Brad Little
Governor

Sara Omundson
Jared Larsen
Co-Chairs

IBHC Meeting Minutes - Approved

October 24, 2025
9 a.m. – 11 a.m.

Location: Idaho Supreme Court, Lincoln Room (basement level)

Meeting Recording

Slide Deck

Members in Attendance: Sara Omundson (AOC), Judge Gene Petty, Dave Jeppesen, Stewart Wilder, Jeff Agenbroad (SDE), Ashley Dowell (IDJC), Christine Starr (COPP), Laura Denner for Jared Larsen (IDHW), Tina Transue for Bree Derrick (IDOC)

Staff in Attendance: Brandi Ellis (AOC), Shannon Fox (DHW), Scott Ronan (AOC), Cheryl Foster (IBHC),

Agenda Items

Welcome
Co-Chair Sara Omundson opened the meeting and skipped approving the meeting minutes because there was not a quorum.

Review of IBHC Vision, Guiding Principles, and Framework
Co-Chair Omundson referenced the council's guiding principles on page 14 of the IBHC strategic plan, and highlighted guiding principal number three: "Evidence and Best Practices

Cheryl Foster shared that the council's behavioral health framework is represented in the council's recommendations.

Medication for Opioid Use Disorder

Co-Chair Omundson introduced Dr. Reid Lofgran to provide a presentation on the use of medications for opioid use disorders.

Dr. Lofgran is the medical director at the Walker Center, which does residential treatment, as well as in-patient, outpatient, partial hospitalization, sober living, and special projects. He is also the medical director for family medicine at North Canyon Medical Center in Gooding and runs an addiction recovery program there.

He explained that MAT is medication-assisted treatment, particularly to treat addiction. MOUD is specifically for medications used for opiate use disorder, while MAT includes medication for alcohol, nicotine, or stimulant disorder.

Addiction and Stigma

Addiction is a complex disease where the medication is used to stabilize the patient to treat the mental and physical health issues. Because if they cannot address the mental health, the patient will eventually bounce back to addiction. Once the mental health and physical issues are stabilized, they can provide counseling to address trauma and behavior, then their core spiritual well-being. In any case, the medications do not fix the problem, they only stabilize.

Judge Petty, who runs a mental health court, asked Dr. Lofgran about the order addressing addiction and then mental health. Dr. Lofgran acknowledged that it can be both ways, but he usually tries to control the addiction first or address both simultaneously.

Dr. Lofgran next talked about addiction as a disease instead of a moral failing. He compared addiction to diabetes, where both require chronic disease management. He compared the choices of addiction to the choices relating to heart disease and hypertension.

He provided a brief history of opioid use in America, where the prescription opioid overdose deaths tripled within a decade to around 10,000 people in 2010. The government told doctors to stop prescribing so many opioids, which in his opinion is a disaster for treating addiction. Opioid withdrawals make people feel like they are going to die, so they turn to heroin. Heroin, then fentanyl rapidly overtook prescription opiates as the number one cause of overdose deaths.

In 2017, 72,000 people died from illicit drug overdose deaths including 49,000 from opioids, which was declared an opioid crisis. He said that in the same year, alcohol killed 88,000 people and tobacco killed 488,000. He noted that addiction is not considered a disease and compared total addiction deaths ~750,000 to the number of deaths from the number one killer heart disease ~681,299. He said that stigma, which includes mental health, prevents treatment. MOUD treatments were available in 2001 but were stigmatized within the medical community until 2017. Opioid deaths are now coming down due to effective treatment.

He explained that there are new addictive drugs are emerging, which he sees in treatment. For example, kratom and synthetic variations, available in gas stations and vape shops, has both stimulant and opiate properties.

Causes of Addiction

Dr. Lofgran explained some brain science on the cause of addictions. As the brain grows during adolescence, exposure to bad environments such as drugs, malnutrition, bullying, sleep deprivation, plus genetics can impact reward pathways. The prefrontal cortex that can override these reward pathways doesn't fully develop until age 24. Companies know that if a youth is addicted before that age, they have a lifelong customer.

He spoke about mental health, as addiction has many comorbid conditions. He believes that most addiction is people self-medicating because of pain – whether physical, emotional, relationship or

financial. They turn to drugs to either numb the pain or try to feel normal. He said having a destructive worldview of shame plays into addiction – where people are ashamed of who they are. Shame should be contrasted to guilt, where they can address patterns of behavior separate from their value as an individual. He related addiction to suicide, which was tied with COVID-19 as the #9 cause of death in America.

He next spoke on Adverse Childhood Experiences, where decades of high-quality studies have shown the significant impacts of trauma on children. Higher ACE scores lead to reduced life expectancy, higher risk of physical and mental health conditions, including addiction.

He talked about trauma and its impact on the body, and specifically the immediate stress hormone release and physiologic changes. The short-term stress provides a fight or flight response and can save us during the situation. Long-term stress causes long-term hormonal disruption leading to outcomes such as diabetes, fertility problems, and heart disease. He linked this to addiction and MOUD, because they need to treat the whole patient.

He shared a series of slides that shows baseline dopamine levels in rats compared to the impacts from food and sex, then morphine, nicotine, alcohol, cocaine, and methamphetamine. He said the addiction potential is based on the amount of dopamine, genetic susceptibility, availability of the drug, and rapidity of the reward reaching the brain.

He explained how drugs impact dopamine in the brain and how high amounts can damage the nerve cells in the reward system. The body will downregulate the receptors so that they need more drugs to reach the same level next time. Chronic use gets the individual to the point where they need the drug just to feel normal and function instead of chasing a high. However, the brain remembers the first high. So even after they are in recovery and normal, the brain will want that feeling again. It never goes away but may lessen after a long period of time.

<u>Medications for Treatment</u>

The role of medication in treatment is to stabilize the addiction and mental health, then address the physiological, trauma and chronic diseases they have. There are drugs to treat three types of addictive substances: alcohol, tobacco, and opioids. Today he will focus on MOUD.

He described how the drugs work by triggering the dopamine neurotransmitters in the brain's reward system. Agonists bind the dopamine receptor and give the full effect of the drug. Antagonists bind the receptor and blocks the effect. There are combined agonist-antagonist drugs, which bind and block some effects while triggering others.

Naltrexone and Vivitrol bind the opiate receptors and completely block them. They also decrease cravings for opiates. Naloxone is a cousin antagonist which lasts about an hour. Narcan or naloxone is given to someone in an overdose, which binds the receptors and puts them into full withdrawal. Because it wears off in an hour, sometimes you have to re-dose. Naltrexone is an oral pill which lasts 22 to 23 hours and costs $45 a month. Vivitrol is a monthly injectable and costs $2000 a month. He believes the injectable is more effective, as it is a higher dose that maintains a constant level each day. The oral dose wears off near the end of the 24-hour period.

Buprenorphine is a partial opioid agonist, which cannot kill you with overdose like Methadone a full agonist can. It is commonly referred to as Suboxone, but they are not the same. Suboxone is a combined product with naloxone to keep buprenorphine from being abused. Buprenorphine does not develop a tolerance because it is a partial blockade, so they can stay on the dose indefinitely. Because it binds the receptors, it takes away withdrawals for people already in withdrawal, which is why it has street value. The injectables prevent diversion and increase stability in cases where people use again.

MOUD is not a big concern in pregnancy with individuals with OUD. The safest transition for those with active OUD is to methadone to prevent the risk of withdrawal and miscarriage. Otherwise, they can remain on buprenorphine if already on it. Neonatal withdrawal is trickier, but nursing helps. Co-Chair Omundson asked whether newborns exposed to opioids would have a lifelong risk of addiction. Dr. Lofgran said that they haven't been doing this long enough to know the impact, but it doesn't appear to be the case. In utero and at that young age, there isn't a correlation with their behavior. The concern when they are older is the connection with their behavior and the reward pathways.

He continued to show the efficacy of the injectables and sublingual buprenorphine by serum levels. He demonstrated the key to getting cravings down appears to be 2 nanograms per milliliter, which is obtainable by the injectable. Some people have higher tolerance and need a higher dosage.

The last MOUD is methadone, which is a full agonist. It was used as end-of-life care, and they discovered it had a long half-life and it decreased heroin use and overdose deaths. It is considered the standard of care, along with buprenorphine. He prefers buprenorphine because methadone has a lethal dose and you have to escalate to higher doses to keep methadone working over time.

He added one more fact about buprenorphine. Because it is a partial agonist and an opiate, they have to slowly taper off, slow enough to avoid withdrawals. At the end they will have a week's worth of mild opiate withdrawals, although some people say they are severe. With the injectables, if they have at least four injections, it provides such a slow taper that they haven't had problems with withdrawals.

Break
The council took a 15-minute break.

ThreatZero Solutions

Doug Hart presented on current trends in safety and violence prevention. He spent 27 years with the FBI working with and learning about violent crime. In retirement he started the organization ThreatZero Solutions – whose aim and mission is to prevent violence using an evidence-based approach. He met with Superintendent Critchfield, who thought this information might be of value to the Behavioral Health Council, as it aligns with its vision and principles.

He began by showing data on the increasing numbers of violent attacks or active shooter events as defined by the FBI. They do not include domestic violence or gang violence, but a mass attack is

three or four people shot in the same incident. They know that all active shooter events are premeditated; there is no evidence that someone snaps and commits a mass shooting.

He said our responses for dealing with violence in society are often what are termed first instinct fallacy. He said that physical security measures are the first instinct for keeping people and organizations safe, but they are expensive and don't align with the actual threat, which is often internal not external. He recommended a book called *The Violence Project*, which says we are not successful at preventing these attacks because we are looking for and reacting to external threats, not addressing internal threats. Their conclusions are the same as found by the FBI, Secret Service, Department of Education and Department of Defense independently.

The evidence shows that known, observable behaviors precede violence, often up to two years in advance. These individuals experience three significant stressors simultaneously (e.g., mental health, financial, job conflict, SUD), and they typically develop a grievance that occupies their life. Then they move down a pathway toward violence.

The evidence-based approach to prevent violence is to identify the warning behaviors and take steps to intervene: Awareness; Willingness to Report; Reporting Tools; Triage; Assessment and Intervention.

The research shows that mental health is the core safety concern for pre-attack behavior. Unfortunately, an alarming number of students report poor mental health and well-being (CDC Youth Risk Behavioral Survey).

Early identification, recognition, and reporting of behaviors is the best approach to prevent targeted violence. As students are the ones who observe these behaviors, Mr. Hart proposes that school-based safety programs be student-centered, based on a culture of shared responsibility.

Many Idaho schools have some tools, but they are underutilized and not necessarily directed to those who could use it.

In summary, many school shootings could have been prevented since most perpetrators leave a long trail of warning signs. We have known for 25 years how to prevent things but have failed to do so.

FindHelpIdaho.org Implementation Projects – Idaho Family Prevention & Resource Network Implementation Framework

Laura Denner and Casie Jones with DHW are leading the work on the Foster Care recommendation, as well as working to integrate FindHelpIdaho.org and 211, the Idaho Care Line. They want to get council's feedback on some strategic work, which is creating a centralized platform for the resources for priority populations, that is now crossing several of the implementation teams: Promotion #1 Program Awareness and Reduction of Stigma, Prevention #1 Primary Prevention and Protective Factors, and Prevention #2 Foster Care.

Before describing the framework, Casie Jones explained that the project has two interconnected approaches. The first is a DHW cross-division strategy to ensure that DHW is aligned, and their

resources are available on FindHelpIdaho.org. The second collaborates with community-based organizations and their resources.

The infrastructure they are developing includes a widget for FindHelpIdaho.org on the 211 webpage. Findhelp is a national platform, and United Way sponsors Find Help Idaho as the customized platform for Findhelp that they are working to optimize. FindHelpIdaho.org complements 211, in that it allows self-navigation. They will also provide a pop-up on the 211 website to prompt talking with a 211 care representative. The goal is to provide multiple access points as a "no wrong door" approach to getting resources. Other infrastructure includes the faith-based community platform and the 211 Navigator program, which provides case management to families or individuals based on 211 services.

The framework for this project has three core areas: Leadership and Stakeholder Engagement, Resource Development and Validation, and Public Outreach and Awareness. The leadership is already in place: the 211 and Navigator program managers, the Find Help Idaho steering committee, and IBHC implementation teams. The Resource Development and Validation Team will focus on priority populations and develop and validate resources for them. They will recruit and support organizations and resources on FindHelpIdaho.org by geographic area. The Public Outreach and Awareness team will increase public awareness and engagement with high quality resources for the priority populations by coordinating public and internal communication efforts.

Ms. Jones shared a number of metrics for evaluating and reporting on the project.

Ms. Denner explained that the widget will be live on the 211 page on Tuesday, and they are embedding another custom widget on the foster parent landing page through DHW. They are looking forward to seeing what resources the foster families are searching for on 211

Co-Chair Omundson asked whether they track how many are online only and those using the phone. Laura said they already have that data on the 211 side, so they will see how many phone calls are diverted based om the widget availability.

Co-Chair Omundson complemented the written material and would like to hear more from them next time.

2026 IBHC Meeting Dates

Co-Chair Omundson proposed the next meeting dates. They try not to meet during the legislative session since many council members are engaged during that time. If there is concern about any of those dates, they can change them: April 24, June 12, August 28, and October 30.

Adjourn

Co-Chair Omundson moved to adjourn.