



MINUTES

REGULAR MEETING OF THE MENTAL HEALTH COMMISSION March 10, 2026 – 3:30 P.M.

The Mental Health Commission Regular Meeting was held on Tuesday, March 10, 2026, at 3:30 p.m. in the MHSA Administrative Office located at 2001 North Garey Avenue, Pomona, California.

CALL TO ORDER Chair Henderson called the meeting to order at 3:33 p.m.

ROLL CALL Roll call was taken by JPA Administrator/Clerk Olmos.

MENTAL HEALTH COMMISSION

PRESENT: Anne Henderson, Chair
Wray Ryback, Vice-Chair
Sandra Christensen
Frank Guzman
Laura Mundy
Danette E. Wilkerson

ABSENT: Sandra Grajeda, GB Member Liaison
Clarence D. Cernal
Mildred Garcia
Janet R. Roy

STAFF

PRESENT: Ontson Placide, Executive Director
Dana Barford, Director of MHSA & Ethnic Services
Elizabeth Renteria, Chief Clinical Officer
Micaela P. Olmos, JPA Clerk/Administrator

REGULAR BUSINESS

I. APPROVAL OF MINUTES OF THE FEBRUARY 10, 2026 REGULAR MEETING OF THE MENTAL HEALTH COMMISSION

Chair Henderson opened the meeting to Public Comment; there was none.

There being no discussion or public comment, Commissioner Guzman, and Commissioner Christensen seconded, to approve the Mental Health Commission Minutes of its February 10, 2026 Regular Meeting. The motion was carried by the following vote: AYES: Commissioner Christensen, Guzman, Mundy, and Wilkerson; Vice-Chair Ryback, and Chair Henderson. NOES: None. ABSTAIN: Commissioners Mundy. ABSENT: GB Liaison Grajeda; and Commissioners Cernal, Garcia, and Roy.

II. PRESENTATIONS

A. OVERVIEW OF TRI-CITY MENTAL HEALTH AUTHORITY'S ADULT OUTPATIENT AND ADULT FULL SERVICE PARTNERSHIP (FSP)

Deputy Chief Clinical Officer Debbie Johnson provided an overview of clinical program restructuring under the Behavioral Health Services Act (BHSA). She explained that BHSA is restructuring programs to ensure more equitable and accessible treatment, introduce new treatment approaches, and expand support and services for individuals with co-occurring conditions. She also talked about the Level of Care Utilization System (LOCUS), an evidence-based assessment tool used to support determination of the appropriate level of care, particularly for adult services. She explained that LOCUS informs treatment planning through a collaborative process with clients and provides recommendations regarding appropriate levels of care, noting that Tri-City Mental Health Authority generally falls between Levels 2 and 4, with the majority of clients served at Levels 3 and 4, and that the tool allows clients to move between levels of care as their needs change. She then reported that the leadership team recently completed LOCUS training and that training will next be extended to clinicians, and emphasized that the tool establishes a shared clinical language across teams.

Deputy Chief Clinical Officer Johnson also described the My Recovery and Wellness Plan, a collaborative approach to care planning designed to actively engage clients in their recovery, pointing out that the plan outlines the services clients will receive, identifies assigned clinicians, highlights available groups, and includes contact information, recommendations, and recovery activities. She explained that clients are expected to leave their first session with a completed plan; that the plan is designed to empower clients to take an active role in their recovery; and that it will be provided to all clients, with adaptations to child-friendly language where appropriate to promote communication. She then shared a client's recovery story, noting that one individual who previously attended a day rehabilitation program five days per week no longer required that level of care after developing a structured routine.

Deputy Chief Clinical Officer Johnson also provided an update on staff training and development efforts, reporting that clinical teams have focused on crisis intervention training which included: postvention, MTAC and dispatch screening tools for risk assessment and intervention, CAMS, and crisis prevention intervention. These efforts include trainings, meetings, and role-play exercises. She further described the implementation of a team-based approach to care, including Assertive Community Treatment (ACT) and the Forensic Assertive Community Treatment (FACT) models, enhanced treatment teams, care coordination and whole-person care, treatment pods, Recovery and Wellness Plans, and team-based clinical decision-making. She also outlined the multidisciplinary team structure, which includes Peer Support Specialists, clinical therapists, medication support teams, co-occurring substance use counselors, behavioral health specialists, and housing and employment specialists.

Commissioner Wilkerson inquired about the difference between clinical therapists and behavioral health specialists. Deputy Chief Clinical Officer Johnson explained that behavioral health specialists provide skill-based, day-to-day services and function as case managers.

Commissioner Mundy asked how individuals are identified for entry into services and how many individuals have participated in those services. Deputy Chief Clinical Officer Johnson responded that individuals enter services through assessments, walk-ins, referrals, and calls from family members, with assessments determining the appropriate level of care. Chief Clinical Officer Renteria reported that TCMHA currently serves approximately 1,500 individuals in Adult Outpatient Programs and 500 individuals in Full Service Partnership; and that CARE assessment tools more accurately identify client needs, noting that approximately one-third of individuals previously served at the FSP level may now transition to lower levels of care.

Vice-Chair Ryback inquired whether the use of LOCUS is required under BHSA and if any challenges have been encountered. Chief Clinical Officer Renteria added that challenges primarily occur at the system level, particularly in aligning all partner agencies to use the tool consistently as clients transition across services, and in coordinating efforts statewide. Deputy Chief Clinical Officer Johnson added that TCMHA is following required timelines, focusing on controllable elements, and prioritizing client needs.

Commissioner Guzman asked whether information would be shared with community partners so they understand what to look for when applying for grants. Deputy Chief Clinical Officer Johnson stated that this topic will be addressed in a future presentation and emphasized that the goal is to create a seamless experience at the community level.

B. MENTAL HEALTH SERVICES ACT (MHSA) TO BEHAVIORAL HEALTH SERVICES ACT (BHSA) TRANSITION

MHSA Projects Manager Sara Rodriguez presented an overview of the Mental Health Services Act (MHSA), the Behavioral Health Services Act (BHSA), and provided a land acknowledgment, stating that Tri-City Mental Health Authority humbly recognizes that it operates on Tongva land, the original caretakers of the cities of Pomona, Claremont, and La Verne. She then talked about the history of MHSA, which California voters passed back in 2004 as Proposition 63 and funded through the Millionaires Tax consisting of five funding components: Community Services and Supports (CSS), which represents approximately 76% of funding; Prevention and Early Intervention (PEI), representing approximately 19%; Innovation (INN), representing approximately 5%; and any excess funds could be allocated to Capital Facilities and Technological Needs (CFTN) and Workforce Education and Training (WET). She explained that CSS was the largest component and historically provided the greatest flexibility in funding distribution. She then talked about Proposition 1 which was passed by California voters in March 2024, expanding MHSA through the Behavioral Health Services Act (BHSA) that consolidates MHSA funding into three required components: Full Service Partnerships (FSP) at 35%, Behavioral Health Services and Supports (BHSS) at 35%, and Housing Interventions at 30%. She explained that BHSA will allow funds to be used for individuals with a primary diagnosis of substance use disorders and that it will officially go into effect on July 1, 2026, and noting that the transition as a significant undertaking for all entities involved.

MHSA Projects Manager Rodriguez reviewed and discussed the difference between MHSA and BHSA funding, and provided an overview of community planning and participation efforts, noting that Community Program Planning (CPP) activities included community forums and that, to date, 13 presentations had been provided to staff and the community. She reported that surveys were conducted, focus groups created that continue to this date, and about how workgroups are being used to gather feedback in real time. She also reported that there was a shift in terminology from

“stakeholder” to “community partner; and acknowledged that outreach and engagement efforts need continued improvement, and that staff is ramping up visibility in the community through site tours, participation in pop-up events, informal interviews, and intentional efforts to connect with community members. She reported that MHSA required input from “diverse pools” and that BHSA identifies 29 specific community groups, noting that the State requires documentation demonstrating meaningful outreach efforts. She also discussed TCMHA’s priority goals which include increasing access to care and reducing homelessness, institutionalization, justice involvement, removal of children from the home, and untreated behavioral health conditions; emphasizing care experience as a key focus area, stating that improved care experience is associated with improved outcomes; increased engagement in school and work, improved quality of life and social connection, prevention and treatment of co-occurring physical health conditions; and reductions in overdoses and suicides.

MHSA Projects Manager Rodriguez then presented an overview of the Integrated Plan (IP) stating that it was a comprehensive document exceeding 150 pages in length; that it serves as a core framework and includes general background information as well as detailed sections addressing service delivery and responsibility, accountability measures, community engagement and transparency efforts, approval processes, and compliance requirements. She explained that it is a statewide report that every county and local mental health authority is required to submit with the purpose of demonstrating how local planning aligns comprehensively with all applicable state requirements and funding structures. She reported that a draft of the IP was submitted to the State on February 20, 2026, noting that this was the first time the State required submission of a draft document prior to final approval; that the IP draft remains available for public comment which can be submitted through TCMHA’s website; and that all feedback received during the public comment period will be included and addressed in the final version of the Integrated Plan. She also reported that a Public Hearing on the IP is scheduled to occur on April 14th during the Mental Health Commission meeting, following Governing Board approval at its meeting on April 15, 2026, and required to be submitted to the State by June 2026.

MHSA Projects Manager Rodriguez reviewed the three new primary funding buckets established under the Behavioral Health Services Act (BHSA), noting that these allocations are required under Proposition 1. She explained that BHSS requires counties to allocate 35% of their local BHSA funds to foundational services and infrastructure, and BHSS consolidates several components previously established under the MHSA, including WET and CFTN into a single flexible category focused on system sustainability and early intervention. She explained that Full Service Partnerships (FSP) require counties to allocate 35% of their local BHSA funding to intensive, comprehensive treatment services utilizing a “whatever it takes” approach, noting that these services prioritize the State’s most vulnerable populations, specifically individuals experiencing Serious Mental Illness (SMI) or Substance Use Disorders (SUD). She also stated that Housing Interventions require counties to allocate 30% of their local BHSA funds toward housing for individuals with Serious Mental Illness or Substance Use Disorders, and pointed out that Proposition 1 shifts the focus of behavioral health funding toward direct housing solutions for the State’s most vulnerable populations. She presented a funding forecast for Fiscal Year 2026–27, noting that projected funding includes carryover funds and that multiple allocation scenarios were reviewed. She then provided an overview of the Behavioral Health Services and Supports (BHSS) funding buckets and the associated systems of care. She explained that the BHSS category includes specific programmatic breakdowns by system of care and that several programs initially identified for potential sunseting were highlighted in green and subsequently granted a two-year extension. She reported that the Children’s System of Care includes non-FSP programs focused

on stigma reduction, family wellbeing, and housing intervention services; that the Adult and Older Adult System of Care includes non-FSP programs such as Community Navigators, Community Mental Health Training, Ending the Silence and NAMI 101 programs, stigma reduction initiatives, peer mentors, family wellbeing services, housing intervention programs, the Therapeutic Community Garden, and the Wellness Center; that the Outreach and Engagement is a new program model in which the individual conducting outreach is considered part of the treatment process, with an emphasis on maintaining rapport and continuity of relationships; that Early Intervention programs, which are non-FSP services, include the Access to Care Program, Mobile Crisis Care, Peer Mentors, Community Wellbeing Grants, and First Episode Psychosis services; and that the Outreach and Engagement Program, also non-Full Service Partnership, includes the Direct Treatment Link Outreach Team.

MHSA Projects Manager Rodriguez then reviewed evidence-based practices incorporated within the BHSS framework which include Assertive Community Treatment (ACT) that represents the highest level of care and utilizes a “whatever it takes” approach with low client-to-staff caseload ratios; Forensic Assertive Community Treatment (FACT), a modification of the ACT model designed to support justice-involved individuals experiencing mental illness; Intensive Case Management (ICM), a service model for individuals requiring a higher level of care who do not meet medical necessity criteria for ACT or FACT; the Individual Placement and Support (IPS) model, a vocational program that follows a “place then train” approach, rather than a readiness-based model; and High Fidelity Wraparound (HFW), an intensive, team-based approach focused on children and youth and incorporates family involvement and coordination across systems. She then talked about Housing Interventions under BHSA which has its own funding bucket, and that 50% of Housing Intervention funds must support individuals experiencing chronic homelessness, that is lasting 12 months or longer or four or more occurrences within the past three years; and that up to 25% of Housing Intervention funds may be used for capital development, including Permanent Supportive Housing and other housing projects. She explained that Housing Intervention funds are restricted to housing-related assistance and cannot be used for specialty mental health services; and discussed allowable uses such as rental subsidies established as either scattered-site or project-based assistance, operating subsidies related to day-to-day physical operation of housing projects, shared housing arrangements, and family housing for eligible children and youth, including housing that accommodates family caregivers of BHSA-eligible individuals; as well as to cover the non-federal share of certain transitional rent, providing an example in which BHSA-eligible individuals may receive an additional six months of rental subsidy when placed in an interim housing setting.

MHSA Projects Manager Rodriguez also reported that TCMHA serves individuals with moderate to severe behavioral health conditions; and reported that WET, Innovation programs, and CFTN will continue during the period of July 1, 2026 through June 30, 2029. She explained that Prevention and WET programs will transition to State administration, and pointed out that staff will evaluate how services will be provided once these programs move from local administration to State-level oversight. She then talked about several State-administered grant programs that will be available to Community-Based Organizations (CBOs), Tribes, schools, and other eligible entities, including the Community Defined Evidence-Based Practices Grant Program, the Trusted Messenger Campaign Grant Program, Training and Technical Assistance Grants, and the 988 and Suicide Crisis Lifeline Outreach Campaign Grant Program. She also explained the WET initiatives that will be administered by the State that include the Medi-Cal Behavioral Health Student Loan Repayment Program, which will provide student loan repayment assistance for behavioral health practitioners; the Medi-Cal Behavioral Health Scholarship Program, which will

provide scholarship payments while participants complete their education; and the Medi-Cal Behavioral Health Recruitment and Retention Program. She added that the Recruitment and Retention Program will support workforce stability through funding for bonuses, supervision, licensure and certification costs, and training backfill for practitioners serving the Medi-Cal population in safety-net settings. Lastly, she discussed of the transition timeline from MHSA TO BHSA programming, noting that the transition process will begin the day after Governing Board approval, which is scheduled for April 15, 2026.

Vice-Chair Ryback inquired whether additional goals could be gathered via a survey data. MHSA Projects Manager Rodriguez explained that a community-wide survey was conducted through the Innovations process from January through June 2025, followed by best-practice interviews with clients. She noted that while state-level data did not indicate service gaps, local data identified gaps, which were subsequently analyzed and established as goals.

Commissioner Guzman asked whether information is only gathered during specific time windows rather than continuously. MHSA Projects Manager Rodriguez explained that if a survey were conducted at the present time, its results would not be ready for the submission of the IP Plan. However, she pointed out that the survey will be conducted in the fall after revisions are received and also the same survey will be administered consistently over a three-year period to allow for comparison over time.

Commissioner Wilkerson commented on the scale of the effort and asked whether the changes could create barriers to services. Executive Director Placide described the BHSA transition as a “jigsaw puzzle,” explaining that the organization is reconfiguring from the original five plan service categories while determining what is new and how services will integrate. He emphasized that finance is a major component of the process, noting that while program goals may be ambitious, fiscal realities require ongoing adjustment, noting that TCMHA remains in the process of honing, refining, and implementing changes. Director of MHSA & Ethnic Services Barford described the transition as “building the plane while flying it,” explaining that the Department of Health Care Services has been continuously updating and changing the IP modules and guidance, requiring TCMHA to perform ongoing pivots as new information is received.

Commissioner Wilkerson asked whether programs were being extended, and Executive Director Placide responded that the organization discovered the availability of carryover funds, which were not initially guaranteed, noting that those funds will be available for the next two years. Director of MHSA & Ethnic Services Barford added that the IP brought staff together as a team and includes broad cross-departmental participation.

Chair Henderson opened the meeting to Public Comment.

Community member Larry Ortega, a Pomona resident, spoke about mental health treatment approaches, stating that mental health disorders should be reframed to focus on root causes, including the gut-brain connection, nutrition deficiencies, and detoxification processes. He asked the Commission to consider forming a group to investigate alternative treatment strategies and pointed out that the BHSA IP currently does not address nutrition. He referenced research related to gut health and its connection to mental health.

Executive Director Placide thanked Mr. Ortega for his comments and explained that all MHSA and BHSA programs utilize evidence-based practices, specifically investigated and established by the California Evidence-Based Clearinghouse, which determines the validity of treatments. He stated that if research meets established scientific standards, it may be submitted to the Clearinghouse for review and it will determine if those practices can be considered for use in treatment.

Director of MHSA & Ethnic Services Barford announced that her last meeting with the MHC will be in April as she would be retiring from TCMHA in May 2026 after 17 years of service with TCMHA.

III. EXECUTIVE DIRECTOR MONTHLY REPORT

Executive Director Placide provided an update on the culmination of the MHSA to BHSA transformation. He then reported that the California Community Care Project, an initiative announced by Governor Newsom which involves the transformation of six vacant buildings, the Metro State Hospital in Norwalk that dates back approximately 110 years, into a unified behavioral health campus, is intended to create a comprehensive mental health and housing community that will provide 162 housing and treatment beds, noting that the project represents a significant statewide investment in behavioral health infrastructure and aligns with broader system transformation efforts.

COMMISSION ITEMS AND REPORTS

Commissioner Guzman reported he attended a Pomona ACTS meeting, during which community members spoke positively about the Wellness Center and described it as an instrumental resource for the community, noting that the feedback highlighted the Wellness Center's importance and impact on local residents.

Vice-Chair Ryback acknowledged recent activity on TCMHA's social media platforms and expressed appreciation for the outreach efforts. Director of MHSA and Ethnic Services Barford explained that the social media work is part of an innovation project, and that a temporary staff member will work through June to test and refine social media strategies using a trial-and-error approach, with the goal of expanding these efforts.

Commissioner Wilkerson asked whether MHSA Projects Manager Rodriguez would be replacing Director of MHSA and Ethnic Services Barford upon her retirement. Director of MHSA and Ethnic Services Barford clarified that her position will be open for recruitment, and that MHSA Projects Manager Rodriguez serves as a subject matter expert on BHSA and would remain available to support and assist the new position once it is filled.

PUBLIC COMMENT

MHSA Projects Manager Rodriguez announced an upcoming webinar related to the Data Notebook for the Wellness and Recovery Center will take place on March 25th and will provide an overview of all data submitted.

Director of MHSA and Ethnic Services Dana Barford noted that March is recognized as Green Ribbon Week.

Program Supervisor Naranjo announced that a Health and Wellness Fair will be held on April 25th in partnership with Pomona Unified School District at the Village Conference Center; that Community Wellbeing Grant applications have been extended, with the application period opening on March 16th and remaining open for 30 days.

ADJOURNMENT

At 4:50 p.m., on consensus of the Mental Health Commission, its meeting of March 10, 2026, was adjourned. The next Regular Meeting of the Mental Health Commission will be held on Tuesday, April 14, 2026 at 3:30 p.m., in the MHSA Administrative Office, 2001 North Garey Avenue, Pomona, California.

Micaela Perez Olmos, CPMC
JPA Administrador/Clerk