Orlando United Assistance Center: Assessing the Needs of Those Impacted by the Pulse Nightclub Tragedy

Report of Survey Findings: Summer 2020

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Introduction

Pulse Nightclub was a popular LGBTQ+ dance club located in Orlando, FL that was opened in 2004. On June 12, 2016 it was the site of, at the time, the deadliest mass shooting event in the country with 49 deaths and another 53 injured[1] when it was attacked by a lone gunman (Alter, 2017). That evening was the club's weekly Latin night which brought in people from all over Central Florida (*Terrorist Gunman…, 2018*).

Around the time of the incident, the Orlando Metropolitan Statistical Area (MSA) included four counties and approximately 2.2 million people. The median age of residents in the Orlando MSA was approximately 33.2 years old (American Community Survey, 2016), 29.2% of residents identified as being of Hispanic descent (American Community Survey, 2016), and 4.1% of residents identified as LGBTQ+ (Newport, 2015). Estimates suggest approximately 80% of the individuals in the nightclub at the time of the tragedy were residing in the Orlando MSA.

At the time of the incident, the motivation behind the gunman's actions was unclear. Many initially believed that it was a hate crime, yet evidence was discovered afterwards that led the Federal Bureau of Investigation to identify this incident as an act of terrorism. Some, however, still believe that this tragedy was a hate crime targeting both the LGBTQ+ and Latinx communities. After the event, the Orlando United Assistance Center (OUAC), a collaboration between the Heart of Florida United Way, City of Orlando, Orange County Government and Osceola County Government with support from Central Florida Foundation, was created in order to help support those who were affected. The OUAC provided immediate resources after the tragedy and has continued supporting the community through mental health services, case management, emergency basic needs, legal referrals, and a crisis hotline. The OUAC was funded initially with an emergency grant from the Antiterrorism and Emergency Assistance Program (AEAP). Four years later, and with its AEAP funding now expired, the organizations have renewed their commitment to evolve the OUAC with the needs of the community.

This research initiative was requested on the behalf of the OUAC in order to aide in the development of an action plan for the future that will best serve the community. Original plans included data collection involving anonymous online surveys and a series of confidential in-person focus groups. Due to the pandemic social distancing guidelines, and out of an abundance of caution for the well-being of the impacted community, the research team decided to postpone the in-person focus groups scheduled for Spring. The research team is dedicated to conducting these focus groups when it is safe to do so.

Community volunteers, Erica Fissel, PhD of the University of Central Florida and Zachary Murray, M.S. led the research initiative with project management and community relations support from Poston Communications. Dr. Fissel, Mr. Murray, and Poston Communications provided their services pro bono to the OUAC.

[1] This captures only physical injuries.

Review of the Literature

While there is no widely accepted definition (see *Mass Shootings: Definitions and Trends,* 2018 for review), mass shooting events are typically defined as incidents involving multiple victims of firearm violence. Despite the unfortunate number of mass shootings that occur in our society, little is known about the short-term and long-term needs of survivors, family members and friends of victims, and first responders. Due to this, the OUAC sought to better understand the long-term needs of Pulse survivors, families and friends of victims, and first responders in order to better serve the impacted community. Research suggests there has been little advancement in what communities can do to help victims of a mass shooting event. The scope of this research is also limited by time, as even fewer longitudinal studies have been completed to help understand the progression of needs over time. Findings from the limited research that has been conducted points to Posttraumatic Stress Disorder (PTSD) as the most prevalent and prevailing problem for survivors.

Pulse Specific Research

There are few research studies that have focused on empirically studying the Pulse tragedy. Molina and colleagues (2019) interviewed six clinical practitioners and community leaders who were involved with Pulse Nightclub survivors and family members of victims. Results revealed that the community of Orlando was strengthened by the event causing a higher level of community resilience (i.e., a community's ability to use resources to prepare for, manage, and recover from adverse events) (Molina, Yegidis, & Jacinto, 2019). The study also found that, one year after the event, the community perception was that survivors would require long-term mental health services and would be best served by an organization that was culturally competent in the Latinx community.

Two additional pieces of research worth noting focus on the event, or behaviors due to the event. The first found that LGBTQ+ individuals who perceived that their peers were using alcohol and drugs to cope with the tragedy were more likely to use them for their own coping (Boyle, 2016). The second found, after the event and, after analyzing the tweets of self-identified LGBTQ+ individuals that the online community was using creative language to re-define their in-group (i.e., a minority group that shares common life experience or interests) in order to strengthen it and provide support to their peers (Jenkins, 2019).

The Mental Health Effects of a Mass Casualty Incidents

A concept related to mass shootings are mass casualty incidents (MCI), which involves "any number of casualties that exceed the resources normally available" (What is a Mass, n.d). Given this definition, a MCI in rural Montana could look very different than one occurring in Chicago. The wide use of this definition causes difficulties in directly comparing MCIs and the resources and services that the impacted communities require afterward. Thus, communities will need to adjust plans to fit their specific needs. With that being said, below is a review of the mental health impacts caused by MCIs.

A major consequence of any MCI is the increase in post-disaster psychopathology in the community (Rubonis, 1991). Major health effects that have been seen after an incident include depression, anxiety, and PTSD (Shultz, 2004). While post-disaster psychopathology rises after an MCI, not every member of the community is affected in the same way. There are a number of variables and individual risk factors that impact how likely it is that someone will develop a psychopathology, such as PTSD. These influences can also affect the length of time to recover.

Two variables, that affect the relationship between a disaster and occurrences of psychopathology are: the number of casualties, and time since the event (Rubonis, 1991). A third variable, perception of human responsibility for the event, is one that has received some empirical support in the existing literature. North and Smith (1997), Green and colleagues (1994), and Galea (2005) all found that psychopathological development was higher in disasters that were perceived to be caused by humans. However, other research has shown that development of psychopathologies was lower in disasters perceived to be caused by humans (Rubonis, 1991). Furthermore, Norris and colleagues (2002) found that when man-made disasters are further divided into categories such as technological (e.g., mechanical failure, fire) and mass violence, that those who perceived the event to be mass violence showed significantly more impairment. It was further noted by the Committee on Responding to the Psychological Aspect of Terrorism (2005) that an event will have the greatest potential for mental health impact if at least two of the following are present: widespread damage to property; human error or human intent; high occurrence of trauma; and severe and continuing financial problems.

Individual risk factors also play a vital in role in the development of psychopathological symptoms after an MCI. Those risk factors include: pre-existing mental health conditions, sexual trauma (Shultz, 2014), previous exposure to traumatic events (Galea, 2005), ability to emotionally regulate (Bardeen, 2013), and gender (North, 1997). Predicting the mental health needs of a community after an MCI can be further complicated as a person's ability to recover from psychopathologies varies greatly among individuals (Littleton, 2011). Recovery time can take longer for those with pre-existing psychopathological conditions (North, 1997), females, those who lost someone close to them, people with prevailing pain or injury from the event (Dyb, 2014), and those with maladaptive coping mechanisms like rumination, avoidance (Littleton, 2011), and drug and alcohol use, which is especially prevalent in gay and bisexual men (Boyle, 2016).

Of the psychopathologies previously discussed, PTSD has been shown to be the most frequent and debilitating (Galea, 2005). PTSD is marked by distress associated with an incident with those affected suffering from symptoms of intrusive thoughts, avoidance of anything that reminds them of the incident, negative thoughts and feelings, and arousal and reactive symptoms (e.g., irritability, anger, outbursts) (What is Posttraumatic, 2020). It has been shown that these symptoms can be seen in almost all survivors of a mass shooting and that the prevalence is 6 times higher than a control group (Dyb, 2014).

There have been very few longitudinal studies examining PTSD symptoms of those affected by an MCI. North (1997, 2002) conducted a 1- and 3-year follow-up of victims of a mass shooting that left 23 individuals dead in 1991. The one-year follow-up included 93 individuals who were directly involved in the event, 9 workers who were not present and 20 first responders, 85% of

these participants were included in the three-year follow-up. Over the course of these two timepoints, findings revealed that symptoms of PTSD diminished with time and that around 50% of those in high exposure groups (directly affected) recovered after 3 years.

Another study was completed by Green and colleagues (1994) regarding the collapse of the Buffalo Creek Dam, an MCI not related to gun violence. The study was a 17-year follow-up with 99 participants who were adolescents at the time of the incident. It found that only 7% of those originally diagnosed with PTSD still had symptoms after 17 years. That said, these findings may not be representative for all populations and further research should be conducted to better understand the long-term recovery of those affected.

While many factors contribute to a longer recovery time for these individuals, research suggests there are ways to help mitigate risk factors and speed overall recovery. Turunen and Punama¨ki (2014) reiterated findings from prior research that showed the need to start all mental health interventions as early as possible. They also offered guidance on the focus for service providers at varying stages. Early and mid-stages of support should be focused on identifying those in the most need and that are the most vulnerable to provide them resources. The later stages of support can then focus on customizing mental health services to individual needs in order to help manage and deal with the symptoms of PTSD. Hobfoll (2007) notes that through the entire process those providing services should continually promote a sense of safety, calming, self and collective efficacy, connectedness, and hope.

With the scarcity of research in the area and the unique nature of the population impacted by the Pulse tragedy, this research initiative will help add to the body of knowledge pertaining to MCIs, specifically those of mass violence, in order to aid future communities in understanding the services that are needed after an incident and what to expect when thinking about long-term needs of those affected.

Methodology

Online Survey Administration

In February 2020, a 31-question survey – designed by the research team with input from the OUAC and committee of community stakeholders and funding organizations – was administered to the community impacted directly by the Pulse tragedy. Specifically, this included: survivors, family members of victims, friends of victims, and first responders.

A total of 735 individuals have been identified as either directly or indirectly impacted by the Pulse tragedy. Of those, 537 have accessed case management or other services at OUAC. The OUAC maintains a database containing the contact information of those who have been identified as impacted by the Pulse tragedy. Prior to the survey launch, the OUAC e-mailed their listserv of 263 addresses providing information related to the research initiative. Of those 263, 39 e-mails bounced back.

The online survey was distributed via the OUAC's e-mail address to improve response rates (i.e., the survey link was coming from a trusted source) to those remaining 224 addresses. A press

release was also distributed to local media in order to reach those individuals whose contact information may have changed. Further, the survey was available in both English and Spanish. Survey participation was voluntary, and responses were anonymous. Prior to completing the online survey, respondents were provided a one-page description of the study, which was approved by the Institutional Review Board at the University of Central Florida.

After one week, the research team observed a limited number of completed survey responses, thus, additional recruitment methods were employed to reach those whose contact information may have changed. Specifically, key community members were asked to share information about the survey on various social media websites, including private survivor Facebook Groups, private family Facebook Groups, business Facebook pages for onePULSE Foundation, One Orlando Alliance, Zebra Coalition, Watermark Media, The Center, and State Representatives Anna Eskamani and Carlos Guillermo Smith. Additional community members personally shared information about the research initiative on their social media pages. Due to the potential that the survey would be accessed by individuals outside of the impacted community, unique questions were added for the general community members to provide their perceptions and opinions on the OUAC.

The online survey closed on March 2, 2020, a little over 3 weeks after launch. In total, there were 115 usable survey responses. Forty-three responses were completed by community members, while 72 were completed by those within the directly impacted community. These 72 respondents from the directly impacted community represent 13.47% of those who have accessed case management or other services from OUAC.

Analytic Strategy

Descriptive statistics (e.g., percentages) are used throughout the findings sections for quantitative data collected via the survey. For the qualitative data collected through open-ended survey questions, both members of the research team independently identified themes within responses and compared. All identified themes were agreed upon.

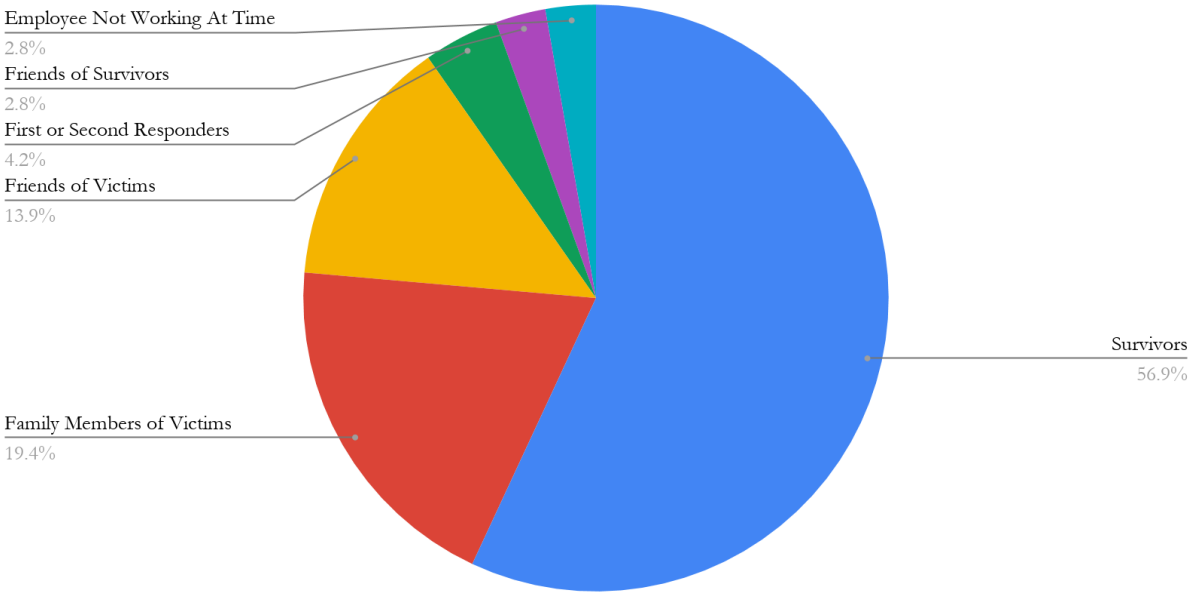
Findings - Impacted Community Sample

Demographic Characteristics

As was mentioned above, 72 individuals who were directly impacted by the Pulse nightclub shooting completed the survey. Respondents were asked to identify their connection to the Pulse tragedy. As displayed in Figure 1, 55.25% (n =41) were survivors[2], 19.44% (n = 14) were family members of victims, 13.89% (n = 10) were friends of victims, 4.17% (n = 3) were first or second responders, 2.78% (n = 2) were friends of survivors, and 2.78% (n = 2) were employees not working at the time. It is possible that a respondent was connected to the Pulse tragedy in multiple ways (e.g., a survivor and family member of a victim), but they were asked to select just one option.

[2] This includes 8 employees working at the time of the shooting.

Figure 1. Connection to Pulse Tragedy



The current age of respondents ranged from 23 to 74, with an average of 39.38 years old (SD = 11.53). With respect to gender identity, 48.61% (n = 35) of the sample identified as men, 44.44% (n = 32) identified as women, 2.78% (n = 2) identified as transgender women, 2.78% (n = 2) identified as genderqueer or gender non-conforming, and 1.39% (n = 1) identified as other. The majority of the sample identified as gay or lesbian (59.72%; n = 43). This was followed by 25% (n = 18) identifying as heterosexual or straight, 9.72% (n = 7) identifying as bisexual, 2.78% (n = 2) identifying as other, 1.39% (n = 1) identifying as asexual, and the remaining 1.39% (n = 1) identifying as questioning.

Three survey items were used to capture race and ethnicity. First, respondents were asked to indicate if they were of Hispanic or Latino/a/x origin. Nearly 46% (n = 33) indicated yes and were then asked to select which of the following best described them: 31.94% (n = 23) Puerto Rican, 8.33% (n =6) Central or South American, 4.17 (n =3) Other, 2.78% (n = 2) Spanish, 2.78% (n = 2) Cuban, and 1.39% (n = 1) Dominican. Finally, respondents were asked to select the racial category (-ies) that best described them. The majority of the sample was composed of White respondents (66.67%; n = 48). This was followed by 20.83% (n = 15) identifying as Black, and 18.06% (n = 13) identifying as another race.

Respondents were asked to indicate the highest level of education they had completed and the findings revealed that 33.33% (n = 24) of the sample had completed some college, 18.06% (n = 13) had an Associate's degree, 16.44% (n = 12) had a Bachelor's degree, 13.89% (n = 10) had a high school diploma, 9.72% (n = 7) had a Graduate degree, 4.17% (n = 3) had a Professional degree, 2.78% (n = 2) had completed technical or vocational schooling, and 1.39% (n = 1) had completed some high school.

At the time of the questionnaire, nearly half (48.61%, n = 35) of the sample was employed full-time, 26.39% (n = 19) were employed part-time, and 25% (n = 18) were unemployed. Relatedly, respondents were asked to indicate their household income. They were informed that this

includes income from all sources such as work, investments, child support, and public assistance. Response options ranged from Less than $5,000 up to $150,000 or more. Nearly 60% (n = 42) indicated that their household income was less than $35,000.

Lastly, respondents were asked to indicate the zip code in which they currently reside. For ease of interpretation, the zip codes were recoded into counties. As is displayed below in Figure 2, results revealed that the majority of respondents live in Orange County (61.11%, n = 44). This was followed by 5.56% (n = 4) living in Osceola County, 4.17% (n = 3) living in Seminole County, 2.78% (n = 2) living in Broward County, and 1.39% (n = 1) each living in Polk, Manatee, Sarasota, Miami Dade, and Volusia County. The remaining 19.44% (n = 14) currently reside outside of the state of Florida. Figure 3 displays where these respondents live. Approximately 14% (14.29%, n = 2) live in Oklahoma, another 14.29% (n = 2) live in New Jersey, and another 14.29% (n = 2) live in Puerto Rico. The remaining out of state respondents live in California (7.14%, n = 1), Michigan (7.14%, n = 1), Mississippi (7.14%, n = 1), Tennessee (7.14%, n = 1), Georgia (7.14%, n = 1), South Carolina (7.14%, n = 1), Maryland (7.14%, n = 1), and Connecticut (7.14%, n = 1).

Figure 2. County of Current Residency

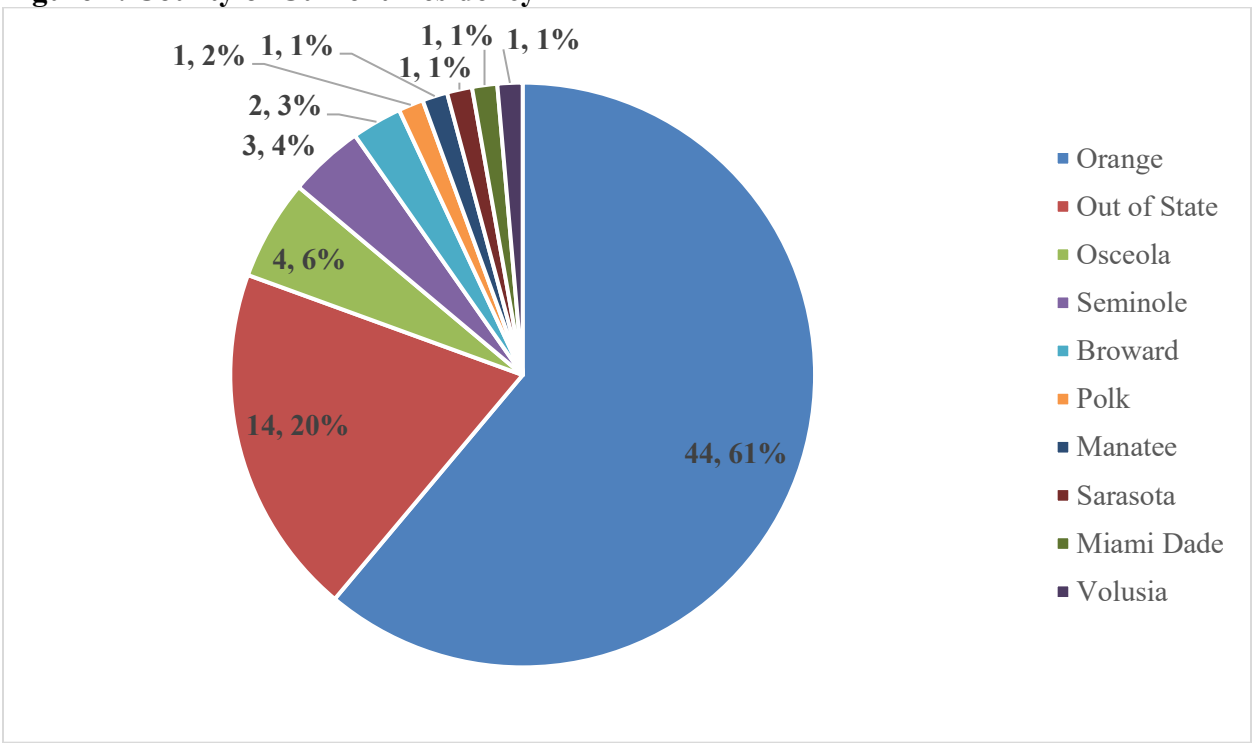
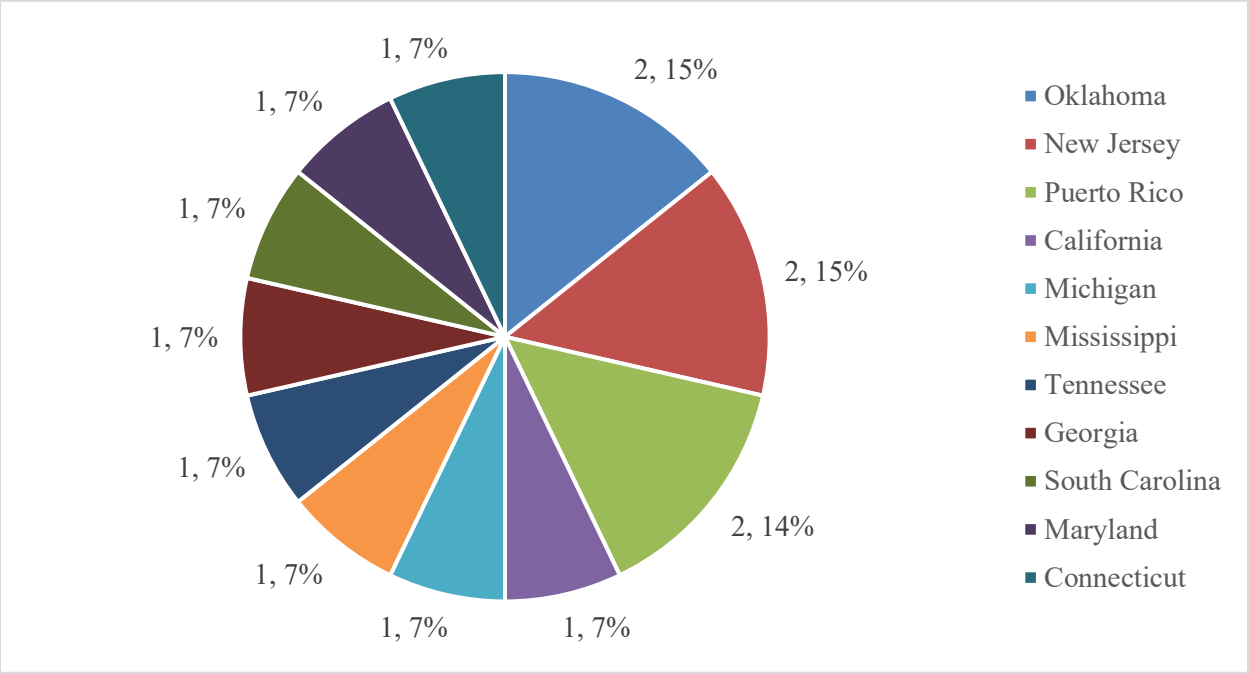


Figure 3. Out of State Residency



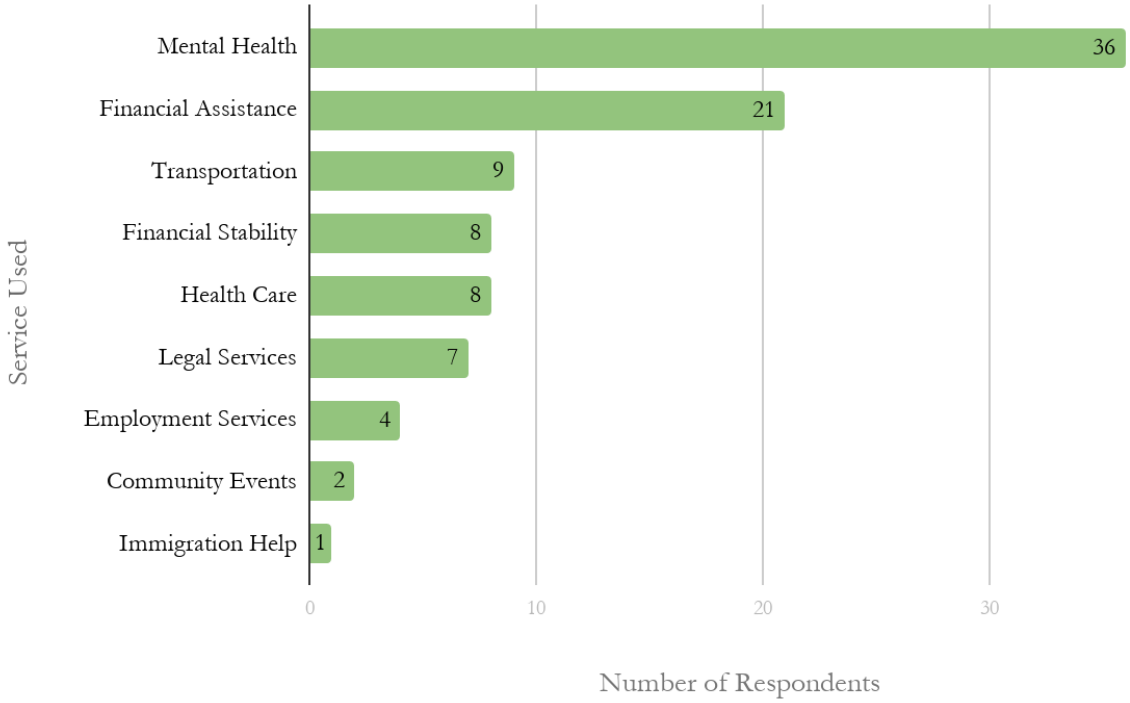
Use of and Satisfaction with Services

Respondents were asked, "Have you utilized services offered by the Orlando United Assistance Center?" Nearly 61% ($n = 43$)[3] indicated that they had used services. These individuals who responded affirmatively were then asked follow-up questions about the services utilized, including when they used each service and their level of satisfaction.

As displayed in Figure 4 below, the most frequently utilized service offered by the OUAC was mental health, with 83.72%[4] ($n = 36$) indicating they have used this type of service. This was followed by financial assistance (48.84%, $n = 21$), transportation assistance (20.93%, $n = 9$), financial stability services (18.60%, $n = 8$), health care (18.60%, $n = 8$), legal services (16.28%, $n = 7$), employment services (9.30%, $n = 4$), community events (4.65%, $n = 2$), and help with immigration (2.33%, $n = 1$). Of those 43 respondents who indicated that they had used services, the average number of service types used was 2.2, thus suggesting that the OUAC was able to assist with multiple needs.

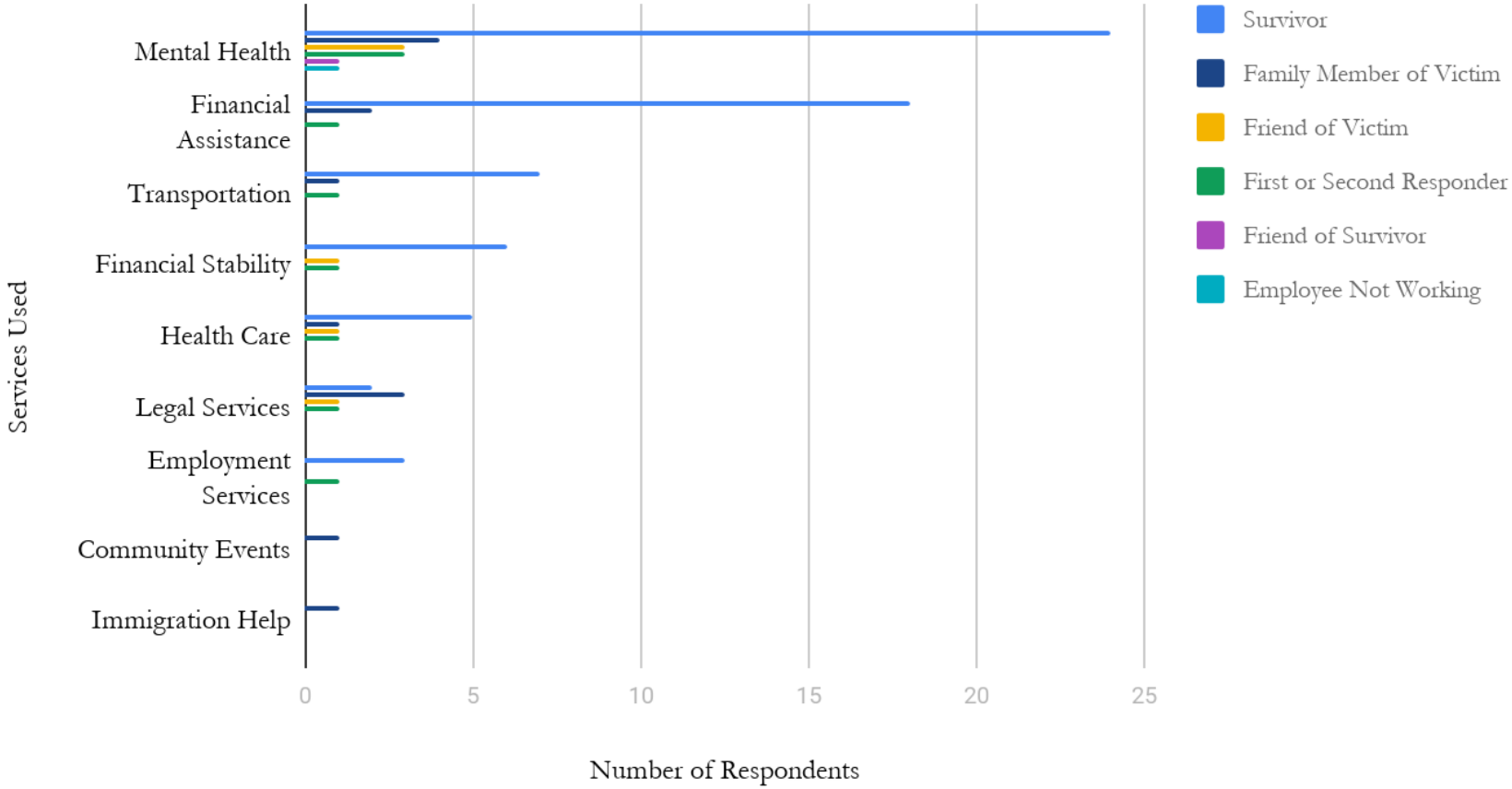
[3] One person dropped out of the questionnaire at this point, leaving the sample size at 71.
[4] Percentages here are based on the subsample of respondents who did use services ($n = 43$).

Figure 4. Orlando United Assistance Center Services Utilized



To assess which services were utilized by whom, Figure 5 below displays the services utilized by their connection to the Pulse tragedy. Given the composition of the sample – largely comprised of survivors – it is not surprising that survivors utilized each of the services more than any other group. One additional noteworthy finding is that first or second responders utilized nearly all the services provided, excluding only community events and immigration help.

Figure 5. Services Utilized by Connection Type



Next, respondents were asked to indicate when they utilized the services, with response options including: within one week; between 1 week and 1 month; between 1 month and 6 months, between 6 months and 1 year, between 1 year and 2 years, and between 2 years and 3 years. Figure 6 below displays when respondents used each type of service. Given that respondents could utilize services across multiple timeframes, they were asked to select all relevant options.

Some interesting trends emerged when assessing when the impacted community utilized each service. Perhaps of greatest importance is the observation related to mental health services, which reflects trends from other communities impacted by mass tragedy and is supported by empirical research. Specifically, the data reveal that there was a slightly delayed use of mental health services. This delayed onset has been shown to be caused by maladaptive coping strategies such as avoidance and rumination (Littleton, 2011). There also appears to have been a spike in use of financial assistance 1 month after the incident up to six months after. For some of these services (e.g., community events, immigration help), the numbers are too low to be able to make any real judgements about temporal trends. While these trends are important to examine to assess the potential services needed moving forward, it is also necessary to note that some of these services may have not be offered during each time frame, which impacts the number of respondents who utilized each.

Those who indicated utilizing services offered by the OUAC were asked to share their level of satisfaction - via a five-point Likert scale ranging from very satisfied to very dissatisfied - with each service they used. Table 1 displays the results, revealing a fairly positive overall satisfaction.

Figure 6. When Services Were Utilized

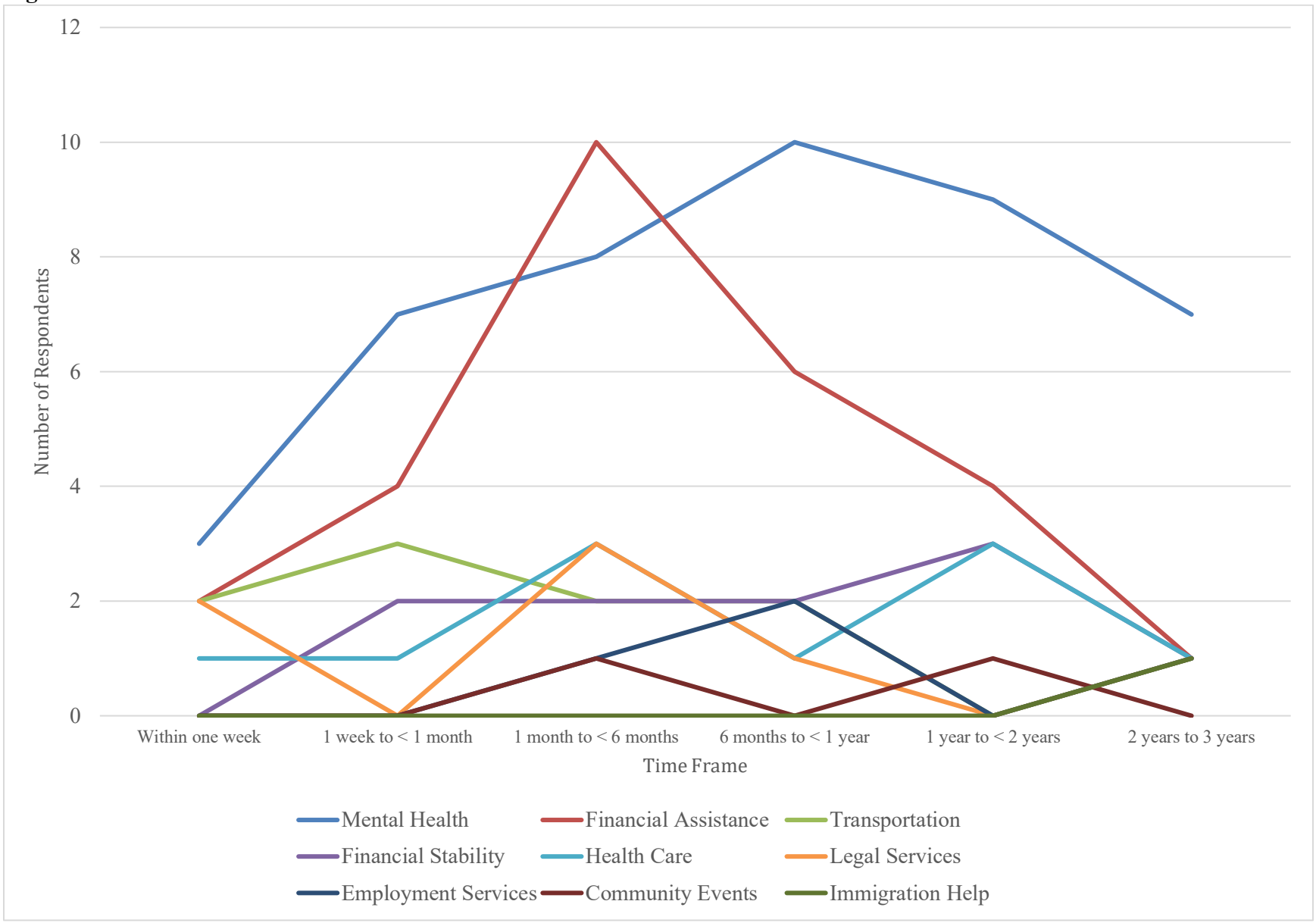


Table 1. Satisfaction with Services

	Mental Health	Financial Assistance	Transportation	Financial Stability	Health Care	Legal Services	Employment Services	Community Events	Immigration Help
Very Satisfied	54.55%	47.62%	44.44%	50.00%	37.50%	66.67%	25.00%	50.00%	0.00%
Somewhat Satisfied	24.24%	28.57%	55.56%	12.50%	25.00%	16.67%	25.00%	50.00%	100.00%
Neither Satisfied nor Dissatisfied	21.21%	14.29%	0.00%	37.50%	25.00%	16.67%	50.00%	0.00%	0.00%
Somewhat Dissatisfied	0.00%	9.52%	0.00%	0.00%	12.50%	0.00%	0.00%	0.00%	0.00%
Very Dissatisfied	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Additionally, respondents were asked to select the geographical area where they typically received services, resources, or support. The large majority of those who used services indicated they did so in Orange County (79.07%; *n* = 34). Osceola, Volusia, and Hillsborough Counties each were selected once, while outside of Florida was selected by two respondents. It is unclear from the survey data if these findings are due to where was most convenient for the impacted community members to utilize the services or if it was due to location services were offered.

Barriers to Services

Approximately 40% (n = 28) of the impacted community indicated that they did not utilize services offered by the OUAC. Multiple questions were included within the online survey to better understand why they chose not to.

First, respondents were asked, "Why have you decided to not utilize services offered by the Orlando United Assistance Center?" This was an open-ended question, allowing participants to openly share their experiences. Twenty-eight respondents answered this question. The most commonly shared reason for not utilizing services was that the respondent did not live in the Orlando area (*n* = 9; 32.14%). This included individuals who were visiting Orlando the weekend of the tragedy, along with those who have since moved away. The second most commonly identified reason for not utilizing services was that respondents were not aware of the services and/or OUAC (*n* = 5; 17.86%). Additional reasons included simply not considering the services (*n* = 3; 10.71%), thinking that the services were not for them (*n* = 3; 10.71%), already had a service provider (*n* = 2; 7.14%), thinking that the services should be left for others in need (*n* = 2; 7.14%), avoidance (*n* = 1; 3.57%), confusion about services (*n* = 1; 3.57%) and confusion about how to access the services (*n* = 1; 3.57%), lack of knowledge about what was available (*n* = 1; 3.57%), dislike of organization (*n* = 1; 3.57%), employee of OUAC (*n* = 1; 3.57%), and unsure (*n* = 1; 3.57%).

Additionally, all participants were asked to indicate any barriers that impacted their ability to use the available resources and/or services. As is displayed in Figure 7 below, the most commonly selected barrier respondents encountered was not being able to call off of work (21.13%, *n* = 15) and was closely followed by no health insurance (19.72%, *n* = 14). Approximately 15% of respondents (*n* = 11) indicated that lack of transportation was a barrier and another 15% (*n* = 11) faced monetary barriers. The remaining barriers selected were that resources were not available in their location (14.08%; *n* = 10), other (11.27%, *n* = 8), lack of childcare (7.04%, *n* = 2), and language barriers (2.82%, *n* = 1).

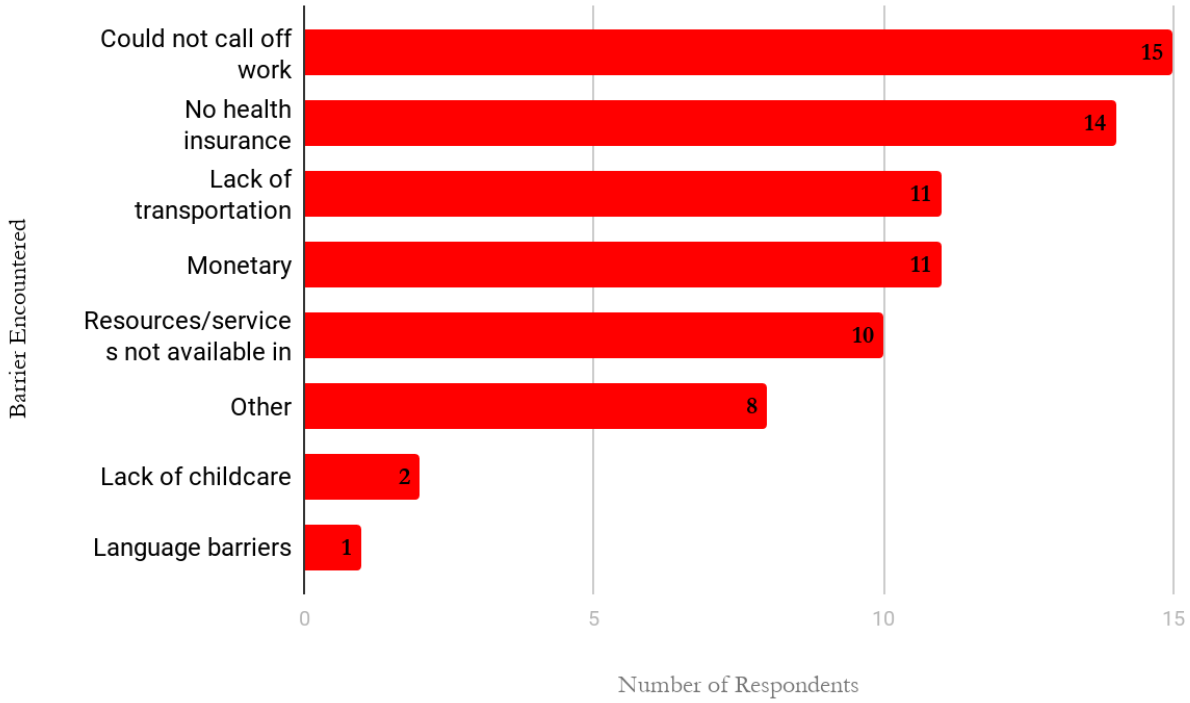
Respondents were given the opportunity to explain the barriers they indicated via an open-ended question. Select quotes are provided below that highlight the barriers encountered.

> *"I have no health insurance to seek help for trauma that I have been through after the incident. Don't know where or how to start to get help."*
>
> *"Medical help is limited and copays are high. I didn't feel the mental health services were that great. They mostly just talked."*
>
> *"Whenever I asked about resources in my area I was told they were not available."*

"My job wouldn't let me take off as much as I felt I needed to to get the counseling I felt I needed."

"After time service were no longer available, and really hard to get assistance elsewhere. My case Manager would help with the resources but many had wait list, I was unable to work, so I had no money and SSDI was not granted. I continue to work but have lost so much with my PTSD."

Figure 7. Barriers to Services



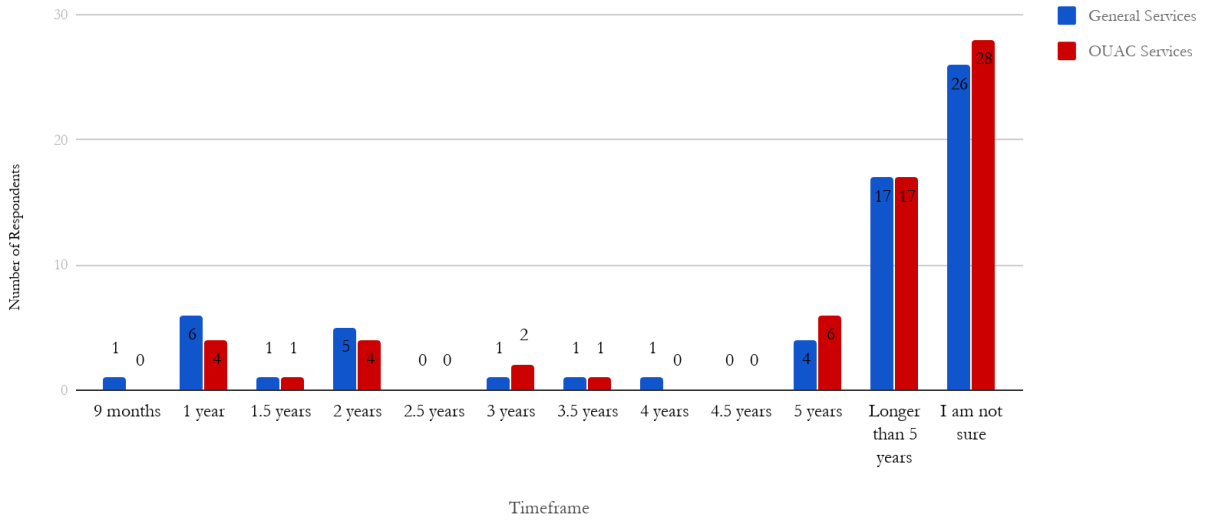
Moving Forward

In an effort to assess the needs of the impacted community moving forward, respondents were first asked (via an open-ended question) to identify the resources or services they expect or think they might need moving forward. Fifty respondents answered this question. The most commonly identified need was mental health services, with 70% (n = 35) mentioning this. The second most commonly identified need was financial assistance (35%, n = 18). Additional resources or services requested by multiple responses were job assistance, school assistance, healthcare, legal assistance, community gatherings, and support groups (group therapy, fitness classes, music therapy, etc.).

Next, respondents were asked (1) "How much longer would you like to have resources or services available, generally?" and (2) "How much longer would you like to have resources or

services available via the Orlando United Assistance Center, specifically?" Response options included: 3 months, 6 months, 9 months, 1 year, 1.5 years, 2 years, 2.5 years, 3 years, 3.5 years, 4 years, 4.5 years, 5 years, Longer than 5 years, and I am not sure. As is displayed in Figure 8, the most common response option for both questions was I am not sure. However, the next most common answer was longer than 5 years, with 27% of those who answered the question selecting this option.

Figure 8. Future Availability



Findings - General Community Sample

Demographic Characteristics

Forty-three respondents were best categorized as general community members. The current age of community members ranged from 24 to 80 years old, with an average age of 41.14 (SD = 14.51). With respect to gender identity, 46.51% (n = 20) identified as women, 37.21% (n= 16) identified as men, 6.98% (n = 3) identified as genderqueer or gender non-conforming, 4.65% (n = 2) identified as other (gender fluid and nonbinary), 2.33% (n = 1) identified as transgender woman, and 2.33% (n = 1) identified as questioning. Considering sexual orientation, the majority of the community members (60.47%; n = 26) identified as gay or lesbian. This was followed by 16.30% (n = 7) identifying as heterosexual or straight, 11.63% (n = 5) selecting other (pansexual and queer), 6..98% (n = 3) identifying as bisexual, 2.33% (n = 1) identifying as asexual, and 2.33% (n = 1) identifying as questioning.

Three survey items were used to capture race and ethnicity. First, respondents were asked to indicate if they were of Hispanic or Latino/a/x origin. Approximately 44% (n = 19) indicated yes and were then asked to select which of the following best described them: 23.26% (n = 10) Puerto Rican, 9.30% (n = 4) Central or South American, 4.65% (n = 2) Mexican, Mexican American, Chicano, 4.65% (n = 2) Dominican, and 2.33% (n = 1) Other. Finally, respondents were asked to select the racial category (-ies) that best described them. The majority of the sample was composed of White respondents (72.09%; n = 31). This was followed by 18.60% (n

= 8) identifying as Black or African American, 9.30% (*n* = 4) identifying as another race, 2.33% (*n* = 1) identifying as Asian, and 2.33% (*n* = 1) identifying as American Indian or Alaskan Native.

Respondents were asked to indicate the highest level of education they had completed and the data revealed that 46.51% (*n* = 20) of the sample had earned a Bachelor's degree, 23.26% (*n* = 10) had a Graduate degree, 13.95% (*n* = 5) had completed some college, 6.98% (*n* = 3) had an Associate's degree, 4.65% (*n* = 2) had completed technical or vocational schooling, 4.65% (*n* = 2) had a professional degree, and 2.33% (*n* = 1) had completed some high school.

At the time of the questionnaire, nearly 91% (90.70%; *n* = 39) of the sample was employed full-time and the remaining 9.30% (*n* = 4) was unemployed. Relatedly, respondents were asked to indicate their household income. They were informed that this includes income from all sources such as work, investments, child support, and public assistance. Response options ranged from Less than $5,000 up to $150,000 or more. Over half (*n* = 22) indicated that their household income was $50,000 or greater.

Perceptions of the Orlando United Assistance Center

In order to gain an understanding of how the general community views the OUAC, respondents were asked three open-ended questions via the online survey. They were first asked, "What is your opinion on the services and support offered by the Orlando United Assistance Center?" Twenty-four community members answered this question. Nearly half of respondents provided praise towards the Orlando United Assistance Center. One community member wrote, *"Orlando United Assistance Center provides services and support that is greatly need in Central Florida"*, while another stated, *"OUAC's service are an amazing asset to the community and provide a space for folks to heal and feel safe."* Similarly, respondents indicated that the OUAC provided important and impactful services. Some did note, however, less than favorable opinions. For example, there was feedback that the services were not good for Black individuals[5], and that the resources were not consistent or reliable.

The next question asked of community members was, "Are there services that you believe the Orlando United Assistance Center should provide but do not?" Twenty community members answered this question. Respondents indicated a lack of knowledge about what is offered and many of the recommended services are already provided by the OUAC. Some noteworthy responses, however, include a need for cultural competency, desire for services offered to everyone in the community, and peer led support groups.

Finally, community members were asked to provide any other feedback they had regarding the OUAC and the services offered to those impacted by the Pulse tragedy. Many of the sentiments expressed in the previous two questions were repeated here, including additional praise and request of more mental health services. Some noteworthy quotes are provided below.

[5] Only one general community member mentioned this. Additionally, given the high level of satisfaction expressed by those who identified as Black in the impacted community sample, we are unable to know if this is perception of services being poor for Black individuals represents the larger impacted community.

"I believe the Orlando United Assistance Center needs to stay open. Those most directly impacted have found refuge and comfort in the OUAC. The entity has been helpful to so many after the tragedy and there is still work to be done."

"I keep hearing that the OUAC is closing. I know that there are people who have not even come out of hiding yet and will need this place when they do. They are still afraid."

"Most of the Black families I worked were not pleased with the services."

"They do such incredible work with a small team. I wonder how much more of an impact they could have if they are continually supported."

"They have good intentions with their community events and scope of case management services but they need to have more onsite therapists and also offer financial assistance for those who are struggling to make ends meet."

Key Takeaways

While we were unable to survey every individual from the impacted community, this research initiative was an important first step at better understanding the ongoing needs of those directly impacted by the Pulse tragedy. Based on the feedback from the impacted community and the general community samples, several recommendations are offered for organizations and agencies providing services to communities impacted by a mass casualty event.

1. Ensure clear and consistent communication about the services offered and who is eligible to receive services.
2. Provide services at varying times and locations to ensure all individuals from the impacted community are able to access them.
3. Provide a core set of services from a centralized organization and augment with referrals to partnering providers.
4. Offer a variety of services that can bring the impacted community together (e.g., support groups; survivor led groups).
5. While the need for mental health services may decrease as time passes, there will likely be spikes and some from the impacted community will require mental health services indefinitely.

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