### Supplemental Table 1. Selected Articles on Recovery in Community Integration and Normative Life Roles

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<th>Author/Year</th>
<th>Study Objectives</th>
<th>Level/Design/Participants</th>
<th>Intervention and Outcome Measures</th>
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<tr>
<td>Anzai et al. (2002)</td>
<td>To examine effectiveness of the Community Reentry Model when adapted for Japanese psychiatric patients in teaching the knowledge and skills required to live and participate in the community</td>
<td>Level I</td>
<td>Intervention:&lt;br&gt;Group 1: Community Reentry Module, a highly structured curriculum that consists of sessions on medication, relapse, finding housing and psychiatric care in the community, reducing stress, and coping&lt;br&gt;Group 2 (control): Conventional occupational rehabilitation program; consists of arts and crafts, reality-orientation groups, and work assignments in the hospital</td>
<td>Group 1 had significant increase in knowledge and skills on a 21-item instrument at 1-yr follow-up. Group 2 showed no significant gains.&lt;br&gt;10 of 14 Group 1 members were discharged from the hospital; only 3 Group 2 members were discharged.&lt;br&gt;At 1-yr follow-up the Community Reentry group lost some skills but were still significantly higher than baseline</td>
<td>Small group sizes&lt;br&gt;Conducted in Japan&lt;br&gt;Focus of measurement was medication management that was specifically taught to one group but not the other</td>
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<td>Bartels et al. (2004)</td>
<td>To assess the effectiveness of a combined ST and HM intervention for older adults with severe mental illness</td>
<td>Level II</td>
<td>Intervention:&lt;br&gt;ST: Hour-long group skills training 2×/wk adapted from manualized skills training programs delivered by a nurse case manager&lt;br&gt;HM: Assessment and monitoring of routine and chronic health care needs and promotion of preventive health care&lt;br&gt;Delivered by same nurse case manager</td>
<td>After 1 yr, the HM + ST group had better functional outcomes with medium to large effect sizes with respect to independent living skills, social skills, and health management compared with those receiving HM alone.&lt;br&gt;After 2 yr, both groups had improved preventive health care.</td>
<td>Lack of randomization&lt;br&gt;Pilot study had a small sample size</td>
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| Bickes, DeLoache, Dicer, & Miller  | Examine the effectiveness of occupation-based verbal therapy vs. occupation-based experiential therapy on the money management skills of consumers of community mental health services | Level II  
Nonrandomized controlled trial  
Participants  
N = 14 consumers from a community mental health day support program  
Diagnoses included schizophrenia, personality disorders, and mood disorders | Intervention  
COPM was administered to determine which occupation clients were most interested. Clients identified money management.  
Group 1: Occupation-based experiential group  
Group 2: Occupation-based experiential group  
Occupational therapy groups conducted 3×/wk for 2 wk by two certified occupational therapy assistant students. | No significant difference was found between the verbal group and the experiential group on the COTE or the MEDLS. Overall performance of both groups improved significantly on the COTE but did not improve significantly on the MEDLS. | Short time frame of intervention may have been inadequate to allow for experiential learning to occur.  
Small sample size  
Lack of control group  
Experiential groups occurred in simulated environment instead of community. |
| Brown, Goetz, Van Sciver, Sullivan, & Hamera (2006a) | To examine the efficacy of a psychiatric rehabilitation weight loss program | Level II  
Nonrandomized controlled trial  
N = 36 participants from a support program for people with psychiatric disabilities with a BMI ≥ 25  
n = 21 experimental group  
n = 15 control group | Interventions  
Experimental group: 12-wk manualized intervention combining evidence-based weight loss and psychiatric rehabilitation strategies  
Control group: Participants recruited after start on experimental group—no intervention provided | At follow-up, the intervention group improved significantly on body weight, BMI, waist circumference, and the physical activity subscale of the Health Promoting Lifestyle Profile II. The intervention group lost 6 lb, and the control group gained 1 lb. There were no differences between groups at follow-up for blood pressure, total and nutrition subscale of the Health Promoting Lifestyle II. | Small sample size, lack of randomization |
| Cook et al. (2010)                 | To evaluate the outcomes of statewide initiatives to teach self-management of mental illness to people in mental health recovery | Level III  
Pretest–posttest design  
N = 341 participants in a peer-led self-management program in Vermont and Minnesota | Intervention  
Wellness Recovery Action Planning (WRAP), in which participants identify internal and external resources for facilitating recovery and use these tools to create an individualized plan | Significant changes were observed in both WRAP programs on posttest in hopefulness for recovery, warning signs of decompensation, use of wellness tools, awareness of symptom triggers, having a crisis plan and a plan for dealing with symptoms, having a social support system, and the ability to take responsibility for wellness. | Two programs used slightly different outcome measures.  
No follow-up after the completion of the program  
Survey measure has not been tested.  
Lack of control group |
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<th>Study</th>
<th>Objective</th>
<th>Level</th>
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<td>Dilk &amp; Bond (1996)</td>
<td>To analyze the effectiveness of skills training for people with severe mental illness</td>
<td>Level I</td>
<td>Meta-analysis</td>
<td>Articles published between 1970 and 1992, doctoral dissertations, and master's theses. Studies with at least 5 participants, Levels I, II, and III</td>
<td>Training programs taught these skills: general interpersonal, assertiveness, prevocational, ADLs, micro interpersonal, dating, affective management, cognitive. Training approaches were either behavioral or cognitive-behavioral. Settings included both inpatient and outpatient.</td>
<td>Skill acquisition, symptom reduction, personal adjustment (GAFS), hospitalization, vocational readiness. Research studies rarely evaluated use of trained skills. Limited number of studies examining skills training in settings other than psychiatric hospitals. Many of the outcome measures were similar to the studied interventions, so the authors warn against the generalizability of the results. Gender and ethnicity were not evenly represented.</td>
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<td>Duncombe (2004)</td>
<td>To answer the question, is there a difference between learning the functional living skill of cooking for people with serious and persistent schizophrenia when it is taught in a clinic or in their home</td>
<td>Level I</td>
<td>RCT</td>
<td>Participants N = 44</td>
<td>Diagnosis of nonparanoid schizophrenia or schizoaffective disorder living in group homes or supported apartments that had kitchens available. Participants were assigned in 22 pairs matched on cognitive level and randomly assigned to one of two groups. Group 1: Cooking skills training in the home. Group 2: Cooking skills training in the clinic. Participants received treatment individually 4× in the designated context with a 1-wk lapse between each session.</td>
<td>Both groups posted significant improvement between their pretest and posttest scores on the KTA-M. The results did not show a significant difference in the level of learning between the two groups in the different contexts. Qualitative differences in the two settings may have affected the results. The clinic was quiet with minimal distractions. The kitchens in the group homes were cluttered and distracting. Multiple intervention sites resulted in inconsistencies in the research. The KTA-M may have had a ceiling effect.</td>
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<td>Frank et al. (2005)</td>
<td>To compare interpersonal and social rhythm therapy (IPSRT) and intensive clinical management (ICM) in the treatment of bipolar I disorder.</td>
<td>Level I</td>
<td>RCT</td>
<td>Diagnosis of bipolar I disorder or schizoaffective disorder, manic type; n = 43 ICM/ICM.</td>
<td>Participants randomized to groups based on ICM or IPSRT in the acute phase followed by ICM or IPSRT in the maintenance phase. IPSRT stresses the importance of maintaining daily routines and identifying potential rhythm disruptors. ICM is a manual-driven approach to the medical management of variables that were later found to be associated with outcome, such as marital status and medical burden, were not distributed equally among the maintenance study conditions.</td>
<td>No difference between groups in time to stabilization was found. Participants in IPSRT in the acute phase survived longer without a new episode regardless of treatment approach in the maintenance phase. In addition, those in IPSRT had higher regularity of social rhythms at the end of acute treatment.</td>
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| Glynn et al. (2002) | To compare the effectiveness of clinic-based skills training with skills training augmented with formal practice within the community to demonstrate generalizabilities | Level I  
RCT  
Participants  
N = 63 between ages of 18 and 60 with a DSM-IV-TR diagnosis of schizophrenia or schizoaffective disorder  
Group 1: n = 32  
Group 2: n = 31 | Interventions  
Group 1: Treatment with risperidone or haloperidol as well as behaviorally oriented clinic-based social skills training either alone  
Group 2: In conjunction with in vivo amplified skills training (N = 31)  
Outcome Measures  
Module tests at baseline and at 24 wk  
Patient version of the Social Adjustment Scale–II and the Quality of Life Scale | Participation in clinic-based plus in vivo amplified skills training was associated with significantly greater improvements in instrumental role functioning and overall adjustment as assessed with the Social Adjustment Scale–II.  
Both conditions showed improvements on the Quality of Life Scale instrumental role, intrapsychic motivation, common objects, and overall composite scores.  
Participants who participated in clinic-based plus in vivo amplified skills training improved more quickly, and often to higher levels, than the clinic-based skills training alone. | 28% loss of participants over 60 wk without clear explanation of intent-to-treat analyses  
Two intervention groups varied in intensity of their treatment; participants in in vivo amplified skills training received more contact with mental health professionals. |
| Granholm et al. (2005) | The comparison of usual treatment vs. usual treatment plus cognitive-behavioral social skills training on social functioning, psychotic and depressive symptoms, cognitive insight, and skill mastery | Level I  
RCT  
Participants  
76 community-dwelling adults diagnosed with schizophrenia or schizoaffective disorder  
Cognitive–behavioral group: n = 37  
Control group: n = 39  
Age: 42–74 yr | Interventions  
Cognitive–behavioral social skills training group: Received 24 wkly, 2-hr group psychotherapy sessions including homework forms and workbooks and received training modules.  
Control group: Received treatment as usual  
Outcome Measures  
• Cognitive Therapy Rating Scale for Psychosis | At end of 6 mo, participants in the cognitive-behavioral social group performed social functioning activities more frequently than the other group; however, they showed no significant improvement when performing everyday functional activities after treatment.  
Group receiving usual treatment alone showed increased score on | Authors reported a moderately small sample size; exclusion of patients with comorbid conditions may limit generalizability. |
Grawe, Falloon, Widen, & Skogvoll (2006)  
To evaluate the benefits derived from continued integrated biomedical and psychosocial intervention for recent-onset schizophrenia  

**Level I**  
**RCT**  
**Participants**  
$N = 50$ people with schizophrenia.  
IT: $n = 30$  
Standard treatment: $n = 20$  

**Intervention**  
Standard treatment: Patients received regular clinic-based case management with antipsychotic drugs, supportive housing and day care, crisis inpatient treatment, rehabilitation that promoted independent living and work activity, brief psychoeducation, and supportive psychotherapy.  
IT: Patients treated by multidisciplinary team independent of the standard treatment program. In addition to standard treatment, IT cases received structured family psychoeducation, cognitive–behavioral family communication and problem-solving skills training, intensive crisis management provided at home, and individual cognitive–behavioral strategies for residual symptoms and disability.  

IT group was superior to ST in reducing negative symptoms, minor psychotic episodes, and in stabilizing positive symptoms, but did not reduce hospital admissions or major psychotic recurrences. More IT patients than standard treatment patients had better 2-yr outcomes.  

To evaluate the effectiveness of a skills training program designed to teach disease management to Latinos with schizophrenia treated in a community mental health center  

**Level I**  
**RCT**  
**Participants**  
92 Latino outpatients 18–60 yrs old and family members  
ST group: $n = 45$; 39 completed  
Customary outpatient care: $n = 47$; 45 completed  

3 mo skills training or customary care then followed for a total of 9 mo. Program was culturally adapted through input of patient's key relatives.  

**Outcome Measures:**  
- PANSS  
- LA County Department of Mental Health  
- Management Information System  
- Independent Living Skills Survey  
- Quality of Life Interview  
- Rating of Medication Influences Scale  

The results indicate that those in the ST group had more skills acquisition and generalization than those in the control group. There was no statistically significant difference between groups for quality of life, caregiver burden, adherence to medication, and attitude toward medication. Rehospitalization and family measures had no statistical significance between groups; however, more people were rehospitalized in the control group at 9- and 15-mo reports.  

Moderately small sample size  
Relatively limited follow-up
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<td>Kurtz, Seltzer, Shagan, Thime, &amp; Wexler (2007)</td>
<td>To evaluate the effects of a treatment with computer-assisted cognitive remediation that included explicit training in attention verbal and nonverbal working and episodic memory and language processing exercises</td>
<td>Level I RCT; single blind</td>
<td>Intervention: 12 mo standardized course of cognitive remediation consisting of a sequence of computerized cognitive exercises designed to improve attention, verbal and nonverbal memory and language processing through repeated drill and practice. &lt;br&gt;Control: Similar exposure to computer and clinician, with nonspecific cognitive challenge &lt;br&gt;Outcome Measures: &lt;br&gt;• <strong>Working memory:</strong> Digit Span, Arithmetic and Letter-Number sequencing subtests from the WAIS–III &lt;br&gt;• <strong>Verbal episodic memory:</strong> Logical memory &lt;br&gt;• <strong>Speed of information processing:</strong> Digit Symbol and Symbol Search subtests from the WAIS–III, Trail Making test, Grooved Pegboard and Letter Fluency &lt;br&gt;• <strong>Visual episodic memory:</strong> Rey Complex Figure Test, Reasoning, Penn Conditional Exclusion Test, Booklet Category Test</td>
<td>Cognitive remediation yields significant improvement in working memory. Other domains show similar progress across both groups. No significant differences were evident between cognitive remediation or computer skills training groups for demographic, clinical, or treatment variables. Analyses of variance for each of the 5 neurocognitive domains revealed main effects of time for working memory, verbal episodic memory, spatial episodic memory, processing speed and reasoning and executive function, suggesting that participants in both groups improved.</td>
<td>Small sample size &lt;br&gt;Relationships among some variables remain unclear. Study did not include an independent measure of cognitive challenge based on performance of functional activity.</td>
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<td>Liberman et al. (1998)</td>
<td>To compare community functioning of outpatients with severe and</td>
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<td>The cohort receiving the social skills training achieved significantly better results.</td>
<td>Limited accounting of attrition in results.</td>
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<td>Study</td>
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<td>Marder et al. (1996)</td>
<td>To determine the effectiveness of behaviorally social skills training versus supportive group therapy in supporting the development of social adjustment in participants with schizophrenia</td>
<td>Level I</td>
<td>RCT</td>
<td>N = 80 community-dwelling patients with schizophrenia. All had at least 2 acute episodes or symptoms lasting for at least 2 yrs.</td>
<td>Social skills training: n = 43</td>
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<td>McGurk, Twamley, Sitser, McHugo, &amp; Mueser (2007)</td>
<td>To evaluate the effects of cognitive remediation for improving cognitive performance, symptoms, and psychosocial functioning in schizophrenia</td>
<td>Level I</td>
<td>Meta-analysis</td>
<td>26 RCTs with 1,151 patients with schizophrenia, schizophreniform disorder, or schizoaffective disorder</td>
<td>Studies included were of psychosocial interventions designed to improve cognitive performance.</td>
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<td>Moriana, Alarcon, &amp; Herruzo (2006)</td>
<td>Determine the outcomes and effectiveness of a social and independent living skills intervention developed by Liberman, Wallace, Blackwell, Kopelowicz, Vaccaro, &amp;</td>
<td>Level II</td>
<td>Non-RCT</td>
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<td>PANSS scores showed a significant Phase × Treatment interaction effect for the intervention.</td>
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<td>Mintz (1998)</td>
<td>Provided in an in-home setting in Spain</td>
<td><em>Participants</em>&lt;br&gt;N = 64 patients with schizophrenia recruited from a mental health facility in Spain&lt;br&gt;All patients were receiving outpatient psychiatric treatment and neuroleptics.&lt;br&gt;n = 32 in each group</td>
<td>Recreation for leisure, basic conversational skill, and community reentry&lt;br&gt;<em>Control:</em> Participants attended day treatment program&lt;br&gt;<em>Outcome Measure:</em> PANSS</td>
<td>The activity group showed a significant improvement in social interaction skills compared with the structured verbal discussion and control groups.</td>
<td>Very expensive to carry out because of the intensity of the contacts</td>
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<td>Schindler (1999)</td>
<td>To examine the effectiveness of an activity group, structured discussion, and control group for social interaction skills of persons with psychiatric disabilities</td>
<td>Level II&lt;br&gt;Nonrandomized controlled trial&lt;br&gt;N = 25 participants with severe psychiatric disability&lt;br&gt;n = 9 structured discussion group&lt;br&gt;n = 6 activity group&lt;br&gt;n = 10 control group</td>
<td><em>Intervention</em>&lt;br&gt;Activity group: Guided purposeful tasks to provide a focus for skill development&lt;br&gt;Structured verbal discussion: Set topic or agenda (e.g., use of leisure time)&lt;br&gt;<em>Control group:</em> Provided with table games&lt;br&gt;Both took place 5 times/wk for 2 wk&lt;br&gt;15 min/wk of individual attention&lt;br&gt;Other meeting times not reported</td>
<td>Participants in the RDP demonstrated greater improvement in social roles, task skills, and interpersonal skills than did participants in the MAP.</td>
<td>Small sample size&lt;br&gt;Other activities may have been taking place during study period.</td>
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<td>Schindler (2005)</td>
<td>To examine whether adults diagnosed with schizophrenia demonstrated improved task, interpersonal skills, and social roles when involved in a individualized intervention based on the Role Development Program (RDP), in comparison to an intervention based on a multidepartmental activity program (MAP)</td>
<td>Level II&lt;br&gt;Nonrandomized controlled trial&lt;br&gt;N = 84 participants, 42 per group&lt;br&gt;100% men with diagnosis of schizophrenia disorder</td>
<td><em>Intervention</em>&lt;br&gt;Group 1 (comparison): MAP—a nonindividualized, therapeutic intervention designed to encourage the productive use of time and socialization in a group setting.&lt;br&gt;Does not address social roles or skills imbedded in social roles&lt;br&gt;Group 2 (experimental): RDP—an enhancement of the MAP—uses individualized theory-based interventions to help each participant develop task and interpersonal skills within meaningful social roles&lt;br&gt;<em>Frequency:</em> Both groups received 15 min/wk of individual attention.&lt;br&gt;Other meeting times are not reported</td>
<td>Results may not generalize to other treatment settings.&lt;br&gt;Staff involved in the RDP may not be typical of staff in other treatment settings.&lt;br&gt;Full validity studies had not been conducted on two of the assessment instruments.</td>
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<td>Study</td>
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| Starino et al. (2010)       | To examine the effect of participating in an illness self-management recovery program on the ability of participants with severe mental illness to achieve key recovery-related outcomes | Level III | Pretest-posttest design<br>
N = 30 adults with severe mental illness at 3 mental health centers in the Midwest | Role Functioning Scale<br>Task Skills Scale<br>Interpersonal Skills Scale | A significant positive time effect was found for hope and recovery orientation. The change in symptoms did not reach statistical significance.<br>Small sample size, lack of control group, limited follow-up period |
| Tungpunkom & Nicol (2008)   | To review the effectiveness of life skills programs with standard care or other comparable programs therapies for people with chronic mental health problems | Level I | Systematic review of 4 randomized trials<br>
Participants: Total of 318 participants between ages 18 and 60 with mental illness<br>Dementia, substance abuse, alcoholism, organic brain syndrome, and serious suicidal risk were excluded. | State Hope Scale<br>Modified Colorado Symptom Index<br>Recovery Markers Questionnaire | This review shows that no evidence indicates that such programs are helpful or harmful with respect to functional outcomes and quality of life. | Limited number of RCTs in this area. Studies included were short-term interventions. |

**Note.** ADLs = activities of daily living; BMI = body mass index; COPM = Canadian Occupation Performance Measure; COTE = Comprehensive Occupational Therapy Evaluation; DSM-IV-TR = Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.); GAF = Global Assessment of Functioning; HM = health management; IT = integrated treatment; KTA–M = Kitchen Task Assessment–Modified; MEDLS = Milwaukee Evaluation of Daily Living Skills; PANSS = Positive and Negative Symptom Scale; RCT = randomized controlled trial; ST = skills training; WAIS III = Wechsler Adult Intelligence Scale III.

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