Antipsychotic switching guide

Cross-taper, plateau, and abrupt switch with class-to-class watchouts. Reviewed against current guidelines as of June 8, 2026.

Three strategies cover almost every antipsychotic switch. Cross-taper (reduce the old, add the new, over 2 to 4 weeks) is the default. Plateau (start the new drug at target before reducing the old) is preferred for stable maintenance patients. Abrupt switch is reserved for tolerability emergencies. Slow is generally safer than fast, and the switch that fails is usually the one that felt urgent to compress.

The three strategies

Strategy	When to use	How to do it
Cross-taper	Default. Most SGA-to-SGA and SGA-to-typical switches	Reduce outgoing in scheduled steps while adding incoming at low dose, titrating up. Total 2 to 4 weeks for typical switches, 4 to 6 weeks for clozapine.
Plateau	Stable maintenance where you can't afford breakthrough; switching to aripiprazole, clozapine, or any LAI	Titrate new drug to full target dose while keeping old drug at current dose. Once at steady state, taper old drug down.
Abrupt	NMS, agranulocytosis, myocarditis, QT emergency, severe intolerance	Stop the outgoing drug fully; start the new drug next day at a standard dose with faster titration than usual.

The switching matrix

FROM	TO	Preferred method	Timeline	Watchouts
SGA	Different SGA	Cross-taper	2 to 4 weeks	Metabolic and EPS profile differences
SGA	Typical (high-potency)	Cross-taper	2 to 4 weeks	EPS emergence as D2 blockade increases
Typical	SGA	Cross-taper	2 to 4 weeks	Cholinergic rebound if strong anticholinergic (chlorpromazine)
Any SGA	Aripiprazole	Plateau preferred	4 to 6 weeks	Rebound activation, akathisia
Any SGA	Clozapine	Plateau	4 to 6 weeks	Concurrent metabolic burden; overlap often extended
Clozapine	Anything	Slow cross-taper	4 to 8 weeks	Cholinergic rebound, rapid relapse; never abrupt outside crisis
Olanzapine	Aripiprazole	Cross-taper or plateau	4 weeks	Metabolic benefit; watch akathisia early
Olanzapine	Lurasidone or ziprasidone	Cross-taper	2 to 4 weeks	Metabolic benefit; both need food
Quetiapine	Anything	Cross-taper	2 to 4 weeks	Rebound insomnia and anxiety
Risperidone	Paliperidone	Direct or short cross-taper	Days	Essentially the same drug
Oral	LAI (same molecule)	Plateau per manufacturer	Per protocol	Different LAIs have different loading rules
LAI	Different LAI	Overlap or short gap	Bridge with oral if needed	Half-lives of LAIs vary widely

LAI	Oral	Wait through LAI washout	Weeks to months	Paliperidone 6-monthly persists for extended periods

Class-to-class watchouts

- Clozapine. Never abrupt outside crisis. Cholinergic rebound (nausea, sweating, diarrhea, agitation) and rapid, sometimes severe, psychotic relapse. Plateau: keep clozapine at current dose while titrating incoming to target, then taper clozapine over 4 to 8 weeks.
- Oral to LAI. Keep oral on board through the LAI ramp-up. Follow manufacturer protocol. Aripiprazole Maintena needs 14 days oral overlap. Risperidone Consta needs 3 weeks oral overlap because Consta releases nothing meaningful until week 3.
- LAI to oral. Meaningful drug persists 1 to 3 months for monthly LAIs. Start oral at a modest dose, monitor for both breakthrough and side effects.
- High-potency to low-potency. Watch for cholinergic side effects unmasked as haloperidol comes off. Quetiapine to haloperidol: expect EPS. Consider prophylactic benztropine 1 to 2 mg BID.
- Withdrawal dyskinesia vs tardive dyskinesia. New movements during taper usually reflect D2 upregulation unmasking, resolve over weeks to months. If they persist beyond 4 to 6 months post-taper, that is TD by consensus.
- Rebound psychosis. Rapid discontinuation of high-D2-affinity antipsychotics (haloperidol, risperidone, olanzapine, paliperidone) can produce worse psychosis than baseline. Taper slowly.
- Metabolic switching. Best evidence is for olanzapine or clozapine to aripiprazole. Gains happen in the first 3 to 6 months. Trade-offs: activation, akathisia, occasional symptom breakthrough. Lurasidone and ziprasidone are other reasonable metabolic switches.

Not medical advice.