GEORGIA DEPARTMENT OF CORRECTIONS **Standard Operating Procedures**		
Policy Name: Psychotropic Medication Use Management		
Policy Number: 508.24	**Effective Date:** 8/15/2022	**Page Number:** 1 of 19
Authority: Commissioner	**Originating Division:** Health Services Division (Mental Health)	**Access Listing:** Level II: Required Offender Access

I. Introduction and Summary:

Psychotropic Medications used in the treatment of mental illness will be prescribed when medically indicated and used in a manner consistent with current pharmacological knowledge. Use of Psychotropic Medications will require informed consent, a physician's order, and regular monitoring for clinical response and side effects. Informed consent is documented for offender care in a language understood by the offender. All necessary screening tests will be ordered at or prior to the initiation of therapy. Prescribing of Psychotropic or behavior modifying medications will be clinically indicated as one facet of a program of therapy and will not be used for disciplinary purposes. This procedure is applicable to all Georgia Department of Corrections (GDC) facilities with a mental health mission.

II. Authority:

A. GDC Standard Operating Procedures (SOPs): 508.21 Treatment/Habilitation Planning, 508.38 Involuntary Psychotropic Medication, 507.04.45 Non-adherence with Medications, and 507.04.43 Medication Distribution System;

B. National Commission on Correctional Health Care (NCCHC): Standards for Health Services in Prisons and Standards for Health Services in Juvenile Detention and Confinement Facilities; and

C. ACA Standards: 2-CO-4E-01, 5-ACI-6A-32 (Mandatory), 5-ACI-6A-43 (Mandatory), 5-ACI-6C-04 (Mandatory), 5-ACI-6C-08 (Mandatory), 4-ALDF-4D-15 (Mandatory), and 4-ACRS-4C-19.

III. Definitions:

Psychotropic Medication - Medication having a direct effect on the central nervous system and used in the treatment of mental illness. These medications usually affect thinking, mood, and behavior, and include antipsychotics, antidepressants, antianxiety agents, sedatives, hypnotics, psychomotor stimulants, and mood stabilizers.

IV. Statement of Policy and Applicable Procedures:

A. Minimum Standards for Initiating or Prescribing Psychotropic Medications:

1. The psychiatrist or advanced practice registered nurse (APRN) will review or complete an Initial Psychiatric or Psychological Evaluation using Attachment 6 (M60-01-06) that will include the following:

    a. Identifying data;

    b. The chief complaint;

    c. Relevant history (present, past, family, and medical);

    d. A complete alcohol and drug use history, including previous treatments;

    e. A complete mental status examination;

    f. Symptoms and behavioral manifestations for which medication may be prescribed;

    g. A medication history, including medication allergies;

    h. The current medication regimen; and

    i. The psychiatric history will include previous hospitalizations for mental illness, previous psychiatric diagnosis, and medication regimens and a brief assessment of previous mental health management.

2. For each mental health patient to receive newly prescribed Psychotropic Medications, the psychiatrist or APRN will insure that there is a diagnosis or diagnostic impression in accordance with the current edition of the Diagnostic and Statistical Manual (published by the American Psychiatric

Association) prior to initiating Psychotropic Medication. The psychiatrist or APRN will review or record and sign the pertinent diagnosis in the Problem List (PI-2009) of the medical record (Section 1). The psychiatrist or APRN will also record the pertinent diagnosis and recommended level of care on the Mental Health Diagnosis List (form M20-01-05) of the mental health record (Section 2) or sign the previously completed Diagnosis List. The psychiatrist or APRN will consider possible organic or physical causes of symptoms of mental illness and either rule them out or refer for evaluation through appropriate testing or consultation. The psychiatrist or APRN will document in the medical record that organic/physical causes have been considered and ruled out or are in the process of evaluation.

3. Current standards require that Psychotropic Medications be prescribed in a prudent manner, consistent with standard psychiatric practice. Any use of a Psychotropic Medication inconsistent with standard psychiatric practice or medications that are not listed in the drug formulary for the GDC must be submitted as a non-formulary request and be approved by the chief psychiatrist for the contract provider.

4. All offenders require a current medical classification profile reflecting their mental health functioning, their need for services, and pertinent information used for housing purposes. Offenders transferred or received at a new facility will have their medication continued until seen by a psychiatrist or APRN, unless medically contraindicated. A psychiatric consultation will be scheduled within fourteen (14) days of arrival at the new facility and documented on Attachment 5, Psychology/Psychiatry Transfer Evaluation (M60-01-05). If an offender is not on psychotropic medication, a psychological or psychiatric consultation will occur within fourteen (14) days of arrival at the new facility and documented on a Psychology/Psychiatry Transfer Evaluation (Attachment 5, form M60-01-05).

5. All offenders who are prescribed Psychotropic Medication for mental illness will be identified on the mental health caseload and will be assigned to a

primary mental health counselor who will develop a comprehensive treatment plan as defined in SOP 508.21.

6. Heat education will be done each year from April 1 – September 30 (using Attachment 4, M60-01-04).

B. There will be a physician's order for each Psychotropic Medication prescribed.

C. The prescription will be recorded on the Physician's Order (form PI-3003) in the medical record (Section 1) and will specify the name of the medication, the amount, and the route and frequency of administration. It will also specify the number of refills if applicable. The order will be signed, dated, and timed by the prescribing physician. A copy of the Physician's Order form will be placed in the mental health record (Section 6). Each physician's order will be accompanied by a Psychiatric Progress Note (form M20-02-03) typed or legible written. The Psychiatric Progress Note will be placed in the medical record (Section 5) with a copy placed in the mental health record (Section 1). If a nurse takes a verbal or telephone order, the nurse will write a Mental Health Progress Note (form PI2000-5) to accompany the order. The nurse's progress note will be placed in the medical record (Section 5) and a copy of the note will be placed in the mental health record (Section 1).

1. The psychiatrist or APRN must have all offenders sign a written informed consent using Attachment 1 (M60-01-01), prior to the initiation of Psychotropic Medication therapy. If the offender is psychotic or incompetent, they will be evaluated for involuntary medication. Multiple medications will not be listed on a single consent. Medication categories/classes can be substituted for individual medication names. The completed Mental Health Informed Consent will be placed in the "Informed Consent" section of the medical record (Section 3). Consents will remain effective for one (1) year from date of the offender's signature, after which time a new consent form needs to be signed.

2. Ongoing Management of Offenders Taking Psychotropic Medications: The psychiatrist or APRN initially prescribing and/or continuing to prescribe Psychotropic Medications must review the patient's condition at appropriate intervals to document persistent symptoms and side effects and to adjust medication dosages when appropriate. Psychotropic Medication therapy and progress of the offenders will be reviewed and documented by the psychiatrist within ten (10) working days of Psychotropic initiation. When released from a psychiatric hospital, a crisis stabilization unit/acute care unit, or observation cell, the offender must be seen within 48 hours by a licensed mental health staff member. If the offender is on Psychotropic Medication, they must be seen by a psychiatrist or APRN within fourteen (14) days of discharge.

3. When a psychiatrist or APRN is obtaining medication informed consent, the medication informed consent is medication-specific, and will include anxiolytics (anti-anxiety), atypical anti-psychotics, mixed action antidepressants, mood stabilizers, selective serotonin reuptake inhibitors (SSRIs), tricyclic anti-depressants, and first generation anti-psychotics (typical anti-psychotics).

4. The frequency of psychiatrist or APRN or psychologist contacts will be as follows:

    a. MH level IV offenders who are being treated with Psychotropic Medication will be seen by a psychiatrist or APRN at least every 30 days;

    b. MH level III offenders who are being treated with Psychotropic Medication will be seen by a psychiatrist or APRN at least every 30-60 days;

    c. MH level II offenders who are being treated with Psychotropic Medication will be seen by a psychiatrist or APRN at least every 60-90 days;

d. Offenders who have been treated with Psychotropic Medication that have been discontinued will be seen by a psychiatrist or APRN for a minimum of at least every 60 days;

e. MH level IV offenders who are not being treated with Psychotropic Medication will be seen by a psychologist at least every 30 days;

f. MH level III offenders who are not being treated with Psychotropic Medication will be seen by a psychologist at least every 60 days; and

g. MH level II offenders who are not being treated with Psychotropic Medication will be seen by a psychologist if there is a clinical need. The number of psychology contacts will be clinically justified and documented in a progress note.

5. The psychiatrist or APRN will include the following in the Psychiatric Progress Note (M20-02-03):

   a. Effects of prescribed medication(s) on targeted symptoms and behavior;

   b. Reason(s) for increasing or decreasing dosage of medication;

   c. The results of any blood testing either indicated for the medication or recommended by prevailing standards (includes screening tests and blood levels);

   d. Suspected adverse reactions or side effects of the medication;

   e. Current level of function and appropriateness of current treatment; and

   f. Current diagnosis or if applicable, reasons for changing diagnosis.

6. The treating psychiatrist or APRN will ensure that all necessary laboratory work and associated medical referrals are complete and up to date prior to starting or routine continuation of any Psychotropic Medication.

D. General Guidelines for the Use of Psychotropic Medication:

1. Psychotropic Medications will be used appropriately as part of a written individualized treatment or habilitation plan (Attachment 2, Comprehensive Treatment Plan (M50-01-02) or Attachment 3, Comprehensive Treatment Plan Review (M50-01-03) from SOP 508.21), as appropriate;

2. The use of Psychotropic Medication will be documented in the treatment plan as an intervention strategy targeted to a specific problem (target symptom) with a specific goal. In the treatment plan, medication categories or classes may be used rather than specific medication names and dosage is not required;

3. Non-psychiatric practitioners will limit their use of Psychotropic Medications for mental illness to those cases in which the offender is already taking Psychotropic Medications at the time of admission or transfer. These prescriptions will be limited to no more than thirty (30) days. The psychiatrist will explain to the patient the need for Psychotropic Medication used to treat or prevent symptoms of mental illness to improve patient participation in medication therapy;

4. The use of Psychotropic Medications without informed consent is restricted to emergency situations in which the offender presents an immediate danger of causing harm to self or others and no less intrusive or restrictive intervention is available or would be effective. If use of Psychotropic Medication without informed consent is required for longer than 24 hours or more than twice within 30 days, procedures for involuntary medication must be initiated in accordance with SOP 508.38, Involuntary Psychotropic Medication;

5. A mental health nurse will advise the psychiatrist or APRN whenever an offender receiving mental health services has been non-adherent with ordered labs or medications according to the definition of non-adherence listed in SOP 507.04.45. Medication for non-adherence offenders will be continued until the next scheduled appointment with the psychiatrist or APRN. In circumstances where an offender has been found to be hoarding Psychotropic Medications, the nurse will notify the psychiatrist or APRN who will then consider discontinuing the medication and will schedule an appointment with the offender as soon as possible;

6. Mental health nurses will follow guidelines for non-adherence counseling and non-adherence tracking as stated in SOP 507.04.45. "Missing" doses include refusals and failure to attend medication administration periods. Non-adherent offenders will be identified as:

    a. MH level II offenders who miss 25% of total doses within a one-month period. Such offenders will receive non-adherence counseling within 30 days; and

    b. MH level III and IV offenders who miss 25% of doses of antipsychotics, antidepressants, or mood stabilizers within a one-week period. Such offenders will receive non-adherence counseling within 14 days. Doses of other medications missed by MH level III and IV offenders will be addressed according to the procedure for MH level II offenders.

7. Offenders who fail to report to non-adherence counseling sessions will be rescheduled within one working day;

8. The mental health nurse will forward a copy of the Non-Adherence Counseling Form (P-33-0003-01) to the psychiatrist or APRN after two unsuccessful counseling attempts due to the offender's failure to adhere with prescribed medication. The offender will be seen by the psychiatrist or APRN within 14 days for MH level III and IV offenders and 30 days for MH level II

offenders to review the reasons for non-adherence and consider adjusting or changing the medication, initiating involuntary medication, or discontinuing the medication;

9. As soon as possible, nurses will notify the psychiatrist when an offender who is on involuntary medication status refuses a single scheduled dose of Psychotropic Medication. A progress note documenting this will be completed by the nurse; and

10. All medication administration records (MAR's) will be copied for psychiatric or APRN review at the time of the appointment.

E. Discontinuation of Psychotropic Medication:

1. Discontinuing Psychotropic Medications such as antipsychotics/ antidepressants and mood stabilizers must be done with caution:

   a. Psychotropic Medications should be discontinued after an appointment with a psychiatrist or APRN;

   b. If Psychotropic Medications, such as (antipsychotics, antidepressants, mood stabilizers) are discontinued, there should be an explanation of the reason they were originally prescribed and clear documentation of what treatment the psychiatrist or APRN recommends;

   c. If no alternative Psychotropic Medication is initiated in its place, the psychiatrist or APRN will carefully assess the need and schedule a follow-up in 60 days;

   d. If the psychiatrist or APRN recommends the offender be discharged from the mental health caseload, the offender will be considered for level I services by the treatment team. The offender will be assessed for discharge at least sixty (60) days after discontinuation of medication;

e. If it is the opinion of the psychiatrist or APRN that the offender should be on a Psychotropic Medication to avoid decompensation, and the offender refuses to follow that recommendation, the psychiatrist or APRN should assess the risk, consider treatment options such as involuntary medication, and document robust educational efforts to get the offender to follow recommendations. An offender that requires medication to avoid serious decompensation will not be taken off the mental health caseload;

f. Changing or discontinuing Psychotropic Medications for offenders who are transfers from other GDC facilities that are already on a mental health caseload should be avoided on the first visit;

g. On the infrequent occasion that changing or discontinuing medication on the first visit is necessary, clear documentation of the reason for the urgency and the clinical rationale for the change are needed;

h. Discontinuing offenders who have been on Psychotropic Medication from the mental health caseload should be a treatment team decision;

i. Offenders with severe and persistent disorders such as schizophrenia, schizoaffective disorder, or bi-polar disorder should remain on the mental health caseload. If an offender has been assigned such a diagnosis but the ongoing clinical presentation warrants a diagnostic change, the offender may be considered for discharge with appropriate documentation;

j. Even the most stable offenders who were recently discontinued from Psychotropic Medication will be monitored on the mental health caseload for a minimum of sixty (60) days;

k. In diagnostic facilities, any discharges from the mental health caseload will be considered after sixty (60) days and agreed upon by the treatment team; and

l. When an offender refuses Psychotropic Medication against medical advice, then a psychiatrist or APRN will monitor the offender for at least two (2) months. If the offender is not diagnosed with a serious and persistent mental illness, the psychiatrist or APRN shall refer the offender to the psychologist for consideration of non-pharmacological treatment interventions.

F. Laboratory Testing for Psychotropic Medication Use:

1. When indicated, laboratory tests will be used for patients on Psychotropic Medications to prevent harmful side effects or to assist in achieving therapeutic levels. Routine laboratory results should be available for physician review within five (5) days of the date they were ordered. Monitoring for metabolic syndrome will occur as clinically appropriate.

2. Required Tests for Antipsychotic Agents:

a. Treatment Initiation:

i. Pretreatment laboratory tests should be ordered as clinically indicated and based upon the patient's past medical history, results of the charted physical examination, previous history of adverse medication reactions, and potential adverse effects associated with specific antipsychotics.

ii. Decanoate forms of neuroleptics are never to be used in emergency situations. Decanoate neuroleptics are to be prescribed only by psychiatrists or APRN and a trial of the oral or parenteral short-acting form of the neuroleptic should be documented; and

iii. Offenders treated with new generation antipsychotic medication will have their weight and waist circumference monitored, using

Attachments 7 and 8 (M60-01-07 and M60-01-08) every six (6) months along with a lipid panel and fasting blood glucose or HgbA1c.

b. Follow-up:

i. Follow-up tests should be ordered as clinically indicated and based upon the patient's past medical history, results of physical examination, previous history of adverse medication reactions, and knowledge of the potential adverse effects of the different antipsychotics; and

ii. Offenders on Psychotropic Medications will be formally evaluated for the presence of tardive dyskinesia, using Attachment 2, Abnormal Involuntary Movement Scale (AIMS) (M60-01-02). Mental health nurses or the psychiatrist or APRN will complete the AIMS form prior to initiation of antipsychotic medication and at least every six (6) months thereafter. The completed AIMS form will be placed in the medical record (section 5).

3. Required Tests for Antidepressant Agents:

a. Pretreatment and follow-up laboratory tests should be ordered as clinically indicated and based on physical exam, past medical history, previous history of adverse medication reactions, and knowledge of potential adverse medication reactions. (e.g., Patients with a history of cardiac pathology or prolonged QT intervals will need periodic EKGs during administration of antidepressants); and

b. Dosage adjustments should be initiated based on need following a clinical assessment. A period of medication compliance consistent with expected response time should be allowed prior to consideration of dosage change.

4. Required Test for Lithium:

    a. Conduct a Pre-Lithium Treatment Work-up, which includes:

        i. CBC;

        ii. BUN, Electrolytes, CR;

        iii. TSH, T3, T4;

        iv. Pregnancy test, if indicated;

        v. EKG if >45 years old or if clinically indicated; and

        vi. Any other tests that are clinically indicated based on examination.

    b. Follow-up for Lithium:

        i. Repeat pre-lithium treatment work-up yearly; and

        ii. BUN, electrolytes, CR., TFT's and EKG if indicated every 6 months.

    c. Assessing Lithium Serum Levels:

        i. Blood for Lithium levels should be collected at least 8 to 12 hours after the last dose and prior to the next dose (usually before breakfast); and

        ii. Desirable serum levels for Lithium vary from laboratory to laboratory. Levels obtained should be compared to the standard range of the contract lab. Many patients respond to sub-therapeutic levels and clinical response must be evaluated.

d. Required Frequency of Assessment:

i. Determine Lithium serum levels seven days after starting or changing dosage; and

ii. After serum level and clinical condition of the patient have been stabilized, Lithium levels should be monitored at least every six (6) months.

5. Required Test for Carbamazepine (Tegretol):

a. Conduct a Pre-Carbamazepine Treatment Work-Up, which includes:

i. CBC with Differential;

ii. Pregnancy test, if indicated;

iii. LFT's (TP, Alk. Phos., GGT, alb., LDH, T. Bili); and

iv. Any other tests that are clinically indicated.

b. The above tests should be repeated every six (6) months and whenever a clinical condition exists. For example, obtain an immediate CBC with differential if there is petechiae, pallor, unexplained weakness, fever, or signs of infection; and

c. Tegretol blood levels perform monthly for two (2) months, then every six (6) months.

6. Required Tests for Valproic Acid:

a. Conduct a Pre-Valproic Acid Treatment Work-up, which includes;

i. CBC with Differential;

ii. Pregnancy tests, if indicated; and

iii. LFTs.

b. Follow-up:

i. Repeat above test in six (6) months; and

ii. Valproic Acid levels every six (6) months and within two (2) weeks of dosage change.

7. Pharmacotherapy of Anxiety:

a. Non-emergency:

i. Pharmacotherapy of anxiety should be limited to well documented anxiety disorders or as an adjunct to treatment of the anxiety component of affective disorders;

ii. Generally, the most appropriate first line treatment of anxiety disorders is with antidepressant medications;

iii. The use of hydroxyzine, diphenhydramine, or similar non-benzodiazepine agents as augmentation for, or treatment of, anxiety is at times appropriate. In refractory cases, anti-hypertensives such as propranolol, clonidine, or prazosin may be considered with appropriate blood pressure monitoring. Alternatively, buspirone may be used with approval of the recognized chief psychiatrist for the GDC;

iv. Anxiolytics should not be used as a treatment for primary insomnia. Insomnia should be addressed through sleep hygiene techniques;

v. In non-emergency situations benzodiazepine usage, generally should not exceed a period of three (3) weeks. Documentation of any history of drug or alcohol dependence and the potential for cross-tolerance must be included in the patient's chart. The three (3) week usage period should include tapering to discontinuation if indicated; and

vi. If a patient is considered for maintenance on benzodiazepines over one (1) year, this will be reviewed with a second psychiatrist or the chief psychiatrist for the contractor or the chief psychiatrist for the GDC and documented efforts to use non-benzodiazepine alternatives and non-pharmacologic interventions.

b. Use in Emergency Situations:

i. Use of benzodiazepines in emergency situations is at times appropriate. However, their usage at such times should not exceed a (24) twenty four-hour period without review and documentation of reasons for continuation of the medication.

G. Self-Administration of Medications ("SAM"):

1. Stable level II mental health offenders are appropriate for self-administered non-Psychotropic Medications;

2. Offenders who have significant and/or on-going behavior patterns of self-injury and/or significantly impaired judgment are not eligible for self-administered non-Psychotropic Medication;

3. Offenders who are not on the mental health caseload and demonstrate unsafe behavior shall be referred to the physical health provider for evaluation for non-SAM status;

4. Offenders in diagnostic facilities who are designated as MH level II will automatically be on SAM status for non-MH medications. The status established will follow the offender to the permanent facility upon transfer;

5. When the offender is evaluated by the psychologist or psychiatrist or APRN and determined to be inappropriate for SAM status, the clinician shall document the reason and either write an order in the medical record or refer the offender to the psychiatrist or APRN to write the order;

6. The nurse who transcribes the order will add "Non-SAM" medication status to the Problem List in the medical record;

7. Any mental health offender who becomes self-injurious, hoards medications, or uses them inappropriately will be immediately referred to the psychiatrist or APRN for evaluation for non-SAM status; and

8. After self-injury, the team will wait at least one year to re-consider the SAM status.

H. Heat Precautions for Patients Receiving Psychotropic Medications:

1. Offenders maintained on Psychotropic Medications may have increased sensitivity to sunlight and may be at higher risk of heat-induced syndromes, including heatstroke, hyperthermia, and heat exhaustion. In view of these factors, the following procedures are to be followed:

   a. Offenders receiving Psychotropic Medication will be counseled by the mental health nursing staff of the potential risk factors and advised:

i. To wear protective clothing and/or use sunscreen when in direct sunlight for extended periods; and

ii. The need for adequate intake of fluids: eight (8) to twelve (12) glasses of water per day, to avoid dehydration. Offenders assigned to outside details may require more.

b. Counseling will be documented on Attachment 4 (M60-01-04), with offender signatures, GDC number, and date signed. The original will be placed in Section 5 of the medical record and a copy placed in Section 5 of the mental health record.

2. If the offender is in lock down, SLU, ACU, or CSU the temperature of the confinement building must be monitored during periods in which the ambient interior temperature exceeds 85 degrees Fahrenheit. Multi-tier and multi-story housing units will have temperatures logged at each floor level. The following procedures will be followed between April 1 and September 30 annually. The temperature will be documented by security once every 6 hours during daylight hours on Attachment 3, Lockdown SLU/ACU/CSU Temperature Log (M60-01-03) and maintained in the respective housing unit. If offender housing areas exceed 85 degrees Fahrenheit, the following measures must be instituted:

a. Increased ventilation to the area through utilization of fans to improve airflow and reduce room temperature to less than 85 degrees;

b. Provision of increased fluids and ice;

c. Allowance of additional showers to provide cooling; and

d. Recommendation to the warden to permit temporary transfer of the offender to an area of the institution that is more compatible with the offender's clinical status.

IV. Attachments:

Attachment 1: Mental Health Medication Informed Consent (M60-01-01)
Attachment 1A: Any Typical Antipsychotic Informed Consent (M60-01-01A)
Attachment 1B: Any Atypical Antipsychotic Informed Consent (M60-01-01B)
Attachment 1C: Any Mixed Action Antidepressant Informed Consent (M60-01-01C)
Attachment 1D: Any SSRI Antidepressant Informed Consent (M60-01-01D)
Attachment 1E: Any SSRI Antidepressant (Itemized) Informed Consent (M60-01-01E)
Attachment 1F: Tricyclic Antidepressant Informed Consent (M60-01-01F)
Attachment 1G: Mood Stabilizer Informed Consent (M60-01-01G)
Attachment 1H: Anxiolytic Informed Consent (M60-01-01H)
Attachment 2: Abnormal Involuntary Movement Scale (M60-01-02)
Attachment 3: Lockdown SLU/ACU/CSU Temperature Log (M60-01-03)
Attachment 4: Medication News for Hot Weather (M60-01-04)
Attachment 5: Psychology/Psychiatry Transfer Evaluation (M60-01-05)
Attachment 6: Initial Psychiatric-Psychological Evaluation (M60-01-06)
Attachment 7: Antipsychotic Monitoring Log (M60-01-07)
Attachment 8: Instructions for Antipsychotic Weight-Waist Record (M60-01-08)

V. Record Retention of Forms Relevant to this Policy:

Upon completion, Attachments 1, 1A-1H, 2, 4, 5, and 6 shall be placed in the offender's mental health file. At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for 10 years. Attachments 3 and 7 shall be maintained in the mental health area for 10 years. Attachment 8 is instructional only and shall be utilized until revised or obsolete.