# Submission to the Independent Review of Commonwealth Disaster Funding

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**Consent option:** Publish with name

**Submitted by:** Ben Norris

**Q1. What experience have you had with Commonwealth disaster funding support?**

I was the Manager of the Mental Health Drought and Disaster Team for Queensland Health between 2014 and 2022 when I retired from the Queensland Public Service. I am currently enrolled in a PhD program with the University of Qld to research decision making in designing and delivering mental health and wellbeing services in response to climate risk events.

In my time as Manager of the Mental Health Drought and Disaster I managed DRFA funding (or NDRA) funding for mental health services in response to TC Marcia 2015, STC Debbie 2017, CQ Bushfires 2018, NW Monsoon and Flood 2019, EQ Bushfires 2019 and SQ Flooding 2021. We worked closely with the QRA in developing funding proposals for DRFA Cat C funding.

**Q2. How could Commonwealth funding support communities to reduce their disaster risk?**

As my primary area of experience and expertise is in the area of mental health service design and funding I will limit my comments to that.

In my experience the disaster risk for communities within a mental health context can best be described as their base level of vulnerability and ability to be resilient, two sides of the same coin. Typically a more vulnerable a community, the less resilient they tend to be (that is their ability to 'bounce back' or recover to pre -disaster levels).

Therefore from a mental health perspective, Commonwealth funding that is aimed at reducing the vulnerability of communities to natural disasters and improving their resilience will work more effectively than non targeted funding.

Vulnerability to natural disasters is where communities have low levels of so called 'Recovery Capital' (Quinn et al, 2021) and resilience is where these levels of ReCap are higher. Targeted funding that is aimed at building up recovery capitals can have the desired outcome of reducing vulnerability and improving resilience whilst mitigating impacts of mental health disaster risk

**Q3. Please describe your understanding of Commonwealth disaster funding processes.**

Funding is provided to State jurisdictions via a 50/50 shared funding arrangement known as the Disaster Funding Recovery Arrangement (DRFA). There are different categories of funding to address recovery in the infrastructure (built and roads), environment, economic and social/community. In Queensland, this is

managed through the Qld Reconstruction Agency (QRA) which brokers funding for a range of relevant State Government and Non-Government Agencies.

Mental Health is administered through DFRA Cat C and falls under the Social Recovery pillar which is led by the Department of Communities here in Qld.

Funding is currently provided for a period of 2 years, which is problematic for responding to mental health issues, which typically do not manifest as a whole until 2-4 years post event, often compounded by loss of homes, business and problems with insurance.

**Q4. Are the funding roles of the Commonwealth, states and territories, and local government, during disaster events clear?**

From a mental health perspective, the arrangements are quite clear. Queensland Health submits a proposal for 2 year funding to the QRA on behalf of impacted Hospital and Health Services (HHS).

Upon receipt of funding from the QRA, regular monthly, quarterly and annual reporting is provided to track funding and activity.

Mental Health funding is primarily used to employ senior mental health clinicians and peer workers. The State Health Department liaises with the QRA on behalf of the local HHS teams. There are monthly Mental Health Disaster Recovery Advisory Group meetings chaired by Qld Health and attended by the QRA and representatives of all local funded Qld Health programs. Thus there is a direct line of communication between the QRA and local mental health programs.

**Q5. Is there any further information you would like to provide?**

My main concern when I was in the role was the rigidity of the DRFA funding. In reality serious mental health issues tend to manifest later rather than more immediately following a natural disaster.

These are often compounded from loss of home, livelihood, community connectedness and insurance issues. These take time to impact and the longer they remain unresolved the worse the impact on people's mental health.

I have previously advocated for a staggered funding model that would allow us to recruit different skilled clinicians and health workers across a 5 year span rather than the 2 years.

In my personal opinion, the first 6 to 12 months could be used to provide immediate psycho-social assistance to those impacted by the event. A mapping of mental health and psychological wellbeing needs could also be undertaken during this time.

In the next phase of 12 to 36 months, relevant clinical staff and programs could be funded, based on the needs identified from the mapping exercise. These will be unique to each location within the impacted region and build on and link with the work done by other partner agencies.

Finally in the 36 to 60 months, capacity could be developed within the local areas. Legacy programs that aim to reduce vulnerability and improve resiliency whilst building up recovery capital can be bedded down for long term and sustainable impacts.

For more information or further discussion I can be contacted at;


121 Marcus Clarke Street, (PO Box 133) Canberra ACT 2601
Level 10, 10 Felix Street, (PO Box 15084) Brisbane QLD 4000

Australian Government
National Emergency
Management Agency

[redacted]

benjamin.norris@uqconnect.edu.au

benjamin.norris@uq.edu.au

Mobile: [redacted]