

Windham County System Navigation

**Vermont Judiciary Commission on Mental Health and the Courts
Fourth Annual Summit**

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The navigation problem

The court may be the moment when a person is reachable. The services they need sit across many organizations, eligibility rules, and schedules.

The practical question is whether the court encounter becomes a usable path to care and stabilization.

What Human Services Providers do in Court

- Identify the immediate need
- Make a direct connection
- Coordinate follow-up
- Bring barriers back to the team quickly

Standing up Windham County

July 20, 2026

First day of the accountability docket

October 20, 2026

Estimated final day of the accountability docket

November 20, 2026

Final contracting date for the care coordination for individuals on the accountability docket

HCRS system approach

- Care coordinators
- Expedited same-day-access to comprehensive assessments
- Clinical staff

AHS system approach

- Include various community providers in a weekly care team meeting
- Prioritized access to services (such as residential Substance Use).
- Availability of flexible funds (for food, shelter, and other necessities)

The Docket client profile for Windham

- Participants have mental health conditions, substance use disorders, and co-occurring needs.
- About half have Medicaid coverage; several had recently lost coverage.
- Most have no diagnosis of a Serious Mental Illness.
- Few currently receive waiver-level services, although a small number have prior involvement (for example, traumatic brain injuries, disability services).

What this profile means for system navigation

Participants may have substantial, complex health-related social needs, including assistance with instrumental activities of daily living, while not meeting the eligibility criteria for available supported-care programs.

The system navigation process

1

Court opportunity

The court identifies a person who may benefit from support.

Assigns the individual's cases to the docket.

2

Direct connection

A care navigator meets the person and helps identify immediate barriers and needs.

Tries to make a plan for follow ups before they leave the courthouse.

3

Provider coordination

The team connects the person to the provider for a more comprehensive assessment.

The team follows up between appearances and tries to address barriers.

4

Court review

The court has ongoing access to current information about level of care needed, engagement in services, and unresolved barriers.

Court maintains consistent status conferences.

Court resolves the case.

Four main questions we review during the care teams

AVAILABLE



Was an appropriate service ready when the opportunity arose?

CONNECTED



Did the person make contact with the service?

ENGAGED



Did the person participate beyond the initial contact?

OUTCOME



Did the person's health and wellness improve?

Early implementation lessons (from previous counties)

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|----------|---|--|
| 1 | Proximity matters | A service connection works better when the person can meet a care navigator at the point of court involvement. |
| 2 | The team needs current information | Regular care-team meetings and short huddles help partners address barriers while an opportunity still exists. |
| 3 | Roles need to be explicit | The court, care navigators, other local providers, and AHS each need a shared understanding of who owns the next step. |
| 4 | A return date can support engagement | Regular court review creates another opportunity to assess engagement and respond to barriers. |
| 5 | Leave a charge open | Resolving all but one charge leaves an opportunity to bring someone back in if the community services are not working. |

What the model still needs

Navigation creates an opportunity. It does not resolve every barrier or ensure individuals will take advantage of the opportunity.

Current gaps

- Data.** We cannot consistently follow participants across providers, court dispositions, and post-court outcomes.
- Shared definition of success.** Partners have not yet agreed on what progress looks like or which outcomes the model should produce. Without that agreement, different parts of the system may be working toward different goals.
- Process for stalled cases.** We do not yet have an agreed mechanism to review cases that show little or no progress, determine whether the current approach remains appropriate, and decide what should happen next.

The risk

Without shared measures, common goals, and a process for changing course, individuals may remain in the support process for months while the system cannot clearly explain whether the intervention is working or what should happen next.

What Comes Next

Shared definition and measures

Agree on what success means and track services offered, connection, continued engagement, court disposition, and post-court outcomes.

Improved data

Develop a plan to track participants across court appearances and aggregate reporting and evaluation of the model.

Case-review process

Establish when and how the team reassesses situations when the approach is not producing engagement and identifies next steps.

Regional learning

Continue to refine. Compare the Windham, Chittenden, and Rutland experiences to identify a consistent statewide framework while preserving necessary local flexibility.

A promising early signal

Clients Accepting Treatment	34 (out of a cohort of 123)
Received a service within the past 30 days	12 (of the 34)
Continued engagement post-resolution	35%

What this may tell us?

When participants connect with a provider, readily available services combined with judicial encouragement may support continued engagement.