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JEFFERSON S. DUNN
COMMISSIONER

May 5, 2017

TO: WARDENS
DIVISION DIRECTORS
HEADS OF STATE AGENCIES
ADMINISTRATIVE REGULATION MONITORS

CHANGE #4
ADMINISTRATIVE REGULATION 601

MENTAL HEALTH FORMS AND DISPOSITION

PURPOSE: To update forms to reflect current practices.

CHANGES TO BE MADE:

Reference:	**Action Required:**
AR 601, *Mental Health Forms and Disposition*, dated May 2, 2016	
ADOC Form MH-028, *Involuntary Mediation Request*	Replace ADOC Form MH-028 dated November 10, 2014 with ADOC Form MH-028 Revised, dated May 5, 2017.
ADOC Form MH-029, *Notice of Involuntary Medication Hearing*	Replace ADOC Form MH-029 dated November 10, 2014 with ADOC Form MH-029 Revised, dated May 5, 2017.
ADOC Form MH-030, *Record of Involuntary Review*	Replace ADOC Form MH-030 dated November 10, 2014 with ADOC Form MH-030 Revised, May 5, 2017.

File this numbered change at the back of the regulation after annotating both the index and the regulation to indicate changes have been completed.

Advise all personnel in your organization of the change to this regulation.

Jefferson S. Dunn
Commissioner

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

INVOLUNTARY MEDICATION REQUEST

Inmate's Name:_____AIS#: _____

Location/Facility: _____

Brief Psychiatric History: _____

_____

Current mental status: _____

_____

Significant medical history: _____

_____

DSM Diagnosis: _____

_____

As a result of this serious mental illness, the inmate has been assessed as presenting a substantial likelihood of *(check all that apply)*

- ☐ Danger to self as evidenced by: _____

_____

- ☐ Danger to others as evidenced by: _____

_____

- ☐ Substantial risk of significant property damage as evidenced by: _____

_____

- ☐ Being unable to provide for essential physical needs as evidenced by: _____

_____

- ☐ Experiencing severe repeated and escalating deterioration as evidenced by: _____

_____

Inmate Name: _____ AIS #:_____

Disposition: Inmate Medical Record, Inmate, Warden, Director of Treatment

Reference: ADOC AR 621
ADOC Form MH-028 – May 5, 2017

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

INVOLUNTARY MEDICATION REQUEST (Continued)

Based on this psychiatric assessment, I have recommended to the inmate that the following medication(s) (are) is required for effective treatment:

Name of Medication(s)	Dose	Frequency	Route

The inmate has been counseled on the importance of medication compliance but continues, on a consistent basis, to refuse to take this medication. The inmate therefore may lack the capacity to give informed consent. Based on this situation, I am requesting that involuntary medication be administered to the inmate. Circle one of the following:

Initial Request Continuation Request

I am requesting authorization for the administration of the following involuntary medications (including injectable and oral alternatives)

Name of Medication(s)	Dosage	Range	Frequency

Medication History (to be completed for initial request only):

List psychotropic medication(s) used in the past: _____

List medication(s) to which the inmate has been most responsive: _____

Medication side effect history (include severity): _____

Past involuntary medication (type, date, response): _____

Current response to involuntary medication (continuation request only): _____

Inmate Name:	AIS #:

Disposition: Inmate Medical Record, Inmate, Warden, Director of Treatment

Reference: ADOC AR 621
ADOC Form MH-028 – May 5, 2017

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

INVOLUNTARY MEDICATION REQUEST (Continued)

Methods used to motivate the inmate to accept voluntary medication and response to these efforts:

_____
_____
_____

Less intrusive alternatives to involuntary medication considered and reason for rejection:

_____
_____
_____

Religious objections to medication (describe): _____
_____
_____

Gains anticipated from proposed involuntary medication: _____
_____
_____
_____

In conclusion, it is my medical opinion that the gains anticipated from the proposed involuntary medication substantially out-weigh the risks of potential side effects and that the administration of the medication is in the inmate's best medical interest.

_____ _____
Psychiatrist Signature Date

Treatment Team Signatures	Discipline	Date	Concur/Dissent

Inmate Name:	AIS #:

Disposition: Inmate Medical Record, Inmate, Warden, Director of Treatment

Reference: ADOC AR 621
ADOC Form MH-028 – May 5, 2017

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

NOTICE OF INVOLUNTARY MEDICATION HEARING

To Inmate:_____ **AIS#:** _____

Date:_____ **Institution:** _____

From: _____
Involuntary Medication Review Committee Chair

You are hereby notified that on_____**(Date) at**_____**(Time)**

an Involuntary Medication Hearing will be held to determine whether or not you may be administered psychotropic medication against your will. The hearing is being conducted because you have been diagnosed with a serious mental illness, involuntary medication has been found to be in your best medical interest, and you are considered to be at risk for:

☐ Danger to self as evidenced by: _____
_____

☐ Danger to others as evidenced by: _____
_____

☐ Substantial risk of significant property damage as evidenced by: _____
_____

☐ Being unable to provide for essential physical needs as evidenced by: _____
_____

☐ Experiencing severe repeated and escalating deterioration as evidenced by:_____
_____

DSM Diagnosis:

Diagnostic Criteria:

Medication has been offered to you but you have refused to accept it. The treatment team is recommending that the following medication(s) be involuntarily administered:

Reference: ADOC AR 621
ADOC Form MH-029 – May 5, 2017

In this process you have the following rights:

- **To be present at the hearing.**
- **To have assistance from a staff advisor to explain the purpose of the hearing and to assist you in presenting objections to involuntary medication. The staff advisor may not be someone involved in your current treatment.**
- **To be un-medicated the day of the hearing.**
- **To present alternatives to involuntary medication at the hearing.**
- **To present information and call witnesses to the hearing.**
- **To question staff who are supporting involuntary medication.**
- **To have a copy of the Involuntary Medication Review Committee's written decision and a copy of the minutes of the hearing.**
- **To appeal the Involuntary Medication Review Committee decision administratively, if the decision authorizes involuntary medication.**
- **To have a staff advisor assist in an administrative appeal.**
- **To seek judicial review in a court of appropriate jurisdiction if the administrative appeal is denied.**

You may not have an attorney present at the hearing.

Your staff advisor is: _____

You may contact your advisor by: _____

I have been given a copy of the Notice of Involuntary Medication Hearing.

Inmate Signature/Date: _____

Witness Signature/Date _____

Inmate Name: _____ AIS #: _____

Disposition: Inmate Medical Record, Inmate, Warden, Director of Treatment

Reference: ADOC AR 621
ADOC Form MH-029 – May 5, 2017

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

RECORD OF INVOLUNTARY MEDICATION REVIEW

Inmate Name:_____AIS #:_____Institution: _____

On_____a hearing was held at_____regarding the administration of Involuntary Medication to the above inmate

The hearing was an: ☐ Initial Request ☐ 90-day Review ☐ 180-day Review

The Name of the Staff Advisor was: _____

The inmate was: ☐ Present ☐ Not Present

If the inmate was not present, the reason for the absence: _____

_____

At the onset of the hearing the following rights were explained to the inmate:

- The nature and purpose of the hearing
- The right to the assistance of an advisor
- The right to review the psychiatric documentation supporting involuntary medication
- The right to question witnesses supporting involuntary medication
- The right to present information and witnesses objecting to involuntary medication
- The right to present alternatives to involuntary medication
- The right to appeal the decision, if averse, administratively with the assistance of an advisor
- The right to seek judicial review in a court of appropriate jurisdiction if the administrative appeal is denied

The following witnesses testified at the hearing:

Supporting involuntary medication	Objection to involuntary medication
_____	_____
_____	_____
_____	_____

If testimony presented by the inmate or his/her witnesses or questioning of witnesses supporting involuntary medication was disallowed or limited, the reasons were:

_____

_____

_____

INMATE NAME:	AIS #:

Disposition: Inmate Medical Record, Warden, Inmate, Director of Treatment

Reference: ADOC AR 621
ADOC FormMH-030 – May 5, 2017

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

RECORD OF INVOLUNTARY MEDICATION REVIEW

Inmate Name:_____AIS #:_____Institution: _____

Based on the information presented or reviewed at the hearing, the following decisions were reached regarding authorization of involuntary medication:

Chair/Psychiatrist	☐ Authorize	☐ Do Not Authorize
Psychologist	☐ Agree	☐ Do Not Agree
Mental Health Professional	☐ Agree	☐ Do Not Agree

Based on the above decisions:

☐ Involuntary medication is not authorized

☐ Involuntary medication(s) is (are) authorized as follows *(include injectable and oral alternatives)*

Medication	Dosage Range	Route

Committee Members:

Signature	Printed Name	Date

Warden Review:

Signature	Printed Name	Date

An inmate has the right to appeal a decision to authorize involuntary medication within one working day of receiving the Record of Involuntary Medication Review. The staff advisor will assist the inmate with the appeal if requested.

I was provided a copy of the Record of Involuntary Medication Review.

Inmate Signature	AIS#	Date

INMATE NAME: AIS #:

Disposition: Inmate Medical Record, inmate, Warden, Director of Treatment

Reference: ADOC AR 621
ADOC Form MH-030 – May 5, 2017