Blank Children's Hospital
UnityPoint Health

Pediatric Acute Agitation Clinical Guideline

INITIATE DE-ESCALATION TECHNIQUES:

- **Assess pain, hunger, and physical needs**
- **Attempt verbal de-escalation ***
- **Attempt behavioral interventions ****

RED FLAGS—EARLY DIAGNOSIS NEEDED

- **Neuroleptic malignant syndrome and serotonin syndrome**
- **Head trauma**
- **Hyperglycemia/hypoglycemia**
- **Substance overdose or withdrawal**

De-escalation ineffective?

Consider medications as below. If all other efforts fail to maintain patients safety, physical restraints may be utilized.

*** VERBAL DE-ESCALATION**

- Respect personal space
- Do not be provocative. Stay calm.
- Establish verbal contact (1 communicator)
- Be concise and give simple instructions
- Identify wants and feelings
- Listen closely to what the patient is saying
- Agree or agree to disagree
- Set expectations and consequences
- Offer choices and optimism.
- Reward cooperation

**** BEHAVIORAL INTERVENTIONS**

- Give praise for adherence to requests
- Place limits on unacceptable behaviors
- Give validation and empathy
- Allow patient to clarify triggers for agitation and promote problem solving

DIAGNOSIS	DELIRIUM	SUBSTANCE INTOXICATION OR WITHDRAWAL	DEVELOPMENTAL DELAY OR AUTISM	PSYCHIATRIC DIAGNOSIS	UNKNOWN ETIOLOGY
NOTES	•Diagnosis: acute onset with fluctuating course. Has disorganized thinking or altered LOC. •Evaluate for medical diangnosis. •Address underlying medical issues. •Assess pain.	•Care is mostly supportive or as directed by toxidrome	•Attempt behavioral interventions •Assess pain, hunger, other physical needs •Utilize sensory tools •Ask what usually soothes child and employ that technique •Ask about prior medication response (positive or negative) especially to benzos and diphenhydramine	•Review charts and with caregiver to clarify diagnosis and triggers for agitation •Consider non-psychiatric etiology	•Obtain extensive H&P •Rule out organic etiology •Work up as appropriate •Consider neurology or psychiatric evaluation
MEDICATIONS **(Details on pg 2)**	**PO:** Risperidone OR olanzapine OR clonidine **IM:** Olanzapine **Seizure concern or catatonia:** lorazepam (PO/IM/IV)	**ETOH/BZD intoxication:** haloperidol (IM/PO) **ETOH/BZD withdrawal:** Lorazepam (PO/IM/IV) ± haloperidol if severely agitated or hallucinating **PCP:** Lorazepam (PO/IM/IV) **Opiate withdrawal:** Clonidine and/or opiate replacement (methadone, suboxone) **Unknown:** Lorazepam (PO/IM/IV) ± haloperidol if severely agitated or hallucinating	**CONSIDER EXTRA DOSE OF PATIENT'S REGULAR MEDICATION** **AVOID BENZOS DUE TO RISK OF DISINHIBITION** **AVOID IM ROUTE** **OTHER MEDS:** Clonidine (PO) Risperidone (ODT) Olanzapine (ODT/PO/IM)	**Agitated catatonia:** Lorazepam (PO/IM/IV) **Anxiety/PTSD:** Lorazepam (PO/IM/IV) **ADHD:** Clonidine (PO) OR diphenhydramine (PO/IM) OR risperidone (PO) **ODD:** Olanzapine (PO/IM) OR risperidone (PO) **Psychosis:** PO: Risperidone or quetiapine IM: Olanzapine OR haloperidol ± lorazepam	**Moderate agitation (aggression against objects or property):** Diphenhydramine (PO/IM) OR olanzapine (PO/IM) OR Lorazepam (PO/IM) **Severe agitation (aggression to self/others):** olanzapine (PO/IM) OR haloperidol + lorazepam (PO/IM)

May 2025

MEDICATION (BRAND NAME)	CLASS OF MEDICATION	DOSE	PEAK EFFECT	MAX DAILY DOSE	NOTES/MONITORING
CLONIDINE (CATAPRES)	Alpha2 Agonist	•PO •Dose range: 0.05 - 0.1 mg	PO: 30-60 minutes	27-40kg: 0.2 mg/day 40-45 kg: 0.3mg/day >45 kg: 0.4 mg/day	•Monitor for hypotension and bradycardia. •Avoid giving benzos or atypicals due to hypotension risk.
DIPHENHYDRAMINE (BENADRYL)	Antihistamine	•I mg/kg/dose •PO/IM •Dose range: 12.5-50 mg	PO: 2 hours	Child: 50-100mg Adolescent: 100-200mg	•Avoid in delirium •Can be combined with haloperidol or chlorpromazine if concerns for extrapyramidal side effects •Can cause disinhibition or delirium in younger kids or developmentally delayed children
HALOPERIDOL (HALDOL)	Antipsychotic	•0.05-0.15 mg/kg/dose •Children: 0.5-2mg •Adolescents: 2-5mg •PO/IM •Dose range: 0.5-5mg	PO: 2 hours; may repeat dose after 2 hours IM: 20 minutes; may repeat dose after 20 minutes	15-40kg: 6 mg >40 kg: 15 mg	•Monitor hypotension •Consider EKG or cardiac monitor for QT prolongation if giving via IV •EPS risk increased with IV dosing OR Max daily dose > 3mg/day. Consider co-administration with diphenhydramine
LORAZEPAM (ATIVAN)	Benzodiazepine	•0.05-0.1 mg/kg/dose •PO/IM/IV •Dose range: 0.5-4 mg	PO/IM: 1-2 hours IV: 10 minutes	Child: 4 mg Adolescent: 6-8 mg	•DO NOT GIVE WITHIN AN HOUR OF PARENTERAL (IM) OLANZAPINE DUE TO RISK OF RESPIRATORY SUPPRESSION •Can cause disinhibition or delirium in younger kids or developmentally delayed children •Can be given with haloperidol, chlorpromazine, or risperidone
OLANZAPINE (ZYPREXA)	Antipsychotic	•PO/ODT/IM •Dose range: 2.5-10mg •IM SHOULD BE 1/4 - 1/2 PO DOSE	PO: 5 hours (range 1-8 hours) IM: 15-45 minutes	10-20 mg	•DO NOT GIVE PARENTARELLY (IM) WITHIN 1 HOUR OF ANY BENZODIAZEPINE GIVEN RISK FOR RESPIRATORY SUPPRESSION
QUETIAPINE (SEROQUEL)	Antipsychotic	•1-1.5 mg/kg/dose •PO •Dose range: 25-50mg	PO: 30 minutes-2 hours	>10 years: 600mg	•More sedating at lower doses •Monitor hypotension
RISPERIDONE (RISPERDAL)	Antipsychotic	•0.005-0.01 mg/kg/dose •PO/ODT •Dose range: 0.25-1 mg	PO: 1 hour	Child: 1-2 mg Adolescent: 2-3 mg	•Can cause akathisia (restlessness/agitation) in higher doses

Gerson R, Malas N, Feuer V, Silver GH, Prasad R, Mroczkowski MM. Best Practices for Evaluation and Treatment of Agitated Children and Adolescents (BETA) in the Emergency Department: Consensus Statement of the American Association for Emergency Psychiatry. West J Emerg Med. 2019 Mar;20(2):409-418. doi: 10.5811/westjem.2019.1.41344.