RESEARCH PAPER

Stigma, Privacy, and Patient-Facing Psychotropic Medication Management: A Scoping Review of Adherence-Support Strategies

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ABSTRACT

Background: Adherence to psychotropic medications is influenced not only by clinical and pharmacological factors but also by stigma, confidentiality concerns, treatment visibility, and practical barriers related to medication management. These challenges may affect treatment initiation, continuity, and sustained engagement, particularly when medication use is socially sensitive or logistically burdensome. Patient-facing interventions such as pharmacist-led support, telepharmacy, digital tools, refill-related services, and low-frequency treatment approaches may help mitigate some of these barriers.

Objective: To map the existing evidence on stigma- and privacy-related barriers to adherence to psychotropic medications and to identify patient-facing adherence-support strategies that may support treatment continuity and medication management.

Methods: A scoping review was conducted in accordance with PRISMA-ScR principles. Searches were performed in PubMed, Scopus, PsycINFO, and Web of Science in February 2026. A total of 350 records were identified; after duplicate removal, 120 records were screened, 45 full-text reports were assessed for eligibility, and 26 studies were included in the final synthesis. Findings were synthesized narratively.

Results: The included literature indicates that stigma, fear of disclosure, treatment visibility, refill burden, service access, and regimen complexity may undermine adherence to psychotropic medications. Pharmacist-led interventions, telepharmacy models, digital adherence-support tools, and lower-frequency treatment strategies emerged as potentially relevant approaches to improving treatment continuity. The evidence also suggests that less visible or simplified treatment models may reduce some patient-facing barriers, although findings remain heterogeneous across populations and settings.

Conclusion: Stigma- and privacy-related factors appear to be important yet underexamined determinants of psychotropic medication adherence. Patient-facing adherence-support strategies show promise, but the available evidence remains varied. Further research is needed to strengthen stigma-sensitive and privacy-conscious approaches to psychotropic medication management.

Keywords: psychotropic medication; medication adherence; stigma; privacy; telepharmacy; long-acting injectables; medication management

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INTRODUCTION

Psychotropic medications remain a cornerstone of treatment for major psychiatric disorders, but adherence is persistently compromised across diagnoses and settings. Systematic reviews and meta-analyses have estimated high levels of psychotropic non-adherence and have shown that non-adherence is shaped by multiple patient-related, treatment-related, and system-related determinants.[1-3]Within that broad problem, stigma and privacy have particular relevance because psychotropic treatment is socially marked in ways that many other chronic therapies are not. Recent reviews indicate that perceived stigma, self-stigma, negative attitudes toward treatment, poor social support, and culturally mediated fears about psychiatric medicines are repeatedly associated with poorer adherence. In low-resource settings, these barriers interact with service fragmentation, travel burden, and medication side effects to make sustained treatment even harder to maintain.[2,4-7]Privacy-related barriers are closely intertwined with stigma but are not identical to it. Patients may avoid taking medicines in front of others, delay refills, switch service locations, or disengage from follow-up when treatment becomes too visible or when confidentiality feels uncertain. Qualitative work in depression and schizophrenia has described how logistical barriers, public exposure, sociocultural expectations, and concerns about treatment visibility can shape everyday decisions about dosing, disclosure, and clinic attendance.[8-11]At the same time, patient-facing adherence-support strategies are expanding. Pharmacist-led transitional care, telepharmacy, digital reminders, refill counseling, regimen simplification, and long-acting formulations all aim to reduce the practical and psychosocial burden of treatment. These approaches are especially relevant to a drug-delivery audience because administration

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frequency, route, and visibility are not merely pharmacotechnical issues; they also shape acceptability, dignity, and persistence with therapy.[12-16]Accordingly, this scoping review aimed to map the available evidence on stigma- and privacy-related barriers to adherence to psychotropic medications and to identify patient-facing adherence-support strategies that may support treatment continuity and medication management.

METHODS

Design

This study was designed as a scoping review to map the available evidence on stigma- and privacy-related barriers to psychotropic medication adherence and on patient-facing adherence-support strategies. The review was conducted in accordance with Joanna Briggs Institute guidance for scoping reviews and reported following PRISMA-ScR principles. A scoping review design was considered appropriate because the topic spans diverse forms of evidence, including qualitative, quantitative, interventional, and review-based literature, and because the aim was to map concepts, barriers, and strategies rather than to estimate pooled effects.

Review question

The review addressed the following question: What evidence exists on stigma- and privacy-related barriers to psychotropic medication adherence, and which patient-facing adherence-support strategies have been reported to support treatment continuity and medication management?

Eligibility criteria

Studies were eligible if they addressed at least one of the following domains in relation to psychotropic medication adherence: stigma, self-stigma, confidentiality concerns, treatment visibility, fear of disclosure, refill-related barriers, dispensing barriers, or other patient-facing barriers to medication management. Studies were also eligible if they examined adherence-support strategies relevant to psychotropic medication management, including pharmacist-led interventions, telepharmacy, digital tools, refill support, medication counseling, or low-frequency treatment approaches such as long-acting formulations.The review considered literature involving individuals receiving psychotropic medications, including antidepressants, antipsychotics, anxiolytics, mood stabilizers, attention-deficit/hyperactivity disorder medications, and related psychiatric pharmacotherapies. Studies in broader mental health populations were included when their findings were clearly relevant to psychotropic medication adherence or patient-facing medication management. Studies without a psychotropic treatment focus were excluded at the full-text eligibility stage.

Eligible evidence included qualitative studies, observational studies, interventional studies, systematic reviews, scoping reviews, and narrative reviews that contributed meaningfully to mapping the topic. The review focused on peer-reviewed literature published in English between 2015 and 2026.

Information sources and search approach

A structured literature search was conducted in PubMed, Scopus, PsycINFO, and Web of Science in February 2026. The search strategy combined controlled vocabulary and free-text terms related to psychotropic medications, medication adherence, stigma, self-stigma, privacy, confidentiality, treatment visibility, refill-related barriers, pharmacist-led support, telepharmacy, digital adherence tools, and long-acting or low-frequency treatment approaches. Search strategies were adapted to the syntax and indexing of each database.

Study selection

A total of 350 records were identified across the four databases. After duplicate removal, 120 records remained for title and abstract screening. Of these, 75 were excluded during screening. Forty-five full-text reports were assessed for eligibility, and 19 were excluded because they did not focus on psychotropic medications. Twenty-six studies were included in the final synthesis. The study selection process is summarized in Figure 1.

FIGURE 1. PRISMA 2020

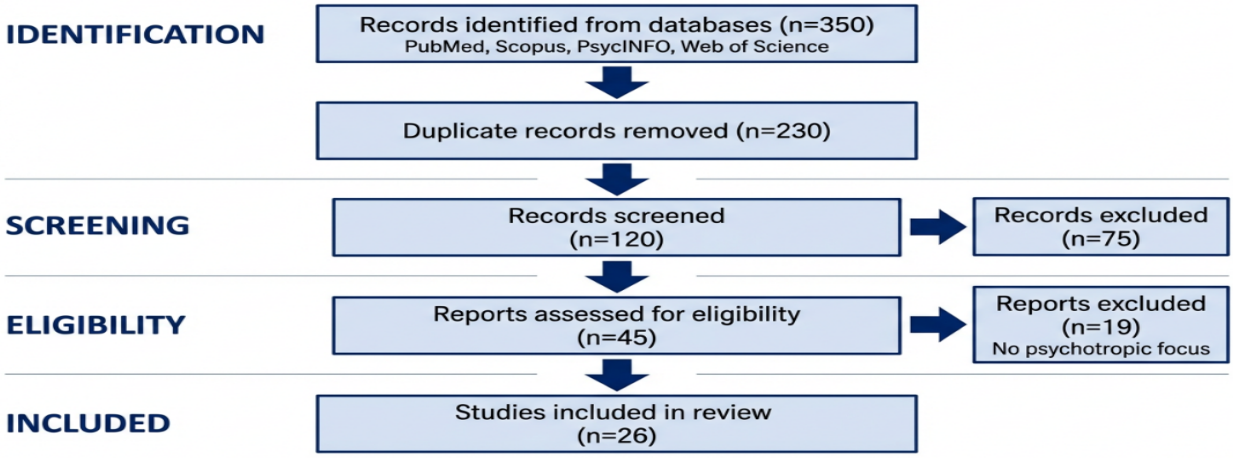

FIGURE 1. PRISMA 2020 flow diagram of study selection

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Screening process

Screening was conducted in two stages. First, titles and abstracts were reviewed for relevance to the review question and eligibility criteria. Second, full-text reports were assessed to confirm psychotropic medication focus, adherence relevance, and contribution to one or more of the analytical domains of the review.
Screening and eligibility assessment were conducted independently by two reviewers, and disagreements were resolved through discussion.

Data charting

Data were charted using a structured extraction framework. For each included study, the following information was documented: author and year, country or setting, population, psychotropic medication context, study design, barrier or intervention studied, whether stigma or privacy was explicit or implicit, adherence-related outcome, and relevance to patient-facing psychotropic medication management.

Synthesis

Given the heterogeneity of study designs and outcomes, findings were synthesized narratively rather than statistically pooled. The mapped evidence was organized into five analytical categories: (1) stigma-related barriers to psychotropic medication adherence; (2) privacy and patient-facing barriers in medication management; (3) pharmacist-led and telepharmacy adherence-support strategies; (4) low-frequency and less visible treatment strategies; and (5) implications for stigma-sensitive psychotropic medication management. Formal risk-of-bias appraisal was not undertaken because the aim of the review was to map the range and character of available evidence rather than to estimate pooled intervention effects.

RESULTS

The final mapped corpus comprised 26 publications spanning qualitative studies, cross-sectional studies, retrospective cohort studies, randomized and pragmatic trials, systematic reviews, scoping reviews, and narrative reviews. The evidence was geographically diverse, with studies from Ethiopia, Malaysia, Iraq, Turkey, China, Saudi Arabia, the United States, the Netherlands, and several global or multicountry syntheses. Most of the literature focused on adults with major depressive disorder, schizophrenia, or mixed psychiatric populations, although several studies also addressed adolescent experiences, pharmacist-facing service models, and technology-based adherence interventions.[2-16,19-25]

Table 1. Characteristics of studies included in the review

No.	Study	Design	Population / context	Primary domain	Main contribution
1	Issac et al., 2025	Qualitative systematic review and meta-synthesis	People with mental disorders, caregivers, and healthcare professionals	Stigma / privacy / adherence barriers	Identified stigma, fear, access barriers, forgetfulness, and support routines as central influences on psychotropic adherence.
2	Tadesse et al., 2025	Systematic review and meta-analysis	Individuals with mental illness	Stigma-related barriers	Quantified perceived stigma as a predictor of psychotropic medication non-adherence.
3	Zewdu et al., 2025	Systematic review and meta-analysis	Patients with psychiatric disorders	Stigma / regimen complexity	Showed self-stigma, negative attitudes, poor social support, and regimen complexity as predictors of non-adherence.
4	Addisu et al., 2025	Systematic review and meta-analysis	Patients with schizophrenia receiving antipsychotics	Stigma-related barriers	Identified perceived stigma, side effects, polypharmacy, and low family support as predictors of non-adherence.
5	Semahegn et al., 2020	Systematic review and meta-analysis	Adults with major psychiatric disorders	Adherence barriers	Synthesized psychotropic non-adherence and associated behavioral, social, and health-system factors.
6	Ho et al., 2017	Qualitative study	Outpatients with major depressive disorder receiving	Patient-facing barriers	Described sociocultural, logistical, and provider-related barriers and facilitators to antidepressant adherence.

			antidepressants		
7	Dikeç et al., 2022	Qualitative phenomenological study	Adolescents with mental disorders and parents	Stigma-related barriers	Reported stigma, parental attitudes, forgetting, side effects, and lack of information as barriers to adherence.
8	Son & Park, 2025	Qualitative meta-synthesis	Adults with schizophrenia	Stigma-related barriers	Linked self-stigma, community prejudice, and medication burden with non-adherence.
9	Yassen et al., 2024	Cross-sectional study	Adults with major depressive disorder receiving antidepressants	Privacy / refill burden	Identified frequent refills, travel burden, service scarcity, and stigma as barriers to treatment continuity.
10	Li et al., 2025	Qualitative study	Community-dwelling adults with schizophrenia and caregivers	Privacy / low-frequency treatment	Highlighted accessibility issues, stigma, and patient interest in long-acting treatment to reduce burden and visibility.
11	Townsend et al., 2022	Systematic review and framework synthesis	Adults with psychotic and mood disorders, healthcare professionals, and caregivers	Route-related stigma	Examined antipsychotic-related stigma and how route of administration may reduce or increase stigma-related barriers.
12	Barrett et al., 2020	Retrospective cohort study	Adults discharged after psychiatric hospitalization	Pharmacist-led / telepharmacy	Showed that pharmacist-led telemental health follow-up improved antidepressant continuity post-discharge.
13	Al Shakhori et al., 2025	Retrospective cohort study	Outpatients receiving broad psychotropic regimens	Pharmacist-led / telepharmacy	Reported pharmacist-led telepsychiatric management of drug-related problems and adherence-focused education.
14	Niznik et al., 2018	Systematic review	Adults in outpatient and ambulatory telemedicine settings	Telepharmacy	Supported telepharmacy models involving education, monitoring, and adherence counseling, including mental health contexts.
15	Milosavljevic et al., 2018	Systematic review	Adults receiving community pharmacist-led care	Pharmacist-led support	Found that community pharmacist interventions improved adherence, including in antidepressant-treated populations.
16	Kooij et al., 2016	Pragmatic cluster randomized controlled trial	Adults initiating antidepressants and other chronic medicines	Telephone counseling	Evaluated pharmacist telephone counseling and showed that brief interventions may have mixed effects on antidepressant adherence.
17	Milz et al., 2023	Narrative review	Adults with schizophrenia receiving long-acting injectable antipsychotics	Low-frequency treatment	Suggested that longer dosing intervals may reduce daily medication burden and potentially reduce stigma.
18	Kane et al., 2021	Narrative review	Adults with schizophrenia	Long-acting injectable treatment	Discussed misconceptions about long-acting injectables and their potential to reduce daily adherence conflict when collaboratively framed.
19	Zaniolo et al., 2024	Network meta-analysis and budget impact model	Adults with schizophrenia receiving long-acting injectables	Long-interval treatment	Supported longer-interval long-acting injectables as schedule-simplifying options associated with sustained outcomes.

20	Fagiolini et al., 2025	Narrative clinical review	Adults with schizophrenia	Oral vs long-acting injectable treatment	Compared oral and long-acting injectable antipsychotics, emphasizing convenience and adherence benefits alongside possible stigma concerns.
21	Markowicz-Piasecka et al., 2023	Formulation-focused review	Patients with severe mental illness receiving depot antipsychotics	Formulation / low-frequency treatment	Positioned long-acting injectable formulations as adherence-supporting options that reduce daily treatment demands.
22	Chukwuma et al., 2024	Systematic review	People with psychiatric illnesses across mixed settings	Stigma and treatment engagement	Synthesized evidence showing that public, self, and structural stigma are associated with poorer treatment adherence and engagement.
23	Jayasree et al., 2024	Narrative review	Adults with depression, schizophrenia, anxiety disorders, and bipolar disorder	Adherence typology / support strategies	Reviewed intentional and unintentional non-adherence and summarized strategies such as simplification, reminders, monitoring, and long-acting formulations.
24	Wang et al., 2025	Scoping review	Mixed chronic-disease populations using mHealth tools, including some mental-health contexts	Digital adherence support	Described digital tools, reminders, monitoring systems, and privacy-related barriers relevant to medication adherence.
25	Borghouts et al., 2021	Systematic review	Users of digital mental health interventions	Digital engagement / privacy	Identified barriers and facilitators to engagement with digital mental health interventions, including personalization, control, and acceptability.
26	Baryakova et al., 2023	Narrative review	Patients receiving chronic pharmacotherapy, including CNS-related treatment	Drug-delivery-informed adherence support	Framed long-acting and extended-release drug delivery systems as approaches to reduce behavioral adherence burden and support treatment continuation.

Stigma-related barriers to psychotropic medication adherence

Stigma emerged as the most consistent patient-facing barrier across the literature. Reviews of psychotropic adherence in Ethiopia and broader resource-limited settings showed that perceived stigma and self-stigma were significant predictors of non-adherence, alongside poor social support, negative treatment attitudes, lack of insight, and medication side effects.[4,5]

Schizophrenia-focused evidence in Sub-Saharan Africa similarly linked non-adherence to perceived stigma, extrapyramidal side effects, polypharmacy, and weak family support.[6]

A broader review of stigmatization in psychiatric illness found that stigma affected adherence, treatment-seeking, and follow-up engagement, reinforcing that stigma is not merely an attitudinal variable but a determinant of care continuity.[7]

Qualitative syntheses added important explanatory detail. Issac and colleagues identified stigma, fear of abuse, medication misperceptions, and poor accessibility as recurrent barriers to adherence across mental disorders.[2]

In Turkey, adolescents and parents described stigmatisation, fear of being judged, parental beliefs, and feeling unlike oneself while taking psychotropics as factors that undermined adherence.[19]

In community schizophrenia care in China, policy-level stigma and community-level barriers to medication access were both described as obstacles to sustained adherence.[10]

Qualitative evidence in schizophrenia populations also suggested that self-stigma, community prejudice, and medication burden may contribute to non-adherence. [29]

Privacy, confidentiality, and treatment-visibility concerns

Compared with stigma, privacy and confidentiality were less often measured directly, but they were clearly embedded in patient narratives and in the practical organization of care. Qualitative work among outpatients with depression in Malaysia highlighted social-cultural barriers, logistical burdens, and healthcare-system constraints that influenced whether antidepressants could be managed discreetly and consistently.[8]

In Iraq, patients with major depressive disorder identified stigma, travel problems, lack of nearby services, and frequent refill demands as barriers to antidepressant adherence, indicating that visibility and repetition of service contact can become part of the adherence burden.[9]

Townsend and colleagues showed that route of administration itself can carry stigma-related meaning. In some studies, long-acting injectables were perceived as coercive or more stigmatizing; in others, they were valued because they reduced the daily reminder of illness associated with oral pills.[11]

Digital adherence technologies also raised privacy questions. A recent scoping review of mHealth interventions reported that privacy concerns, data-security worries, and limited digital literacy could reduce adoption, even when reminder functions and monitoring features had potential adherence benefits.[12]

Pharmacist-led and telepharmacy adherence-support strategies

Pharmacist-led interventions constituted one of the clearest patient-facing adherence-support categories. A pharmacist-led telemental health transitions-of-care clinic in the United States substantially improved antidepressant continuity after psychiatric hospitalization, with a markedly higher proportion of patients achieving a 90-day medication possession ratio of at least 0.8 than historical controls.[13]

A broader systematic review of outpatient and ambulatory pharmacist telemedicine interventions found that scheduled and continuous pharmacist contact, most often by telephone, generally improved adherence and self-management outcomes across chronic conditions, including depression and post-traumatic stress disorder medication management.[14]

Community pharmacist-led interventions have also shown adherence benefits, although evidence specific to psychotropics remains less abundant than evidence for somatic conditions. Reviews of community pharmacy interventions suggest that counseling, follow-up contact, medication review, and refill support can improve adherence behaviors, even when downstream symptom improvement is less consistent.[15]

More recent telepsychiatry pharmacy data from Saudi Arabia described pharmacist-led remote management of psychotropic drug-related problems with a strong emphasis on patient education to improve adherence, alongside dose optimization and adverse-effect management.[20]

Digital tools and refill-related support

Digital adherence supports were usually studied as reminder- and monitoring-based interventions rather than as explicitly stigma-sensitive tools. Nevertheless, their patient-facing value lies partly in the possibility of supporting medication use without requiring visible public dosing or repeated in-person contact.[12]

Telephone counseling by pharmacists shortly after treatment initiation has been tested in community pharmacy settings. In the TelCIP cluster trial, the intervention did not improve adherence among antidepressant starters, suggesting that early low-intensity counseling alone may be insufficient in depression when adherence barriers are more psychosocial and complex.[21]

Across the broader literature, refill frequency, travel demands, irregular follow-up, and poor service accessibility recurred as practical burdens that can compound stigma and privacy concerns. This is especially important in psychotropic care, where each refill or clinic encounter may also carry symbolic exposure and fear of judgment.[4,5,8-10]

Low-frequency and less-visible treatment strategies

The strongest drug-delivery signal in the mapped evidence concerned low-frequency treatment strategies, especially long-acting injectable antipsychotics. Reviews consistently suggested that longer dosing intervals may reduce the burden of daily oral medication, support normalization of life, and improve persistence by reducing opportunities for missed doses.[16,22]

Narrative clinical reviews emphasized that long-acting injectables can be particularly useful when daily tablets are difficult to sustain, although organizational issues and patient perceptions of injections may still shape acceptability.[23]

Economic and comparative analyses of extended dosing intervals, including 3-month and 6-month paliperidone formulations, suggested that lower administration frequency may preserve effectiveness while decreasing relapse burden and simplifying treatment routines.[24]

Formulation-focused reviews likewise framed depot antipsychotics as a means of improving long-term compliance by shifting medication management from daily pill-taking to periodic administration.[25]

At a broader drug-delivery level, reviews of innovative adherence-oriented delivery systems argued that reducing administration frequency and the behavioral workload of treatment may be especially helpful where educational or behavioral adherence strategies alone are insufficient.[26]

DISCUSSION

This scoping review suggests that psychotropic medication adherence is influenced by a three-way interaction between social meaning, service design, and dosage form. First, stigma remains a robust driver of non-adherence. Second, privacy and treatment visibility shape how tolerable ongoing medication management feels in daily life. Third, patient-facing support strategies appear most promising when they reduce both psychosocial exposure and practical effort at the same time.[2,4-7,11]

For nursing and mental health practice, the findings indicate that adherence counseling should move beyond generic reminders and focus more explicitly on what patients are trying to avoid socially: disclosure,

surveillance, embarrassment, and repeated visible contact with stigmatized services. Nurses, pharmacists, and prescribers can address these concerns by normalizing discussion of stigma, offering private follow-up channels, simplifying regimens when feasible, and proactively asking about refill logistics, travel burden, and medication-taking in shared living environments.[8-10,19]

For a journal audience interested in drug-delivery technology, the most relevant implication is that delivery systems may influence adherence partly through social mechanisms, not only pharmacokinetic ones. Long-acting injectables, extended dosing intervals, and other low-frequency approaches may improve treatment persistence because they reduce the number of visible medication events and the cognitive labor of daily adherence. Future work in psychotropic drug delivery should therefore evaluate outcomes such as perceived stigma, confidentiality, convenience, treatment visibility, and willingness to continue therapy, rather than focusing exclusively on relapse or hospitalization endpoints.[16,22-26]

This interpretation is also consistent with evidence from other long-term medication contexts showing that fear of being seen taking medication or collecting refills may alter where, when, and how treatment is managed, thereby affecting continuity of care. [28]

Important evidence gaps remain. Direct measures of privacy-sensitive outcomes were uncommon. Refill confidentiality, discreet dispensing, packaging, and the visibility of community pharmacy encounters were discussed more often indirectly than explicitly. Student and campus populations were also underrepresented, and few studies tested combined interventions that integrated psychosocial stigma reduction with delivery-system redesign or pharmacist follow-up. Digital mental health research further suggests that personalization, user control, and trust are important for sustained engagement, which is likely relevant when psychotropic adherence tools incorporate reminders or remote monitoring.[12,27]

This review has several limitations. First, as a scoping review, its purpose was to map the breadth and thematic structure of the available evidence rather than to estimate pooled intervention effects or establish causal relationships. Second, the included literature was heterogeneous in study design, population, intervention type, and outcome reporting, which limited direct comparability across sources. Third, some constructs central to this review—particularly privacy, treatment visibility, and patient-facing medication-management burden—were not consistently defined across studies. Fourth, the synthesis included both primary studies and review-level evidence, and the findings should therefore be interpreted as a structured conceptual and practice-oriented synthesis rather than as a hierarchy of effectiveness. Finally, the review was restricted to peer-reviewed literature published in English, which may have excluded relevant evidence from other languages or publication types. Despite these limitations, the review provides a coherent overview of a fragmented field and identifies themes that appear highly relevant to future psychotropic medication management research and practice.

CONCLUSION

The available evidence indicates that stigma and privacy are not peripheral issues in psychotropic medication adherence; they are central determinants of whether treatment can be lived with, sustained, and integrated into ordinary life. Patient-facing adherence support appears most credible when it combines empathic clinical communication with practical design solutions such as telepharmacy access, pharmacist follow-up, reminder tools that respect confidentiality, refill-sensitive service organization, and low-frequency treatment regimens. Future primary research should explicitly measure how delivery mode, refill processes, treatment visibility, and confidentiality protections influence psychotropic adherence in real-world settings.

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