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# Burlington Accountability Court

**Agency of Human Services Clinical Interventions**

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# Goals

The Accountability Court was designed to support individuals whose mental health, substance use, and physical health needs, housing instability, or social conditions contribute to repeated criminal justice involvement. The goal is to:

- Provide a structured pathway from court involvement into treatment, housing, and stabilization in the community.
- Respond swiftly when community-based engagement is not successful.
- Test a model that is collaborative, data-informed, and adaptable in order to understand the value of expanding statewide.

## Clinical Goals

1. Screen participants to determine mental health and substance use treatment needs.
2. Screen participants for health related social needs.
3. Connect people to services using a team based care approach and support them in attaining goals.

# Key features of clinical model

## Screening and Assessment

Screening of health-related social needs and psychosocial assessment.

## Team-based approach to care coordination

Care coordination using tools of team-based care such as Relationship mapping and Shared Care Planning

## Care Team Meetings

Community Provider meeting to keep each other informed on treatment engagement and opportunities.

## Daily Huddles

Clinical team met daily to troubleshoot any issues or barrier to access to care



# Care Team Partners

- **Burlington Community Justice Center, Pre-trial Services**
- **Burlington Police Department Crisis, Advocacy Intervention Programs**
- **Chittenden County Public Defender's Office**
- **Chittenden County State's Attorney's Office**
- **Community Health Center**
- **DOC Probation and Parole**
- **Howard Center**
- **Pathways Vermont**
- **Therapeutic Works Incorporated**
- **Vermont Chronic Care Initiative**
- **VDH Division of Substance Use Programming**
- **Wellpath**

# Team based care model

1. Relationship mapping
2. Goal setting
3. Care conference with care team to develop shared care plan
4. Identification of lead care coordinator in the provider team.

**Supporting  
efforts in  
addition to the  
clinical  
interventions**

- Pretrial supervision
- Expanded 3.1 Recovery Beds
- Recovery shelter
- Wellpath's participation on Care Team
- Availability of treatment in facility
- Burlington Care Team
- Coordination with residential treatment facilities – Valley Vista and Serenity House

# Initial Positive Client Outcomes

- At least 5 Residential Substance Use Treatment stays initiated\*
- 2 people connected to residential mental health treatment
- 26 people connected to community services
- To date 2 people placed in Pathways supportive housing, 2 other people awaiting placement
- 10 people not working with Chittenden Treatment Court, 1 person working with Federal Treatment Court
- Participant reports of gratitude for the opportunity to have the supports to connect and stay engaged with treatment opportunities.

\*TWI worked with 2 additional people to access SUD treatment, however there is no release of information to share the efficacy of these connections

## Lessons Learned

1. Collaboration and communication among the team is essential.
2. Clearly defined roles and responsibilities and shared understanding of goals of project.
3. The weekly care team meetings and daily huddles enhanced collaboration and communication. Aided in swift response to any barriers to access to care.
4. Being called back to court on regular basis aided in accountability and increased engagement in services.
5. Consistent access to support.