ALPRP

COMPREHENSIVE REFORM FRAMEWORK

Five Stages. One Correctional Journey.

A statewide correctional operating framework for safer institutions, accountable rehabilitation, victim-centered support, professional correctional work, measurable progression, and structured return to the community.

CANONICAL FRAMEWORK v3.3 | **September 2026**

Policy architecture - not legislation, procurement specification, or facility engineering plan

CANONICAL FRAMEWORK v3.3 Change Note

September 12, 2026 synchronized release

This version preserves the prior document except where the following synchronized policy updates modify or control the earlier text.

- Replaces the prior Behavioral Health and Counseling Continuum with the Behavioral Health & Life Recovery Continuum.
- Makes psychotherapy universal at Revive entry while keeping continuing intensity individualized and professionally governed.
- Adds the five coordinated layers, one integrated rehabilitation operating sequence, role-based clinical-record governance, vendor independence, and institutional non-delivery safeguard.
- Preserves existing-resources-first doctrine: ADOC programs are retained and integrated before duplicative capacity is created.

Document-control rule

Where this change note or the inserted replacement section conflicts with the earlier body text, the newer synchronized language controls. All other prior provisions remain in effect unless separately revised.

Document Status and Authority

This Framework is the canonical statement of the current Alabama Prison Reform Proposal (ALPRP) model. It consolidates the mature decisions developed across the ALPRP Policy Foundation, five-stage materials, website, technology prototypes, officer/victim/family designs, reentry work, and Pilot 100 implementation engineering. When an older ALPRP description conflicts with this Framework, this Framework controls unless it is later formally revised.

Version 3.3 preserves the v3 operating model while adding governance, implementation-fidelity, Anchor-definition, support-intensity, document-control, and cross-document synchronization clarifications.

DOCUMENT CONTROL: Until a formal ALPRP governing entity is established, the ALPRP founder/project director serves as document-control authority. Material doctrine changes require a new Framework version, effective date, rationale, and change log, followed by a synchronization review of the Policy Foundation, Pilot 100, website, apps, and public briefs. Once formal institutional agreements exist, revisions affecting partner authority, resident rights, security, clinical practice, evaluation, or implementation are subject to those agreements.

The Policy Foundation explains why reform is needed. This Framework defines what ALPRP proposes. Pilot 100 defines how the model can be tested before statewide scaling.

Document	Question answered	Role
ALPRP Policy Foundation	Why should Alabama change?	Evidence, fiscal case, coalition strategy, parole accountability, extraction-economy critique.
Comprehensive Reform Framework	What should the correctional system change to?	Canonical statewide operating model and governing principles.
Pilot 100 Master Plan	How can Alabama test the model safely?	Limited demonstration, implementation engineering, cost model, evaluation.
Independent Evaluation	What actually worked?	External evidence on safety, cost, implementation, outcomes, harms and failures.
Scale / Modification Plan	What should Alabama do with the evidence?	Expand, revise, stop, or reject components based on results.

Three Types of Statements

Type	Meaning
Framework doctrine	A core ALPRP principle that should remain consistent across implementation sites.
Statewide design standard	A preferred operating requirement that should be implemented unless law, security, clinical judgment, or evidence requires adaptation.
Implementation variable	A number or mechanism that must be set by facility analysis, legislation, procurement, labor-market data, clinical governance, or evaluation.

Executive Framework

ALPRP does not propose eliminating incarceration, eliminating accountability, or assuming every incarcerated person is ready for release. It proposes changing what incarceration is organized to produce. Alabama already pays for custody, healthcare, food, staffing, buildings, programming, work, and reentry activity. ALPRP asks whether those resources can be organized into one measurable correctional pathway rather than a custody system surrounded by disconnected programs.

Source basis: ALPRP FAQ states that Alabama already has education, vocational, substance-use, reentry, religious, work, and other programs; ALPRP targets fragmentation and measurable change. Project FAQ, Sept. 2026.

CORE QUESTION: If Alabama is already paying for the time, what should Alabama expect that time to produce?

The model therefore connects security, treatment, education, work, accountability, family stability, victim support, officer professionalism, technology, parole preparation, and reentry. The resident progresses through five stages only when evidence supports progression. Officers remain correctional professionals rather than therapists. Victims remain independent stakeholders whose healing is never subordinated to resident rehabilitation. Families are supported without being made financially responsible for the correctional system. Technology expands capacity and continuity but does not replace human authority.

PART I - The Case for System Reform

1. The Problem Is an Operating-System Problem

ALPRP treats Alabama prison conditions as a connected system problem: overcrowding, chronic staffing pressure, violence, contraband, treatment limitations, fragmented programming, family disruption, parole preparation, reentry instability, workforce shortages, and weak cross-agency continuity reinforce one another. New buildings can improve physical conditions and replace obsolete beds, but buildings alone cannot resolve those operating failures.

Source basis: ALPRP Policy Foundation and project research; ADOC/ABPP/DOJ statistics are maintained separately with as-of dates and source-specific denominators.

2. Accountability and Rehabilitation Are Not Opposites

ALPRP rejects two false choices: that accountability requires purposeless incarceration, and that rehabilitation requires minimizing harm or excusing conduct. A person can be held accountable for an offense while also being expected to address the behavior, skills, beliefs, health needs, obligations, and decision patterns relevant to future risk.

ACCOUNTABILITY: A sentence imposes a consequence. ALPRP then requires the correctional period to be used deliberately: stabilize, treat, learn, practice responsibility, repair where possible, prepare for release when lawful, and remain accountable after release.

3. Violent Offenses and Current Risk

ALPRP does not equate a violent offense label with automatic release, nor does it equate that label with permanent unchangeable risk. Current risk should be evaluated through lawful, validated, human-reviewed processes that consider offense history together with dynamic factors such as age, institutional behavior, treatment, programming, demonstrated responsibility, and release conditions. Some residents will remain too dangerous for release; meaningful treatment and humane, professionally managed custody still apply.

Source basis: ALPRP Policy Foundation, Section I, argues for distinguishing offense history from current risk and preserves continued incarceration for genuinely high-risk people.

4. Existing Resources Before New Spending

EXISTING-RESOURCES-FIRST: ALPRP will not duplicate an existing ADOC, ACCS/Ingram, ABPP, healthcare, food-service, workforce, or community capability merely to place an ALPRP name on it. Retain what works; integrate what is fragmented; modify what is inadequate; build only what is missing.

PART II - The Five-Stage Correctional Model

5. Five Stages. One Correctional Journey.

Stage	Purpose	Primary correctional task	Community exposure
1 - Revive	Stabilize	Safety, assessment, health/treatment stabilization, routine, accountability, individualized plan.	Institutional
2 - Rehabilitate	Treat. Learn. Develop.	Education, counseling, coping skills, vocational foundations, discipline, decision-making.	Institutional
3 - Rebuild	Practice. Work. Take responsibility.	Productive responsibility, paid work when qualifying labor begins, teamwork, financial responsibility, mentoring.	Institutional only
4 - Restore	Repair. Reconnect. Demonstrate readiness.	Advanced work, family responsibility, victim-conscious accountability, structured transition, controlled off-site opportunities where lawful.	Transitional
5 - Release	Return prepared. Remain accountable.	Employment, housing, transportation, healthcare, supervision, family obligations, continued support.	Community

Source basis: ALPRP grounded assistant specification and FAQ preserve Stage 3 as entirely inside, Stage 4 as transitional, and Stage 5 as community-based.

6. Progression Is Fluid, Evidence-Based, and Human-Decided

Stage durations are planning assumptions, not automatic advancement schedules. Residents progress based on demonstrated change and readiness. A resident may advance faster, remain longer, pause, or move temporarily to a more structured setting. Long-sentence residents may remain productively engaged in later institutional stages as mentors or skilled workers rather than being forced through an artificial timetable.

Evidence domain	Examples
Safety and behavior	Seriousness/pattern of disciplinaries, violence, contraband, compliance with safety plans.
Treatment	Engagement, clinically relevant progress, coping and self-regulation where applicable.
Education	Literacy, coursework, credentials, vocational competencies.
Responsibility	Reliability, honesty, problem solving, restitution/obligations where applicable.
Work	Readiness, attendance, quality, productivity, teamwork, safety, mentoring after Stage 3 begins.

Reentry	Documents, housing, employment, transportation, healthcare, supervision and support plan.

HUMAN AUTHORITY: Technology may organize evidence, identify gaps, and flag patterns. It may not independently determine discipline, guilt, custody classification, diagnosis, medication, stage movement, parole, or release.

VALIDATION BOUNDARY: ALPRP stage-readiness criteria are correctional operating and rehabilitation criteria; they are not presented as a validated risk instrument, actuarial parole tool, or prediction of legal suitability for release. Stage advancement does not create a presumption of parole, sentence reduction, lower custody, or release. Pilot 100 and subsequent independent evaluation should test whether the factors ALPRP uses for progression are associated with institutional safety, program completion, and post-release stability. If those relationships are weak, inconsistent, biased, or unsupported, the progression model must be revised.

6A. Release-Pathway Override, Two Clocks, and Accelerated Preparation

ALPRP stage status never creates authority to extend incarceration and never overrides a lawful release pathway. A resident may leave custody through sentence expiration, parole, a split sentence, a court order, medical or other authorized release mechanism. When release becomes legally effective, the resident leaves custody regardless of whether the resident is in Revive, Rehabilitate, Rebuild, or Restore. Stage status describes rehabilitation, structure, and readiness; it is not an additional sentence and is not a substitute for lawful release authority.

SENTENCE-END OVERRIDE: Sentence status determines when a person may or must leave custody. ALPRP stage determines what the person should be doing while in custody and what support should follow afterward. Neither substitutes for the other.

When the remaining lawful term is too short for normal stage progression, ALPRP activates an Accelerated Release Protocol rather than artificially advancing the resident. Release-critical needs take priority: stabilization and safety, medication and healthcare continuity, identification documents, housing, benefits, supervision requirements, transportation, family/community support, employment or education connection, and a documented community continuity plan. Treatment and education continue as time permits.

Situation	ALPRP response	What ALPRP may not do
Release date arrives in Stage 1 or 2	Release as legally required; record current stage and activate accelerated community continuity.	Extend custody or falsely label the resident as having completed later stages.
Release date arrives in Stage 3 or 4	Release as legally required; transfer unfinished treatment, education, work, and reentry goals to community supports where available.	Delay release until ALPRP milestones are completed.
Resident reaches advanced readiness but substantial sentence remains	Continue meaningful institutional work, education, mentoring, treatment, and responsibility consistent with custody status.	Release the resident solely because ALPRP progression is complete.

Stage 5 does not require formal completion of Stages 1-4. When lawful release occurs, Stage 5 begins in the community even if institutional progression was incomplete. The record should state the actual stage at release and why progression ended, for example: “Released from Stage 2 - Rehabilitate; required release date reached; institutional progression incomplete; community continuity plan activated.”

6B. The Rehabilitation Clock and the Release Clock

ALPRP manages every resident on two related but independent timelines. The rehabilitation clock tracks stage progression, treatment, education, behavior, work competency, responsibility, and demonstrated readiness. The release clock tracks every known or reasonably foreseeable legal pathway out of custody, including sentence expiration, split-sentence dates, parole eligibility and hearings, and other release mechanisms. Reentry preparation begins at intake and intensifies as either clock indicates that community transition may be approaching.

KNOWN AND UNKNOWN RELEASE DOCTRINE: Develop a concrete pathway for release events Alabama can reasonably anticipate; maintain portable readiness for events that cannot be predicted; accelerate immediately when circumstances change; and provide a warm handoff for every resident who leaves custody.

Release pathway	Planning posture	Trigger	ALPRP response
Known / fixed	Work backward from date	Sentence expiration; known split-sentence release date; other fixed lawful date	Build and verify education, healthcare, housing, employment, transportation, family/support and supervision continuity before release.
Probable / conditional	Maintain release-ready plan without assuming release	Parole eligibility/hearing; pending court decision; conditional mechanism	Prepare documents, education transfer, job leads, housing alternatives, treatment continuity and support network so a favorable decision does not create a last-minute scramble.
Rapid / unexpected	Emergency compression	Release ordered or effective with little notice	Activate Emergency Warm Handoff Protocol; prioritize immediate safety, medication, ID, destination/housing, transport, supervision contact and live receiving contacts; complete secondary connections after release.

SHORT-SENTENCE DESIGN RULE: A statewide ALPRP system must accommodate short remaining sentences. It cannot select only residents whose sentences fit the five-stage sequence. Pilot 100 may use a projected-release-horizon eligibility rule for research validity, but that pilot rule is not a statewide eligibility rule.

6C. Universal Warm Handoff Standard

Every ALPRP resident leaving incarceration receives an individualized warm handoff regardless of stage, sentence type, release mechanism, length of notice, parole outcome history, or degree of institutional program completion. Release from custody changes the setting in which the plan is carried out; it does not erase the rehabilitation plan.

NO COLD REFERRAL STANDARD: A telephone number, website, brochure, resource list, or instruction to contact an agency does not by itself satisfy ALPRP's warm-handoff requirement. Whenever practicable, a receiving person or organization must be identified, contacted, and prepared to receive the resident, with an appointment, enrollment step, intake, or other verifiable next action.

The handoff is individualized to unfinished needs and demonstrated progress. It may include transfer from J.F. Ingram or another institutional education pathway to an appropriate local Alabama Community College System college; continued access to the community version of Saharah Compass; scheduled appointments with Alabama Career Centers, job-placement organizations, apprenticeship programs, or ALPRP industry partners; treatment and medication continuity; ABPP supervision coordination where applicable; housing and transportation; Family Connect transition to reunification/stability support; and Covenant Connect coordination with employers, mentors, faith/community organizations, and service providers.

Example - release during Stage 2: A resident released from Rehabilitate does not receive a false Stage 3 or Stage 4 designation. The record may show: "Released from Stage 2 - Rehabilitate; lawful release pathway became effective; institutional progression incomplete." The warm handoff then carries forward the active education, treatment, employment-readiness, family, and reentry plan into community settings. An Ingram/ACCS course may continue through a local ACCS college; Saharah Compass may shift to community mode; job-placement or industry-partner appointments may already be scheduled; and the family/support network may receive a coordinated transition plan.

Handoff status	Evidence
Referred	Resource identified and referral transmitted.
Scheduled / accepted	Appointment, enrollment, intake, supervision contact, employer interview, or receiving contact confirmed.

Connected	Resident actually makes contact or appears for the receiving service.
Service initiated	Education, treatment, employment, supervision, mentoring, or other support begins.
Continuity maintained	Connection remains active at defined follow-up points such as 30, 90, and 180 days.

7. Daily Structure Across the Five Stages

The daily architecture remains recognizable across all stages: meals, exercise, counseling/behavioral support, education or work, Saharah-supported reflection, recreation, hygiene, and sleep remain present. What changes is the degree of structure, autonomy, productive responsibility, and community exposure. Revive is generally the most structured. As residents progress, the ratio of structured support to self-directed activity generally shifts toward greater self-management; however, the intensity and frequency of counseling, behavioral-health support, and Saharah use remain responsive to individual need, clinical judgment, safety, and the resident's active plan rather than being mechanically tapered by stage. By Stage 5, the routine should resemble a normal workday while retaining exercise, reflection, treatment/support as needed, and supervision obligations.

ANCHOR DEFINITION: An Anchor is a long-sentence resident who has demonstrated sustained institutional stability, responsibility, appropriate interpersonal conduct, and readiness for an approved peer-support, mentoring, service, or continuity role. Anchor designation does not alter sentence, custody authority, parole eligibility, disciplinary standards, or legal release criteria. Assignment remains subject to classification, safety, clinical, PREA, disability, and facility requirements.

8. Housing Progression

Stage	Preferred housing concept	Purpose
1 - Revive	Open-bay / highly observable stabilization housing	Maximum structure, observation, orientation, stabilization.
2 - Rehabilitate	Up to 8 residents per room (4 bunks)	Structured peer living while education/treatment intensify.
3 - Rebuild	Up to 6 residents per room (3 bunks)	Greater responsibility and study/work preparation.
4 - Restore	Up to 4 residents per room (2 bunks)	Increasing privacy, responsibility, and transition readiness.
5 - Release preparation / transitional housing	2 separate beds per room where institutional Stage 5 preparation exists; community housing after release	Approximate ordinary shared living and independent responsibility.

Rooms should include personalized storage and study space. Dedicated recreation and television spaces remain available. Where operationally justified, specialized Anchor housing may use 2-4 residents per room as a preferred housing concept, not an entitlement or custody-status reward. Residents requiring continuous medical observation may use an appropriately staffed open-bay medical unit. Housing design remains subject to fire code, ADA, PREA, clinical need, classification, separation requirements, and facility engineering.

PART III - Treatment, Education, Work, and Responsibility

Updated section follows.

9. Behavioral Health & Life Recovery Continuum

Version 3.3 replaces the prior Section 9 with the following statewide behavioral-health operating doctrine.

Existing capacity is the starting point

ALPRP recognizes that ADOC already operates mental-health, substance-use, reentry, cognitive-behavioral, family, trauma, education, pastoral, and other rehabilitation programs. The statewide design standard is therefore **existing resources first**: retain what works; integrate what is fragmented; modify what is inadequate; add capacity or a new intervention only where the resident's assessed need cannot be met reliably through existing resources.

The system failure ALPRP targets is not merely program absence. It is the gap between having programs somewhere in the correctional system and providing timely, clinically appropriate, equivalent, continuous access to the residents who need them. Access, scale, integration, continuity, facility-to-facility equity, delivery verification, and accountable outcomes are core operating requirements.

Universal psychotherapy begins in Revive

Every new resident entering Stage 1 - Revive begins psychotherapy as part of stabilization and whole-person assessment. The initial decision is not whether a resident receives access to psychotherapy; it is what level, frequency, modality, and type of care are appropriate.

Universal entry does not create a permanent one-size-fits-all schedule. Clinical intensity remains individualized and may change through qualified professional review.

Initial level	Typical need	ALPRP response
Wellness / lower need	Stable adjustment; no major acute disorder	Regular psychotherapy, core groups, and Saharah-supported exercises
Support	Grief, adjustment, anger, family disruption, moderate stress	More frequent counseling plus targeted interventions
Clinical	Depression, anxiety, PTSD, substance-use disorder, or other diagnosed condition	Structured licensed therapy and appropriate clinical treatment
Intensive	Serious mental illness or high clinical need	Frequent clinical contact, psychiatry, and specialized treatment
Crisis	Suicidality, psychosis, acute withdrawal, or other emergency	Immediate stabilization and higher-level care as indicated

Clinical need, safety, professional judgment, resident choice where legally applicable, and treatment response govern intensity. Advancement to a later ALPRP stage does not automatically end psychotherapy. A resident who no longer needs routine individual psychotherapy may step down to lower-intensity support; a resident with continuing clinical need may remain in therapy through every stage and after release.

Five coordinated layers

ALPRP separates functions that are often blurred together.

1. **Clinical Behavioral Health** - psychotherapy, psychiatry, medication management, crisis response, substance-use treatment, and specialized clinical care.
2. **Targeted Rehabilitation Programs** - evidence-informed cognitive, behavioral, recovery, trauma, relationship, parenting, anger-management, educational, and other structured interventions matched to assessed need. Existing ADOC programs are used before duplicative alternatives.
3. **Saharah Digital Behavioral Support** - counseling requests, scheduling, approved telebehavioral-health access, clinician-assigned exercises, journaling, coping practice, recovery plans, reminders, education, and follow-through.
4. **Peer, Family & Community Support** - trained peers, mentors, family programming, recovery groups, community partners, and voluntary faith-based services that reinforce but do not substitute for clinical treatment.
5. **Continuity of Care** - the active treatment and rehabilitation plan follows the resident across transfers, stages, and lawful release into community care.

Technology expands access to human care; it does not replace clinicians. Saharah may organize information, support practice, surface missed services, and improve continuity. It may not diagnose, prescribe, independently determine treatment,

expose protected psychotherapy content to unauthorized staff, or make stage, disciplinary, custody, parole, or release decisions.

One integrated operating layer

Behavioral health is connected to the wider correctional journey through one governed sequence:

one assessment -> one Individual Rehabilitation Plan -> one governed resident record -> coordinated programs -> measurable competencies -> human-reviewed stage progression -> community handoff

The assessment is updated when circumstances change. The Individual Rehabilitation Plan combines clinical care, targeted programming, education/work goals, family and victim-safety considerations where applicable, release-readiness needs, and measurable milestones. Program completion is evidence, not conclusive proof of rehabilitation. Multidisciplinary stage review considers actual behavioral competencies, clinical progress, institutional conduct, education/work performance, responsibility, safety, and the resident's own documented goals.

Role-based record governance

One governed resident record does not create unrestricted access to clinical information.

- **Clinicians** may access clinical notes, diagnoses, treatment history, assessments, and medication information as permitted by law and professional rules.
- **Program staff** receive assignments, attendance, competencies, and program-progress information needed for their role.
- **Custody staff** receive only information legitimately necessary for safety and operations.
- **Stage-review panels** receive authorized progress indicators and professional recommendations rather than raw psychotherapy conversations unless a separate lawful basis requires disclosure.
- **Public and oversight reporting** uses aggregate or appropriately de-identified information.

Minimum-necessary access, audit logs, retention limits, consent/authorization rules, breach response, and protected clinical spaces are statewide design requirements.

Vendor-independent service architecture

ADOC remains responsible for correctional healthcare authority and the service standards required by law and policy. ALPRP does not make BetterHelp, NaphCare, SMART Recovery, Celebrate Recovery, or any other provider the operating model. Qualified public, contracted, nonprofit, university, telebehavioral, and community providers may deliver services within the architecture, subject to licensure, security, privacy, quality, continuity, and procurement requirements.

If a contractor changes, the resident's treatment history, Individual Rehabilitation Plan, authorized record, scheduled services, and continuity obligations remain with the correctional system rather than disappearing with the vendor.

Service-delivery safeguard

A resident cannot be penalized in stage progression because the institution failed to deliver an assigned service. If counseling, assessment, medication follow-up, a required program, education, or another assigned intervention is unavailable because of staffing, lockdown, transfer, vendor failure, scheduling, technology outage, or another institutional cause, the failure must be recorded separately from resident refusal or nonparticipation.

Stage review may evaluate how the resident engaged when services were actually available. It may not treat institutional non-delivery as resident failure.

Behavioral health across the five stages

- **Revive:** universal psychotherapy begins; safety, crisis stabilization, assessment, medication continuity, substance-use needs, trauma/loss, cognitive/behavioral needs, family needs, and the Individual Rehabilitation Plan are established.
- **Rehabilitate:** the resident receives the primary treatment and structured interventions identified in the plan. Technology extends access and reinforces clinician/program work.
- **Rebuild:** formal classroom intensity may decrease for some residents while actual skills are tested in work, peer conflict, responsibility, emotional regulation, and daily decision-making. Therapy and recovery support continue according to need.
- **Restore:** the system begins the warm handoff to community clinicians, medication providers, recovery supports, family services, and other receiving organizations before lawful release.

- **Release:** treatment, recovery, medication continuity, accountability, employment, housing, supervision, and support continue in the community. Release changes the setting; it does not erase the plan.

Statewide measurement requirement

Behavioral-health performance is measured through access and delivery, not program inventory alone. Measures should include time to first psychotherapy session, scheduled versus delivered sessions, wait-list duration, clinician caseload, crisis events, continuity after transfer, access to assigned programs, resident-reported access, service-related grievances, telebehavioral-health use, medication continuity, community-care appointments scheduled and completed, and cost per resident.

Pilot 100 is responsible for testing whether universal early psychotherapy and tiered continuing intensity are clinically beneficial, operationally feasible, fiscally sustainable, and scalable. Statewide frequency standards should be revised when evidence shows a better model.

10. Education as a Correctional Core Function

Education is not an optional reward attached to incarceration. It is a core capability-building function. ACCS/J.F. Ingram State Technical College is the preferred statewide anchor because Alabama already uses Ingram across correctional facilities. ALPRP integrates adult education, academic progression, career/technical education, digital literacy, financial literacy, and employer-informed credentials into the stage pathway.

Source basis: ALPRP Policy Foundation identifies Ingram as an established correctional education partner; Pilot 100 uses Ingram as the anchor rather than creating a competing school system.

- Secure LMS and approved online learning expand reach but do not replace hands-on trade instruction.
- VR/simulation may supplement technical, safety, interview, conflict, and scenario training where evidence and cost justify it.
- Credentials should be portable, employer-recognized, and linked to actual Alabama labor-market demand.
- Education records should follow the resident into reentry and community education.

11. Work Begins When Productive Work Begins

Treatment addresses why a person behaves as they do. Education develops capability. Work requires the person to practice responsibility under real expectations.

ALPRP does not pay residents for being incarcerated. It does not pay residents merely for receiving treatment or education. Stage 1 Revive and Stage 2 Rehabilitate are unpaid. Paid employment begins in Stage 3 only when a resident performs qualifying productive labor. Work is an opportunity to demonstrate reliability, patience, cooperation, emotional regulation, delayed gratification, competence, safety, and self-support.

COMPENSATION FLOOR: For qualifying productive Stage 3 labor, ALPRP proposes an enforceable compensation floor no lower than the generally applicable minimum-wage benchmark, even where ordinary prison-labor law might permit less. The legal mechanism must be established by legislation, appropriation condition, operating agreement, enterprise contract, or other lawful authority.

Wages increase with verified competency, credentials, productive hours, quality, independence, reliability, and responsibility - not simply because the resident moved to another stage. Stage 4 may include advanced institutional work, mentoring, and lawful off-site work. Stage 5 transitions toward ordinary market compensation.

12. Financial Responsibility, Restitution, and Reentry Savings

Paid work must produce both accountability and a meaningful economic benefit to the worker. Residents pay applicable taxes and lawful court-ordered obligations. A transparent room-and-board contribution may begin modestly and increase as income and autonomy increase. Restitution is addressed where legally owed. Protected

reentry savings build assets for deposits, transportation, tools, clothing, identification, housing, and other release costs.

NO DISGUISED CONFISCATION: Mandatory deductions must not become so large that productive employment ceases to provide meaningful accessible earnings. Resident-owned protected savings are reported separately from institutional deductions because the money remains the resident's asset.

Exact statewide percentages are implementation variables. Pilot 100 tests one graduated model; statewide adoption requires legal review and paycheck simulations across wage levels and obligations.

13. Fair Competition and Enterprise Governance

ALPRP supports correctional enterprises only when they provide legitimate skill practice and economic value without using incarceration to undercut ordinary Alabama workers. Customer discounts must be attributable to novice productivity, supervision requirements, correctional access burdens, scheduling limitations, or warranty differences - not simply to cheap incarcerated labor.

- Non-displacement protections for ordinary workers.
- Transparent enterprise accounting: revenue, payroll, materials, supervision, equipment, insurance, overhead, surplus/deficit.
- Skills Passport documenting verified hours, credentials, competencies, attendance, quality and mentoring.
- Training equipment before residents work on high-value customer assets.
- Portfolio economics: viable enterprises may cross-subsidize necessary but less-profitable work; no resident is made economically disposable because of disability or lower productivity.
- No unrestricted correctional profit from ALPRP resident labor.

PART IV - One Correctional Ecosystem Around the Resident

14. Officers: Shield & Standards

ALPRP cannot succeed by increasing demands on officers while treating staff as interchangeable security labor. Shield & Standards is the officer-side operating framework: professional training, predictable supervision, de-escalation, procedural justice, technology competence, trauma awareness, wellness, peer support, leadership accountability, recognition, and clear misconduct standards. Serious misconduct remains subject to normal ADOC processes.

Source basis: Project FAQ identifies Shield & Standards as the officer component and states that ALPRP addresses resident rehabilitation, victim support, family connection, employee wellness/accountability, and community reentry as one ecosystem.

- Officer wellness is a safety metric, not an employee perk.
- Technology assists observation and documentation; it does not replace correctional judgment.
- Staff outcomes belong on the reform scorecard: assaults, use of force, overtime, sick leave, turnover, grievances, job satisfaction, safety perception and training completion.
- Pilot or specialized-unit officer selection must be evaluated for selection bias before claims are generalized statewide.

15. Victims: Haven Alabama

Victims and survivors are independent stakeholders, not instruments of offender rehabilitation. Haven Alabama provides a separate, permissioned victim-support pathway. Healing may include forgiveness for a victim who chooses it, but forgiveness, reconciliation, communication, or restorative participation is never required.

Participation level	Victim choice
0	No participation beyond legally required notification.
1	Information only.
2	Support, resources, counseling referrals, healing tools and safety planning.

3	Accountability input, impact information, restitution information.
4	Restorative process only if the victim affirmatively requests it, the resident consents, the case is appropriate, and trained professionals facilitate it.

VICTIM INDEPENDENCE: Victim participation or nonparticipation cannot cause resident stage advancement, punishment, parole, or release. Victim services are successful when they improve victim information, control, safety, respect, access to support, or healing - even if resident outcomes do not improve.

16. Families: Family Connect

Family Connect supports families without making them unpaid case managers or a revenue source. It provides authorized status information, planning tools, communication, document preparation, reentry coordination, education, referrals, and structured participation. Basic family communication should be treated as rehabilitative infrastructure; optional enhanced communication may be priced transparently subject to affordability protections.

17. Community and Reentry: Covenant Connect

Covenant Connect coordinates employers, faith/community organizations, mentors, service providers, housing resources, transportation, education continuity, and other reentry supports. Community participation must be structured, screened, measurable, and subject to professional boundaries rather than dependent on informal goodwill alone.

18. Parole Preparation Without a Shadow Parole Board

ALPRP may help residents and families organize verified records through the Parole Packet Assistant, but ALPRP does not guarantee parole and does not bind the Alabama Board of Pardons and Paroles. The purpose is to improve completeness, accuracy, transparency, and continuity of information - not to substitute ALPRP judgment for ABPP discretion.

Source basis: Project FAQ expressly distinguishes parole hearing grant rates from releases and states that ALPRP does not guarantee parole.

PART V - Correctional Operations, Technology, and Rights

19. Saharah Platform Architecture

Interface	Primary user / function
Saharah Compass	Resident goals, reflection, case-plan continuity, education/treatment support and progress evidence.
Shield & Standards	Officer training, support, professional development and approved operational tools.
Haven Alabama	Victim/survivor information, support, safety and voluntary accountability/restorative pathways.
Family Connect	Family communication, planning, information and reentry coordination.
Covenant Connect	Community, employer and reentry partner coordination.
Transparency Dashboard	Public/oversight reporting using appropriately aggregated and de-identified measures.

PERMISSION FIREWALL: Shared infrastructure does not mean shared access. Victim, family, resident, officer, clinical, custody, research, and public data require separate permissions, retention rules, audit logs, and disclosure standards.

20. Technology-Assisted Supervision

ALPRP anticipates extensive technology-assisted supervision and data continuity, including secure devices, controlled networks, access management, approved surveillance, incident documentation, education, telehealth, and case management. Privacy does not disappear in prison; surveillance must have a correctional purpose, access controls, retention limits, auditability, and protected spaces where law or clinical ethics require them.

21. Cybersecurity and Failure Continuity

- Offline operating procedures for count, movement, medication, meals, incidents and emergency response.
- Backups and disaster recovery for critical records.
- Vendor service-level agreements and breach notification.
- Access revocation and device quarantine.
- Penetration testing and recurring security audits.
- No correctional process should become unsafe merely because Saharah, tablets, or the network is unavailable.

22. Food, Commissary, and Telecommunications

ALPRP treats food, commissary, and communications as correctional operating systems with safety, health, family, and financial consequences. Food should be nutritious and professionally managed at every stage. Culinary training may be integrated where it adds educational value, but students cannot be the unpaid labor required to keep meals operating. Commissary should prioritize necessities and transparent pricing rather than captive-market extraction. Communications should support family stability and required programming without forcing families to finance basic rehabilitation access.

PROCUREMENT NEUTRALITY: ALPRP specifies outcomes and safeguards, not preferred brands. Existing statewide contracts are reviewed first; carve-outs, amendments, integration, or competitive procurement follow law and contract authority.

23. Healthcare Boundaries

ADOC and its authorized healthcare structure retain medical, psychiatric, medication, emergency, and crisis responsibilities. ALPRP may coordinate non-acute counseling, telebehavioral access, wellness supports, and continuity but cannot blur clinical accountability. Medical and mental-health decisions remain with qualified professionals.

24. Due Process, Grievances, Disability, and Special Populations

- Stage movement and work suspension require documented reasons and a reconsideration/appeal pathway appropriate to the decision.
- Earned wages are never retroactively confiscated as punishment.
- One disciplinary event does not automatically define treatment failure or moral failure; response considers severity, pattern, cause, risk, treatment need and workplace relevance.
- ADA and disability accommodation apply to education, work, technology, communication, housing and progression.
- Productive responsibility is expected consistent with capacity; conventional employment is not the sole measure of progress.
- PREA, separation/protection needs, language access, cognitive limitations, serious mental illness, medical acuity, age and other legally relevant factors shape implementation.

PART VI - Restore, Release, and Community Continuity

25. Reentry Begins at Intake

ALPRP rejects the model in which reentry starts shortly before release. Identity documents, education, employability, financial preparation, family obligations, victim safety, healthcare continuity, housing barriers, transportation, and supervision requirements should be identified early and updated throughout the sentence. Each case plan therefore contains a standing Release Readiness File that is kept current throughout incarceration rather than assembled only after release is approved. The file should be usable whether release occurs by expiration, parole, split sentence, court action, or another lawful mechanism.

Partner / system	Continuity function
ALEA	Identification, driver-license eligibility, driving-record barriers.
Vital Records / ADPH	Birth-certificate coordination.
Social Security Administration	Social Security documentation.
Alabama Department of Labor / Career Centers	Workforce registration, job matching, employer services.
ABPP	Parole/supervision continuity and lawful conditions.
ACCS/Ingram	Transcripts, continuing education, credentials and post-release enrollment.
Employers	Curriculum input, mock interviews, apprenticeships, interviews and hiring.
Community partners	Housing, transportation, mentoring, treatment/recovery, faith/community support and resource navigation.

26. Stage 4 - Restore

Restore is the controlled bridge between institutional competence and community responsibility. Residents demonstrate reliability under increased autonomy. Depending on custody status and law, this may include off-site employment, community-facing training, family planning, restitution/accountability work, mentoring, transportation practice, budgeting, and increasingly realistic schedules. Stage 4 remains correctional custody; increased freedom is earned, monitored, and reversible when safety requires it. Stage 4 intensifies and tests reentry preparation in realistic conditions; it does not mark the first time reentry work begins.

27. Stage 5 - Release

Release begins in the community. The objective is not to terminate correctional support at the prison gate but to transition responsibility. Employment, housing, transportation, healthcare, supervision compliance, family obligations, financial management, treatment/recovery, and community support remain measurable. Covenant Connect and appropriate state/community systems provide continuity without creating indefinite digital surveillance beyond lawful authority. Stage 5 is triggered by lawful community release, not by a requirement that the resident first complete Stages 1-4. Residents released before completing institutional progression enter Stage 5 with an individualized continuity plan reflecting unfinished needs. The first Stage 5 task is confirmation of the warm handoff: the resident reached the destination, knows the supervision requirements, has access to essential medication and documents, and can reach the designated education, employment, family, treatment, and community contacts. Failed connections trigger follow-up rather than being recorded as completed merely because a referral was issued.

PART VII - Accountability, Financing, and Evidence

28. Transparency Dashboard

ALPRP proposes public reporting that is useful rather than performative. Measures require clear denominators, as-of dates, definitions, comparison periods, and source provenance. Individual protected information remains private. Public reporting focuses on aggregated safety, staffing, treatment, education, work, victim/family service, reentry, cost, and outcome measures.

Domain	Examples
Safety	Assaults, staff assaults, use of force, weapons, drugs/contraband, lockdowns, serious incidents.
Staff	Vacancies, turnover, overtime, sick leave, injuries, training, safety perception.
Progression	Stage movement, pauses/regressions, major disciplinaries, grievances, program access.
Education	Enrollment, completion, credentials, literacy/numeracy growth.
Treatment	Access, engagement, continuity, crisis events; no public clinical PII.
Work	Verified hours, credentials, wage progression, quality, enterprise economics.
Victim/family	Voluntary service use, access, satisfaction, safety and communication measures.
Reentry	IDs, housing, employment, wages, healthcare, supervision, 30/90/180/365-day stability.
Recidivism	Rearrest, reconviction and reincarceration using explicit definitions and follow-up windows.
Cost	Resident-day cost, full economic cost, cash requirement, cost per credential/employed release/successful reentry.

29. Fiscal Doctrine

ALPRP does not promise that reform is free or that every dollar spent on incarceration becomes cash savings when population declines. Fixed and semi-fixed prison costs remain. Fiscal analysis therefore separates marginal savings, avoidable costs, full economic costs, capital, partner-funded services, enterprise revenue, and state cash requirements.

Source basis: ALPRP Policy Foundation explicitly warns that ADOC per-resident cost is not equivalent to immediate marginal savings because prisons retain fixed and semi-fixed costs.

COMPARABLE ACCOUNTING: Do not compare a partially loaded ALPRP cost with a fully loaded ADOC cost. Every pilot or scale proposal should show both the state cash requirement and the full economic value of shared, donated, partner-funded, and existing resources.

30. Independent Evaluation

ALPRP should be evaluated by independent research institutions with predefined methods, access to appropriate de-identified data, and the right to publish unfavorable findings. Pilot 100 is primarily a feasibility, safety, implementation, cost, and outcome demonstration; a sample of 100 should not be used to overclaim small recidivism effects. Larger or multisite studies follow only if early evidence warrants them.

31. Readiness Is Measured, Not Declared

ALPRP may maintain a transparent research Readiness Index combining education, behavior, treatment, work, financial preparation, documents, housing, employment, and self-management. The index is an evaluation tool, not an automated liberty score. Researchers should test whether the factors ALPRP believes represent readiness actually predict successful community outcomes. The index and the stage-progression criteria are analytically distinct from validated actuarial or structured-professional-judgment risk instruments used by legally authorized agencies. Neither may be represented as a substitute for those instruments unless independently validated for that use.

32. Failure Must Be Defined Before Scaling

Decision	Framework meaning
Scale	Safety acceptable; implementation fidelity high; material gains in core outcomes; cost justified; no major rights failure.
Modify	Some domains improve but components require redesign, cost control, adoption changes, or narrower use.
Stop component	A technology, enterprise, restorative practice, procurement model, or service produces persistent safety, rights, cost, or effectiveness problems.
Do not scale	Safety materially worsens, rights violations persist, staffing is unsustainable, costs are structurally excessive relative to value, or credible benefit is absent across core domains.

PART VIII - Implementation Architecture

33. Governance

Statewide implementation requires clear authority rather than overlapping committees. ADOC retains custody and correctional command. ACCS/Ingram controls education within its authority. Licensed clinical providers control clinical decisions. ABPP retains parole authority. ALPRP functions as framework designer, implementation integrator, technology/program steward where authorized, and accountability partner - not as a private prison operator or shadow state agency.

OFFICER-MISCONDUCT AND RIGHTS CONCERNS: Allegations involving staff conduct proceed through ADOC's legally authorized investigative and disciplinary channels and any required external reporting process. ALPRP may elevate unresolved implementation, rights, or fidelity concerns to the oversight body and evaluator, but does not operate a parallel employee disciplinary system.

IMPLEMENTATION-FIDELITY DISPUTES: ADOC retains final authority over custody, classification, discipline, security, healthcare, emergency operations, sentence administration, and other powers reserved by law. Disputes over whether an ALPRP site or Pilot 100 is being implemented according to the approved protocol are referred to a Joint Pilot Oversight Committee or equivalent governance body established by written agreement. ALPRP may document an unresolved fidelity objection and provide it to the independent evaluator. Nothing in this process permits ALPRP to override ADOC's lawful correctional authority.

Function	Primary authority / role
Custody, classification, discipline, security	ADOC
Education and credentials	ACCS / Ingram within authorized programs
Medical/psychiatric/crisis care	ADOC-authorized healthcare professionals

Parole decisions	ABPP
Victim rights / notifications	Applicable state agencies and victim-services authorities
Framework integration	ALPRP with authorized partners
Independent evaluation	University / independent research institution
Public accountability	ADOC/partners + Transparency Dashboard + statutory oversight

34. Resident Voice Without Resident Control of Custody

Facilities implementing ALPRP should maintain structured resident feedback, such as a rotating Resident Advisory Council. Residents may identify food, schedule, technology, program-access, commissary, communication, incentive, and implementation problems. They do not decide discipline, classification, security, another resident's progression, parole, or release.

35. Implementation Sequence

Phase	Purpose
1 - Verify	Reconcile current ADOC/ABPP data, legal authority, contracts, costs, staffing and facility conditions.
2 - Design	Translate Framework standards into site-specific posts, schedules, clinical protocols, education, technology, procurement and data governance.
3 - Pilot	Use Pilot 100 or comparable controlled demonstration with independent evaluation.
4 - Evaluate	Publish safety, cost, implementation, staff, victim/family, resident and reentry findings including failures.
5 - Modify	Correct weak components; reject components that fail.
6 - Scale selectively	Expand only demonstrated components, with site-specific adaptation and continuing measurement.

36. What Is Not Locked Statewide

- Exact officer-to-resident ratios and posts.
- Exact facility conversion plans and capital costs.
- Specific technology, food, commissary, telehealth, or communications vendors.
- Exact resident wage steps above the compensation floor.
- Exact room-and-board, restitution, and protected-savings percentages.
- Exact stage durations.
- Exact career-academy mix at every facility.
- Specific AI models or scoring formulas.
- Final statutory language, procurement method, implementation date, or statewide appropriation.

These are not omissions. They are implementation variables that should be set with current data, legal authority, facility engineering, clinical governance, labor-market evidence, procurement, and evaluation - not guessed in a statewide philosophy document.

PART IX - Pilot 100 as the Test of the Framework

Pilot 100 is not the Framework itself. It is a deliberately limited implementation of selected Framework components with 100 eligible voluntary new entrants, dedicated space, a comparison design, independent evaluation, and predefined scale/modify/stop rules. Pilot-specific assumptions - staffing, food budget, counselor count, career-academy seats, tablet pricing, startup costs, and wage scenarios - do not automatically become statewide standards.

37. What Pilot 100 Must Test

- Whether five-stage progression can be operated consistently and fairly.
- Whether officers can safely support a more structured rehabilitation model without role confusion or burnout.
- Whether integrated education, counseling, work and reentry produce measurable readiness gains.
- Whether victim/family services can operate independently and safely.
- Whether technology improves continuity without replacing human authority or creating unacceptable privacy/cybersecurity risk.
- Whether paid productive work can be fair to residents, taxpayers, victims, outside workers and businesses.
- Whether the full economic cost is justified by measurable institutional and post-release value.

Appendix A - ALPRP Non-Negotiable Doctrines

Doctrine	Canonical meaning
Five stages, one journey	Revive -> Rehabilitate -> Rebuild -> Restore -> Release.
Fluid progression	Advancement is evidence-based and human-reviewed, not automatic by time.
Stage 3 remains inside	Rebuild productive work is institutional; Restore is the transitional stage.
Technology informs; humans decide	No AI independently determines consequential correctional or clinical decisions.
Victim independence	Healing does not require forgiveness; victim participation never controls resident progression or release.
Officer inclusion	Staff safety, wellness, professionalism and accountability are reform outcomes.
Education before paid work	Stages 1-2 provide treatment and education without ALPRP wages; paid work begins with qualifying productive Stage 3 labor.
Fair labor	Incarceration is not used as the justification for nominal compensation once productive economic labor begins.
Fair competition	Enterprise pricing cannot undercut free labor merely because workers are incarcerated.
Existing resources first	Integrate what Alabama already has before duplicating it.
Reentry begins at intake	Documents, skills, housing, employment, healthcare and supervision continuity are planned throughout incarceration.
Measure failure	ALPRP publishes negative findings and stops or modifies components that do not work.
Two clocks	Rehabilitation progression and legal release timing are tracked simultaneously; neither controls the other.
Universal warm handoff	Every resident leaving custody receives an individualized, verifiable transition to receiving people and services, regardless of stage or release mechanism.
No cold referrals	A resource list or phone number alone is not a completed handoff; ALPRP seeks a scheduled, accepted, or otherwise verified receiving connection whenever practicable.
Progression is not a parole-risk instrument	Stage criteria organize rehabilitation and institutional progression; they do not independently predict legal release suitability or substitute for validated risk assessment and lawful parole authority.

Appendix B - Source and Evidence Discipline

ALPRP should preserve a source hierarchy in every public document and dashboard. Claims must be labeled according to what the source can actually establish.

Evidence type	Required treatment
Statute / regulation / court order	State as law or legal requirement only within its actual scope and effective date.
ADOC / ABPP / Alabama agency data	State as official agency data with report date, denominator and as-of date.
DOJ / federal agency findings	Attribute precisely; distinguish allegations, findings, motions, orders and final judgments.
Complaint / litigation filing	Use "alleges," "reports," or "documents"; do not convert allegations into adjudicated fact.
News investigation	Use "reporting found" or equivalent; prefer primary records where available.
Academic research	State population, design, limits and applicability; do not imply Alabama-specific proof when evidence is external.
ALPRP policy judgment	Label as proposal, doctrine, planning assumption, target, or recommendation.

Appendix C - Relationship to the Policy Foundation

The Policy Foundation and Comprehensive Reform Framework should be maintained together but not merged. The Policy Foundation is the evidence-and-strategy case. The Framework is the canonical operating model. Where the Policy Foundation contains an older policy recommendation that conflicts with a later Framework doctrine, the Foundation should be revised rather than allowing two ALPRP positions to coexist.

SYNCHRONIZATION MECHANISM: A material Framework doctrine change triggers a documented crosswalk review of the Policy Foundation and Pilot 100. A material evidence, legal, or fiscal change in the Foundation triggers review of Framework assumptions and public claims. Pilot changes that alter the intervention being evaluated must be logged and reviewed for evaluation impact. No superseded public version should remain presented as current without a visible archive or superseded label.

Reconciliation status: Policy Foundation v2 now reflects the Framework's current compensation doctrine: Stages 1-2 are unpaid treatment/education stages, while qualifying productive Stage 3 labor uses an enforceable compensation floor no lower than the generally applicable minimum-wage benchmark, subject to lawful implementation. Future Foundation revisions should continue to defer to this Framework if compensation doctrine changes.

Source basis: Policy Foundation v2 now reflects the Framework compensation doctrine; Pilot 100 provides the current implementation-level compensation model.

Appendix D - Core Project Source Baseline

1. ALPRP Policy Foundation v2 - Five Gaps Closed: Evidence, Costs, Coalitions, Parole Accountability, and the Extraction Economy (September 2026).
2. ALPRP Pilot 100 - Five-Year Correctional Rehabilitation Demonstration Master Plan v5.1 (September 2026).
3. ALPRP grounded assistant specification / knowledge-base design preserving the five-stage terminology, progression rules, systems, and evidence hierarchy.

4. ALPRP FAQ / website materials describing the five-stage model, fragmentation thesis, comprehensive stakeholder ecosystem, parole limits, victim support, and officer support.
5. ALPRP Apps documentation for Family Connect, Haven Alabama, Covenant Connect, Parole Packet Assistant and related prototypes.
6. ADOC and ABPP annual, quarterly, and monthly statistical reports maintained in the ALPRP research library for current baseline statistics.
7. ALPRP immersive prototype and stage-design materials for housing, schedules, treatment, education, technology, and facility concepts.

ALPRP is not asking Alabama to assume the model works. It is defining the model clearly enough to test it, measure it, criticize it, improve it, and reject any component that fails.