ALPRP EXECUTIVE POLICY BRIEF v2.1

September 2026

FROM EVIDENCE TO IMPLEMENTATION

A disciplined pathway for testing comprehensive correctional reform in Alabama - without asking the state to adopt an unproven model statewide.

Current system snapshot

- 21,214 held in-house - Mar. 31, 2026
- 12,115 reported design capacity - Mar. 31, 2026
- 175.1% system occupancy - 10,099 over design
- 2,386 security-classified staff - Mar. 31, 2026

THE POLICY PROBLEM

Alabama's prison crisis is an operating-system problem, not a single-program problem. Overcrowding, staffing pressure, violence, treatment access, fragmented education and rehabilitation, parole preparation, family disruption, officer wellbeing, victim needs, and weak release continuity interact. New facilities can improve physical conditions, but replacement construction alone cannot repair these connected operating failures.

ALPRP does **not** claim ADOC has no treatment or rehabilitation programs. Alabama already operates mental-health, substance-use, cognitive-behavioral, education, family, reentry, pastoral, and other services. The failure ALPRP targets is the gap between having programs somewhere in the system and providing timely, equivalent, continuous, measurable access to the people who need them.

Current core package

1. **Policy Foundation v2.2 - Why should Alabama change?** Evidence and policy case: public safety, parole accountability, costs, reentry, workforce, family burdens, behavioral-health access, and institutional reform.
2. **Comprehensive Reform Framework v3.3 - Change to what?** Canonical operating model: five stages, human authority, Behavioral Health & Life Recovery Continuum, officers, victims, families, work, technology, accountability, and release continuity.
3. **Pilot 100 Master Plan v5.2 - How should Alabama test it?** A limited 100-resident demonstration with universal early psychotherapy, tiered clinical intensity, independent evaluation, full-cost accounting, predefined thresholds, implementation-fidelity controls, and ADOC authority preserved.

THE FIVE-STAGE OPERATING MODEL

1. **REVIVE - Stabilize.** Safety, whole-person assessment, universal psychotherapy, clinical stabilization, routine, and one Individual Rehabilitation Plan.
2. **REHABILITATE - Treat. Learn. Develop.** Targeted treatment, education, credentials, coping and decision skills.
3. **REBUILD - Practice. Work. Take responsibility.** Inside-the-fence productive responsibility, paid work when qualifying labor begins, teamwork, financial responsibility, and demonstrated behavior.
4. **RESTORE - Repair. Reconnect. Demonstrate readiness.** Advanced responsibility, family/victim-conscious accountability, structured transition, and community-care handoff.
5. **RELEASE - Return prepared. Remain accountable.** Community treatment continuity, employment, housing, transportation, supervision, family obligations, and continued support.

BEHAVIORAL HEALTH & LIFE RECOVERY CONTINUUM

Five coordinated layers connect what Alabama already has:

1. Clinical Behavioral Health
2. Targeted Rehabilitation Programs
3. Saharah Digital Behavioral Support
4. Peer, Family & Community Support
5. Continuity of Care

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

Every new Revive resident begins psychotherapy. Intensity is tiered by clinical need and may continue through later stages when qualified professional judgment supports it. Technology expands access to human care; it does not replace clinicians.

PAROLE DATA CONTEXT

ABPP reported a 79% guideline-recommended grant rate for FY2025 under the prior guideline framework. Revised guidelines became effective September 14, 2025; through July FY2026, the published suggested-grant rate was 13% and concurrence was 86%. ALPRP treats this shift as a question for transparent longitudinal validation - not proof that either framework is correct.

ALPRP's proposition is not: "Trust us." It is: define the problem, define the alternative, test it independently, publish the results, and scale only what earns the evidence.

PILOT 100: TEST BEFORE SCALE

A five-year correctional rehabilitation demonstration designed to test feasibility, safety, implementation fidelity, cost and outcomes before statewide expansion.

WHAT PILOT 100 TESTS

- **100 eligible residents.** Voluntary participation with an independently designed comparison strategy. Pilot 100 is a feasibility and outcome demonstration, not a claim that 100 participants can prove modest statewide recidivism effects.
- **ADOC retains sovereign correctional authority.** Custody, security, classification, discipline, healthcare, emergency response, sentence administration, and legally reserved decisions remain with ADOC.
- **Existing resources before new spending.** ADOC, ACCS/J.F. Ingram, existing contractors, ABPP, state agencies, and qualified vendors are evaluated before duplicating capabilities.
- **Universal early psychotherapy.** Every Pilot resident begins psychotherapy in Revive. Initial intensity is tiered by need. The five-counselor planning model is starting capacity, not a fixed cap; qualified capacity must scale if access standards cannot be met.
- **Technology informs. Humans decide.** AI may organize evidence and flag needs; it does not independently determine punishment, diagnosis, treatment, stage movement, parole, or release.
- **Vendor-independent continuity.** Healthcare or telebehavioral contractors may change without erasing treatment history, the Individual Rehabilitation Plan, or continuity obligations.

ACCOUNTABILITY BUILT INTO THE MODEL

- **Two clocks, one continuity standard.** Reentry begins at intake. Residents are managed on both rehabilitation progress and every legally plausible release pathway. Every lawful release receives a warm handoff regardless of stage.
- **No institutional-failure penalty.** Residents are not held back because an assigned counseling session, assessment, class, or treatment was unavailable due to staffing, lockdown, scheduling, vendor failure, transfer, or technology outage.
- **Victim-centered without compelled forgiveness.** Haven Alabama supports information, resources, safety, and accountability input; restorative contact occurs only when voluntarily requested, appropriate, and professionally facilitated.
- **Implementation disputes have a channel.** ADOC remains final on custody, discipline, security, healthcare, and legally reserved authority. Fidelity disputes go to joint oversight and may be documented by the independent evaluator.

WHAT ALABAMA WOULD MEASURE

Safety

Violence, serious incidents, use of force, disciplinaries, contraband, victimization, crisis events, and institutional stability.

Behavioral health & rehabilitation

Time to first psychotherapy session; sessions scheduled versus delivered; wait-list duration; clinician caseload; crisis response; treatment and program engagement; institutional non-delivery; validated measures; education; credentials; behavior; progression; and program fidelity.

Work & responsibility

Verified competencies, productive work, lawful wages, savings, restitution where owed, employment readiness, and enterprise economics.

People around the system

Officer outcomes, clinical workload, family stability, victim-reported experience, privacy incidents, and access to requested support.

Reentry

IDs, housing, healthcare and medication continuity, education, employment, supervision, and confirmed warm-handoff continuity at 30/90/180 days.

Evidence & cost

State cash requirement, full economic cost, cost per resident, cost of behavioral-health capacity, and longitudinal outcomes that can inform - but do not replace - ABPP's independent parole authority or validated risk assessment.

THE BEHAVIORAL-HEALTH DECISION RULE

By the end of Pilot Year 2, the independent evaluator should determine whether broader continuing psychotherapy is producing sufficient safety, clinical, behavioral, continuity, and readiness benefit to justify the staffing and cost. If it does, maintain or expand access. If it does not, retain universal Revive initiation and step ongoing frequency down according to clinical need. The answer is scale, modify, or stop a component - not a predetermined permanent frequency.

THE OVERALL DECISION RULE

- **SCALE:** safety no worse, fidelity credible, outcomes materially improve, and cost premium is justified.
- **MODIFY:** promising results, but correctable implementation, staffing, adoption, or cost problems remain.
- **STOP COMPONENT:** a specific intervention creates persistent safety, rights, cost, or effectiveness problems.
- **DO NOT SCALE:** safety worsens, rights failures persist, staffing is unsustainable, costs are structurally excessive, or no credible core benefit appears.

FISCAL DISCIPLINE

ALPRP will not use conflicting FY2026 ADOC appropriation figures interchangeably. Statewide funding totals should be published only with the specific legislative source and funding scope identified. Pilot comparisons use separately identified, like-for-like cost measures.

THE IMMEDIATE ASK

ALPRP seeks technical review and institutional partners to determine whether Pilot 100 can advance from policy design to implementation engineering. The request is not statewide adoption. It is disciplined feasibility review, independent evaluation design, legal and operational validation, and a limited test of an integrated correctional operating model.

Current core package: Policy Foundation v2.2 | Comprehensive Reform Framework v3.3 | Pilot 100 Master Plan v5.2 | Executive Policy Brief v2.1.