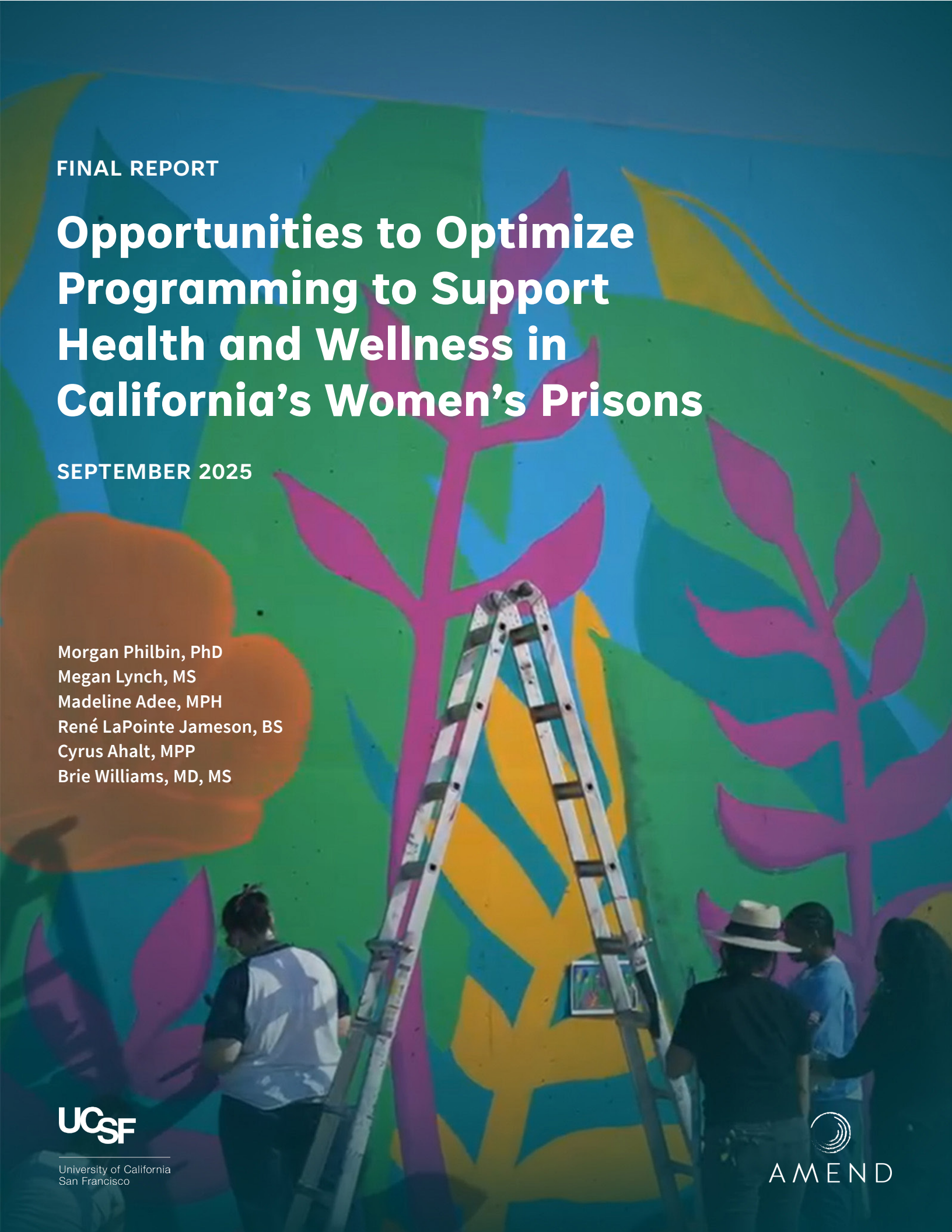


FINAL REPORT

Opportunities to Optimize Programming to Support Health and Wellness in California's Women's Prisons

SEPTEMBER 2025

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AMEND

Amend at UCSF (Amend), based at the University of California San Francisco School of Medicine (UCSF), works to transform prisons by partnering with departments of correction and sharing public health expertise to reduce harm and promote the health and humanity of both incarcerated people and prison staff.

This report, "Opportunities to Optimize Programming to Support Health and Wellness in California's Women's Prisons" is the first in a three-part series by Amend aimed at identifying strategies to support and empower people incarcerated in the California Department of Corrections and Rehabilitation (CDCR)'s women's prisons to improve their health and wellness.

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Table of Contents

Table of Contents 4

Executive Summary 5

Introduction 6

Section 1. Reimagine California's Women's Prisons to Prioritize Health and Wellness 10

1.1 Establish a Dedicated Health and Wellness Center in Each Women's Prison 10

1.2 Deliver Comprehensive, Gender-Responsive, Trauma-Informed Health and Wellness Services 12

1.3 Implement a Structured, Personalized, and Collaborative Learning Model 14

Section 2. Develop Dynamic, Individualized Rehabilitation Plans and Ensure Programming Addresses Individuals' Unique Needs and Strengths 17

2.1 Implement Gender-Responsive, Trauma-Informed Assessment Tools to Inform Individualized Health and Wellness Programming 18

2.2 Create Individualized Rehabilitation Plans that Reflect Individuals' Dynamic Health and Wellness Needs Over Time 19

2.3 Ensure Programming is Responsive to the Health and Wellness Needs of Individuals Incarcerated in Women's Prisons 21

2.4 Develop and Deliver Parole Board Readiness Programming and Adjust each Person's Individualized Rehabilitation Plan Following Parole Board Hearings to Comply with Board Requests 23

2.5 Optimize Health and Wellness Programming Opportunities for Non-English Speakers 25

2.6 The Tailoring of a Program Should Not be Shaped by the Desire to Obtain Rehabilitative Achievement Credits Accreditation 26

Section 3. Optimize the Timeliness, Accessibility, and Reliability of Health and Wellness Programming 27

3.1 To Enhance Empowerment around Health and Wellness, Do Not Remove People from Programming as a Punitive Tool 27

3.2 Establish a Consistent, Collaborative Process to Optimize Delivery of CBO-led Health and Wellness Programs 30

3.3 Streamline and Centralize the Operationalization of CDCR Health and Wellness Programming to Ensure Consistency, Availability, and Accessibility 32

3.4 Create a Centralized List of all Programs and Publicize a Facility- Wide Daily Schedule of Programs to Maximize Communication 34

Section 4. Improve Health and Wellness Programming Access, Quality, Relevance, and Funding Processes 36

4.1 Establish Resident Participation in Health and Wellness Program Planning and Development 36

4.2 Regularly Evaluate Health and Wellness Program Quality and Prioritize Evidence-Based, Gender-Responsive Offerings 37

4.3 Improve Waitlist Management to Optimize Access to Health and Wellness Programming 39

4.4 Develop and Maintain Transparent and Equitable Funding Processes for all Programming 41

Section 5. Ensure that Programs are Deployed in a Safe Environment that Supports Health and Wellness and is Trauma-Responsive 44

5.1 Ensure Health and Wellness Centers Create a Trauma-Responsive Environment Where People Can Thrive and Engage in Activities That Support their Rehabilitation 45

5.2 Ensure a Safe and Supportive Trauma-Responsive Environment for Residents to Engage in Daily Activities and Programming 47

Conclusion 50

Appendix 51

A1: Example Individual Schedules 51

A2: Sample Health and Wellness Pathways and Course Progression 53

A3: Detailed Core Wellness Pathways 54

Executive Summary

This report presents recommendations to reimagine California's women's prisons with a focus on health, wellness, and empowerment through the creation of health and wellness centers and an emphasis on individualized rehabilitation. It includes action steps to ensure that programming is gender-responsive, trauma-informed, timely, accessible, high-quality, relevant, and delivered in a safe environment. While our focus is on CCHCS initiatives, our findings and recommendations address relevant operations and needed collaboration between CDCR's Divisions. An integrated approach will maximize rehabilitation and improve public safety.

RECOMMENDATIONS TO SUPPORT THE HEALTH AND WELLNESS OF PEOPLE IN WOMEN'S PRISONS INCLUDE:

1. **Reimagine California's women's prisons to prioritize health and wellness.**
   With a plethora of Community-Based Organization (CBO)-led programs in women's prisons, California has an unparalleled opportunity to optimize healing, education, and empowerment during incarceration. This should occur through the establishment of a dedicated Health and Wellness Center at each prison. The Center should deliver comprehensive, gender-responsive, trauma-informed and meaningful health and wellness services through a structured, personalized, and collaborative learning model.
2. **Develop dynamic, individualized rehabilitation plans that address individuals' needs and strengths.**
   Residents' needs and strengths vary significantly based on a multitude of factors, including life experiences, personal characteristics, time since arrival, and sentence. These needs should be identified via gender-responsive and trauma-informed tools and used to inform individualized rehabilitation plans that reflect changing needs over time. All programming that CDCR coordinates and/or delivers should be responsive to incarcerated individuals' needs, strengths, and goals.
3. **Optimize the timeliness, accessibility and reliability of programs.**
   Programming must be accessible, consistently delivered, and seamlessly integrated into daily life. To accomplish this, CDCR should remove punitive barriers to participation, improve collaboration with CBOs, and implement streamlined and centralized operations.
4. **Improve programming access, quality, relevance and funding processes.**
   Programming must be responsive to individuals' needs. Incarcerated individuals should be involved in determining what programs are offered. There should be regular evaluation and prioritization of evidence-based and gender-responsive programs, improved waitlist management, and transparent and equitable funding processes to sustain high-quality programs.
5. **Ensure that programs are deployed in a safe environment that supports health and wellness.**
   Programs must be delivered in a space where people feel physically and emotionally safe. California should create conditions supporting the health, wellness, and empowerment of people incarcerated in its women's prisons.

Introduction

DEFINITIONS AND PRINCIPLES USED IN THIS REPORT

Programming, Health and Wellness

In this report:

- **Programming** refers to all rehabilitative programs and services offered by various divisions in the department, and includes academic and vocational programming; substance use disorder treatment; nursing-, peer-, and CBO-led programs; and other behavioral health interventions.
- **Health** reflects physical, mental, and social well-being, not merely the absence of disease or infirmity.[1]
- **Wellness** is shaped by a balance of eight key dimensions: physical, social, spiritual, emotional, intellectual, financial, environmental, and occupational.[2]

Principles for Effective Programming

To support health and wellness, programming inside women's prisons should be gender-responsive and:

- **Timely** – responsive to current needs of participants
- **Accessible** – available to those who need it, when they need it
- **High quality** – evidence-based and meaningful to participants
- **Relevant** – aligned with the lived experiences and goals of participants
- **Delivered in a safe environment** – where participants feel secure and able to engage

Rehabilitation in California State Prisons

In 2005, California enacted SB 737, which restructured the state's correctional system and renamed the California Department of Corrections as the California Department of Corrections and Rehabilitation (CDCR), reflecting a renewed focus on rehabilitation.[3] In October 2023, AB 1104 clarified that rehabilitation, not punishment, is the primary purpose of incarceration in California.[4] Aligned with international best practices and the Medical Receiver's initiatives to improve correctional healthcare, this shift toward rehabilitation recognizes that the deprivation of liberty should be the only punitive element of incarceration. Everyday life inside prison should focus on rehabilitation, including programming that promotes health, wellness and public safety.

The Population in California State Women's Prisons

As of June 30, 2025, California housed 3,197 individuals in its state prisons—1,962 at the Central California Women's Facility (CCWF) and 1,235 at the California Institution for Women (CIW).[5] This population includes transgender and nonbinary individuals who are increasingly represented in women's facilities and housed based on a combination of personal preference and CDCR oversight. As of June 30, 2025, the women's prisons population in CDCR included 59 nonbinary individuals and 237 male-identifying transgender individuals at CCWF and 62 nonbinary individuals

1 "Health and Well-Being." *World Health Organization.* https://www.who.int/Data/Gho/Data/Major-Themes/Health-and-Well-Being

2 "Creating a Healthier Life: A Step-by-Step Guide to Wellness." *Substance Abuse and Mental Health Services Administration.* 2016. https://library.samhsa.gov/sites/default/files/sma16-4958.pdf

3 California Legislature Reorganizes DOC to Add Rehabilitation." *Prison Legal News.* 06/15/06. https://www.prisonlegalnews.org/news/2006/jun/15/california-legislature-reorganizes-doc-to-add-rehabilitation/

4 AB 1104: Rehabilitation and Reentry Prep for Incarcerated People." *Alameda Post Inc*. October 13, 2023.

5 "Monthly Report of Population as of Midnight June 30, 2025." Division of Corrections and Rehabilitation Office of Research, *California Department of Corrections and Rehabilitation*. July 1, 2025. https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2025/07/Tpop4_d2506.pdf

and 109 male-identifying transgender individuals at CIW.[6] We were not able to access data on the number of female-identifying transgender individuals.

Nationally, over 90% of incarcerated women have experienced victimization or trauma.[7] Women are more likely than men to be incarcerated for crimes linked to substance use and mental illness.[8] Transgender and nonbinary individuals also report high rates of trauma and victimization,[9] and experience high rates of substance use disorder[10,11] and mental illness,[12] leading to complex behavioral health needs.

Applying a trauma lens to programming in women's prisons is imperative to maximize positive outcomes and facilitate rehabilitation. Research has identified three ways that programming within the carceral system must address trauma in order to be successful.[13,14] These include being: 1) trauma-informed—knowing about adversity and trauma and their impacts on individuals, communities and societies; 2) trauma-responsive—ensuring that policies and practices are in place to minimize damage and maximize healthy growth and; 3) trauma-specific—providing services that specifically address violence, trauma and related systems and that facilitate healing and recovery. While we use the term "trauma-informed" throughout this report we are referring to the multiple approaches that programming in women's prisons must employ in order to successfully address trauma and support rehabilitation.

Gender-responsive programming reduces recidivism and increases retention in treatment following release.[15] It is imperative that gender-responsive programming acknowledges and incorporates the different experiences of people across the gender spectrum. A gender-responsive approach should consider the role of prior abuse in women's substance use and should integrate treatment addressing trauma, substance use, and mental health.[16] Gender-responsive approaches must be trauma-informed, responsive and specific, and consider the gendered pathways that lead women to crime. Effective programming in women's facilities must also reflect gender-specific needs such as parenting, intimate partner violence, financial literacy, anger management, trauma recovery, substance use, and mental health.

6 "Monthly Report of Population as of Midnight June 30, 2025." Division of Corrections and Rehabilitation Office of Research, *California Department of Corrections and Rehabilitation.* July 1, 2025. https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2025/07/Tpop4_d2506.pdf

7 Women's Justice: A Preliminary Assessment of Women in the Criminal Justice System. *Council on Criminal Justice.* July 2024. https://counciloncj.org/womens-justice-a-preliminary-assessment-of-women-in-the-criminal-justice-system

8 Miller H. "FY 2020 Report to Committees on Appropriation. Formerly Incarcerated Women and Reentry: Trends, Challenges, and Recommendations for Research and Policy." Office of Justice Programs, *NIJ*. October 2021. https://www.ojp.gov/pdffiles1/nij/303933.pdf

9 James S, Herman J, Rankin S, Keisling M, Mottet L, et al. "2015 U.S. Transgender Survey." *US Trans Survey.* December 2016. https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

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12 Kidd J, Tettamanti N, Kaczmarkiewicz R, et al. "Prevalence of substance use and mental health problems among transgender and cisgender U.S. adults: Results from a national probability sample." *Psychiatry Research.* August 2023.

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14 Covington S., (2025). *Using a Trauma Lens on the Criminal Legal System for Women.* Oxford University Press.

15 Women's Health Care in Correctional Settings." *National Commission on Correctional Health Care*. 2020. https://www.ncchc.org/position-statements/womens-health-care-in-correctional-settings-2020/

16 Gobeil R, Blanchette K, Stewart L. "A Meta-Analytic Review of Correctional Interventions for Women Offenders: Gender-Neutral Versus Gender-Informed Approaches." *Criminal Justice and Behavior.* January 13, 2016.

Report Series

This report is the first in a 3-part series that includes:

- **Programming:** Opportunities to Optimize Programming to Support Health and Wellness in California's Women's Prisons
- **Best Practices:** Emerging Innovations to Optimize Women's Health, Wellness and Empowerment in Prison
- **Staff Training:** Strengthening the Women's Prisons Workforce: Recruitment and Training

While CCHCS' purview includes most of health and wellness, there are additional outside factors—e.g., education and vocational attainment—that also shape health and wellness. Therefore, while this report focuses on opportunities to maximize CCHCS programming, it also includes some additional CDCR programs that address health and wellness.

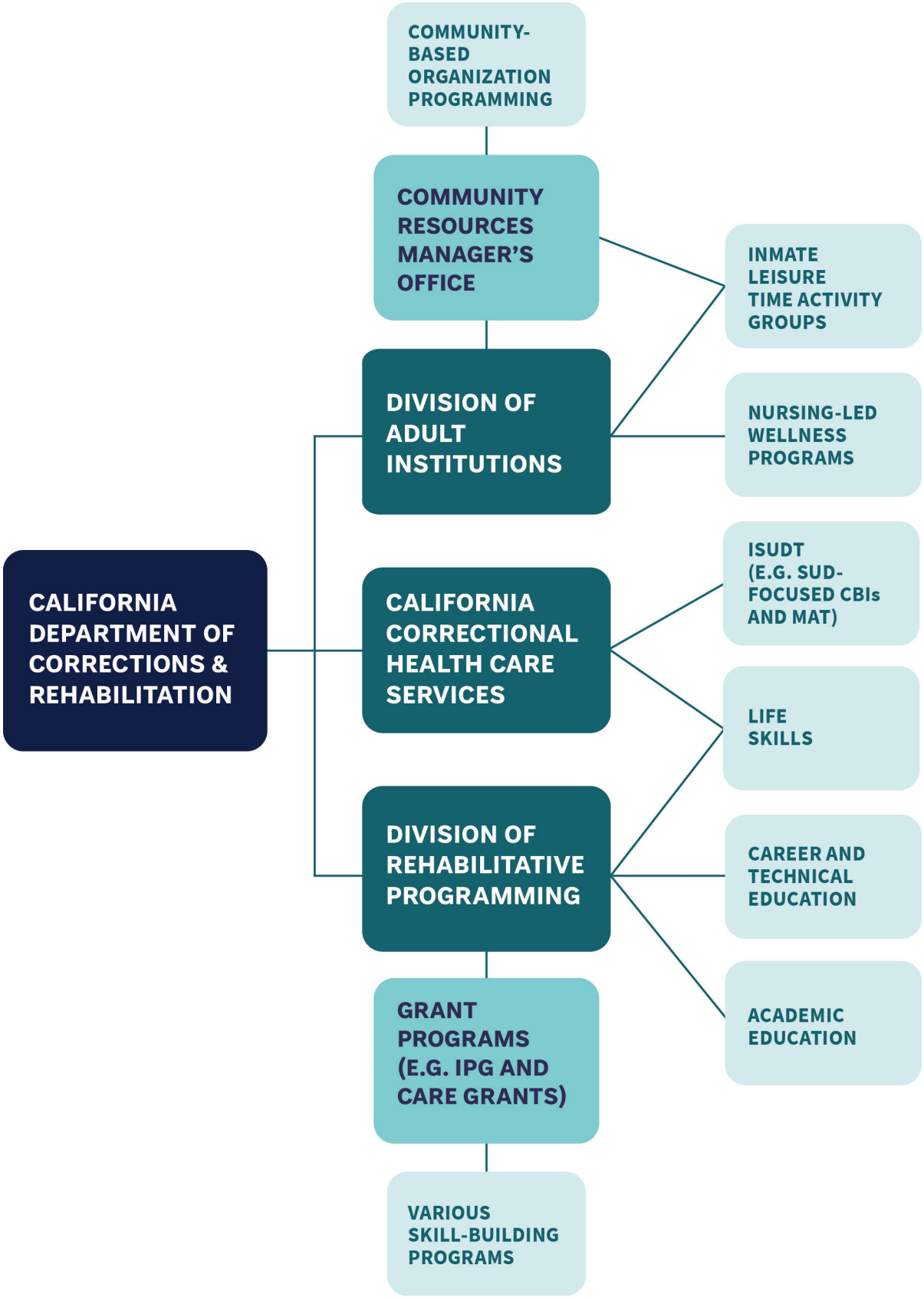
Many of the report's recommendations are operational, since improving access to high-quality programming is essential to advancing health and wellness. Some system-level changes, if addressed, could put California's women's prisons on the path to being a national model for women's health, wellness, and empowerment.

The recommendations in this report draw on a range of sources, including a literature review, interviews with leaders from 9 CBOs currently operating in California prisons, and conversations held during in-person visits at the Central California Women's Facility (CCWF) and the California Institution for Women (CIW) with both staff [17] and incarcerated persons.[18]

17 CDCR staff across the following units/divisions: Leadership/The Warden's Office, Administrative teams, Health care services, Division of Rehabilitative Programs, Classification and Parole, Community Resources Manager offices, Reception and Receiving, Receiving and Release, Education, Family Support, Vocation, ISUDT, and the ADA office.

18 We conducted focus groups with the Inmate Advisory Councils (IAC), older adults, people sentenced to life without parole, newly arrived individuals, peer support counselors, LGBTQ+ individuals, people designated as 'C status', people housed in the EOP unit, people housed in the skilled nursing facility step-down units, people in the honor unit, and non-English speakers.

Figure 1: Programming Offered within CDCR



Section 1. Reimagine California's Women's Prisons to Prioritize Health and Wellness

California's robust CBO-led programming in women's prisons positions the state to redefine daily life during incarceration to center on coordinated approaches to healing, education, and empowerment. A new vision should integrate CBO-led and CDCR-provided services while addressing critical gaps through a centralized Health and Wellness Center at each facility.

RECOMMENDATIONS

1.1 Establish a dedicated Health and Wellness Center in each women's prison

1.2 Deliver comprehensive, gender-responsive, trauma-informed Health and Wellness Services

1.3 Implement a structured, personalized, and collaborative learning model

1.1 ESTABLISH A DEDICATED HEALTH AND WELLNESS CENTER IN EACH WOMEN'S PRISON

Introducing a centralized, trauma-informed Health and Wellness Center within each women's prison, designed with input from incarcerated individuals, should aim to create a transformative space rooted in dignity, community, rehabilitation, healing and care. These centers should consolidate wellness initiatives, promote health, empowerment and personal growth, and foster community connection.

The development of dedicated Health and Wellness Centers offers CDCR a critical opportunity to establish criteria for program review to ensure all Center offerings are evidence-based (where possible), trauma-informed, and responsive to participants' needs. To develop and implement these criteria, CDCR should convene a Governing Board with authority to evaluate and vet existing programs and proposed programs before they can operate through the Center. The Board should begin meeting at least one year before each Center opens to assess programs and inform key hiring decisions including the Health and Wellness Coordinator position, ensuring these centers function as dignified spaces rooted in rehabilitation, healing, and care.

The infrastructure of health and wellness centers should include:

- Gender-Responsive, Trauma-Informed Physical Spaces – including calming, noise-dampening, and non-institutional aesthetics, shaped with input from incarcerated individuals and community-based organizations that provide programming.
- Multidisciplinary Teams – trained in trauma-informed and gender-responsive care, including clinicians, educators, paid peer navigators, Health and Wellness Coordinators, and CBO staff.
  - » Paid Peer Navigators should be a required team component, trained using community health worker models similar to patient navigators. Managed by Health and Wellness Coordinators, they would provide operational capacity and a specialized role given their expertise and experience. It will be critical that attention is paid to developing and maintaining an appropriate scope to avoid undue burden during their own incarceration.[19, 20]

19 We understand that nomenclature for paid peer mentors and navigators is variable throughout the department, terms include: peer mentor, peer advisor, peer facilitator. We believe the closest community comparison to the role envisioned here is a peer navigator.

20 Peer Navigators could be Peer Support Program workers who receive additional training in health and wellness since they will be assigned to support the Health and Wellness Centers.

- » Health and Wellness Coordinators should be established as a full-time non-custody job classification with minimum qualifications of a masters degree in counseling, social work, or a related field. While positions for individuals with degrees such as a Masters of Social Work or Masters in Marriage and Family Therapy may be harder for CDCR to fill, their expertise makes them well suited for this position as they have unique trainings that other, lower-level classifications do not have—e.g., an understanding of the unique forces that affect the health and wellness of people incarcerared in women's prisons, what service and referrals they need, and thus how to develop their individualized rehabilitation plans. Also trained in de-escalation and safe restraint techniques like youth residential facility staff, these supervisors would minimize the need for uniformed correctional presence and foster a healing-centered environment.

- Governance and Accountability Structures – to ensure oversight, transparency, and responsiveness to community needs:
  - » Establish a governing board comprised of formerly incarcerated individuals, behavioral health professionals, educators, leaders of coalitions of CBO programs operating in California prisons (i.e., TPW and/or a similar program if one exists), and retired CCHCS/CDCR staff.
  - » Empower the board to provide input on program design, review outcomes, and comprehensively evaluate the Health and Wellness Centers every 2–3 years.
  - » Include a modest stipend for board members funded through CDCR's allocation for programming to recognize their time and expertise.
  - » Require regular reporting on participation, outcomes, and access, with results made publicly available to build trust and accountability.
  - » Create formal channels for incarcerated individuals to share feedback and influence programming, ensuring the Centers remain responsive to needs.

ACTION STEPS

ISSUE:	RECOMMENDATION:
Women's prisons lack centralized, gender-responsive and trauma-informed spaces that prioritize health and wellness.	Establish a dedicated Health and Wellness Center at each women's prison; this would ideally (at least initially) be a repurposing of existing space.

Action Area	Action Steps
Gender-Responsive, Trauma-Informed Physical Spaces	Ensure the space is gender-responsive, trauma-informed, culturally relevant and designed with input from incarcerated people.
	Include calming, non-institutional aesthetics—e.g., quiet spaces, communal areas, and access to technology.
Health and Wellness Center Staff	Establish a Health and Wellness Coordinator role.
	Employ multidisciplinary staff teams within the Center.
Governance and Accountability Structures	Form a Governing Board at least one year before the opening of the Center and ensure that it meets regularly.

Action Area	Action Steps
Governance and Accountability Structures *(continued)*	The responsibilities of this Governing Board will be to assess the Health and Wellness Center's development and implementation, the quality and appropriateness of CDCR and CBO-led programs, the hiring of new staff, and to inform the funding appropriations for CBO-led programs.

1.2 DELIVER COMPREHENSIVE, GENDER-RESPONSIVE, TRAUMA-INFORMED HEALTH AND WELLNESS SERVICES

Once Health and Wellness Centers are established, their impact depends on the quality and range of services provided. Programming should foster healing, skill-building, and reentry readiness, while ensuring accessibility for all incarcerated individuals. Services must reflect lived experience, cultural relevance, and the needs of women in prison. See Figure 2 below.

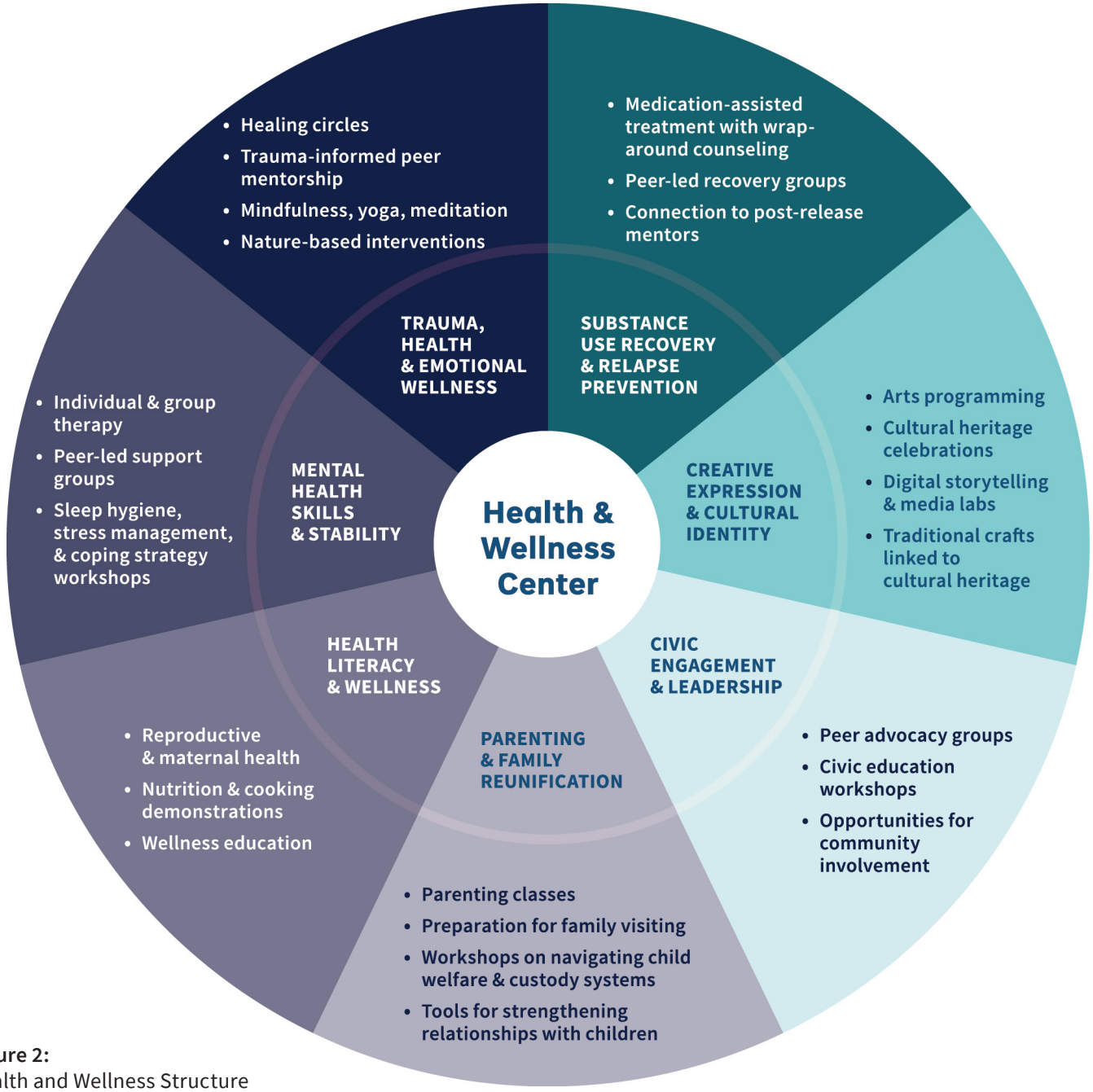


Figure 2:
Health and Wellness Structure

Health and Wellness Center Program Requirements

Since most people incarcerated in women's prisons have experienced trauma, evidence-based, foundational programming that addresses trauma should be offered to everyone. Other programs should be mandatory for certain people based on their needs and experiences—e.g., classes on parenting or domestic violence. Decisions about which programs should be required and offered to women at the outset of their sentence should be decided by a governing body that includes experts in trauma-informed and trauma-specific care and mental health treatment.

Attending Programs and Classes

Some courses, such as those led by CBOs or nursing staff, require a set time during each person's individualized rehabilitation plan (see Section 2). Required programming should be supplemented by "drop-in" health and wellness activities that can be attended during free time. Examples could include yoga, meditation, journaling or painting, while weekly classes might include nutrition, cooking or financial literacy.

- Exercise and Wellness Programming. To support wellness through exercise, implement staggered gym schedules across facilities ensuring universal access. Instructors should offer identical classes multiple times daily to accommodate varying schedules.
- Expanded Drop-In Model. Also apply this drop-in framework to pre-release planning services, including video calls with external providers for insurance enrollment, job interviews, and housing assistance. Post sign-up sheets one week in advance at the Health and Wellness Center and make them accessible via tablets.

ACTION STEPS

ISSUE:
Women in prison often lack access to consistent, coordinated, and trauma-informed health and wellness services that address their needs. Existing programming is fragmented, not always culturally relevant, and frequently offered only to those nearing release.

RECOMMENDATION:
Deliver a comprehensive range of trauma-informed, gender-responsive health and wellness services within the Centers that foster healing, build skills, and prepare individuals for successful reentry, regardless of sentence length.

Action Area	Action Steps
Gender-Responsive Services and Wellness Activities	A governing board that includes experts in trauma-informed and trauma-specific care and mental health (See Recommendation 1.1) should decide: • Which programs should be required "Core Programming" and taken by all incarcerated individuals. • Which programs should be offered to all women at the outset of their sentence.
	Ensure that the programming CDCR and CBOs offer is evidence-based and trauma-informed and trauma-specific (e.g., addressing PTSD, grief, domestic violence). This "core programming," will require that programs (and staff delivering programs) reflect knowledge of women's pathways into incarceration.

Action Area	Action Steps
Gender-Responsive Services and Wellness Activities *(continued)*	Ensure availability of culturally relevant and gender-responsive supports, such as peer mentorship programs, parenting groups, and healing circles that build trust and foster community.
	Develop a menu of programs that are evidence-based to support incarcerated individual rehabilitation plans and goals (see Section 2).
	Offer accessible, drop-in wellness activities e.g., physical fitness and yoga, meditation, and peer-led support circles.
Pre-Release Preparation	Equip Centers with computers and peer navigators to assist with job interviews, benefits enrollment, and housing searches.
	Facilitate partnerships with other state agencies for support (e.g., parental rights and custody cases).
	Provide clothing closets for family visits, job interviews, and pre-release transitions.
Community Partnerships and Philanthropy	Collaborate with philanthropic organizations, universities, and public health institutions to design, fund, and evaluate the effectiveness of the Health and Wellness Centers.
	Expand access to fresh produce and nature through initiatives like farmers' markets and gardening programs.
Restorative Spaces	Provide areas for mindfulness, journaling, and art.
Tablets	Leverage tablets for self-directed learning as an addition to, but not as a substitute for, in-person group work.
	Publish, and offer on tablets, a program calendar of available programs and specify which are available on a drop-in basis.

1.3 IMPLEMENT A STRUCTURED, PERSONALIZED, AND COLLABORATIVE LEARNING MODEL

Programming in a Health and Wellness Center should be designed and scaffolded like higher education, with courses progressing from foundational ("100-level" courses) to advanced ("400-level") content. While participants should be able to shape their wellness journey based on personal interests and goals, foundational skills (like substance use recovery, literacy, and addressing trauma) should be prioritized. A trained Health and Wellness Coordinator should be available to help each person to develop their personalized wellness plan. This plan should reflect their goals, learning style, and wellness activities. The result should be a responsive and accountable health and wellness plan with clear milestones.

Core Wellness Pathways

To effectively organize and coordinate programming and services within a Health and Wellness Center, CDCR should develop Core Wellness Pathways, modular programs that build toward tangible skill development (including leadership and empowerment), and reflect the intersectional needs of incarcerated individuals.

Sample wellness pathways might include:

1. **Trauma Healing & Emotional Wellness**
2. **Parenting & Family Reunification**
3. **Civic Leadership & Advocacy**
4. **Creative Expression & Cultural Identity**
5. **Health Literacy**
6. **Substance Use Recovery & Resilience**
7. **Mental Health Skills & Stability**
8. **Exercise & Wellness**

Each pathway should be co-designed with experts, including educators (from the University of California, California State University, or California Community College systems), clinical professionals, peer mentors, formerly incarcerated people, and CBOs to ensure relevance, trust, and alignment with best practices. (See Appendix A2 and A3 for more detailed sample wellness pathways.)

Introduce Individualized Wellness Pathways

Many incarcerated women experience interrupted education, learning differences, trauma-related challenges, or language barriers. To meet these needs, all programming should be differentiated and designed using Universal Design for Learning principles.[21]

Supports should be integrated into the health and wellness pathways offered at the Health and Wellness Center to ensure that participants, regardless of background or ability, have the opportunity to engage, grow, and succeed. Services should include:

- Feedback through peer mentorship and tutoring
- Trauma-informed teaching approaches
- Multilingual and culturally relevant instructional materials
- Flexible pacing in response to findings from learning difference assessment tools
- Accessible instructional design and technological accommodations
- Learning designed for relevance to interests and aligned with values.

Leveraging the Expertise of the Health and Wellness Center Team to Maximize the Impact of the Proposed Center and its Programming

- **Individualized Wellness Pathways.** Implement needs and strengths screening for all individuals—both newly arrived and currently incarcerated. The Health and Wellness Center team should collaborate with the Governing Board to establish a screening schedule and system for those who are already incarcerated. Gather data on completed programs, education, and parole hearing recommendations where applicable. Prioritize individuals with the longest remaining sentences for screening and wellness plan development.
- **Peer Navigator Role.** The peer navigator position is critical to program success. Training navigators using the Community Health Worker model enables them to:
  - » Collaborate with Health and Wellness Coordinators to develop Core Wellness Pathways

21 Cast. “The University Design for Learning (UDL) Guidelines”. https://udlguidelines.cast.org

» Support individuals in staying engaged with programming

» Intervene when barriers arise (e.g., meeting with individuals who have high absences to identify needed support)

Similar peer navigator programs have proven successful in other correctional settings, including a decades-long New Mexico initiative that trains incarcerated individuals as peer educators on substance use risks and health system navigation[22] and is currently being deployed successfully at San Quentin Rehabilitation Center.

Delivery of Programs and Classes

- Given differences in learning styles, schedules and accessibility, multiple approaches should be offered to deliver courses at the Health and Wellness Centers. For example, while in-person classes should be the norm, remote access via personal tablets for pre-recorded classes (e.g., yoga, guided meditation, art) should be offered as well.

ACTION STEPS

ISSUE:
People struggle to progress through programming in a meaningful way and often face barriers to accessing programs that support their rehabilitation.

RECOMMENDATION:
Develop Core Wellness Pathways within the Health & Wellness Centers that are accessible in multiple formats to meet diverse learning styles, interests, and needs.

Action Area	Action Steps
Progressive Wellness Pathways	Design scaffolded pathways to progress from foundational to advanced program offerings.
Flexible and Accessible Delivery	Offer a mix of scheduled and drop-in classes.
	Provide multiple learning formats (e.g., self-paced modules, tablet-based courses, in-person instruction) to accommodate different learning styles and schedules.
Individualized Wellness Plans	Embed programming within each person's individualized wellness plan to track progress and align courses with goals and milestones.
	Ensure that wellness pathways support skill-building and wellness objectives.

22 New Mexico Peer Education Project. https://iecho.org/echo-institute-programs/nm-peer-education/

Section 2. Develop Dynamic, Individualized Rehabilitation Plans and Ensure Programming Addresses Individuals' Unique Needs and Strengths

Access to programming during incarceration reduces recidivism.[23,24] However, the impact of rehabilitative programs is limited when they do not align with life experiences, health status, or rehabilitative goals. Residents' needs vary based on factors such as time since arrival, sentence length, life circumstances (e.g., being a parent), and histories of trauma, mental health conditions, or substance use disorder.

For programming delivered through Health and Wellness Centers to facilitate rehabilitation, a comprehensive approach to assessing individuals' assets and needs must be deployed to determine which programs can best serve them.[25] While validated assessment tools often guide prison-based classification and case management, most were developed for men and fail to account for the unique pathways that lead women (and nonbinary or transgender individuals) into incarceration.[26,27] While gender-neutral, evidence-based approaches have shown positive results for both men and women, gender-responsive programming that addresses women's specific pathways to incarceration and rehabilitation has greater positive impacts for women.[28,29]

Best Practices in Correctional Programming[30] Emphasize the Need to:

- Conduct a needs assessment to ensure the program aligns with the target population, and
- Use curricula that have been evaluated in the target population

To Achieve Maximum Impact,[31] Prisons Must Have:

- Staff with adequate time and capacity who are trained to deliver programming, and
- Processes for evaluation, including assessing quality and participant feedback.

As individuals gain new tools, skills, and insights, their needs change and individualized rehabilitation plans should be regularly updated to reflect that growth. These individualized plans should ensure programming remains responsive and timely while anticipating critical transitions, such as preparation for the Board of Parole Hearings or release.

23 Esperian, J. "The Effect of Prison Education Programs on Recidivism." *Journal of Correctional Education.* December 2010.

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26 Belisle L, Parker K, Trejbalová T, Kelly B, Salisbury E. "Advances in female risk assessment." In S. L. Brown & L. Gelsthorpe (Eds.). *The Wiley Handbook On What Works With Girls And Women In Conflict With The Law: A Critical Review Of Theory, Practice, And Policy* (p 89–101). Wiley Blackwell. https://doi.org/10.1002/9781119874898.ch7

27 Cobbina J. "Reintegration Success and Failure: Factors Impacting Reintegration Among Incarcerated and Formerly Incarcerated Women." *Journal of Offender Rehabilitation.* March 24, 2010. https://doi.org/10.1080/10509671003666602

28 Gobeil R, Blanchette K, and Stewart, Lynn. "A Meta-Analytic Review of Correctional Interventions for Women Offenders: Gender-Neutral Versus Gender-Informed Approaches." *Criminal Justice and Behavior.* January 13, 2016. https://doi.org/10.1177/0093854815621100

29 Summers R, Pemberton S, Long J. "Examining the effectiveness of interventions for Criminal Justice-Involved Women." *Criminal Justice and Behavior.* March 2025, 1-26.

30 Ross R, Gendreau P. "Program Structure and Effective Correctional Practices: A Summary of CaVIC (Canadian Volunteers in Corrections) Research. Effective Correctional Treatment." *Law Reform Commission of Canada.* 1980 (p 441-463).

31 Dowden C, Andrews D. "The Importance of Staff Practice in Delivering Effective Correctional Treatment: A Meta-Analytic Review of Core Correctional Practice." *International Journal of Offender Therapy and Comparative Criminology.* 2004.

RECOMMENDATIONS

- **2.1 Implement gender-responsive, trauma-informed assessment tools to inform individualized health and wellness programming**
- **2.2 Create individualized rehabilitation plans that reflect individuals' dynamic health and wellness needs over time**
- **2.3 Ensure programming is responsive to the health and wellness needs of individuals incarcerated in women's prisons**
- **2.4 Develop and deliver parole board readiness programming and adjust each person's individualized rehabilitation plan following parole board hearings to comply with board requests**
- **2.5 Optimize health and wellness programming opportunities for non-English speakers**
- **2.6 The tailoring of a program should not be shaped by the desire to obtain Rehabilitative Achievement Credits (RAC) accreditation**

2.1 IMPLEMENT GENDER-RESPONSIVE, TRAUMA-INFORMED ASSESSMENT TOOLS TO INFORM INDIVIDUALIZED HEALTH AND WELLNESS PROGRAMMING

Standard risk and needs assessment tools often misclassify women, usually by overestimating risk. This leads to inappropriate housing placements, reduced access to rehabilitative programming, and ineffective rehabilitation planning.[32] The Women's Risk Needs Assessment (WRNA) was developed to address these limitations. It is validated, gender-responsive, trauma-informed, and designed to identify individual needs and strengths.[33] The United Nations Office on Drugs and Crime[34] and the National Institute of Corrections[35] recommend using tools like the WRNA in women's correctional settings. CDCR administers the California's Correctional Offender Management Profiling for Alternative Sanctions" ("COMPAS") during intake to assess needs and risk. However, this tool is not designed to guide program placement nor tailored to women or gender-diverse populations in prison.[36] During interviews, some staff indicated that portions of the WRNA may be used during intake, but it is unclear whether staff are trained or certified to properly administer and interpret the tool. Even when assessments are conducted, the results do not appear to inform individualized programming or rehabilitation.

ACTION STEPS

ISSUE:	RECOMMENDATION:
CDCR's needs assessment process is not gender-responsive.	Implement gender-responsive assessment tools.

32 Wainstein E. "The Need for Fairness and Accuracy for Women in Sentencing: Surmounting Challenges to Gender-Specific Statistical Risk Assessment Tools." UC Berkeley. *JCLC Online*. 2023. https://scholarlycommons.law.northwestern.edu/cgi/viewcontent.cgi?article=1032&context=jclc_online#

33 Salisbury E, Boppre B, Kelly B. "Gender-Responsive Risk and Need Assessment Implications for the Treatment of Justice-Involved Women." *Handbook on Risk and Need Assessment: Theory and Practice* (1st Edition). 2016. Routledge.

34 "Handbook on The Classification of Prisoners." United Nations Office on Drugs and Crimes. May 2020. https://www.unodc.org/documents/dohadeclaration/Prisons/HandBookPrisonerClassification/20-01921_Classification_of_Prisoners_Ebook.pdf

35 "WCSS Toolkit." National Institute of Corrections. *Dept of Justice.* May 26, 2023. https://nicic.gov/collection/wcss-toolkit

36 An independent assessment of COMPAS commissioned by the CDCR (conducted by UC Davis Center for Public Policy Research) found COMPAS does not reliably assess criminogenic needs nor recidivism risk. It noted *"Given the current state of evidence, we cannot recommend that CDCR utilize COMPAS with individual offenders."* [Skeem J, Louden J. "Assessment of Evidence on the Quality of the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS)." Center for Public Policy. 12/26/07. https://bpb-us-e2.wpmucdn.com/sites.uci.edu/dist/0/1149/files/2013/06/CDCR-Skeem-EnoLouden-COMPASeval-SECONDREVISION-final-Dec-28-07.pdf

Action Area	Action Steps
Gender-Responsive Assessment Tools	Implement tools like the WRNA to assess criminogenic risk, needs, and individual strengths.

2.2 CREATE INDIVIDUALIZED REHABILITATION PLANS THAT REFLECT INDIVIDUALS' DYNAMIC HEALTH AND WELLNESS NEEDS OVER TIME

The 2024 report "*Reimagining San Quentin*,"[37] developed for Governor Newsom, recommends introducing a "Rehabilitation and Reentry Plan" (referred to herein as an "individualized rehabilitation plan") from the first day of incarceration to help residents identify and access programs that support their rehabilitation. These plans should be tailored and realistic (e.g., starting with shorter educational sessions, or prioritizing trauma-informed programming before engaging in full-time work). This approach should reflect the international principle of "normalization" and trauma-informed practice by empowering incarcerated individuals to participate in developing their own rehabilitation plan, a practice that is beneficial to successful reentry.[38]

Residents at CCWF and CIW express a need for structured, individualized support from staff to identify relevant programs and build effective schedules for themselves. They also report:

- A lack of guidance on available programs and how to prioritize them.
- Having limited information on waitlists or how CBO-led programs relate to CDCR-mandated programming.
- Signing up for multiple programs without a clear strategy, just to stay busy.

Balancing Work and Programming is Challenging

Residents struggle with schedules that make it challenging to balance work, mandatory programming and CBO-led programs.

- Aligning work schedules with programming opportunities is difficult. Although CDCR has reduced most work assignments from 8 to 4 hours, conflicts persist, especially for those engaged in "Double or triple programming" (e.g., work, education, vocational training and/or CBO programs). Moreover, work schedules can shift unexpectedly, and people are sometimes reassigned to jobs that conflict with their programming.
- CBOs find it difficult to provide evening programming due to the often long distances required to travel back to their home county late at night.
- The logistics of travelling between work, programming and other activities present barriers. There is typically little time between work and programming, and long distances across the prison compound cause delays. Residents often must return to their housing units to drop off items restricted at their next activity (e.g., a school laptop at work or food at an education class), adding further delays.
- At CCWF, the mandatory 'work change' security checkpoint can take up to 30 minutes, causing lateness that cannot be controlled by residents. Nonetheless, such delays can result in disciplinary write-ups and removal from programming.

37 Williams B, Bond D, Steinberg D. "Reimagining San Quentin: Recommendations to Transform San Quentin State Prison into a Rehabilitation Center." *San Quentin Transformation Advisory Council.* January 2024. Note: given overlap in authorship between the San Quentin Advisory Council Report and this report, and to optimize consistency across programming recommendations to CDCR, we made an effort to use similar language in both reports.

38 Van de Rijt J, Ginneken E, Boone M. "Normalisation by default and normalisation by design: A systematic review of empirical studies on the normalisation of prison life." *Incarceration*. August 30, 2023. https://journals.sagepub.com/doi/full/10.1177/26326663231196671

ACTION STEPS

ISSUE:
Need for individualized rehabilitation plans that shift to meet people's evolving needs over time.

RECOMMENDATION:
Implement individualized, realistic, and empowering rehabilitation plans that change alongside the needs of individuals

Action Area	Action Steps
Collaborative Intake Process	Upon arrival, each person should meet with the following people to develop an individualized rehabilitation plan: • A correctional counselor • A Health and Wellness Coordinator • A representative from the CRM's office • A paid peer navigator who describes how to access and navigate programs
Personalized Rehabilitation Plans	Develop a personalized rehabilitation plan for each resident.
	Guide individuals to inform and update their own Individualized Rehabilitation Plan.
	Match individuals with programs aligned to their health and wellness needs and goals.
	Rehabilitation Plans should include and integrate programs offered by CDCR, peer navigators and CBOs.
	Each plan should be: • Reviewed annually at a minimum • Revisited at key transition points (e.g., parole board preparation) • Used by residents to reflect, set new goals, and adjust course
Alignment of Programming With Essential Activities	Schedule CBO- and nursing-led programs to minimize conflicts with treatment, essential services, or work assignments.
	Ensure adequate transition time between activities, allow time to return to housing units to comply with property restrictions.
	Give health and wellness programming (including CBO programming) the same level of importance as education and vocational activities.
	Pilot flexible work and programming shifts, including staggered sessions and alternative time blocks (e.g. "triple programming").

Action Area	Action Steps
Alignment of Programming With Essential Activities *(continued)*	Work with the CBO Advisory Council (Section 3.2) to develop innovative and out of the box approaches to managing and offering work and programming options outside of the traditional 8am-4pm schedule.

2.3 ENSURE PROGRAMMING IS RESPONSIVE TO THE HEALTH AND WELLNESS NEEDS OF INDIVIDUALS INCARCERATED IN WOMEN'S PRISONS

At CIW and CCWF, many pressing needs are not addressed by the current suite of program offerings. Most program assignments are not tailored to individual needs, including by sentence type and time served. With the exception of initial screenings for education level and substance use history, few programs prioritize alignment with personal characteristics such as age, parental status, physical capacity, needs, or trauma history. In order to maximize the likelihood of rehabilitation and success upon release, it is imperative to minimize barriers to accessing health and wellness programming. Key challenges include:

Lack of Prioritization for High-Need Individuals

- Sometimes people cannot access programs when they need them most. For example, parenting classes have long waitlists (e.g., 2,000+ people at CCWF), making it nearly impossible for people with minor-aged children to access them (sometimes for years). No prioritization system seems to be in place for people who are actively parenting.
- Notable, positive exceptions to the waitlist prioritization problems are the screenings for educational achievement and substance use history, which are both effectively used to prioritize access to academic and ISUDT-related programming.

Insufficient Attention to the Need of Young People within Women's Prisons

- We heard from people who are incarcerated and CBOs that there needs to be increased attention to the needs of young people who are incarcerated, including tailoring existing programming and adding new programs. There has been years of focus on "Young Offender Program" (YOP) for males within CDCR but there is little corresponding programming for young people in women's prisons.

Insufficient Accommodation for Older Adults and Those with Health Conditions

- Many residents with physical or cognitive limitations are unable to meaningfully participate in standard programs, but few modified or alternative options are offered.

Limited and Non-Inclusive Programming for LGBTQ+ Individuals

- Programming rarely addresses common experiences or trauma histories of LGBTQ+ residents—a few exceptions include Healing Trauma+ and Beyond Violence +.

Lack of Programming in Essential Life Skills

- Residents identify a need for more programs focused on anger management, victim impact, domestic violence, parenting and family reunification, and financial literacy. These courses were also frequently requested by the Board of Parole Hearings. Yet, these offerings are either limited or oversubscribed.[39]

Program Offerings Do Not Evolve with Individual Progress

- As residents advance through their rehabilitation, their needs and interests shift. Yet programming options remain largely static, often failing to adapt to personal growth, aging, or new rehabilitative goals.

39 CDCR's Life Skills programming is open to all incarcerated people based on their time to serve.

Inadequate Response to Broader Societal Changes

- Programs rarely integrate technological advancements in the community.
- Residents express interest in learning digital skills, including basic computer use, coding, and artificial intelligence, but such opportunities remain largely unavailable.

Access to Existing Programming is Sometimes Restricted Based on Sentence or Time Served

- Limited access for newly-arrived individuals
  - » Residents who recently entered the facilities (especially those with active or historical substance use) report urgent needs for supportive programming (e.g., Alcoholics Anonymous, Narcotics Anonymous, or trauma-focused groups).[40]
  - » Long waitlists and barriers to enrollment can leave new arrivals idle and isolated, exacerbating risks of relapse, mental health deterioration, or rule violations.
  - » According to medical staff, sometimes residents with known substance use disorders and repeated overdoses are not prioritized for ISUDT.[41]
- Program ineligibility for people with indeterminate or life sentences
  - » Residents serving life without parole sentences reported being excluded from vocational training, under the assumption that they will not need job skills post-release.
  - » This same population is frequently deprioritized for rehabilitative programs despite a demonstrated interest and potential benefit for personal development and positive institutional behavior.
  - » Statewide policy changes can result in unexpected eligibility for release, such that anyone would benefit from such programs.

ACTION STEPS

ISSUE:
Many needs of people in women's prisons remain unmet by the current suite of programs, and some people are excluded from certain programs—e.g., based on sentencing and stage of incarceration.

RECOMMENDATION:
Expand and adapt programming to address the diverse and evolving needs of people incarcerated in women's prisons.

Action Area	Action Steps
Alignment of Needs to Programs	Provide programs that address specific needs and experiences, including by age (e.g., YOPs), life stage, trauma history, gender-identity, health, parental status, and sentencing.
	Adapt or introduce new offerings for older adults and people with disabilities.
	Use need-based tools to prioritize access.

40 CDCR's Peer Support Program could be used to offer targeted support to newly arrived individuals.
41 According to CDCR, CBI placement is based on MAT and SUD risk, and placement is automated by quality management.

Action Area	Action Steps
Life Skills	Strengthen and expand life skills programs: e.g., financial literacy, anger management, nutrition, domestic violence prevention, and family reunification.
Progression Pathways	Develop and organize programming offerings to advance with rehabilitation stages, from foundational skills to advanced, therapeutic, leadership, and mentorship opportunities.
Future Readiness	Regularly update curricula to reflect societal and technological change, including digital communication and emerging technologies (e.g., AI).
Rapid Access for New Arrivals	Rapidly engage new arrivals through fast-track enrollment based on urgent needs (substance use, mental health conditions, trauma) and provide peer/staff support to reduce isolation.
Equitable Access Across Sentences	Ensure all incarcerated individuals, regardless of sentence, can participate in programs aligned with their rehabilitation needs and goals.
	Prioritize participation based on individual need and readiness, not solely on release dates.
Outreach and Consistency in Program Announcement	Mandate consistent communication of program availability through flyers, tablets, CRM bulletins, IAC announcements, and unit staff briefings.
	Ensure updated program listings are visible in housing units and common areas in multiple languages.

2.4 DEVELOP AND DELIVER PAROLE BOARD READINESS PROGRAMMING AND ADJUST EACH PERSON'S INDIVIDUALIZED REHABILITATION PLAN FOLLOWING PAROLE BOARD HEARINGS TO COMPLY WITH BOARD REQUESTS

As residents approach their parole hearing date, targeted support is essential to help them prepare, present their rehabilitation progress, and navigate post-hearing recommendations. Many individuals report feeling unprepared for their parole hearings and uncertain about how to engage in the process effectively. CDCR's Peer Support Program is an example of an intervention designed to help incarcerated individuals prepare for the Board of Parole Hearings. However, additional specific concerns include:

Lack of Support Leading up to the Hearing

- Residents express confusion about how to prepare for the hearing, including what the Board is looking for, how to document rehabilitation progress, and how to discuss their readiness for release. They emphasize the need for programming that could demystify the parole process and provide clear, accessible guidance.

Barriers to Completing Post-Hearing Recommendations

- After their hearings, residents often receive recommendations to attend programs that have limited availability or long waitlists. This delays their eligibility for (and success in) future hearings.

Gender Inequities in Program Expectations

- Some Board recommendations reference programs available only in men's institutions, with little apparent understanding of the programming landscape in women's prisons. This disconnect leads to unrealistic expectations that penalize residents despite their willingness to comply.

ACTION STEPS

ISSUE:	RECOMMENDATION:
Lack of parole hearing preparedness and uncertainty over how to engage in the process.	Provide tailored support before and after parole board hearings so residents can demonstrate their rehabilitation, incorporate Board recommendations, and engage meaningfully in their release planning.

Action Area	Action Steps
Board of Parole Hearing Readiness Programming	Partner with CBOs (e.g. UnCommon Law[42]) to develop and deliver a structured program (available to all who are parole eligible) to demystify and plan for the parole hearing process.
	Readiness programming should include guidance on understanding board expectations and how to effectively communicate rehabilitation progress.
	Offer the BPH readiness course at regular intervals and ensure residents can access it at least six months prior to their hearing.
Post-Hearing Planning and Support	Implement structured case management sessions to help residents interpret the Board's recommendations, identify relevant available programs, receive priority on the waitlist, and document realistic completion timelines.
	Offer trained peer navigators to further assist in following through on post-hearing recommendations.
	Match individuals with programs aligned to their health and wellness needs and goals.
Coordination With the Board of Parole Hearings	Establish regular communication between CDCR programming staff and BPH representatives to align Board recommendations with the actual availability of programs in women's prisons.
	Create a shared reference tool outlining available programs at each facility, their frequency, and average wait times, to inform feasible and equitable recommendations.

42 https://www.uncommonlaw.org

2.5 OPTIMIZE HEALTH AND WELLNESS PROGRAMMING OPPORTUNITIES FOR NON-ENGLISH SPEAKERS

To fulfill CDCR's rehabilitative mission, all incarcerated individuals—regardless of language proficiency—must have meaningful access to programming. Language barriers can contribute to inequities in program participation, completion, and parole readiness. Providing programming in multiple languages is essential for fostering health, wellness, and rehabilitation for California's linguistically diverse prison population.

- Translators are often unavailable, delayed, or inconsistently provided.
- Incarcerated individuals indicated that ISUDT and Life Skills materials are not available in other languages (sometimes with the exception of Spanish). However, CDCR shared that CBI is available in other languages.
- CBO-led programming is primarily delivered in English. Required sign-up forms and announcements are often only available in English.
- A few exceptions exist, e.g., Narcotics Anonymous and Beyond Violence+, and Healing Trauma+ are delivered in Spanish at CIW, but these are limited in scope and availability.
- Some CBO-led Spanish-language programs have not been approved even when the same programs have been operating for years in English.

ACTION STEPS

ISSUE:
Limited or unavailable programming for non-English speakers.

RECOMMENDATION:
Expand multilingual program offerings.

Action Area	Action Steps
Multilingual CBO Programming	CRMs should actively recruit and prioritize new opportunities from CBOs that can deliver programming in Spanish and other commonly spoken languages among residents
Multilingual Program Materials and Communication	Ensure all written announcements, flyers, and tablet-based notifications about CBO-led and CDCR-run programs are translated into commonly spoken languages.
	Provide ISUDT, Life Skills, and other core program material in multiple languages.
Translation Support	Ensure timely access to professional interpreters or bilingual staff during in-person program sessions.

2.6 THE TAILORING OF A PROGRAM SHOULD NOT BE SHAPED BY THE DESIRE TO OBTAIN REHABILITATIVE ACHIEVEMENT CREDITS (RAC) ACCREDITATION

Current requirements for CBO-led programs to be "RAC eligible" can have negative implications for their tailoring and focus. RAC credits are critical motivators to engage in programing and provide an appropriate reward for completing the difficult personal work associated with engaging in such programming. Incarcerated individuals and CBOs express some frustrations with the organization of the RAC accreditation structure:

- CBOs can apply for their program to be RAC-earning as long as the program is open to everyone. Some programs choose not to tailor to a population with specific needs because doing so would limit their ability to qualify as a RAC-earning program.
- Some residents describe being reticent to sign up for programs that are not RAC-earning and instead chose programs that are less useful to them because they award RACs.
- The provision of RAC credits should not be curbed or limited; it should be available to all programs regardless of whether they are considered "core programming." Individuals we spoke with highlight the need for a systematic process for awarding of RAC credits since it currently feels inconsistent.

ACTION STEPS

ISSUE:	RECOMMENDATION:
Programs cannot award RACs if they tailor programming to a specific audience.	Revise regulations outlying RAC accreditation to maximize benefit.

Action Area	Action Steps
RAC Credit Eligibility	Programs should be RAC eligible even if they focus on a specific population (e.g., Veterans, parents, domestic violence survivors, etc.).
	Create a systematic process for awarding RAC credits to ensure that all programs that are eligible can provide the credits (i.e., not just "Core programming").

Section 3. Optimize the Timeliness, Accessibility, and Reliability of Health and Wellness Programming

To fulfill their mission of "providing education, treatment, rehabilitative, and restorative justice programs in a safe and humane environment," CDCR offers a wide variety of programming. (See Figure 1.) These programs (many of which we recommend delivering through Health and Wellness Centers), must be accessible, consistently delivered, and seamlessly integrated into residents' daily lives.

RECOMMENDATIONS

3.1 To enhance empowerment around health and wellness, do not remove people from programming as a punitive tool

3.2 Establish a consistent, collaborative process to optimize delivery of CBO-led health and wellness programs

3.3 Streamline and centralize the operationalization of cdcr health and wellness programming to ensure consistency, availability, and accessibility

3.4 Create a centralized list of all programs and publicize a facility-wide daily schedule of programs to maximize communication

3.1 TO ENHANCE EMPOWERMENT AROUND HEALTH AND WELLNESS, DO NOT REMOVE PEOPLE FROM PROGRAMMING AS A PUNITIVE TOOL

Rehabilitative and therapeutic programming, particularly CBO-led and educational programs, are foundational to CDCR's mission and essential to health, well-being, and rehabilitation. However, at both CIW and CCWF, these programs are often treated as privileges rather than necessities. As a result, enrollment can be revoked as a disciplinary measure, even for minor or uncontrollable infractions. Ending the routine denial of programming as a punitive tool is a necessary step toward a trauma-informed, health-centered, and outcomes-driven prison environment. *Key findings:*

Missed or Late Attendance Leads to High Numbers of Rules Violation Reports (RVRs)

These RVRs reduce engagement, increase frustration, break trust with facilitators and can lead to parole denials. Those benefitting from programming often lose access just as they are beginning to make progress.

- RVRs are issued due to missed or late attendance that can result in subsequent removal from programs. Many of these RVRs stem from lack of communication around concurrent medical appointments, work assignments, lack of timely cell release, missing ducats, scheduling conflicts, temporary (~72-hour) PREA investigations, or logistical challenges.
- At CCWF and CIW, missing education programs and medical visits are the leading cause of RVRs, which paradoxically disrupt the rehabilitative services CDCR seeks to promote.
- Residents report program removals after missing just 2 or 3 sessions, even when the reasons are outside their control.

Program Access is Closely Linked to Housing Assignments

Housing-based disruptions further undermine consistent participation in rehabilitative programming.

- Individuals in honor housing typically have increased access to programming, but a single RVR can trigger a housing transfer, resulting in loss of programming.

- According to staff, during a PREA investigation, the accused person is automatically moved to new housing. This process takes at least 24 hours and often causes missing one or more sessions, enough to result in program removal; some individuals report being pulled from all programming due to a PREA investigation even when they are later exonerated of the charge. This disrupts program participation and discourages reporting PREA violations.

Program Access is Curtailed for People with a "C-Status" Designation

- The C-status policy permits minimal access to programming, typically one religious service, and one self-help program per week.[43] In practice, CIW and CCWF residents and staff report that even these minimal allowances are inconsistently granted and sometimes denied. Participation in educational and vocational classes is suspended entirely and access to services that might directly address the reasons for being placed on C-status (e.g., behavior modification programs) is often restricted. At CCWF, individuals were only allowed outside for a few hours every other day (on alternate days they could be in the Day Room). At CIW, individuals were sometimes allowed outside but could not access the day room and the reading materials located within it.

- Canteen access is restricted to hygiene items, vitamins, and stationery, limiting access to alternate food options.

Program Access and Ducats

- The ducats that are issued for programming are not priority ducats. Priority ducats are generally only used for medical and legal appointments which, while important, may be issued at times that conflict with programming and then given precedence, leading incarcerated people to miss programming activities. In addition, people described sometimes being prohibited by housing unit officers from attending programs because they did not have priority ducats. A few CBOs reported requesting priority ducats to maximize attendance but this is not common practice.

CCWF's ACT Program is Promising but not Maximized for Success

- CCWF's ACT Program, designed to "flood" individuals on C-status with programming, offers a promising model but lacks full implementation to maximize its potential for success. Participants in the ACT Program still do not have access to education or vocational programs, and access to CBO-led programs is extremely curtailed.

- One positive aspect is that access to peer support counseling and programming remains, though there is no standardized system to facilitate these sign-ups.

Program Removal is Detrimental to Overall Health and Wellness

- Removing residents from programs they benefit from as a punitive measure or to prioritize mandatory activities (such as ISUDT, GED, or work assignments) can negatively impact overall attendance and completion rates across voluntary and mandatory programming.

People often resist mandatory programs when they are excluded from the ones they find most meaningful. This practice undermines rehabilitation and harms institutional safety and broader public safety by denying programming to those who could benefit most.

43 Macomber, Jeffrey. "Department of Corrections and Rehabilitation Notice of Change to Regulations." *California Department of Corrections and Rehabilitation.* May 1, 2020.

ACTION STEPS

ISSUE:
Program enrollment can be revoked as a disciplinary measure, even for minor or uncontrollable infractions. This directly undermines rehabilitation and public safety.

RECOMMENDATION:
Protect access to some form of programming, especially for people who need it most, even when they have engaged in problematic behavior.

Action Area	Action Steps
Program Removal	Treat rehabilitative programming as a right—not a privilege.
	Codify access to programming as essential to CDCR's rehabilitative mission.
	Restrict access to routine programming only in cases of serious disruption or safety threats. Do not revoke for minor infractions, scheduling conflicts, or circumstances outside the resident's control, and reinstate access once the immediate threat has been addressed.
	For the few who pose a serious ongoing safety threat, offer alternative, therapeutic programming designed to ready them for return to regular programming opportunities.
	Allow temporary absences before triggering removal, with flexible re-enrollment plans.
	Track causes of absences/delays to inform process improvements.
Routine Use of RVRs	Establish clear guidelines that restrict program staff from issuing RVRs for lack of attendance/tardiness.
	Encourage alternative, restorative and motivational approaches to address program disruptions or absences.
Reinforcing Progression	Introduce positive reinforcement and recognition for attendance and engagement.
	Continue to use certificates or milestones to encourage continued participation. Create opportunities to earn increased responsibility.
Program-Related Absences	Establish a reliable system for proactively notifying program facilitators when participants will be absent.
	Allow residents to use the secure messaging system to contact CDCR staff and/or CBO staff to indicate why they will miss or have missed a programming session (e.g., for a medical appointment).

Action Area	Action Steps
ACT Program	Ensure comprehensive programming is available in the ACT Program so C-status residents receive individualized rehabilitative support
	Expand the ACT program to CIW.
Root-Cause Interventions	Prioritize consistent access to programs that address the behaviors contributing to C-status classification (e.g., mental health care, anger management, substance use support, and trauma-informed services).
Polices Around Restrictions	Revise policies that unnecessarily restrict movement, outdoor access, or canteen purchases of healthy food items.
Ducats	Ensure that individuals with ducats for programming are able to leave their housing units to attend, even if they are not "priority ducats."

3.2 ESTABLISH A CONSISTENT, COLLABORATIVE PROCESS TO OPTIMIZE DELIVERY OF CBO-LED HEALTH AND WELLNESS PROGRAMS

CDCR relies on CBOs to deliver a wide range of programming that promotes health, wellness, and rehabilitation. These programs range from trauma recovery, emotional support, parenting support, substance use counseling, job skills, leisure time activities, exercise, to pre-release planning. Residents consistently describe these programs as meaningful and transformative, often highlighting them as the cornerstone of their rehabilitation. Some of these CBO-led programs should be centralized and offered through the Health and Wellness Center.

However, CBO leaders report systemic barriers that compromise their ability to deliver their programs effectively. Many of the challenges stem from inconsistent implementation, lack of coordination, limited infrastructure, and unclear or rapidly changing approval policies. These issues reduce access, strain trust, and undermine CDCR's rehabilitative mission. Program implementation, infrastructure, and coordination challenges must be addressed.

Key issues identified by CBO leaders included:

Inconsistent and Opaque Program Approval Processes

- Approval timelines for new or renewing programs vary drastically between institutions and over time.
- Required documents and procedures (e.g., proposal forms, volunteer training, staff contacts) often change without notice.
- Programs are sometimes delayed for months (and approval is sometimes rescinded) due to leadership turnover or internal policy shifts. This causes staffing and budgetary strain for CBOs and loss of access for residents.

Unpredictable Rules Around Allowable Program Tools and Materials

- Tools such as art supplies, workbooks, yoga mats, or laptops may be allowed one week and denied the next, depending on which entrance officer is on duty.
- Items previously cleared are sometimes rejected without explanation.
- These sudden changes can delay or derail scheduled programming, create inconsistent resident experiences, and require program leaders to adjust lesson plans unexpectedly.

Lack of Clarity Around Sponsor Requirements

- Some CBO staff report they no longer need a sponsor after receiving a "Brown Card" (a Volunteer Identification Card that allows a regular volunteer to enter an institution without a staff escort.)[44] Other CBO staff are required to maintain a sponsor indefinitely, even when working at the same facility.
- Program cancellations occur due to sponsor unavailability (e.g., illness, reassignment), even when alternate trained, cleared staff are on site. This disrupts program continuity and disincentivizes participation.

Sponsors are Not Always Trained or Suited to Support Programming

- While some CDCR staff sponsors are deeply supportive, others make dismissive or inappropriate comments, including during sensitive programs involving trauma or emotional vulnerability.
- In some cases, residents report feeling retraumatized or silenced when sponsors misuse or misinterpret program discussions.
- CBO leaders have no formal capacity to request a change or vet a sponsor.

Inconsistent Program Outreach and Communication to Residents

- Announcements about CBO-led programs vary across housing units and facilities. Some programs are advertised via flyers in the CRM office or in Inmate Advisory Council ("IAC") announcements, others rely on word of mouth or informal peer communication.
- As a result, many residents are unaware of programs that match their needs, interest in programming is not maximized, and program enrollment seems unfairly high for those who are more aware of this communication channel because they sign up first.

Delayed or Ineffective Communication Between CDCR and CBOs

- CBO leaders frequently wait weeks to receive answers to basic logistical questions (e.g., classroom changes, program status, paperwork updates).
- In several instances, CBO staff describe travelling hours for a scheduled class, only to find the session canceled without notice.
- CRM staff are overwhelmed by seemingly unnecessary paperwork requirements and a lack of the administrative support needed to manage program coordination effectively.
- Communication between departments (e.g., Education and CRM) is often siloed.

Lack of a Feedback Loop or Collaborative Planning Mechanism

- CBO leaders express interest in offering suggestions to improve operations, coordination, and outcomes, but lack a formalized way to do so.
- Many CBO leaders believe their program experience could inform policy refinement and implementation, but their insights are not consistently solicited or used.

44 "Chapter 10, Article 9, Section 101090.6.3.D.4." Department of Operations Manual. *California Department of Corrections and Rehabilitation.*

ACTION STEPS	
ISSUE: Systemic barriers compromise CBO's ability to deliver their programs effectively.	**RECOMMENDATION:** Implement processes to facilitate effective program delivery.

Action Area	Action Steps
CBO Program Approval Process	Create a consistent, transparent approval process for CBO-led programs.
	Maintain continuity of program approvals across staff or leadership transitions.
Uniform Policies For Equipment and Tool Use	Create memoranda clarifying which general items CBOs are permitted to use inside facilities. Allow tailored lists according to unique program needs.
	Ensure that front gate officers follow this policy consistently.
	Designate a CDCR point of contact who can quickly resolve disputes about items, including on evenings and weekends.
Sponsor-Related Policies And Compatibility	Create an advisory council of CBO leaders, staff, CRM staff and people who are incarcerated to evaluate and revise the sponsor role.
CDCR and CBO Communication	Assign a CRM liaison to each CBO to streamline communication.
	Implement a required response timeframe (e.g., 3–5 days) for CBO inquiries related to ongoing programming operations.
	Create a shared email or online tracking system for scheduling and documenting new CBO program inquiries.
Creation of a CBO Advisory Council	Create a CBO Advisory Council and mandate that it convenes at least once per quarter. This CBO Advisory Council will include CBO representatives, currently/formerly incarcerated individuals, front-line CDCR staff (e.g., from the CRMs office), and relevant CDCR leadership.
	This council will review program-related implementation challenges, suggest improvements, and share best practices. This convening could be done in partnership with TPW, an organization that already serves as a nexus for CBOs who provide programming inside CDCR facilities.
	Use CBO Advisory Council input to update policies, training, and infrastructure investments.

3.3 STREAMLINE AND CENTRALIZE THE OPERATIONALIZATION OF CDCR HEALTH AND WELLNESS PROGRAMMING TO ENSURE CONSISTENCY, AVAILABILITY, AND ACCESSIBILITY

CDCR's reliance on outdated, paper-based systems for program operations undermines effective delivery of

rehabilitation services. Digitized database and tracking systems at CIW and CCWF (i.e., SOMS) are fragmented and much of the programming information is paper-based, making it difficult to manage programs efficiently or equitably. High staff turnover, staff vacancies, and inconsistent internal processes reinforce the need for digitized systems to standardize program operations across facilities. This would be particularly important for the coordination of services in a Health and Wellness Center. By modernizing and integrating digital infrastructure CDCR can improve consistency, reduce staff workload, and ensure that residents have timely, equitable access to health and wellness programming.

Fragmented and Non-Integrated Data Systems

- CDCR operates multiple data platforms that do not communicate with each other. For example, RAC credits earned through participation may be tracked in one system but missing from the records system used to calculate release dates.
- This disconnect leads to serious consequences for incarcerated individuals, including needlessly prolonged sentences, and undermines transparency and trust.

Inefficiencies from Relying on Paper-Based Systems

- Most CRM programming functions (such as CBO program approvals, gate clearances, resident sign-ups, attendance) are processed and catalogued manually using paper forms, or through personal email chains, which get lost as CDCR or CBO staff turnover.
- CDCR staff describe being buried in paperwork, with time lost managing backlogs.

Unreliable and Inconsistent Communication with CBOs

- CBOs are inconsistently approved to communicate with program participants, and there is no dedicated platform for providers or CRM staff to send communications to CBOs about program changes.
- Lack of a centralized communication system limits CDCR's ability to offer external partners timely information about changes that affect programming delivery (e.g., lockdowns or staff trainings).

Limited Collaboration Across Programming Divisions

- Internal programming divisions (e.g., education, ISUDT, and CBO-led) often operate in silos. Staff lack visibility into overlapping efforts, resulting in missed opportunities to align programming or coordinate schedules to serve residents more effectively.
- Lack of public daily facility-wide schedules including programs and other activities limits staff understanding of scheduling challenges (e.g., trying to get from education programs to the dining hall to programs within a small window of time).

Barriers to Accessing and Signing Up for Programming

- Use of paper forms and office-based sign-ups is difficult for residents who are non-English speakers, have learning differences, or face mobility restrictions. This also impacts incarcerated individuals' ability to learn about their status on the waitlist and whether they've moved up.

ACTION STEPS

ISSUE:	RECOMMENDATION:
Digitized database and tracking systems are fragmented and programming information is often paper-based, making it difficult to efficiently and equitably manage programs.	Implement an integrated digital infrastructure to improve operations.

Action Area	Action Steps
CDCR Computer Systems and Databases	Ensure CRM programming data is integrated with central records, scheduling platforms, and release date systems.
	Allow staff across divisions to view programming data to improve coordination between education, ISUDT, vocational, and wellness programs.
CRM Programming Processes	Replace manual paper forms with digital systems.
	Introduce ID-based sign-ins (e.g., barcode system) to log attendance.
Centralized Notification System	Use digital alerts to notify CBOs and residents of program changes, cancellations, or institution-wide updates. Ensure this notification system allows CBOs to communicate directly with program participants (e.g., via a dedicated platform on the tablet) to share information about potential program changes.
Access to Digital Tools	Design interfaces to be accessible to people with disabilities and available in multiple languages.
	Maintain alternative access options (e.g., paper or peer support) for residents who lack digital literacy or device access.

3.4 CREATE A CENTRALIZED LIST OF ALL PROGRAMS AND PUBLICIZE A FACILITY-WIDE DAILY SCHEDULE OF PROGRAMS TO MAXIMIZE COMMUNICATION

Residents and Staff Would Benefit from a Comprehensive and Accurate List of Available Programs

The lack of a centralized list has led to:

- Siloed programming and limited communication and visibility between teams delivering offerings. For example:
  - » Education staff are often unaware of the content or goals of CBO-led health and wellness programs that might support individuals' educational attainment.
  - » Correctional Counselors, who meet with residents annually to assess eligibility for CDCR programs, lack access to up-to-date information about CBO-led and peer-led programming. The CRM team that oversees these external programs is very small and siloed, severely limiting residents' ability to access comprehensive guidance.
- Missed opportunities to sequence programs effectively or build on residents' learning.
- Misunderstandings about program eligibility and relevance, which translates into problems with attendance—e.g., many residents avoid the mandated Life Skills program due to a mistaken belief that it includes ISUDT, even for people without a substance use disorder.
- Limited information about the content and benefits of CBO-led programs prevents residents from making informed choices to support rehabilitation, health, and wellness.

Incarcerated Individuals and Staff Report a Need for Clear, Coordinated Information about Program Schedules

- Time Conflicts: Individuals often must choose between being on time for a program and finishing a meal,

especially when CBO-led programs occur during or right after mealtime.

- Lack of visibility into drop-in programs: There is no centralized calendar for informal or drop-in opportunities, such as exercise classes, that residents can join in their free time.

ACTION STEPS

ISSUE:	RECOMMENDATION:
Limited knowledge or understanding of available programs and services.	Create a centralized and transparent scheduling system to maximize awareness of available programs for incarcerated people and staff.

Action Area	Action Steps
Transparency of Available Programs	Develop and maintain a comprehensive, user-friendly list of all available programs. For each program include: • Program name and provider • Eligibility or requirements • Goals, skills, and knowledge focus • Program duration and frequency • Language availability • RAC credit eligibility Update this list at least annually, and make it accessible to residents and staff
	Audit and update program lists, removing inactive or defunct programs from public lists at least annually.
	Clearly distinguish between recurring programs and one-time offerings to avoid confusion and unrealistic expectations.
Facility-Wide Programming Calendar	Assign the CRM's office to coordinate and maintain a master schedule for all CDCR- and CBO-led programing.
	Display calendars in communal areas (housing units, day rooms, waiting areas) and on tablets; make available in many languages.
Communication and Coordination Meetings Between Correctional Counselors and CRM	Share updates on available programs and services.
	Identify opportunities to align and sequence offerings.
	Improve shared understanding of residents' program progress and evolving needs.
	Provide Correctional Counselors with training and written materials about CBO-led and peer-led programs, so they can guide residents.

Section 4. Improve Health and Wellness Programming Access, Quality, Relevance, and Funding Processes

Classes and programs delivered through the proposed Health and Wellness Centers must be relevant to incarcerated people and evaluated regularly to ensure they remain of high quality. Incarcerated individuals are the primary stakeholders in rehabilitative programming; excluding their perspectives in program offerings and design can result in programs that are outdated, irrelevant, or even traumatizing. Actively including residents in decision-making can foster greater trust, engagement, program effectiveness, and empowerment. Residents can also only benefit from programs they can access and that do not have years-long waitlists.

Effective rehabilitative programming must be evidence-based [45] when possible and evaluated regularly to ensure it meets evolving participant needs and maintains a high standard of quality. Program evaluation should vary: a marathon preparation class might be evaluated for its acceptability while a program on domestic violence might prioritize recidivism-related outcomes.

RECOMMENDATIONS

- **4.1 Establish resident participation in Health and Wellness Program planning and development**
- **4.2 Regularly evaluate Health and Wellness Program quality and prioritize evidence-based, gender-responsive offerings**
- **4.3 Improve waitlist management to optimize access to Health and Wellness Programming**
- **4.4 Develop and maintain transparent and equitable funding processes for all programming**

4.1 ESTABLISH RESIDENT PARTICIPATION IN HEALTH AND WELLNESS PROGRAM PLANNING AND DEVELOPMENT

Programs should focus on topics identified as relevant by people incarcerated in women's prisons. CDCR should leverage IAC meetings and town halls to gain insight into residents' needs.

Limited Input Regarding Programming from Incarcerated People

Residents at CIW and CCWF report minimal involvement in determining which programs are offered. As a result, programming often fails to align with their needs, interests, or life experiences.

Lack of Regular Feedback Mechanisms

There is no standardized mechanism for residents to suggest changes to existing educational, vocational, or CBO-led programs, including the need for additional offerings, although Inmate Advisory Councils exist at each facility.

Residents' Needs Do Not Inform Funding Priorities

State funds, dispersed through Rehabilitative Investment Grants for Healing and Transformation "RIGHT Grants," are distributed equitably to all CBO-led programs and incentivize programming at women's prisons. This means that the funding is awarded regardless of whether residents find a given CBO program to be meaningful or beneficial.

45 "CrimeSolutions - The Evidence-Based Guide for Justice Agencies in Search of Practices and Program that Really Work." *National Institute of Justice.* December 29, 2021. https://nij.ojp.gov/topics/articles/crimesolutions-evidence-based-guide-justice-agencies-search-practices-and-programs

ACTION STEPS	
ISSUE: Individuals in women's prisons lack opportunities to influence available programming.	**RECOMMENDATION:** Include residents in program planning and development through a Health and Wellness Center governing body (see Recommendation 1.1) and through the following action steps.

Action Area	Action Steps
Feedback on Program Offerings and Evaluation	Create formal advisory bodies of incarcerated individuals, or empower existing IACs, to provide input into program selection, design and scheduling. Revise offerings based on this feedback.
	Ensure these groups represent the prison population (e.g., age, race/ethnicity, gender-identity, parental status, sentence length).
	Implement annual or biannual surveys and optional focus groups to solicit resident input on programming gaps. • Use tablets, paper forms, and in-person methods to optimize accessibility • Allow residents to submit programming suggestions or feedback anonymously • Communicate how feedback is considered in decisions
	Involve resident representatives and external community experts in reviewing new and existing programs for alignment with rehabilitative goals and population-specific needs.
Resident Input into Programming	Develop a policy framework that prioritizes programs co-developed or strongly endorsed by incarcerated individuals during selection, approval, fundings and scheduling process.

4.2 REGULARLY EVALUATE HEALTH AND WELLNESS PROGRAM QUALITY AND PRIORITIZE EVIDENCE-BASED, GENDER-RESPONSIVE OFFERINGS

For programs to reliably meet the needs of residents and maximize their rehabilitation they should be evidence-based and evaluated for quality.

Lack of Quality Assessment Infrastructure

CIW and CCWF lack consistent mechanisms to evaluate whether programs are evidence-based, gender-responsive, or trauma-informed.

Barriers to Research and Evaluation

- The CDCR Research Oversight Committee (ROC) frequently denies approval for evaluation projects, even those not classified as research by academic review boards. This impedes CBO-led programs from improving the quality of their programs and CDCR's ability to assess whether programs are having their intended impact.

- CBOs are sometimes prevented from collecting quality improvement surveys.
- Most requests to survey large segments of the incarcerated population, including through tablets, are denied.
- Some CBOs reported experiences where CDCR would deny or rescind a study that had initially been approved mid-way through (e.g., Year 3 of a five year study). This is detrimental to the research process and reliability of the resulting data.

Inconsistent Feedback Mechanisms

There are no standardized ways for residents to provide input on educational, vocational, or CBO-led programming. Some organizations solicit input from participants, but practices vary widely.

Programs may Cause Harm if not Adequately Supported

Some programs designed to explore histories of trauma (particularly one-day programs) can evoke strong emotional responses. If these programs lack follow-up care, participants run the risk of becoming retraumatized.

Uncertainty around Gender-Responsivity of Core Programs

Per discussions with staff and residents, critical (and mandatory) programs like ISUDT and Life Skills are not always tailored to meet the needs of women, including those with trauma histories.

ACTION STEPS

ISSUE:	RECOMMENDATION:
Many programs are not evidence-based and are prevented from evaluating themselves.	Programs should be evidence-based, or given a pathway to become evidence-based, and evaluated regularly to ensure they are high quality and support rehabilitation.

Action Area	Action Steps
Evidence-Based, Gender-Responsive and Trauma-Informed Programs	Develop a formal review process to assess whether current and proposed programs are evidence-based. • Some programs (e.g., painting) may focus on accessibility and participant experience whereas others (addressing domestic violence) might focus on participant outcomes such as recidivism and engaging in healthier relationships.
	Once CDCR has allowed, and in fact required, all CBO programs to be evaluated and/or to evaluate themselves (Section 4), they will give scheduling preference to programs with demonstrated outcomes, based on promising evidence-based theories of change, and/or alignment with best practices in correctional rehabilitation.
	Require contracted programs to follow gender-responsive principles.
	Ensure residents' emotional safety by coupling trauma-focused programming with access to counseling, peer support groups, or therapeutic debriefing (e.g., organized availability of post-program peer support and mental health counseling).

Action Area	Action Steps
Routine Program Evaluation	Evaluate all core CDCR programs—educational, vocational, ISUDT, Life Skills, and CBO-led offerings—at regular intervals.
	CDCR should provide support (at a minimum allow collection of participant surveys) for CBOs to evaluate their programs.
	Collect resident feedback, program completion data, and behavioral or recidivism outcomes wherever feasible.
Resident Feedback Mechanisms	Mandate anonymous program feedback forms for all participants at the conclusion of all courses and workshops to facilitate evaluation and the continuation of meaningful and impactful programming.
	Allow program leads to review and incorporate resident input in line with ongoing quality improvement.
ROC Support	Establish clear pathways for quality improvement assessments to proceed without excessive barriers.
	Encourage ROC to prioritize studies that assess program effectiveness, acceptability, and safety for incarcerated women.
	Programs that were funded via DRP mechanisms (e.g., CARE and Innovative Programming Grants) and that received ROC approval for research should not be terminated mid-way in the research process

4.3 IMPROVE WAITLIST MANAGEMENT TO OPTIMIZE ACCESS TO HEALTH AND WELLNESS PROGRAMMING

When demand for programming outpaces availability, long waitlists prevent individuals from participating in programs that support their health, recovery, and readiness for release. Long waitlists also generate mistrust and frustration. Residents at CIW and CCWF consistently encounter long and opaque waitlists for programs, particularly for vocational, substance use treatment, and CBO-led classes. ***Key issues include:***

High Demand and Limited Availability

Popular programs such as coding, parenting, and cosmetology have years-long waitlists.

Limited Access to ISUDT

- Individuals with substance use disorders report facing delays in accessing treatment programs which may lead to increased RVRs that extend their sentence, disruption of public safety or even overdose and death.
- CDCR leadership explains that people get access to medication assisted treatment (MAT) as soon as they need it, and while all people with a history of substance use disorder will gain access to ISUDT, prioritization must be made for people nearing release and those on MAT. The waitlist placement process is automated by quality management.
- Anecdotally, we heard stories of individuals who were not currently using substances but decide to re-initiate substance use in order to receive the wrap-around services that came with MAT and access to ISUDT. CDCR leadership explained that there is a urine drug screening that is part of the screening process for ISUDT and

that other medical factors are considered during the biopsychosocial assessment. Healthcare staff should meet with incarcerated people to understand the potential unintended adverse consequences of policies and procedures that regulate who has access to substance use treatment and related programming; this suggests that there is a need for ongoing substance use recovery and treatment services.

Outdated or Inaccurate Waitlists

- Nearly all CBO-led programs have waitlists.
- Many of the listed programs with waitlists are no longer active.
- Some waitlists include people who have transferred, paroled, or no longer meet eligibility criteria. Sometimes waitlist numbers exceed the incarcerated population.
- The long, and oftentimes inaccurate, waitlists discourage residents from signing up (even when spots are available), and create inefficiencies in enrolling new participants.

Lack of Transparency and Communication

- Residents report being unsure how waitlists are maintained. There is confusion when, for example, they see that their waitlist position has moved backward after waiting a year. This confusion can result in distrust, resentment, and disinterest in programming.
- Residents were told that RAC-eligible programs should be "first come—first served" but we could not find documentation mandating this. In addition, residents described inconsistencies in who came off the waitlists, leading to beliefs about favoritism.

Reducing excessive wait times and improving the accuracy and transparency of waitlist systems are critical to improve access to rehabilitative programming. These changes will increase trust, improve resource allocation, and facilitate quicker access to programs that meet needs, ultimately advancing rehabilitation and public health.

ACTION STEPS

ISSUE:	RECOMMENDATION:
Demand for programming outpaces availability leading to long waitlists.	Reduce long wait times and improve waitlist accuracy and transparency.

Action Area	Action Steps
Waitlist Management System	Implement an integrated, centralized, digital waitlist management system.
	Ensure real-time updates to reflect resident status (e.g., transfers, releases, changes in need).
Waitlist Transparency	Revise prison orientation materials to explain how waitlists are maintained and offer regular refresher sessions for anyone to learn about program availability and waitlist management.
	Ensure the CRM's office regularly reviews (~quarterly) waitlists to remove ineligible individuals and prioritize those in need.

Action Area	Action Steps
Waitlists Demonstrate Unmet Need	Offer more classes for programs that are in highest demand, particularly where long waitlists persist. Cut programs that are not meeting needs or producing quality.

4.4 DEVELOP AND MAINTAIN TRANSPARENT AND EQUITABLE FUNDING PROCESSES FOR ALL PROGRAMMING

Aligning funding decisions with institutional needs and resident priorities, and ensuring CBOs have the resources to deliver programs, will allow CDCR to maximize the reach and effectiveness of its rehabilitative mission. Funding for CBO-led rehabilitative and enrichment programs generally occurs through the following state grant mechanisms (in addition to independent philanthropic fundraising support generated by CBOs):

- **California Reentry and Enrichment (CARE) Grants:** Support nonprofits delivering insight-oriented and restorative justice programs inside prisons.[46]
- **Rehabilitative Investment Grants for Healing and Transformation (RIGHT Grants)[47]:** Target experienced nonprofits (3–5+ years of in-prison programming) to expand trauma-informed and restorative justice programs. They are distributed across all eligible organizations based on their size, budget and scope, rather than through a competitive application process.
- **Innovative Programming Grants (IPG):** Competitive grants awarded to nonprofits to replicate successful programs in new CDCR institutions, particularly those grounded in restorative justice, personal responsibility, and skill-building.[48]
- **Arts in Corrections:** A partnership between CDCR and the California Arts Council that provides funding to many arts organizations that offer programing within all 35 of California's adult correctional facilities.[49]

Despite the promise of these funding sources, support for CBO-led programming is a small fraction of CDCR's rehabilitative budget. Moreover, the system is plagued with inconsistent communication and lack of a centralized, transparent system for grant allocation. Funding does not seem to incorporate feedback from residents around program impact or relevance. CDCR notes that the state has established funding processes through BCPs and that they cannot work outside of that process for funding.

Lack of Transparency

- CBOs frequently report confusion about how funding decisions are made.
- Organizations sometimes lose funding without clear explanation, even after years of successful program delivery.
- Numerous CBOs receive insufficient support, limiting the number of participants they can serve despite long waitlists and rave participant reviews.
- Many CBO providers perceive favoritism in how funding is awarded, citing unclear standards or inconsistent application of selection criteria.

46 "California Reentry and Enrichment (CARE) Grant Awards." *California Department of Corrections and Rehabilitation.* https://www.cdcr.ca.gov/rehabilitation/2022-2025-care-grant-awards/

47 "Grant Programs." *California Department of Corrections and Rehabilitation.* https://www.cdcr.ca.gov/rehabilitation/grants/

48 "Grant Programs." *California Department of Corrections and Rehabilitation.* https://www.cdcr.ca.gov/rehabilitation/grants/

49 Arts in Corrections: Bridging culture and community behind prison walls: https://actaonline.org/program/arts-in-corrections/

- Challenges with funding timeliness and delivery.
- Some CBO providers reported challenges with regards to funding delays and gaps between when a grant was awarded and when the contract was received.

Limited Influence Over Programming Focus

- CDCR—at the headquarter level and institutional level—has limited input into which programs are submitted for funding or approval. This makes it difficult to coordinate offerings, ensure alignment with needs, avoid duplication of programming, and manage scheduling.

Mismatch Between Funded Programs and Resident Needs

- Because incarcerated people and facility staff are not systematically involved in setting programming priorities, programs may receive funding even if they are not responsive to the needs of residents, particularly in women's facilities.

Inadequate Funding Undermines Access

- Underfunding leads to insufficient programming slots, creating long waitlists and leaving critical rehabilitative needs unmet.

ACTION STEPS

ISSUE:
Inconsistent communication and the lack of a centralized, transparent system for grant allocation contributes to unmet needs among incarcerated individuals and CBO programs.

RECOMMENDATION:
Develop and maintain transparent and equitable funding processes.

Action Area	Action Steps
Funding Processes	Publicly share the criteria, timeline, and decision-making structure for all grant awards for CBO programming.
	Publish a regularly updated list of funded programs and their scope, including program start/end dates and frequency.
Funding Adequacy and Sustainability	Maintain funding levels that reflect the volume and variety of programming needed to meet women's rehabilitative needs.
	Consider creating a dedicated line-item in California's budget for CBO-led programs, especially those that are gender-responsive and trauma-informed.
Funding and Resident-Identified Needs	Prioritize funding for CBOs whose programs address needs according to people who are currently incarcerated.
	Include residents in the grant scoring and review process.
	Encourage inclusion of new and/or smaller CBOs to broaden the scope and diversity of offerings.
	Scale funding to match program impact.

Action Area	Action Steps
Funding and Resident-Identified Needs *(continued)*	The Health and Wellness Center Governing Board (Recommendation 1.1) should develop a framework for allocating funding.
CDCR Oversight and Coordination	Improve coordination between CDCR, grant administrators, and facility leaders to ensure funded programs are complementary, non-duplicative, and aligned with institutional needs.
	Collect and incorporate feedback from residents, CBOs, and staff about programming gaps and funding priorities.

Section 5. Ensure that Programs are Deployed in a Safe Environment that Supports Health and Wellness and is Trauma-Responsive

A Health and Wellness Center should serve as a place where people feel physically and emotionally safe, supported, and empowered to engage in rehabilitation. These Centers should create opportunities to address factors such as violence, trauma, substance use and housing—recognized public health issues that contribute to women's incarceration.[50] The physical space,[51] access to healthy food,[52] exercise,[53] family visits,[54] and healthcare[55] are all crucial components of wellness and health.

This report's recommendations are situated within a broader context of documented abuse and a systemic failure to keep people safe in California's women's prisons in recent decades. Some examples are described below, and others can be found in the popular press.[56,57,58]

Forced Sterilizations

Although California repealed its eugenics laws in 1979, coerced sterilizations continued after that date.[59] In recognition of the state's role in these cases, Assembly Bill 137 formally acknowledged the abuse and introduced memorials at CIW and CCWF.[60]

Sexual Harassment and Assault

Hundreds of residents at CIW and CCWF have alleged sexual harassment, molestation, and/or rape by prison staff, leading to multiple lawsuits.[61] Some report experiencing retaliation after coming forward. CIW's sole gynecologist was charged with physical and sexual abuse committed during the provision of medical care between 2016 and 2023.[62]

50 Miller H. "FY 2020 Report to Committees on Appropriation. Formerly Incarcerated Women and Reentry: Trends, Challenges, and Recommendations for Research and Policy." Office of Justice Programs, *National Institute of Justice*. October 2021. https://www.ojp.gov/pdffiles1/nij/303933.pdf

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52 De Viggiani N. "Unhealthy prisons: exploring structural determinants of prison health." *Sociol Health Illn.* 2007.

53 ibid

54 De Claire K, Dixon L. "The Effects of Prison Visits from Family Members on Prisoners' Well-Being, Prison Rule Breaking, and Recidivism: A Review of Research." *Trauma, Violence, and Abuse*. August 31, 2015. https://doi.org/10.1177/1524838015603209

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56 Levin S. "DOJ opens investigation into sexual abuse at California women's prisons." *The Guardian*. September 5, 2024. https://www.theguardian.com/us-news/article/2024/sep/05/california-womens-prisons-investigation

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62 Levin S. "California prison gynecologist accused of 'horrific' abuse of patients in lawsuit." *The Guardian.* February 5, 2025. https://www.theguardian.com/us-news/2025/feb/05/california-prison-gynecologist-abuse

Excessive Use of Force and Violence

During a contraband search in August 2024, over 100 incarcerated people were locked in a cafeteria at CCWF for hours without air conditioning, food, medication, or restroom access. Reports allege correctional officers used chemical spray, pepper bombs, and physical violence—even on restrained individuals—resulting in three hospitalizations.[63]

Health and wellness-focused programming requires a safe, respectful, and trauma-informed environment to be successful. In women's prisons, where many residents are survivors of trauma, safety must be understood holistically—not just the absence of physical violence, but also emotional and psychological safety, freedom from retaliation, and the ability to express oneself without fear. Unsafe environments deter participation, limit disclosure, and erode the rehabilitative impact of programs. When people do not feel physically or psychologically safe, the effectiveness of even the most well-designed programs is undermined.

The culture of staff conduct, relationships between correctional officers and CBOs, and institutional operations (e.g., physical searches, timely release for programming) all shape the degree to which incarcerated people feel safe participating in programming and able to pursue growth. CDCR's recent history of harm and the ongoing atmosphere of fear have direct consequences for the delivery of, and engagement in, programming. Addressing these systemic issues is essential to optimizing the rehabilitative goals outlined in CDCR's Mission Statement.

RECOMMENDATIONS

5.1 Ensure Health and Wellness Centers create a trauma-responsive environment where people can thrive and engage in activities that support their rehabilitation

5.2 Ensure a safe and supportive trauma-responsive environment for residents to engage in daily activities and programming

5.1 ENSURE HEALTH AND WELLNESS CENTERS CREATE A TRAUMA-RESPONSIVE ENVIRONMENT WHERE PEOPLE CAN THRIVE AND ENGAGE IN ACTIVITIES THAT SUPPORT THEIR REHABILITATION

Certain operations could be better coordinated within a Health and Wellness Center.

Limited Access to Healthy Food, Products and Opportunities to Support Holistic Wellness

Residents express a strong desire to improve their health through better exercise, nutrition, and hygiene; they describe limited access to healthy food options (e.g., fresh produce) and non-toxic and culturally-specific personal care and hygiene products.

- Residents describe that the dining hall and canteen lack sufficient fresh fruits and vegetables, and what does exist is expensive and sells out quickly. Farmers' markets within the prison are popular, but do not occur frequently enough to improve health since they are coordinated and paid for by a CBO (i.e., Land Together) versus being organized by CDCR.
- Residents desire more knowledge about healthy eating and food preparation.
- Inadequate access to exercise opportunities and nutritious food undermines residents' empowerment to manage their own health. For instance, people with high blood pressure express frustration at having to rely on medication instead of being able to incorporate healthy eating and exercise into their treatment plans.

63 Bolaños M. "'Like a War Zone': Prison Officers Used Unprecedented Force in August Attack, Incarcerated Women Say." *KQED*. September 12, 2024. https://www.kqed.org/news/12004368/like-a-war-zone-prison-officers-used-unprecedented-force-in-august-attack-incarcerated-women-say

- Limited canteen choices rarely include options that meet the wide variety of cultural and ethnic groups represented in CDCR in regards to skin color or hair texture, sometimes undermining people's feelings of beauty and wellness.

Inadequate Physical Space for Wellness Activities

- Exercise is constrained by outdated gym equipment, limited space and exercise classes, and gym hours that conflict with work or program schedules.
- Many express a need for expanded hours at CIW's older adult center and that staff should refrain from repurposing the space for unrelated programming.

Barriers to Family Connection

Residents consistently endorse the rehabilitative value of maintaining family bonds:

- Some visiting rooms lack family-friendly features, such as toys, books, and child-safe spaces.
- Two of the family visiting apartments at CIW are unusable, and current policies restrict families from bringing in food—limiting the comfort and connection of visits.

Opportunities to Improve Access to Medical Care by Coordinating with Programming Schedules

Residents and medical staff noted the following issues:

- Medical appointments often conflict with programming, contributing to no-shows.
- Communication gaps between medical and program staff hinder referrals for ISUDT.
  - » Some medical staff report frustration that they don't have input into who should be prioritized for ISUDT programming (e.g., people with repeated overdoses).
- Missed medical appointments result in RVRs, which limit future programming eligibility and also make people reluctant to schedule medical appointments
- Even when residents request a short appointment and medical note to demonstrate they are too sick to attend programming, they may not get a response for days, leading to RVRs. As a result, people feel pressure to attend programs even when they are sick.

ACTION STEPS

ISSUE:
People at CCWF and CIW do not feel safe and supported in ways that would maximize their ability to engage in programming and facilitate rehabilitation.

RECOMMENDATION:
Ensure the Health and Wellness Centers create an environment where people can thrive and engage in activities that enhance rehabilitation.

Action Area	Action Steps
Health and Wellness via Diet, Exercise and Hygiene	Increase access to fresh fruits and vegetables, including coordinating with CBOs such as Land Together to expand options such as farmers' markets.
	Expand laundry access; consider solar power installations to support increased washer/dryer capacity.

Action Area	Action Steps
Family Visitation	Repair and maintain family visiting apartments with design input from the IAC.
	Develop child-friendly visiting areas with books, toys, and outdoor spaces (e.g., playgrounds). Recently remodeled visiting rooms in some areas at CCWF can be a reference point.
	Reevaluate policies restricting outside food during family visits.
Dedicated Spaces for Wellness	Adapt existing areas and consider new construction to build a centralized Health and Wellness Center.
	Ensure spaces like the older adult center have dedicated hours when they are not repurposed for other uses; expand gym hours so times are available that don't conflict with work / education.
Communication Between Medical and Program Staff	Do not issue RVRs for missed medical appointments due to scheduling conflicts. Create mechanism for people to request that an RVR be reversed if issued due to a scheduling conflict.
	Create standardized sick-leave policies to model workplace expectations and help individuals prepare for employment in the community.

5.2 ENSURE A SAFE AND SUPPORTIVE TRAUMA-RESPONSIVE ENVIRONMENT FOR RESIDENTS TO ENGAGE IN DAILY ACTIVITIES AND PROGRAMMING

Staff Behavior Sometimes Undermines Safety and Programming Access.

Numerous residents describe feeling like some CDCR staff contribute to an environment that discourages or blocks access to programs. Tactics include failing to release people for programming (especially during 'modified' scheduling), refusing to advertise CBO-led events, and assigning staff believed by residents to have histories of abuse to monitor programs.

Grievances are Dismissed for Illegitimate Reasons

Residents, particularly those in honor dorms, report filing grievances that are ignored, "lost," or returned because of claims that 'inorganic matter' is on the paper.

Non-English Speakers Face Increased Risk and Isolation

Residents with limited English proficiency report frequent misunderstandings with correctional staff, leading to unwarranted RVRs and discipline. Spanish-speaking residents describe staff sometimes refusing to try to communicate or penalizing them for failing to follow instructions they didn't understand.

Peer Support Counselors are Underutilized

Sometimes trained peer support counselors are not deployed during crises. For instance, during the mass use-of-force incident in August 2024, peer counselors were not systematically activated.

Body Searches are Traumatizing and Outdated

Newly arrived residents are subject to body searches as a first point of contact, despite the availability of donated body scanners. This contradicts international best practices, which prioritize non-invasive scanning to avoid re-traumatizing populations with histories of abuse.

The following steps do not represent a comprehensive plan for ensuring safety in California's women's prisons. Instead, they outline a set of initial measures that can immediately strengthen or revise existing policies and practices, laying the groundwork for a broader culture of safety.

ACTION STEPS

ISSUE:	RECOMMENDATION:
When safety is undermined, rehabilitation is compromised.	CDCR must proactively create trauma-responsive environments that protect the dignity, autonomy, safety, and well-being of every resident.

Action Area	Action Steps
Culture of Safety and Accountability	Enforce zero tolerance policies for staff misconduct, abuse, and retaliation (against residents and CBOs), including sexual abuse, intimidation, and manipulation.
	Ensure programs are delivered in safe settings that foster rehabilitation and growth.
	Introduce safety audits and ensure anonymous feedback loops for residents to report unsafe conditions without fear of retribution.
	Expand staff and leadership training to include scenario practice for maintaining professional boundaries.
	Develop continuous learning processes for staff for all Use of Force incidents that identify what could have been done differently including deployment of peer counselors and de-escalation techniques. These can be incorporated as case-based scenarios in future trainings at the facility.
Peer Support Counselors	Expand and expedite plans to integrate peer counselors into emergency response and crisis de-escalation efforts.
	Empower peer counselors to support ongoing wellness initiatives, assist in programming, and serve as trusted liaisons between residents and staff.
Respectful Partnerships With CBOs	Incorporate an introduction to CBO-led programming in required staff training that includes the purpose and scope of CBO programs and reinforces the role of CBOs as essential rehabilitative partners.
Language Access	Ensure that key announcements, instructions, forms and policies are translated and communicated clearly.
	Assign trained bilingual staff/translators to high-contact roles.
	Monitor and address disciplinary trends / RVRs among non-English speakers to eliminate inequities.

Action Area	Action Steps
Entry and Search Procedures	Introduce body scanners as the first mode of screening upon intake, visitation, and other relevant operations; only use invasive physical searches when strictly necessary (e.g., when someone "fails" a body scan).
	Invest in proper maintenance contracts and timely repair services for scanning equipment.
	Revise staff training to include scenario practice for trauma-informed and trauma-responsive search practices.
External Oversight and Accountability	Advance partnerships with outside monitors and partners (e.g., Sister Warriors) to assess program implementation and adherence to safety-related mandates.

Conclusion

This report provides background, findings, and recommendations to inform and optimize the tailoring and delivery of programs within California women's prisons. While it focuses primarily on programs delivered through CCHCS, the comprehensive nature of factors that shape health and wellness makes it also relevant to the delivery of programs and operations outside of CCHCS' purview, such as education and vocational programing. Programs in women's prisons should address the unique needs of the population, including being trauma and gender-responsive.

This report also calls for the establishment of Health and Wellness Centers in California's women's prisons. These centers should serve as safe spaces that offer the integrated delivery of programs and services that support health, wellness and empowerment. The counseling teams and staff in these Centers should administer gender-responsive needs assessment tools and work with residents to develop individualized rehabilitation plans that focus on promoting their health, rehabilitation and wellness.

When delivered well, programming supports incarcerated individuals to lead healthier lives by addressing issues like substance use, anger management, healthy living, trauma, and mental illness. It also prepares them for reentry through education and job training, and enhances safety inside facilities by providing constructive and meaningful activities. There is a critical need to optimize programming in California women's prisons with an eye towards relevance to the population and quality. All program delivery must occur in a place where incarcerated people feel safe and supported to maximize successful rehabilitation and, ultimately, community safety.

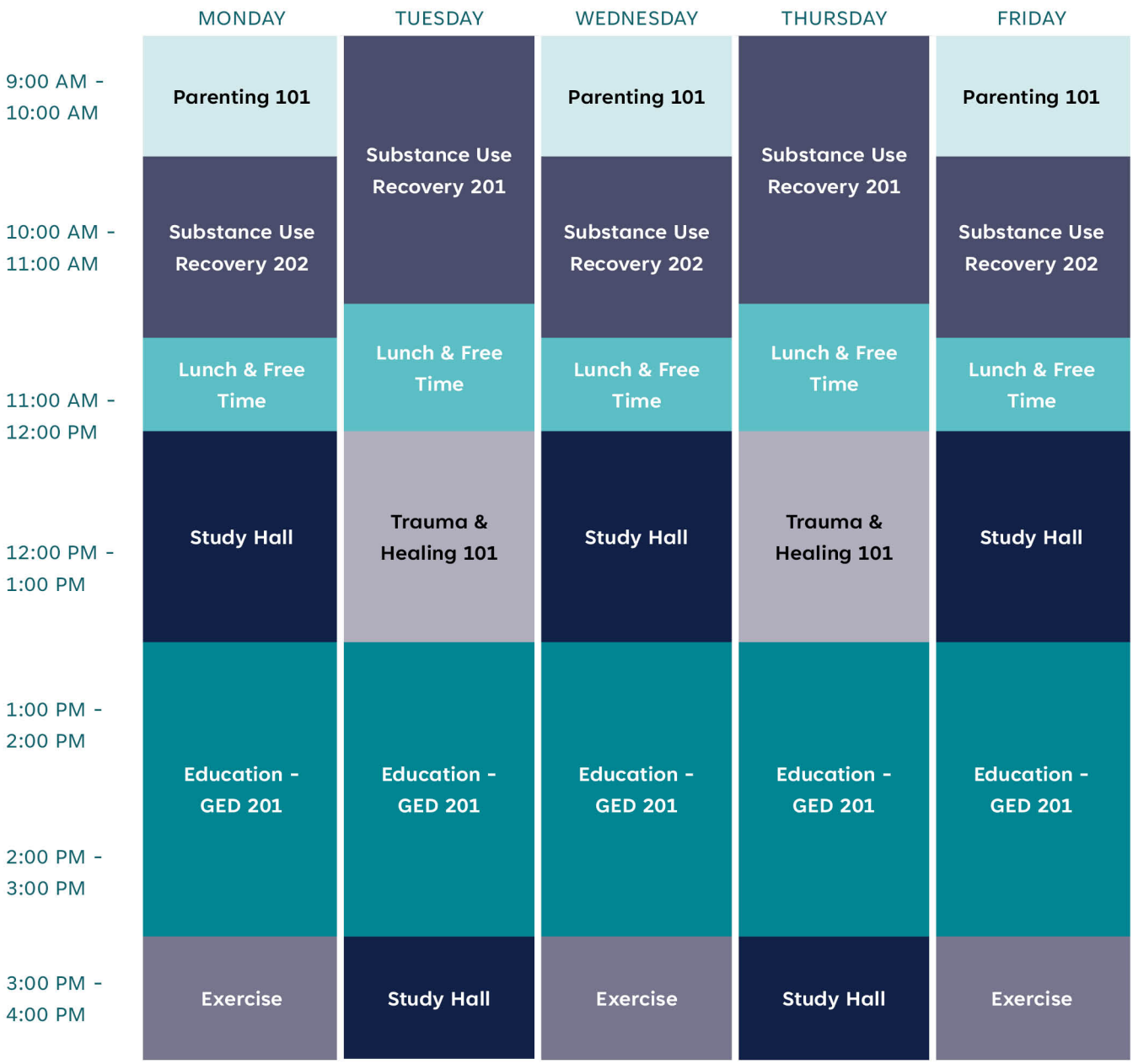
Introducing centralized Health and Wellness Centers that are conceived of in partnership with residents and CBO leaders, and addressing the recommendations in this report will allow California's women's prisons to be at the vanguard of delivering gender-responsive and trauma-informed programs that benefit the health, wellness and empowerment of people in women's prisons.

Appendix

A1: EXAMPLE INDIVIDUAL SCHEDULES

Example Individual Schedule 1 - Daily

'Melissa,' General Population, in her third year of incarceration



Example Individual Schedule 2 - Weekly

'Maria', Medium-Security, in reentry prep phase

Goals: Heal from trauma, prepare for reunification with her children, improve reading level, & train to be a peer navigator

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
7:00 AM - 8:00 AM	AM Routine & Mindfulness	AM Routine & Yoga	AM Routine & Peer Check In	AM Routine & Walk	AM Routine & Reflection/ Journaling	Optional: Poetry Circle	Personal Journaling
8:00 AM - 9:00 AM	Trauma & Healing 201	Parenting & Communication 201	Trauma & Healing 201	Literacy Tutoring (1:1)	Reunification Planning 301	Open Studio: Visual Arts	Rest / Faith Service
9:00 AM - 10:00 AM	College Prep	College Prep	College Prep	College Prep	College Prep	Peer Mentor Circle	Rest / Phone Time
10:00 AM - 11:00 AM	Peer Mentorship Training 301	Trauma-Informed Parenting Circle	Mental Health Skills 201 (CBT)	Peer Mentorship Training 301	Optional: Recovery Group	Family Visit & Lunch	Rest
11:00 AM - 12:00 PM							Lunch & Free Time
12:00 PM - 1:00 PM	Lunch & Free Time	Lunch & Free Time	Lunch & Free Time	Lunch & Free Time	Lunch & Free Time		
1:00 PM - 2:00 PM	Nutrition Drop-in Hours	Nutrition Drop-in Hours	Nutrition Drop-in Hours	Nutrition Drop-in Hours	Restorative Justice Circle	Community Theater Rehearsal	Creative Writing
2:00 PM - 3:00 PM	Health Literacy: Women's Wellness	Work-out Drop-in Hours	Meditation & Body Mapping	Cultural Identity & History	Work-out Drop-in Hours	Optional: CBO Workshop	Community Forum
3:00 PM - 4:00 PM	Career Development Drop-in Hours	Career Development Drop-in Hours	Career Development Drop-in Hours	Career Development Drop-in Hours	Career Development Drop-in Hours	Open Mic Afternoon (Monthly)	Rest & Free Time
4:00 PM - 5:00 PM	Free Time	Free Time	Free Time	Free Time	Free Time	Free Time	
5:00 PM - 6:00 PM	Dinner & Walk	Dinner & Group Game Night	Dinner & Walk	Dinner & Film Discussion Group	Dinner & Phone Time	Dinner & Music Hour	Dinner & Letters Home
6:00 PM- 7:00 PM	Optional: Spiritual / Support Group	Writing Group or Study Hall	Reading / Peer Tutor Support	Talking Circle	Weekly Reflection / Journal	Movie Night	Meditation Circle

A2: SAMPLE HEALTH AND WELLNESS PATHWAYS AND COURSE PROGRESSION

1. TRAUMA, HEALTH & EMOTIONAL WELLNESS	
101	Introduction to Trauma-informed Healing
201	Building Healthy Relationships & Boundaries
301	Peer Mentorship Training in Trauma Recovery
401	Trauma-informed Peer Facilitator Certification

2. PARENTING & FAMILY REUNIFICATION	
101	Foundations of Parenting, including nurturing from a distance
201	Co-Parenting & Communication with Caregivers
301	Reunification Planning & Advocacy
401	Parent Educator or Peer Support Training

3. CIVIC ENGAGEMENT & LEADERSHIP	
101	Introduction to Community Organizing
201	Public Speaking
301	Peer Leadership or Inside-Out College Programs
401	Policy Fellowship or Community Organizing Practicum

4. CREATIVE EXPRESSION & CULTURAL IDENTITY	
101	Journaling, Spoken Word & Visual Art
201	Cultural History & Identity Development
301	Public Exhibits, Performances, or Published Work
401	Capstone Portfolio & Cultural Leadership Lab

5. HEALTH LITERACY	
101	Understanding your Body: Reproductive and General Health
201	Nutrition, Movement, and Stress Management
301	Health Advocacy & Peer Education
401	Certified Peer Health Educator Program

6. SUBSTANCE USE RECOVERY & RELAPSE PREVENTION	
101	Foundations of Recovery: Understanding Addiction, Shame, and Change
201	Relapse Prevention, Triggers, and Coping Strategies
301	Peer Recovery Coaching
401	Advanced Recovery Leadership or Internship

7. MENTAL HEALTH TREATMENT & STABILITY	
101	Mental Health Literacy: Understanding Diagnosis & Reducing Stigma
201	Managing Symptoms: Skills for Emotional Regulation & Daily Functioning
301	Wellness Planning & Post-Release Mental Health Navigation
401	Mental Health Peer Specialist Training

8. EXERCISE & WELLNESS	
101	Movement for Women's Health
201	Building Strength & Resilience
301	Women's Wellness Leadership
401	Peer Wellness Coach Certification

A3: DETAILED CORE WELLNESS PATHWAYS

1. Trauma Healing & Emotional Wellness

A large percentage of incarcerated women have histories of physical, emotional, or sexual trauma.[64] Without addressing this, learning in other areas can be difficult.

Sample Pathway:

101: Introduction to Trauma-Informed Healing (e.g., grounding, self-regulation)

201: Building Healthy Relationships and Boundaries

301: Peer Navigator Training in Trauma Recovery

401: Trauma-Informed Peer Facilitator Certification

Outcome:

Increased emotional literacy, readiness for social reintegration, and reduced recidivism through internal transformation.

2. Parenting & Family Reunification

Nearly 60% of incarcerated women are mothers, and family is a key motivator for rehabilitation.[65]

***Sample Pathway*:**

101: Foundations of Parenting, including nurturing from a distance

201: Co-Parenting and Communication with Caregivers

301: Reunification Planning and Advocacy

401: Parent Educator or Peer Support Training

***Outcome*:**

Stronger family ties, healthier child outcomes, and improved mental health.

3. Civic Leadership & Advocacy

Women in prison often develop strong insights into justice reform and community leadership; channeling this can shift systems.

***Sample Pathway*:**

101: Introduction to Community Organizing

201: Public Speaking, Storytelling, and Policy Advocacy

301: Peer Leadership or Inside-Out College Programs

401: Policy Fellowship or Community Organizing Practicum

***Outcome*:**

Creation of peer navigators, organizers, and system-impacted leaders with a voice in policy change.

4. Creative Expression & Cultural Identity

64 "Women's Justice: A Preliminary Assessment of Women in the Criminal Justice System. *Council on Criminal Justice.* July 2024. https://councilonj.org/womens-justice-a-preliminary-assessment-of-women-in-the-criminal-justice-system

65 Maruschak LM, Bronson J, Alper M. "Parents in prison and their minor children: Survey of prison inmates." *Bureau of Justice Statistics.* 2021. https://bjs.ojp.gov/library/publications/parents-prison-and-their-minor-childrensurvey-prison-inmates-2016

Art- and culture-related programming supports healing, identity formation, and emotional expression.[66]

***Sample Pathway*:**

101: Journaling, Spoken Word, or Visual Art Workshops

201: Cultural History and Identity Development

301: Public Exhibits, Performances, or Published Work

401: Capstone Portfolio and Cultural Leadership Lab

***Outcome*:**
Reclamation of narrative, improved self-worth, and social connection.

5. Health Literacy

Incarcerated women often face chronic health issues and reproductive health concerns.[67]

***Sample Pathway*:**

101: Understanding Your Body: Reproductive and General Health

201: Nutrition, Movement, and Stress Management

301: Health Advocacy and Peer Education

401: Certified Peer Health Educator Program

***Outcome*:**
Better self-care, reduced medical crises, and peer support networks for health.

6. Substance Use Recovery & Relapse Prevention

Many incarcerated women struggle with substance use disorders, often rooted in trauma and mental health conditions.[68]

***Sample Pathway*:**

101: Foundations of Recovery – Understanding Addiction, Shame, and Change

201: Relapse Prevention, Triggers, and Coping Strategies (e.g., CBT, DBT-informed)

301: Peer Recovery Coaching or Certified Recovery Support Training (e.g., OMCP Training)

401: Advanced Recovery Leadership or Internship in Community Recovery Work

***Outcome*:**
Sustainable recovery mindset, reduced relapse risk, peer-based leadership opportunities, and integration with post-release recovery support networks (like NA/AA or harm reduction programs).

7. Mental Health Treatment & Stability

Many incarcerated women live with conditions such as PTSD, anxiety, bipolar disorder, and depression.[69] Mental

66 Littman D, Sliva S. "Prison Arts Program Outcomes." *Journal of Correctional Education*. December 2020.

67 "Women's Justice: A Preliminary Assessment of Women in the Criminal Justice System. *Council on Criminal Justice.* July 2024. https://councilonj.org/womens-justice-a-preliminary-assessment-of-women-in-the-criminal-justice-system

68 Council on Criminal Justice. (2024). *Women's justice: A preliminary assessment of women in the criminal justice system.* https://councilonj.org/womens-justice-a-preliminary-assessment-of-women-in-the-criminal-justice-system

69 Council on Criminal Justice. (2024). Women's justice: *A preliminary assessment of women in the criminal justice system*. https://councilonj.org/womens-justice-a-preliminary-assessment-of-women-in-the-criminal-justice-system

health management, thorugh the support of mental health and trauma-focused services is critical for emotional regulation, safety, and long-term stability.

***Sample Pathway*:**

101: Mental Health Literacy – Understanding Diagnosis and Reducing Stigma

201: Managing Symptoms – Skills for Emotional Regulation and Daily Functioning

301: Wellness Planning and Post-Release Mental Health Navigation

401: Mental Health Peer Specialist Training

***Outcome*:**
Increased mental health self-awareness, improved daily functioning, reduced crises, and stronger linkage to care after release.

8. Exercise & Wellness

Women in prison face higher rates of chronic medical and psychiatric illness and trauma.[70]

***Sample Pathway*:**

101: Movement for Women's Health

201: Building Strength & Resilience

301: Women's Wellness Leadership

401: Peer Wellness Coach Certification

***Outcome*:**
Improved physical health, reduced stress and trauma symptoms, enhanced self-confidence, stronger peer wellness networks, and access to meaningful post-release employment opportunities in women's health and fitness fields.

70 Lamberton C, Vaughn M. (2022). Correctional Medical Care for Female Prisoners: Legal Issues Surrounding Inadequate Treatment of Chronic and/or Preexisting Health Conditions. The Prison Journal, 102(4), 493-514. https://doi.org/10.1177/00328855221109824 (Original work published 2022)





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