TO: WARDENS
DIVISION DIRECTORS
HEADS OF STATE AGENCIES
CHANGE #4
ADMINISTRATIVE REGULATION 601
ADMINISTRATIVE REGULATION MONITORS

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

Replace ADOC Form MH-028 dated November 10, 2014 with

ADOC Form MH-028,
Involuntary Mediation
Request

ADOC Form MH-029,
Notice of Involuntary
Medication Hearing

Replace ADOC Form MH-029 dated November 10, 2014 with

ADOC Form MH-030,
Record of Involuntary
Review

Replace ADOC Form MH-030 dated November 10, 2014 with

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

IN VOLUNTARY 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
IN VOLUNTARY 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:

<table>
<thead>
<tr>
<th>Name of Medication(s)</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
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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)*

<table>
<thead>
<tr>
<th>Name of Medication(s)</th>
<th>Dosage</th>
<th>Range</th>
<th>Frequency</th>
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</table>

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):

<table>
<thead>
<tr>
<th>Inmate Name:</th>
<th>AIS #:</th>
</tr>
</thead>
</table>

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  

IN VOLUNTARY 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 IN VOLUNTARY 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 521
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-019 – 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 adverse, 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, Warlen, 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 IN VolUNtARY 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:

<table>
<thead>
<tr>
<th>Chair/Psychiatrist</th>
<th>Authorize</th>
<th>Do Not Authorize</th>
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</thead>
<tbody>
<tr>
<td>Psychologist</td>
<td>Agree</td>
<td>Do Not Agree</td>
</tr>
<tr>
<td>Mental Health Professional</td>
<td>Agree</td>
<td>Do Not Agree</td>
</tr>
</tbody>
</table>

Based on the above decisions:

- [ ] Involuntary medication is not authorized
- [ ] Involuntary medication(s) is (are) authorized as follows (include injectable and oral alternatives)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage Range</th>
<th>Route</th>
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Committee Members:

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<tr>
<th>Signature</th>
<th>Printed Name</th>
<th>Date</th>
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Warden Review:

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<th>Printed Name</th>
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</table>

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.

<table>
<thead>
<tr>
<th>Inmate Signature</th>
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INMATE NAME: ____________________________ AIS #: __________

Disposition: Inmate Medical Record, inmate, Warden, Director of Treatment
Reference: ADOC AR 621
ADOC Form MH-030 – May 5, 2017