Evaluation Report

Mental Health Recovery Program
Community Recovery Package

North and Far North Queensland Monsoon Trough
25 January 2019 – 14 February 2019

December 2022

Queensland Government

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Queensland Reconstruction Authority
PO Box 15428
City East QLD 4002
Phone (07) 3008 7200
info@qra.qld.gov.au
www.qra.qld.gov.au

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Introduction

The North and Far North Queensland Monsoon Trough – 25 January to 14 February 2019 (the Monsoon Trough) produced exceptional rainfall that caused disruption and damage to communities in Far North Queensland. This record-breaking rainfall cut off communities, devastated the livestock industry, left the freight industry at a standstill and destroyed infrastructure, homes and businesses.

In total, 39 of Queensland's 77 Local Government Areas (LGAs) were activated for disaster assistance for this event and more than 116,667 people identified as experiencing hardship. The economic and social recovery from this large-scale disaster was beyond the capacity of local communities to facilitate and continues to require long-term support from all functional lines of recovery.

A Community Recovery Package was announced as a joint Commonwealth and State funded program through the Disaster Recovery Funding Arrangements (DRFA) under Category C. The package included the Mental Health Recovery Program.

The purpose of the Mental Health Recovery Program is to improve the mental health of those adversely affected by monsoon flooding in January and February 2019 and to enhance the resilience of affected communities.

Queensland Health (QH), through their Mental Health, Alcohol and Other Drugs Branch (MHAODB) led the design and implementation of the program, which concluded in June 2021. Administrative support was provided by the Queensland Reconstruction Authority (QRA).

This evaluation is carried out in accordance with A Monitoring and Evaluation Framework for Disaster Recovery Programs (2018: 2). The framework allows for examination of the effectiveness, efficiency, appropriateness and implementation of the grants. It also considers if the grants supported disaster affected communities to become more sustainable and resilient.

Developed for QRA, the Deloitte Overarching Disaster Recovery Evaluation Framework has also been reviewed and incorporated within this evaluation.

In conclusion, the evaluation of the Mental Health Recovery Program was shown to contribute to the recovery of the communities and local economies impacted by the North and Far North Monsoon Trough (the Monsoon Trough). Detailed findings were documented in response to key evaluation questions.

Recommendations have been provided to improve the effectiveness of a Mental Health Recovery Program in future, with the evaluation of grants being an important contribution to improve subsequent disaster programs in government.

Publishing of this report will occur on the National Disaster Recovery Monitoring and Evaluation Database hosted by the Australian Institute for Disaster Resilience.

Program Implementation

Summary

Scope

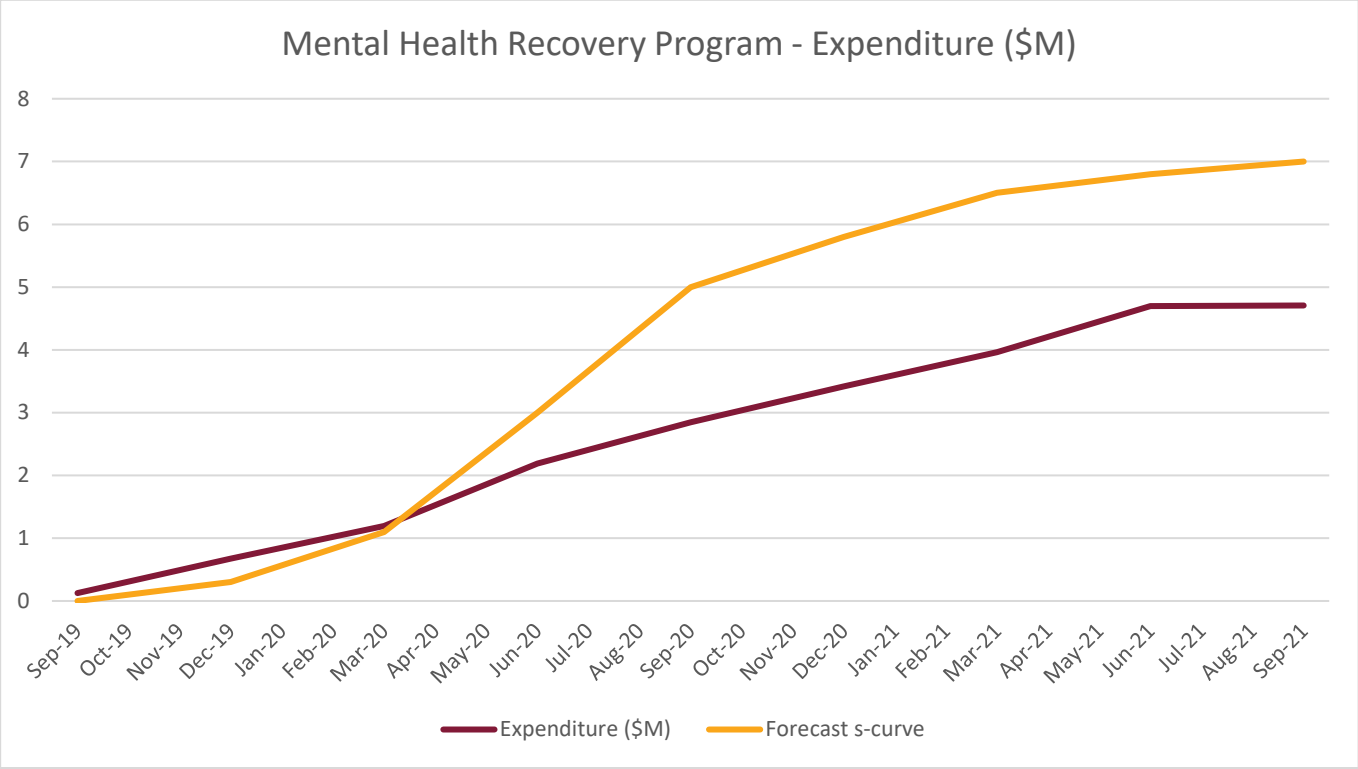
As part of the DRFA Category C assistance, a total of $7 million was available under the Mental Health Recovery Program, delivered from April 2019 to end June 2021. Objectives of the program are to deliver a range of mental health recovery strategies to individuals and communities impacted by the Monsoon Trough, in order to:

- reduce psychological distress and symptoms resulting from flooding experiences and resulting dislocation and disruption
- psychologically prepare impacted communities for future disasters.

Cost

The program was implemented for the actual cost of approximately $4.707 million, which was significantly less than the original program budget allocation of $7 million (67% funds expended).

Expenditure reporting over time is shown below, contrasted with a standard s-curve.



The flattened expenditure profile suggests the initial rollout phase of the program was successful, however the main delivery phase – early 2020 through to early 2021 – underperformed expectations. The analysis throughout this report will examine the practical, on-the-ground delivery results to understand the program underspend.

Time

Planned delivery timeframes were set for the program as per below, with a due date for completion of 30 June 2021. All funds were to be fully expended and acquitted by 30 September 2021.

Milestone	Target commencement date	Target completion date
Recruitment	April 2019	15 May 2019
Model of Service creation	April 2019	15 May 2019
Resource sourcing	April 2019	30 April 2019
Clinical service delivery	April 2019	30 June 2021
Final program acquittal reports		30 September 2021

Program delivery was completed by 30 June 2021 per the original schedule.

Governance activity

The *Queensland Health - Mental Health Sub-plan November 2018* is a sub-plan of the Queensland Health Disaster and Emergency Incident Plan, which itself forms part of the Queensland State Disaster Management Plan.

The Sub-plan's purpose is to provide direction for the mental health response to disasters and emergency incidents in Queensland. This sub-plan mandates the roles and responsibilities of QH and HHS personnel for the governance of mental health support in the event of a disaster.

These governance structures were activated for the Monsoon Trough event and performed their roles through the recovery phase.

Advisory group

Queensland Health (QH) established an Advisory Group chaired by the Senior Director, Strategy, Planning and Partnerships, Mental Health, Alcohol and Other Drugs Branch (or delegate) to oversee the Program.

The Advisory Group included representatives from the:

- Queensland Reconstruction Authority (QRA)
- Department of Communities, Disability Services and Seniors (DCDSS)
- Townsville, North West and Central West Hospital and Health Services (HHSs)
- Mental Health, Alcohol and Other Drugs Branch (MHAODB).

Operational oversight and coordination

The MHAODB maintained operational oversight and coordination for the state-wide disaster response operations. Verbal updates by managers (or delegates) were provided at Advisory Group meetings with QRA and DCDSS.

A statewide Model of Service (MoS) for Mental Health Recovery Programs was developed by MHAODB with input from the HHSs. The statewide MoS provided a framework to ensure a consistency of practice across the sites. Local clinical governance involving a range of service providers for Mental Health Recovery Teams were provided by the funded psychiatrist position.

Program reviews

QRA conducted regular program reviews which incorporated financial and progress assessments of the Mental Health Recovery Program. The DRFA program as a whole portfolio was reviewed by QRA in detail three times each year, for a total of nine reviews throughout the program. These reviews included a program briefing from the DCDSS Director of Community Recovery directly to QRA's Executive Leadership Team.

QRA provided quarterly progress reports on all Category C packages, including the Mental Health Recovery Program, to Emergency Management Australia (EMA) – as the Commonwealth and State jointly funded the program. These reports were made available for evaluation.

Progress monitoring

From the program guidelines it is noted that:

A stepped model of psychosocial and mental health care is the accepted service approach for psychological recovery from disasters. A stepped care model comprises a hierarchy of interventions involving different health and community care service providers where multiple levels of service available to consumers according to their changing needs.

- *In the immediate aftermath of a disaster, psychosocial interventions are universally applied to psychologically affected persons.*
- *Over time there will be a shift from high frequency, low intensity interventions to low frequency, high intensity psychosocial and mental health interventions. These range from services delivered by primary care and community service providers for those individuals who are struggling to recover onto specialised mental health services for those who develop mental disorders.*

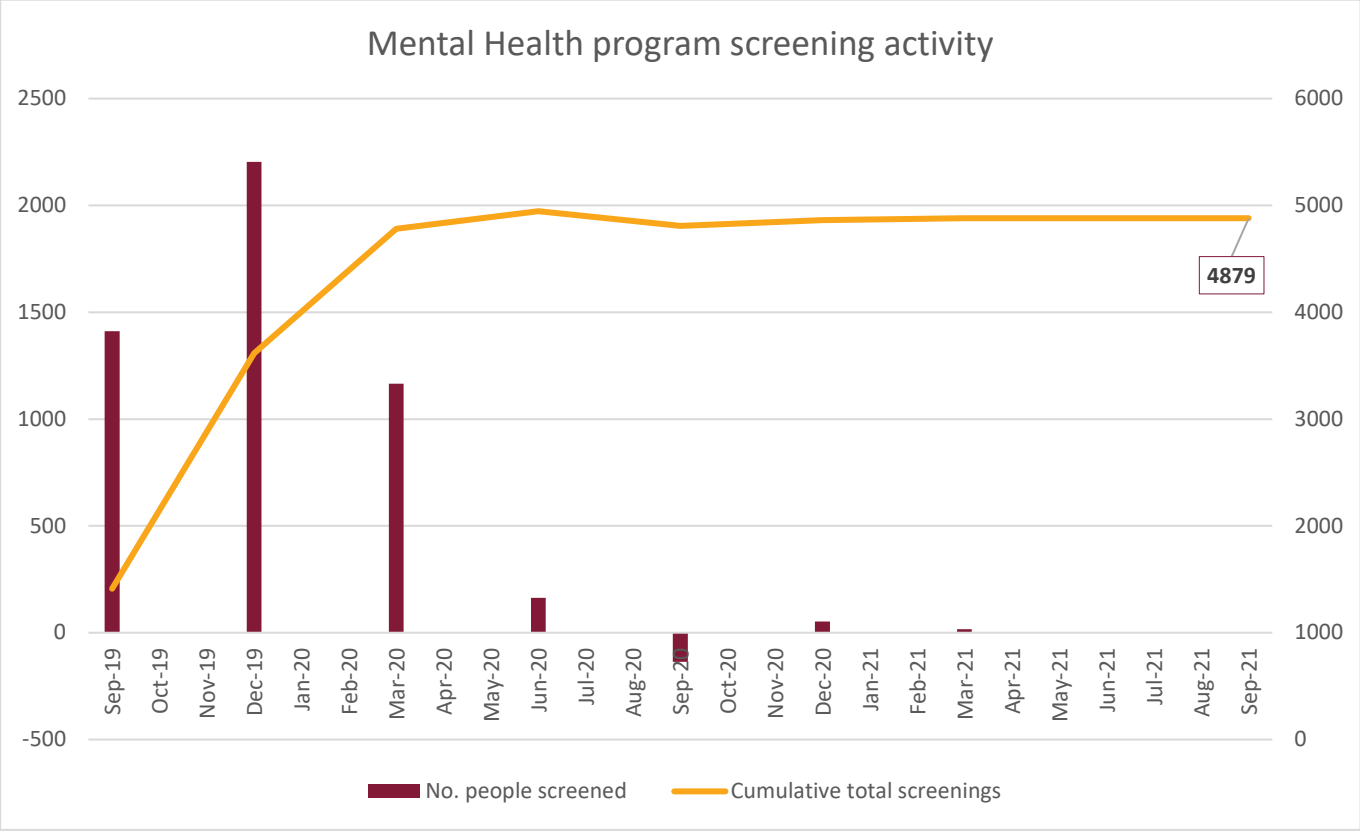
The following data includes information provided by DCDSS, QH and other service providers, including for psychosocial support provided in the "immediate aftermath" and funded and operated separately to the Mental Health Program.

This data capture allows for consideration of interaction issues between various funding programs and providers in the context of the stepped model outlined above.

Quantitative

People screened

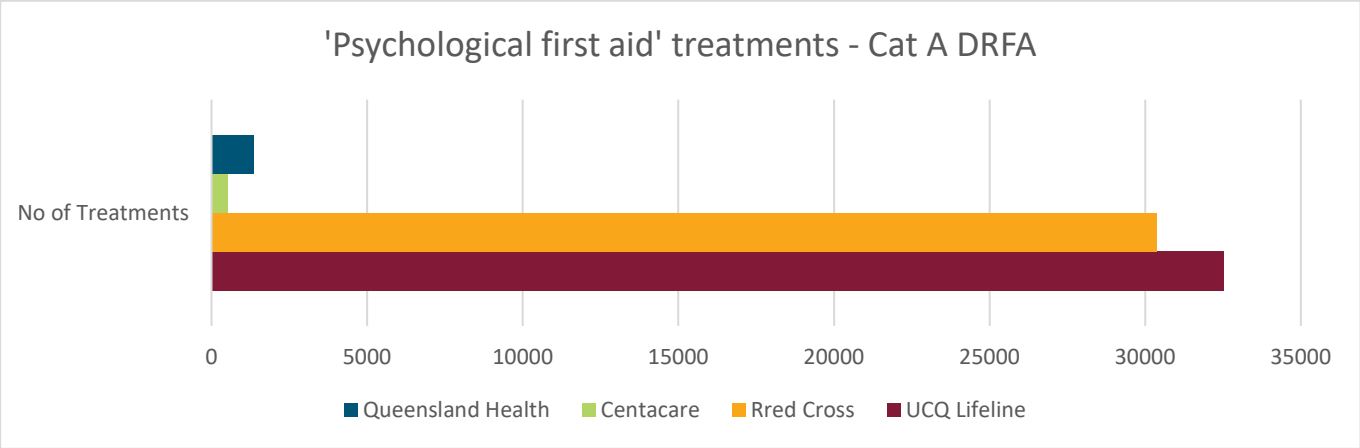
Initial reporting provided in the September 2019 quarter indicated 1,412 people were screened up to the end of the reporting period – that is, within the first six months of the event. This represented 28.9% of the total screenings over the program duration, or nearly one third of total screenings.



An anomaly in the data includes a negative number for screenings in the September 2020 quarter. Disregarding this figure, it is clear screening activity peaked within approximately six months of the event and rapidly declined thereafter. This result also confirms initial triage activity (screenings within the affected communities) occurred relatively quickly following approval of the Mental Health program.

Importantly however, in addition to the mental health screening activity under the Mental Health program, agencies and service providers also undertook psychological first aid treatments (Category A funding) in the immediate period after the event. This treatment is designed to reduce the occurrence of post-traumatic stress disorder.

A total of 64,834 instances of psychological first aid were provided.



The psychological first aid treatments represent government's first line of response to the disaster event and are crucial to establishing effective mental health support within affected communities. The Mental Health program cannot be viewed in isolation to this initial frontline support.

Uniting Care Queensland (UCQ) commenced the provision of psychological first aid (PFA) to North Queensland communities impacted by disaster, together with providing case management to Townsville residents and surrounding areas for a period of six months. These services were delivered by staff who had undertaken Psychological First Aid training and Aboriginal and Torres Strait Islander Psychological First Aid training workshops."

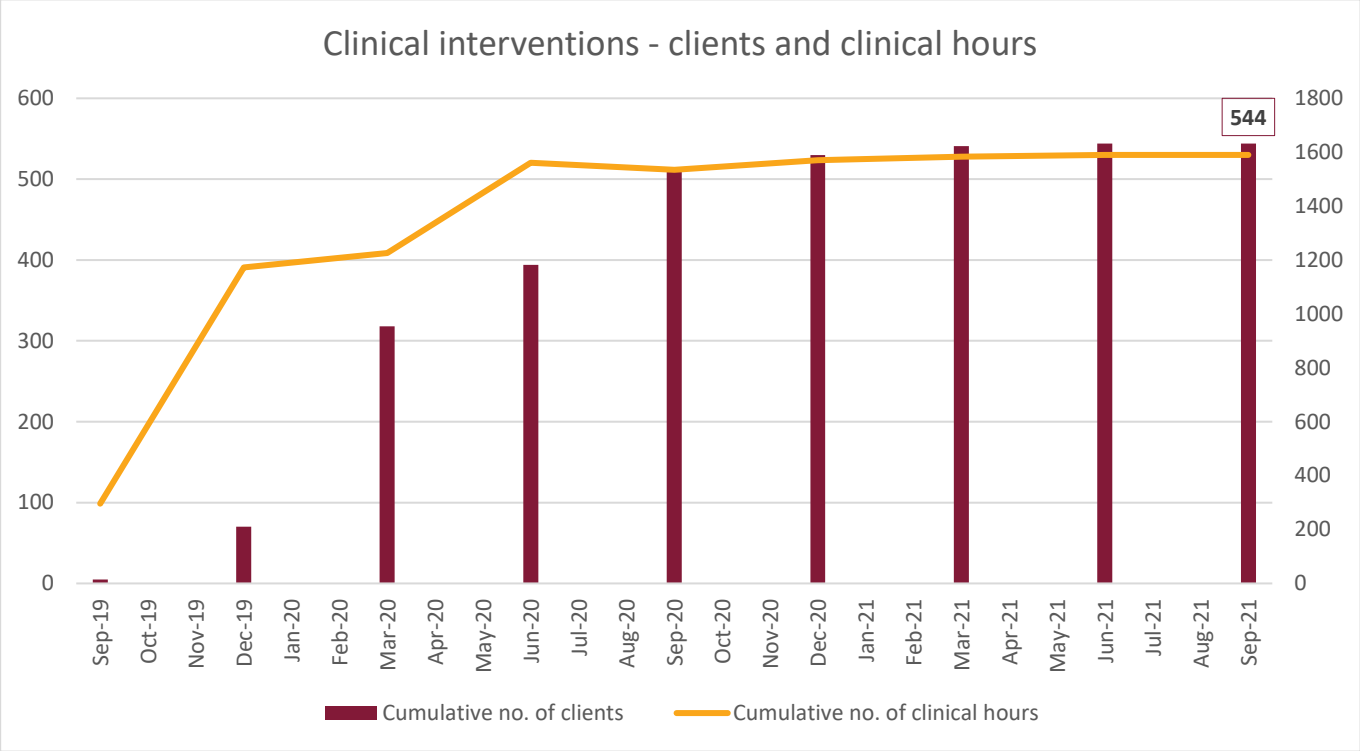
"During the response and early recovery stages, the Australian Red Cross (ARC) was activated on 21 January 2019 under Standing Offer arrangements by the Department of Communities, Housing and Digital Economy (formally Department of Communities, Disability Services and Seniors) to provide Psychological First Aid to affected communities."

The Salvation Army provides referrals to local service providers via disaster recovery case workers employed through jointly funded DRFA - Category A funding."

Clinical intervention

Clinical interventions are the second stage in the stepped care model – being the low frequency, high intensity stage of treatment delivery

Interventions and the associated treatment hours are as follows.



Clinical interventions accelerated rapidly from early 2020 to reach a stable peak of total interventions within a year.

The commencement of interventions can be seen as a reflection of the stepped model – that is, interventions necessarily follow initial screening activity as a "second wave" of activity. However the screening activity was clearly well advanced by the end of the third quarter 2019. Clinical intervention activity only accelerated appreciably through the first quarter 2020.

More likely, the timing may be reflective of staffing issues alluded to in reporting:

"There were two main challenges that the MHRP faced during its operation: high staff turnover, and the COVID-19 pandemic. Unfortunately, the program saw high internal staff movement for various reasons and the program experienced this as it approached its second year. One of the main reasons for the staff movement was the tenure of the program which to some reflects career instability.

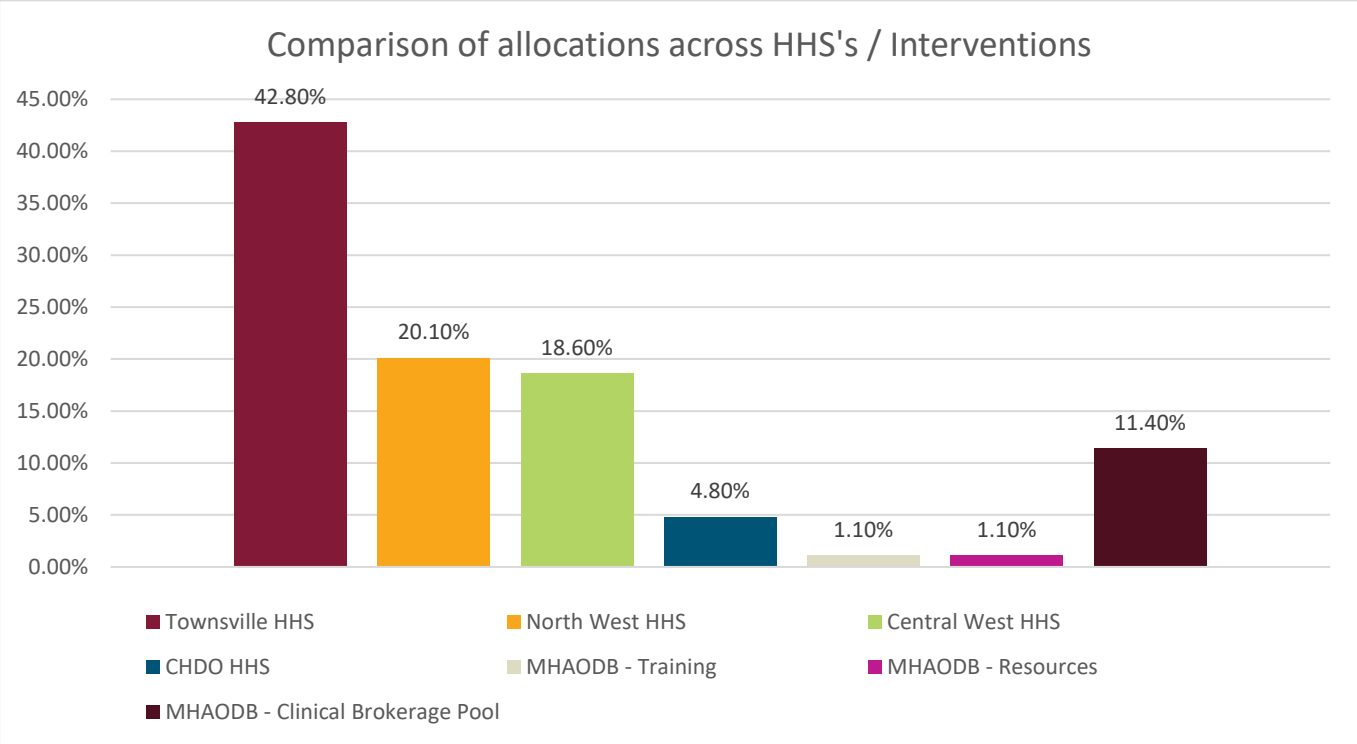
The arrival of the pandemic was unexpected and uncertain which caused some program plans to be revised and customized to suit the current situation causing delays and negative effects on service delivery in communities."

Team staffing

The program budget allocation is unspecified in the guidelines but shown in separate program documentation. Budgetary allocation for the Mental Health program and the associated staffing levels are as follows.

Service provider	Budget ($M)	Staffing description (QRA – MaRS system)
Townsville HHS	2.996	Operation of 9.2 x FTE multidisciplinary mental health team, delivering clinical services to Townsville region. Establishment is made up of Team Leader, 5 Senior MH Clinicians; 1 MH Clinician; 2 Advanced Health Workers, 0.2 Consultant Psychiatrist
North West HHS	1.407	Establishment and operation of 4.2 x FTE multidisciplinary mental health team, delivering clinical services to the North West region. Made up of Team Leader, 1 Senior MH Clinician; 2 Peer Workers, 0.2 Consultant Psychiatrist
Central West HHS	1.303	Establishment and operation of 3.2 x FTE multidisciplinary mental health team, delivering clinical services to the Central West region as per program guidelines. Made up of 2 Senior MH Clinicians, 1 Community Engagement Worker, 0.2 Consultant Psychiatrist
CHDO HHS	0.337	Child and Youth Mental Health Services: Establishment and operation – Birdies Tree Resources and Training Program for HHS's and local Services Providers to develop skills and capacity to work with disaster impacted children during recovery. Establishment is made up of 1 Advanced Specialist Mental Health Clinician
MHAODB - Training	0.080	FY1: Education and Training for Disaster Recovery and Trauma Treatment and Recovery Approaches included: o Program and Framework Approach o Foundation Therapies for Disaster Trauma and MH Recovery o Dulwich Centre Narrative Therapy Training o Sensory Approaches o Bessel Van Der Kolk Trauma Intervention o EMDR Comprehensive Accreditation o Perinatal and Infant Mental Health Stepped Care Approach o PPP for Disaster
MHAODB - Resources	0.080	Clinical Needs assessment - completed and delivered in first 6 months of program

Service provider	Budget ($M)	Staffing description (QRA – MaRS system)
MHAODB - Clinical Brokerage pool	0.796	Clinical brokerage - where needed



Staffing structure and capacity correlates with the mental health delivery model subscribed in the program guidelines:

- Multidisciplinary Mental Health Recovery Teams may include allied health, nursing and psychiatrist staff. The exact composition of the team will be based on the most suitable applicants and community needs.

The funding breakdown and resulting team size appears to weight towards the Central West and North West HHS regions in comparison to Townsville HHS on a strict population criteria.

HHS Region	Population estimate*	% of population
Townsville	235,000	80%
North West	45,000	15%
Central West	15,000	5%

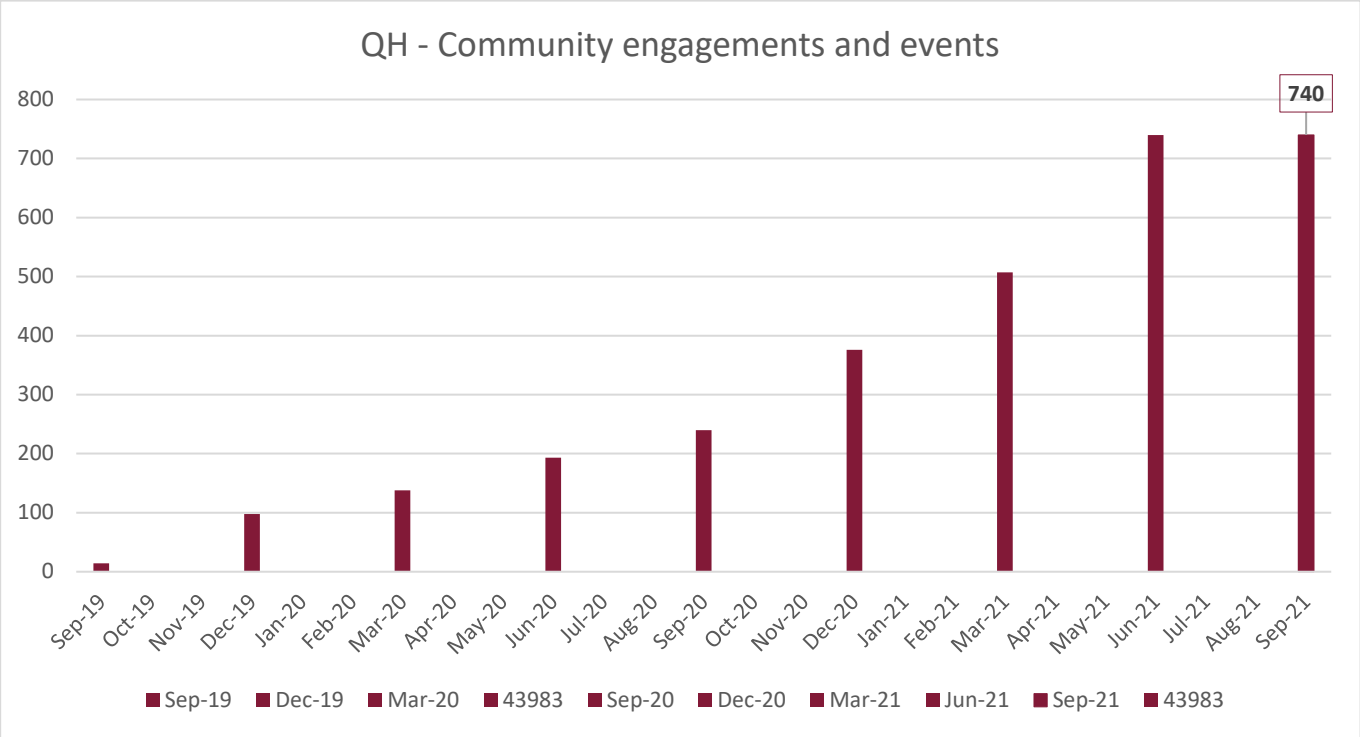
**Detailed population estimates for HHS boundaries not available – figures based on approximate geographical areas and 2011 census*

Funding weighting appears to consider a minimum effective size of a mental health team and the additional effort due to relative geographical size and accessibility.

Therefore it appears issues of equity of service are reflected in the structure of funding arrangements.

Community events and engagements

Community engagement events show a smooth delivery path through the program funding period.



People attending engagement events	›10,000

Quarterly reporting indicates an appropriate breadth of activity:

"Outreach and partnership development with key community leaders and agencies in Richmond, Hughenden and Palm Island has been established, with targeted mental health program planning in place December 2019 for the anniversary period and into 2020."

"Health Promotion / public engagement events this quarter have increased to 18, up from 10 in the previous quarter. 980 residents were engaged in the health promotion presences at these events…"

"Health promotion events highlight - Birdie's Tree resources disseminated at Julia Creek Community Recovery Day attended by 75 children with their families and supported North West MH Disaster Team."

Further resources delivering a component of psychosocial support as part of their function include Category A-funded services below.

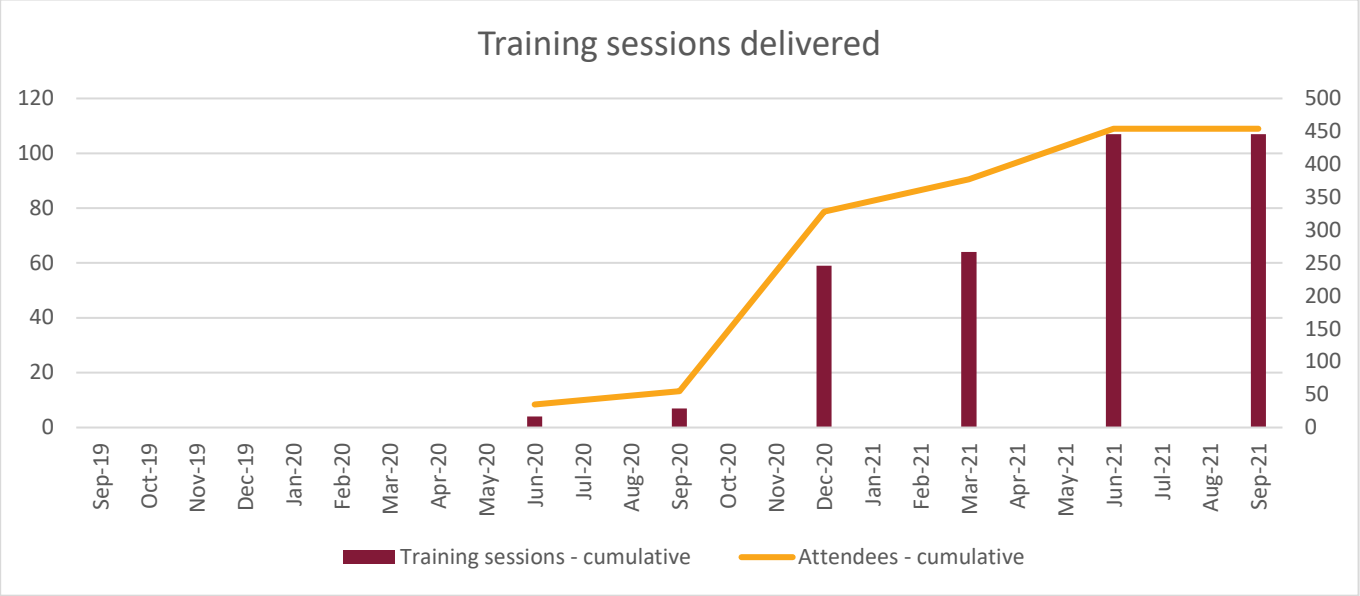
Service provider	Resource
Family Emergency Accommodation Townsville (FEAT)	Generalist counsellor
Financial Counsellors Foundation of Australian	Financial counsellor
North Townsville Community Hub (NOTCH)	Generalist counsellor
Salvation Army	Generalist case worker
Townsville Migrant Support Group	Generalist counsellor
Townsville Women's Centre	Generalist counsellor
Townsville Community Legal Service	Financial and legal advocacy support

For example, the Salvation Army reported:

> *"The Salvation Army (TSA) was successful in securing Category A funding to employ a Recovery Support Worker (RSW), specifically to support the community members impacted by the monsoon. The RSW was employed for six months following the monsoon event and their primary role was to provide long-term recovery support including case work and advocacy to assist community members. The RSW worked with other local agencies assisting community members such as the Disaster Recovery Team (psychosocial support) and Townsville Community Law (legal support)."*

Resources and training materials

Training was delivered across community events, community hubs, health services and partner agencies. Content was focussed on skills for psychological recovery and education about services delivered by the mental health program.



Training guides developed	77

"Training was delivered across community events, community hubs, health services and partner agencies. Focus of content was skills for psychological recovery and education about services delivered by the mental health program. Sessions fitting this definition have been provided to (among others):

- *Mercy Community*
- *the Primary Health Network*
- *Yumba Meta*
- *Townsville Aboriginal and Torres Strait Islander Health Service*
- *Red Cross*
- *Tropical Brain and Mind Foundation*
- *Drop-In-Centre*
- *Women's Centre*
- *NOTCH*
- *Townsville City Council*
- *Uniting Care*
- *Coast to Country*
- *Selectability*
- *Palm Island Community Company*
- *Prospect Disability Service*
- *Charters Towers Regional Council."*

Qualitative

Case studies

Throughout grants implementation, case studies were used to highlight examples of qualitative outcomes. Several case studies were collated for evaluation as indexed below.

Index	Case study
CS01	Supplying mental health and wellness information to middle-aged men in North West Queensland
CS02	Supporting emergency planning for vulnerable people
CS03	Addressing domestic violence, alcohol and drug abuse rising from natural disasters
CS04	Providing evidence-based psychological treatments to monsoon affected residents in the Townsville region

Evaluation findings

The stepped model of delivery for mental health services is a foundational principle for the delivery of mental health support following a disaster event. This model of care has been endorsed by Queensland Health and is the key principle underlying the development of the *Queensland Health - Mental Health Sub-plan November 2018*.

All evaluations in this document will have regard for the key principle of: How well does the Mental Health Recovery Program (MHRP) deliver against the stepped model of service delivery?

The stepped model will be most severely challenged in an environment of multiple service providers delivering a variety of mental health services, across a wide geographical area to diverse communities experiencing differing effects of a disaster – this is exactly the complex circumstances of the Monsoon Trough event.

Governance

Coordinated phases

G10 – Has the governance structure coordinated response and relief efforts with the recovery process so that the two 'work together'?

The action plan of the State Recovery Plan provides a clear summary set of guiding activities reflecting the stepped model of mental health service delivery for the Human and Social domain, and the importance of community engagement:

Impact consequence	Recovery activity	Projected outcome	Timing
People have experienced injury, trauma or other psychosocial impacts affecting their wellbeing.	Coordinate the provision of psychosocial and practical supports lead by DCDSS in conjunction with non-government organisations. Referrals to existing personal support and generalist counselling services. Establishment of local case coordination mechanisms (as required).	Community members have access to psychosocial support	Feb '19 – Jun '21

Metric	Measure
Cat C Mental Health Program (DCDSS and QH)	• Gradual commencement of mental health recovery services. • Number of people receiving mental health clinical services.

The service provider environment for the Monsoon Trough event included the following agencies and organisations:

Department of Communities, Disability Services and Seniors (DCDSS)	
Queensland Health (QH)	MHAODB; Children's Health Qld
Regional Health and Hospital Services (HHS)	Townsville; Central West; North West
Partner service delivery organisations	Red Cross; Centacare; Uniting Care Queensland (UCQ); Salvation Army
Supporting NGOs	Family Emergency Accommodation Townsville (FEAT); Financial Counsellors Foundation of Australia; North Townsville Community Hub (NOTCH); Townsville Migrant Support Group; Townsville Women's Centre; Townsville Community Legal Service

Local Government	39 activated LGAs

To deliver services effectively and efficiently within a complex environment as indicated above, the relationships and structures for managing, controlling and monitoring service delivery need to be robust and widely inclusive.

Governance (people and processes) must have authority to organise and deliver resources; the collaborative nature to seek to engage with local communities and organisations and listen to their needs and critiques; and the self-awareness to change, based on reasonable and appropriate recommendations.

A clear example of the latter two characteristics in delivery of mental health disaster recovery programs generally was the *Mental Health Disaster Recovery Summit*, *June 2021* and the resulting report. This report is a valuable and insightful document collating the views and opinions of a broad range of service providers and community organisations.

Finding 1: The report on the Mental Health Disaster Recovery Summit, June 2021 is an important resource documenting the strengths and weaknesses of mental health disaster program delivery.

While the document notes it is a tool for improvement – *"[this] report is intended for program managers at state, regional and local levels, and for future team leaders and members"* – the delivery of a more formal document to government would ensure the report's potential is fully realised.

Recommendation 1: The report on the Mental Health Disaster Recovery Summit, June 2021 is further examined and tested by MHAODB and QRA, and a resultant set of clear and precise recommendations for action are presented to government – to improve the function on mental health recovery services in future disaster events.

The report itself provides qualitative responses to the topic of program delivery and its enabling capacity to join front end response and relief efforts with recovery efforts. The following Monsoon Trough State Recovery Plan diagram provides a visual representation of the task of governance in this regard:

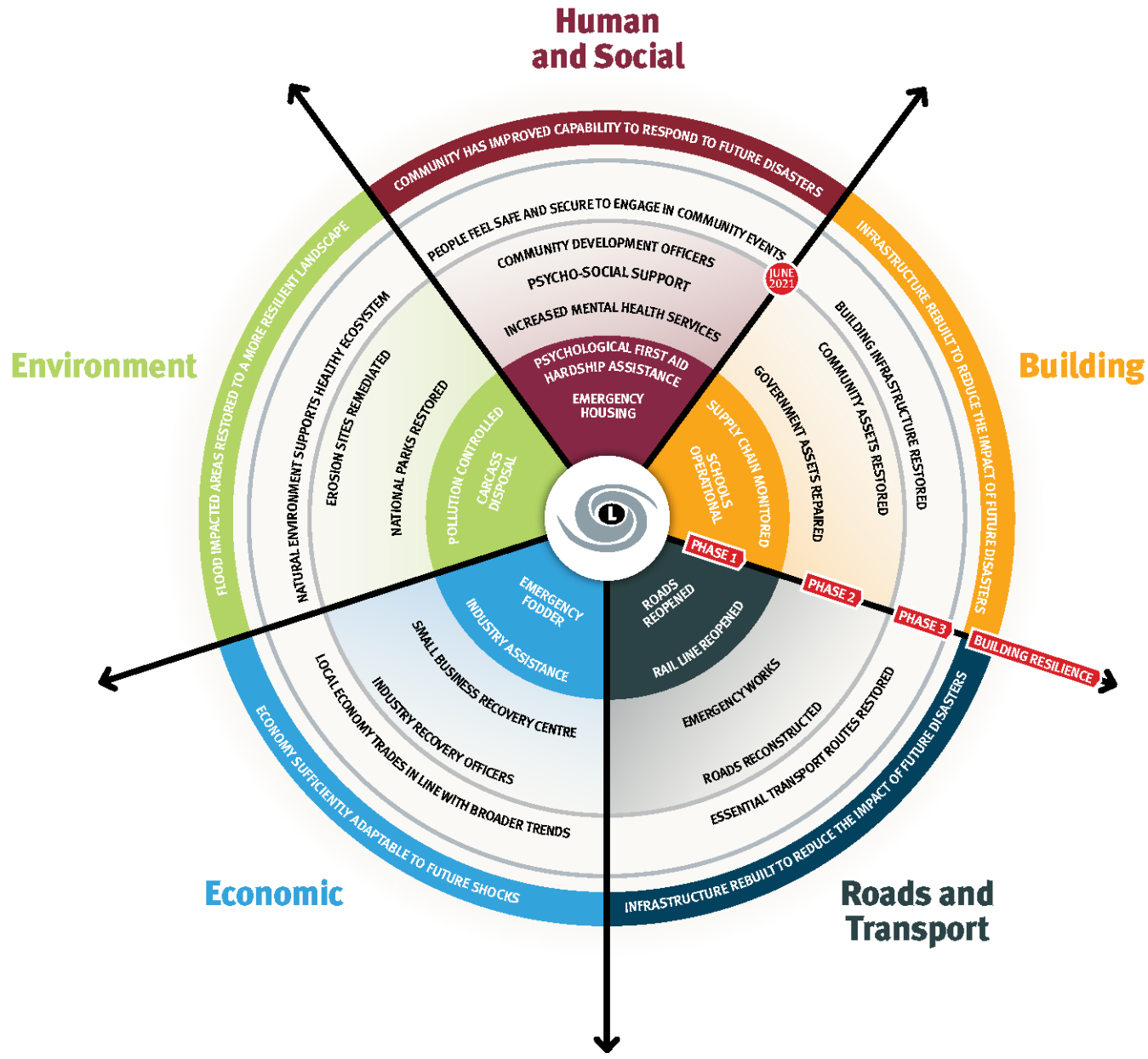


Diagram of state recovery objectives

This diagram visualises the 'boundary effects' all disaster programs must deal with – whether the program creates a 'cliff edge' between response and relief efforts (in this instance, psychological first aid and hardship assistance) and the support and recovery services that follow.

The report from the *Mental Health Disaster Recovery Summit, June 2021* provides a multifaceted response:

"***All presenters stated or implied that we need to visualise the team as part of a broader recovery effort.*** *Working with other dedicated recovery services and a bank of existing health, education and social service providers was essential.*"

"A very clear message was **the likelihood of effectiveness in a long-term mental health recovery program is increased when concerted actions are taken in the response and early recovery phase following a disaster**. Participants stressed that staff operating in disaster hubs need to have information at hand about how to position people to access future recovery services including what to expect at different phases of recovery and what help would be available."

There is evidence people who will experience long term difficulties in recovering from a disaster will develop signs of distress and symptoms of disorders in the days and weeks following the event, and will be experiencing problems in mood and social functioning from that point forward. ***Starting MHRPs between six to nine months after the event is problematic****. There is a gap between the pouring in of mental health staff in the first few weeks following an event and the start-up of the MHRTs several months later. People are unlikely to receive specialist mental health assistance in the intervening period unless they actively pursue it from whatever existing services are available."*

"In certain communities attitudes and related behaviours ranged from scepticism and reticence through to suspicion and avoidance. ***These attitudes were amplified when there was a long gap in services from the disaster event to the point when teams commenced****. There was resentment in certain places because "*you left us alone…*""*

It is clear frontline staff regard the 'cliff edge' between initial relief efforts and establishment of recovery programs as real and have an impact on mental health recovery outcomes.

This is a structural 'disaster planning' issue. This evaluation can only note the structural relationships between programs. In this case, Category A psychosocial support and Category C mental health recovery programs should be reviewed to address the cliff edge in program delivery.

Recommendation 2: QRA in consultation with program delivery partners should review the structural relationship between Category A and Category C activation and funding arrangements to minimise the potential for delivery dislocations.

Regarding the specific governance actions of the MHRP however, the data on initial screenings indicates once activated, the program rapidly mobilised the delivery of mental health services – given Mental Health program activation and subsequent recruitment and resourcing only commenced in April 2019.

This rapid mobilisation is a proxy indicator for effective governance arrangements regarding preparedness and planning – initial services were ready to go once resources could be expended.

This preparedness was highlighted in quarterly reporting. Queensland Health advised:

"*An ongoing seasonal preparedness program ensures that a pool of trained and response-ready clinicians are able to attend emergency events as required*."

"Mental health teams from Queensland Health are operational in Townsville, Central West and North West Hospital and Health Services. Skills for psychological recovery and specialist psychological treatment have been provided across all activated LGAs in partnership with local community agencies. Teams are engaging with stakeholders, communities and also providing clinical treatment. Teams are ensuring that cultural needs for Aboriginal, Torres Strait Islander and culturally and linguistically diverse groups are being met."

"Teams are engaging with stakeholders, communities and also providing clinical treatment. Teams are ensuring that cultural needs for Aboriginal, Torres Strait Islander and culturally and linguistically diverse groups are being met."

This Queensland Health perspective on success is supported by commentary from various delivery partner and stakeholder organisations:

"It was generally agreed the model of service, namely a stepped care approach with trauma-informed methods for individuals allied with a capacity-building framework for work with the communities, worked well."

"Working with local Community Development Officers (CDOs) and Regional Adversity Integrated Care Clinicians (RAICCs), where available, was pivotal. RAICCs had established networks that made entry to rural and remote communities smoother and more efficient. CDOs were strong promoters of the program and enabled access to local organisations and communities. Both proved to be allies in building community confidence in the teams, whose members were often unknown to local people."

"Nurturing close relationships with Cat C and other recovery people – that allowed us to be flexible and outside silos and lots of good examples of doing this well, for example, the Salvation Army…"

Furthermore, governance processes as delivered sought to mitigate the 'cliff edge' where possible:

"In at least one instance where a manager had prior disaster experience existing staffing resources were deployed to start work early, but relying on this happening leaves too much to chance."

In summary, the evidence available regarding how the MHRP is run –governance processes that guide the operation of the program – indicates clarity of the activities required to deliver the program, and recognition of the interplay of different programs at various times through the post-disaster period.

The governance arrangements do not mitigate against effective coordination of response and relief efforts with the recovery process so the two 'work together'. However, these governance arrangements are not sufficient in themselves to resolve 'cliff edge' issues with respect to service delivery.

Finding 2: Governance arrangements for the Mental Health Recovery program are robust and effectively integrated throughout the oversight, management and delivery chain of activity. The model of care implemented under these governance arrangements is widely accepted.

Community engagement

Adequate representation

C2 - Has community engagement occurred in a timely and on-going way that provides adequate representation of community views?

Further central organising principles of the Mental Health program are:

- **Consultation with local communities** should occur to promote involvement in program design and development. **Continual reassessment of community needs** should take place as needs will change over the course of the funding period.
- Engagement with all relevant stakeholders is important to ensure **community recovery programs are integrated and collaboratively run**.
- Mental Health Monsoonal Flooding Recovery services should be delivered in collaboration with other Category C funded agencies, existing local community service agencies, general practitioners, schools, private mental health professionals and other important stakeholders, **as determined by each local community**. [bold added]

It is clear the program design has community engagement and empowerment as a focus of activity, with the program structured around devolved service delivery through the HHSs. The HHS mental health teams' engagement with affected communities is confirmed by commentary from service organisations and stakeholders:

"The team presentations consistently implied that passivity in relation to program implementation was unproductive. It was important that teams took the initiative to seek out key community leaders including Indigenous elders, local government representatives and MPs, and 'local champions' to gain traction with communities or with particular groups, for example men's sheds. In one instance engaging with the farmers who had set up a 'farmer to farmer' program proved advantageous.

Teams benefitted from taking the time to identify places and times where its members could connect to the community, for example stock feed places. In certain areas this involved hours of travel to cattle stations. Meeting with local media and newspapers to promote the program increased referrals and 'cold calling' local businesses was beneficial."

Through these processes of engagement, valuable service delivery occurred:

"Two of the highlights of the program were the Birdie Tree Roadshows *in schools and childcare centres which saw children and young adults get oriented and trained on resilience and natural disasters. Another highlight was the* Small Talk, Big Difference Communication Campaign *in partnership with the Royal Flying Doctor Service (RFDS). The campaign has raised significant public awareness about natural disasters and mental health.*

The Disaster Recovery Team had been very successful working side by side with different partner groups and champions of the community. The success of the program would not have been made possible if not for our partners in the local area."

Finding 3: Community engagement is a fundamental requirement for a mental health program. The MHRP is active in establishing community networks and linkages, and supportive of engagement efforts.

Successful engagement also requires a flexible approach to service delivery, responding to circumstances on the ground. Whilst the devolved service delivery model – from Queensland Health through to HHSs and further connection to LGAs, NGOs and community organisations – provides a picture of a web of connectivity; satisfying the objective of community empowerment, however the lived experience of front-line staff does not always reflect this view:

"As stated above, teams felt the current service model was appropriate and effective while noting that the value of community capacity-building was not well recognised by some important stakeholders, as it departed from the priorities of most existing mental health clinical services. It was acknowledged that the MHRP needed to continue monitoring and reviewing developing evidence on best practices in the field.

The other issue that surfaced was whether there were instances where an alternative service provider may be better placed than HHSs to deliver the MHRP. This may be the case in more remote areas. The matter was not resolved but the issue deserves more consideration."

Recommendation 3: The MHRP guidelines should be reviewed to consider frameworks that further strengthen HHS community networks and build community capacity for mental health service delivery.

Effectiveness

Sustainability

E1 - To what extent did the disaster recovery program produce a sustainable community?

The DRFA program logic pathway to community sustainability enhancement provides the relevant considerations for successful outcomes.

The key drivers in this logic are:

- Provision of the level of mental health services necessary in the community and disaster context
- Informing the community on mental health issues, services and support
- Consultation and training for localising service provision.

Regarding service provision, the data on screenings indicates a rapid rollout and effective completion of the activity within the first year of the program.

Similarly, clinical interventions peaked by September 2020. There is no indication of unmet need in the feedback or reporting.

> *"Referrals for individuals have continued to decrease in the Townsville catchment with 10 new referrals received in this quarter. Closures and transfers to longer term care pathways continue." (April 2021)*

While the level of unmet need for mental health support is not quantified, the extent of community engagement and the efforts by the mental health teams and other service providers to engage (indicated in the quarterly reporting and the *Mental Health Disaster Recovery Summit*, *June 2021* report) suggests community awareness was generally high.

It is reasonable to propose given one third of the program budget was not expended, the shortfall constitutes an indication the original estimates of service need were excessive.

However, the mechanics of the MHRP – establishment of mental health teams including recruitment for a two-year service – suggest minimum funding envelopes are driven by fixed operational costs rather than a unit 'consumption' cost.

In this scenario, underspend is likely due to delays in recruitment noted in the reporting.

Regardless, it appears the MHRP met the threshold for delivery of services to improve community sustainability. No evidence is available of significant shortfalls in meeting need.

Finding 4: The MHRP enhances community sustainability through delivery of key objectives in the areas of meeting needs, provision of information and training. Sufficient resources are available for communities to meet health needs.

Similarly, the quantity and variety of information and training delivered was significant and considered to be successful. The key concern expressed through reporting relates to the timing of this support, particularly across the 'cliff edge' between relief and recovery.

"Participants stressed that once recruitment is successfully completed everything needed to be ready so the team could start work immediately. This would require the advance design of 'ready to go' information resources, training packages for clinicians etc."

"Participants stressed that staff operating in disaster hubs need to have information at hand about how to position people to access future recovery services including what to expect at different phases of recovery and what help would be available."

Recommendation 4: Sustainability of communities is enhanced if disaster delivery is seamless. The MHRP should address the need for preparedness of resources to minimise the time gap between relief and recovery efforts.

Resilience

E2 - To what extent did the disaster recovery program produce a resilient community?

The DRFA program logic pathway to community resilience enhancement provides the relevant considerations for successful outcomes.

Key drivers in this logic are:

- informing the community on mental health preparedness
- training for localising service provision.

The focus is on information and training around preparedness. Examining the reporting, it is clear 'resilience' in a disaster preparedness sense is recognised through the MHRP.

"The Mental Health recovery program contributes to restoring social networks and improving community resilience and capacity building. Activities include:

- *Community members in Burke Shire received Rural Minds training.*
- *Birdies Tree program delivered to 135 young people and 14 teaching staff across three schools in Carpentaria Shire.*
- *Yoga and Wellbeing session and community Health BBQ events held in Cloncurry Shire; Birdie's Tree delivered over three sessions.*
- *Birdies Tree program delivered in McKinlay shire."*

Significant resilience activity occurred through NGOs. For example, the Red Cross as part of a 2-year funding arrangement separate to the MHRP reported on preparedness activity:

- *"building resilience of children - 432 children reached through Pillowcase Project*
- *working with Aboriginal and Torres Strait Islander communities - 19 Aboriginal and Torres Strait Islander community members engaged*
- *working with the homeless community around disaster resilience*
- *engaging culturally and linguistically diverse communities in recovery and resilience building activities - 50 families attended a disaster preparedness session with Red Cross and the Open-Hands Service."*

The extent of mental health engagement activity – 740 events reaching over 10,000 people – is indicative of significant community impact throughout the affected areas. The Birdie's Tree project alone (137 books and 15 sets of puppets), targeted at building disaster resilience in children, was delivered to over 500 students and further disseminated via eBook, print book and animation.

Finding 5: The MHRP enhances community resilience through delivery of key objectives in the areas of provision of information and training. Sufficient resources are available for communities to psychologically prepare for future disasters.

Implementation

Delivery as intended

I1 - To what extent was the program delivered as intended?

The MHRP delivery followed a structured pathway of services rollout and clearly operated within its guidelines. This approach was perceived to be overly rigid by some stakeholders in their feedback on the program:

"The lack of pre-existing information resources, delays in approval of brochures or other media resources, and the opportunity cost of having to repeatedly recruit and train staff in some instances caused frustration. Duplication of data sets in reporting was also challenging. The sense that HHS executives, including Chief Executives and Chief Financial Officers, didn't understand the requirements of mental health service provision to people recovering after disasters was prevalent. Restrictive financial and HR practices reduced flexibility and program effectiveness."

The issues at play here, whilst understandable from a front-line service perspective, do not necessarily recognise the conservative processes and procedures inherent in any health intervention. There will always be a tension between fast rollout of services following disasters and the necessity for process to be followed by large organisations. This will be most acute in the health arena.

Reduction of 'red tape' should always be an objective organisationally. Whether the bureaucracy was inhibiting in this instance is an internal issue for the relevant departments and authorities.

Generally, the MHRP was delivered as intended. Staffing issues, and lack of timely delivery of other resources impeded prompt rollout of the program.

This evaluation report notes at least some issues raised can be dealt with through further preparedness planning, and as in a military scenario, forward deployment of resources.

Finding 6: The MHRP was delivered as intended.

Recommendation 5: MHRP delivery can be improved by further preparedness planning and consideration of program flexibility measures, to address front-line delivery concerns.

Conclusion

The evaluation has concluded the Mental Health Recovery Program contributed to the recovery and resilience of the communities impacted by the Monsoon Trough disaster. Key findings of the evaluation are provided below.

Governance

1. The report on the Mental Health Disaster Recovery Summit, *June 2021* is an important resource documenting the strengths and weaknesses of mental health disaster program delivery.
2. Governance arrangements for the Mental Health Recovery program are robust and effectively integrated throughout the oversight, management and delivery chain of activity. The model of care implemented under these governance arrangements is widely accepted.

Community engagement

3. Community engagement is a fundamental requirement for a mental health program. The MHRP is active in establishing community networks and linkages, and supportive of engagement efforts.

Effectiveness

4. The MHRP enhances community sustainability through delivery of key objectives in the areas of meeting needs, provision of information and training. Sufficient resources are available for communities to meet health needs.
5. The MHRP enhances community resilience through delivery of key objectives in the areas of provision of information and training. Sufficient resources are available for communities to psychologically prepare for future disasters.

Implementation

6. The MHRP was delivered as intended.

Recommendations

The following recommendations are provided to improve the effectiveness of future disaster recovery programs:

Recommendation 1

The report on the Mental Health Disaster Recovery Summit, June 2021 is further examined and tested by MHAODB and QRA, and a resultant set of clear and precise recommendations for action are presented to government – to improve the function on mental health recovery services in future disaster events.

Recommendation 2

QRA in consultation with program delivery partners should review the structural relationship between Category A and Category C activation and funding arrangements to minimise the potential for delivery dislocations.

Recommendation 3

The MHRP guidelines should be reviewed to consider frameworks that further strengthen HHS community networks and build community capacity for mental health service delivery.

Recommendation 4

Sustainability of communities is enhanced if disaster delivery is seamless. The MHRP should address the need for preparedness of resources to minimise the time gap between relief and recovery efforts.

Recommendation 5

MHRP delivery can be improved by further preparedness planning and consideration of program flexibility measures, to address front-line delivery concerns.

Appendices

Appendix A – Background

2019 North and Far North Queensland Monsoon Trough

Impacts

The North and Far North Queensland Monsoon Trough – 25 January to 14 February 2019 (Monsoon Trough) produced exceptional rainfall that caused disruption and damage to communities in Far North Queensland.

The record-breaking rainfall cut off communities, devastated the livestock industry, left the freight industry at a standstill and destroyed infrastructure, homes and businesses. Over 56 per cent of the state's land mass was impacted, with 39 LGAs activated for joint State and Commonwealth DRFA assistance.

More than 70 locations experienced record daily rainfalls, 20 experienced record accumulated rainfall over 10 days and 18 locations set new records for the number of consecutive days of high (50mm or more) rainfall. In and around Townsville, the accumulated daily rainfall totals were the highest since records began in 1888.

The cascading and compounding consequences of this event are yet to be fully quantified but the long-term social and economic cost has been estimated by Deloitte Access Economics at $5.68 billion. Damage to agriculture is estimated at $432 million, including livestock losses of up to 500,000 cattle and 30,000 sheep.

Small business disruption has been estimated at $116 million with 97 per cent of small businesses surveyed across the most heavily flooded areas reporting financial impacts including closures, trade interruptions, forward booking cancellations and damage to premises and equipment.

The extraordinary scale of damage to critical infrastructure included impacts to 6420km of state roads, 307km of Mount Isa rail line, 1000km of water pipelines, 15,000km of on-farm roads and 10,000km of fencing, bringing ongoing financial hardship to individuals, small business and industry until repairs can be undertaken across some of the most remote and challenging terrain in the country.

The closure of the Mount Isa rail line critically disrupted mining and minerals production – the major employer in North West Queensland. Glencore's Collinsville mine, Newlands Coal mine and Incitec Pivot's fertiliser facility were partially shut down – incurring extraordinary costs associated with alternative storage and freight of product.

With more than 116,667 people identified as experiencing hardship, the economic and social recovery from this large-scale disaster is beyond the capacity of local communities to facilitate and will be a long-term effort requiring collaboration and cooperation by all levels of government.

Response

Human and Social

DCDSS, together with partner agencies, established more than 30 community recovery hubs in the most impacted areas in the north, far north and north west of Queensland, providing services to more than 37,000 people.

Building

Queensland Fire and Emergency Services (QFES) coordinated initial Damage Assessments (DAs) to determine immediate impacts. With the assistance of QRA, QFES undertook 8467 Damage Assessment inspections with approximately 40 per cent of the properties reported as damaged and 15 per cent as uninhabitable. QFES also assisted residents by providing targeted wash out services to more than 300 flooded homes.

Roads and Transport

The Department of Transport and Main Roads (TMR) has been progressively assessing and restoring access to the 6420km of state-controlled road network impacted from the event. Inspections and emergency works were required to maintain road access where possible with more than $20 million spent on counter disaster operations, emergency and immediate reconstruction works. TMR also removed 131 carcasses from state-controlled roads in impacted LGAs.

The Flood Recovery Road Access Group (FRRAG) was activated to manage emergency and disaster heavy vehicle access for freight consignors and heavy vehicle transport operators travelling in the affected areas; 86 enquiries were received with 31 permits issued.
The Rail Recovery Taskforce was established to lead the repair of 204 sites across 307km of flood-damaged track on the Mount Isa rail line. Over 400 employees and contractors were mobilised to accelerate the repairs and temporary workers camps established at Julia Creek and Richmond.

Economic

Recovery assistance for primary producers, small business and non-profit organisations has been activated under DRFA. As at 23 August 2019, more than $93 million has been paid to 2224 primary producers, small businesses and not for profits. In addition, 46 Disaster Assistance Loans totalling over $6.3 million have been approved for 15 primary producers and 31 small businesses impacted by the event.

As at 23 August, the Townsville Small Business Recovery Centre had provided 2450 lines of assistance to local businesses. Surveys were also conducted with a total of 794 small businesses and 172 primary producers participating.

Environment

Assessments have been undertaken with regards to riparian damage, biodiversity and habitat loss including the assessment and reopening of 41 national parks. Helping to ensure the safety of the community, saltwater and freshwater crocodiles surveys were undertaken and high risk animals relocated (if safe to do so) as well as increasing key messaging to the community on high risk native wildlife.

Early engagement was undertaken with mining and industrial sites to ensure recovery actions were environmentally safe and compliant with environmental approvals.

Consequences

Estimated impacts	Economic cost
Human and Social • Health, wellbeing and community impacts • Emergency response and clean-up	$2.419 billion
Building • Residential damage • Commercial damage • Public asset damage	$1.927 billion
Roads and Transport • State road damage • Local road damage • Rail damage	$742 million
Economic • Primary production damage and disruption • Small business disruption	$548 million
Environment • Riparian streambank damage • Coastal erosion • Pest and disease outbreaks	$44 million
Total cost	$5.68 billion

Source: Deloitte Access Economics estimates – The social and economic cost of the North and Far North Queensland Monsoon Trough (2019)

Queensland's disaster in numbers

$5.68 billion estimated social and economic cost of the Monsoon Trough event

HUMAN AND SOCIAL

66,728 calls to the Community Recovery Hotline

$2.419 billion estimated health, social and community impacts

$33 million in PHAS grants paid benefitting **116,667 people**

1800 people assisted with housing support

64,823 people assisted with psychological first aid

39 Local Government Areas (LGAs) activated for Disaster Recovery Funding Arrangements **DRFA ACTIVATION**

4483 requests for assistance received by State Emergency Service during the event

Activated LGAs cover an area of 100 million hectares = 56% of Queensland's land mass

BUILDING

$50 million estimated damage to other **public** assets

3,300 properties damaged

$1.46 billion estimated damage to **residential** property

$14.5 million estimated damage to public **water** and **sewerage** infrastructure

$402 million estimated damage to **commercial** property

ROADS AND TRANSPORT

$742 million estimated damage to roads and transport infrastructure

307km of Mt Isa rail line impacted including **200km** severe damage, **204** sites of severe erosion, **38** bridge abutments damaged

6420km of State road network impacted

40,000km of local government roads in the impact zone

ECONOMIC

More than **27,300** insurance claims lodged with a combined value of **$1.132 billion**

$432 million estimated damage and disruption to primary production

Livestock losses up to **500,000 cattle** and **30,000 sheep**

Direct impacts to small business estimated at **$44.8 million**

More than **17,000 small businesses** in the impact zone

Small business disruption estimated at **$116 million**

on-farm infrastructure damage

10,000km of fencing
1000km of water pipelines
15,000km of on-farm roads

$320 million mining revenue losses estimated due to **rail closure**

2300 bales of hay transported for Fodder Drop Operations

ENVIRONMENT

Rainfall & Flooding
TOWNSVILLE – 1257mm in 10 days
PALUMA, WOOLSHED & UPPER BLUEWATER – more than 2000mm in 12 days
70 locations BROKE **DAILY** RECORDS
20 locations BROKE **ACCUMULATED 10 DAY** RECORDS

Ross River Dam reached **248%** capacity

Accumulated **TOTALS** from consecutive days of heavy **RAINFALL** in and around Townsville were the **highest** since records began in 1888

41 national parks and state forests **closed**

Floodwaters **700km** long and up to **70km** wide covered **15,000km²** in the Flinders and Norman River basins

≥$40 million **estimated damage** to riparian, streambank and coastal areas

Recovery Package

State recovery planning

North and Far North Queensland Monsoon Trough – State Recovery Plan

Major General (Retired) Stuart Smith, had his role extended on 8 February 2019 to include leading recovery from the Monsoon Trough flooding. The role involved development and implementation of the North and Far North Queensland Monsoon Trough – State Recovery Plan 2019-2021 (Recovery Plan) to assist communities to recover, rebuild and reconnect as stronger and more resilient.

The Recovery Plan acknowledges that successful recovery relies on a collaborative, coordinated, adaptable, scalable approach where the responsibility for disaster recovery is shared between all sectors of the community. This includes individuals, families, community groups, businesses and all levels of government. Locally-led approaches to recovery support rapid restoration of services essential to human wellbeing and present an opportunity to build resilience and improve community circumstances and preparedness beyond their pre-disaster state.

The Recovery Plan follows this framework to be delivered across five recognised lines of disaster recovery – Human and Social, Building, Roads and Transport, Economic and Environment. The Recovery Plan recognises the lead role local governments play in the recovery process and the need for them to develop local recovery plans to help guide restoration and enhancement of infrastructure, support vulnerable and isolated members of the community, increase disaster preparedness and build resilience for the future.

Roles and responsibilities

Local government
The Recovery Plan recognises that local governments have a legislated responsibility through the *Disaster Management Act 2003* for implementation of local disaster management plans.

Queensland Reconstruction Authority
QRA is the lead agency for coordination and development of disaster recovery, resilience and mitigation policy in Queensland. QRA supports the delivery of recovery and reconstruction projects for communities impacted by the Monsoon Trough from a state perspective by providing coordination and facilitation of communication across the five Functional Recovery Groups (FRGs) to achieve whole of community outcomes. QRA also administers funding assistance on behalf of the Commonwealth and Queensland governments under the DRFA. QRA will provide regular recovery reports outlining progress across local governments, as informed by the FRGs at a state level. QRA will also report on the recovery process to the QDMC.

State Recovery Policy and Planning Coordinator
The Chief Executive Officer of QRA also fulfils the role of the State Recovery Policy and Planning Coordinator (SRPPC). The SRPPC works with the SRC to ensure a smooth transition between response and recovery, as well as overseeing recovery operations including state level preparedness and recovery policy, planning and capability development.

State Recovery Coordinator
The SRC works in partnership with the SRPPC to coordinate recovery activities for the Monsoon Trough, report regularly to the QDMC and provide strategic advice to government agencies undertaking disaster recovery work.

Deputy State Recovery Coordinator
The DSRC provides local support – geographically located in Townsville for the Monsoon Trough – to the SRC and Queensland Government with critical insights on how to best assist communities on their road to recovery.

Other groups

Further information on the roles and responsibilities of the following entities and positions are detailed in the *Queensland Recovery Plan* and the *State Recovery Coordinator Guide 2018*:

- Local Recovery Groups (LRGs)
- Local Disaster Management Groups (LDMGs)
- Functional Recovery Groups (FRGs)
- Queensland Disaster Management Committee (QDMC)
- The Minister responsible for reconstruction and recovery
- State Recovery Coordinator (SRC)
- Deputy State Recovery Coordinator (DSRC).

Human and social recovery plan

Impact summary

DCDSS has identified a number of key community support, health and wellbeing recovery impacts and issues across various locations and interest groups.

Financial counsellors have reported a significant increase in demand for financial support and low levels of financial literacy with issues being raised such as:

- Nil or insufficient insurance coverage.
- Uninsured but contractually rented contents destroyed by floods. This means renters are not eligible for grants (as they do not own the contents) but must continue to pay rent as per the contract.

Provision of a range of social, emotional and psychological support services:

- Partner agencies have provided 63,600 instances of psychological first aid.
- More than 30 Community Recovery Hubs and Pop-Up Hubs established.
- 8880 Outreach visits conducted to provide support to impacted communities.
- Four Community Recovery Referral and Information Centres and a Rental Recovery Hub have provided support across North, Far North and North West Queensland.

Mental health and wellbeing:

- The cumulative impact of many years of drought, as well as unanticipated flooding, has had a profound effect on the wellbeing of community members.
- To date, 1344 instances of acute mental health support have been provided by agencies such as Queensland Health and North West Rural and Remote Health Services.

Housing and accommodation:

- 3300 properties damaged
- 805 requests received for Emergency Housing Assistance.

Community Disruption:

- Disruption of community social events, volunteering and community service activities due to impacts upon volunteers and staff; impacts upon sporting or service facilities; access and egress issues; financial capacity of business to support events and community members capacity to attend.

Recovery outcomes

Sustainability

- Adequate housing is available to community members at appropriate times in the recovery process.
- Community members have access and are able to meet health needs (including mental health) arising from the disaster.

- Community members have access to psychosocial support.
- Households, families and individuals can act autonomously to contribute to the recovery process.
- Community members have access to education services.
- Community members have access to appropriate and coordinated social services.
- Community members feel sufficiently safe and secure following a disaster to engage in social activities and interactions with other members of the community.

Resilience

- The community has improved capacity and capability to respond to future disasters.
- The Community Recovery Package delivered targeted support to individuals and families to recover from the Monsoon Trough event, as well as building community capacity to more effectively respond to future events.

Program

Program guidelines

Eligibility criteria

Eligible communities

Individuals and communities who have been adversely affected by the Monsoon Trough event, in the Hospital and Health Services districts of Townsville, North West and Central West.

Mental health recovery teams

Multidisciplinary Mental Health Recovery Teams may include allied health, nursing and psychiatrist staff. The exact composition of the team will be based on the most suitable applicants and community needs. All staff will have both clinical and community engagement and outreach, and training skillsets. State-wide staff training will be supplied pending available funding. All staff will have access to the QH Employee Assistance Service as staff may experience vicarious trauma and burn-out due to possible direct personal impacts of the floods and through exposure to the trauma of those they are assisting.

Eligible costs

- Extraordinary staffing and/or salary costs of mental health recovery teams
- costs directly associated with delivering the program activities
- contractor costs
- travel costs, such as airfares to identified locations
- vehicle costs including leasing, fuel, insurance etc.
- staff incidentals paid as per the award arrangements for travel
- telecommunications purchases and expenses to ensure safety on outreach and remote visits
- computer hire and IT levies such as right to access QH IT networks and software licences to enable clinicians to document clinical treatment provision. all other non-labour expenses includes individual treatment and group work resources, such as materials and minimal catering costs and also recruitment and on-boarding costs such as staff swipe cards and police checks.
- clinical training programs (pending available funding) to upskill the mental health recovery workforce in the latest evidence based treatment approaches to post disaster conditions such as PTSD or complex grief.

Ineligible costs

- legal costs
- core business activities
- purchase of core business capital equipment such as motor vehicles, phones and office equipment
- remuneration of permanent or executive officers
- office rental, furnishings and supplies
- remuneration of employees for work not directly related to the Program
- unsupported on-cost charges

- vehicle leasing, unless directly related to the delivery of the project
- costs of preparing applications, reports, acquittals or associated supporting material.

Appendix B – Evaluation plan

Program outcomes

The North and Far North Queensland Monsoon Trough State Recovery Plan 2019-2021 identified high level recovery outcomes organised around the five functional lines of recovery. The community recovery objectives that relate to the Mental Health Recovery Program are as follows:

- reduce psychological distress and symptoms resulting from flooding experiences and resulting dislocation and disruption
- psychologically prepare impacted communities for future disasters.

Program logic

A program logic diagram has been developed and is included as *Appendix D*.

The diagram shows the logical relationship for how:

- outputs can be measured against indicators
- indicators relate to the program strategies
- program strategies achieve recovery objectives
- recovery objectives align to the overall recovery objective of sustainable and resilient communities.

Program monitoring data

Quantitative

The quantitative data planned for regular and ongoing monitoring is the:

- people screened
- clinical intervention
- team staffing
- community events and engagements
- resources and training materials.

Qualitative

The qualitative data planned for regular and ongoing monitoring are:

- case studies.

Financial

The financial data planned for regular and ongoing monitoring is the:

- total expenditure to date
- comparative breakdown of expenditure by HHS or intervention.

State reporting

Recovery reporting

The quantitative and qualitative monitoring data and financial progress reports were referenced by QRA to inform the requirements of progress reports prepared as part of the North and Far North Queensland Monsoon Trough State Recovery Plan 2019-2021.

Community Recovery Package reporting

The quantitative and qualitative monitoring data and financial progress reports were reviewed, aggregated and summarised by QRA; then submitted to EMA as part of the DRFA Category C Community Recovery Package reporting arrangements.

Program reviews

QRA conducted regular program reviews of all DRFA funded programs, including a comprehensive program review three times each year. The Community Development Program was incorporated in this review, with time allocated for DCDSS representatives or QRA liaison officers to brief the QRA Executive team on the program and progress.

Program evaluation

Key evaluation questions

Key evaluation questions (KEQs) give focus to different aspects of a disaster recovery program. A list of KEQs is provided in the framework, which has been considered and sampled in the evaluation of the Flexible Funding Grants Program. Additional KEQs have been developed by QRA to support further evaluative activity specific to this program.

KEQs have been sampled based on:

- relevance to this program
- availability of monitoring data
- coverage of all five evaluation aspects of a disaster recovery program.

KEQs sampled for this evaluation are indicated with a tick (ü).

Governance

To evaluate the governance of disaster recovery programs, the following KEQs were sampled to assess whether the governance structure helped to achieve recovery outcomes.

Governance key evaluation questions		Sampled
G1	Has the governance structure taken a long-term perspective on outcomes and recognised the complexity of the process?	
G2	Has the governance structure ensured recovery programs are monitored on a regular basis?	
G3	Has the governance structure ensured programs are adaptive to changing needs and impact?	
G4	Has the governance structure ensured recovery plans clearly define roles and responsibilities for disaster recovery?	
G5	Has the governance structure ensured governance procedures conform to legislation, policies, and other plans?	
G6	Has the governance structure established community-managed funds and other resources for disaster recovery?	
G7	Is there a shared understanding among stakeholders regarding disaster recovery responsibilities, authority and decision-making?	
G8	Has the governance structure ensured that governance is transparent and accountable?	
G9	Has the governance structure managed unintended consequences that might flow from recovery activities?	
G10	Has the governance structure coordinated response and relief efforts with the recovery process so that the two 'work together'?	ü

Community engagement

To evaluate the community engagement on disaster recovery programs, the following KEQs have been sampled to assess whether the engagement process appropriately drew from the community to ensure the community was integral to the recovery process.

Community engagement key evaluation questions		Sampled
C1	To what extent did the community have access to and were engaged in the program?	
C2	Has community engagement occurred in a timely and on-going way that provides adequate representation of community views?	ü
C3	Is there shared vision of a sustainable and resilient community that is understood by the community?	
C4	Has there been joint planning between community actors and emergency teams and structures?	
C5	Do organisations have capacity to develop and manage community volunteers for disaster recovery?	
C6	Are recovery plans developed through participatory processes?	
C7	Does the community have the capacity and formal avenues to lobby and challenge external agencies on disaster recovery plans, priorities, and actions?	
C8	Is there inclusion/representation of vulnerable groups in community decision-making and management of disaster recovery?	
C9	Are agreed plans and management arrangements well understood by the community and all disaster management agencies?	
C10	Has information been developed and disseminated in multiple media, multi-lingual formats, alternative formats; is appropriate to a diverse audience, user-friendly; and accessible to under-served populations?	
C11	Do community members have information they need to continue recovering from the disaster?	
C12	Are evolving community needs assessed and prioritised during the recovery process to inform recovery activities?	
C13	Are governance processes appropriately inclusive and representative of the affected community?	

Effectiveness

To evaluate the effectiveness of disaster recovery programs, the following KEQs have been sampled to assess whether the program was effective in achieving the overarching recovery outcomes.

Effectiveness key evaluation questions		Sampled
E1	To what extent did the disaster recovery program produce a sustainable community?	ü
E2	To what extent did the disaster recovery program produce a resilient community?	ü
E3	Was there any trade-off between achieving resilient outcomes and sustainable outcomes?	
E4	To what extent did program activities and resources allow positive interaction among the recovery domains (lines of recovery / other programs)?	

Efficiency

To evaluate the effectiveness of disaster recovery programs, the following KEQs have been sampled to assess whether the program was efficient in its implementation.

Efficiency key evaluation questions		Sampled
H1	How cost effective was the program?	
H2	To what extent did the program achieve the right balance between centralisation of some activities to achieve economies of scale while at the same time being responsive to local needs and conditions?	
H3	Did the program prevent price escalation stemming from the level of demand and competition between organisations?	
H4	How well did the program balance the need to optimise between cost of restoring essential public assets and the cost of delaying such projects?	
H5	How appropriate were the price benchmarks used to evaluate service providers?	
H6	Did the program achieve value for money relative to the disaster recovery context?	

Equity

To evaluate the equity of disaster recovery programs, the following KEQ has been sampled to assess whether the program was equitable in its implementation.

Equity key evaluation questions		Sampled
Q1	To what extent was program delivered across different stakeholder, regions and social groups?	

Implementation

To evaluate the effectiveness of disaster recovery programs, the following KEQs have been sampled to assess whether implementation of the program was appropriate.

Implementation key evaluation questions		Sampled
I1	To what extent was the program delivered as intended?	ü
I2	Was the program consistent with the National Principles for Disaster Recovery?	
I3	To what extent has the program been implemented according to the recovery plan?	
I4	Did the speed of the recovery process compromise quality of services?	
I5	Did the recovery program meet community needs as they changed over time and in response to changes in disaster impact?	
I6	To what extent did program activities and resources effectively encourage interaction between outcome domains?	
I7	Where disaster recovery involved several separate components or projects, how well coordinated were these with each other?	
I8	To what extent was the recovery process affected by external factors that may have had an impact on the community's ability to recover?	

Dissemination of findings

The evaluation will be shared with relevant Queensland Government departments and agencies.

A copy of the evaluation report will be uploaded to the National Disaster Recovery Monitoring and Evaluation Database hosted by the Australian Institute for Disaster Resilience.

Queensland Reconstruction Authority
PO Box 15428
City East QLD 4002
Phone (07) 3008 7200
info@qra.qld.gov.au
www.qra.qld.gov.au