



## Message from the BLMA President

*Dr Hasthika Ellepola*

## Upcoming Events

*in 2026*

.....

**25 February 2026** – Annual General Meeting & Educational Event – All members

**March** – DiT Exclusive Event

**May** – Educational Event – All members

**June/July** – DiT Exclusive Event

**June** – Educational Event – All members

**August** – Avant & BLMA Medico-Legal Symposium

**October** – Educational Event – All members

**November** – End of Year Celebration & Educational Event – All members

Dear BLMA Members,

Over the past three years, it has been an immense honour and privilege to serve as **President of BLMA**. I am truly humbled by the trust and support you have shown me. Together, we have made significant progress—strengthening our academic programs, expanding member networking opportunities, and placing a strong focus on **supporting doctors in training**. Our initiatives have helped foster **leadership, career progression, and professional growth** for many of our members.

BLMA continues to be guided by values that define our purpose:

- ▶ **Excellence in education and clinical practice**
- ▶ **Support for professional and personal wellbeing**
- ▶ **Collaboration and community**
- ▶ **Leadership and advocacy for the medical profession**

As frontline healthcare professionals, I encourage each of you to **lead with purpose**—to drive the excellence in patient care that we deliver day in and day out. Your leadership, compassion, and resilience are the foundation of our healthcare system, and BLMA is proud to stand beside you in that journey.

I would also like to extend my sincere thanks to our **valued partners—Mater Health, AVANT, and Q4 Financial**—whose unwavering support has been instrumental in our success. Their partnership has helped us grow and deliver meaningful value to our members.

As we look ahead to 2026, I believe the time is right to begin the

transition to new leadership. This change will take place during the **BLMA Annual General Meeting (AGM)** next year. I am confident that under fresh leadership, BLMA will continue to thrive and evolve as one of the leading professional bodies in our field.

I invite you to join us in celebrating the festive season together. Our upcoming **November event** will feature a **door-entry raffle draw** to bring some Christmas cheer to our gathering. This small gesture reflects our ongoing commitment not only to **professional development** but also to the **collegiality that we have fostered at BLMA**.

In the midst of our busy clinical responsibilities, it's important to remember to care for **ourselves, our families, and our colleagues**. **Doctor wellness** is essential to sustaining the compassion, energy, and excellence we bring to our profession. BLMA remains deeply committed to supporting the **holistic wellbeing** of our medical community.

Finally, I want to express my heartfelt gratitude to the **BLMA Management Committee**. Their dedication, collaboration, and tireless efforts have been the backbone of our organisation's progress. I am deeply thankful for their support throughout this journey.

I look forward to celebrating with you all at our November event. Wishing you and your loved ones a joyful **Festive Season** and a prosperous **New Year** ahead.

**Warm regards,**  
**Dr Hasthika Ellepola**

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The Brisbane Local Medical Association welcomes contributions from members, especially **“Letters to the Editor”**.

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## Issue 20 | 2026 Newsletter

**Content Deadline:**  
**23 February 2026**

- ▶ Would you like to comment or suggest articles to be published?
- ▶ What would you like to see in the newsletter?

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## Your 2025 Management Committee



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Dr Andrew Cronin



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Committee Member:**  
Dr Holly Dignan





# Have men's testosterone levels really dropped since the 1970s?

By A/Prof Tim Moss, Healthy Male Health Content Manager

A/Prof Tim Moss  
Healthy Male Health Content Manager

Originally published by Healthy Male on 15 October 2025  
<https://healthymale.org.au/>

Whether it's to justify testosterone injections, encourage us to tan our balls or bemoan the pathetic state of modern men, claiming that men's testosterone levels are lower now than they were back in the day is pretty common. Are these claims true? If so, what is the cause and what can we do about it?

## What does the research say?

The idea that there might be a population-level decrease in testosterone over time was raised about 20 years ago by a study of three groups of men. They had their testosterone levels measured in either 1987-9, 1995-7 or 2002-4. Total testosterone levels declined from a median of 501 ng/dl in 1987-9, to 435 ng/dl in 1995-7, and 391 ng/dl in 2002-4. Since that time, there have been at least 10 other studies showing similar decreases in population testosterone levels.

## What is causing this drop in testosterone levels?

None of these studies tells us the cause (or causes) for this decrease in testosterone levels. There are a lot of things that are known to affect men's testosterone levels, and many have changed in prevalence or severity over the time period that testosterone levels have been falling (since the 1970s). Things like diet, physical activity levels, alcohol and other drugs, sleep, environmental exposures, and chronic diseases

like high blood pressure, diabetes, overweight and obesity and stress can all affect testosterone levels and have all changed during the last 50 years.

Some of the studies that show a fall in testosterone have tried to account for some of the possible causes. These use statistical techniques to 'adjust' for differences that can affect testosterone without being the main thing the researchers are looking at. After these sorts of adjustments, some studies show that the decline in testosterone levels disappears, and others show that it remains. The different outcomes from these adjustments are probably because they adjust for different things (some studies don't measure important confounding factors like specific health conditions), and because these types of adjustments are not perfect.

Here's an example of why statistical adjustments might not work: There's a well-established negative relationship between body fat and testosterone (the higher your body fat, the lower your testosterone), so most studies try to deal with that by adjusting for body mass index (BMI). The problem is, BMI isn't a measure of body fat. BMI is increased by weight gain, regardless of whether the increased weight is due to body fat or muscle (lean mass). Fat mass and lean mass have opposite effects on testosterone (the higher your lean mass the higher your testosterone level), so adjustment for BMI is inaccurate.

The studies that show a decrease in testosterone over time do the best

they can at using data that were usually collected for another reason to answer an important question. There might be other studies, using other data sets and similar analysis, that have also looked at this question and found that there is no change over time, but they are less likely to be published so we don't know about them. The reason these same types of studies keep getting done is because we still aren't confident with our answer to the question. What we really need is a properly designed study, but it would take decades to perform and cost heaps of money, so no one is going to do it.

## The main takeaway

I think that the decline in testosterone levels over the past 50 years is probably due to increasing rates of chronic disease, especially obesity and diabetes. We know from longitudinal studies of individual men that those who stay healthy as they age don't have a fall in testosterone. It makes sense that this effect of poor health would work on a population level too.

There's plenty of speculation that endocrine-disrupting chemicals, microplastics or other pollutants might be contributing to the decline in testosterone, but there's not a lot of good-quality evidence to support those claims. The evidence for the effect of poor diet, lack of exercise and increasing rates of disease on testosterone is much more compelling, and these are factors that are generally within individuals' control.



Queensland X-Ray Proudly Delivering Australia's

# NATIONAL LUNG CANCER SCREENING PROGRAM

Queensland X-Ray is playing a key role in delivering the Australian Government's first-ever National Lung Cancer Screening Program (NLCS), launched on 1 July 2025.

Through the NLCS, Queensland X-Ray practices across Greater Brisbane are providing low-dose CT (LDCT) scans at no cost to eligible high-risk patients.

Lung cancer screening is a quick, non-invasive procedure that uses low-dose CT imaging to detect lesions and signs of cancer before symptoms appear. Research has shown that LDCT scans can detect lung cancer at its earliest stage, when it is most treatable.

**Dr Sanjay Dhupelia, Queensland X-Ray Radiologist, said:** "The National Lung Cancer Screening Program gives at-risk Australians access to critical, potentially life-saving screening. We're proud to be delivering this vital screening service as part of a nationwide push to help detect lung cancer earlier and improve patient outcomes."

**Patients are eligible for the program if they\*:**

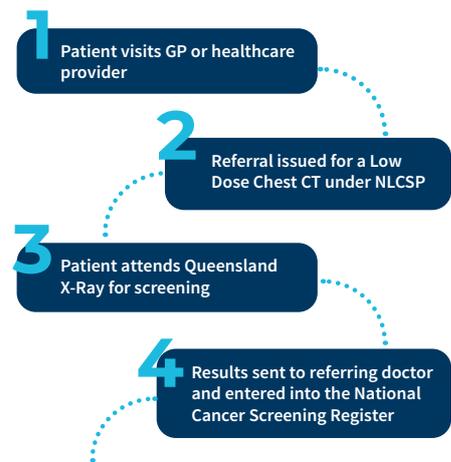
- ▶ are aged between **50 and 70 years**
- ▶ show **no signs or symptoms** of lung cancer
- ▶ have a history of **at least 30 pack-years** of cigarette smoking and are either a **current smoker** or **quit within the past 10 years**

\*For full eligibility criteria, visit [www.health.gov.au/our-work/nlcs](http://www.health.gov.au/our-work/nlcs)

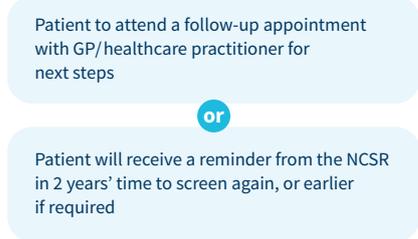
Program participants will require a referral from their GP/healthcare practitioner to undergo screening. Imaging will be performed by our expert team using advanced low-dose CT technology and analysis systems.

As a participating provider, Queensland X-Ray is committed to delivering high-quality imaging services, ensuring that eligible Australians have access to the best possible diagnostic care.

## How screening works



## Depending on the results



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- |            |                           |                           |                |
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## Beyond the expiry date: when medical records become a privacy risk

It's late afternoon in a suburban general practice. A long-standing patient has just moved interstate, and the clinic is looking to make space for those files in its storage room. Among the boxes are records from patients who haven't attended in over a decade. The practice manager hesitates - should they be kept just in case? Or is it time to let them go?

While it may seem harmless to retain old medical records, doing so longer than necessary can pose serious privacy risks.

In healthcare, the line between caution and compliance is often blurred, and well-meaning decisions can inadvertently breach privacy laws.

### *The legal landscape: how long is too long?*

Medical records are vital for continuity of care, but retaining them longer than necessary can pose serious privacy risks. Privacy legislation requires that personal information is stored securely and only retained for as long as it is legally required. While Queensland does not have specific legislation for retaining health records, it is recommended that adult records are held for seven years from the last entry, and for children, until they turn 25. Beyond these timeframes, unless there's a compelling reason - such as ongoing litigation or research with consent - records should be securely destroyed or permanently de-identified.

Holding onto records 'just in case' may feel like a safeguard, but it can actually increase the risk of unauthorised access, data breaches, and non-compliance with privacy obligations. If a breach occurs that includes outdated records, there may be additional consequences for the doctor or practice.

### *The hidden risks of over-retention*

Medical records contain some of the most sensitive personal information. Retaining them unnecessarily can expose doctors and practices to:

- ▶ **Data breaches:** older records may be stored in less secure formats or locations, making them vulnerable to theft, loss, or unauthorised access.
- ▶ **Legal liability:** if a breach occurs, doctors may face regulatory action, reputational damage, and loss of patient trust.
- ▶ **Operational inefficiencies:** excessive record-keeping can

## A new treatment for Osteoarthritis

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Did you know that Low Dose Radiation Therapy is an option for the management of osteoarthritis?

To discuss patient suitability, referral pathways, or to learn more about current clinical practice and outcomes, contact:

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Disclaimers: 1. Evidence suggests that some patients may need a second or third course  
2. Depending on the individuals position within Medicare Safety Nets for Medicare eligible patients



clutter systems, slow down workflows, and complicate audits or transitions to digital platforms.

For example, a clinic that stored paper records in an offsite facility experienced a break-in. The compromised records included both former and current patient information, prompting a formal investigation and mandatory patient notifications. Despite some records being over 15 years old, the breach still triggered compliance obligations. While these processes are essential for meeting legal requirements and patient expectations, they also carry reputational risks and can place significant strain on administrative resources.

**Balancing retention with responsibility**

Managing medical records responsibly means knowing when

to keep them and when to let them go. Here are some practical tips:

- ▶ Know your obligations: familiarise yourself with the retention requirements under the health records legislation applying in Queensland.
- ▶ Audit regularly: schedule periodic reviews of stored records to identify those eligible for secure destruction.
- ▶ Document your process: keep clear records of when and why files are destroyed, including the method used.
- ▶ Secure disposal: use professional services to ensure records are shredded or digitally wiped in accordance with privacy requirements.
- ▶ Ensure your privacy policy makes it clear to patients how records are stored and when they will be securely disposed of.

**Privacy is proactive, not passive**

Doctors and practice staff play a critical role in safeguarding patient information - not just during care, but long after the patient has left. By embedding privacy into record-keeping policies and routines, doctors can reduce medico-legal risk, maintain compliance, and uphold the trust that patients place in their healthcare providers.

For more guidance on managing medical records, visit Avant's resource hub:



**Medical records – the essentials – Avant**



**Storing, retaining and disposing of medical records – Avant**

**Could Low Dose Radiation Therapy (LDRT) help your osteoarthritis patients?**

As GPs, you often see patients living with chronic osteoarthritis pain who are no longer experiencing pain relief from conservative therapy, but for whom surgery is not yet indicated.<sup>1</sup> Low-dose radiotherapy (LDRT) has emerged as a non-invasive alternative for pain relief and functional improvement, particularly in patients unresponsive to conservative measures.<sup>1</sup>

LDRT uses carefully controlled, low doses of radiation to help reduce inflammation in affected joints. It has been used in Europe for decades and is now emerging as a treatment option in Australia for selected patients with osteoarthritis.<sup>1</sup>

**What can your patients expect?**

- Symptom relief: Some patients may experience a reduction in pain and improved mobility following treatment.<sup>2-4</sup>
- Minimal acute side-effects: LDRT has been shown to have very minimal acute side effects<sup>1-4</sup>

**Patient suitability**

- Age ≥50 years
- Confirmed diagnosis of osteoarthritis (Kellgren-Laurence (KL) scores 1-3)
- Upper and Lower limbs (no axial spine)
- Failure of conservative therapy >3/12
- Contraindications; pregnancy, rheumatoid arthritis, active connective tissue disease

**Treatment**

A treatment course is typically six sessions over two weeks. Depending on outcomes, patients may require a second or third course of treatment.



Osteoarthritis affects around 8.3% of the Australian population<sup>5</sup> (2022 data)



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References: 1. Hoveiddei A, et al. Cur Ther Res. 2025;102:100777. 2. Fazilat-Panah D, et al. Int J Radiat Biol. 2025;101(5):541-548. 3. Makarova M V, et al. Rheumatol. 2023;31(4):7. 4. Koneru BN, et al. Int J Rad Onc Biol Phys. 2025;123(2):352-360. 5. Australian Government. Australian Institute of Health and Welfare: Chronic musculoskeletal conditions: Osteoarthritis. Available from: https://www.aihw.gov.au/reports/chronic-musculoskeletal-conditions/osteoarthritis (accessed October 2025).



### National Specialist clinical immunology and allergy support

In partnership with the National Allergy Council, ACRRM offers Members and Non-Members across Australia free expert allergy advice and education from clinical/immunology specialists within 48 hours. The allergy assist™ platform will be provided as a pilot service for 12 months.

Available to all GPs in Australia, *allergy assist™* enables doctor-to-doctor written discussion on patient cases:

- ▶ Registered GPs can ask a question about any suspected allergic presentation (including food allergy, medication allergy, insect sting or bit allergy, history of anaphylaxis, allergic rhinitis or atopic dermatitis) and share relevant information about a patient case. Cases must be de-identified and shared with the patient’s consent.
- ▶ A clinical immunology or allergy specialist is assigned the case and responds within 48 hours with high quality advice to assist with management and guidance on appropriate referral where necessary.

GPs can find out more and register to use the platform [online](#).



### Pregnancy self-referral portal now live – *Improving access to antenatal care*

Queensland Health have launched a pregnancy care self-referral portal. The portal is not intended to replace existing referral pathways, but provides an additional pathway for women to access timely antenatal care.

Accessible online and including a dedicated pathway and information for Aboriginal and Torres Strait Islander mothers, the portal will help identify at-risk women early, and provide positive interventions, preventative health strategies and linkages to promote engagement or re-engagement with primary care providers, enabling a seamless transition back to primary carers in the community.

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# A Comprehensive Display of Cutaneous Melanoma in Queensland



Mark Smithers AM  
MBBS, FRACS, FRCS(Eng),  
FRCS(Ed)

Recently published by Cancer Alliance Queensland, this **report** provides the first comprehensive statewide analysis of cutaneous melanoma in Queensland, by stage at diagnosis. It offers critical insights into patterns of disease epidemiology, treatment practices, and survival outcomes.

Cutaneous melanoma ranks as the second most common cancer for both men and women in Queensland—and the leading cancer among people aged 20 to 39. In 2022, almost 4,300 Queenslanders were diagnosed with cutaneous invasive melanoma, with males making up well over half of cases.

Cancer Alliance Queensland has studied and reported on most solid organ cancers. Commonly, a Quality Index report has been published for these cancers. Given that surgery for most cancers (other than melanoma) occurs in hospitals, the existing reports assess access to surgery, referral practices, timing and outcomes from surgery and associated treatments including intravenous therapies and radiotherapy. However, for the majority of cases of cutaneous melanoma, the definitive diagnosis and treatment commonly occur outside of hospitals. The potential to diagnose the disease at an early stage, when it is eminently curable, exists more than for other solid organ cancers, so our report differs

from others from Cancer Alliance Queensland. There is a focus on the stage of disease at first diagnosis and the factors that may impact the stage. People with more advanced stages of the primary melanoma or with metastatic disease are likely to have been treated in hospitals and thus we are able to assess and report that information.

This report provides a comprehensive statewide analysis of invasive cutaneous melanoma in Queensland by stage at diagnosis, offering critical insights into patterns of disease epidemiology, treatment practices, and survival outcomes. There is a focus on staging because it assists clinicians to plan appropriate treatment and determine the likely outcome or course of the disease. Additionally, the staging information may be used by health services, researchers, and policymakers to identify trends in diagnosis by population subgroups and to evaluate the effectiveness of early detection programs.

## As a broad summary we report:

### The incidence of invasive melanoma is declining in younger generations.

- ▶ The cutaneous melanoma in situ rates continue to increase.

- ▶ The invasive melanoma rates steadily increased but have plateaued since 2017.
- ▶ There is a decline in incidence in the younger cohorts and signs of stabilisation among some of the middle-aged generations.
- ▶ A higher incidence rate in males compared with females occurs after age 50.
- ▶ Mortality rates in both males and females have been falling since the early 2010s.

### Most people had their initial diagnosis at an early stage of disease, implying early detection.

- ▶ Between 2013 and 2022, 79% of people were diagnosed at stage I. There were 3.6% diagnosed at stage III (melanoma had spread to nearby lymph nodes or tissues), and 2.5% at stage IV (indicating the melanoma had spread to distant sites—for example, distant lymph nodes, lung, bone, brain, or liver).
- ▶ The increase in stage III disease at time of diagnosis, from 2008, likely represents an increased sentinel lymph node biopsy (SLNB) rate.
- ▶ Those with thicker melanoma on pathology occurred more commonly in males, melanoma on the head or neck, older people, those living in socioeconomically disadvantaged areas, or from Central or Northern Queensland.

### **For complex, more advanced stage melanoma – notably stage III and many with stage IV disease – Multidisciplinary Team (MDT) assessment is best practice.**

- ▶ The number of people with melanoma who receive MDT assessment is increasing.
- ▶ Between 2013 and 2022, almost two-thirds (63%) of people with stage III melanoma were reviewed at MDT, increasing by 28% over the previous decade.
- ▶ There are gaps in MDT data, for instance in the private sector.

### **In hospital treatment patterns reflect modern practice at the time of diagnosis.**

- ▶ Treatment data from 2015–2022 are shown to reflect the impact of new anti-cancer therapies.
- ▶ Sentinel lymph node biopsy (SLNB) was performed in 32% of people with T stage 1b–T4b.
- ▶ SLNB was positive in 15% of people who had a biopsy, with higher rates in thicker tumours.
- ▶ Intravenous systemic therapy was provided to 57% of people with stage III and 70% with stage IV.
- ▶ Diagnosis with stage IV led 41% to receive radiation therapy.

### **Survival is improving, especially for people with advanced disease.**

Five-year melanoma-specific survival:

- ▶ Stage I: remained high at 98-99% for both 2003-2012 and 2013-2022.
- ▶ Stage II: increased from 79% between 2003-2012 to 85% between 2013-2022.
- ▶ Stage III: increased from 59% between 2003-2012 to 75% between 2013-2022.
- ▶ Stage IV: more than doubled from 15% between 2003-2012 to 35% between 2013-2022.

### **Approximately one in 10 people diagnosed with invasive**

### **melanoma for the first time were diagnosed with a second primary invasive melanoma over the next 20 years.**

- ▶ Males were 57% more likely than females to be diagnosed with a second primary invasive melanoma.
- ▶ The risk was nearly twice as high if aged 60-69 at first diagnosis compared to those under 40.
- ▶ Between 1982 and 2022, 4% of people were diagnosed with a second primary invasive melanoma within five years of their first diagnosis, 7% within ten years, and 11% within 20 years.
- ▶ Those diagnosed with a first melanoma more recently have a higher risk of a second primary melanoma compared with people who were first diagnosed in earlier time periods.

Overall, the message is positive, likely more so than we might have presented five years ago. Being able to assess where we are with a disease such as melanoma, at different timepoints, allows for better understanding and data to inform steps for the future. This is highly relevant at a time when the role of screening for melanoma is being explored at a federal level. Additionally, to be able to formally report the positive impact that the new systemic treatments—typically immunotherapy—provide for Queenslanders is very special for a person who is from an era when there was no real treatment for these people. This also provides evidence to justify our political leaders agreeing to assist with funding these expensive treatments.

I wish to acknowledge the commitment and work from those in Cancer Alliance Queensland who were directly involved with producing this report: Theresa Negrello (Principal Project Officer), Artika Nath (Data Analyst), Danny Youlden (Biostatistician), and Danica Cossio (Senior Director).

### **Acknowledgements**

A comprehensive display of cutaneous melanoma in Queensland has been developed under the auspices of the Queensland Cancer Control Safety and Quality Partnership (The Partnership).

The Clinical Outcomes from Melanoma Management Advisory (COMMA) Committee of the Queensland Cancer Control Safety and Quality Partnership was established to examine and improve outcomes for Queenslanders with melanoma.

The analysis and writing for this report was carried out by the Cancer Alliance Queensland team with the support of the COMMA Committee.

The authors acknowledge and appreciate the work of the Cancer Alliance Queensland team who contribute to and participate in the maintenance of the Queensland Cancer Register, the Queensland Oncology Repository, QOOL and the other tools which support the collection, analyses, and interpretation of cancer data in Queensland.

### **Where has the data come from?**

Since 2004 Cancer Alliance Queensland (CAQ) have compiled and analysed a vast amount of information about cancer patient characteristics, incidence, mortality, survival, treatment and prognostic factors for the entire cancer population. Key to CAQ's program of work is the ability to match and link population-based cancer information on an individual basis.

This matched and linked data is housed in the CAQ managed Queensland Oncology Repository (QOR) which contains information on over 1.5 million people with cancer between 1982-2022. This centralised repository compiles and collates data from a range of source systems including the legislated Queensland Cancer Register, hospital admissions data, death

data, treatment systems, public and private pathology, hospital clinical data systems and QOOL.

**How was the cohort identified?**

**Inclusions**

- ▶ Queensland residents who were diagnosed with histologically confirmed melanoma between 1st January 1982 to 31st December 2022.

**Exclusions**

The following groups of people are excluded from this report:

- ▶ People who received treatment for melanoma during the reporting period but were diagnosed in a prior year.
- ▶ People diagnosed outside of Queensland who subsequently received treatment within Queensland.

- ▶ People identified solely through death certificate or autopsy with histological confirmation.
- ▶ People whose initial melanoma diagnosis was based on clinical assessment alone, even if a subsequent melanoma was histologically confirmed.

This report focuses exclusively on invasive cutaneous melanoma. For comparative purposes, data on in situ melanoma is provided in supplementary table A3 in the Appendix. Although mucosal melanomas are not within the primary scope of this report, an Appendix supplementary table provides a comprehensive breakdown of both cutaneous and mucosal melanoma types by age and sex in Queensland from 1982 to 2022.

**Spotlight cohort**

The Spotlight on multiple primary melanomas shows data on all histologically confirmed melanomas, including multiple melanomas per person. This is distinct from other sections of this report, which show the first melanoma diagnosis per person.

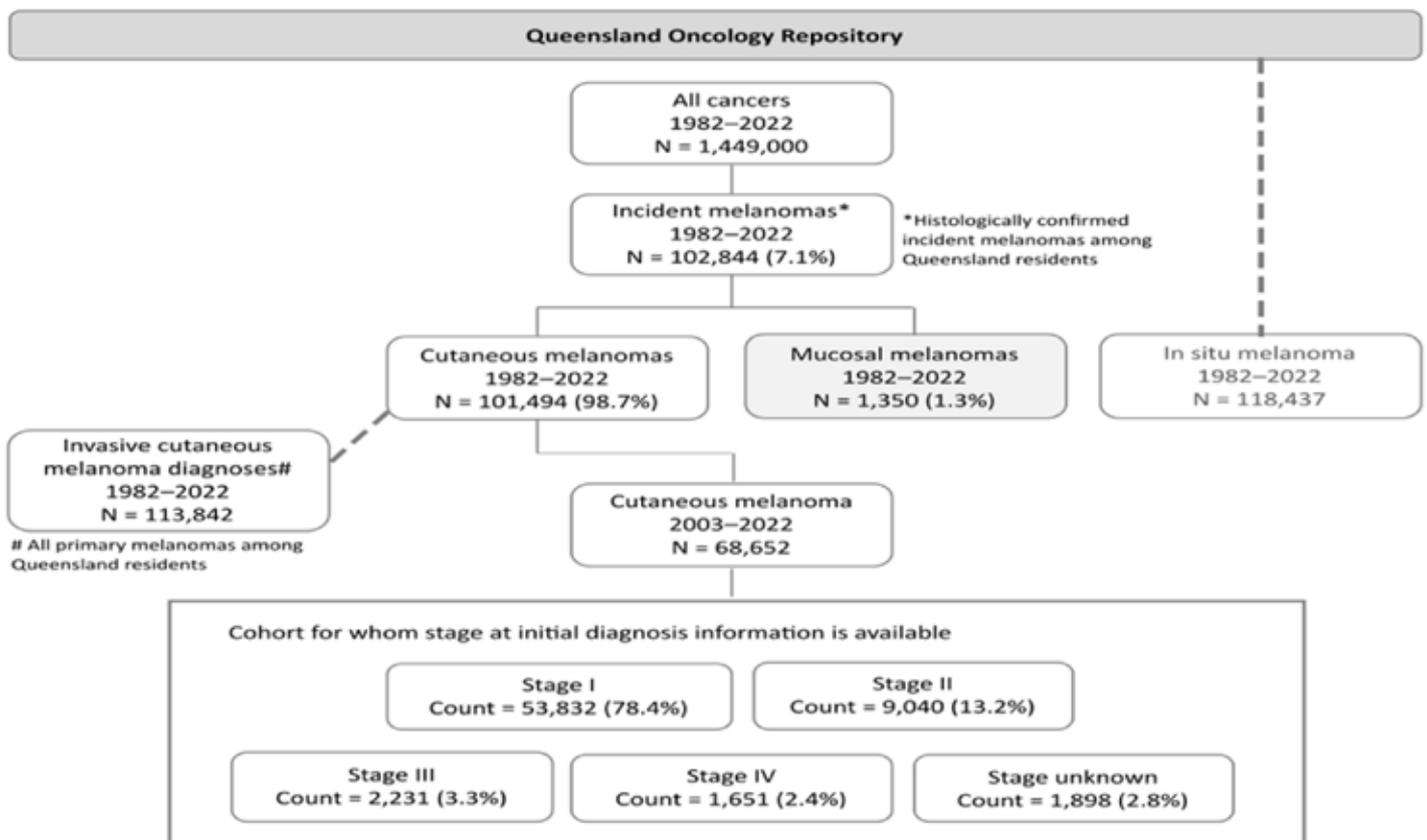
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**Need help?**

Please contact us if you require any assistance at Cancer Alliance Queensland Metro South Hospital and Health Service  
 Tel: (+61) (07) 3176 4400  
 Email: [cancerallianceqld@health.qld.gov.au](mailto:cancerallianceqld@health.qld.gov.au)  
<https://cancerallianceqld.health.qld.gov.au>

**Cohort flow chart**



# Decision Making in HIV PEP



[www.ashm.org.au](http://www.ashm.org.au)

**HIV post-exposure prophylaxis (PEP) is a 28 day course of antiretroviral (ARV) drugs prescribed to reduce the risk of transmission of human immunodeficiency virus (HIV) following HIV exposure.**

For complete Australian HIV post-exposure prophylaxis (PEP) guidelines see: [pep.guidelines.org.au](http://pep.guidelines.org.au)

## FUNDAMENTALS OF HIV PEP PRESCRIBING

- **Start PEP as soon as possible and within 72 hours of exposure.**
- **Take daily for 28 days.**
- PEP is not recommended for any sexual exposure with a person living with HIV with undetectable viral load (U=U) [https://www.unaids.org/sites/default/files/media\\_asset/undetectable-untransmittable\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/undetectable-untransmittable_en.pdf)
- Provide the whole 28-day course at the initial visit. If a starter-pack is given, ensure there is a clear process for obtaining the remaining supply.
- Order baseline pathology for all people presenting for PEP.
- Provide education on the importance of PEP adherence.
- Strongly encourage transition directly to PrEP after completion of the PEP course where there are likely to be ongoing HIV exposures and/or there have been multiple previous PEP courses.
- Consult with a paediatric ID specialist for minors under 16 years of age.

## HIV RISK ASSESSMENT

- Date and time of exposure
- Exposure type
- HIV status of source/partner
- HIV viral load (VL) where source is a person living with HIV
- Co-factors increasing HIV transmission:
  - Detectable HIV VL in the source
  - Uncircumcised status of exposed person for insertive penile-anal and penile-vaginal exposures
  - Presence of blood, trauma, or STI
- Date of last HIV test
- Use of PrEP by exposed person or source (see Prescribing HIV PEP in the context of PrEP use box).

ASHM thanks its clinical advisors for their review and endorsement.  
Disclaimer: ASHM does not endorse or promote any product or service.

## MANAGEMENT OF OTHER CONDITIONS

- Test and treat those with STI symptoms empirically [www.sti.guidelines.org.au](http://www.sti.guidelines.org.au)
- Consider Doxy-PEP for STI prevention in MSM sexual exposures <https://ashm.org.au/resources/doxy-pep-decision-making-tool/>
- Consider hepatitis B immunoglobulin (HBIG) if the exposed person is non-immune and the source has hepatitis B (HBV) <https://immunisationhandbook.health.gov.au/>
- PEP can safely be commenced in people with HBV. Seek specialist advice for ongoing management.

## GP PRESCRIBING OF HIV PEP

- Unlike PrEP, PEP is not PBS listed. However, all GPs can prescribe generic 2-drug PEP on private prescription: Tenofovir disoproxil 300 mg / Emtricitabine 200 mg (28 days, no repeat).
- Contact your local HIV/sexual health/ED/ID specialist if a third drug is required.

## TESTING

Test	Baseline	Week 6 <sup>A</sup>	Week 12
HIV Ag/Ab	X	X	X
Hepatitis B (HBV)	X		X
HBsAg, Anti-HBs, Anti-HBc <sup>B</sup>			
Hepatitis C (HCV) Ab <sup>C</sup>	X		X
Chlamydia & gonorrhoea PCR <sup>D</sup>	X	X	X
Syphilis serology <sup>E</sup>	X	X	X
UEC (including eGFR) <sup>F</sup>	X	X	
Pregnancy test <sup>G</sup>	X	X	

<sup>A</sup> Where PEP has not been prescribed (i.e. low risk exposure or outside 72 hour window), a negative HIV test 45 days post exposure is definitive and requires no further follow-up. Recall at 4 weeks if considering transitioning directly to PrEP.

<sup>B</sup> HBV surface antigen; HBV surface antibody; HBV core antibody. PEP can be safely commenced in people with HBV (HBsAg positive). Seek specialist consultation in regard to safely ceasing PEP in those with HBV: <https://ashm.org.au/about/news/b-referred/> Non-immune individuals (Anti-HBs <10 mIU/mL) should be offered immunisation and follow-up to 6 months.

<sup>C</sup> Where HCV Ab positive and no known HCV treatment Hx, recall for HCV PCR. Consider PCR and LFT at 6 weeks for occupational exposures.

<sup>D</sup> Sexual exposures. Conduct a full STI screen from all relevant sites as per Hx.  
<sup>E</sup> Sexual exposures.

<sup>F</sup> Seek specialist input for recommendation of alternative PEP drugs if eGFR<60.

<sup>G</sup> Consider emergency contraception.

EXPOSURE AND PEP RECOMMENDATION			
Exposure	HIV status unknown	Source known to have HIV	
		Viral load (VL) not detected (<200 copies/mL)	Not on ARVs, VL >200 copies/mL, or VL unknown
<b>PEP for non-occupational exposures</b>			
Receptive anal intercourse with or without ejaculation	Recommend 2 drugs if source is a man who has sex with men (MSM), trans or gender diverse (TGD), or from a high prevalence country (HPC)*	Not recommended <sup>†</sup>	Recommend 3 drugs
Insertive anal intercourse (uncircumcised)	Recommend 2 drugs if source is MSM, TGD, or from HPC*	Not recommended <sup>†</sup>	Recommend 3 drugs
Insertive anal intercourse (circumcised)	Consider 2 drugs if source is MSM, TGD, or from HPC* and STI, trauma or blood	Not recommended <sup>†</sup>	Recommend 3 drugs
Receptive vaginal intercourse	Consider 2 drugs if source is MSM, TGD, or from HPC*	Not recommended <sup>†</sup>	Recommend 3 drugs
Insertive vaginal intercourse	Consider 2 drugs if source is TGD or from HPC*	Not recommended <sup>†</sup>	Recommend 3 drugs
Receptive and insertive fellatio or cunnilingus	Not recommended	Not recommended <sup>†</sup>	Not recommended <sup>‡</sup>
Semen splash to the eye	Not recommended	Not recommended	Not recommended
Human bite	Not recommended	Not recommended	Not recommended
Shared contaminated injecting equipment	Recommend 2 drugs if source is MSM/TGD or from HPC*	Consider 2 drugs	Recommend 3 drugs
Needlestick injury (NSI) from discarded needle in community	Not recommended	Not applicable	Not applicable
<b>PEP for occupational exposures</b>			
Needlestick or sharps exposure	Consider 2 drugs	Consider 2 drugs <sup>§</sup>	Recommend 3 drugs
Mucous membrane and non-intact skin	Consider 2 drugs	Consider 2 drugs <sup>§</sup>	Recommend 3 drugs

\* To determine country HIV prevalence, see <https://aidsinfo.unaids.org/>  
<sup>†</sup> Provided source is adherent to medication, attends regular follow up and has no inter-current STI.  
<sup>‡</sup> PEP (2 drugs) may be recommended for receptive fellatio with ejaculation if the exposed person has a significant breach in their oral mucosa.  
<sup>§</sup> Co-factors that may influence decision-making following occupational exposures: (a) deep trauma; (b) bolus of blood injected.

### OCCUPATIONAL HIV PEP

- In occupational settings the source is usually able to be tested for HIV. PEP should be initiated while awaiting the source HIV result, and either continued, modified, or ceased based on the result.
- PEP may also be considered where the source has HIV risk factors but cannot be tested.
- PEP should be offered to any healthcare worker with a significant exposure to a source who is known to have HIV.
- It is likely that U=U also applies to occupational exposures, but there is a lack of data to support this currently.

### WHAT TO PRESCRIBE

**Standard 2-drug regimen\***  
 Tenofovir disoproxil<sup>†</sup> 300mg / Emtricitabine 200mg orally daily for 28 days

**Standard 3-drug regimen\***  
 As above plus  
 Dolutegravir <sup>‡</sup> 50mg orally daily for 28 days  
 For drug-drug interactions go to <https://www.hiv-druginteractions.org/checker>

\* Prescriptions may be written for 30 days in keeping with pack size.  
<sup>†</sup> Several bioequivalent generic formulations in Australia.  
<sup>‡</sup> Where use of Dolutegravir is contraindicated use Raltegravir 1200 mg daily.

### FURTHER HIV EXPOSURES WHILST ON HIV PEP

Exposure	How long to extend PEP course after most recent exposure
Anal sex	48 hours
Receptive vaginal sex – cis women and TGD persons on gender affirming hormones	7 days
Sharps or blood exposure	28 days

### PRESCRIBING HIV PEP IN THE CONTEXT OF PrEP USE

- If exposed person or source has taken PrEP as prescribed\*, PEP not required.
- If exposed person or source has not taken PrEP as prescribed\*, conduct risk assessment as for person not on PrEP.

\* Note: For casual partners, source adherence is often unknown.

### RESOURCES AND CONTACTS

GETPEP Website: <https://www.getpep.info/>  
 National PEP Guidelines: <https://pep.guidelines.org.au/>  
 PEP Phonelines: VIC 1800 889 887; NSW 1800 737 669; QLD 1343 2584; WA 1300 767 161; SA 1800 022 226

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# General practice guide to free mental health, suicide prevention and alcohol and other drugs programs

General practice guide to free mental health, suicide prevention and alcohol and other drugs programs

Brisbane South PHN's [Mental Health Services Guide](#) is a quick and easy reference guide of free mental health, suicide prevention, and alcohol and other drug (MHSPAOD) treatment services.

The listed MHSPAOD services are sorted by the level of care that service can provide to your patients according to their need (otherwise known as stepped care model).

The guide is easily printable, downloadable or bookmarked for quick reference on our website, and can be used during consultation while sitting with your patient, to help you refer your patient to the right service according to their need.

Brisbane South PHN commissions a range of mental health, suicide prevention, and alcohol and other drug (MHSPAOD) treatment services

to ensure patients can access free, flexible support that meets their individual needs. Our commissioned service providers and partners listed in the guide can help determine the most suitable service for your patients. The guide provides contact details for health provider and patient service navigation support.

There is no wrong entry point—any of the listed organisations in our [Mental Health Services Guide](#) can assist in connecting your patient to a support service.

## About the Mental Health Services Guide

The [Mental Health Services Guide](#) outlines a stepped care list of MHSPAOD services that are freely available in the Brisbane South PHN region. The guide aims to help streamline access to local, integrated support systems that are aligned with best practice models of primary mental health care.

The guide is designed to help general practitioners (GPs) understand and refer patients to appropriate services depending on the severity of need (from low to high intensity).

It includes details on:

- ▶ patient eligibility
- ▶ service types (e.g. peer led support, crisis intervention, early psychosis care)
- ▶ how to make referrals via the Initial Assessment and Referral Decision Support Tool ([IAR DST tool](#)).

## Free training for GPs and mental health professionals: Initial Assessment and Referral Decision Support Tool (IAR-DST)

The [Initial Assessment and Referral Decision Support Tool \(IAR-DST\)](#) is a national initiative that assists

general practitioners (GPs) and other clinicians in recommending a level of care for a person seeking mental health support.

Brisbane South PHN is delivering training on the IAR-DST. The 2-hour training session covers:

- ▶ how to best make use of the IAR Decision Support Tool
- ▶ how the tool can be simply implemented into general practice workflows.

This training is for general practitioners (GPs), GP Registrars, other clinicians, intake teams and mental health service providers involved in the mental health assessment and referral process.

## Added benefits of IAR-DST training

GPs and GP Registrars will receive 2 CPD hours for completing the training.

All participants will receive a Statement of Attendance.

[View or register for up-coming IAR-DST training events in our event calendar.](#)

Email [iar@bsphn.org.au](mailto:iar@bsphn.org.au) with questions or if you would like to organise face-to-face training at your practice.

## Further information for general practitioners

- ▶ Learn more about our [commissioned MHSPAOD care providers on our webpage](#).
- ▶ Access [free IAR-DST training for GPs and mental health professionals](#).

# Christmas Appeal 2025

Opening conversations and increasing support for mental health and suicide prevention.

[Donate today](#)

**AMA QUEENSLAND FOUNDATION**

## Support the AMA Queensland Foundation Christmas Appeal

While we prepare for the upcoming Christmas festivities and look towards the holiday season, there are those among us who are struggling with pain, distress, or loneliness. Mental ill-health and suicide are not joyous topics, but unfortunately, many of us have felt their impact. For some members of our community, the risk factors increase for suicide, and this includes medical professionals. For isolated, vulnerable and underserved Queenslanders, the barriers to support can be higher.

### Target of \$50,000

The AMA Queensland Foundation 2025 Christmas appeal will raise much-needed funds to increase services and support for mental health and prevention of suicide. Together, we can expand our ability to save lives.

Donate to the appeal on our website [amaqfoundation.com.au/donation/](http://amaqfoundation.com.au/donation/)



**AMA QUEENSLAND FOUNDATION**

## Medical Student Scholarships

[Apply now](#)

Ann Vincent  
2025 IMAO - AMA QLD Foundation S&S Scholarship Recipient

Noah Steel  
2025 Scholarship recipient

Alexandra Green  
2025 Scholarship recipient

Rheannon Griffin  
2025 Scholarship recipient

Applications close 28 February 2025, 5PM (AEST)

## Applications now open for Medical Student Scholarships

The AMA Queensland Foundation offers its annual Medical Student Scholarships to financially disadvantaged students studying an MBBS, MD course or equivalent at a university in Queensland. **Applications for 2026 scholarships are now open and will close on 28 February 2026.**

Scholarships of \$10,000 paid in two equal instalments will be awarded to

up to four students in 2026 to enable them to continue studying and reach their dreams of becoming a doctor.

Applications can be made here: [amaqfoundation.com.au/page/scholarships/AMA\\_Queensland\\_Foundation\\_Medical\\_Scholarships/](http://amaqfoundation.com.au/page/scholarships/AMA_Queensland_Foundation_Medical_Scholarships/)





Dr Nick Yim  
AMA Queensland President



Dr Brett Dale  
AMA Queensland CEO



[amaq.com.au](http://amaq.com.au)

## AMA Queensland

# Latest wins: President and CEO update

## November 2025

The start of November marked the federal government's changes to bulk billing.

AMA Queensland has long advocated for an increase to the Medicare rebate instead to ensure a better deal for all patients when it comes to seeing a GP.

We know many general practices will not be able to sign up to the government's incentive program, because doing so will mean an effective cut in income.

GP clinics, like everyone else, are dealing with rising wages, consumables, insurances and other business costs.

The issue of safety on personal mobility devices such as e-bikes and e-scooters has also exploded, workforce and planned surgery waiting lists continue to be hot button issues, while we welcomed a new Chief Health Officer and enjoyed a fantastic Women in Medicine Brisbane breakfast.

## Bulk billing

The federal government is spending \$8 billion on its bulk billing reforms, with Health Minister Mark Butler trumpeting the claim that patients won't need their credit card, just their Medicare card, to see a doctor.

AMA Queensland has passionately advocated against this approach since it was first announced before this year's election.

Now November has arrived, and the bulk billing changes are here.

But only around one-fifth of the practices the government wants to sign up for the incentive program have actually done so.

We know this is because hundreds of practices have done the sums and realised they cannot be financially viable if they do so.

We need the scheme to reward primary care that takes time and is not compromised by a financial incentive.

Ultimately, sacrificing time to investigate ongoing or developing medical issues to boost throughput risks patients' health.

That \$8 billion would be better spent increasing baseline Medicare rebates, so that all patients would benefit from reduced primary care costs, and GPs could stay open, viable and able to treat patients with proper attention.

All in all, this is a missed opportunity for real reform.

## Personal Mobility Devices (e-bikes, e-scooters)

The tragic death of two boys – aged just 8 and 15 – in separate e-bike accidents in late October sparked calls for the Queensland government to immediately ban electric personal mobility devices for under 16s.

Our key recommendation to this year's parliamentary inquiry into e-PMDs was to do just that. Simply put, children and younger teens do not have the experience or awareness to be safe on these devices.

Premier David Crisafulli says he won't act until the inquiry's report is handed down in March, but that "change is coming".

We know our emergency doctors and surgeons are horrified by some of the injuries they see from accidents involving e-scooters and e-bikes, particularly in children.

We believe the government could step up right now with increased enforcement of existing regulations and an education campaign about safety.

With Christmas around the corner, we have been active across the media calling for parents to do their research on the speed and power of e-PMDs, and to hold off purchasing them if they are concerned.

## Workforce

As Queensland Health continues to work on its needs-based medical workforce plan, due early next year, the issue of clinician shortages continues to be the key underlying factor in many media stories.

Planned surgery waiting lists were again in the spotlight in October, with an increase in the number of patients waiting longer than recommended for their procedures.

We know our own Workforce Action Plan tackles the main challenges of recruiting and retaining doctors and getting them to where they're needed most across Queensland.

We continue to advocate to the government to use those strategies in their own response.

## Prescriber Bag

AMA Queensland has been advocating for an improved PBS-funded Prescriber Bag for more than 12 months.

Commonly known as the 'Doctor's Bag', the Prescriber Bag contains medicines that improve access to healthcare for countless Australians, particularly in regional, rural and remote areas without easy access to pharmacies.

We recently welcomed the Pharmaceutical Benefits Advisory Committee recommendation for the inclusion of the antibiotic ceftriaxone, used to treat suspected sepsis.

We're also pleased PBAC plans to review the PBS-funded Prescriber Bag – but we'd like to see a focus change to reduce hospital visits.

## New Chief Health Officer

The start of October saw the appointment of Dr Marianne Gale to the role of Chief Health Officer, commencing in December.

Dr Gale began her career at Townsville Hospital, and we welcome her back to Queensland to put her stamp on public health here.

The appointment provides certainty and direction at a time when misinformation and disinformation about public health is on the rise.

We have just come through our worst flu season since before the COVID-19 pandemic, and we look forward to supporting Dr Gale to provide strong leadership and effective public health messaging.

## Free cancer accommodation for young people

The Patient Travel Subsidy Scheme (PTSS) has been in the news again recently, with Health Minister Tim Nicholls pledging a review of the program.

Doctors know the subsidy has not kept pace with the rising cost of travel and accommodation. We have also advocated for reducing the red tape GPs have to battle through to get the subsidy for their patients.

In the meantime, we profiled a fantastic initiative of the Sony Foundation, which has extended eligibility for its 'You Can Stay' accommodation service for 15- to 29-year-olds, ensuring more rural young people have the support they need during cancer treatment in metropolitan areas.

## AMA Queensland Foundation Christmas Appeal

Each year the AMA Queensland Foundation chooses a worthy cause to be the focus of its Christmas fundraising campaign.

This year, we hope to bring light to the darker aspects of the holiday season by supporting mental health programs and suicide prevention.

The goal is \$50,000 which will be used to support services that otherwise might not exist.

We encourage doctors and our allies to give generously, knowing for someone it may help make a brighter Christmas.



## Women in Medicine Brisbane Breakfast

A splash of red and pink greeted 250 guests at our annual Women in Medicine Brisbane breakfast on Thursday 30 October at Victoria Park Golf Club.

The theme was 'Accelerate Action for Gender Equality', and AMA Queensland Vice-President Dr Emilia Dauway was the keynote speaker. She highlighted some of the trailblazing women of medicine and science whose shared qualities of tenacity, bravery and self-worth drove real change, and discussed moments in her own career where she and other women doctors lifted each other up.

We then enjoyed a sparkling panel session moderated by QUT Dean of Medicine and Head of School of Clinical Medicine, Professor Jen Williams, and featuring AMA Queensland Immediate Past President Dr Maria Boulton, Associate Professor Jane Smith and Dr Elizabeth Rushbrook.

# Introducing most: a free, evidence-based digital mental health service for young people

MOST is a free, safe and innovative digital mental health platform that offers young people aged 12-25 access to safe, evidence-based mental health support.

Developed by Orygen Digital and backed by over 15 years of research, MOST plays a key role in supporting young people with mild, moderate or severe mental health concerns, no matter where they are. Easy, direct access to MOST allows young people to sign up without a clinician referral if they are not seeking care through a face-to-face youth mental health service.

MOST's Clinical Implementation Lead for Queensland, Michelle Armstrong, says young people are looking for new ways to access support.

"The way young people are seeking help is changing rapidly. As are the needs of young people as they navigate life, identity, culture and wellbeing.

"MOST gives young people strategies to cope with the challenges of daily life, extra tools that are fun and interesting and a safe place to get professional mental health support that is as unique and diverse as they are."

Young people aged 15-25 can sign up online or via the MOST app ([Apple](#) and [Android](#)). Those aged 12-14 can join via referral from a [participating mental health service across Queensland](#).

"Mental health interventions no longer need to be inside a clinic or office to be effective. With MOST, digital mental health support can be accessed anytime, anywhere. Better still, it's safe and free for young people because it's funded by the Queensland Health

– Mental Health and Other Drugs Branch," says Michelle.

MOST offers young people a unique combination of therapeutic content, professional support, and community connection:

## **Evidence-based therapeutic content**

MOST's content is delivered through tailored 'Journeys' that help young people develop practical strategies for managing challenges such as anxiety, low mood, sleep, work and study stress, and social anxiety. Activities are available in a variety of formats, including videos, audio tracks, animations and written exercises. All the activities within MOST can be completed at a young person's own pace.

## **Support from real people**

Qualified mental health clinicians, peer workers and career consultants are available to provide one-on-one support, ensuring each young person receives an experience that's tailored to their needs.

## **A safe online community**

MOST's moderated online community offers a safe and supportive space where young people can connect with peers experiencing similar challenges and peer workers who've been through it, engineered to reduce isolation and foster meaningful connection. The Community is moderated by MOST peer workers and clinicians and supported by a safety filter to ensure that it is a safe space.

## **Personalised toolkit**

The Toolkit is a space for young people to save helpful activities and build their own personalised therapy library. Content can be saved to their toolkit from Journeys or the Explore section. Explore library houses an extensive range of resources covering topics such as body image, communication skills, navigating the mental health system, relationships and more.

## **How young people use MOST day-to-day**

MOST is designed to be flexible and work with young people, meaning

there's no pressure to follow a strict schedule or finish content quickly. Young people can move at their own pace and revisit resources they've found helpful whenever they need them.

This means they can use it as part of their daily commute to school and work or just dip in when they need some extra support around exams, work challenges or relationship changes.

One MOST user shared how MOST has helped them feel less alone.

"I'm so glad I got told about MOST. I think more young adults should know about it because it has honestly helped me so much being able to connect with young people that are going through the same thing as me."

## **Supporting thousands of young people across Queensland**

MOST has recently achieved a milestone of supporting 20,000 young people across Australia.

"With more than 3,000 of those young people coming from QLD, it's a milestone we're incredibly proud of and a reminder of how many young people we're reaching and supporting every day," Michelle said.

Digital mental health support tools are especially important in a large and geographically diverse state like Queensland. MOST helps bridge the gap by offering immediate access to tools, strategies and real human support, regardless of whether a young person lives in Brisbane, Rockhampton or a remote regional community.

Michelle says for many, MOST is the first step towards building confidence, learning new skills, and eventually engaging with face-to-face services.

"MOST continues to provide a safe, flexible and inclusive way for young people, particularly those in regional and remote areas, to access free mental health support whenever they need it."

You can watch a full demo of MOST [online](#) and learn more at [most.org.au](https://most.org.au).

If you'd like more information on MOST, please reach out to [michelle.armstrong@orygen.org.au](mailto:michelle.armstrong@orygen.org.au)

## Event Wrap Up

On 14 October 2025, BLMA members came together at Waters Edge Wedding and Events at Portside for an informative and enjoyable evening, proudly sponsored by Radiology Queensland Group and Mater.

Dr. Hien Lu of Radiology Queensland Group commenced the program with an insightful presentation titled "The Shoulder Uncovered: Diagnostic Imaging and Image-Guided Intervention." This was followed by Dr. Ryan Braun, interventional radiologist from Carlisle Health, who explored radiological approaches to back pain.

Kelly and Rod from our partners, q4 financial, conducted an entertaining Q & A session with our members. q4 also donated the evening's lucky door prize which was won by our very own newsletter coordinator, Renee O'Brien.

The evening concluded with an engaging presentation by Dr. Joseph Garcia-Redmond, neurosurgeon from Mater shared his expertise in brain and spinal surgery, bringing the event to a strong close.

Thank you to our sponsors and speakers for contributing to such a valuable professional development evening.



## Dr Joseph Garcia Redmond

MBBS, MS (Neurosurgery), PGDipAnat, FRACS

### Neurosurgeon Brain & Spine Surgery

IPSWICH & BRISBANE, QUEENSLAND

Dr Joseph Garcia Redmond is a specialist Neurosurgeon with advanced training in brain tumour, skull base surgery and Gamma Knife radiosurgery. He is dedicated to providing world-class care with a focus on safe, effective, and compassionate treatment.

Dr Garcia Redmond trained in neurosurgery at major hospitals in Australia and New Zealand, before completing a fellowship in Skull Base and Neuro-oncology at Toronto Western Hospital in Canada. He then undertook subspecialty training in Gamma Knife radiosurgery at the Cleveland Clinic in the United States, where he gained expertise in minimally invasive treatment of brain tumours, vascular conditions, and functional disorders.

He has extensive experience in treating complex conditions such as pituitary tumours, meningiomas, vestibular schwannomas, and metastatic brain disease, as well as advanced procedures such as awake brain surgery and functional mapping. Dr Garcia Redmond also provides spinal surgery, including treatment for degenerative and tumour-related conditions.

Alongside his clinical practice, he is actively involved in research and teaching, with a particular interest in advancing molecular understanding of brain tumours.

His guiding principle is “global expertise, local care” – bringing international training and techniques back to benefit patients in Brisbane.



Dr Joseph Garcia Redmond | Neurosurgeon

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