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Commentary

Beyond Certification: A Commentary on Community Mental Health First Aid Capacity Building in Black, Caribbean, and African Communities and Its Implications for Psychiatry

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Abstract

This commentary extends Chapter 14, Mental Health First Aid Certification to Build Capacity in Black, Caribbean, and African Communities, by repositioning Mental Health First Aid (MHFA) certification as one element of community mental health infrastructure rather than a stand-alone outcome. Although MHFA is widely used to improve mental health literacy, certification counts alone do not indicate whether community capacity, help-seeking pathways, or equitable access to care have meaningfully improved. In Black, Caribbean, and African (BCA) communities, MHFA must be interpreted within contexts shaped by structural inequities, racialized stigma, mistrust of services, and uneven access to culturally safe care.

Drawing on the original chapter's account of a BCA-focused MHFA initiative implemented with the Ghanaian Canadian Association of Ontario, this commentary argues that MHFA capacity building is best understood as a multi-level intervention. Its impact depends on individual knowledge and confidence, relational trust, community organizational strength, and the ability to connect participants to appropriate services. It further argues that cultural relevance is a core condition of effective implementation, not an optional enhancement. Contextual adaptation, trusted community delivery, and culturally grounded case examples increase the practical usefulness of MHFA in everyday settings.

For psychiatry and public mental health, the key implication is that community MHFA should be linked to curated referral pathways, culturally safe service encounters, and shared accountability between community organizations and formal care systems. The commentary also identifies major risks, including burden transfer, superficial adaptation, and premature claims of impact, and proposes safeguards and a staged evaluation agenda to assess pathway, equity, and sustainability outcomes beyond training outputs.

Introduction

Mental health inequities in Black, Caribbean, and African (BCA) communities raise a practical question for psychiatry and public mental health: Which community-based strategies improve pathways to support and care rather than simply increasing program activity? Mental Health First Aid (MHFA) is frequently regarded as a scalable intervention for enhancing mental health literacy. However, its effectiveness in marginalized communities cannot be adequately assessed solely through certification metrics [1]. In contexts where communities encounter structural barriers, racialized stigma, mistrust of services, and inconsistent access to culturally appropriate care, capacity building must be conceptualized as extending beyond mere completion of training [2–5].

This commentary extends Chapter 14, "Mental Health First Aid Certification to Build Capacity in Black, Caribbean, and African Communities," in the book *"Critical Ethics on Mental Health and Madness"*, by repositioning certification as one element of community mental health infrastructure rather than an endpoint [6]. The chapter documents a BCA-focused MHFA initiative implemented in partnership with the Ghanaian Canadian Association of Ontario (GCAO), including instructor training, broad community reach, and efforts to develop culturally relevant case examples [6].

For psychiatry and public mental health audiences, the extension of this work is clear: certification programs are most valuable when embedded in community trust structures and linked to culturally safe care pathways, rather than assessed as stand–alone educational events [1,7,8].

This commentary argues that MHFA capacity-building in BCA communities should be treated as a multi-level intervention. Its effects depend not only on curriculum delivery, but also on cultural adaptation, trusted community institutions, instructor support, and the availability of services that people can access with dignity [3,8,9]. The key question, therefore, is not only whether certification can be expanded, but whether expansion is accompanied by the relational and structural conditions required for impact.

Chapter 14: The Anchor Contribution

Chapter 14 provides a strong platform for a psychiatry-facing extension because it links structural inequity, pandemic context, and a concrete community response [6]. The chapter is situated within an edited volume that foregrounds ethics, colonialism, anti-Black racism, and mental health care, matters that prevent the MHFA initiative from being read as a decontextualized training exercise [6].

The chapter presents certification as a community capacity-building strategy developed in response to unequal mental health burdens and access conditions [6]. It highlights implementation through a trusted community organization, a train-the-trainer model, and efforts to improve cultural relevance through case development. Its importance is therefore not limited to implementation outputs [6]. It also creates a basis for rethinking success in mental health literacy initiatives in racialized communities, asking not only how many people were certified, but what forms of community, relational, and system capacity were built [6,8,10].

More specifically, the GCAO-linked initiative trained 24 MHFA instructors and subsequently reached 406 community participants across multiple provinces through community-based delivery [6]. The intervention did not rely solely on standard dissemination. It collaborated with trusted Black-led, Black-focused community organizations and networks, and developed culturally relevant case examples intended to better align with the lived experiences of Black, Caribbean, and African communities [6]. At the same time, the initiative faced practical challenges common to equity-oriented community programs, including the demands of adaptation work, the need to sustain instructor engagement, the uneven availability of culturally responsive referral options and the broader difficulty of translating training gains into consistent pathways to care [6,10]. These details matter because they show that the initiative was not simply a certification exercise, but an implementation effort shaped by trust, context, and system constraints.

Beyond Certification Counts, What Capacity Should Mean

Discussions of MHFA scale-up often assume that capacity building can be measured adequately by the number of people trained, the number of instructors certified, or the number of workshops delivered [1,7]. These outputs are important indicators of reach and implementation activity. However, they do not establish whether community capacity has increased in ways that improve mental health support, help-seeking, or service linkage [1,8].

This limitation is especially important in BCA communities, where mental health action unfolds within conditions shaped by migration histories, racism, stigma, economic stress, and uneven trust in formal systems [5]. In these settings, a participant may gain knowledge and confidence from MHFA training yet still face major barriers when applying those skills [4,5,11]. They may not know which services are culturally safe, anticipate dismissive treatment, avoid referral conversations due to stigma or concerns about social reputation, or encounter service bottlenecks that reduce the practical value of mental health literacy [4,5,12].

A more useful framework is to understand MHFA capacity building as multi-layered. Individual capacity includes recognition of mental health concerns, confidence in responding, and reduced fear of engagement [10]. Relational capacity concerns whether participants can initiate supportive conversations and respond in ways that sustain trust [8]. Community organizational capacity includes trusted institutions, local champions, and delivery networks that allow MHFA knowledge to circulate over time [10]. System interface capacity refers to the practical ability to connect people to appropriate care, including culturally safe services, crisis resources, and follow-up support [8,10].

This framing has direct implications for psychiatry. Community MHFA is not best understood as a separate educational activity outside clinical systems. It functions upstream within a broader ecosystem of recognition, support, and navigation for care. Psychiatry relevance therefore begins before specialist treatment, in the conditions that shape whether people seek help, how they are referred, and what happens at first contact [13,14].

MHFA in Relation to Competing and Complementary Frameworks

MHFA remains useful because it offers a recognizable, scalable, and non-clinical framework for early recognition and supportive response [7]. Its strengths include improvements in mental health literacy, confidence, and willingness to help [1,7]. At the same time, critiques of MHFA are important to engage directly. Some scholars note that MHFA may privilege

standardized recognition models that do not fully align with local idioms of distress or community ways of responding [1,15]. Others argue that training-focused approaches risk individualizing responsibility for care in contexts where structural barriers and system inadequacies are central [1,16]. Still others caution that educational gains do not necessarily translate into effective helping behavior, successful referral, or improved recipient outcomes [7,12]. These critiques do not undermine MHFA; Instead, they suggest that MHFA should be regarded as one element within a broader framework of culturally grounded mental health promotion, peer support, community leadership, and responsive clinical care. For BCA communities, the question is not whether MHFA should replace other frameworks, but how it can be adapted and combined with approaches that better address structural inequity, community knowledge, and service mistrust.

Cultural Relevance as a Core Intervention Condition

An Essential implication of extending this research for psychiatric audiences is the recognition that cultural relevance must be regarded as a fundamental condition of intervention, rather than an optional enhancement [9,12]. In numerous mental health training frameworks, adaptation is often treated as a secondary step following standardization or reduced to mere translation and superficial representation [17]. This approach is insufficient for BCA communities if the objective is to achieve meaningful engagement and application within everyday social contexts.

The chapter's efforts to develop community-specific case studies and culturally relevant facilitation materials point toward a stronger implementation model [6]. In this context, cultural relevance includes the language and idioms through which distress is recognized, the social conditions that shape distress, such as migration strain and racism-related stress, culturally grounded sources of meaning and support, including family and spirituality, and the social risks associated with disclosure, such as stigma, gossip, and reputational concerns [4].

When these realities are absent from training examples, participants may understand MHFA concepts in abstract terms yet struggle to apply them in real situations. Training may be perceived as technically useful but socially distant. By contrast, culturally relevant cases and facilitation can create interpretive bridges between formal MHFA concepts and community ways of naming and responding to distress [6]. This strengthens comprehension, acceptability, confidence, and likely use [9,17].

For psychiatry, the ethical implication is significant. If systems promote community mental health literacy interventions in marginalized populations without investing in contextual adaptation, they shift the burden of fit onto communities [5,17]. A more equitable approach recognizes adaptation work as part of the intervention itself and resources it accordingly [9].

This perspective also helps avoid two common errors. The first is assuming that one adaptation can fit all Black, Caribbean, and African communities despite substantial variation in migration histories, national and ethnocultural identities, language, religion, gender roles, class location, generational position, and prior experiences with formal care [18]. The second is assuming that adaptation undermines rigor. In practice, well-governed adaptation can improve implementation quality while preserving the core intent of the intervention [17]. For this reason, future MHFA work in BCA settings should distinguish between shared structural conditions, such as anti-Black racism and service mistrust, and subgroup–specific realities that may shape how distress is recognized, discussed, and acted upon. A culturally responsive model should therefore be layered rather than uniform, combining common principles with local tailoring [8,17].

Implications for Mental Health Promotion and Psychiatry Care Systems

The implications of this work for mental health promotion and psychiatry are practical, ethical, and organizational. Although Chapter 14 focuses on MHFA certification as a capacity-building strategy, its broader significance lies in what it reveals about the relationship among community knowledge, trust, and service systems [4,6]. For psychiatry readers, community MHFA should not be treated as peripheral education outside formal care, but as an upstream component of the mental health care ecosystem [5,19]. If psychiatry services seek earlier engagement, more effective help–seeking, and better continuity into care, community–based capacity building must be linked to referral pathways, communication practices, and culturally safe service encounters; otherwise, certification may increase recognition of distress without increasing the likelihood of meaningful support [15].

Mental Health Promotion as Infrastructure, Not Outreach Alone

The chapter presents MHFA certification as a strategic enhancement of mental health resources in BCA communities and highlights a PHAC–supported collaboration with GCAO, including a train-the-trainer model and cultural adaptation work [6,20]. This points to a broader systems lesson. Mental health promotion in marginalized communities is strongest when treated as social infrastructure, meaning sustained investment in local institutions, trusted messengers, recurring delivery mechanisms, and continuity supports, rather than one-time workshops alone [13].

Community associations, faith institutions, and cultural organizations are not only recruitment sites. They are implementation environments that shape who attends, what becomes discussable, how stigma is negotiated, and whether participants use what they learn. For psychiatry systems, this requires a shift from dissemination-oriented partnerships toward co–design and co–navigation relationships with community organizations [2,6,9].

Culturally Safe Care Pathways, Not Generic Referral Advice

Mental health literacy programs often assume that once people recognize symptoms and are encouraged to seek help, services can respond appropriately [15,19]. This assumption is frequently weak in contexts where trust is low, services are fragmented, and care experiences are shaped by anti-Black racism or cultural mismatch [5,11].

The chapter's emphasis on cultural relevance, therefore, also has implications for pathways. If participants are trained to identify distress but are referred into services experienced as alienating or context-blind, the intervention chain breaks at the point of system contact [1,5,21]. This can delay future help-seeking and reduce confidence in both training and services.

Psychiatric systems should support curated referral pathways linked to community MHFA initiatives. These pathways should identify options that are demonstrably responsive to BCA communities, including providers and teams with cultural humility and anti-racism capacity [5]. At minimum, pathway materials should clarify who receives referrals, likely wait times, language supports, crisis and non-crisis routes, and follow-up options. Community programs should not assume responsibility for referrals while systems remain unclear about the quality of responses.

Trust as a Clinical and Systems Variable

Trust is often acknowledged in mental health services but not routinely operationalized in service design or evaluation [22]. The chapter's use of an established community organization demonstrates that existing relationships are integral to the intervention itself. The project builds on GCAO's links with Black, African, and Caribbean associations, and that organizational legitimacy likely shapes participation and uptake [6].

Psychiatric systems can draw a clear lesson from this. Trust is built through repeated respectful interactions, transparent communication, and evidence that services understand the social realities of patients and families. It is damaged by dismissiveness, stereotyping, rushed assessments, poor follow-up, and decontextualized treatment planning [2,23]. Community MHFA can improve readiness for help–seeking, but psychiatry services determine whether that readiness is met with safety and usefulness [5].

Shared Accountability between Community Mental Health Promotion and Formal Care Systems

The next systems step is to move from a handoff model to a shared accountability model. In a handoff model, community programs educate and encourage, and formal systems receive referrals without reciprocal adaptation [24]. In a shared accountability model, community organizations and psychiatry services jointly define goals, pathways, feedback loops, and quality standards [8].

The chapter's design already points in this direction by combining community leadership, public funding support, and adaptation for local relevance [6,20]. The extension of this work should formalize such collaborations into pathway agreements and evaluation partnerships. For psychiatry readers, the question is no longer whether community MHFA training has value, but whether psychiatric systems are organized to translate community–generated capacity into equitable care.

Implications for Individual Clinicians

For individual clinicians, the practical implications are immediate. First, clinicians should ask how patients and families understand distress in their own terms rather than assuming shared meanings of symptoms or care [25]. Second, they should treat community-based helpers and organizations as legitimate partners in care navigation, not as peripheral actors [15]. Third, clinicians should be prepared to discuss referral options in concrete and culturally informed ways, including likely barriers, wait times, and concerns about fit or stigma [11]. Fourth, they should recognize that mistrust may be a rational response to prior experiences of dismissal or racism rather than a simple lack of engagement [12]. Finally, clinicians should view culturally safe care not as interpersonal sensitivity alone, but as a commitment to contextualized assessment, transparent communication, and follow-through [26].

Risks, Tensions, and Safeguards for Equity-Oriented MHFA Capacity Building in BCA Communities

A commentary that calls for greater investment in community-based MHFA capacity building must also address limits and implementation tensions directly. This is especially important in BCA communities, where under-resourced systems may endorse community initiatives while shifting practical burdens onto community organizations without sustained support [4,5]. Articulating risks and safeguards is therefore part of responsible program design and interpretation.

1. Overextending MHFA beyond its scope

MHFA can improve recognition, supportive response, and referral readiness, but it is not a substitute for psychotherapy, psychiatric assessment, crisis services, or long–term mental health care.

Safeguard

Maintain clear role boundaries, crisis escalation guidance, and helper support; do not present MHFA scale-up as evidence that service gaps are solved [1,7].

2. Burden transfer to community organizations and leaders

Community organizations hold trust and social reach, but these strengths can be exploited if systems rely on them without funding or partnership infrastructure.

Safeguard

Ensure resource parity and shared accountability, including support for coordination, mentorship, referral mapping, and participation in evaluation [4,12,24].

3. Superficial or static cultural adaptation

Adaptation can become superficial when reduced to representation or to isolated examples, and static when a single version of BCA adaptation is treated as universally applicable.

Safeguard

Establish adaptation governance, document changes, and revise over time while protecting core intervention intent [9,15,17].

4. Cultural essentialism and homogenizing BCA communities

Efforts to improve relevance can unintentionally treat BCA communities as culturally uniform.

Safeguard

Use layered and local adaptation and examine variation within BCA communities, not only aggregate outcomes [17,27].

5. Increased recognition without improved access to care

MHFA may increase awareness and willingness to seek help yet create frustration if services are inaccessible or culturally unsafe.

Safeguard

Pair community MHFA initiatives with maintained referral pathways, clear service information, and system partners that commit to response quality [1,8,27].

Overall, these risks do not undermine the argument for building community–based MHFA capacity in BCA communities. Instead, they help clarify the conditions under which such initiatives are most likely to be ethical, effective, and sustainable. These guidelines also highlight what a credible evaluation framework must be designed to identify.

Next-Generation Evaluation Agenda for Psychiatry-Linked Community MHFA Initiatives

For psychiatry and public mental health audiences, the next evaluative step is not simply whether MHFA certification can be expanded, but under what conditions certification contributes to durable equity gains in support, referral, and care experience. Chapter 14 appropriately documents training outputs and reach [6]. The extension of this work should now examine pathway and equity outcomes more directly [1,8].

A useful strategy is a staged, multi–level evaluation.

- Stage 1 addresses feasibility, reach, and acceptability, including participation patterns, instructor retention, delivery settings, and perceived relevance of culturally adapted content.
- Stage 2 examines behavioral and relational outcomes, such as helping conversations initiate, confidence to intervene, perceived quality of support interactions, and stigma-related behavior change.
- Stage 3 focuses on pathway outcomes, including referrals attempted, referrals completed, barriers encountered, and time to connection.
- Stage 4 examines experience and equity outcomes, including perceived cultural safety, usefulness of care encounters, trust in services, and variation across subgroups within BCA communities. Equity outcomes should be disaggregated where possible to examine whether implementation works differently across linguistic, migration, gendered, faith-based, and generational subgroups within BCA populations.
- Stage 5 assesses sustainability and systems outcomes, including instructor pipeline continuity, partnership durability, and whether psychiatry or mental health services adapted pathways or practices in response to collaboration.

This agenda is best pursued through mixed methods. Quantitative measures can track trends in reach, behavior,

and pathway outcomes, while qualitative data can clarify how participants interpret distress, Why MHFA skills are or are not used, how trust changes over time, and where referrals succeed or fail. This combination is especially important in equity-oriented work, where similar interventions may produce different effects across settings because of differences in context and service response [8,9].

A psychiatry-oriented framework should also distinguish what can reasonably be attributed to MHFA from what depends on service system conditions. Community training may improve recognition and help–seeking readiness, but downstream outcomes are also shaped by wait times, clinician availability, quality of interaction, and organizational responsiveness. This is precisely why evaluation should include both community-side and system–side indicators [1,5,8].

Conclusion

Boakye-Yiadom *et al.* (2026) [6] show that MHFA certification can function as a meaningful community capacity–building strategy in BCA communities when implemented through trusted organizations and supported by efforts to improve cultural relevance. Its significance, however, extends beyond training outputs. For psychiatry and public mental health audiences, the key lesson is that certification is most useful when embedded in trust structures, linked to culturally safe care pathways, and interpreted within the structural conditions that shape mental health inequities. The next phase of this work should move beyond a narrow question of scale. A more useful question is how to build community-to-care systems in which culturally grounded mental health promotion, ethical adaptation, and responsiveness to psychiatric services reinforce one another. If psychiatry systems seek earlier engagement, better continuity, and more equitable outcomes in BCA communities, investment in community MHFA initiatives should be paired with reciprocal institutional change, shared accountability, and evaluation strategies that measure the full pathway from recognition to care.

Conflict of Interest

The authors declare no conflicts of interest.

Consent for Publication

Not applicable.

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