RACGP
Royal Australian College of General Practitioners

Healthy Profession.
Healthy Australia.

10 July 2026

Dementia Guideline development group
Monash University

Via email: dementia.guidelines@monash.edu

Dear Guideline development group,

Re: Public consultation for the review and update of the Dementia clinical practice guidelines and principles of care

The Royal Australian College of General Practitioners (RACGP) thanks Monash University for the opportunity to provide feedback on the Dementia clinical practice guidelines and principles of care (the Guidelines). The RACGP acknowledges the significant work undertaken in developing the Guidelines including the comprehensive evidence synthesis. Our feedback has been structured to align with the sections outlined in the Guidelines, with comments provided where applicable.

General practitioners (GPs) are often the first point of contact for individuals experiencing cognitive concerns and play a central role in the recognition, diagnosis, management and coordination of dementia care. This includes clinical assessment and identifying changes in cognition and function, facilitating access to appropriate services, and provide ongoing, person-centred support to patients, carers and families. GPs also coordinate multidisciplinary care, support care planning and referrals, and ensure continuity of care in response to the patient's changing needs over time.

1. Key considerations

The RACGP's feedback is guided by the following key considerations:

- Successful implementation will depend on equitable access to services, appropriate funding, specialist support, clearly defined care pathways, and guidance that reflects the realities of clinical practice.
- Some areas of the Guidelines have important implications for general practice and primary care and will require clear pathways, practical guidance, and appropriate support.
- A living guideline approach would support usability, consistency, and ongoing relevance.

2. Overall comments

2.1 Implementation and system considerations

Several of the recommendations rely on services that are unevenly available, costly, or dependent on specialist input, including advanced diagnostics, rehabilitation services, and multidisciplinary supports. Without clear pathways, funding and adequate system supports, implementation may be inconsistent across settings.

Access challenges are not limited to rural and remote areas. Cost, workforce availability, and service distribution are also experienced in outer metropolitan areas, particularly in communities with higher levels of socioeconomic disadvantage. These factors should be acknowledged, as they affect how care can be delivered in practice.

Wording such as 'consider offering' may create expectations that cannot be met where services are unavailable or unfunded. The Guidelines appropriately specify where some services are not currently Medicare-funded, and consistent application of this approach throughout would support clearer expectations for implementation.

The Guidelines should acknowledge that some aspects of care depend on specialist services and support, and GPs may not be able to independently initiate, interpret or manage these pathways in the absence of clearly

defined referral processes and access to specialist input. Consideration should also be given to consultation time constraints in general practice, administrative requirements, and the complexity of coordinating referrals and supporting patients, carers and families in routine practice.

2.2 Existing guidelines and resources

The RACGP *Guidelines for preventive activities in general practice (Red Book)* and the National Guide to preventive healthcare for Aboriginal and Torres Strait Islander people include recommendations and guidance on brain health, cognition, and dementia for GPs and primary healthcare teams. Consistency with these existing guidelines should be considered where relevant, as they may provide useful supporting information for clinicians using the Guidelines.

The RACGP aged care clinical guide (Silver Book) includes guidance on the assessment and management of dementia and may be a useful additional resource for clinicians, and resources such as the Clinical practice guidelines for deprescribing in older people and the Best Practice guide to cognitive impairment and dementia care for Aboriginal and Torres Strait Islander people attending primary care, may also be helpful.

2.3 Content gaps

The Guidelines do not cover pragmatic tasks of dementia prevention and management in general practice, including cardiovascular risk factor management, lifestyle interventions, vaccinations, and the use of structured care frameworks such as chronic condition management plans and health assessments. While recognising the need to balance length, inclusion of this content would improve relevance to routine primary care.

The Guidelines does not address frailty, despite it being a common comorbidity in people living with dementia and a significant risk modifier of outcomes, including loss of independence and hospitalisation. Frailty can be managed and slowed through interventions such as nutrition, medication review, exercise and social prescribing, many of which are conditionally recommended elsewhere in the Guidelines.

Inclusion of content relating to the investigation of cognitive change, including blood testing and radiological work-up will be helpful for practitioners.

There is no guidance on clear referral pathways and limited guidance on how or when to offer cognitive testing as a screening approach (this may not be within the scope of the Guidelines).

3. Risk reduction (Section 7 of the Guidelines)

3.1 Multi-domain interventions in people with mild cognitive impairment (Section 7.1 of the Guidelines)

While current evidence is limited and does not demonstrate a clear long-term reduction in incident dementia, multidomain interventions are important as they address a range of risk factors which may contribute to mild cognitive impairment (MCI). The accompanying good practice statement is useful in supporting clinicians to discuss these interventions with patients, recognising that the evidence is often uncertain and complex.

Significant concerns remain regarding equitable implementation. Access to appropriately skilled practitioners is limited, and there are no Medicare Benefits Schedule (MBS) funded pathways to support these interventions. As outlined in the evidence, these interventions often require ongoing support to be effective, which requires substantial resources that are not currently available. Investment in accessible, well-resourced support services with adequate funding will support primary care practitioners in recommending these interventions.

4. Diagnosis and therapies (Section 8 of the Guidelines)

4.1 Blood-based biomarkers in the diagnostic workup of a person with suspected Alzheimer's Disease dementia (Section 8.1 of the Guidelines)

GPs will provide advice and discuss the potential benefits, limitations and costs of blood-based biomarker testing with patients and refer for testing where appropriate. While these tests have the potential to improve equity, these are currently offered as private pathology services and costs can be prohibitive. Tests for blood-based biomarkers are approximately $200-250 and tests for confirmation of diagnosis, including testing of cerebrospinal fluid from lumbar puncture (which are more likely to be undertaken within specialist settings) is approximately $350. As such, access to blood-based biomarker tests remains limited and appropriate MBS funding and the development of accessible pathways will need to be available to ensure equity as uptake will depend on financial affordability and geographic accessibility.

While the guideline notes the need for increased specialist capacity, consideration should also be given to the role of primary care in facilitating appropriate access to tests. With appropriate education and support, GPs will be well placed to use these tests as part of the diagnostic pathway, helping to streamline referrals, reduce unnecessary specialist demand, and support more timely access to care. GPs' longitudinal relationships with patients and understanding of their medical and family context also place them in a strong position to support informed decision-making about testing.

The inconsistency between the rationale that testing should not be undertaken where it does not change clinical management, and the narrative on the value that individuals with lived experience place on knowing their diagnosis should be more clearly addressed. A confirmed diagnosis may influence individual decision-making, including advance care planning and engagement with support services, and therefore represents a meaningful change in management.

3.2 18-Fluoro-deoxy glucose Positron Emission Tomography (FDG-PET) in the diagnostic workup of a person with suspected dementia or dementia subtype (Section 8.2.1 of the Guidelines)

Access to FDG-PET remains limited and is often constrained by cost and availability, making it largely confined to specialist settings. The Guidelines should clearly acknowledge these limitations and avoid creating expectations that these investigations are readily accessible.

3.3 Referral for a practical driving assessment at the time of diagnosis of dementia (Section 8.4 of the Guidelines)

Expectations and requirements regarding clinician and driver responsibilities, including reporting responsibilities, vary across jurisdictions. For this recommendation to be implemented effectively, it will need to be incorporated into Austroads guidance to support greater national consistency.

Linking a diagnosis of dementia more directly to a practical driving assessment has implications for GPs, given their role in diagnosis and management. As MCI does not warrant a conditional licence, determining when an individual transitions from MCI to dementia will require clinical judgement. Linking this decision to a practical driving assessment may make diagnostic decision-making more challenging, and increase reliance on specialist referral to confirm a diagnosis. This may affect the timeliness of diagnosis and access to driving assessment. The use of the term ‘consider’ provides some flexibility, however, the practical implications are still significant.

Greater clarity is needed on when a practical driving assessment is required, and if the assessment should be undertaken by a driving instructor alone or if a specialised occupational therapy driving assessment is necessary. Those conducting driving assessments should have appropriate training to identify issues specific to people living with dementia. Without this expertise, assessments may not accurately reflect driving capacity.

Occupational therapy driving assessments are often costly, and many patients may be unwilling or unable to meet these costs. Availability may also be limited. These factors may restrict access to appropriate assessment and create equity concerns for some people living with dementia.

5. Post-Diagnostic Care (Section 9 of the Guidelines)

5.1 Physical rehabilitation for people living with dementia (Section 9.1.1 of the Guidelines)

Access and feasibility considerations are reflected in the overall comments.

5.2 Cognitive rehabilitation for people living with dementia (Section 9.1.2 of the Guidelines)

Cognitive rehabilitation is important. However, implementation is likely to be challenging due to limited access to services and the need for additional training and support. Cost and equity considerations may further affect access.

5.3 Non-pharmacological therapies for distress, changed behaviours and behavioural symptoms in people living with dementia (Section 9.3 of the Guidelines)

Good practice statement 11, which emphasises the use of non-pharmacological strategies as first-line care, is particularly important and should be given prominence. This is especially relevant in residential aged care settings, where it aligns with Australian Commission on Safety and Quality in Health Care (ACSQHC) standards and restrictive practice obligations.

The Guidelines could better reflect the realities of clinical practice. While the good practice statements describe the ideal pathway, they should also address situations where practice deviates such as when GPs are pressured to prescribe sedation where non-pharmacological options have not been adequately resourced. These scenarios create a significant risk of harm, and additional practical guidance on how to manage such requests would be valuable.

Additional education and support are needed to assist primary care practitioners in assessing pain in people living with dementia, which may present as distress or changed behaviours.

5.4 Deprescribing of cholinesterase inhibitors and memantine (Section 9.4 of the Guidelines)

Ongoing education will support primary care practitioners to regularly review medication use and deprescribe when appropriate, particularly for patients who may not have regular access to specialist care.

The structured adverse-event timing framework is useful. The Guidelines could include:

- cross-reference to existing medication review pathways, including Medication Use Reviews (MUR) or Home Medicine Reviews (HMR), Residential Medication Management Reviews (RMMRs), and broader polypharmacy review pathways.
- noting that the ‘no demonstrated improvement after 6 months’ trigger assumes baseline and follow-up measures are appropriately documented. This is frequently absent in residential aged care records and may limit the applicability of this criterion in practice.

Consideration could also be given to reviewing Pharmaceutical Benefits Scheme (PBS) restrictions that require specialist initiation of certain medicines, including cholinesterase inhibitors, as these may further limit the ability of GPs to manage prescribing across the full course of treatment.

5.5 Opioids for the treatment of chronic non-cancer pain in people living with dementia (Section 9.5 of the Guidelines)

We agree that opioids should not be routinely used for the treatment of chronic non-cancer pain in people living with dementia. However, under-treatment of pain is a significant real-world risk in people living with dementia. Pain is often under-recognised and may present as distress or changed behaviour and requires active assessment using validated observational tools (for example Abbey Pain Scale or the Pain Assessment in Advanced Dementia scale [PAINAD]).

Clear distinction between chronic non-cancer pain and pain related to cancer or end-of-life care should be maintained in any summary or supporting materials, to support appropriate clinical decision-making.

Consideration could also be given to whether other medicines that contribute to Drug Burden Index warrant similar attention.

6. Draft resources (Section 10 of the Guidelines)

Example fact sheet 1 – Cognitive Rehabilitation

Example fact sheet 2 – Physical Rehabilitation

Both factsheets are clear and accessible. However, neither clearly outlines how to access services or the likely costs involved, which are key considerations for people living with dementia, carers and families. Many services, including physiotherapy, occupational therapy and psychology, are not bulk billed and may be unaffordable for some individuals. Availability may also vary across settings and population groups.

In practice, access to allied health services typically occurs via GP referral pathways, for example using Chronic Condition Management Plans or Aboriginal and Torres Strait Islander health check Enhance Primary Care MBS items, or via referrals to public hospital outpatient services. Consideration should be given to making this role more visible within the factsheets, for example by including a prompt such as 'Talk to your general practitioner about local services or referral options.'

It would be helpful to state the intended audience and scope of each factsheet (for example, cognitive rehabilitation may be most relevant to people with mild to moderate dementia, while physical rehabilitation may apply across a broader range of stages).

The physical rehabilitation factsheet should also include advice on safety and supervision, particularly given the emphasis on falls risk within Recommendation 10.

7. Future updates

A living guideline model would support timely updates and ongoing relevance as evidence in dementia care continues to evolve rapidly. This would enable the Guidelines to respond to important developments that may emerge before the next formal review.

Thank you again for the opportunity to provide feedback. If you have any questions, please contact Mr Stephan Groombridge, Head of eHealth, Quality Care & Standards at Stephan.groombridge@racgp.org.au or (03) 8699 0544.

Yours sincerely

Rowena Ivers

Professor Rowena Ivers
Deputy Chair, RACGP Expert Committee – Quality Care