health and medical history

- What medications are you taking? What for? Have you noticed changes in your cognition or thinking since taking them?
- Do you have any current health problems or symptoms? Are you currently seeing a GP or specialist for ongoing physical health problems?
- Are there any conditions that run in your whānau?
- Have you ever hit your head, been knocked unconscious for more than 30 minutes, or had a brain scan?
- Have you ever been in a car crash, been injured playing sports (like rugby), had a fall, or been involved in violence or assaults?
- Have you ever been hospitalised? Did you self-discharge?
- Do you sleep well? Do you feel well rested in the morning?
- Do you have any challenges with hearing? Do you wear hearing aids?
- Have you been tested for viruses like HIV or Hepatitis C? (Especially relevant for tāngata whai ora with a history of injecting substances).
- Check for previous blood tests like vitamins B1 and B12, and liver, kidney, and thyroid function.

Note: If people raise any flags about physical health conditions, then refer to physical health services including primary care for support. Physical health problems are common among tāngata whai ora accessing AOD services and may get missed due to

overshadowing by substance use and associated symptoms.^{135,136} Many physical health problems are preventable and require workers to proactively support people's physical health needs.

Legal/forensic history

Check if people have been referred from the justice system as this could indicate higher risk of cognitive impairment.³

Personal/developmental history

- Have you experienced any significant life events in your childhood? Adverse childhood experiences are associated with a range of cognitive difficulties.^{23–25}
- Have you ever been diagnosed with a neurodevelopmental condition, such as intellectual disability, ADHD, dyslexia, ASD, or FASD?

Use the prompts below to find out more about possible neurodevelopmental conditions. If these are suspected refer for a neuropsychological assessment – neurodevelopmental conditions are usually diagnosed in childhood, but service barriers may mean people have been missed.

- Did you experience difficulties with milestones like learning to walk, talk, read, write, or communicate?
- Do any developmental problems run in your whānau?
- Did you feel behind relative to your peers at school?
- Did you need support or have problems with emotions or behaviour at school?
- Were you able to make connections easily with others at school?
- Did you leave school early or have to repeat school years?
- How do you find building and maintaining friendships and other significant relationships? Have you noticed any changes in your relationships?
- Have you noticed any changes to your personality or behaviour?

- What do you think are your strengths?

Note: In some cultures, it is not appropriate to identify one's own strengths so people may need support to help identify them.

Psychosocial functioning and daily living

Changes in these daily living activities over time can help to determine functional impacts of cognitive impairment.

- Have you noticed any changes in daily functioning? For example, do you lose things more easily than you used to, do you find it harder to plan or make decisions, are you forgetting things more often?
- How are you managing daily living tasks like cooking, shopping, making appointments, accessing services needed, driving or catching public transport? Do you need any support? Are you finding these things harder than in the past?
- Have you noticed any changes with your mobility? Can you give examples?
- How are you managing tasks like showering, eating regularly, or dressing yourself? Do you require assistance? Can you give examples?
- Are you currently volunteering or employed? If not, when was the last time you were employed? Is there anything you find difficult about holding down a job? Have you experienced any ongoing problems at work (previous or current)?
- Do you have caregiving responsibilities? Do you find it difficult to meet any of these responsibilities?
- Have you ever experienced homelessness? Homelessness is particularly associated with TBI.¹³⁷
- Are you able to manage your finances well? Are you able to pay your bills on time?
- What helps you to cope with stressors or problems? For example, traditional cultural practices or therapies, or alternative medicine.
- Do you experience challenges coping in certain situations? Can you give examples?
- Are you able to manage any regular physical activity?
- Do you experience food insecurity? This means not having reliable access to safe and nutritious food that meets personal and cultural needs.¹³⁸

Ensure to also ask whānau members about their daily functioning, how they are coping, and any support they need.

How to screen for cognitive impairment and identify strengths

This section focuses on cognitive screening rather than in-depth neuropsychological assessment by specialised roles. It covers who should screen, when to screen, how to prepare tāngata whai ora for screening, what tools can be used, and considerations for neuropsychological and other referrals.

Cognitive screening refers to initial information gathering to help workers identify and indicate if cognitive impairment **may** be present in the context of holistic wellbeing.

Neuropsychological assessment refers to in-depth information gathering to determine if cognitive impairment **is** present, its causes, people's level of functioning, and their strengths and adaptations.³ This includes use of in-depth cognitive measures, history gathering, and behavioural observations. The main aim may be either diagnostic (to diagnose specific cognitive impairment), or descriptive (gather further detailed information about people's strengths and functioning to inform a clearer treatment plan).

Summary

Focus

- › Identifying cognitive impairment and people's strengths to support the recovery journey.
- › Understanding the difference between cognitive screening and neuropsychological assessment, and the role of the AOD treatment workforce.

Actions

- › Screen for cognitive impairment when tāngata whai ora enter services and at ongoing intervals - use clinical judgement for the right timing. Options for cognitive screening tools for trained workers include the MoCA, BEAT, ACE-III-NZ, and mini-ACE-NZ.
- › Consider the impact of English comprehension and schooling when using and interpreting information from screening tools.
- › Interpret screening results in context of the comprehensive assessment information to determine if a neuropsychological assessment (and/or other referrals) are required.
- › Keep tāngata whai ora and whānau fully informed throughout the process.

- Outcomes**
- › Cognitive impairment is identified in a strengths-based manner.
 - › Tāngata whai ora and whānau feel comfortable and empowered.

Use cognitive screening to identify the support tāngata whai ora need and their strengths, rather than focusing on impairments or deficits and stigmatising people.^{54,139}

See Appendix D for a cognitive screening pathway.

Who can screen: Undertake cognitive screening with proper training and/or supervision to avoid harm

AOD treatment workforce has a key role in screening for cognitive impairment. Training, cultural understanding, and clinical skill² are required to avoid harm and potentially retraumatising tāngata whai ora.

Rather than having a specific role title, workers who use screening tools should have undergone the specific training required to safely use those tools and may require supervision (like from a clinical psychologist) to safely interpret the information. Check the requirements of the screening tool for administration and interpretation.

When to screen: Screen when tāngata whai ora enter services and at ongoing intervals

Cognitive screening should take place when tāngata whai ora feel safe and any immediate risks have been mitigated. It may be that screening needs to be postponed

to put a safety plan in place. For example, if someone is experiencing thoughts of suicide then support takes priority over screening.

Ideally, screen for cognitive impairment when tāngata whai ora enter AOD services, and any time that tāngata whai ora or whānau raise concerns about their cognitive function. Aim to screen for cognitive impairment and refer for a neuropsychological assessment (if indicated or as required) during the first one-third of a treatment programme.⁵

Substance use and withdrawal symptoms can affect the validity and usefulness of the information collected as it can cause temporary changes to a person's cognitive functioning.

A period of abstinence prior to screening should be prioritised. A timeframe of one to two weeks of no substance use supports validity, with 6 weeks being ideal. However, this is likely to be challenging for many tāngata whai ora and unrealistic in some services.

In this case, take a harm reduction approach and work with tāngata whai ora to reduce substance use leading up to screening, and preferably have them not use substances on the day of screening. Check with tāngata whai ora if a particular time of day would better support minimal substance use.

The results of screening are a snapshot of the person's cognition at that time. When substances are used, clinical judgement and flexibility are required to determine if it is helpful for screening to go ahead. For example, if the tangata whai ora is experiencing minimal acute effects and they are comfortable to proceed it may be appropriate to continue. However, this should be factored in when interpreting screening information, and repeat screening becomes more important. Substance use should be noted on the screening form.

An example of when it may not be appropriate to screen is during heavy alcohol use or while someone is taking benzodiazepines as part of the withdrawal process.

Non-clinical roles should seek advice or supervision to determine appropriate timing and interpretation of results when there is current or recent substance use.

⁵ This recognises different programme lengths across Aotearoa New Zealand.

As well as substance use and intoxication, it is ideal for other short-term potential causes of cognitive impairment (such as experiences of psychosis) to be identified and support provided prior to screening, though this may not be feasible.³

Repeat cognitive screening (ideally by the same person) at regular intervals (for example every 3 or 6 months, or at mid-point and discharge in residential services) to:

- continue building trusting relationships with tāngata whai ora and whānau
- determine if cognitive function requires more or less support and adapt treatment plans accordingly, and to determine long-term cognitive impairment after support for short-term causes
- show changes in cognition over time where relevant (such as when there is reduced substance use). This can often be motivating and inspire hope
- ensure accuracy and validity due to the many situational factors that can influence cognition.

When repeating screening, use a different version of the same screening tool where available to minimise learning effects. This is so that tāngata whai ora can't remember the answers from last time.

How to prepare: Ensure tāngata whai ora feel informed, comfortable, and ready for screening

Provide information about screening ahead of time so people know what to expect. Let people know the purpose and limitations of screening, reassure them of confidentiality, how the information will be used, how long it might take, and that you will discuss the results and next steps with them afterwards.

Before screening, check if the tangata whai ora:

- understands why they are being asked the screening questions, and that they've given their consent¹⁴⁰
- has any basic needs that can affect results. For example, check if they are feeling well physically (such as not feeling hungry or thirsty, needing a toilet break, or feeling too hot or cold), or if they need glasses or hearing aids
- prefers a language other than English. Check if the screening tool is available in their language of choice. Direct word-for-word translation of questions from English tools is

not recommended due to differences in cultural context, word and sentence structure.^{141,142}

Sharing results back with tāngata whai ora and whānau

After screening, share the results back with tāngata whai ora and whānau in a strengths-based and mana-enhancing manner.

Offer tāngata whai ora information and results of screening in both writing (to take away with them) and an in-person hui.

Ask tāngata whai ora to reflect back their understanding of the screening results, rather than simply asking them if they understand. In many cultures people may simply nod to show respect but may not necessarily understand the information.

If needed, discuss other referrals and their purpose.

What tools to use: Choose from the MoCA, BEAT, ACE-III-NZ, and mini-ACE-NZ when screening for cognitive impairment

Purpose of cognitive screening tools

While screening tools are important, they are not able to diagnose cognitive impairment. Screening tools are designed to identify people with possible cognitive impairment. This may include identifying some people without cognitive impairment. Therefore, if available and required, neuropsychological assessments are important to accurately diagnose cognitive impairment and/or clarify factors that may be impacting on cognition.

Screening tools are useful but should be interpreted in context amongst a range of other information. Cautious interpretation is especially important when using Western developed tools for Māori, Pasifika, and other diverse cultures, and for people with an intellectual or learning disability. Score differences in diverse cultures are driven by language (English as a second language) as well as the quality and length of formal schooling, and may also be associated with a lack of familiarity with the screening situation or materials.^{141,143}

- Introduce screening tools in a non-threatening manner that minimises anxiety for the tangata whai ora.¹⁴⁴ Explain that it is normal to find the questions challenging or difficult, and the main thing is to try their best.
- Have pictures and visual representations handy to aid in the explanation of screening questions, if these are not already included with the screening tool. Give tāngata whai ora the options of responding on a written form, or verbally to screening questions. If written, some tāngata whai ora may require verbal clarification of questions.
- Consider the wide range of factors that can affect screening results. Aside from English comprehension, schooling, and substance use, these could include: suitability of the screening tool for the tangata whai ora (for example, their age), medications, medical conditions, fatigue, fluctuations in mental health challenges and wellbeing, literacy, stress and screening anxiety, and low motivation or shyness.³
- Use a brief screening tool.
- summarises options that workers can use. All the tools below are administered tools, which means they should be carried out by a trained worker. Services should use the tool that best suits their resources and what is most appropriate for the tangata whai ora. Tools that tāngata whai ora can fill out themselves (self-report) are covered in the next section.

Table 6. Screening tool options

<p>MoCA - Montreal Cognitive Assessment</p> <p>Certification and training are required. Any worker who is certified can administer, but interpretation requires health professionals with expertise in cognition (such as clinical psychologists).</p> <p>There are three versions of the standard full MoCA (with different examples to minimise learning effects). It has 30 items.</p> <p>Pros</p> <ul style="list-style-type: none"> • Takes 10 to 15 minutes to administer. • Screens for a range of conditions including different types of dementia, sleep disorders, brain tumours, head trauma, and mental health challenges. • Is translated into many languages. • Has versions for different impairments (such as the MOCA-Blind).
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Cons

- Not developed for AOD settings, though has since been validated.^{2,3}
- Ongoing cost every 2 years for certification and training.
- No published validation studies in Aotearoa New Zealand AOD populations but has been used in AOD services locally.

Find the tool, scoring, and training information on the MoCA Cognition website.

Mini-ACE-NZ – mini Addenbrooke’s Cognitive Examination

Health professionals who have undergone training can administer and interpret.

There are three versions of the mini-ACE-NZ. It has 5 items.

Pros

- Takes 5 minutes to administer.
- The recommended screening tool for primary care in Aotearoa New Zealand.¹⁴⁵
- Free for Aotearoa New Zealand based health professionals.

Cons

- Not developed for AOD settings and executive function insight is limited.
- Its main purpose is to screen for dementia.¹⁴⁶

Find the tool, scoring, and training information on the Healthify website.

BEAT – Brief Executive-function Assessment Tool

Any worker who has watched the training videos can administer, but extra training and/or supervision from a psychologist is recommended for interpretation.

One version with 20 items.

Pros

- Free to use.
- Developed specifically for AOD settings.⁹⁴
- Screens for a range of conditions particularly those affecting executive function.

Cons

- Not currently validated in Aotearoa New Zealand.
- Takes 20 minutes which is longer than some other screening tools.

Find the tool, scoring, and training information on the NSW Health Agency for Clinical Innovation website.

ACE-III-NZ – Addenbrooke’s Cognitive Examination

Any worker who has completed online training can administer and interpret. It does not require clinical training.

Three versions with 19 items.

Pros

- Free for Aotearoa New Zealand based health professionals.
- Validated in Aotearoa New Zealand among older people.¹⁴⁷
- No specialist training required for its use.

Cons

- Not developed for AOD settings.
- Not reliable for people with limited education, or those with a learning, communication, visual, or other impairment.
- Best for dementia screening.
- Takes 20 minutes which is longer than some other screening tools.

Find the tool, scoring, and training information on the Sydney University website.

Note: The Mini Mental State Examination (MMSE) is not recommended in AOD settings for cognitive impairment screening.^{2,3}

Self-report tools

Tāngata whai ora can fill in some tools themselves that can be useful alongside information from administered screening tools.

The Behaviour Rating Inventory of Executive Function (BRIEF-A) and the Alcohol and Drug Cognitive Enhancement (ACE) Screening Tool have been validated in AOD settings.^{3,148,149}

- The ACE takes 2 minutes and is recommended as part of a two-stage process, followed by a worker-administered screening tool like those outlined above. It is available for free. [Learn more about the ACE on the Agency for Clinical Innovation website.](#)
- The BRIEF-A takes 10 to 15 minutes and can also be completed by whānau. There is a cost for the manual and forms. Psychologists or psychiatrists are required to interpret the information. [Learn more about the BRIEF-A on the PAR website.](#)

Information to inform referral for a neuropsychological assessment

Either a neuropsychologist or clinical psychologist can undertake neuropsychological assessments.

Neuropsychological assessments can take a few hours (sometimes over multiple days), and include detailed information gathering, review of records, behavioural observation, and administration of in-depth measures of cognitive function.³ Examples of measures include the Wechsler Adult Intelligence Scale 4th edition (WAIS-IV), Wechsler Memory Scale 4th edition (WMS-IV), and the Delis-Kaplan Executive Function System (D-KEFS).

Considerations when referring for a neuropsychologist assessment

Consider the following questions before making a referral for a neuropsychological assessment.³

- Does the tangata whai ora want to have a neuropsychological assessment? Do they understand why they're being referred and why a neuropsychological assessment may be needed?
- Do you have a clear referral question and reason for referral? (Is it necessary?)

- Does the tangata whai ora know what to bring with them to the assessment?
- Have you checked expectations around substance use before the assessment? Have you communicated the requirements to the tangata whai ora?
- Does the tangata whai ora know how to get to the assessment, do you need to remind them?
- Can the assessment accommodate whānau if the tangata whai ora wants them to be involved?
- Is there the possibility of doing the assessment in the home of the tangata whai ora or another place where they feel more comfortable?
- Is there resourcing to help with travel to the assessment if it is outside of the home?
- Is there an accurate history and knowledge of whether previous neuropsychological assessments have been recently conducted?
- Who will explain the results to the person, whānau, and (if needed) other agencies?
- Does a report need to be provided to other agencies?
- Who will pay for the assessment and report?

Referrals for a neuropsychological assessment will be prioritised by the team undertaking the assessment. They will determine clinical need by considering factors indicating greater cognitive impairment. This includes significant reported impact on the person's life (like difficulty managing day-to-day tasks – a neuropsychological assessment may help qualify some people for government support), presence of multiple co-existing issues, and lack of supportive psychosocial circumstances (such as stable housing, employment, and supportive relationships).

Explain to tāngata whai ora and whānau that waitlists for neuropsychological assessments can be long and referrals may not always be accepted, so they know what to expect.

While waiting for a neuropsychological assessment (or if one isn't possible), use the information gathered as part of the comprehensive assessment and cognitive screening process to inform next steps, which may include other referrals. Next steps should be driven by areas the tangata whai ora feel they need support with and adapted accordingly (see next section for support strategies). For example, if

they have expressed concerns about their memory then teach external strategies they can begin using in their daily life.

Substance uses before a neuropsychological assessment

It is ideal for there to be no substance use at least one to two weeks (and up to 6 weeks) prior to the neuropsychological assessment phase. If the neuropsychological assessment aims to diagnose a neurocognitive disorder, it is very important for the person to not use substances for 2 weeks prior. The optimal time needed may differ depending on the substance/s used.

Some clinicians will not undertake neuropsychological assessments if there has been any substance use within a set period of time, whereas others take a more flexible approach. If referring for a neuropsychological assessment, check requirements ahead of time so tāngata whai ora are clear on their expectations.

To find a neuropsychologist or clinical psychologist contact or search the website registry of the [New Zealand Psychologists Board](#) or the [New Zealand College of Clinical Psychologists](#).

Other referrals to consider

Neuropsychological assessment referrals are most appropriate when the aim is to achieve a fuller understanding of a person's cognition, for a diagnosis of a neurocognitive disorder, or identifying the need for ongoing support and/or remediation. However, other referrals may be more relevant or practical depending on the main presenting issue. Each service will have different options available and a different pathway for referrals.

- **Referral to a primary care provider is beneficial in most circumstances.** When referring to a primary care provider, it is helpful to give some suggestions on concerns and potential specialist referrals that may be useful. For example, if you are concerned that a person's nutrition status is impacting their cognition, a dietitian may be helpful. If you are concerned about dementia, then a geriatrician or psychogeriatrician may be helpful. For brain injuries, a neurologist may be helpful.
- Geriatricians and psychogeriatricians often work with older people experiencing neurocognitive conditions (like dementia), mental health challenges, and other conditions affecting behaviour.

- Neurologists work with people experiencing conditions affecting the nervous system (brain, spinal cord, and nerves). They will often be involved for conditions like TBI or stroke, or for managing seizures.
- Some significant or acute physical or mental health concerns warrant urgent referral to hospital emergency departments or mental health crisis services, rather than primary care. For example, if someone appears to be experiencing symptoms of a stroke then refer them to a hospital emergency department. If risk assessment indicates there is immediate danger of someone harming themselves (such as thoughts of suicide) or others, then refer to a mental health crisis service.
- Where it is helpful to gather detailed information around day-to-day functioning (such as judgement and safety skills), consider referral for a functional assessment by an occupational therapist (OT). OT functional assessments are particularly helpful when assessing the need for daily practical supports, especially in the context of establishing and quantifying the degree of functional impact.

The threshold to refer on for specialist assessments requires clinical judgement. Needing to refer to other specialists would be indicated by the initial cognitive screen administered and the cut-off score, alongside additional clinical information from the comprehensive assessment and people's presenting issues. A multi-disciplinary team meeting may be helpful to discuss prioritising potential referral pathways.

Referral to primary care or other specialists may also be warranted if cognitive function does not appear to improve over time with repeat screening after verified abstinence.

Cognitive impairment, decision-making capacity, and SACAT

- The SACAT Act is a last resort option for compulsory assessment and treatment when people are at serious risk of harm from their problematic substance use and do not have the capacity to make decisions about treatment.
- Providing support for cognitive function might impact people's decision-making capacity and the SACAT Act may no longer need to be applied.
- The Compulsory Assessment and Treatment-Capacity Assessment Tool (CAT-CAT) can be used as part of the SACAT Act assessment process to determine decision-making capacity among people using substances problematically and experiencing cognitive impairment.¹⁵⁰ It takes into account the impact that cognitive impairment can have on decision making.

- Refer to the Ministry of Health Manatū Hauora guidelines for assessing capacity to make decisions for substance use treatment and the Code of Health and Disability Services Consumers' Rights for more on informed consent and decision-making (Right 7).

How to support tāngata whai ora experiencing cognitive impairment to enhance outcomes

This section contains practical tips to support tāngata whai ora experiencing cognitive impairment and whānau. It covers evidence-based support options, integrated and community support, and whānau support.

Summary

Focus	<ul style="list-style-type: none"> › Supporting tāngata whai ora and whānau to enhance outcomes. › Tailoring support to needs, wants, worldviews, and strengths.
Actions	<ul style="list-style-type: none"> › Adapt problematic substance use support options to enhance engagement. › Teach cognitive training and remediation strategies (including compensatory strategies) to enhance quality of life. › Encourage tāngata whai ora to eat nutritious foods, engage in safe and enjoyable physical activity and social activity, set up a routine to support sleep, and connect to places and people that heal wairua. › Consider culturally responsive resources such as alternative medicine and traditional protocols. › Work with other sectors and agencies to meet wider needs. › Ensure whānau access good information and support.
Outcomes	<ul style="list-style-type: none"> › Tāngata whai ora and whānau are supported in ways that meet their needs and are culturally responsive. › Support provided for cognitive impairment enhances people's wellbeing and recovery journey.

Tailor support to tāngata whai ora aspirations, goals, worldviews, and strengths.

Review support plans regularly as cognitive support needs can change over time.

Evidence-based support options

Figure 6 summarises four main strategies helpful for tāngata whai ora experiencing cognitive impairment. Be guided by what works best for each tangata whai ora. Appendix E includes tips for supporting specific groups of people like diverse cultures, rainbow communities, people in contact with the justice system, and younger and older people.

As part of the support plan, include basic education on how substance use affects cognition and expected recovery with abstinence.

Figure 6. Four evidence-based support options for cognitive impairment

<p>Compensatory strategies</p> <p>Compensatory strategies are tools that people can use in their daily life to help with day-to-day tasks.</p>	<p>Adapting treatment for problematic substance use</p> <p>Adapting therapies for problematic substance use helps people to get the most out of treatment.</p>
<p>Cognitive training and remediation</p> <p>Cognitive training and remediation approaches generally aim to restore people's cognitive function or compensate for cognitive impairment.</p>	<p>Lifestyle recommendations</p> <p>Lifestyle changes can support wellbeing and recovery, and slow worsening cognitive impacts over time.</p>

Cognitive training and remediation strategies are generally better suited to long-term cognitive impairment, while the other approaches can be used for both short- and long-term cognitive impairment.

However, short-term or transient causes of cognitive impairment may be better addressed in other ways, such as providing support for acute distress or a review of medications that may be causing cognitive impairment.

Compensatory strategies

Compensatory strategies can be divided into two groups:

- internal strategies refer to those that require mental effort, see Table 7

- external strategies involve the use of aids, tools, or modifications to the external environment, see Table 8.³

External strategies are usually quicker and easier to use for tāngata whai ora experiencing cognitive impairment. These strategies can be used and taught by a range of different roles and are not limited to clinical practitioners.

Many people already use compensatory strategies. Start by asking and finding out what people already use and what they find most helpful. While some examples are listed below, adapt and use examples that are relevant to people's daily lives.

Internal strategies

Table 7. Internal strategies and examples^{3,151}

Strategy	Examples
Repetition	<p>Repetition enhances attention to information and strengthens neuronal pathways.</p> <ul style="list-style-type: none"> Repeat key information in different ways (like writing, speaking) and ask people to repeat back information in their own words. Encourage people to talk out loud to themselves.
Spaced repetition and retrieval	<p>Spaced repetition refers to repeating key information over increasing time intervals, such as 5 minutes and 10 minutes, then 1 hour.</p> <ul style="list-style-type: none"> Prompt people to retrieve information at spaced time intervals by giving specific cues. For example, "What is my name, it starts with S?" or "When is your next court date? It is in July." If the person struggles to recall the information, shorten the time intervals. Only lengthen the time intervals again once they can recall information at the shorter intervals.
Bilingualism – using	<p>Speaking different languages can enhance people's cognitive function, particularly in older people.¹⁵²</p>

additional languages	<ul style="list-style-type: none"> • Where helpful, encourage tāngata whai ora Māori to enhance and use their te reo Māori learning. • Encourage people who speak other languages to use them as much as possible. Use interpreters to assist this process.
Association	<p>Associations help people to remember things better. Tāngata whai ora may benefit from learning associations using words, images, or materials associated with their culture.</p> <ul style="list-style-type: none"> • Encourage people to create associations to remember information. For example, “I need to catch the number 4 bus to get to my appointment at 4pm”. • Familiar associations are easier to remember compared to unusual associations that have no clear link. For example, “My new case manager’s name is Kathy Cook, and I remember her name because she is nice, and I have nice memories of visiting Aoraki/Mt Cook”.
Chunking	<p>Chunking reduces the load on memory by grouping similar things together. For example, teach people to:</p> <ul style="list-style-type: none"> • break a phone number into three groups (021 123 456) as that is easier to remember than the whole number • use lists when shopping to group similar items together (like milk and yoghurt).
Self-prompting	<p>Self-prompting uses contextual information to aid recall.</p> <ul style="list-style-type: none"> • For example, ask people to think about where they were and what they were doing. • Ask people to retrace their steps and ask questions like who they were with and what room they were in when they learned a piece of information, or an event happened (like losing keys).
If-then plans	<p>If-then plans help with remembering to do things in the future.</p>

	<ul style="list-style-type: none"> Encourage people to create if-then plans in their mind and visualise themselves doing it. For example, "If I drive past the supermarket on my way home, then I will stop to buy milk".
Musical mnemonics	<p>A mnemonic is a pattern of letters, ideas, or associations that assists with memory. Musical mnemonics use songs or rhymes and requires some creativity.</p> <ul style="list-style-type: none"> Work collaboratively with each tangata whai ora to identify what's most helpful or meaningful for them.
Acronyms and acrostics	<p>Acronyms are abbreviations formed from the initial letters of a phrase.</p> <ul style="list-style-type: none"> For example, ID for intellectual disability. Acrostics use sentences that help people remember the order of things. For example, what is my GAP (Goal and Plan)?
Narrative mnemonics	<p>Narrative mnemonics involve people creating a short story out of important information. This is similar to the association strategy.</p> <ul style="list-style-type: none"> Encourage people to make simple stories. For example, "If you need to remember to bring your work boots, lunch, and glasses to work, imagine your work boots wearing glasses and eating lunch".
Memorised movements	<p>People can use body language gestures when words are forgotten.</p> <ul style="list-style-type: none"> Encourage people to 'act out' gestures that help them to remember actions. For example, using movements to remember a pin number when paying with an eftpos card.

External strategies

External strategies are most often used for people with memory problems.³ Smartphones are a helpful memory aid tool. Table 8 includes external strategies with and without a smartphone and strategies for remembering medications. Be mindful of the load and impact on people's whānau when they are taking on new responsibilities.

Table 8. External strategies and examples³

Type	Examples
Strategies for people with smartphones	<ul style="list-style-type: none"> • Take photos of important information to refer back to. • Use the note function to write important information. • Set up text or smartwatch reminders to remember appointments and other events. Multiple reminders can be helpful (such as a month, week, and day before).
Strategies for people without smartphones	<ul style="list-style-type: none"> • Ask whānau to remind people of important information. • Set routines, like booking an appointment at the same time and day each week. • Use a physical diary or calendar to record important dates or information. • Use to-do lists. • Set alarm clock reminders for specific tasks. • Consider wearable emergency response alarms for older people.¹⁵³ • Suggest people take notes or record sessions to look at later. • People can set up and use memory stations at home. These usually include a whiteboard or pinboard and a small table to keep important items. For example, it could be where people keep their keys, medications, wallet, glasses, and/or important documents like bills to be paid. The board can be used to write down upcoming appointments, important dates, or tasks that need to be completed.

Strategies for remembering to take medications

- Link taking medications to daily events, like eating a meal or brushing teeth.
- Keep medications somewhere in plain sight (but out of reach of children).
- Ask pharmacies if they can organise medications into separate blister packets by time of day if taking multiple medications.

Adapting treatment for problematic substance use

Many strategies for problematic substance use need to be adapted to ensure people experiencing cognitive impairment can fully engage. Examples include cognitive behavioural therapy (CBT), motivational interviewing (MI), and mindfulness based relapse prevention (MBRP).³ The general principles listed below can be used across roles.

- Modify how people engage with support, like having shorter, more frequent encounters with regular breaks to help consolidate learning.³
- For tāngata whai ora Māori, ask if te reo Māori and Te Ao Māori concepts and imagery would be helpful.
- Set shared goals and clear expectations for each person's role in the therapeutic relationship.^{154,155} For one-on-one support, this could include outlining the goals of the therapeutic process (like learning skills to better cope with peer pressure to use substances). The worker's role might include suggesting evidence-based approaches that can be explored collaboratively with the person. The person's role might include outlining their day-to-day challenges, making a genuine attempt to implement agreed-upon strategies, and providing clear feedback about what works and what doesn't.

- Provide a clear structure for each session and activity, while allowing for flexibility.¹⁵⁵



- Figure 7 outlines a simple session structure.



Figure 7. Example of a session structure

Table 9 summarises specific strategies that can be used during treatment to adapt for various aspects of cognition.

Table 9. Adaptations based on affected aspects of cognition

Challenge	Adaptations to treatment
Alertness and fatigue ^{3,54,155}	<ul style="list-style-type: none"> • Consider if the tangata whai ora is on medication and ask if that impacts their alertness and fatigue

- Provide quiet rest areas and schedule rest after any mental activity
- Pace activities, start with more complex information or activities when people are most alert
- Regularly have a stretch break
- Encourage people to have a snack before meeting if it helps with their alertness
- Consider shorter, more frequent sessions
- Simplify and break down information or activities into chunks

Attention and processing speed^{3,54,156}

- Make information or tasks more engaging (such as using videos)
- Reduce distractions in the environment
- Present one idea at a time, per session if possible
- Make it clear when the topic is being changed
- Make priorities or most important information clear
- Keep concepts and ideas simple
- Slow down speech and give people enough time to process, ask, and respond to questions
- Check peoples' understanding and repeat back
- Go at the person's pace
- Maintain eye contact if culturally appropriate
- Use peoples' name and pronounce them correctly – ask how people prefer to be addressed (such as Mr...)
- Take breaks as needed – agree on a signal for needing a break
- Link new information back to ideas already discussed

Visuospatial awareness³	<ul style="list-style-type: none"> • Encourage people to follow a routine like sleeping and eating at regular times • Make plans with people for if they get lost on their way to an appointment • Refer to a GP to rule out problems with vision and/or spatial awareness • Determine if people can safely drive to appointments and plan alternatives for getting around if needed • Determine if people can safely use power tools and other machinery and plan accordingly (for example, they may need to renegotiate work duties)
Memory^{54,157}	<ul style="list-style-type: none"> • Encourage people to use the external strategies listed earlier • Focus on and emphasise the most important information • Use internal strategies like associations • Ask people to summarise key information • Use visual aids and pictures if appropriate • Provide a written list of key points at each session • Wear a name tag
Executive functioning such as abstract thinking, mental flexibility, problem solving, impulsivity, and insight ^{3,54,158}	<ul style="list-style-type: none"> • Help and encourage people to use to-do lists • Use cues to think about triggers as these are often automatic. For example: • ‘Stop and think’ or STOP (stop, think, observe, proceed) encourages people to consider an action before doing it like using substances • ‘Zoom in and out’ encourages people to consider elements of the bigger picture that might be missing – like not wanting to try a certain treatment as it hasn’t been explained properly or not knowing how to get to an appointment on public transport

- Use short simple sentences
- Use examples from a person's life when doing decisional balance exercises using MI, or when exploring core beliefs in CBT
- Use role play to practice strategies to cope with triggers or high-risk situations
- Try to avoid changes to routine (like appointments booked at the same time) but if these happen, remind people several times
- For problem solving, work with people to break tasks into smaller parts. Frameworks can help with set steps, like identifying the problem, setting realistic goals, generating solutions, and monitoring. Equip whānau with the skills to follow this process at home too
- Use mind maps when generating ideas to solve problems with people – people can then choose and work through the simplest most practicable option for them
- Encourage the practice of new skills in different environments
- Use neutral language and speak in a calm manner
- Set clear boundaries with people
- If people are frustrated, ask them to explain how they're feeling, what led to them feeling that way, and what would help them
- Help people to set realistic goals and break longer term goals up into achievable parts
- Praise peoples' strengths and use positive reinforcement – give specific examples by naming the strength and how they used it well

Language^{3,155}

- Ask simple questions that can have yes/no answers if people find open-ended questions unhelpful
- Use short sentences and avoid long words or clinical jargon

- Use consistent and familiar terminology
- Use alternative communication strategies like writing, pictures, or body language gestures
- Avoid interrupting people and their train of thought
- If needed discuss referral to a speech pathologist for further support

Social cognition³

- Indicate that interruptions may be needed to progress the session
- Make clear statements about how you or others might be feeling, as the person may not be able to pick this up from non-verbal cues
- Be open to discussing relationship dynamics with the person
- Roleplay common social situations and practice assertiveness and skills like maintaining eye contact, active listening, and asking questions to show interest in others
- Consider peoples' developmental level and adapt accordingly, especially skills like understanding others' perspective and recognising emotions
- Practice recognising different emotions using pictures
- Encourage people to take notice of other people's reactions, and work through any negative situations with them
- Involve whānau to practice these techniques

Adapting group sessions

Extra considerations for adapting group sessions are listed below.^{156,159}

- Set rules and expectations to maximise participation including reducing noise, distractions, and interruptions.
- Cover the agenda at the beginning.

- Appoint a timekeeper to help the group stay focused and on track.
- Incorporate role-playing and skills practice.
- Offer time after sessions for anyone who needs one-on-one time or further support to understand information.

Cognitive training and remediation

Cognitive training and remediation include strategies aimed at restoring cognitive function, as well as compensatory strategies aimed at working around impairments in cognitive function. Cognitive training and remediation can be taught alongside problematic substance use treatment as part of abstinence oriented and harm reduction support options, and are ideally taught early on in a person’s recovery journey.^{160,161}

Use one or more of the following best practice recommendations for cognitive training and remediation.¹⁶¹ These can be taught or delivered by both specialised roles and the broader AOD treatment workforce. However, some training is required.

- Cognitive bias training – retrains implicit biases, automatic processes, and preferences for substances.^{3,161}
- Cognitive remediation and rehabilitation – aims to improve cognitive function through both training and compensating, by strengthening executive control processes and reducing automatic or impulsive cognitive processes.^{3,161}
- Contingency management⁶ – where people are rewarded based on behaviour change to encourage desired behaviours.^{161,162}
- Emotional regulation training – trains people to use adaptive or helpful strategies to manage or regulate their emotions.^{161,163}

Use the techniques in Table 10 when implementing cognitive training and remediation.¹⁶¹

Table 10. General techniques for implementing cognitive training and remediation

Technique	Action
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⁶ This option is dependent on service resourcing.

Practice	<ul style="list-style-type: none"> • Encourage tāngata whai ora to repeat tasks so they become better at it
Feedback	<ul style="list-style-type: none"> • Provide feedback to tāngata whai ora on how they are doing
Titration or progressive difficulty	<ul style="list-style-type: none"> • Gradually increase the difficulty of tasks so tāngata whai ora get better over time
Goal setting	<ul style="list-style-type: none"> • Collaboratively design an action plan designed to motivate and guide tāngata whai ora towards a goal
Metacognitive strategy learning	<ul style="list-style-type: none"> • Encourage people to monitor their own cognition such as planning intentions, monitoring or awareness of task performance, and monitoring and regulating behaviour and emotions

Lifestyle strategies

As well as supporting wellbeing, lifestyle strategies can help to slow cognitive impairment in conditions that tend to worsen over time, like dementia.^{3,153,164,165} Lifestyle strategies can be encouraged across all types of roles.

Primary care plays a key role in supporting people with lifestyle strategies and to reduce any modifiable risk factors for cognitive impairment. This includes support to reduce or quit smoking. Refer to a primary care practice for support in this area. Some primary care practices have integrated mental health and addiction teams including support workers, health improvement practitioners, and health coaches who provide free support with these strategies. To find a provider go to the [wellbeing support website](#).

Figure 8. Key lifestyle strategies to support cognition³



Food and nutrition	Physical and social activity	Sleep
<ul style="list-style-type: none"> › Encourage a variety of nutritious foods. › Encourage people's traditional/cultural foods and practices. › Explore food insecurity and reduced access to food. › Explore barriers like difficulty swallowing. › Supplement with thiamine where appropriate. › Refer to a dietitian if people want more support. 	<ul style="list-style-type: none"> › Encourage physical activity that is safe and enjoyable. › Physical activity helps both cognitive functioning and supports reduction of problematic substance use as part of a support plan. › Encourage social activity especially for older people to slow cognitive changes. 	<p>Encourage people to:</p> <ul style="list-style-type: none"> › have a regular bedtime routine › reduce caffeine and stimulant use after midday › use blue light filters on devices and reduce screen time before bed › get outside in the morning › use relaxation techniques like deep breathing.

- Encourage tāngata whai ora Māori who find it helpful to access support for wairuatanga (spirituality). For example, accessing environmental places of significance (marae, maunga/mountain, whenua/land, awa/river, moana/sea), and connecting with tūpuna (ancestors) in ways that are meaningful for them.

- Encourage access to traditional cultural approaches like rongoā (such as mirimiri), herbal medicine, acupuncture, and other traditional practices that support people's cognitive wellbeing.
- For healthy eating and activity guidance see the Ministry of Health Manatū Hauora **Eating and Activity Guidelines for New Zealand Adults**.

Thiamine supplementation

Vitamin B1/thiamine supplementation is helpful for most people using alcohol problematically and is generally safe with minimal (if any) side effects. Also encourage thiamine rich foods like wholegrain breads and cereals, nuts and seeds, and meat.

Different doses and methods of administration are appropriate in different situations. For example, oral thiamine supplements are not sufficient to treat or prevent Wernicke's Encephalopathy during alcohol withdrawal.¹⁶⁶ Seek medical review for tāngata whai ora that may benefit from thiamine supplementation, including information on the method of administration and dosage.

Tāngata whai ora experiencing cognitive impairment benefit from integrated and community support

Integrated support is beneficial for people experiencing cognitive impairment, who are more likely to need to access multiple services and have unmet needs.^{3,167–170} Design a support plan in partnership with tāngata whai ora and whānau while collaborating across the health and social sectors to ensure holistic needs are met. Multidisciplinary team meetings may be helpful for considering the range of supports available for wider needs.

- Develop working relationships with different services and agencies to ensure people accessing AOD services receive appropriate support. Work with agencies that have long-term, trusted relationships with tāngata whai ora, especially for those who have had previous bad experiences in the health system.
- If available, have someone dedicated to coordinating support for people with multiple co-existing issues (such as a care coordinator).
- Equip tāngata whai ora and their whānau with the skills and supports to live well in the community before leaving services.

Figure 9 covers the five basic principles of integrated support.¹⁷¹

Figure 9. Principles of integrated support



Examples of referrals for holistic needs are listed below.

- **Housing needs:** Housing First, Kāinga Ora, rest homes, or local marae.
- **Employment support:** Workwise or Work and Income.
- **Finance and budgeting:** Moneytalks (free online services).
- **Head injuries:** ACC for support (including for sensitive claims⁷ if appropriate), or Brain Injury New Zealand for education and support.
- **Meaningful everyday activities** or occupations: occupational therapists, nurses who do nurse-led aftercare, or support workers (such as through Pathways).
- **Social issues:** social workers or support workers (including help navigating support options).

⁷ Sensitive claims include those due to sexual abuse or assaults(s), or specific actions listed in the *Crimes Act 1961*. **For more information on sensitive claims see the ACC website.**

- **Strength and mobility:** physiotherapists or neurologists.
- **Nutrition and eating patterns:** dietitians or registered nutritionists.
- **Speaking and language support:** speech therapists.
- **Cultural needs:** culturally specific providers like Kaupapa Māori services, Ka’aute Pasifika Trust, or Asian Family Services.
- **General health needs including preventative healthcare, risk reduction, and long-term goals:** GPs and other integrated primary mental health and addiction support practitioners such as health coaches and health improvement practitioners.
- **Mental health challenges:** GPs, community providers, specialist mental health services, or crisis services.
- **Relationship or whānau issues:** psychologists or counsellors.
- **Live-in support:** residential or respite care facilities, or a managed alcohol programme.⁸

It is also helpful to link tāngata whai ora and whānau with community peer support groups.

More on ACC coverage for cognitive impairment

- ACC provides support to people who have been injured due to an accident.
- Injuries such as TBI and concussion can be covered. Injuries that are not covered are those that happen over time, are related to ageing or emotional challenges (unless related to a physical injury), and some other injuries.
- If a person was injured or in an accident, a health professional can make claims on the person’s behalf.
- Claims can be made up to 12 months after an injury. ACC may consider claims after 12 months if there is a good reason it wasn’t made sooner, but they may require more information.

⁸ Such as Te Pā Maru established by the Wellington City Mission.

- To access information ACC holds about someone you are working with, complete an 'authority to act' to ensure you have the right to this information. See **the ACC website for the right forms to complete**.
- Each injury is considered on a case-by-case basis. See **the ACC website for more information including a video and list of what type of claims are covered**.

Brain Injury New Zealand has offices around Aotearoa New Zealand and can help both tāngata whai ora and workers navigate through ACC processes.

Concussion services

The ACC concussion service provides interdisciplinary support specifically for mild to moderate TBIs. This service supports daily living and aims to prevent long-term consequences from TBI. For more on eligibility criteria and referral processes, **see the concussion services operational guidelines on the ACC website**.

An example of a TBI pathway from acute presentation to long-term management can be found on this ACC infographic.

Specifically, in addition to support to reduce or stop using substances, and the cognitive strategies already discussed, the following is a guide for who to involve in support.

For **people who can live independently but have some functional impacts** from cognitive impairment, consider the following referrals.¹⁷²

- Housing, employment, and training support.
- Finance and budgeting support.
- Primary care provider for health, fitness, nutrition, and smoking cessation.
- Support for relationship or whānau issues.
- Other health and social care agencies depending on individual need.

For **people with more significant cognitive impairment who require assistance with daily living**, abstinence (where achievable) is a priority. Additionally it may be useful to make the following referrals.¹⁷²

- Brain injury support – ACC and/or Brain Injury New Zealand.

- An occupational therapist and/or nurse-led aftercare to assist with daily living skills, home aids and adaptations, management of hazards around the home, and meaningful daytime activities.
- Housing support.
- Nutrition and diet support.
- Support for whānau.
- Refer eligible people to the needs assessment and service co-ordination (NASC) service.

Needs assessment and service co-ordination (NASC)

NASC is a government provided service for people with long-term disabilities, mental health challenges, or older people needing age-related support. It is for people who need long-term support to live independently, or to live in a rest home or hospital.

The first step is a needs assessment by the NASC team, who will work with people and whānau to find out what support is needed. People need to be eligible for public healthcare in Aotearoa New Zealand.

The assessor will want to know about:

- a person's health including any diagnosed cognitive impairment
- how they cope with day-to-day tasks and any support they have
- how they're feeling about the future.

There are different NASC teams around the country. Workers can refer on to a local team – each locality may have different referral procedures. To find your local team and process, visit the [**Needs Assessment Service Coordination Association website**](#).

Support whānau needs alongside tāngata whai ora

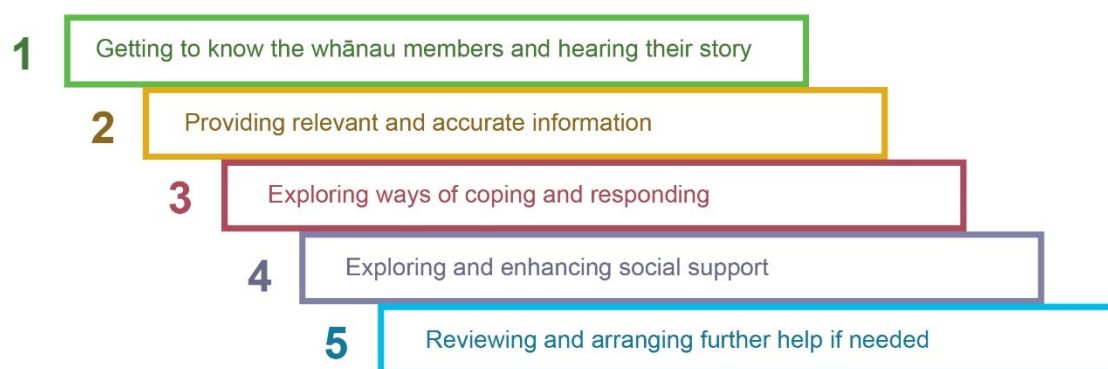
Check whānau support needs

It is important to acknowledge and validate whānau experiences in supporting someone with a cognitive impairment. Listen to their story and identify their support needs.

The 5-Step Method in addiction services is an evidence-based and trauma-informed model for involving whānau (including children) in support.^{173,174} It equips workers to help whānau focus on their wellbeing.

Figure 10 outlines the steps involved.

Figure 10. The 5-Step Method in addiction services



As part of the 5-Step Method, trained workers can use Single Session Family Consultation (SSFC). This is a brief model of whānau engagement and inclusion that aims to clarify how whānau will be involved in support and helps them identify and address their own needs. Specific training is required to effectively use the 5-Step Method and SSFC.

Educate whānau about how to support people at home

When talking to whānau, ensure they have a realistic understanding of their whānau member's situation. This also helps instil a sense of hope about what can be accomplished. This is particularly important for conditions that may get worse over time, like dementia. Explain that much can be done to improve the person's quality of life.¹⁷⁵

When a person is diagnosed with a specific cognitive impairment, explain the cause, prevalence, treatment, and outcomes expected. This helps to avoid blame and shame among whānau, especially when there is stigma attached.

Check what whānau need to confidently support people at home. Connect whānau with practical, social, and emotional support to minimise burnout. Examples of ways whānau can support people experiencing cognitive impairment in a strengths-based way are listed below.^{176,177}

- Aim to give the person as much control as possible over their life and the decisions made.
- Aim to keep stable and consistent routines and structure within the home.
- Focus on what people can do, rather than what they can't.
- Adjust expectations. Remember the phrase “can't, not won't” – this is a good reminder that people are doing their best and if they don't do something you are expecting it may be because they can't, rather than choosing not to.
- Adapt the environment, rather than the person. Look at changes around the home that would make life easier for the person and adapt accordingly, rather than expecting people to do things that are unrealistic. For example, **set up a memory station as outlined earlier**.
- Make time for self-care – it is important whānau look after themselves so they can support others.

Some examples of whānau resources are listed below.

- Health & Disability Commissioner *When Someone You Care About Has a Mental Health or Addiction Issue*¹⁷⁸
- Brain Injury New Zealand *Coping With Brain Injury for Family and Friends*¹⁷⁹
- FASD-CAN *Caregiver and Whānau Support*¹⁷⁶
- Alzheimers New Zealand, *Supporting a Person with Dementia*¹⁸⁰

Review quizzes

This section contains three review quizzes – one on cognitive impairment and its impacts, one on screening, and one on support.

Review quiz: Cognitive impairment and its impacts

1. What are some of the brain's functions?
2. What processes are involved in executive function?
3. All cultures consider cognitive impairment as a deficit. True or false?
4. Cognitive impairment is considered relative to a person's 'usual' context, including what factors?

5. All types of cognitive impairment are permanent. True or false?
6. What are two key causes of cognitive impairment from prolonged high alcohol use?
7. What does cognitive recovery from substance use depend on?
8. Which substance is most consistently associated with cognitive impairment when used at high levels over a long period of time?

Review quiz: Screening

1. Why is a trauma-informed approach necessary for screening?
2. Screening can diagnose cognitive impairment. True or false?
3. What is the most important factor when determining who can safely screen for cognitive impairment?
4. What are three factors that can influence the screening process?
5. What sort of information can be collected to help interpret screening tool results in context?
6. Whānau should not be involved in the screening process. True or false?
7. What are two other referrals (aside from neuropsychological assessment) that could be considered for cognitive impairment?

Review quiz: Support

1. What are some ways that problematic substance use treatment can be adapted to support people experiencing cognitive impairment?
2. What are compensatory strategies?
3. What key types of cognitive training and remediation can help improve cognitive impairment?
4. What lifestyle recommendations support people experiencing cognitive impairment?
5. Why is integrated support beneficial for people experiencing cognitive impairment?
6. What are some examples of integrated support and referrals?
7. What is the 5-step method?

Answers on page 79

Part 3: Practice Examples

This section contains practice examples to support workers to apply information including choosing a screening tool and tailoring support to tāngata whai ora and whānau contexts.

These practice examples are based on case worker experiences - situations and contexts have been changed for the purpose of these guidelines. There is no identifying information and pseudonyms have been used. Each example contains a narrative followed by a plan.

Standard procedures of consent, engagement, risk assessment, and whakawhanaungatanga should be carried out throughout each stage of the process. A collaborative, strengths-based, and culturally responsive approach should be used.

Before any cognitive screening is carried out ensure the person is well informed of the reasons for screening, what results could mean and what they do not mean, and how they can be used to develop support and wellbeing strategies.

Encourage the person to bring a support person, be well rested, wear comfortable clothing, ensure they've had enough to eat or drink, and not be under the influence of substances on the day of screening. If possible, have snacks and hot drinks available.

Practice example 1

Referral

Joshua (he/him) was referred to an AOD service by a probation officer within Ara Poutama Aotearoa, having been involved in a series of 'incidents' in the local township. Most incidents were described as nuisance value, like setting fires in rubbish bins, but Joshua had also been involved in several fights while intoxicated.

A brief AOD assessment was carried out initially and indicated the need for more in-depth information to understand Joshua's situation and needs. With Joshua's permission, he was referred for a comprehensive assessment. Following the comprehensive assessment, the following summary was developed with Joshua.

History

Joshua is a 24-year-old Pākehā male who currently lives with his mother supported by a Jobseeker support benefit. He has previously lived in shared flats, but these have not lasted long, and he describes himself as being unable to live easily with other people. He also describes his relationship with his mother as difficult as she tries to 'control' his behaviour. His childhood was 'happy' until his parents separated when he was 13 years old, at which time he began to start hanging out with mates who were drinking alcohol and smoking cannabis. He is not aware of a whānau history of substance use problems. He has had no long-term relationships and has few friends apart from old school friends he has known since his teens.

At age 14 Joshua was involved, as a passenger, in a motor vehicle accident (MVA) and went through the front windscreen of the vehicle. He was knocked unconscious in the accident for 'a while' and briefly hospitalised for observation, before being discharged home with no follow up. He stated that his interest in school, having been an average student previously, declined after this as he found it difficult to concentrate in class and would get into arguments with other students and teachers. Leaving school at 16 with no qualifications he has had the odd brief period of employment as a labourer but has been unable to sustain work as he finds it difficult to follow instructions and ends up arguing with his employers.

Joshua first drank alcohol occasionally socially with friends at 13, rarely getting intoxicated until he was 14, following the MVA. Since then, he has regularly consumed about 25 standard drinks every Friday and Saturday night. He has drunk to blackout point many times and considers those times a 'good night out'. Joshua also first used cannabis at 13 and has enjoyed smoking about 3 or 4 cones a night since that time. He has also used a range of other substances opportunistically but not regularly. This includes 'pills', synthetic cannabinoids, methamphetamine, LSD, and 'party drugs'.

Joshua keeps good physical health and apart from the head injury in the MVA has never been hospitalised or received any other major injuries. His memory and language skills appeared intact and age appropriate. He describes his mood as low because of his living situation but still enjoys going out with his mates and partying. Apart from the incidents which led to his referral he has had several arrests and convictions for property damage and being unlawfully on premises and is currently on a supervision order and a last warning from the Court.

Assessment

Joshua currently meets the criteria for a DSM-5³³ moderate cannabis and alcohol use disorder. It is possible that he may have mild to moderate cognitive impairment following the MVA that has neither been diagnosed or treated, notably executive function (problems

with impulse control, multitasking, decision making, and planning) and social cognition (finding it difficult to interpret the emotions or intentions of others in new situations). Joshua believes this is likely to be contributing to his impulsivity and difficulty with relationships and employment and he is very keen to find out how to improve his circumstances.

His stated goals are to avoid prison and find work so that he can move out of home. He acknowledges alcohol may contribute to his offending and is interested in learning how to manage this better to avoid trouble. He states cannabis calms him down and he has no interest in addressing this.

Strengths

Joshua's strengths are his insight into his possible cognitive impairment and the role of alcohol in his offending, his stated goals around work and avoiding prison, his physical wellbeing, long-term friendships, and his desire for greater independence.

Plan

1. Whakawhanaungatanga process, assess risk and contextual factors, and develop a good therapeutic relationship with Joshua.
2. Support Joshua to develop safer drinking strategies using concrete MI strategies such as decisional balance and continue to explore the role of cannabis in his life.
3. With his consent and explanation of the purpose, carry out cognitive screening using the BEAT. This considers Joshua's age and apparent executive functioning. Screening should preferably be carried out on a day he has not used excess alcohol or cannabis (such as a Thursday morning) to reduce the impact of these substances on his cognitive results. Share the screening results back with Joshua using a strengths-based approach, considering any potential detrimental impacts on his self-esteem and any history of risk.
4. With Joshua's permission, contact his mother to explore a whānau perspective of the impact of the TBI and if appropriate, introduce her to an online 5-Step group and/or Brain Injury New Zealand for further support.
5. Depending on the outcome of the BEAT screening, explore if further in-depth neuropsychological assessment and support could be accessed via ACC.
6. Support Joshua with developing skills around cognitive and emotional regulation training.
7. Liaise with Joshua's probation officer to ensure coordination of support.
8. Refer and introduce Joshua to Workwise for employment planning and support.

Practice example 2

Referral

Hine is a 46-year-old wahine Māori who has been in an 8 week AOD residential treatment programme for the past 4 weeks. Her case worker has referred her for cognitive screening as she has struggled with the content of the programme and has found it difficult to make changes in her behaviour and attitudes. She is described as being agreeable and pleasant in group and individual work but appears to retain little of the content at next sessions and her self-care, such as showering, clean clothes and grooming, is basic even with reminders.

History

Hine has a 30-year history of heavy alcohol use, consuming at least a bottle of wine most nights since she was 17. She has also smoked tobacco daily since she was 12 and continues to smoke 15 to 20 cigarettes a day despite being on nicotine replacement therapy (NRT) while in residential treatment.⁹ Her other substance use has been rare and limited to when intoxicated or overuse of benzodiazepines prescribed for anxiety on three or four occasions. Based on available records, she has had two hospital admissions related to alcohol and benzodiazepine use. One was for an unintentional benzodiazepine overdose and the other was for possible Wernicke's Encephalopathy, although she was signed out by a friend and medical investigations were unable to be completed whilst in hospital.

This is her third time in residential treatment since she was 32 and, on this occasion, she required support with managed withdrawal before admission. She has previously been prescribed naltrexone and disulfiram with limited success and is currently continuing to take thiamine daily under supervision. She is no longer prescribed benzodiazepines because of overuse and does not appear to have any symptoms of anxiety, post-traumatic stress disorder (PTSD), or protracted withdrawal.

Hine's whānau history is somewhat contradictory as from records she has always stated that her whānau were lovely and that she had a very happy childhood, while it appears she has had many issues often associated with adverse childhood experiences and trauma throughout her life. Hine has been married twice but is currently single and has no children or known close relationships with whānau. She lives in her own home and is supported by a family trust having worked as an accountant up until recently.

⁹ In a residential treatment facility that has dedicated smoking times.

Hine was somewhat confused about the reasons for cognitive screening as she thought she was doing well in 'rehab' but accepted that her memory has not been great lately. After discussion and explanation of what was involved in screening and possible benefits to her, she agreed it would be helpful to find out more about her own functioning.

Strengths

Hine's strengths are her friendliness towards others, financial independence, having her own home, and apparent resilience and high functioning.

Plan

1. Whakawhanaungatanga process to support developing a good therapeutic relationship with Hine, assess risk and contextual factors. Consider using a Māori model such as the Meihana model to guide the process.
2. Before screening ask Hine if she would like any whānau involved. As Hine was initially unsure of the process, check if she needs any support to feel comfortable during the screening process including engaging in te reo Māori. Give her information about screening ahead of time and give her some time to process and go through this. Proceed when she is feeling comfortable and has asked all the questions she had about the process.
3. Check comprehensive assessment notes and kōrero with Hine about any cultural needs or concerns she may have during the cognitive screening process.
4. Considering her age, sex/gender, and alcohol use history either the MoCA or BEAT would be useful screening tools to use. As it is possible from her history and presentation that Hine has significant cognitive impairment, the MoCA is preferred as it is more likely to be recognised by external agencies that may need to be involved in supporting her in the future. Check if a trained kaimahi Māori is available to undertake or support the screening process.
5. Results on the MoCA (17:-2 for trails and cube; -2 for serial 7s; -1 for fluency; -5 for delayed recall; -3 for orientation) indicate that Hine has significantly impaired executive functions and episodic memory. Consider whether other factors might explain these lower results on the MoCA such as feeling anxious or distressed.
6. The screening results when interpreted in context of the information from her comprehensive assessment are at a level that could indicate difficulties managing her activities of daily living (ADLs) without support in the future. If accessible and available, a neuropsychological assessment and/or psychogeriatric assessment could confirm and clarify whether these initial screening results are consistent with a diagnosable cognitive impairment.

7. Share the results of screening back with Hine using a sensitive strength-based approach, considering any potential detrimental impacts on her self-esteem and any history of risk. This might be best done first through kōrero and then in writing, with a support person present if she wishes.
8. Ask Hine about consent to contact whānau. If so, contact whānau to find out more about her background, discuss her current living situation and care for her in the future. Whānau may also be aware if an EPA is in existence as this would help future planning.
9. While remaining in residential treatment Hine is likely to benefit from a more structured approach to support regarding her self-care and cognitive remediation. In particular, external strategies such as routines and monitoring for showering, dressing, and meals will be helpful. Prior to discharge it would be helpful for a staff member to help her set up mobile phone reminders and alarms for these routines and other ADL needs.
10. Prior to discharge from residential treatment a needs assessment via Hine's local NASC team is recommended to ensure she has supports available in her home to remain as independent as possible.
11. The PPPR Act may need to be initiated if Hine continues to lack capacity for self-care but Hine and her whānau should be involved in this process early on and be provided information about it. If Hine returns to excess alcohol use this would likely worsen the existing issues.

Practice example 3

Referral

Jason is a 52 year old of Māori descent who identifies as takapāpui using they/them/ia pronouns. They have been brought to their local CADS service by whānau concerned about their current alcohol and methamphetamine use and worsening behaviour. Following karakia and mihihihi the addiction practitioner identified that they were not from the local area but their mother had previously worked at the local high school and taught whānau members in the past. Throughout the initial assessment Jason sat quietly with their head down and only occasionally nodded when asked to confirm what whānau stated.

History

Whānau describe Jason as a hard worker who has looked after their partner and three children, now adult, well over the years. They have always been a heavy occasional drinker with their rugby mates, having been a competitive regional representative until their late 30's. About 10 years ago they stopped playing rugby following a serious concussion, following which the whānau noticed that Jason's personality changed. The major change for the whānau was that Jason became withdrawn and very reactive, occasionally 'exploding' into verbal aggression and violence with no obvious trigger. The whānau stated that they and Jason's club mates rallied around at this time and cared for Jason until they were more like their old self, though Jason tired easily. Following the recovery from the concussion Jason had begun to use methamphetamine to get going in the morning and to combat fatigue and low energy at work. They also began to drink alcohol more regularly to manage stress. The whānau believe Jason is currently drinking about a dozen stubbies of beer most nights with a litre of spirits on both Friday and Saturday nights. They were unsure how much methamphetamine Jason is using but believe it is in the region of one to two points a day. When asked directly Jason nodded to confirm these estimates.

Over the past year Jason has become more withdrawn and aggressive. As a consequence, they are no longer living with their partner and children and are staying with an older widowed sister, who is struggling to support them. Jason has continued to work in the forestry industry as a skidder operator and still associates with their old rugby club mates to drink. As far as the whānau are aware there have been no issues with their work.

On further discussion with the whānau it became apparent that Jason, who had played as a forward, had received numerous head injuries, but no other concussions, while playing rugby and had also had two motorcycle accidents with blows to the head when younger. Jason has never had any involvement with ACC or mental health services despite these injuries and apparent low mood. Following this the practitioner discussed the possible impact of multiple minor head injuries and concussion and wondered if Jason and the whānau would like to know if that was possibly what was happening for them. Jason and the whānau were relieved to be taken seriously and a plan was made to return in a few days to carry out an initial screen using the ACE-III-NZ. It was explained that the ACE is useful to help understand what type of impact the head injuries may have had over time and could help with exploring further community support. The whānau undertook to bring Jason back on the day agreed and Jason agreed to not use methamphetamine or alcohol on that day.

Strengths

Jason's strengths are their whānau and their ongoing support and care including housing, their willingness to be engaged in the process of cognitive screening, continuing employment, and long-term relationships with mates.

Plan

1. Whakawhanaungatanga process, assess risk and contextual factors, and develop a good therapeutic relationship with Jason. Use Jason's pronouns correctly.
2. Complete comprehensive assessment. Consider using a Māori model such as Meihana or Te Whare Tapa Whā to guide the process.
3. Carry out cognitive screening, ensuring the screening room is quiet and refreshments are available. Check if a trained kaimahi Māori and/or rainbow kaimahi is available to undertake or support the screening process.
4. Share the results of cognitive screening back with Jason using a sensitive strengths-based approach, taking into account any potential detrimental impacts on their self-esteem and any history of risk. This might be best done first through kōrero and then in writing, with a support person present.
5. Use MI strategies to address substance use and consider the use of contingency management strategies to reduce methamphetamine use.
6. Discuss the use of naltrexone and a possible alcohol reduction plan if Jason agrees and suggest the regular use of thiamine to reduce additional cognitive impairment.
7. Discuss any safety issues regarding Jason's substance use and its impact on their work where heavy equipment is used. Collaboratively work on mitigation strategies.
8. Provide Jason and the whānau psychoeducation about head injuries, substance use, and the interaction between these. Also offer this to Jason's rugby club mates.
9. Introduce strategies such as energy conservation and scheduling important cognitive activities when most alert to address post TBI fatigue.
10. Discuss a plan for a healthy lifestyle including food, sleep, and exercise. Explore options like waka ama or taiaha training to support wellbeing and wairuatanga.
11. Introduce the whānau and Jason to a range of internal and external strategies to use to manage aggression and social withdrawal.
12. Repeat cognitive screening if/when substance use is substantially reduced and if necessary, explore with Jason referral for in-depth neuropsychological assessment.

Practice example 4

Referral

Jessica (she/her) is a 36-year-old Pākehā female who lives in a group home and was brought to the local addiction NGO by her case worker following a series of late night 'blowouts' while intoxicated.

History

The case worker had informed the service that Jessica had an intellectual disability, with an IQ of 67, which meant that she was capable of much of her self-care but not without support with more complex cares such as finances and forward planning. A longstanding PPPR Act is administered on her behalf by her older sister who lives in the South Island, delegating care to the agency operating the group home. Her behaviour, playing loud music and singing when intoxicated, was very disruptive to other residents and she often could not recall what she had done the next day. She was described as irritable and difficult to motivate.

Jessica presented as well-dressed and tidy with apparent good social and language skills. She engaged easily with the practitioner, only asking her case worker for clarification of minor points about dates and finances during the comprehensive assessment process. She stated that she enjoyed living in the group home and wanted to stay with her friends there. She acknowledged that her behaviour was loud at times but found it difficult to not drink and smoke cannabis on benefit days as she enjoyed partying with friends outside the house. She was unable to recall how much alcohol and cannabis she usually consumed but did say she had been drinking and smoking with this group of friends for the past 15 years.

When asked about her friends she described them as people she had met at school and their friends. It appeared that the group regularly get together at a local park to drink and smoke on benefit days, usually two or three times a week. Jessica stated that sometimes one or other of the males tries to have sex with her after drinking, which she does not like as she has a partner in the home.

Strengths

Jessica's strengths include her good daily functioning without substance use, financial security, agency support, being in a group home, and having sustained long-term friendships.

Plan

1. Whakawhanaungatanga process, assess risk and contextual factors, and develop a good therapeutic relationship with Jessica.
2. Cognitive screening may be unnecessary as with a recorded IQ of 67 Jessica has known limitations with learning complex information and some of the more complex aspects of self-care. However, there may be other factors that could explain these previous results, that are no longer present in her life. Before undertaking screening and if Jessica gives her consent, request a copy of previous cognitive screens or neuropsychological assessments.
3. If needing greater clarity or historical information seems out of step with current observations, the Mini-ACE could quickly help to identify areas of strength without potentially frustrating or upsetting Jessica.
4. Adapting MI to her cognitive abilities in repeated brief sessions over several weeks with the case worker attending will support Jessica to develop motivation to reduce her substance use and improve her safety and subsequent behaviour in the home.
5. The internal and external strategies for working with cognitive impairment including chunking, repetition, audiovisual, and concrete information sharing along with benefit day phone alerts will all support a harm reduction approach to her substance use.
6. It would also be useful to explore if the agency operating the group home or her sister has a small budget for 'rewards' (like a café voucher) that can be used to encourage Jessica to avoid disrupting the house at night after benefit days. This contingency management approach should be explored and agreed with Jessica and her whānau before being implemented.
7. Explore with Jessica and her case worker other social group activities that do not centre on substance use.

Quiz answers

Review quiz: Cognitive impairment and its impacts

1. Any of – attention, learning, memory, problem-solving, language, motor functioning.
2. Any of – planning, decision making, inhibition of impulses or restraint, concept formation, abstract thinking, mental flexibility.

3. False – it is conceptualised differently across diverse cultures, so it is best to explore each person’s beliefs within their own cultural context.
4. Whānau, culture, social groups, and age.
5. False – some causes are short-term or transient.
6. Fetal alcohol spectrum disorder (FASD; alcohol use during pregnancy), and alcohol induced neurocognitive disorder (which includes Wernicke-Korsakoff Syndrome).
7. Type of substance, how often it is used, how much is used, what time period, age and health, periods of abstinence and reduced use.
8. Alcohol.

Review quiz: Screening

1. Trauma is common among people accessing AOD services. For Māori, a trauma-informed approach recognises the significant impact of colonisation. The screening process can be traumatising or retraumatising for some people if not done right and trauma may explain unexpected reactions to screening questions.
2. False – screening is only able to indicate possible cognitive impairment but only a neuropsychological assessment can accurately diagnose.
3. The training and skill required to safely use and interpret a particular screening tool.
4. Any of – age, culture, medications, substance use, medical conditions, fatigue, mental health challenges, literacy, English comprehension, disability, school/academic history, stress and screening anxiety, low motivation, shyness, physical comfort, understanding (like language), not having aids like glasses or hearing aids with them.
5. Mood and emotions, substance use history, traumatic brain injury, medical conditions, neurodevelopmental conditions, psychosocial functioning and daily living, justice contact, and history of homelessness.
6. False – whānau can be a valuable part of the screening process, but it is up to the person if they want whānau involved and who should be involved.
7. Any of: GP/primary care, neurologist, geriatrician or psychogeriatrician, emergency or crisis services, occupational therapist.

Review quiz: Support

1. Any of – modify session length, allow regular breaks, incorporate culturally appropriate imagery, use multiple methods for information like diagrams and videos, provide a clear structure for each session and use simple concepts (no clinical jargon), encourage people to write down information or provide handouts.
2. Strategies that work around any cognitive impairment that help people in their day-to-day lives.
3. Cognitive bias training, cognitive remediation and rehabilitation, contingency management, and emotional regulation training.
4. Nutritious food, physical exercise or activities that people enjoy, spiritual connections, cultural practices, social activity, and good sleep.
5. People experiencing cognitive impairment are more likely to need to access multiple services and have unmet needs.
6. Housing and employment support, financial support, primary care, allied health like occupational therapy, physiotherapy, dietitians, and speech pathologists, ACC for injuries, community services.
7. An evidence-based approach to identifying and providing support to whānau of tāngata whai ora accessing AOD services

Part 4: Helpful Resources

This section provides links to information, resources, and services relevant to tāngata whai ora, whānau, and workers in AOD settings. Though this list is not exhaustive, many of the listed websites and resources provide further links to other supportive resources or services.

Resources are categorised into the following sections.

- Consumer rights and service standards.
- Workforce development resources including relevant guidelines.
- Community resources and support for tāngata whai ora and whānau experiencing cognitive impairment.
- Making information and resources accessible.

Consumer rights and service standards

Code of Health and Disability Services Consumers' Rights

Establishes the rights of consumers, and the obligations and duties of providers to comply with the Code. It is a regulation under the Health and Disability Commissioner Act.

Privacy Act 2020

The Privacy Act 2020 governs how organisations and businesses can collect, store, use and share peoples' information.

Sector guidance for Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021)

Supports providers to meet the updated Ngā Paerewa Health and Disability Services Standard.

United Nations Convention on the Rights of Persons with Disabilities

Information about the Convention and its implementation in Aotearoa New Zealand.

United Nations Declaration on the Rights of Indigenous Peoples

Information about the Declaration and its implementation in Aotearoa New Zealand to improve outcomes for Māori in areas such as health and housing.

Workforce development resources

Strategic documents – all roles

New Zealand Health Strategy

Outlines the long-term goals to achieve the vision of pae ora.

Te Mana Ola: The Pacific Health Strategy

Outlines the priorities for Pasifika health.

Te Tiriti o Waitangi framework

A tool for the health and disability system to fulfil its stewardship obligations and special relationship between Māori and the Crown.

Whakamaua: Māori Health Action Plan 2020-2025

Outlines the actions required to achieve better health outcomes for Māori.

Knowledge and skill frameworks – all roles

dapaanz code of ethics

Code of ethics for the addiction workforce.

Equitable access to wellbeing framework

A competency framework for working with people with a disability and experiencing mental health challenges or problematic substance use.

Equity of health care for Māori: A framework

This framework guides health practitioners, organisations, and the wider system to achieve equitable health care for Māori.

Let's get real

A values, attitudes, knowledge, and skills framework for all health workers.

Principles for orange

Competencies and implementation framework for integrated support.

Real Skills Plus CAMHS

A framework for working with children and young people.

Real Skills Plus Seitapu

A framework for working with Pasifika peoples.

Pae Tata Pae Tawhiti

A brief and early intervention framework for practitioners in different settings.

Takarangi competency framework

A competency framework to guide effective engagement with Māori.

Training programmes or e-learning – all roles

eCALD

Online and in-person courses to support working with people from Asian, Middle Eastern, and African backgrounds.

Engaging Pasifika

A cultural competency training programme for working with Pasifika peoples.

Groundwork

Helps organisations to understand and apply Te Tiriti o Waitangi by providing self-paced and facilitated workshops and mentoring for those leading organisational transformation.

He Punu Whakaata

Values based programme that enhances therapeutic engagement with Māori.

Intercultural capability

E-learning related to working effectively with people from diverse cultures.

Guides and resources – all roles

5-Step Method

An approach for working with whānau in addiction services.

Bridging the gap

Resource on working with young people experiencing problematic substance use.

Ethnicity matters: A guide to working with ethnic communities

A guide for working with ethnic communities.

Let's get talking toolkit

Seven tools aimed at leaders, managers, therapists, and practitioners across primary and secondary healthcare services.

Manaaki: Mana enhancing and mana protecting practice

Explores mana protecting and enhancing practice in the implementation of the SACAT Act.

Single Session Family Consultation

A model for engaging and meeting with whānau as part of the support process in mental health or addiction services. The website also lists trainers.

Tātou tātou being with people and whānau

A resource on effective engagement with tāngata whai ora and whānau.

Weaving together knowledge for wellbeing

A resource on trauma-informed approaches.

Working with rainbow communities

A practical guide for working with people from rainbow communities. Written for mental health workers but widely applicable.

Yavu: Foundations of Pacific engagement

A report to guide effective engagement with Pasifika peoples.

Language guides – all roles

Language matters

A resource on language and its power when talking about addiction.

Te Mana o te Kupu

A report on stigma, racism, discrimination, and AOD harm – how words influence outcomes.

Te Reo Hāpai – The language of enrichment

A Māori language glossary from a strengths-based and mana-enhancing Māori worldview.

Consumer, peer support, and lived experience (CPSLE) roles

CPSLE competencies

Competencies for the consumer, peer support, and lived experience workforce.

CPSLE strategy

Consumer, peer support, and lived experience strategy.

Tupu a Nuku ki te Wheiao

Alcohol and other drug lived experience workforce framework.

Support workers

Online training for support workers

A range of training options available for support workers in different areas including addiction and physical health.

Supervision for support workers

Evidence updates on supervision for support workers.

Roles assessing for the SACAT Act

CAT-CAT tool

E-learning for authorised officers and responsible clinicians.

Guideline on assessing capacity to make decisions about treatment for severe substance addiction

Guidelines on how to properly assess capacity within a SACAT Act context.

Relevant guidelines

Mental health and addiction screening and assessment

Provides guidance on AOD screening and comprehensive assessment.

Substance withdrawal management: Guidelines for medical and nursing practitioners

How to manage withdrawal. Includes guidance for thiamine supplementation.

Supporting Parents, Healthy Children

Guide for supporting children of people accessing mental health and addiction services.

Te Ariari o te Oranga: The assessment and management of people with co-existing mental health and substance use problems

Provides guidance on assessment and support for co-existing problems.

Workforce Community support for people and whānau

ACC

Resources for people and whānau. Financial support for healthcare after any injury.

ADHD New Zealand

Support services for people with ADHD and whānau.

Asian Family Services

Support for Asian peoples including how to navigate health services, crisis, and emotional support.

Alzheimers New Zealand

Support services and information for people with Alzheimer's disease and whānau.

Autism NZ

Support services and resources for autistic people.

Brain Injury New Zealand

Support services and resources for people with a brain injury and whānau. Local teams can also provide the workforce and tāngata whai ora support with navigating ACC.

Burnett Foundation Aotearoa

Support services for HIV.

Dementia NZ

Support services and resources for dementia.

FASD-CAN

Support services and resources for people with FASD and whānau.

Idea services

Support services for people with an intellectual disability.

IHC NZ

Information about family-whānau liaisons for intellectual disability.

Māori disability support services

Whaikaha webpage that lists disability support specific for Māori.

Mental Health Foundation

Support services and resources for mental health challenges.

New Zealand Disability Support Network

Links to support for any disability. Links to a range of support services specifically for people with a cognitive or intellectual disability.

Parent2parent

Website page for whānau of someone with any disability or impairment.

Stroke Foundation NZ

Support services and resources for people and whānau affected by stroke.

Support for ethnic communities

A directory of support for migrants and ethnic communities (not specific to AOD or disability).

Tagata Sa'ilimalo – disability services

Disability services for Pasifika people and their whānau.

The Hepatitis Foundation of New Zealand

Resources and training for people and health professionals around Hepatitis C.

Whaikaha

Information about how to access support for any disability, including NASC assessments.

Whāraurau

Resources for whānau of people accessing mental health or addiction services.

Accessible communication and resources

Ministry of Health

Webpage about engaging with people with complex communication needs. Links to webpages about using written and printed materials accessibly, accessible presentations and verbal communication, and engaging with people with learning/intellectual disabilities.

People First

Free Easy Read translation service to convert resources. Email makeiteasy@peoplefirst.org.nz to find out more or request a translation.

Guideline summary

- Cognitive impairment is common in AOD settings and requires adaptations to support and treatment.
- Identifying cognitive impairment early is important and can help people get the most out of problematic substance use treatment and support. Failing to provide support for cognitive impairment perpetuates stigma, discrimination, and inequities for tāngata whai ora accessing AOD services.
- The impact of cognitive impairment on people varies based on strengths and adaptations to daily functioning, the importance placed on particular aspects of their lives, and the support available around them.
- Problematic substance use can be both a cause and consequence of cognitive impairment. All substances can potentially cause cognitive impairment but recovery is possible.

- Cognitive screening should be incorporated into AOD service processes. However, the right training and skill is required to use and interpret screening information, as well as determine the right time for screening to take place. Information collected requires interpretation within the person's context including culture.
- A holistic, respectful, trauma-informed, and mana-enhancing approach to screening, assessment, and support is needed. Support should be driven by tāngata whai ora and whānau strengths, priorities, and preferences.
- There are a range of support options for cognitive impairment in the context of addiction that can be adapted to suit people and whānau. These include compensatory strategies, adapting problematic substance use treatment, cognitive training and remediation, and lifestyle approaches.
- Consider environmental changes and how communication can be simplified to enhance understanding and focus.
- These approaches can help to minimise the impacts of cognitive impairment and help people and whānau live well.

Glossary

Abstinence – a period of time when a person does not use a particular substance or substances.

Capacity – a legal term referring to a person’s ability to understand the information necessary for decision making and understand likely outcomes of decisions. This includes having the ability to: understand and retain relevant information; use or weigh relevant information as part of a specific decision-making process; and communicate a decision.¹⁸¹

Cognition – the brain’s ability to collect, integrate, organise, store, and process information.³

Cognitive functioning/processes – functions of the brain such as attention, learning, memory, and problem-solving.³

Cognitive impairment – noticeable and measurable reduced function or difficulties in one or more areas of cognition (relative to a person’s usual function and age).³ A distinction can be made between temporary (or short-term) and long-term cognitive impairment; and between mild, moderate, and severe cognitive impairment.³

Cognitive remediation or rehabilitation – techniques to restore or compensate for cognitive impairment.³

Compensatory strategies – techniques that work around any cognitive challenges.³

Comprehensive assessment – refers to the personalised and individualised information gathering process that is standard in specialist AOD services. A comprehensive assessment gathers information that allows workers to develop an understanding of the social, clinical, and cultural context of a person, their whānau, and their strengths.¹³³

Diverse cultures – refers to the range of cultures in Aotearoa New Zealand.

Harm reduction approaches – aim to help people prevent or reduce potential health, social, or legal harms associated with substance use.¹⁸² ‘Harm reduction’ can mean different things in different contexts, including: policies and legislation; programmes, practices, and approaches that support people who use substances to minimise potential health, social, and legal impacts; and information, tools, and support to help people reduce the risk of potential harms. All meanings emphasise autonomy, compassion, and human rights for people who use substances without coercion, judgement, or discrimination.

Kanohi ki te kanohi – in-person, face-to-face.³⁸

Mana – dignity.³⁷ Mana motuhake means autonomy, self-government, self-determination, independence, sovereignty, and authority.³⁸

Mātauranga – knowledge, wisdom.³⁸

Mihimihi – greeting.³⁸

Mental health challenges – a strengths-based term preferred by people with lived experience that describes experiences from symptoms through to meeting diagnostic criteria for a mental health condition.

Neuropsychological assessment – refers to in-depth assessment specific to cognition and cognitive impairment. A neuropsychological assessment measures and evaluates thinking, mood and behaviour through interview, observation, testing, and other relevant information.³ In Aotearoa New Zealand these can be carried out by clinical psychologists and neuropsychologists.

Prevalence - the proportion of people living with a condition who meet diagnostic criteria at a specific point in time or within a specific time period.¹⁸³

Problematic substance use – patterns of substance use that negatively impact people's lives, including those that do not meet diagnostic criteria for substance use disorders. Aligning with a more strengths-based and recovery-oriented approach, problematic substance use is a preferred term when talking about people's experiences and experienced harm.¹⁸⁴

Relapse – refers to the return to problematic substance use after a period of abstinence. Many people experience (multiple) relapses as part of their recovery journey.

Tāngata whai ora – refers to people seeking wellness.³⁷ Tāngata whai ora Māori is used when specifically referring to Māori. The singular version (person) is tangata whai ora. Tāngata whaikaha refers to disabled people.

Whānau – is used to refer to peoples' support networks including and beyond their immediate families, such as partners, friends, and others in their support network.

Whakapapa whānau is used if referring specifically to genealogical links, while kaupapa whānau refers to those with responsibilities and/or obligations to others based on a shared interest or kaupapa rather than by genealogy.

Whakawhanaungatanga – refers to the process of establishing good relationships.³⁸

Validated – in the context of cognitive screening tools this refers to measuring what the tool is intended to measure (for example, cognitive function).

Appendices

Appendix A : Māori cultural model

This Appendix contains more information about two possible models that can be used as a framework for information gathering with tāngata whai ora Māori. These are:

- the Meihana model
- Te Waka Kuaka.

Meihana model

The Meihana model has been used and evaluated in clinical practice in Aotearoa New Zealand (though not specifically for cognitive impairment), and is shown to increase quality interactions between workers, tāngata whai ora Māori, and whānau.¹¹¹ It can be used by both Māori and non-Māori workers and can also be used to guide cultural supervision.^{111,115} Its use broadens the range of a comprehensive assessment to provide quality support and reduce inequities for Māori.¹¹¹ Table 11 below describes key aspects of the Meihana

Table 11. Aspects and definitions included in the Meihana model^{111,115}

Component	Definition and inclusions
The person	<ul style="list-style-type: none"> • A person with whakapapa Māori.
Whānau	<ul style="list-style-type: none"> • A person's support network. • Permission to include whānau should be sought from the person. • Include whānau in the process if the person wants them involved.
Tinana	<ul style="list-style-type: none"> • Physical health and functioning. • Tinana cannot be considered in isolation from other components in the model. • Assessment of tinana can include physical symptoms, medications, substance use, diet, exercise, and any physical examinations.

<p>Hinengaro</p>	<ul style="list-style-type: none"> • Psychological and emotional wellbeing. • Assessment should include a person’s perceptions and impact on their wellbeing, beliefs, and emotions – as these influence ways in which any symptoms or challenges are discussed.
<p>Wairua</p>	<ul style="list-style-type: none"> • Beliefs regarding connectedness and spirituality. • Identify the beliefs, values, and priorities for the person and whānau that may impact their engagement. Ask about spiritual or religious beliefs, and attachments to people, places, and taonga (treasured items).
<p>Taiao</p>	<ul style="list-style-type: none"> • The physical environment. • Workers can ask questions about the home environment, neighbourhood, and workplaces. This also involves critiquing the clinical environment that the person/whānau might be currently connecting with. For example, adequate seating for whānau.
<p>Iwi katoa (Note: replaced with ratonga hauora in the 2017 version for psychologists. This means access to quality health services)</p>	<ul style="list-style-type: none"> • Services and systems that provide support for people and whānau within the health environment. • This includes assessing if people have had or need access to other services that can improve their broader health context, like social and housing services, and kaupapa Māori services. Explore barriers to accessing services to inform the support plan.
<p>Colonisation</p>	<ul style="list-style-type: none"> • Colonisation, both historic and ongoing, occurs through the loss of land, political reorganisation, and dehumanisation of Māori and communities. • Be aware of any deficit stereotypes about Māori that cause biased decision making, and explore impacts of colonisation like socioeconomic status, employment, and housing.
<p>Racism</p>	<ul style="list-style-type: none"> • Understand the impact of generational, institutional, interpersonal, and internalised racism on a person’s concerns or wellbeing.

	<ul style="list-style-type: none"> • Explore people’s experiences of racism and discrimination in different settings (such as education, health, or community) to help break down barriers for engagement with health services. This requires sensitivity and competency, and critique of any systemic processes that contribute to racism. • Be aware of internalised racism and the impact this can have on people’s self-worth and identity.
<p>Migration</p>	<ul style="list-style-type: none"> • Understanding internal migration of Māori from traditional iwi land to other regions within Aotearoa New Zealand, tracking possible external migration, and establishing where support networks are located. • Explore this to understand a person’s connection to land, levels of support and where support is located, reasons behind migration, and how such events have enabled or become a barrier to health care. If no migration occurred or people do not know about it, explore the available support networks for people and whānau, and where they are located.
<p>Marginalisation</p>	<ul style="list-style-type: none"> • Knowledge of health information which identifies current Māori health status, including health disparities and health gains. • Learn about prevalence and incidence of specific conditions to reduce further marginalisation of Māori.
<p>Ahua</p>	<ul style="list-style-type: none"> • Personal indicators of Te Ao Māori that are important to the person and whānau. • Explore these as opportunities to connect and for meaningful whakawhanaungatanga. This might include exploring personal and whānau use of te reo Māori, wearing of specific taonga, and having an ingoa Māori (Māori name).
<p>Tikanga</p>	<ul style="list-style-type: none"> • Māori cultural practices. • Implement knowledge of cultural practices and integrate into assessment and support. For example, make space for karakia which is essential for protecting and maintaining spiritual, mental, and emotional wellbeing.

Whānau	<ul style="list-style-type: none"> • The relationship, roles, and responsibilities of the person within Te Ao Māori, including whānau, hapū, and iwi. • Identify roles to understand priorities, values, and beliefs, as well as why some whānau might be more active in certain parts of the assessment and support process.
Whenua	<ul style="list-style-type: none"> • Specific genealogical or spiritual connection between the person and/or whānau and land. • Places identified may be a key part of identity for the person and whānau. Explore this to help build the relationship.
Navigation	<ul style="list-style-type: none"> • Navigating the most appropriate course is influenced by all of the other components. The process of plotting a course refers to the person and whānau collaborating with the workers for support.

Te Waka Kuaka

Te Waka Kuaka ('a flock of godwits') is a bilingual cultural needs assessment tool for whānau developed by Dr Hinemoa Elder.³⁶ Te Waka Kuaka helps whānau to identify their needs in order to better navigate their healing journeys, like how godwits organise themselves to navigate their long-distance migrations. The four navigational priorities that form the assessment subscales are helpful in grouping areas of focus: Wairua; Tangata (people); Wā (time); and Wāhi (place).³⁶

Te Waka Kuaka is used as a rehabilitation model at ABI Rehabilitation Services New Zealand.¹⁸⁵ Whānau are asked to rate the importance of statements in the tool in relation to healing. The responses can then be reviewed by the clinical team to see what the needs and priorities are for the whānau. This model acknowledges that whānau mātauranga (family knowledge systems) can greatly improve outcomes for tāngata whai ora Māori.^{36,185}

Appendix B: Pasifika cultural models

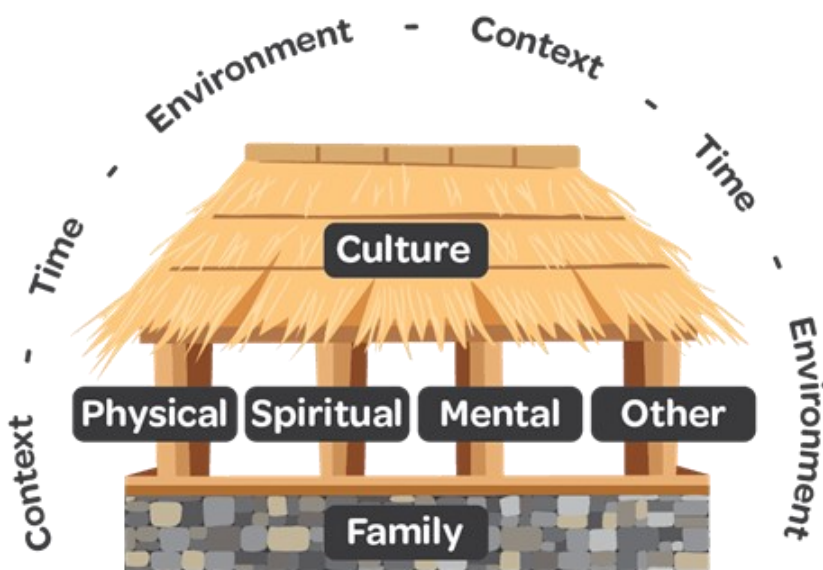
This Appendix contains brief information on two models for Pasifika peoples considering holistic wellbeing and cultural needs. These are the:

- Fonofale model (Samoan and Pan-Pacific)
- Fonua/Fonua Ola model (Tongan).

Fonofale model

Developed by Fuimaono Karl Pulotu-Endemann, the Fonofale model (Figure 11) represents a fale (traditional Samoan House).¹⁸⁶ This model takes into account the different foundations of life which can be explored as part of holistic wellbeing including family, culture, physical, spiritual, mental and other aspects of a person in their context.¹¹⁹

Figure 11. The Fonofale model



From “*The Fonofale Model of Health*”, Mana Services, 2021.¹⁸⁷ In the public domain.

Fonua/Fonua Ola model

The Fonua model is a Tongan framework (developed by Sione Tu’itahi) which originally encompassed five key dimensions – physical, mental, spiritual, community, and environmental.¹⁸⁸ In 2017, the model was revamped to *Fonua Ola*, and now includes six dimensions, see Figure 12. The new model includes ecological and cultural aspects.

The cyclical representation of the model illustrates the interdependence and connection of the network of life (relationship between dimensions and levels of wellbeing) towards the ultimate purpose of wellbeing.¹⁸⁹

Figure 12. The Fonua Ola model



Adapted from “A Latent Profile Analysis of Pacific Health Values”, by Kapeli et al., 2021, *The Journal of Pacific Research*, 21(8), p541. In the public domain.

Appendix C: Mental health screening tools

This Appendix contains brief information about mental health screening tools. It is helpful to screen for mental health challenges as the associated cognitive impairment can resolve if the underlying challenge is well supported.³

A few questions to find out more about mental health challenges include:³

- have you ever been admitted into psychiatric care/mental health facilities?
- have you ever seen a psychiatrist, psychologist, or counsellor for your mental health?
- are you currently using any therapeutic support tools and/or medications to manage your mental health?
- have you experienced hearing voices?

A range of screening tools exist for mental health challenges. These include the Kessler 10 (K10), Modified Mini International Neuropsychiatric Interview (MINI), or PsyCheck.

The K10 is commonly used in Aotearoa New Zealand and is a quick, 10 item scale that may indicate more common challenges like depression or anxiety. The K10 can be self-completed or administered by any worker. **Information about the tool and scoring can be found on the NZGP website.**

PsyCheck has been developed specifically for AOD settings. More information on the MINI and PsyCheck tools can be found on pages 19 to 26 of the **Matua Raki screening and assessment resource.**

Appendix D: Cognitive screening pathway

This Appendix contains a diagram covering a screening pathway for cognitive impairment.

Figure 13. Cognitive screening pathway



Appendix E: Considerations when supporting diverse population groups

This Appendix contains considerations when supporting people from diverse cultures, in contact with the justice system, rainbow communities, older people, younger people, and parents or caregivers.

People from diverse cultures

Aotearoa New Zealand is a diverse country. Although you may not know everything about all cultures, challenge your own biases, respect differences, and be flexible and open to learning about others.^{190,191} Effective support requires the integration of cultural beliefs and values that empower people to live their best life.¹⁹² Some fundamentals to support tāngata whai ora from diverse cultures and build trust include to:

- pronounce names correctly and ask how they want to be addressed (like Dr, Mrs)
- take time to establish and build relationships and trust
- learn about people's background, experiences, and beliefs; and be willing to share about yourself to build a reciprocal relationship
- if appropriate, clarify how the screening, assessment, and support process may impact their Visa or immigration status
- ask what tāngata whai ora and whānau need for their comfort and safety such as their unique cultural practices and ways of engaging
- consider cultural understandings and expectations about whānau roles and how whānau take care of each other, and how this impacts whānau
- use a conversational or storytelling approach to gathering information, as that may feel less intimidating than a direct question and answer approach
- use open-ended rather than leading yes/no questions – in some cultures people may nod or say OK even if that is not what they mean
- consider that cultural whānau dynamics may impact how people answer the questions (especially if whānau are in the room). Offer one-on-one sessions alongside whānau sessions as this may give people space needed to talk without guilt
- ensure physical safety by meeting with a tangata whai ora somewhere convenient, private, quiet, and comfortable for them where possible

- build emotional safety by making sure the tangata whai ora understands who you are and knows you are upholding their rights
- consider different cultural beliefs around decision-making – for example, in some cultures only parents should make decisions for young people, so difficulty making decisions could be a cultural behaviour rather than due to cognitive impairment.
- provide information in a way that each tangata whai ora can easily access and understand (consider language, literacy, and disability)
- recognise and break down any cultural-specific barriers to accessing and engaging with support for cognitive impairment, like whakamā, stigma, shame, 'saving face', and language barriers
- take time to find out if extra support is needed for navigating services. People may have primarily relied on whānau and communities rather than formal treatment in the past. People may also have no prior knowledge of our health system due to moving from overseas. Ensure people are given the time and support needed to understand information and processes. For example, concepts of privacy and consent may be different including how whānau are involved in care and support.

People in contact with the justice or corrections system

People in contact with the justice or corrections system are at higher risk of cognitive impairment and are more likely to use substances problematically.³ Cognitive impairment may be an underrecognised contributing factor to justice contact.³

Māori experiencing problematic substance use are significantly over-represented in the corrections system in Aotearoa New Zealand.¹⁹³ In addition, Māori in corrections have a very high rate of TBI¹⁹⁴, which has often been associated with substance use.⁵⁴ However, with the exception of special treatment units (like the Karaka Unit or Waikeria Prison), there is very limited screening for cognitive impairment.

Tāngata whaikaha (particularly people with an intellectual disability and FASD) are also overrepresented in the justice system.^{195,196} Some people with an intellectual disability may be detained under the *Intellectual Disability Compulsory Care and Rehabilitation Act*.

- People who are currently or have previously been in contact with the justice or corrections system may not want to talk about these experiences and may disengage from treatment if forced to do so.³

- People may have learned strategies to survive within a corrections environment that may not be helpful in other settings.¹⁴⁰ For example, people may find it safer to withhold emotions, personal information, or not participate in group settings. Let the person know you want to support them to feel safe and give them time to adjust. Ask them what they need to feel safe.¹⁴⁰
- Lack of safety or needing time to adjust can be misinterpreted as lack of motivation. Give people time to adjust to new/different rules or expectations.¹⁴⁰
- To help with engagement, focus on a person's ability to live day-to-day, including independent living and supporting eventual return to work or activities they enjoy, including contribution to their whānau or collectives.³

Rainbow communities

People in rainbow communities are at higher risk of cognitive impairment which may be due to experiences like discrimination and trauma.^{10,16} For takatāpui Māori, there is a lack of specific evidence on the prevalence of cognitive impairment. However, this group may be at higher risk due to higher rates of substance use, trauma, mental health challenges and exposure to a range of social factors such as stigma, racism, and violence.¹⁹⁷ A trauma-informed approach is needed, ideally involving kaimahi from the rainbow community where possible.

- When communicating with people from rainbow communities, use gender neutral language such as partner and parent.¹⁹⁸
- Share your pronouns and ask for the person's pronouns. Gender identity can't be assumed from how someone looks.¹⁹⁸
- Check if people have different ways they would like to be referred to in private versus public situations (like one-on-one sessions versus a group session).
- Have resources tailored to rainbow communities to show inclusivity.
- Kaupapa whānau are often significant support networks for rainbow identifying people. Treat kaupapa whānau with the same respect as whakapapa whānau.

Sex and gender differences from substance use

- Females tend to experience health related problems from alcohol earlier than males, even for similar amounts of use.⁴⁵ Females also show different patterns and severity of cognitive impairment from alcohol.⁴⁵
- The effects from other substances can also differ. For example, adolescent females may have greater risk of brain structural abnormalities than adolescent males from regular cannabis use.¹⁹⁹ For stimulant use, females may be more susceptible to their reinforcing (rewarding) effects.¹⁹⁹

Older people

Older people are more likely to experience cognitive impairment due to conditions of ageing like dementia. For older Māori, the Māori Assessment of Neuropsychological Abilities (MANA) tool has been developed to screen for cognitive impairment.²⁰⁰ Conditions such as *mate wareware* or dementia may develop earlier in Māori.^{6,22} The MANA tool was specifically developed to address the cultural needs of older Māori with cognitive impairment.¹⁰

Older people are more likely to experience greater cognitive impairment with lower levels of alcohol use.³ There is an increased risk of overdose among older people due to age related changes in how alcohol and substances are processed.²⁰¹

When communicating use a slower pace, speak louder, and adapt for age-related impairments.²⁰²

- Respect and acknowledge people's seniority and expertise gained through life experiences.
- Conditions of ageing (like dementia) may make speaking their language difficult, check what support they need to understand information.
- Link older people with grief services if needed as older people may have limited *whānau* for support.²⁰²
- Check for a history of falls. Older people are more likely to be taking multiple medications and/or have multiple medical conditions that can compound cognitive impairment (falls can be a side effect).²⁰³ A history of falls can be associated with TBI.⁴³ People who are older at the time of a TBI tend to have worse outcomes.³

¹⁰ [More information about the MANA can be found on the New Zealand Dementia Foundation website.](#)

- Ask about eating habits and any related difficulties such as difficulty swallowing. There is a higher risk of malnutrition among older people which can impact cognitive function.^{146,204}
- Teach cognitive rehabilitation and remediation which can improve activities of daily living in mild cognitive impairment and early stage dementia.²⁰⁵
- Encourage physical and social/community activity as it is associated with better cognitive functioning.²⁰⁶
- Consider usual or normal cognitive changes with age rather than assuming all changes are due to a specific condition.²⁰⁷
- If available, link people to services that are specific to older people.

Younger people

Young people are at higher risk of cognitive impairment from substance use due to the developing brain. Substance use during adolescence can have more significant and long-term impacts.⁴⁴

Higher risk youth in particular are those that have experienced homelessness or are in contact with the justice system.^{3,5,21,208} Rainbow communities are more likely to have experienced trauma, with young rainbow people at highest risk.^{26,126} Young people in contact with the justice system may be more likely to experience a range of learning difficulties.³

A TBI during childhood or adolescence may impact brain development (and TBI is more common among Māori children and adolescents compared to non-Māori).^{54,209} People who started using cannabis when young, or who use regularly (daily or almost daily) during adolescence can have more significant and lasting impacts on cognitive function.^{3,101}

- While whakawhanaungatanga is important for everyone, it is particularly important for young people.²¹⁰ Refer to *Te Tapatoru: A Model of Whanaungatanga to Support Rangatahi Wellbeing* for a model that can be used with Māori rangatahi (youth).²¹⁰
- Young people may need extra support or adaptations to treatment to enhance engagement.²¹¹ This includes specific tailored support for Māori and Pasifika peoples who have a younger age profile.^{118,212}
- Consider a young person's developmental stage when screening for cognitive impairment. Continuing brain development can affect functions like decision making.²¹³

- Reassure young people that their information is confidential and that you are not judging them on the information they share or the results of their screening.²¹³
- Consider the need to balance relationship dynamics with parents when involving whānau, especially for adolescents who might be experiencing changes in these relationships.
- Link people to services specifically for younger people where available.

Parents and caregivers

- Check if people experience challenges with caregiving responsibilities and need specific support.
- If children are accompanying parents, they can sometimes become bored and restless during processes like cognitive screening. This can be distracting for parents and affect screening results. Check if parents need specific childcare support to engage in the screening process.
- Children may need specific support for their own wellbeing as part of the wider whānau. The **Supporting Parents Healthy Children** guideline outlines how to provide support to parents and children in mental health and addiction services.⁵³

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