patients. It is unlikely that the military would permit such patients to be transported on their aircraft or that distant hospitals would be willing and prepared to receive them. More likely, medical and health assets would need to be brought into the disaster zone rather than moving patients out. However, NDMS protocols currently do not permit this.

Were resources exceeded or was it a lack of leadership and an incident management system?
All areas of the US have vast medical and public health resources. In recent history, until the time of Hurricane Katrina, the last time our health care resources were truly exceeded probably was during the influenza pandemic of 1918. Even during the World Trade Tower terrorist attacks in 2001, the number of surviving victims requiring medical and health care in New York City did not exceed the city's capacity to provide that care. So, was the "black tag triage" that occurred in New Orleans in 2005 a result of insufficient resources? Or could we have organized the public health response more effectively to direct our assets to the locations where they were needed at the times they were needed? Could effective resource typing have matched the personnel and supplies to the people who needed primary care as well as acute medical care? Few people understand the background described above regarding the formation of DHS. How can we expect a well-rehearsed effective response from an organization that had been recently created and consists of personnel from differing backgrounds and corporate cultures? This unique case study (a widespread disaster within a large resource-rich nation) affords an excellent opportunity to study key issues of leadership and incident management.

Conclusions
While planners have expended large amounts of resources into frequent education and training for the NDMS for more than 20 years, Hurricane Katrina represents the first US disaster where the evacuation portion of the system was activated on a large scale. Hurricane Katrina represents a classic public health emergency. Nothing that occurred in the disaster aftermath was unpredictable. Two years later, a large negative public health impact remains, manifested by infrastructure deficiencies. There is a great opportunity to further the multidisciplinary science of disaster medicine by studying the multiple logistical and healthcare policy issues surrounding Hurricane Katrina.

Panelists
Kelly Klein (University of Texas Southwestern at Dallas)
Kathy Rinnert (University of Texas Southwestern at Dallas)
Aileen Marty (Battelle/DHS)
Special thanks to the volunteer medical student scribe: Kevin De Decker (Netherlands)
Prehospital Disast Med 2008;23(4):s83–s86

Psychosocial Aspects

Prevention

Chair: Gloria Leon
Correspondence: leonx003@umn.edu

This session addressed the psychosocial needs of a range of affected groups, from children to the aged, with a focus on prevention and early intervention. Saenz described the use of play therapy with children exposed to trauma either personally or vicariously through the media, to teach them through games and stories that the world is not as bad as they see it.

Other papers described national programs that provide aid to groups under threat. One example is the Israel Trauma Coalition (Levanon), an NGO that responds immediately to terrorist or other events by organizing evacuations, psychological screening, and support, placement of children in schools in evacuee areas, and later follow-up. Cole described a state-wide disaster mental health training plan developed in New York after the terrorist attacks of 11 September 2001, consisting of a multi-module curriculum applicable for both rural and urban responders.

The final paper, presented by Qureshi, focused on the comprehensive and continuing procedures implemented to protect the mental health of participants and researchers during a longitudinal study of the psychological and psychiatric sequalae of the World Trade Center attack. The ethical concerns in conducting research on victimized groups were addressed.

In summary, this series of papers, presenting programs and experiences from different countries and different types of trauma, has application for planning and implementation by other groups tasked to deal with the psychosocial effects of disasters and terrorism.
Prehospital Disast Med 2008;23(4):s86

First Aid

Chair: Carol Amaratunga
Correspondence: carol.amaratunga@uottawa.ca

This session provided a dynamic and excellent overview of psychosocial aspects of first aid. A common theme espoused by all speakers was the social imperative to mainstream psychosocial dimensions into disaster management structures and protocols. The five presentations illustrated both individually and collectively how psychosocial aspects embrace multiple dimensions—the individual, family, community, as well as related social and cultural sequelae.

Collectively speaking, the presenters created a strong consensus with respect to the need to incorporate psychological "first aid" into best-practice protocols. The five case studies addressed vulnerable populations and demonstrated the need for culturally appropriate and sensitive interventions, along with the need for psychometrically robust instruments for assessing stress and post-traumatic stress, including intergenerational stress as indicated in the case of Ukrainian women who were exposed to radiation during the Chernobyl disaster.

Both Stephan Vymetal and Paul Deignan's presentations provided clear and interesting examples with respect to the need for critical stress debriefing and psychological first aid. The colorful handout from the Czech Republic for journalists during disasters illustrated an excellent case in point. The five presentation topics covered a wide, yet interrelated, range of issues from psychosocial assistance in emergencies, psychological first aid, family witnessed resuscitation, the integration of mental health policies into dis-

https://doi.org/10.1017/S1049023X00021385 Published online by Cambridge University Press