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Older Persons' Mental Health: Up to Half the Residents, and the Word 'Depression' Appears Nowhere in 184 Pages

Programme descriptor

Programme	Older Persons' Mental Health (OBA-OPM-2026)
Version	1.0, issued 28/09/2026. Review due 28/03/2027.
CPD	7.5 hours, MEASURED from the content
For	Registered nurses, enrolled nurses, care staff and team leaders in residential aged care, home care and acute settings

READ THIS BEFORE THE TITLE

The title states a count. THE ABSENCE OF THE WORD IS NOT THE ABSENCE OF THE DUTY, and this count is NOT evidence that nothing is required of you. Action 5.5.6 of the strengthened Aged Care Quality Standards requires the provider to respond to deterioration in a person's mental health and to distress, self-harm and suicidal thoughts. Action 5.6.1 requires identifying and responding to the needs of people with delirium, dementia and other cognitive impairment, and being alert to deterioration. Action 3.2.5 requires workers to identify deterioration in mental health and cognitive function and to ESCALATE IT. The obligation is there - it is written as 'mental health' and 'cognitive impairment', which is why you will never find it by searching for the diagnosis.

The finding this programme is built on

THE FINDING

UP TO HALF THE PEOPLE LIVING IN AUSTRALIAN RESIDENTIAL AGED CARE ARE THOUGHT TO EXPERIENCE DEPRESSION. Across the two documents that between them define what an aged care provider must DO and what it must COUNT - the strengthened Aged Care Quality Standards (49 pages) and the National Aged Care Quality Indicator Program Manual (135 pages) - THE WORD 'DEPRESSION' APPEARS ZERO TIMES. Not once in 184 pages. 'DELIRIUM' appears TWICE in the Standards and ZERO times in the Manual. In the Manual, 'dementia' and 'mental health' are ZERO as well - against 'ANTIPSYCHOTIC' 34 TIMES, which is one of the fourteen mandatory quality indicators.

AND THE SENTENCE THAT TRAVELS WITH IT, EVERY TIME

- AND HERE IS THE SENTENCE THAT TRAVELS WITH THAT COUNT, EVERY TIME IT IS SAID OUT LOUD. THE ABSENCE OF THE WORD IS NOT THE ABSENCE OF THE DUTY, and this

count is NOT evidence that nobody requires anything of you. Action 5.5.6 requires the provider to respond to deterioration in a person's mental health and to distress, self-harm and suicidal thoughts. Action 5.6.1 requires identifying and responding to the needs of people with DELIRIUM, DEMENTIA and other cognitive impairment, and BEING ALERT TO DETERIORATION. Action 3.2.5 requires workers to identify deterioration in mental health and cognitive function and to ESCALATE IT. The obligation is there. It is written as 'mental health' and 'cognitive impairment', which is why you will never find it by searching for the diagnosis.

- The practical consequence is the one that matters on a shift. NOTHING IN THE MANDATORY DATA WILL FLAG THESE THREE FOR YOU. Pressure injuries are counted. Falls are counted. Weight loss is counted twice. Antipsychotics are counted. Depression, delirium and dementia are counted NOWHERE - so no report will arrive, no dashboard will turn red, and no indicator will trigger a review. THE ONLY DETECTION SYSTEM FOR ALL THREE IS A PERSON NOTICING A CHANGE AND SAYING SO, and that person is usually whoever sees the resident every day.

The two counts, side by side

Strengthened Aged Care Quality Standards, November 2025 - 49 pages

Term	Occurrences
depression	0
delirium	2
dementia	11
cognitive	9
mental health	7
antipsychotic	0
wellbeing	13

National Aged Care Quality Indicator Program Manual, Part A, November 2025 - 135 pages

Term	Occurrences
delirium	0
depression	0
dementia	0
mental health	0
antipsychotic	34
restrictive practice	46
quality of life	53
cognitive	15 - every one about a QUESTIONNAIRE

AND WHAT THESE COUNTS DO NOT MEAN

- THEY DO NOT MEAN NOTHING IS REQUIRED. Actions 3.2.5, 3.2.6, 5.5.6 and 5.6.1 of the Quality Standards all bind, and Action 5.6.1 names delirium and dementia explicitly. The duty is written as 'mental health' and 'cognitive impairment'.
- AND THE FIFTEEN 'COGNITIVE' MENTIONS IN THE MANUAL WERE CHECKED ONE BY ONE. Every single one is about whether a resident can fill in a survey - self-completion, interviewer-facilitated completion, or proxy completion of the consumer experience and quality of life instruments. In 135 pages, cognitive impairment appears ONLY as a reason somebody cannot answer a questionnaire. It never appears as something to be recognised, assessed or responded to.

What you will be able to do

Module 00 - Orientation: One Hundred and Eighty-Four Pages, and the Word Appears Nowhere (22 min)

This programme starts with a count rather than a definition, because the count explains why so much of this goes unnoticed. Up to half the people living in Australian residential aged care are thought to experience depression, and the two documents that define what a provider must do and what it must count do not contain the word. This module states the count, states the counterweight, and says what the programme will and will not do.

- State the count, and name the two documents it was taken from
- Explain why the absence of the word is not the absence of the duty
- Name the three Quality Standards actions that bind despite the count
- Say what follows on a shift: no report, no dashboard, no trigger

Module 01 - The Three Ds: Fifteen Features, and Two of Them Do Most of the Work (30 min)

Australian general practice compares delirium, dementia and depression across fifteen features. This module gives all fifteen, verbatim, and then does the more useful thing: it names the two rows that separate the three fastest at a bedside, and the one condition without which none of the fifteen means anything.

- Use the fifteen-feature comparison of delirium, dementia and depression
- Name the two features that discriminate fastest, and say why
- State what each of the three does through the course of a day
- Explain why the comparison is useless without a known baseline

Module 02 - Delirium: The Only One of the Three That Is Expected to Resolve Completely (26 min)

Delirium is the one of the three with a deadline on it. It is a symptom of an underlying physical cause, recovery is expected to be complete if that cause is found and corrected, and it is preventable in more than a third of older people with risk factors. It is also missed constantly - and this module ends with a count showing exactly who the national guidance was written for.

- State what delirium is, using the standard's own definition
- Explain why delirium is different in kind from the other two conditions
- List the risk factors the standard names, including the one that is another D
- Name the eight quality statements of the Delirium Clinical Care Standard

Module 03 - Hypoactive Delirium: The Quiet One, More Often Missed, With the Worse Prognosis (24 min)

One sentence in the Delirium Clinical Care Standard reverses the way most wards and most homes allocate attention: hypoactive delirium is more common in older people, is often missed, and has a worse prognosis than the other subtypes. This module is about the delirium that does not shout, what it actually looks like on a shift, and why the words used in handover make it invisible.

- State the three subtypes of delirium and which is most common in older people
- Quote what the standard says about hypoactive delirium's prognosis
- Describe what hypoactive delirium looks like in a residential setting
- Recognise the handover language that conceals it

Module 04 - Dementia: Timely Recognition Is Required of You. Diagnosis Is Not. (26 min)

Of the three conditions, dementia is the one the aged care Quality Standards name most often - eleven times in 49 pages - and what they require is TIMELY RECOGNITION, a system, training and a connection to specialist services. None of that is diagnosis. This module separates the two tasks, gives the definition's own requirements, and names the cognitive instruments without stating a single score.

- Distinguish recognition from diagnosis, and say which is required of a worker
- Name the Quality Standards actions that deal with dementia
- State what a dementia diagnosis requires beyond memory changes
- Explain why delirium must be excluded before dementia can be diagnosed

Module 05 - Depression in Older People: Under-Detected, and Not a Normal Part of Ageing (26 min)

Depression is the condition this programme was built around, because the numbers and the silence are so far apart. Up to half the people in residential aged care are thought to experience it; it is named zero times in 184 pages of aged care regulation; and the reason it is missed has been written down explicitly - its symptoms are mistakenly attributed to normal ageing.

- State the prevalence figures and their source and date
- Quote the mechanism by which depression in older people is missed
- List what is NOT a normal part of ageing
- Explain pseudodementia, and why it matters in both directions

Module 06 - All Three at Once: Delirium on Dementia, and Depression on Top of Both (24 min)

The neat three-column table implies a single right answer. Real residents do not cooperate: dementia raises the risk of delirium, depression raises it too, depression both mimics and accompanies dementia, and delirium is hardest to see in exactly the people most likely to have it. This module works five recurring situations and gives one rule that handles most of them.

- Explain why the three conditions are not mutually exclusive
- State the rule for a person with dementia who suddenly becomes worse
- Recognise a decline whose speed fits neither delirium nor dementia
- Describe what changes when a new or altered medicine is in the picture

Module 07 - Screening: What a Tool Is For, and What a Score Is Not (24 min)

Screening is the difference between a condition being present and a condition being known about: where screening rates were higher, recognition was five times higher. This module says what a screening tool actually achieves, when to use one, what to check before you do, and why this programme states no score for any instrument.

- State what a screening tool does, and what a positive score is not
- Quote the effect of screening rates on recognition rates
- Say what the 4AT is, what it costs and what it requires
- Name the moments at which screening should happen

Module 08 - Noticing, Describing and Escalating a Change in Mental State (24 min)

This is the module that is entirely yours. Nothing in the mandatory data will flag these three conditions, so the whole detection system is a person noticing a change and saying so. Noticing is a skill, describing it is a different skill, and escalating it has a form of words that works and a form of words that does not.

- Observe the six things that make a report useful
- Write a change rather than a label
- Explain why a note without a time has removed the defining features of delirium
- Use one escalation sentence, and say why the wording matters

Module 09 - Person-Centred Responses, and the Medicine That Gets Counted Instead (24 min)

Escalating is not the end of the shift. This module is about what happens in the hours between noticing and review: the reversible obstacles that account for most of what gets called behaviour, what the Delirium Clinical Care Standard asks for around the person and the family, and the uncomfortable symmetry that the consequence of missing all this is measured nationally every quarter while the conditions themselves are measured nowhere.

- Apply six person-centred responses in order, starting with the reversible
- Explain why most of what is called behaviour is an unmet need
- State what quality statement 7 says about antipsychotics and delirium
- Describe the relationship between the antipsychotic indicator and the three conditions

Module 10 - What Is Not Yours: Diagnosis, Prescribing, and the Mental Health Acts (22 min)

This module draws the line, and it is the one most likely to keep somebody out of trouble. Seven tasks in this subject belong to somebody else, and three of them are refused outright here - not because they do not matter but because the sources that would settle them were not retrieved, or because they are a different legal system entirely. Eight things are yours, and together they are the entire detection system.

- State seven tasks in this subject that are not a worker's
- State eight that are, and say why they are enough
- Explain why this programme says nothing about any Mental Health Act
- Say what this programme refuses to state, and why refusing is the correct answer

How it is assessed

Summative assessment	60 items, 80% to pass, 2 attempts. Every item answerable from the programme.
Knowledge checks	One per module, formative, no attempt limit, rationale on every option including the wrong ones.
Case studies	Constructed. Nobody is named and no service is real.
Certificate	7.5 CPD hours on completion.

How the CPD figure was measured

	Measured
Module 00 - Orientation: One Hundred and Eighty-Four Pages, and the Word Appears Nowhere	22 min
Module 01 - The Three Ds: Fifteen Features, and Two of Them Do Most of the Work	30 min
Module 02 - Delirium: The Only One of the Three That Is Expected to Resolve Completely	26 min
Module 03 - Hypoactive Delirium: The Quiet One, More Often Missed, With the Worse Prognosis	24 min
Module 04 - Dementia: Timely Recognition Is Required of You. Diagnosis Is Not.	26 min
Module 05 - Depression in Older People: Under-Detected, and Not a Normal Part of Ageing	26 min
Module 06 - All Three at Once: Delirium on Dementia, and Depression on Top of Both	24 min
Module 07 - Screening: What a Tool Is For, and What a Score Is Not	24 min
Module 08 - Noticing, Describing and Escalating a Change in Mental State	24 min
Module 09 - Person-Centred Responses, and the Medicine That Gets Counted Instead	24 min
Module 10 - What Is Not Yours: Diagnosis, Prescribing, and the Mental Health Acts	22 min
Programme reading	90 min
Case study assessment	34 min
Summative assessment	52 min
TOTAL	448 min = 7.47 hours
CLAIMABLE	7.5 CPD hours

ROUNDED TO THE NEAREST HALF HOUR, INCLUDING DOWNWARDS

448 minutes is 7.47 hours, which rounds to 7.5. The figure is DERIVED, not chosen - which is the whole reason it can be checked. If a higher figure is wanted, the answer is to add content, never to change the number.

What this programme will not do

	Why
ANY SCREENING SCORE, ITEM OR CUT-OFF, FOR ANY INSTRUMENT	THE PRIMARY ONE. The 4AT scoring page 404'd and no other instrument was retrieved. A threshold recalled from a slide is exactly the error a validated tool exists to prevent.
A DIAGNOSIS OF DELIRIUM, DEMENTIA OR DEPRESSION IN ANY INDIVIDUAL	The standard is explicit: the diagnosis is determined and documented by a clinician working within their scope of practice. This programme teaches recognition and escalation.
ANY MEDICINE RECOMMENDED, DISCOURAGED OR NAMED AS A TREATMENT FOR AN INDIVIDUAL	Prescribing is not a nurse's decision, and nothing in this programme is a prescribing instruction. The cautions quoted are quoted to explain why observation matters.
A SUICIDE RISK ASSESSMENT, OR ANY SCALE, SCORE OR CATEGORY OF RISK	Establishing intention, plan, means and time frame is a clinical assessment. Receiving a disclosure and escalating it the same day is what is taught.
THE COUNT PRESENTED AS MEANING NOTHING IS REQUIRED, OR THAT AGED CARE DOES NOT CARE	The absence of the word is not the absence of the duty. Actions 3.2.5, 3.2.6, 5.5.6 and 5.6.1 all bind, and the response to the count is to notice and escalate, not to shrug.
ANY POWER, PROVISION OR PROCESS UNDER A MENTAL HEALTH ACT	Eight jurisdictions, none read. Detention, transport and involuntary treatment are a different system entirely.
A RESTRICTIVE PRACTICE AUTHORISED, RECOMMENDED OR DESCRIBED AS A RESPONSE	Restrictive practices have their own law, authorisation and consent requirements, and they are a separate programme.
BEHAVIOUR DESCRIBED AS DELIBERATE, ATTENTION-SEEKING OR MANIPULATIVE	Most of what is called behaviour is an unmet need expressed with the communication the person has left.
A NAMED INDIVIDUAL, REAL SERVICE OR REAL FAMILY IN ANY SCENARIO	Every scenario is constructed and nobody is named.
A VERDICT ON WHETHER ANY SERVICE OR PRACTITIONER COMPLIES WITH ANYTHING	Professional development, not a compliance sign-off.

AND WHAT THIS PROGRAMME STATES ABOUT EVERY INSTRUMENT IT NAMES

- AND THIS PROGRAMME STATES NO 4AT ITEM, NO SCORE AND NO THRESHOLD - deliberately. The tool's user guide and scoring page RETURNED HTTP 404 to this build on 28/09/2026, so nothing about its scoring was read. It takes two minutes, it needs no training and it costs nothing: DOWNLOAD THE CURRENT VERSION AND USE ITS OWN SCORING. A threshold half-remembered from a slide is exactly the failure mode a validated tool exists to prevent.
- The same applies to every other instrument named anywhere in this programme - the GDS, the Cornell Scale, the PAS, the DASS21, the K10, the SMMSE, the GPCOG, the clock drawing test, the RUDAS, the KICA and the modified KICA. NONE was retrieved for this build. They are named because an authoritative Australian source names them, and NO ITEM, NO SCORE AND NO THRESHOLD IS STATED FOR ANY OF THEM.
- And a score is never a diagnosis. The Delirium Clinical Care Standard: 'a positive score on a screening tool is not a diagnosis, but a prompt for further assessment'.

And the eleven things it did not read

Not read	Why	What follows
The 4AT's items, scoring and threshold	Scoring page returned HTTP 404	SO NO 4AT SCORE OR CUT-OFF IS STATED ANYWHERE in this programme.
The GDS, the Cornell Scale, the PAS, the DASS21 and the K10 themselves	Named by the Silver Book, not retrieved	No item, no score and no threshold is stated for any of them.
The SMMSE, GPCOG, clock drawing test, RUDAS, KICA and modified KICA themselves	Named via the RACGP Red Book, not retrieved	Named only. No scoring is stated.
The Confusion Assessment Method and the AMTS	Named in the standard, not retrieved	Named only.
The Aged Care Act 2024 and the Rules 2025, provision by provision	Not opened	The finding is scoped to the QUALITY STANDARDS and the QI PROGRAM MANUAL by name and page count, and claims nothing about the Act.
The NSQHS Standards themselves	Not retrieved	Actions 1.27b, 1.28, 5.29, 8.05, 8.06, 8.07 and Advisory AS19/01 are taken from Appendix D of the Delirium Clinical Care Standard.
AIHW, Depression in residential aged care 2008-2012	Not opened	The 10-15% and up-to-50% figures are quoted AS THE SILVER BOOK STATES THEM, and the underlying data period is 2008-2012.
NHMRC Clinical Practice Guidelines and Principles of Care for People with Dementia (2016)	Named, not retrieved	Nothing is attributed to it.
Any Mental Health Act, in any State or Territory	Deliberately not read	No power, provision or process under any of them is stated anywhere.
Any medicine's dose, indication or interaction	Out of scope	Nothing is prescribed, recommended or named as a treatment for an individual.
Your service's own screening schedule, escalation pathway and forms	Not knowable from here	The documents that actually govern your shift.

WHERE THE LINE IS

WHERE THE LINE IS. The word counts, the quoted statements, the prevalence figures, the fifteen-feature comparison and the named Quality Standards actions all come from documents read in full on 28/09/2026 and listed in the syllabus. The practical suggestions - the escalation sentence, what to write in a note, what the quiet change looks like, the order of person-centred responses - are OBA'S TEACHING and are labelled as such wherever they appear.

SCOPE

This programme is professional development. IT IS NOT CLINICAL ADVICE AND IT IS NOT A DIAGNOSTIC COURSE. It teaches RECOGNITION, DESCRIPTION and ESCALATION of a change in an older person's mental state. It states NO screening score, item or cut-off for any instrument - the 4AT scoring page returned HTTP 404 and no other instrument was retrieved. It does not diagnose delirium, dementia or depression in anybody, does not recommend, name or discourage any medicine for any individual, does not teach suicide risk assessment, and says NOTHING about any Mental Health Act or any restrictive practice authorisation. Confirm every procedure with your own organisation's policy and your jurisdiction's law.