Recruitment of Young Black Men into Trauma and Mental Health Services Research: Recommendations and Lessons Learned

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Abstract

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Keywords

African American; Community-Based Participatory Research; Mental Health Services; Qualitative Research; Minority Health

Cover Page Footnote

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ABSTRACT
Young Black/African American men are more likely to experience repeated trauma that escalates throughout young adulthood, compared to young White men. Exposure to trauma has impacts on mental health outcomes, but young Black men face substantial barriers to mental health care. In order to begin to address these disparities, it is imperative to increase understanding of the needs, preferences, and priorities of young Black men for mental health care services following trauma. Yet, young Black men are often underrepresented in mental health services research. The purpose of the current study was to describe strategies for recruitment of young Black men with previous trauma exposure from broad urban community settings in Kansas City, Missouri, for participation in a qualitative study exploring beliefs, attitudes, and norms regarding mental health care. A total of 70 young Black/African American men aged 18-30 completed the initial recruitment process, and 55 of these men were consented as participants who completed the study. The majority of participants were recruited from barbershops (n = 21), followed by community-wide events (n = 11) and referrals (n = 11). Few participants were recruited from faith-based settings. Strategies for facilitation of study recruitment and focus group attendance are discussed. These practices may contribute to development of mental health interventions that are relevant, feasible, and sustainable, as well as restoring and advancing research relationships with racial/ethnic minority populations and contributing to racial equity.

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INTRODUCTION

Young Black/African American men are more likely to experience trauma compared to young White men, particularly exposure to community violence (Smith & Patton, 2016; Woods-Jaeger et al., 2020), being in a fight or threatened with a weapon (Boyraz et al., 2015; Eaton et al.,

2012) or experiencing a traumatic loss (Samuel, 2015; Smith, 2015; Smith, 2014). Furthermore, young Black men are at risk for repeated trauma as they progress through adulthood (Rich & Grey, 2005; Richardson et al., 2016; Seal et al., 2014; Smith, 2015; Smith & Patton, 2016; Smith, 2014). This escalation of traumatic experiences contributes to further risk of hospitalization due to violent injury and increased risk for homicide, which is the leading cause of death for Black men in early and middle adulthood (Centers for Disease Control & Prevention, 2019; Richardson et al., 2016).

Exposure to trauma also increases risk for developing mental health concerns (Wolff & Shi, 2012), including posttraumatic stress disorder (PTSD), depression, and problematic substance use (Butcher et al., 2015; Myers et al., 2015; National Alliance on Mental Illness, 2017; Smith & Patton, 2016; Stimmel et al., 2014; Voisin et al., 2016). Although rates of PTSD, depression, and substance use are similar between Black and White adults, Black individuals report greater severity, impairment, and duration of symptoms compared to Whites (Alegría et al., 2013; Benítez et al., 2014; Himle et al., 2009; Lincoln et al., 2011; Mays et al., 2018; Mouzon et al., 2016; Roberts et al., 2011; Sayed et al., 2015; Williams et al., 2007). Despite these disparities in trauma exposure and psychopathology, young Black men are less likely to seek and receive mental health services compared to young White men, young Black women, and older Black adults (Green et al., 2014; Neighbors et al., 2007; Ward et al., 2013). Complex, intersectional barriers to care have been documented among young Black men at multiple levels, including systemic racial inequalities (Clement et al., 2015; Gulliver et al., 2010; Hankerson et al., 2015; Rich et al., 2018; Watson, 2014).

In order to begin to address these disparities, it is imperative to increase understanding of the needs, preferences, and priorities of young Black men for mental health care services following trauma. Researchers and national organizations (e.g., National Institute of Mental Health) have called for investigations into the mental health needs of Black men by conducting purposeful discussions with members of this population (Gordon, 2020; Watkins et al., 2017), particularly given the potential for persistent tension or conflict in urban neighborhoods and subsequent impact on mental health (Rich et al., 2018). However, young Black men are often underrepresented in mental health services research (Graham et al., 2018; Randolph et al., 2018). Traditional barriers to recruitment for this type of research include medical mistrust and mistrust of research, particularly given the historical mistreatment of the Black populations by the medical research community; logistical issues (e.g., transportation); and inadequate information provided by study staff (Huang & Coker, 2010; Randolph et al., 2018; Spence & Oltmanns, 2011; Thompson et al., 1996; Woodall et al., 2010; Yancu et al., 2011). Young Black men have also reported stigma beliefs regarding mental health symptoms and treatment, as well as culturally-specific ways of discussing mental health, which may inhibit willingness to participate in mental health-related research and studies that include researcher-led, in-depth discussions on mental health (Huang & Coker, 2010; Kranke et al., 2011; Watkins & Neighbors, 2007).

Recent studies have reported on recruitment of low-income, Black adult men (Graham et al., 2018) and Black college students (Yancu et al., 2011) in health promotion research. However, only a few studies have described recruitment procedures for depression research, particularly with older Black adults (Bryant et al., 2014; Shellman & Mokel, 2010), and no reports have provided details on strategies to specifically recruit and engage young, urban Black men with previous

trauma exposure in mental health research. The purpose of the current study was to describe strategies for recruitment of trauma-exposed young Black men from broad urban community settings for focus groups discussing beliefs, attitudes, norms, perceived control, and intentions regarding mental health care.

METHODS

Study Description

In 2017, Missouri ranked first in the nation for Black homicide victimization, with rates increasing for more than a decade and rising by 64% between 2014 and 2017 (Violence Policy Center, 2020). There has been great interest among local public health, community, and faith-based organizations on understanding how to address exposure to violence, homicide, and traumatic loss, particularly through increasing access, engagement, and retention in mental health services for young Black men (Bauer et al., 2020; Berkley-Patton et al., 2021; City of Kansas City Missouri Health Department et al., n.d.; Williams & Rheingold, 2020; Woods-Jaeger et al., 2020). This research was conducted in alignment with these research and public health priorities.

This study was guided by the Theory of Planned Behavior (TPB), which is comprised of beliefs, attitudes, norms, and intentions to engage in health behaviors. The TPB describes three primary constructs of behavioral, normative, and control beliefs regarding engagement in a health behavior. Taken together, these constructs are expected to predict intentions to perform the behavior, which informs subsequent behavioral outcomes. The TPB has been widely used to guide the design of health promotion interventions that increase uptake of health behaviors and utilization of care services among Black adults (Bauer et al., 2019; Berkley-Patton et al., 2019; Blanchard et al., 2009; Demyan & Anderson, 2012; Thompson et al., 2013). The study was conducted across three phases: 1) elicitation of information using focus groups; 2) development of a culturally tailored survey on mental health attitudes, beliefs, and norms; and 3) validation of the survey, all with young, urban Black/African American men. In Phase 1, the primary goal was to qualitatively explore TPB beliefs related to mental health care among young Black men who had experienced trauma. Qualitative findings from this phase of the project were used as foundational, formative research to develop and pilot a brief TPB-guided measure, which was administered with a larger sample in a later phase of the study. The recruitment strategies described in this paper are drawn from Phase 1 of the study, although similar strategies were used across subsequent phases.

Participants and Procedures

Eligibility for the study included self-identifying as Black/African American and male, being aged 18-30, and having experienced at least one traumatic incident. Participants were assessed for trauma history using items drawn from the Stressful Life Events Screening Questionnaire-Revised (SLESQ; Goodman et al., 1998), which has been used to measure potentially life-threatening experiences among Black populations (Green et al., 2006). In order to be eligible for the study, participants were also required to have no active psychotic symptoms or active suicidal/homicidal ideation (SI/HI). Psychotic symptoms and SI/HI were determined by a screener adapted from subscales of the Mini International Neuropsychiatric Interview (MINI-7.0; Sheehan et al., 1998). Planned procedures included referrals for individuals with active SI/HI to care at the Kansas City (KC) Care Health Center, a local community mental health center where

free to low-cost behavioral health services (dependent on insurance coverage) were available. However, this step was not necessary throughout recruitment. Interested young men completed eligibility screening, and information on focus group meeting was provided if the selection criteria were met. Contact information (i.e., name, two phone numbers, e-mail address) was collected from interested men in order to send them a reminder about the upcoming focus group/interview meeting. Participants also indicated whether they gave permission for the research staff to leave voicemail messages and send texts or emails.

Nine focus groups were held, with an average of seven participants in each group. Six individual interviews were also held, for ease of scheduling for some participants. Eligibility criteria were identical for both focus groups and interviews. Just before the start of each focus group or interview, each participant completed informed consent and a brief survey, which took approximately 15-20 minutes. All participants, whether completing a focus group or interview, were compensated $40 in cash and provided a meal for participation. Focus groups and interviews lasted up to 90 minutes. All discussions were held as closed sessions in local community locations (e.g., community colleges, churches), and participants were instructed to use pseudonyms to increase confidentiality. A TPB-guided, semi-structured discussion guide was used for interviews and focus group sessions, with prompts related to attitudes, norms, and barriers related to mental health care. Interviews/focus groups also included discussions on experiences with trauma and mental health care and potential strategies to increase use of mental health services among Black communities. Study procedures were approved by the University of Missouri-Kansas City Institutional Review Board.

Survey Measures

Measures included in the brief survey included demographics and mental health beliefs and behaviors. Only demographics and previous trauma exposure were reported for the purposes of the current study. Demographics assessed were age, sex at birth, socioeconomic status (i.e., education level, average monthly income), and health insurance coverage. Participants were also asked to describe their history of trauma exposure, including whether any of ten potentially traumatic events (e.g., “Being threatened with a weapon [knife, gun, etc.],” “Losing a loved one as a result of accident, suicide, or homicide”) happened to them, someone close to them, or neither. All ten events parallel items from the SLESQ and were the most commonly reported potentially traumatic events in previous studies of young Black men (Boyraz et al., 2015). Checked responses were coded as yes (1), and unchecked responses were coded as (0), with Cronbach’s $\alpha = .714$.

RESULTS

Phase 1 Final Sample

A total of 70 young Black/African American men were eligible and completed the initial recruitment process; 55 of these men were consented as participants who completed the study. The remaining 15 young men were lost to follow-up and did not participate in the study. Participants average age was 23 years old (*SD* = 3.9). Among study completers, more than one-third of participants had a high school diploma or GED, and slightly fewer participants had some college, but no degree (Table 1). Participants commonly did not know their average monthly household income, although 27% reported more than $3,000 per month. One-third of participants had no

health insurance. The most commonly reported types of trauma experienced were being threatened with a weapon and losing a loved one to accident, suicide, or homicide. Participants were recruited from several community sites across urban Kansas City, including a community college, a midsize university, barbershops, churches, and resource fairs. The largest proportion of participants was recruited from barbershops, followed by referrals, community-wide events, and a local university (Table 2).

Table 1. Demographic characteristics of Black men aged 18-30 who participated in the study

	N	%
Sex		
Male	54	98.2
Missing response	1	1.8
Education		
11th grade or less	6	10.9
High school graduate or GED	20	36.4
Post high school technical training	1	1.8
Some college (but no degree)	18	32.7
Associates degree (AA) or technical school certificate	3	5.5
Bachelors (BA, BS)	2	3.6
Some graduate school or graduate degree	2	3.6
Not reported	3	5.5
Average monthly household income		
$0 - 1,000	7	12.7
$1,001 - 2,000	6	10.9
$2,001 - 3,000	4	7.3
More than $3,000	15	27.3
Don’t know	21	38.2

Refuse to answer	2	3.6
Health insurance		
Medicare or Medicaid	14	74.5
Private insurance	17	30.9
Other	5	9.1
No insurance	18	32.7
Exposure to trauma		
Life threatening illness or accident	19	34.5
Robbery or mugging	18	32.7
Being threatened with a weapon	23	41.8
Witnessing someone be seriously injured, assaulted, or killed	15	27.3
Losing a loved one to accident, suicide, or homicide	23	41.8
Serious injury or threat to life	15	27.3
Physical harm from a parent or caregiver as a child	7	12.7
Being physically harmed or beaten as an adult	8	14.5
Forced sexual activity	8	14.5

Table 2. Participant enrollment by recruitment site

	Enrolled in Study (*N* = 70)		Completed Study (*N* = 55)	
	N	%	*N*	%
Community college	3	4.3	2	3.6
Craigslist	4	5.7	4	7.3
University	8	11.4	8	14.6
Barbershop	21	30.0	17	30.9
Community event	11	15.7	6	10.9
Church	4	5.7	2	3.6
Referral	11	15.7	11	20.0
Word of mouth	6	8.6	5	9.1
Other/unknown	2	2.9	0	0.0

Development of Recruitment Strategies

The recruitment activities were primarily enabled through the research team's community contacts and its collaborations with local community colleges, and faith- and community-based organizations. Referrals to owners of two Black-owned barbershops were also made by research team members with long-time roots in Kansas City. Additionally, recruitment activities were also conducted online through Craigslist and social media (e.g., Facebook).

The PI was given permission to share information about the study in community meetings led by the research team's community partners. For example, the research team co-leads a quarterly KC FAITH Initiative community action board (CAB) meeting with its long-term faith-based health promotion partner, Calvary Community Outreach Network. The highly engaged CAB is made up of representatives from faith, community, health, and academic organizations who contribute to the design, implementation, evaluation, interpretation, and dissemination of the research team's community-based health intervention studies.

The PI also held initial, individual meetings with leaders of organizations and business owners, and explained the study's purpose, goals, and procedures, including the type of qualitative questions being asked and how confidentiality would be protected. The importance of hearing directly from the community, particularly young Black men, in order to improve community health was also discussed. The discussion guides were provided to, and reviewed with, leaders of the organizations. These meetings also included a request to distribute recruitment materials to their

constituents and a discussion on how recruitment strategies could be tailored for their specific location and young urban male population. For example, church leaders commented it would be best if they could receive recruitment information in multiple formats (e.g., church bulletin, flyer) to inform their members.

Evolution of Study Recruitment Strategies

Early efforts to recruit participants primarily focused on passive or indirect outreach, which included posted flyers, church bulletin inserts, and distribution of announcements via social media and email. These strategies resulted in $n = 4$ participants enrolled between October and December 2018. Thus, direct contact with potential participants was increased to improve recruitment accrual. With each community leader's agreement, and after coordinating days and times for recruitment, research staff were present at community sites to meet directly with interested young Black men, provide information about the study, and conduct enrollment procedures. For instance, study staff attended community engagement events to recruit participants. Events were hosted by local community organizations that serve Black youth and held in the heart of the Kansas City metropolitan area. Each event offered music and local performers, as well as free food, clothing, and other educational resources for the public. Revised recruitment strategies resulted in $n = 51$ participants enrolled in February through April 2019.

Interested young men and potential participants were informed that this was a community-based research study, which emphasized the importance of hearing directly from young Black men as the experts within their community to better understand their needs, preferences, and concerns related to improvement of community mental health. Recruitment materials also used terms such as "experienced or witnessed violence" instead of the word "trauma," given the potential for stigmatizing language and that broadly, young Black men may not define these experiences as being traumatic, particularly when they are persistent and pervasive (Rich et al., 2018; Smith & Patton, 2016). However, detailed descriptions of the study's purpose, aims, and inclusion criteria, including the definition of trauma were provided and discussed as part of the informed consent process. To underscore the need for community input and to facilitate trust, the PI was also forthcoming about her research and personal background as a Black and Hispanic female, who was not originally from the Kansas City area. All study staff that contributed to recruitment were Black/African American.

Recruitment approaches were tailored to each community site. At some sites, such as the community college cafeteria or quad, it was advantageous to have a table set up with information about the study, as this provided increased visibility and interaction. In other settings (e.g., busy barbershops), a more casual and conversational approach was more feasible, due to level of ongoing activity and/or limited space. These approaches allowed the researchers to actively approach potential participants where they were (e.g., waiting to get their hair cut), rather than waiting for young men to initiate contact.

The PI was responsible for all direct communication with participants, which simplified the enrollment process and allowed participants to have a direct contact to get information about the study, complete eligibility, or confirm their participation. Flyers were distributed with her name and contact information, including e-mail address and phone number, both of which were created and maintained solely for study purposes. When following up with interested young men who had

met a member of the research team in person, they were also asked about the date and location of when they heard about, or were enrolled in, the study. This allowed the PI to more effectively establish familiarity with the location and previous conversations held, along with providing further information about the project and, if applicable, confirm their enrollment.

Increasing Focus Group Attendance

Throughout active recruitment, focus group attendance was facilitated by having a session date, time, and nearby location already scheduled in order to refer participants at the time of their enrollment. Once they'd joined the study and were assigned to a focus group, participants were more likely to attend if the PI confirmed their spot and the focus group details within 24 hours. Furthermore, reminders were sent via phone, text, and/or email (dependent on each participant's given permissions) the day before the focus group meeting.

Focus groups were held in accessible community locations that were familiar to participants, including private meeting rooms at the public library, community college, a church, and a barbershop after closing. Business owners were provided with an incentive of $75 for hosting focus groups onsite. Also, attendance was improved if focus group meetings were held on transit routes and in the late afternoon or early evening.

Early participants told friends about the study and extended recruitment within their social networks. Thus, the PI added a $5 referral incentive for each eligible participant they referred, up to 20 individuals. Of the 51 participants who participated in spring 2019, n = 11 (22%) were referrals from previous participants. Participants who were interested in referring friends were provided with printed recruitment flyers. They also expressed willingness to share study information with friends through text and social media. Furthermore, several community members expressed willingness to assist recruitment by sharing study flyers and announcements on through their professional networks and on their personal social media accounts, in addition to discussing the focus group opportunity at their churches. Business owners and community leaders who facilitated recruitment also shared study information via social media; told young men about the study; posted flyers informing potential participants about upcoming focus group dates, times, and locations; and directed young Black men to speak with the researcher on-site to find out more about the study. One barber also arranged for the researcher to make an announcement at his church, where recruitment flyers were also posted on an announcement board.

Other Lessons Learned

In each focus group, participants were assured of their role as experts within the community. The researchers assured participants that although one of the study's goals was to improve access and utilization of mental health care, they were under no obligation to be in favor of professional mental health care and were encouraged to speak candidly. The researchers invited participants to be open about their experiences, perceptions, and beliefs, as there were no wrong answers to any of the questions posed and expressing negative beliefs about mental health care would not affront the researchers. Participants exhibited candor within focus groups, as well as willingness to comment on a wide breadth of areas related to their mental health beliefs, attitudes, and norms, as well as trauma, stressors, and systemic issues facing Black communities. Often, focus groups felt like relaxed, casual spaces for participants to discuss these issues. Participants remarked on being able to openly discuss these viewpoints and having opportunities for "talking

things like this," where they could discuss mental health. Some participants contributed a small amount to their respective focus groups, but others exhibited a sense of willingness to discuss these topics more deeply.

The PI made efforts to be open to comments and discussion throughout each session, even if not directly related to the prompts. These conversations led to additional observations, comments, and experiences that helped to give context and clarity to the primary findings. The PI and other members of the research team took notes throughout the focus group. At the end of each focus group, the research team used their notes to summarize the topics discussed and key points made related to the TPB. Additionally, at the conclusion of focus group discussions, participants were encouraged to take leftovers from the provided meal, with small food storage containers or supplies available. The PI found that this was an important time for any further wrap-up and conversation with participants, giving out flyers for referral, and discussing further goals of the study. After completing the focus group, participants commented on the ease of participating, saying that they were initially skeptical about what the "catch" would be to get the $40 participation incentive. As one participant commented, "I want to say this is cool. I didn't think it was going to be like this," and another commented on how "we hit it all."

DISCUSSION

This study is among the first to report on the recruitment of trauma-exposed young Black men from broad, community-based settings for participation in a qualitative study exploring beliefs, attitudes, and norms regarding mental health care. The majority of participants were recruited from barbershops, which is consistent with the literature on recruitment of Black men (Graham et al., 2018; Randolph et al., 2018). However, this study also recruited from several types of community sites, with representation across socioeconomic categories. Researchers have noted limitations of barbershops (e.g., recruitment being labor-intensive, samples potentially not representing the broader community of Black men) (Graham et al., 2018) and qualitative explorations of mental health among Black young adults have largely focused on college students (Mesidor & Sly, 2014) or women (Barksdale & Molock, 2009; Chen et al., 2016). Thus, this qualitative study has potential to provide a broader perspective into attitudes, norms, barriers and facilitators with young Black men residing in urban communities, particularly those who may have low propensity to seek care, or lower access to mental health care, after experiencing trauma.

Notably, few participants were recruited from faith-based settings, which contrasts with previous findings among Black men (Owens et al., 2017). Although Black adults have demonstrated high religiosity in general, national studies indicate that young Black men are less likely to endorse religious beliefs, and attendance at church services has been waning (Diamant & Mohamed, 2018; Pew Research Center, 2009; Taylor et al., 2014). Therefore, recruitment in faith-based settings may limit opportunities to reach young Black men for participation in research studies and mental health promotion interventions. Future mental health research and promotion programs designed to reach young Black/African American men may also be more feasible and effective if implemented in broad community settings (Lindsey et al., 2017). Given the individual limitations of traditional community recruitment sites, research is needed with this population to

gather information about additional community settings that could have greater impact for recruitment and retention in research studies.

As in previous studies with Black men (Namageyo-Funa et al., 2014; Randolph et al., 2018; Shellman & Mokel, 2010), it was crucial to collaborate with individuals who served as "gatekeepers," or trusted individuals with close connections to the community. Ongoing collaboration efforts included involving them early in the process, thoroughly explaining the study, clarifying their role, and maintaining contact throughout recruitment. This allowed gatekeepers and the research team to maintain clear expectations about their involvement and level of commitment, as community health researchers have recommended (Berkley-Patton et al., 2018; Namageyo-Funa et al., 2014; Randolph et al., 2018). Few participants were recruited using passive strategies (e.g., flyers, announcements) – even in working with gatekeepers to post study materials in various locations across the community. This understanding led to one of the most important changes during the recruitment process which focused on the shift from indirect/passive recruitment to direct/active recruitment (e.g., face to face contact, confirming participation within 24 hours). Studies have documented the importance of having the research team be visible when conducting research and recruitment activities with racial/ethnic minorities (Ibrahim & Sidani, 2014), particularly for young Black students from college/university settings (Yancu et al., 2011) and Black adult men (Spence & Oltmanns, 2011). Active recruitment methods allow for more direct communication about the study and transparency with research personnel, which can help to overcome enrollment issues (e.g., misunderstanding of informed consent or study intent) and the mistrust of research and medical systems stemming from historical and ongoing mistreatment of Black/African American communities (Scharff et al., 2010).

Previous research has also recommended racial/ethnic and gender diversity within research teams, and the importance of the team reflecting the population of interest when possible (Ibrahim & Sidani, 2014; Randolph et al., 2018). However, while diversity of the researchers plays a key role, the intersectionality of race and gender has had differential impacts across studies with Black men. For instance, a recent qualitative study by Randolph and colleagues (2018) demonstrated that Black male participants were most comfortable when the researchers were Black men, with less discussion when Black women were present. In contrast, a review of the literature by Woodall and colleagues (2010) found that racial/ethnic match of researchers did not substantially extend recruitment, and another study found no difference in rates of participation by racial/ethnic match between inpatient African American participants and researchers (Thompson et al., 1996). Furthermore, Black men and women have also expressed willingness to participate in research led by White investigators (Kerkorian et al., 2007). Thus, beyond racial/ethnic match, recruitment of young Black men may be influenced by other factors, such as the topic being discussed, as well as the researchers' general interpersonal approach (Spence & Oltmanns, 2011). In the current study, the PI and members of the recruitment team were Black, but there were no male members on the team. Future research studies in this area should consider creation of diverse research teams that reflect the population being studied, including intersections of race/ethnicity, gender, and age, which may be particularly important for potentially stigmatized mental health research.

As described by studies of Black men who had experienced community violence, a casual, conversational approach was used when introducing the research team and study purposes

(Schwartz et al., 2010). This style has potential to put people expressing interest in research studies at ease, as well as providing an early opportunity to build rapport with young Black men who could possibly participate in the study. Studies have highly recommended that researchers have an ongoing presence, or immersion, in community settings of interest, such as barbershops, by informally spending time in participating in the setting's activities and getting to know its members, culture, and traditions when possible, as a less formal approach (Randolph et al., 2018). The research team's engagement in these activities was particularly beneficial to the study and contributed to the development of trusted relationships with community partners.

Several other factors also facilitated participation. Focus groups were held in community-based locations that were easily accessible (e.g., close to transit routes) and had private rooms to ensure privacy and confidentiality. Key logistical considerations included holding focus groups in locations that were near where participants were recruited (e.g., metropolitan public library) or at the same site when possible (e.g., barbershops after-hours). This increased the likelihood that participants would be familiar and comfortable with the focus group location. Additionally, most focus groups were held in the late afternoon on weekdays, as participants frequently reported that this time helped accommodate their work and personal schedules. Finally, participants were assigned to focus groups at the time of enrollment and were given all of the focus group information (e.g., date, time, location) on the spot. Although efforts were made to confirm enrollment and remind participants of focus group dates/times, this strategy helped to promote attendance with participants who were difficult to reach later with reminders about their upcoming focus groups.

Effective communication was also facilitated by using a streamlined approach between participants and a single member of the research team. This strategy seemed to help promote familiarity between the researcher and participant, especially when contacting participants following their enrollment, and when participants reached out to ask questions about the study. Given previously reported challenges in communicating with young Black men after traumatic injury (Schwartz et al., 2010) and methodology used in the current study, it may also be important for the researcher managing communication to have a phone number that is solely dedicated to the study's purposes – not affiliated with a medical center or other institutional authority, and to have alternate methods of contact beyond phone calls (e.g., text messaging).

There were some limitations to the current study. No demographic information was available on the 15 young men who did not complete the study, limiting comparisons between completers and non-completers. Second, this study did not include a focused effort to recruit Black men with diverse sexual and gender identities, so it is unclear whether the recruitment strategies reached transgender and sexual minority men or impacted their willingness to participate. For instance, transgender men have expressed unique concerns about participation in research studies over and above those of Black/African American men (Owen-Smith et al., 2016), which may not have been specifically addressed with the current methodology. Third, some individual interviews were held due to participant scheduling limitations, so it is unclear whether these participants' responses would have been different in a group setting. However, the number of interviews conducted represented a small percentage of the total sample, and the breadth of responses was similar between individual interviews and focus group discussions. Finally, the research team did

not partner with the community in overall study design or development of study materials (e.g., flyers, survey instruments, discussion guide), which is an important facet using community-engaged research approaches. However, this study represented an initial exploration into the beliefs, attitudes, and norms regarding mental health screening care among young Black men who had experienced trauma. Qualitative findings from this study will help to inform the design and implementation of future mental health promotion interventions by A) establishing a foundation of knowledge regarding the multilevel influences on engagement in mental health care among young Black men who have experienced trauma, and B) providing initial guidance on their needs, preferences, and priorities regarding mental health care. Research conducted as a result of this initial study, including future health promotion interventions, should seek to align with community-based participatory research (CBPR) principles.

Despite being underrepresented in the mental health service literature, Black men and women have demonstrated interest in participating in health research (McElfish et al., 2018; Shellman & Mokel, 2010) and have expressed beliefs that doing so can be beneficial to their communities (James & Harville, 2017). Recruitment and retention of young Black men may warrant additional considerations that may not be needed for research with young White men. It is imperative to continue to build collaborative partnerships with Black/African American communities to identify effective recruitment strategies that yield larger samples of young Black men, especially considering the persistent inequities in trauma and mental health. In particular, researchers should actively partner with Black/African American community-based organizations and businesses and use flexible, culturally tailored recruitment strategies adapted for their settings. Even more so, it is crucial for researchers to have a genuine understanding of the value and importance of using CBPR approaches, which includes having humility and respect for experiential knowledge, engaging the community in all phases of the research, and sharing study results with community partners. These efforts can also help build long-term relationships and counter the historical, and warranted, mistrust that many Black communities have in regard to participation in research. These practices may lead to development of mental health interventions that are relevant, feasible, and sustainable, as well as restoring and advancing research relationships with racial/ethnic minority populations. Furthermore, establishing community-academic partnerships, and advancing the research in ways that foster community capacity and build on existing strengths, can contribute to racial equity by addressing multilevel determinants of mental health, improving personal, social, and occupational well-being across the lifespan, and fostering sustainable change.

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