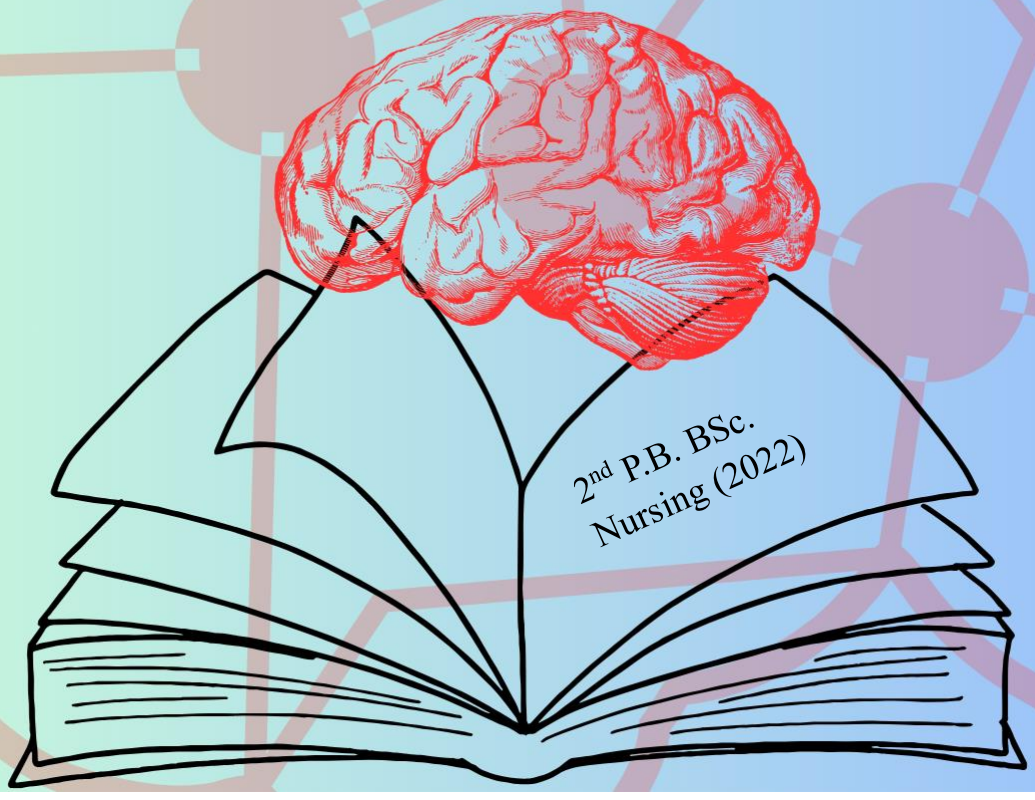
HOLY SPIRIT INSTITUTE OF NURSING EDUCATION
Holy Spirit Hospital, Mahakali Road, Andheri (East), Mumbai - 400 093

PSYCHIATRIC DRUG HANDBOOK



2nd P.B. BSc. Nursing (2022)

PREFACE

In the corridors of the mind, where emotions ebb and flow like tides, psychiatric medications stand as both silent sentinels and formidable architects of change. This book seeks to demystify the realm of psychopharmacology, unraveling the intricate tapestry woven by drugs that strive to alleviate, regulate, and sometimes transform the landscape of mental health.

As we embark on this literary journey, we navigate not only the chemical pathways these medications traverse but also the labyrinth of emotions, stigma, and societal perceptions that accompany them. Through the prism of individual narratives, we witness the intimate dance between hope and uncertainty, as lives are reshaped by the profound influence of psychiatric drugs.

This preface extends an invitation to explore the corridors of the mind, where science converges with personal narratives, shedding light on the dynamic relationship between psychotropic medications and human experience. Welcome to a narrative that transcends the prescription pad, delving into the profound implications of these drugs on the human psyche.

ACKNOWLEDGEMENT

We thank the Lord Almighty, who has given us the privilege and strength to inscribe this Mental Health Drug Handbook.

We would like to express our heartfelt thanks to Dr. Sr. Lalitha Rosali, Principal for her consistent encouragement and support, as she constantly strives for excellence, which makes our minds and hands work ….

Special thanks to Dr. Supriya Mane. (Associate Professor), her captivating ideas and thirst to make the concept clear about the drug study will hope to come true...

Thanks, are not enough to Ms. Jayshree Shrigan (Nursing Tutor) and Ms. Trupti Sawal for their constant motivation and support while creating this drug handbook

Thanks to Ms. Leena our librarian for her support and help in finding us different books and content.

My dear viewers, hope to see smile on your face, as we have made easy for you to learn about mental health drugs. Our team has toiled hard to make this drug handbook handy for you all

Thank You!!!

INDEX

INTRODUCTION

Psychopharmacology is the study of drugs used to treat psychiatric disorders. Medications that affect psychic function, behavior, or experience are called psychotropic medications. They have a significant effect on higher mental functions. Psychopharmacology agents are the first line of treatment for almost all psychiatric ailments nowadays.

With the growing availability of a wide range of drugs to treat mental illness, the nurse practicing in modern psychiatric settings needs to have a sound knowledge of the pharmacokinetics involved, the benefits & potential risks of pharmacotherapy, as well as her role & responsibility.

DEFINITION OF PSYCHOTROPIC DRUG: -

1. A psychotropic drug is any drug that has primary effects on behavior, experience, or other psychological functions.

- (Logman Dictionary of Psychology & Psychiatry)

2. Psychotropic or psychoactive drugs can also be defined as a chemical that affects the brain & nervous system and alters feelings & emotions. These drugs also affect the consciousness in various ways. A broad range of these drugs is used in emotional and mental illnesses. Nurses must be familiar with certain terminologies utilized in medication therapy.

These terms include -

1. EFFICACY: refers to the maximal therapeutic effect that a drug can achieve.

2. POTENCY: describes the amount of the drug needed to achieve that maximum effect; low-potency drugs require higher dosages to achieve efficacy, whereas high-potency drugs achieve efficacy at lower dosages.

3. HALF-LIFE: the time it takes for half of the drug to be removed from the bloodstream. Drugs with a shorter half-life may need to be given once a day.

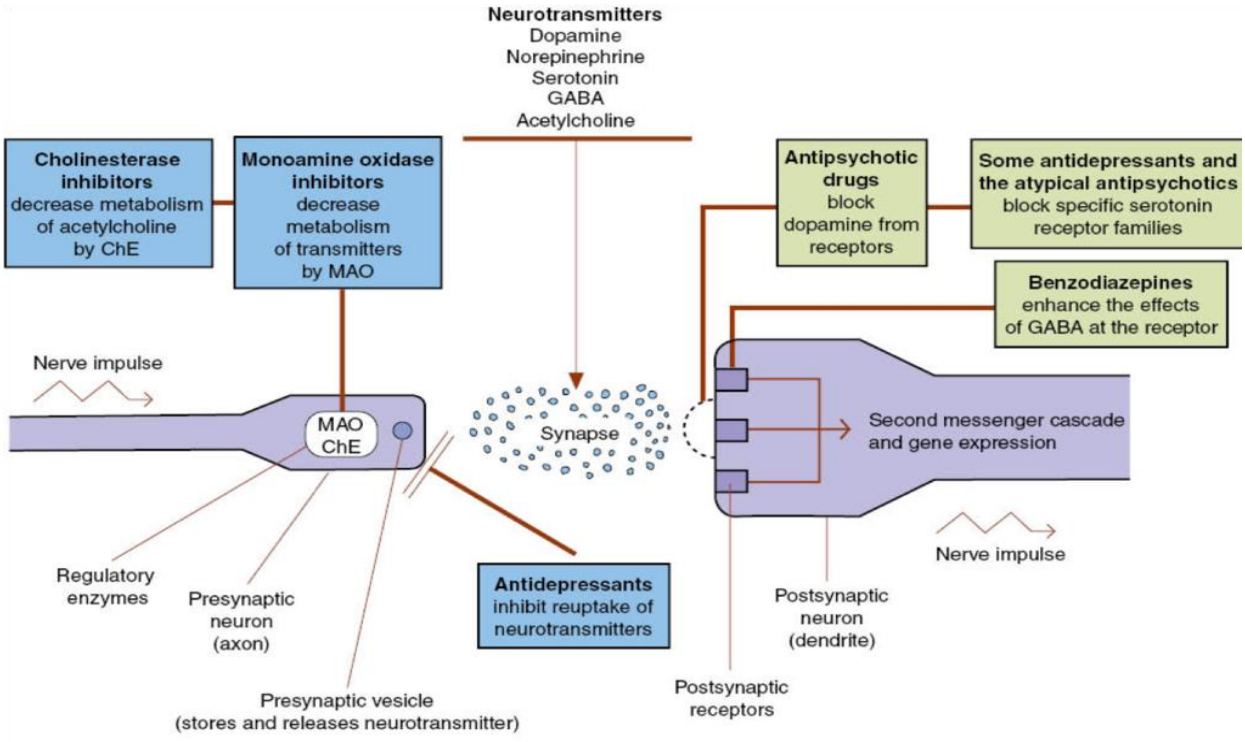
4. AGONIST: Drugs that activate receptors are termed agonists.

5. ANTAGONIST: Drugs that block receptors are termed antagonists.

CORE CONCEPT

Neurotransmitters: are the chemical messengers that travel from one brain cell to another and are synthesized by enzymes from certain dietary amino acids or precursors.

Receptors: are molecules situated on the cell membrane that are binding sites for neurotransmitters. The synapse separates the two neurons (pre- and postsynaptic cells).



GENERAL GUIDELINES REGARDING DRUG ADMINISTRATION IN PSYCHIATRY

•The nurse should not administer any drug unless there is a written order. Do not hesitate to consult the doctor when in doubt about any medication.

•All medications given must be charted on the patient's case record sheet.

While giving medication:

- Always address the patient by name & make certain of his identification.
- Do not leave the patient until the drug is swallowed.
- Do not allow one patient to carry medicine to another.
- If it is necessary to leave the patient to get water, do not leave the tray within the reach of the patient.
- Do not force oral medication because of the danger of aspiration. This is especially important in stuporous patients.
- Check drugs daily for any change in color, odor & number.
- Bottle should be tightly closed & labeled. Labels should be written legibly & in bold lettering. Poison drugs are to be legibly labeled & to be kept in separate cupboard.
- Make sure that an adequate supply of drugs is on hand, but do not overstock.
- Make sure no patient has access to the drug cupboard.
- Drug cupboards should always be kept locked when not in use. Never allow a patient or worker to clean the drug cupboard. The drug cupboard keys should not be given to patients.

PATIENT EDUCATION RELATED TO PSYCHOPHARMACOLOGY

•Nurses assess for drug side effects, evaluate desired effects, & make decisions about prn (pro re neta) medication.

•Nurses must understand general principles of psychopharmacology & have specific knowledge related to psychotropic drugs.

•Teaching patients can decrease the incidence of side effects while increasing compliance with the drug regimen.

Specific areas of education include the following: -

1. Discussion of side effects: Side effects can directly affect the patient's willingness to adhere to the drug regimen. The nurse should always inquire about the patient's response to a drug, both therapeutic responses & adverse responses

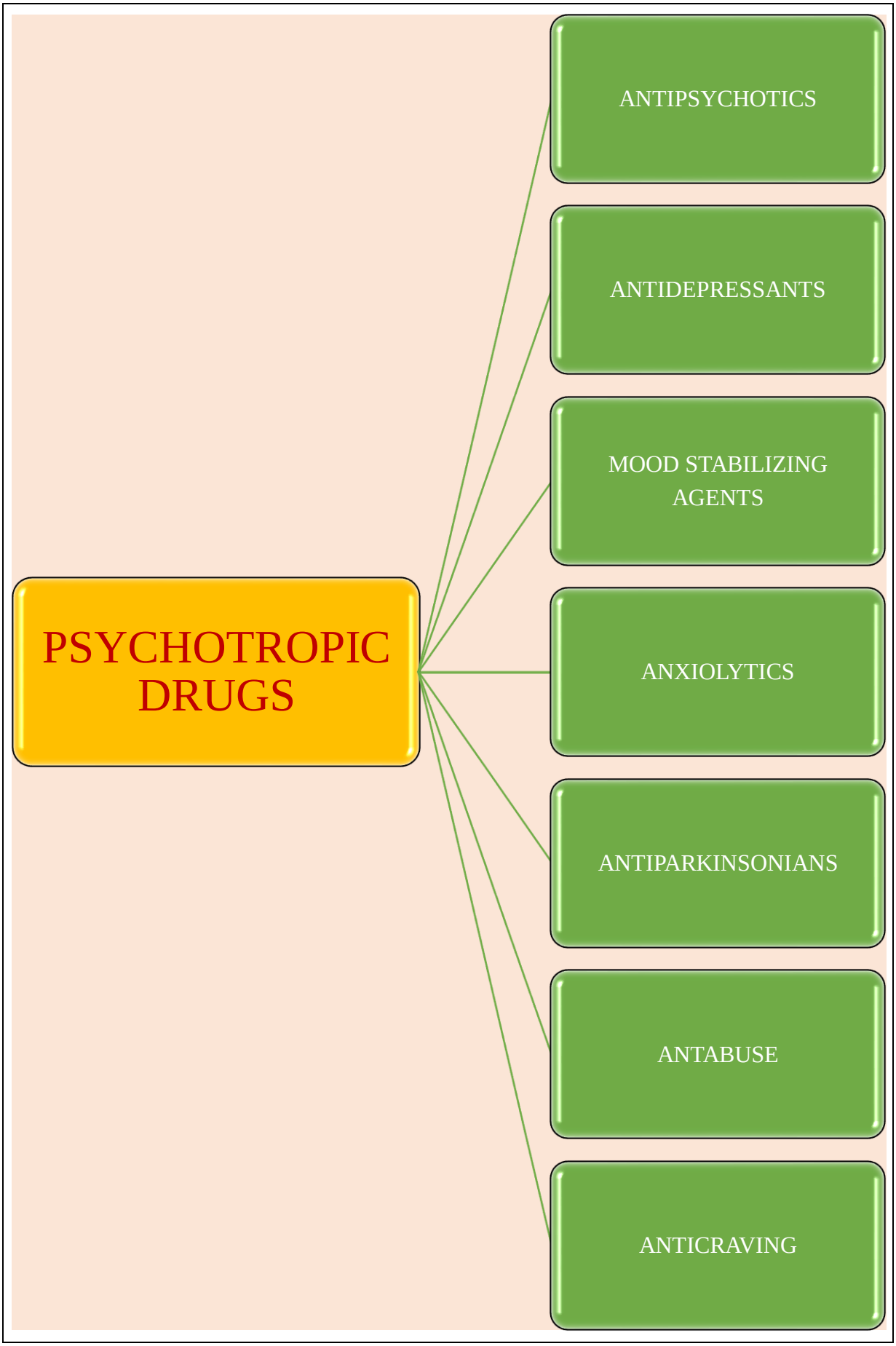
2. Drug interactions: Patients & families must be taught to discuss the effects of the addition of over-the-counter drugs, alcohol & illegal drugs to currently prescribed drugs.

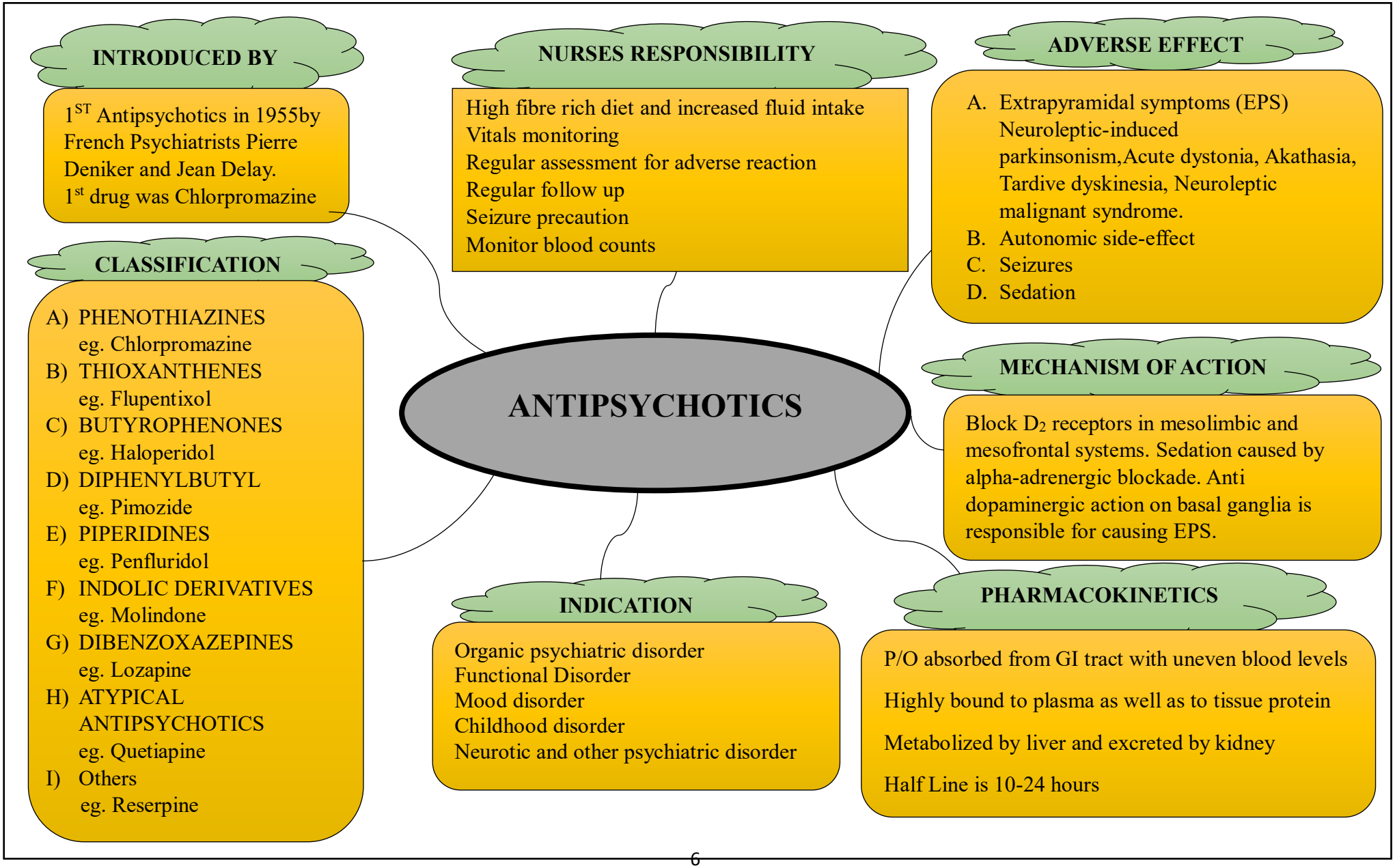
3. Discussion of safety issues: Because some drugs, such as tricyclic antidepressants, have a narrow therapeutic index, thoughts of self-harm must be discussed.

- Discuss abruptly discontinued effects
- Many psychotropic drugs cause sedation or drowsiness, discussions concerning the use of hazardous machinery, and driving must be reviewed

4. Instructions for older adult patients: Because older individuals have a different pharmacokinetic profile than younger adults, special instructions concerning side effects & drug-drug interactions should be explained.

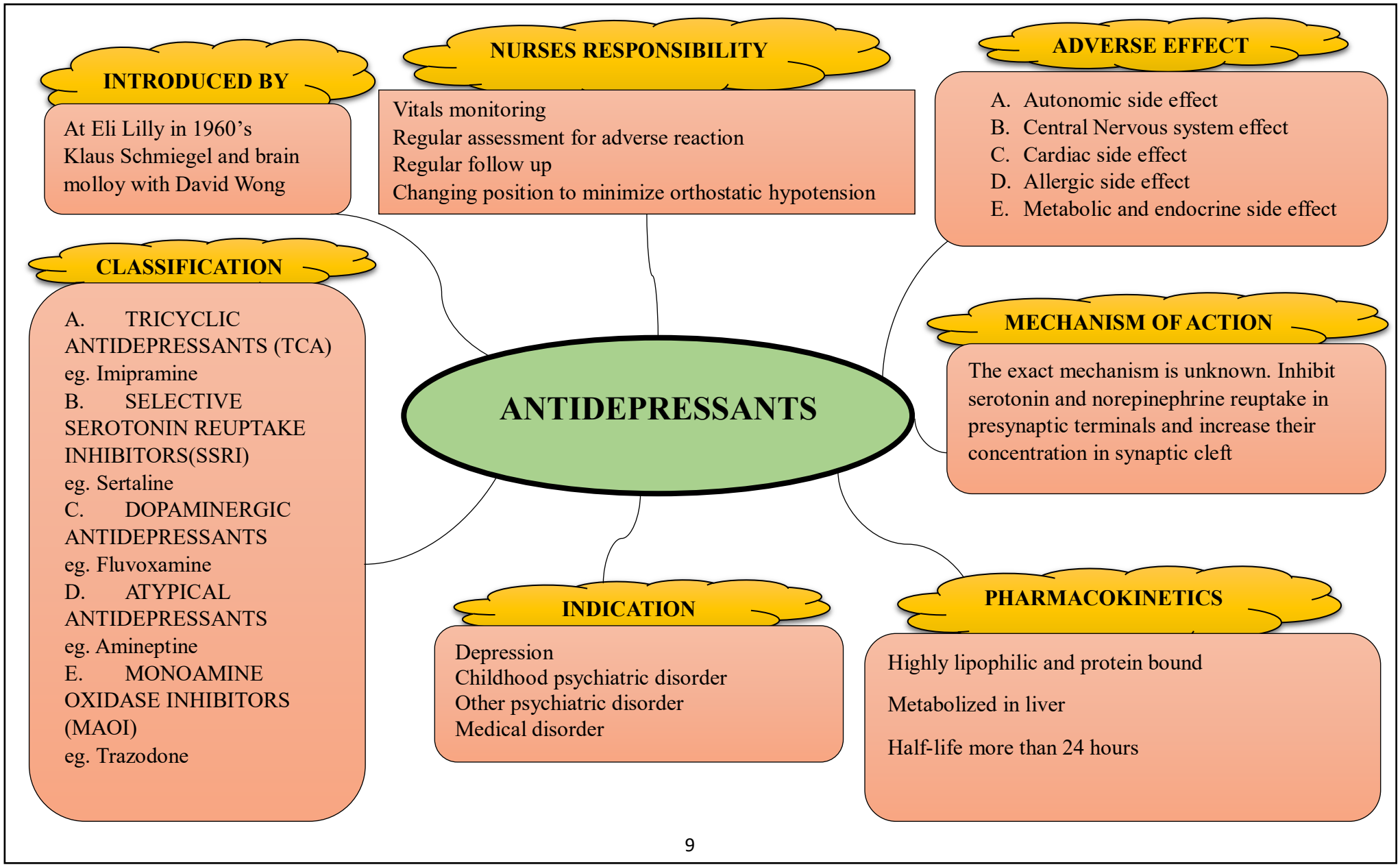
5. Instructions for pregnant or breastfeeding women: As pregnant or breastfeeding patients have special risks associated with psychotropic drug therapy, special instructions should be tailored for these individuals. Teaching patients about their medications enables them to be mature participants in their care & decreases undesirable side effects.


PSYCHOTROPIC DRUGS
ANTIPSYCHOTICS
ANTIDEPRESSANTS
MOOD STABILIZING AGENTS
ANXIOLYTICS
ANTIPARKINSONIANS
ANTABUSE
ANTICRAVING


ANTIPSYCHOTICS
INTRODUCED BY
1ST Antipsychotics in 1955by French Psychiatrists Pierre Deniker and Jean Delay.
1st drug was Chlorpromazine
NURSES RESPONSIBILITY
High fibre rich diet and increased fluid intake
Vitals monitoring
Regular assessment for adverse reaction
Regular follow up
Seizure precaution
Monitor blood counts
ADVERSE EFFECT
A. Extrapyramidal symptoms (EPS) Neuroleptic-induced parkinsonism,Acute dystonia, Akathasia, Tardive dyskinesia, Neuroleptic malignant syndrome.
B. Autonomic side-effect
C. Seizures
D. Sedation
CLASSIFICATION
A) PHENOTHIAZINES
eg. Chlorpromazine
B) THIOXANTHENES
eg. Flupentixol
C) BUTYROPHENONES
eg. Haloperidol
D) DIPHENYLBUTYL
eg. Pimozide
E) PIPERIDINES
eg. Penfluridol
F) INDOLIC DERIVATIVES
eg. Molindone
G) DIBENZOXAZEPINES
eg. Lozapine
H) ATYPICAL ANTIPSYCHOTICS
eg. Quetiapine
I) Others
eg. Reserpine
MECHANISM OF ACTION
Block D2 receptors in mesolimbic and mesofrontal systems. Sedation caused by alpha-adrenergic blockade. Anti dopaminergic action on basal ganglia is responsible for causing EPS.
INDICATION
Organic psychiatric disorder
Functional Disorder
Mood disorder
Childhood disorder
Neurotic and other psychiatric disorder
PHARMACOKINETICS
P/O absorbed from GI tract with uneven blood levels
Highly bound to plasma as well as to tissue protein
Metabolized by liver and excreted by kidney
Half Line is 10-24 hours

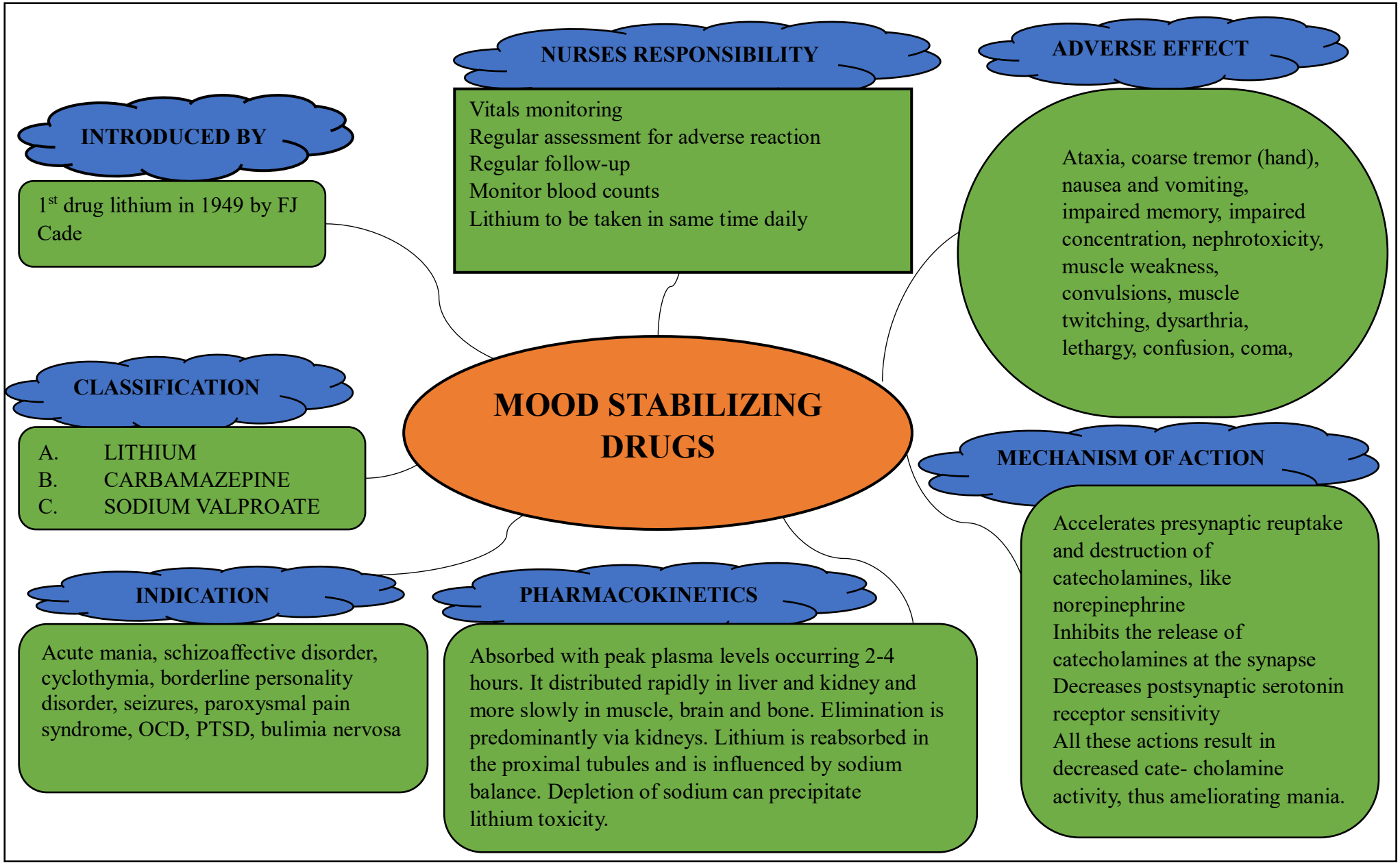
DRUG NAME	DOSE ROUTE	ACTION	INDICATION / CONTRAINCATION	SIDE EFFECT	NURSES RESPONSIBILTY
Haloperidol **Classification** *Dopamine receptor Antagonist butyrophenone*	Oral 0.5- 100mg/ml Parental 5 to 100mg/ml	**Mechanism of action** Antipsychotic antiemetic Antidyskinetic agent that competitively blocks post-synaptic dopamine receptor interrupts nerve impulse movement and increase the turnover of dopamine in the brain **Pharmacokinetics** Metabolized by liver; excreted in urine, bile; crosses placenta; enters breast milk protein binding 92%; terminal half-life 12-36 hr (metabolites)	**Indication** ▪ Psychotic disorder in schizophrenia and schizoaffective disorder ▪ Mania ▪ -Depression with psychotic syndrome ▪ -Delirium Dementia ▪ -Mental disorder due to medical condition ▪ -Tourette's syndrome ▪ -Huntington's syndrome **Contraindication** ▪ -Angle-closure glaucoma ▪ -CNS depression ▪ -Severe cardiac disease ▪ -Severe hepatic disease ▪ -Parkinson's disease ▪ -Myelosuppression	▪ -Blurred vision ▪ -Constipation ▪ -Orthostatic ▪ -Dry mouth ▪ -Peripheral edema ▪ -Difficulty urination ▪ -Decrease Thirst ▪ -Dizziness ▪ -Decrease sexual function ▪ -Drowsiness ▪ -Nausea, vomiting ▪ -Photosensitivity ▪ -Lethargy ▪ -Parkinson ▪ -Akathisia	▪ Assess patients' behavior and emotional status ▪ Susceptible dystonia ▪ Orthostatic hypotension ▪ Extrapyramidal and anticholinergic effects ▪ Casual uses in cardiovascular disease ▪ Watch for hepatic and renal dysfunction ▪ 21-gauge needle for IM use ▪ Monitor BP while lying and standing ▪ Avoid alcohol ▪ Avoid to exposure to sunlight that may cause dehydration

RUG NAME	DOSE ROUTE	ACTION	INDICATION / CONTRAINCATION	SIDE EFFECT	NURSES RESPONSIBILTY
Risperidone **Classification** *Atypical anti-psychotic serotonin dopamine antagonist* .	Oral: 0.5 to 6 mg/day	**Mechanism of Action** Antiserotonergic, antiadrenergic and antihistaminergic actions. It has less action as antidopaminergic especially D2 receptors. **Pharmacokinetics** PO: Extensively metabolized by liver to major active metabolite, determined by poor metabolizer or average metabolizers; plasma protein binding 90%, peak 1-2 hr, excreted 90% in urine, terminal half-life 3-24 hr	**Indications** ▪ -Positive and negative symptoms of schizophrenia, ▪ -Other psychosis ▪ schizoaffective symptoms. **Contraindications** ▪ -Hypersensitivity ▪ -Heart diseases ▪ -Epilepsy ▪ -Hyperprolactinemia ▪ -Parkinsonism ▪ -Renal impairment ▪ -Hepatic impairment	▪ CNS: Somnolence, ▪ seizures, ▪ headache ▪ CVS: Orthostatic ▪ hypotension ▪ dizziness ▪ tachycardia ▪ syncope ▪ Other adverse reactions: ▪ Weight gain ▪ constipation, ▪ erectile dysfunction, ▪ vomiting, ▪ rash, abdominal pain.	▪ Assess for blood urea nitrogen levels serum alkaline phosphatase ▪ bilirubin, creatinine, renal, and hepatic functions. ▪ Assess for behavioural and emotional status The elderly may require a dosage adjustment ▪ Monitor the patient's BP, heart rate, ▪ Observe the patient for fine tongue movement ▪ Monitor for neuroleptic malignant syndrome. ▪ Take measures to reduce constipation. avoid alcohol during therapy


ANTIDEPRESSANTS
INTRODUCED BY
At Eli Lilly in 1960's
Klaus Schmiegel and brain
molloy with David Wong
NURSES RESPONSIBILITY
Vitals monitoring
Regular assessment for adverse reaction
Regular follow up
Changing position to minimize orthostatic hypotension
ADVERSE EFFECT
A. Autonomic side effect
B. Central Nervous system effect
C. Cardiac side effect
D. Allergic side effect
E. Metabolic and endocrine side effect
CLASSIFICATION
A. TRICYCLIC ANTIDEPRESSANTS (TCA)
eg. Imipramine
B. SELECTIVE SEROTONIN REUPTAKE INHIBITORS(SSRI)
eg. Sertaline
C. DOPAMINERGIC ANTIDEPRESSANTS
eg. Fluvoxamine
D. ATYPICAL ANTIDEPRESSANTS
eg. Amineptine
E. MONOAMINE OXIDASE INHIBITORS (MAOI)
eg. Trazodone
MECHANISM OF ACTION
The exact mechanism is unknown. Inhibit serotonin and norepinephrine reuptake in presynaptic terminals and increase their concentration in synaptic cleft
INDICATION
Depression
Childhood psychiatric disorder
Other psychiatric disorder
Medical disorder
PHARMACOKINETICS
Highly lipophilic and protein bound
Metabolized in liver
Half-life more than 24 hours

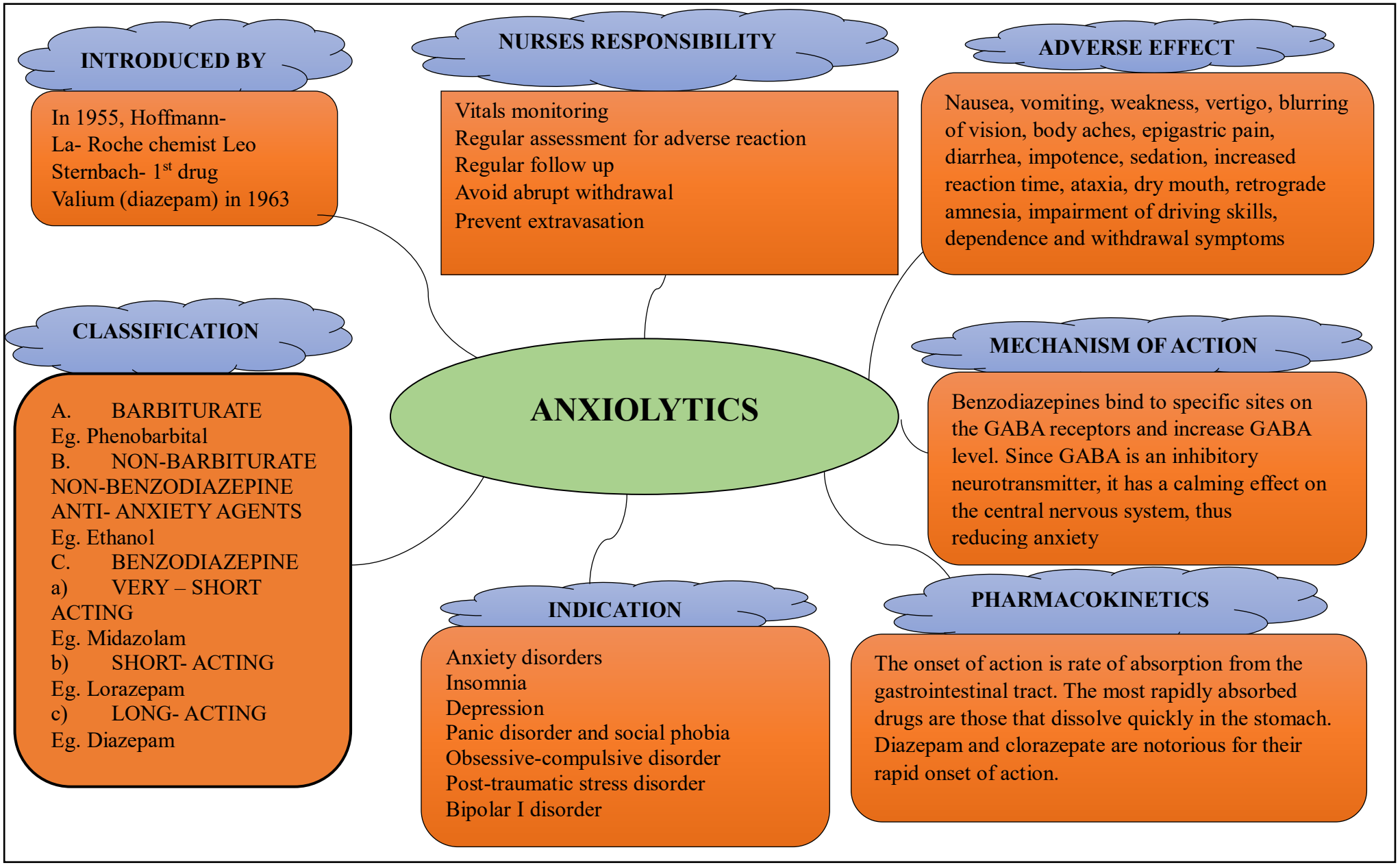
DRUG NAME	DOSE ROUTE	ACTION	INDICATION / CONTRAINCATION	SIDE EFFECT	NURSES RESPONSIBILITY
IMIPRAMINE **Classification:** ***Tertiary tricyclic antidepressant drugs***	75-300 mg per day orally	**Mechanism of action** -Blocking the reuptake of norepinephrine (NE) and serotonin (5-HT) at the nerve terminals, thus increasing NE and 5-HT levels at the receptor site. -Regulation of the beta-adrenergic receptors.	**Indications:** O- Other psychotic C-childhood D-Depression M- Medical disorder **Contraindications:** ▪ -Cardiac disorders ▪ -Acute recovery period after MI ▪ use within 14 days of MAOIs.	▪ -Autonomic: Dry mouth, constipation, urinary retention, hypotension, blurred vision, ▪ -GNS: Sedation, tremors, seizures. ▪ CVs: arrhythmias, direct myocardial depression. ▪ Allergic: cholestatic jaundice. ▪ Other reactions: Weight gain, insomnia, tiredness	▪ Monitor vital ▪ High fibre diet ▪ Perform CBC ▪ Plan ECG if risk for arrhythmias ▪ Give with food or milk ▪ Do not crush the tab Children below 6 years are not recommended ▪ Assess the elimination pattern

DRUG NAME	DOSE ROUTE	ACTION	INDICATION / CONTRAINCATION	SIDE EFFECT	NURSES RESPONSIBILITY
SERTRALINE HYDROCHLORIDE **Classification:** ***Antidepressant-Serotonin-Specific reuptake inhibitors.***	50-200 mg	**Mechanism of action** Selectively inhibits serotonin uptake in the CNS, enhancing serotonergic function. It blocks the reuptake of the neurotransmitter	**Indications:** ▪ -Depression ▪ -Obsessive-compulsive disorder (OCD) ▪ -Panic disorder and other anxiety disorders ▪ -Bulimia nervosa ▪ -Premenstrual dysphoric disorder. **Contraindications:** ▪ -Hypersensitivity ▪ -Severe hepatic or renal impairment ▪ -Pregnancy ▪ -Lactation ▪ -History of seizures.	▪ -Headache ▪ -Nervousness ▪ -Drowsiness ▪ -Anxiety ▪ -Seizures ▪ -Rarely EPS ▪ apathy ▪ -Anorexia ▪ -Nausea ▪ -Diarrhoea ▪ -Sexual dysfunction. ▪ -Insomnia	▪ Perform complete blood count (CBC), ▪ Use cautiously in patients with cardiac dysfunction, diabetes, ▪ Perform complete blood count (CBC), ▪ Use cautiously in patients with cardiac dysfunction, diabetes, or seizures ▪ Give with food or milk* Assess the patient's pattern of daily bowel and stool ▪ Urge the patient to avoid alcohol


MOOD STABILIZING DRUGS
INTRODUCED BY
1st drug lithium in 1949 by FJ Cade
NURSES RESPONSIBILITY
Vitals monitoring
Regular assessment for adverse reaction
Regular follow-up
Monitor blood counts
Lithium to be taken in same time daily
ADVERSE EFFECT
Ataxia, coarse tremor (hand), nausea and vomiting, impaired memory, impaired concentration, nephrotoxicity, muscle weakness, convulsions, muscle twitching, dysarthria, lethargy, confusion, coma,
CLASSIFICATION
A. LITHIUM
B. CARBAMAZEPINE
C. SODIUM VALPROATE
MECHANISM OF ACTION
Accelerates presynaptic reuptake and destruction of catecholamines, like norepinephrine
Inhibits the release of catecholamines at the synapse
Decreases postsynaptic serotonin receptor sensitivity
All these actions result in decreased cate- cholamine activity, thus ameliorating mania.
INDICATION
Acute mania, schizoaffective disorder, cyclothymia, borderline personality disorder, seizures, paroxysmal pain syndrome, OCD, PTSD, bulimia nervosa
PHARMACOKINETICS
Absorbed with peak plasma levels occurring 2-4 hours. It distributed rapidly in liver and kidney and more slowly in muscle, brain and bone. Elimination is predominantly via kidneys. Lithium is reabsorbed in the proximal tubules and is influenced by sodium balance. Depletion of sodium can precipitate lithium toxicity.

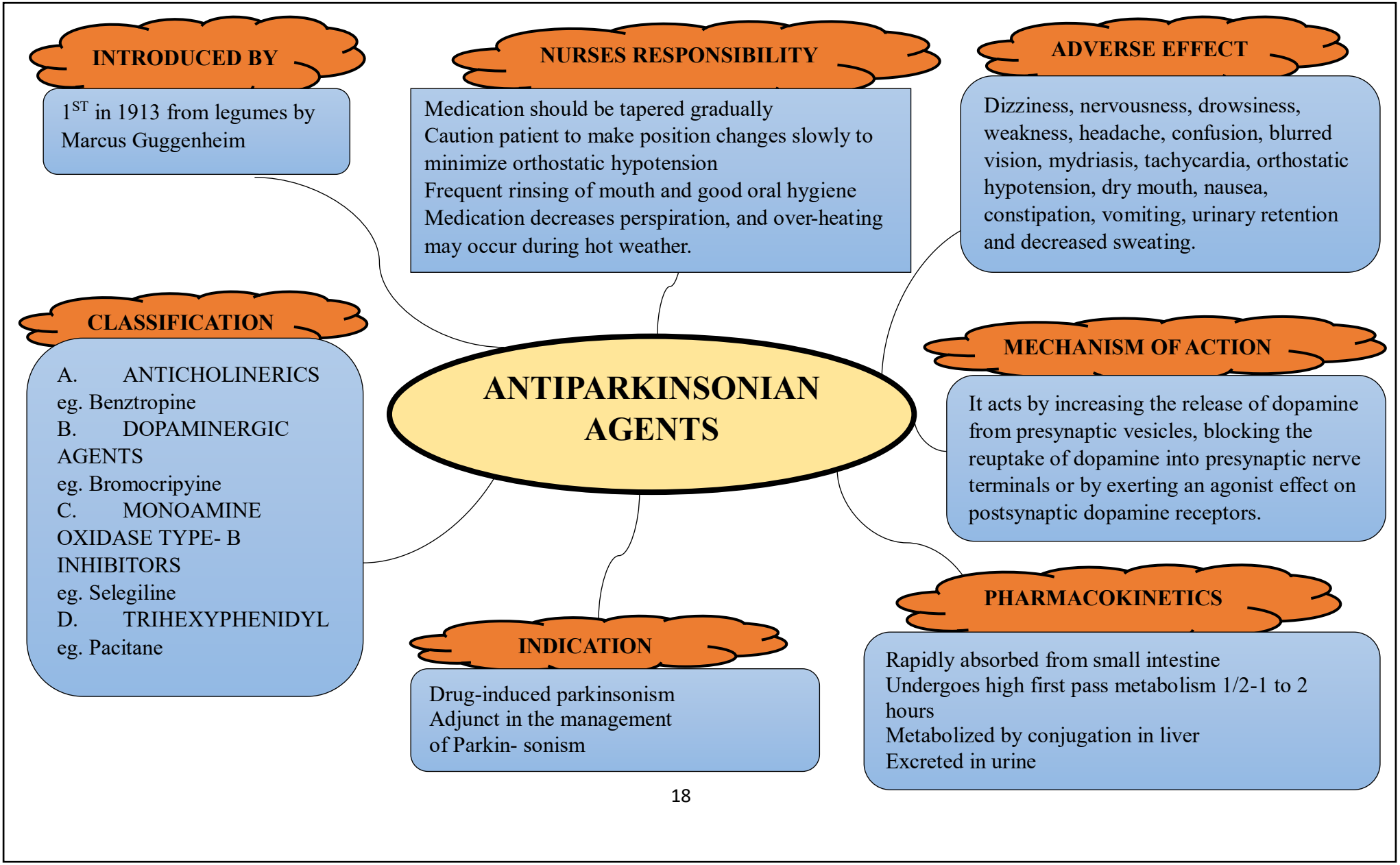
DRUG NAME	DOSE ROUTE	ACTION	INDICATION / CONTRAINCATION	SIDE EFFECT	NURSES RESPONSIBILITY
LITHIUM **CLASSIFICATION:** ***Mood stabilizer***	900 to 2100mg BD/TDS blood lithium level 0.8 to 1.2meq/lit lithium toxicity level	**Mechanism of action** Inhibitor and release catecholamine Postsynaptic receptors sensitivity Decrease catecholamine activity Decrease mania	**Indication:** ▪ -Acute mania ▪ -Schizoaffective disorder ▪ -Impulsive aggression ▪ -Borderline personality disorder ▪ - Bulimia nervosa	▪ -Nausea ▪ -Vomiting ▪ -Hypertension ▪ -Polyuria ▪ -Lithium toxicity ▪ -Weight gain ▪ -Muscular weakness	▪ Taken regular base ▪ Drink more water ▪ Serum lithium evaluation ▪ Regular follow-up ▪ Side effects should notify ▪ Monitoring of patient

DRUG NAME	DOSE ROUTE	ACTION	INDICATION / CONTRAINCATION	SIDE EFFECT	NURSES RESPONSIBILITY
SODIUM VALPROATE **CLASSIFICATION:** *Mood stabilizer*	15mg/kg/day Orally	**Mechanism of action** Acts on Gama aminobutyric acid GABA transaminase Increased cone of GABA in the brain Inhibit: 1] presynaptic disorder 2]postsynaptic discharge	▪ **INDICATION:** ▪ -Aute mania ▪ -Prophylactic treatment of bipolar disorder ▪ -Rapid cycling bipolar disorder ▪ -Schizoaffective disorder ▪ -Seizures ▪ Other disorders like ▪ -Bulimia nervosa ▪ -Obsessive compulsion disorder ▪ -Agitation and PTSD	▪ -Stomach pain ▪ -Dry or sore mouth ▪ -Feeling tired ▪ -Headache ▪ -Weight gain ▪ -Shake body parts ▪ -Diarrhoea	▪ Drugs taken immediately after a meal ▪ To reduce GI Irritation ▪ Regular follow-up ▪ Periodic examination ▪ The therapeutic serum level has to be checked ▪ Side effects should be notified


ANXIOLYTICS
INTRODUCED BY
In 1955, Hoffmann-
La- Roche chemist Leo
Sternbach- 1st drug
Valium (diazepam) in 1963
NURSES RESPONSIBILITY
Vitals monitoring
Regular assessment for adverse reaction
Regular follow up
Avoid abrupt withdrawal
Prevent extravasation
ADVERSE EFFECT
Nausea, vomiting, weakness, vertigo, blurring of vision, body aches, epigastric pain, diarrhea, impotence, sedation, increased reaction time, ataxia, dry mouth, retrograde amnesia, impairment of driving skills, dependence and withdrawal symptoms
CLASSIFICATION
A. BARBITURATE
Eg. Phenobarbital
B. NON-BARBITURATE
NON-BENZODIAZEPINE
ANTI- ANXIETY AGENTS
Eg. Ethanol
C. BENZODIAZEPINE
a) VERY – SHORT ACTING
Eg. Midazolam
b) SHORT- ACTING
Eg. Lorazepam
c) LONG- ACTING
Eg. Diazepam
MECHANISM OF ACTION
Benzodiazepines bind to specific sites on the GABA receptors and increase GABA level. Since GABA is an inhibitory neurotransmitter, it has a calming effect on the central nervous system, thus reducing anxiety
INDICATION
Anxiety disorders
Insomnia
Depression
Panic disorder and social phobia
Obsessive-compulsive disorder
Post-traumatic stress disorder
Bipolar I disorder
PHARMACOKINETICS
The onset of action is rate of absorption from the gastrointestinal tract. The most rapidly absorbed drugs are those that dissolve quickly in the stomach. Diazepam and clorazepate are notorious for their rapid onset of action.

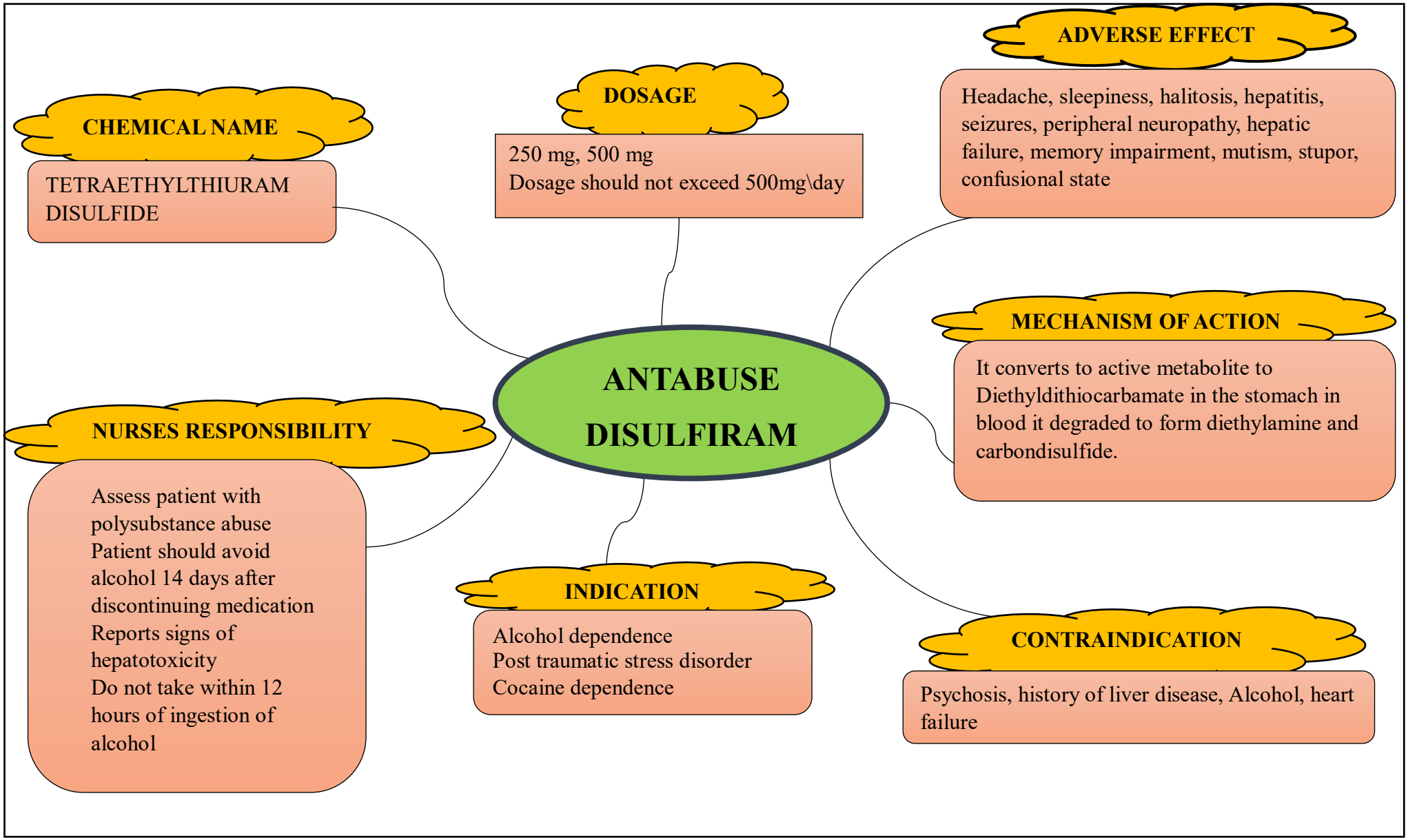
DRUG NAME	DOSE ROUTE	ACTION	INDICATION / CONTRAINCATION	SIDE EFFECT	NURSES RESPONSIBILITY
PHENOBARBITAL **OTHER NAME** **Phenobarbitone** **Phenobarb** **CLASSIFICATION** *Barbiturates*	5mg/1kg - P/O, IV - OD	**Mechanism of action** Increases in the amount of chloride channels are open Depressing CNS depression Acting on GABA - Receptors **Pharmacokinetic** Completely absorbed after P/O Metabolized in liver	**Indications** ▪ -Status epilepticus ▪ -Hyperbilirubinemia ▪ -Pruritis ▪ -Cerebral irritation ▪ -Seizures ▪ -Sedative ▪ -Hypnotic ▪ -Encephalopathy ▪ -Neonatal seizures **Contraindications** ▪ -Hypersensitivity ▪ -Latent porphyria ▪ -Liver impairment ▪ -Nephrotic syndrome	▪ -Dizziness ▪ -Drowsiness ▪ -Excitation ▪ -Headache ▪ -Tiredness ▪ -Loss of appetite ▪ -Vomiting	▪ Assess CNS status ▪ Assess the patient's seizures ▪ Assess BP monitoring ▪ Assess laboratory value ▪ Monitor fluid balance ▪ Monitor pulmonary status

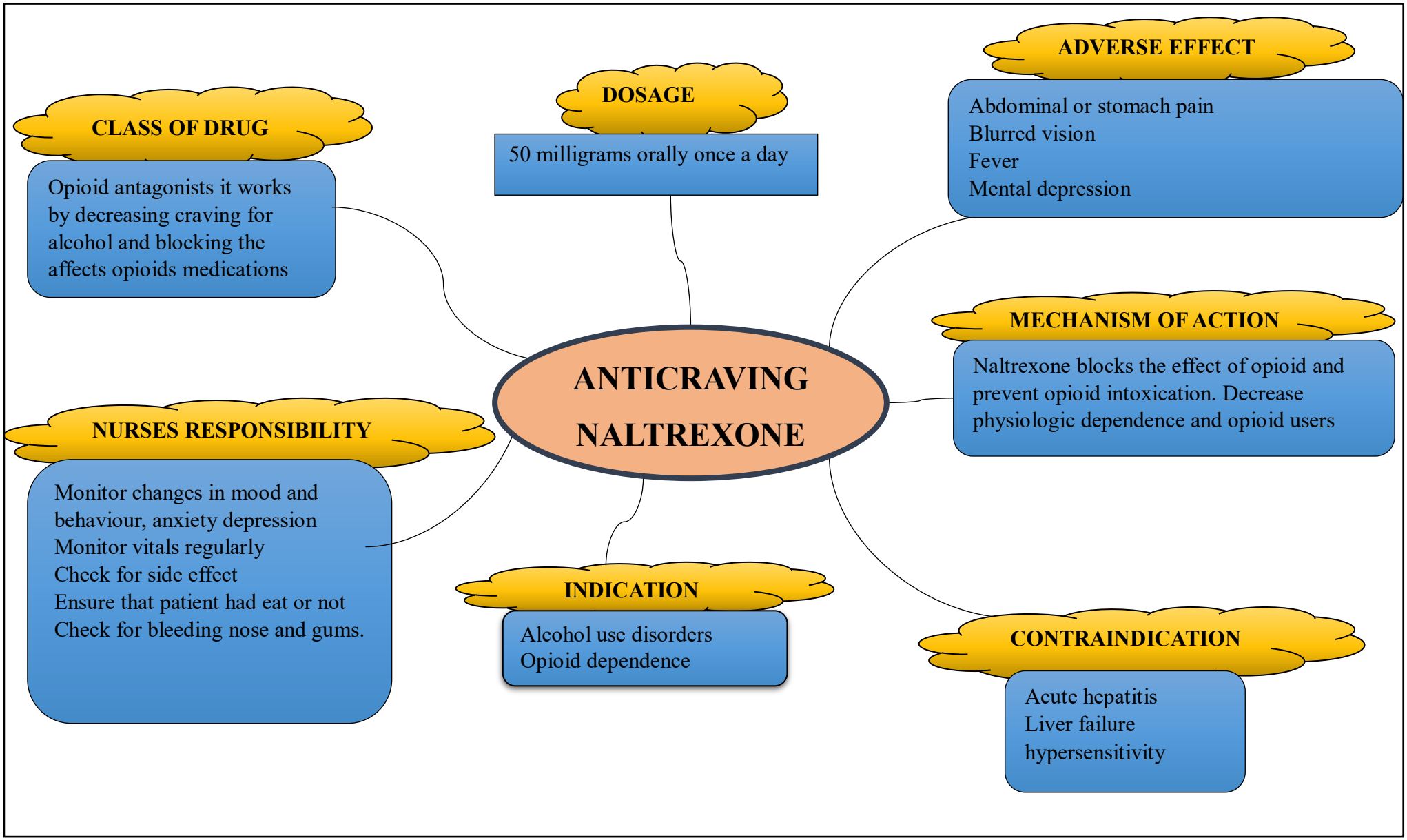
DRUG NAME	DOSE ROUTE	ACTION	INDICATION / CONTRAINCATION	SIDE EFFECT	NURSES RESPONSIBILITY
LORAZEPAM **OTHER NAME** **Tab. Ativan** **o - choroxazepam** **CLASSIFICATION** *A) Benzodiazepine* *1) short Acting*	2-6mg P/O, IV, IM - BD, TDS	**Mechanism of action** Binds to benzodiazepine receptor Postsynaptic GABA-A ligand-gated chloride canal neuron Several sites within the CNS Increases the conductance of chloride ions in the cell **Pharmacokinetics** Well absorbed P/O Peak concentration within 2 hrs Crosses the blood/brain barrier freely by passive diffusion	**Indication** ▪ -Seizure ▪ -Spasms ▪ -Alcohol withdrawal ▪ -Insomnia ▪ -Anxiety disorder **Contraindications** ▪ -Hypersensitivity ▪ -Acute narrow-angle glaucoma ▪ -CNS depression ▪ -Acute pulmonary insufficiency ▪ -Sleep apnoea	▪ -Drowsiness ▪ -Dizziness ▪ -Loss of coordination ▪ -Headache ▪ -Nausea ▪ -Blurred vision ▪ -Change in sexual interest ▪ -Constipation ▪ -Heartburn ▪ -Change in appetite	▪ Administer slowly ▪ Dilution ▪ Monitor respiratory rate after IV dose ▪ Assess side effects


ANTIPARKINSONIAN AGENTS
INTRODUCED BY
1ST in 1913 from legumes by Marcus Guggenheim
NURSES RESPONSIBILITY
Medication should be tapered gradually
Caution patient to make position changes slowly to minimize orthostatic hypotension
Frequent rinsing of mouth and good oral hygiene
Medication decreases perspiration, and over-heating may occur during hot weather.
ADVERSE EFFECT
Dizziness, nervousness, drowsiness, weakness, headache, confusion, blurred vision, mydriasis, tachycardia, orthostatic hypotension, dry mouth, nausea, constipation, vomiting, urinary retention and decreased sweating.
CLASSIFICATION
A. ANTICHOLINERICS
eg. Benztropine
B. DOPAMINERGIC AGENTS
eg. Bromocripyine
C. MONOAMINE OXIDASE TYPE- B INHIBITORS
eg. Selegiline
D. TRIHEXYPHENIDYL
eg. Pacitane
MECHANISM OF ACTION
It acts by increasing the release of dopamine from presynaptic vesicles, blocking the reuptake of dopamine into presynaptic nerve terminals or by exerting an agonist effect on postsynaptic dopamine receptors.
INDICATION
Drug-induced parkinsonism
Adjunct in the management of Parkin- sonism
PHARMACOKINETICS
Rapidly absorbed from small intestine
Undergoes high first pass metabolism 1/2-1 to 2 hours
Metabolized by conjugation in liver
Excreted in urine

RUG NAME	DOSE ROUTE	ACTION	INDICATION / CONTRAINCATION	SIDE EFFECT	NURSES RESPONSIBILITY
BROMOCRIPTINE **CLASSIFICATION** *Antiparkinsonian*	1.25mg per oral BD	**Mechanism of action** Inhibits prolactin release by activating postsynaptic dopamine receptor Activation of striatal dopamine receptors may be the reason for improvement in Parkinson's disease **Pharmacokinetics** -90%-96% protein bound, half-life 3hr -Metabolized by liver -85%-98% of the dose excreted in feces	**Indication** ▪ -Alcoholism ▪ -Cocaine withdrawal ▪ -Neuroleptic malignant syndrome **Contraindications** ▪ -Severe ischemic disease ▪ -Uncontrolled hypertension - Migraine	▪ -Headache ▪ -Restlessness ▪ -Blurred vision ▪ -Nausea, vomiting ▪ -Anorexia ▪ -Constipation ▪ -Hypoglycaemia	• Assess the BP • Assess the seizures • Assess the MSE • Assess cause of orthostatic hypotension • Monitor fluid balance

DRUG NAME	DOSE ROUTE	ACTION	INDICATION / CONTRAINCATION	SIDE EFFECT	NURSES RESPONSIBILITY
SELEGILINE **CLASSIFICATION** *Antiparkinsonian agent* **CHEMICAL NAME** **MAOI type B**	5-10mg Per oral BD	**Mechanism of action** Increase dopaminergic activity by inhibition of MAOI type B activity, not fully understood **Pharmacokinetics** ▪ Absorption 40-90min ▪ Rapidly Metabolized ▪ Protein binding up to 85%	**Indication** ▪ -Major depression ▪ -OCD ▪ -PTSD ▪ -Panic disorder ▪ -Social anxiety disorder **Contraindications** ▪ -Hypersensitivity ▪ -Hypertensive crisis ▪ -Suicide	▪ -Increased tremors ▪ -Dizziness ▪ -Mood change Anxiety ▪ -Vertigo ▪ -Lethargy	• Assess the BP • Assess the seizures • Assess the MSE • Assess the cause of orthostatic hypotension • Monitor fluid balance


ANTABUSE
DISULFIRAM
CHEMICAL NAME
TETRAETHYLTHIURAM DISULFIDE
DOSAGE
250 mg, 500 mg
Dosage should not exceed 500mg\day
ADVERSE EFFECT
Headache, sleepiness, halitosis, hepatitis, seizures, peripheral neuropathy, hepatic failure, memory impairment, mutism, stupor, confusional state
MECHANISM OF ACTION
It converts to active metabolite to Diethyldithiocarbamate in the stomach in blood it degraded to form diethylamine and carbondisulfide.
NURSES RESPONSIBILITY
Assess patient with polysubstance abuse
Patient should avoid alcohol 14 days after discontinuing medication
Reports signs of hepatotoxicity
Do not take within 12 hours of ingestion of alcohol
INDICATION
Alcohol dependence
Post traumatic stress disorder
Cocaine dependence
CONTRAINDICATION
Psychosis, history of liver disease, Alcohol, heart failure


ANTICRAVING
NALTREXONE
CLASS OF DRUG
Opioid antagonists it works by decreasing craving for alcohol and blocking the affects opioids medications
DOSAGE
50 milligrams orally once a day
ADVERSE EFFECT
Abdominal or stomach pain
Blurred vision
Fever
Mental depression
MECHANISM OF ACTION
Naltrexone blocks the effect of opioid and prevent opioid intoxication. Decrease physiologic dependence and opioid users
NURSES RESPONSIBILITY
Monitor changes in mood and behaviour, anxiety depression
Monitor vitals regularly
Check for side effect
Ensure that patient had eat or not
Check for bleeding nose and gums.
INDICATION
Alcohol use disorders
Opioid dependence
CONTRAINDICATION
Acute hepatitis
Liver failure
hypersensitivity

CONCLUSION

This book has delved into the crucial function that these drugs perform for dealing with mental health disorders by exploring the intricate landscape of psychiatric medications From their historical development to their various modes of action, we've seen the remarkable impact these medicines have on relieving symptoms and improving the quality of life for countless people.

Despite these advances, we are reminded of the complexities of mental health and the necessity for tailored holistic interventions. Side effects, stigma, and accessibility remain issues, highlighting the importance of continued research, new medicines, and compassionate care. As we end, let us push for continuous innovation, empathy, and cooperation, encouraging a future in which psychiatric drugs adapt to better serve the different needs of persons navigating the complex landscape of mental health.

REFERENCES

- Sreevani R, Guide to mental Health and Psychiatric Nursing, 4th edition, Jaypee Brothers
- Linda Skidmore-Roth, Mosby Nursing drug reference, 7th South Asia edition, Elsevier
- April Hazard Vallerand, Davis drug guide for nurses, 14th edition, Unbounded Medicine
- Rebecca Tucker, Lippincott Drug Guide for Nurses, 16th edition, Wolter Kluwer
- Suresh K Sharma; Jogindra Vati, JP Nursing Drug Book, 15th edition, Jaypee Brother
- Niraja Ahuja, A Short Textbook of Psychiatric, 7th edition, Jaypee Brother
- P. Prakash, Textbook of Mental Health and Psychiatric Nursing, CBS Publisher and distributors
- Polishuk WZ, Kulcsar S. Effects of chlorpromazine on pituitary function. J Clin Endocrinol Metab 16:292–3. [PubMed]
- Turkington RW. Prolactin secretion in patients treated with various drugs: Phenothiazines, tricyclic antidepressants, reserpine, and methyldopa. Arch Intern Med. 1972; 130:349–54. [PubMed]