Text S1

Search terms:

("schizophren*" OR "psychosis" OR "psychotic" OR "paranoid" OR "dementia praecox" OR "Hallucinat*") AND ("soteria" OR "minimal medication" OR "low medication" OR "no medication" OR "unmedicated" OR "not prescribed antipsychotic*" OR "not taking antipsychotic*" OR "low-dose" OR "drug-free" OR "therapeutic community" OR "drug-naïve" OR "medication-naïve" OR "unmedicated" OR "non-adheren*" OR "non-complian*" OR "noncomplian*" OR "nonadheren*" OR "treatment-free" OR "no psychotropic medication" OR "chestnut lodge" OR "not prescribed neuroleptic*" OR "not taking neuroleptic*" OR "hearing voices network" OR "hearing voices movement" OR "holistic" OR "intervoice")

Table S1

Quality scoring for non-randomised studies using the Effective Public Health Practice Project (EPHPP)

Intervention and study	Selection bias	Study design	Confounders	Blinding	Data collection methods	Withdrawals and drop-outs	Intervention integrity[a]	Analyses	Selective reporting[b]
CBT									
Morrison et al., (2012)	Moderate	Moderate	Strong	Weak	Strong	Moderate	% participants received intervention: Can't tell, intervention consistency measured? Yes, did participants received an unintended intervention: Can't tell	Analysis appropriate and used intent-to-treat	No
Psychodynamic psychotherapy									
Gottlieb & Huston (1951)	Weak	Strong	Strong	Weak	Weak	Strong	% participants received intervention: Can't tell, intervention consistency measured? No, did participants received an unintended intervention: Yes (ECT group)	Did not report intent-to-treat analysis and analysis was not appropriate	Can't tell
Soteria									
Bola & Mosher, (2003)	Moderate	Strong	Strong	Moderate	Weak	Moderate	% participants received intervention: 60-79%, intervention consistency measured? Can't tell, did participants received an unintended intervention: Can't tell	Analysis appropriate and used intent-to-treat	No
Ciompi et al., (1991, 1992, 1993)	Moderate	Strong	Strong	Weak	Strong	Strong	% participants received intervention: 80-100%, intervention consistency measured? Yes, did participants received an unintended intervention: Can't tell	Analysis appropriate and used intent-to-treat	No
Need Adapted									

Intervention and study	Selection bias	Study design	Confounders	Blinding	Data collection methods	Withdrawals and drop-outs	Intervention integrity[a]	Analyses	Selective reporting[b]
Treatment									
Lehtinen, Aaltonen, Koffert, Räkköläinen, & Syvälahti, (2000)	Strong	Strong	Strong	Moderate	Strong	Moderate	% participants received intervention: 60-79%, intervention consistency measured? Yes, did participants received an unintended intervention: No	Did not report intent-to-treat analysis and analysis was not appropriate	Maybe
Cullberg, Levander, Holmqvist, Mattsson, & Wieselgren, (2002), Cullberg et al., (2006)	Moderate	Moderate	Weak	Weak	Strong	Moderate	% participants received intervention: 60-79%. intervention consistency measured? Somewhat, did participants received an unintended intervention: Can't tell.	Analysis appropriate but intent-to-treat was not reported	Yes
Open dialogue									
Seikkula et al., (2003)	Strong	Moderate	Weak	Weak	Strong	Strong	% participants received intervention: 80-100%. intervention consistency measured? No, did participants received an unintended intervention: Can't tell.	Appropriate analysis, used intent-to-treat	No
Seikkula, Alakare, & Aaltonen, (2011)	Strong	Moderate	Weak	Weak	Strong	Moderate	% participants received intervention: 60-79%. intervention consistency measured? Yes, did participants received an unintended intervention: Can't tell.	Analysis not appropriate, unclear if intent to treat is reported	Maybe
Psychosocial (inpatient) treatment									
Carpenter et al., (1977)	Weak	Moderate	Weak	Weak	Weak	Weak	% participants received intervention: 80-100%. intervention consistency measured? Yes, did participants received an unintended intervention: Can't tell	Analysis appropriate, intent to treat reported	No

a. Selective reporting is not rated as part of the EPHPP but we have reported this as it is a potentially important source of bias.

Table S2

Quality scoring (risk of bias) for randomised studies using the Cochrane Collaboration's tool for assessing risk of bias

	Random sequence generation	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Other bias
CBT							
Morrison et al (2014)	Low risk	Low risk	High risk	Low risk	High risk	Low risk	Unclear risk: no placebo control, small sample, did not use a diagnostic assessment or report substance use at baseline
Morrison et al (2018)	Low risk	Low risk	High risk	Low risk	Low risk	Low risk	High risk: poor intervention fidelity, small sample, no placebo control, did not use a diagnostic assessment or report substance use at baseline
Psychosocial (outpatient) treatment							
Carpenter, Douglas, Heinrichs, & Hanlon, (1987)	Low risk	Unclear risk	Unclear risk	Unclear risk	High risk	Low risk	High risk: small sample size, no intention to treat analysis, abrupt antipsychotic withdrawal
Carpenter et al., (1990)	Low risk	Unclear risk	High risk	Low risk	High risk	Low risk	Unclear risk: abrupt antipsychotic withdrawal
Psychoanalysis/							

	Random sequence generation	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Other bias
Psychodynamic psychotherapy							
Messier et al., (1969)	Unclear risk	Unclear risk	Unclear risk	High risk	Low risk	Low risk	High risk: small sample size, intervention fidelity not reported, abrupt medication withdrawal, no statistical analysis section
Karon & Vandenbos, (1972)	Unclear risk	Unclear risk	High risk	Low risk	Unclear risk	Low risk	High risk: very small sample, inexperienced therapists, poor data analysis, heterogeneous group
Psychodynamic psychotherapy and general inpatient milieu							
May et al., (1976, 1981)	Unclear risk	Unclear risk	High risk	Unclear risk	High risk	High risk	High risk: Psychotherapists not properly trained, lack of transparent data reporting
Major Role Therapy							
Hogarty et al (1973, 1974a, b)	Unclear risk	Unclear risk	Unclear risk	High risk	Unclear risk	Low risk	Unclear risk: drop-outs are not clearly reported, unclear intervention integrity.

Table S3

Description of psychosocial interventions and control groups

Study	Experimental intervention	Control/comparison interventions
CBT		
Morrison et al., (2012)	**Content:** CBT followed the principles developed by Beck (1976), it was problem oriented, time limited, and encouraged collaborative empiricism, guided discovery and homework tasks, and was based on a written manual. The cognitive model it was based on emphasises the culturally unacceptable interpretations that people with psychosis make for events, their responses to such events, their beliefs about themselves, other people and control strategies. The central features involve, normalizing people's interpretations, helping them to generate and evaluate alternative explanations, decatastrophizing their fears, helping them to test out such appraisals using behavioural experiments and helping them to identify and modify unhelpful cognitive and behavioural responses. **Duration:** A max of 26 sessions over 9 months, sessions were ~ 1 hour, mean number of sessions was 16.7. **Delivered by:** Clinical psychologists, nurses with an additional specialist cognitive therapy qualification, a psychiatrist.	NA no control.
Morrison et al., (2014) (UK)	**Content:** Participants in the experimental group received treatment as usual plus cognitive therapy. Cognitive therapy was conducted according to a specific model (Morisson, 2001). The therapy is an individualised, problem-oriented approach which incorporates a manualised process of assessment and	Treatment as usual: Early intervention: regular care-coordination, psychosocial interventions, family interventions.

Study	Experimental intervention	Control/comparison interventions
	formulation. The main features of the approach involved normalisation and evaluation of the appraisals that people make, helping them to test such appraisals with the use of behavioural experiments, and helping them to identify and modify unhelpful cognitive and behavioural responses. **Duration:** Participants were offered 26 weekly sessions for a maximum of 9 months, plus up to 4 booster sessions for the subsequent 9 months. **Delivered by:** Clinical psychologists, nurses with a specialist qualification in cognitive therapy and a consultant psychiatrist with specialist training in cognitive therapy.	Community based services: occasional contact with care-coordinators. A number of participants were discharged from these services during the trial.
Morrison et al., (2018)	**Content:** CBT was individualised and problem focused and based on an empirically tested cognitive model (Morrison, 2017). The following principles were stressed in delivery: a shared goal, collaboration, a normalising approach, an evaluation of how accurate and how helpful their appraisals are, behavioural experiments, and active involvement and choice, between session tasks, the process of thinking and the content of thoughts. **Duration:** 26 sessions over 6 months with 4 optional booster sessions in the final 6 months. **Delivered by:** Qualified psychological therapists.	Antipsychotics only or antipsychotics + CBT.
Psychosocial outpatient treatment		
Carpenter et al., (1990, 1987) 2 studies (USA)	Participants in both control/experimental were almost all on antipsychotics when starting the trial. They underwent a 4-8 week stabilisation period. Antipsychotics were then discontinued with a 4 week drug-free period. After a successful drug-free period (or after two unsuccessful attempts) the participants entered the study.	Continuously medicated with antipsychotics (Carpenter et al., 1987). Continuously medicated with antipsychotics and received the

Study	Experimental intervention	Control/comparison interventions
	Content: A psychosocial treatment programme which has three main components: **1. An ongoing individual relationship - weekly meetings - with a therapist or case manager.** The therapist/case manager has direct access to a psychiatrist if necessary. The therapist/case manager has four primary functions: a. Early in the treatment the therapist/case manager talks to the participant about their illness. Signs of relapse and a relapse plan are written out. b. Environmental stressors are discussed on an ongoing basis and the therapist/case manager will work with the participant to try to reduce these stressors and improve the participants coping strategies. c. Help the participant to improve their functioning, including work-related advice and encouragement. d. Coordinate the participants participation in therapeutic and research procedures. **2. Involvement of the family:** At the start of the programme families are invited to 6 weekly sessions with the therapist. The aim is to learn more about the illness and ask questions. Potential stressors which may have triggered/exacerbated the illness are identified and methods to reduce these stressors are discussed. The family is encouraged to contact the therapist at times of crisis. **3. Social club:** Patients, under the supervision of a social worker, carry out a range of social activities.	psychosocial intervention (Carpenter et al., 1990).

Study	Experimental intervention	Control/comparison interventions
	Weekly meetings are held with the whole clinical team to discuss the patients. The psychiatrist has occasional meetings with the patient. **Duration:** 2 years. **Delivered by:** Psychiatrists, therapists, case managers.	
Psychoanalytic/psychodynamic psychotherapy		
Messier, (1969) (USA)	**Content:** Psychoanalytic psychotherapy + therapeutic milieu + placebo: The therapeutic milieu included therapeutic community meetings, other group or individual ward activities (unspecified), and also outings (to the beach, museums etc.). **Duration:** Participants were in the research ward for 2 years. Psychoanalytic psychotherapy occurred twice a week over two years. **Delivered by:** Psychotherapy - psychiatrists (either psychoanalysts or psychoanalytically oriented). Therapeutic milieu: nurses, occupational therapists, social workers.	**Control 1:** Psychoanalytic psychotherapy + therapeutic milieu + antipsychotics (the control group received the same as the experimental group with antipsychotics). **Control 2:** Antipsychotics only (in a local state hospital).
Karon & Vandenbos, (1972) (USA)	**Content:** Psychoanalytic psychotherapy of an active variety. **Duration:** The therapy was available to participants for 20 months. For the first 8 weeks psychotherapy sessions were held 5 days a week and then once a week after. Participants received an average of ~ 70 sessions. **Delivered by:** An experienced psychotherapist and 5 inexperienced psychotherapists (2 psychiatrists and 3 graduates in clinical psychology).	**Control 1:** Psychoanalytic psychotherapy of an "ego analytic" variety + antipsychotics. **Control 2:** Received antipsychotics only.
May et al., (1976, 1981) (USA)	**Content:** Individual psychodynamic psychotherapy.	Antipsychotics alone, psychotherapy + antipsychotics, electro convulsive

Study	Experimental intervention	Control/comparison interventions
	Duration: 6 months-1 year. **Delivered by:** Psychiatric residents or recently graduated psychiatrists (supervised by a senior consultant).	therapy (ECT), Milieu.
Gottlieb, Gottlieb, & Huston (1951)	**Content:** Brief psychodynamic psychotherapy – this was based on the theory that the patients had problems and conflicts which they were unable to solve and these difficulties related to the development of their mental health problems. They would try to understand the patient's personalities with emphasis on aspects that brought difficulties. Efforts were made to provide reassurance, permit emotional release, provide support, and relieve guilt. Group activities on the ward were also encouraged. **Duration:** Mean = 7 weeks (range= 1-27 weeks). **Delivered by:** Not specified, most likely the ward psychiatrists.	ECT, Insulin therapy
General Inpatient Milieu		
May et al., (1976, 1981) USA	**Content:** The ward milieu is described as routine nursing care, sedation, hydrotherapy, occupational, industrial, and recreational therapies, ward meetings, and social case work. **Duration:** 6-12 months. **Delivered by:** Trainee psychiatrists supervised by consultant. psychiatrists and other ward staff (not specified).	Drug alone, psychotherapy + drug, ECT, psychodynamic psychotherapy only.
Major Role Therapy		
Hogarty & Goldberg, (1973, 1974 a, b) (USA)	**Content:** A sociotherapy which consisted of intensive individual social casework and vocational rehabilitation counselling. The aim was to resolve personal or environmental problems, improve interpersonal relationships and reduce social isolation. **Duration:** 2-3 years, at least 1 session per month (but occurred more	1. Drug (chlorpromazine) only. 2. Placebo only. 3. Drug (chlorpromazine) + Major Role Therapy.

Study	Experimental intervention	Control/comparison interventions
	frequently according to need). **Delivered by:** Social workers.	
Soteria		
Cohort 1: Mosher & Menn, (1979); Matthews et al., (1979); Mosher et al., (1975) **Cohort 2:** Mosher et al., (1995) **Cohort 1 and 2** Bola & Mosher, (2003) (USA)	**Content:** Treatment occurred in a 12 room house which can house only 6 patients at a time. Staff work 36-48 hour shifts to allow prolonged, intensive 1-to-1 contact. Staff and residents share responsibility for the daily running of the house. All activities are viewed as potentially therapeutic, without any formal therapy sessions. Potting, painting and yoga are listed as activities residents can engage in. Relationships can be maintained between residents and between residents and staff after discharge. Staff were often peer workers. Recently admitted, very unwell patients receive 1-to-1 or 2-to-1 attention. **Duration:** ~5-6 months. **Delivered by:** Mental health professionals, non-professionals and former clients.	Control patients were admitted to the inpatient wards of the community mental health centre where they received 'treatment as usual' (antipsychotics, groups, therapies).
Ciompi et al., (1991, 1992, 1993) (Switzerland)	**Content:** 'Soteria Berne' is a 12 room house, the house can accommodate 6-8 patients and 2 nurses. Treatment is in 4 phases: 1) Each patient is assigned their own carer who stays with them during the initial and most acute phase. The aim is to calm the patient by providing them with constant support. 2) The patient is gradually integrated back into reality by e.g. going for walks, doing simple chores. 3) Gradual social and vocational rehabilitation by e.g. providing part-time employment. 4) This stage lasts for at least 2 years from discharge and focuses on relapse prevention and stabilising the patient. The patient may be given individual (psychosocial therapy) or family therapy. Relatives and significant others are systematically involved in the therapy process.	Patients treated in private and state psychiatric inpatient units. Controls were matched to the experimental participants on age, sex, premorbid social adjustment, and positive or negative symptoms.

Study	Experimental intervention	Control/comparison interventions
	Duration: Average length of stay: 154 days. **Delivered by:** Mental health professionals (nurses, psychotherapists, medical director), and non-professionals.	
Need Adapted Treatment		
Lehtinen et al., (2000) (Finland)	**Content: Need adapted treatment** has the following principles: 1. Therapeutic activities are carried out flexibly to meet the needs of the patient and their network. The main way in which the patients' needs are established are through joint therapy meetings with the care team, the patient, and their wider interpersonal network. 2. Treatment and understanding of the condition are dominated by a psychotherapeutic attitude. 3. Different therapeutic approaches should support and not impair each other. 4. Treatment is considered to be an ongoing process that can be examined and modified accordingly. The treatment consisted of: Initial family centred intervention, individual psychotherapy, family therapy, group therapy, home visits. **Duration:** Varies - some therapies were given for at least 6 months whilst others were a minimum of 3 sessions. **Delivered by:** Psychiatrists, non-psychiatric doctors, psychologists, mental health nurses, social workers.	The control group were the remaining three hospitals that used the Need Adapted Treatment approach but were medicated as usual.
Cullberg et al., (2002, 2006) (Sweden)	**Content (Need adapted treatment):** 1. After the first contact intervention is provided without delay, preferably in the patient's home. 2. The intervention is structured according to the patient's needs including staff continuity, coherence in attitudes, psychodynamic	A historical control group: This group received treatment as usual in the same clinics that took part in the parachute project, 5 years earlier, with a focus on medication strategies. Appears that the data was collected as part of an earlier,

Study	Experimental intervention	Control/comparison interventions
	psychotherapy, cognitive methods. 3. Immediate and recurrent family meetings will take place including psychological support, family treatment, and psychoeducation. 4. Access to a stable specialised treatment team during the 5-year period. 5. Access to a small, homelike, low stimulus overnight care (crisis house). The crisis house is situated preferably outside the hospital, can house 3-6 patients, with a low staffing level, staff should be present overnight. Hospital inpatient care should only be used in an emergency. The intervention involved individual treatment sessions. **Duration:** Not specified by patient but clinics had to guarantee follow-ups over 5 years. States that duration of treatment sessions varied according to patient's needs. **Delivered by:** All staff members in the clinic.	separate study.
Open dialogue		
Seikkula et al., (2003, 2011) (Western Lapland)	Group 1 (API group) received 'Need adapted treatment' (see above: Lehtinen et al., 2000). Group 2 (ODAP group) received 'open dialogue', developed from 'Need adapted treatment'. **Content: Open Dialogue treatment, main principles:** **1. Immediate help:** The first meeting is made within 24 hours of first contact. **2. A social network perspective:** The first meeting will involve the	An API (Need Adapted Treatment) project centre which organised treatment in a more institutional way (there generally was no continuity of care) and prescribed antipsychotic medication straight away (only Seikkula et al., (2003) included a control group)

Study	Experimental intervention	Control/comparison interventions
	patient, their family and any other key members of the patient's social or support network. **3. Flexibility and mobility:** Treatment is flexible according to the changing needs of the patient. **4. Responsibility:** The person who is first contacted becomes responsible for the first meeting, the team is then in charge of the entire treatment process. **5. Psychological continuity:** The same team is responsible for treatment in both inpatient and outpatient settings. Members of the patient's social network are also invited to participate in meetings. **6. Tolerance of uncertainty:** Premature decisions about treatment (such as with antipsychotics) are avoided. Regular meetings are ensured. **7. Dialogism:** Focus is on promoting dialogue and then change in the patient or family. **Duration:** 2-3 years. When the patient is in crisis there may be meetings every day for 10-12 days. **Delivered by:** Psychiatrists, psychologists, nurses, social workers.	
Psychosocial inpatient treatment		
Carpenter, (1977) (USA)	A hospital programme which emphasises psychosocial treatment whilst limiting the use of antipsychotic medication. **Content:** Psychoanalytically oriented psychotherapy 2-3 times a week, group therapy once a week, and family therapy once a week.	Patients receiving treatment as usual (primarily antipsychotic medication) in an inpatient hospital ward.

Study	Experimental intervention	Control/comparison interventions
	Therapeutic milieu: Social adaptation was the main focus of the therapeutic milieu. Staff helped patients control/understand their behaviour and explore alternative expressions of ideas. For 45 minutes per day all staff and patients would meet to discuss issues relevant to patient care. **Duration:** Average length of stay: 117 days. **Delivered by:** Nurses, nursing assistants, occupational therapists, recreational therapists, psychiatrists, psychoanalysts, social workers.	

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