

Author, Year PEDro Score, Country	Sample size	Intervention	Outcome and significance: (+) significant (-) not significant
Alexopoulos et al., 2012 PEDro score: 4 Country: USA	24 patients with stroke (stage of stroke recovery unspecified)	Ecosystem Focused Therapy (EFT) (n=12) vs. Education on Stroke and Depression (ESD) (n=12) Treatment details: 45-minutes/session, 1 session/week for 12 weeks. EFT is a specialised psychotherapy that was provided by a trained therapist and consisted of describing the prognosis of depression, its interaction with disability, role of rehabilitation, and valued/rewarding activities that are still possible, along with correcting patients' misconceptions. EFT used education and direct suggestions for developing an adherence enhancement structure. EFT provided training in problem solving in daily functioning; assisted the family to reengineer its goals and plans; motivated the patient, and helped patient/family to develop a plan for participation in rehabilitation, make use of community resources. ESD consisted of education about depression, stroke, role of available treatments in form of discussion and education material.	At 12 weeks (post-treatment): (-) Hamilton Depression Rating Scale (+) World Health Organization Disability Assessment Schedule II
Burton & Gibbon, 2005 PEDro score: 7 Country: UK	176 patients with acute/subacute stroke	Discharge support and education from stroke nurse (n=87) vs. Usual care and discharge follow-up (n=86) Treatment details: Delivered over 2 months with an average of 3 contacts (range 0-28). Discharge support from stroke nurse consisted of a follow-up visit from the stroke nurse at the place of	At 3 months post-stroke (post-treatment): (-) Barthel Index (-) Nottingham Health Profile (NHP) – Energy (+) NHP – Emotional reaction (-) NHP – Physical mobility (+) NHP – Pain (+) NHP – Social isolation (-) NHP – Sleep (-) NHP – Total score

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<p>Chaiyawat, Kulkantrakorn & Sritipsukho, 2009 PEDro score: 7 Country: Thailand</p>	<p>60 patients with acute stroke Note: length of hospitalization was of 10 ± 1.7 and 10.9 ± 2.3 days for the home rehabilitation and standard care groups respectively.</p>	<p>discharge within two working days of discharge, subsequent follow-ups and telephone contacts. The stroke nurse provided information and additional support regarding stroke recovery. Usual care and follow-up consisted of inpatient case management by stroke nurse, liaison with the stroke survivors' general practitioner, outpatient follow-up, and access to multi-professional rehabilitation services on discharge from hospital.</p> <p>Individual home rehabilitation program (n=30) vs. Standard care (n=30) Treatment details: 60-minutes/session, 1 session/month for 3 months Individual home rehabilitation program was provided by a physical therapist and included exercises for indoor/outdoor mobility and basic ADLs and individual counseling (education, applying learned information, problem solving) Exercises were based on mirror neuron concept of exercise physiology and motor learning, where</p>	<p>(-) Frenchay Activities Index (+) Caregiver Strain Index (-) Beck Depression Inventory</p> <p>At 12 months post-stroke (follow-up): (-) Barthel Index* (-) NHP – Energy (+) NHP – Emotional reaction (-) NHP – Physical mobility (-) NHP – Pain (+) NHP – Social isolation (-) NHP – Sleep (+) NHP – Total score* (-) Beck Depression Inventory (-) Frenchay Activities Index (-) Caregiver Strain Index* * statistically significant change in scores from 3 to 12 months post-stroke.</p> <p>At 3 months (post-treatment): (+) Barthel Index (+) Modified Rankin Scale (+) EQ-5D (+) Hospital Anxiety and Depression Scale-Depression (-) Thai Mental State Examination</p>

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<p>Chaiyawat & Kulkantrakorn, 2012 (follow-up of Chaiyawat et al., 2009) PEDro score: 7 Country: Thailand</p>	<p>60 patients with acute stroke Note: length of hospitalization was of 10 ± 1.7 and 10.9 ± 2.3 days for the home rehabilitation and standard care groups respectively</p>	<p>patients watched DVD of rehabilitation procedures for passive/active/resistance/ADLs training exercises and practiced the observed actions. Standard care consisted of providing instructions for home rehabilitation to patients and caregivers prior to discharge from the hospital. Patients may have also received outpatient rehabilitation.</p> <p>Individual home rehabilitation program (n=30) vs. Standard care (n=30) Treatment details: 60-minutes/session, 1 session/month for 6 months (i.e. 3 additional months to Chaiyawat, Kulkantrakorn & Sritipsukho, 2009 intervention) Individual home rehabilitation program was provided by a physical therapist and included exercises for indoor/outdoor mobility and basic ADLs and individual counseling (education, applying learned information, problem solving). Exercise was based on mirror neuron concept of exercise physiology and motor learning, where patients watched a DVD of rehabilitation procedures for passive/active/resistance/ADLs training exercises and practiced the observed actions. Standard care consisted of providing instructions for home rehabilitation to patients and caregivers prior to discharge from the hospital. Patients may have also received outpatient rehabilitation.</p>	<p>At 24 months post hospital discharge: (+) Barthel Index (+) Hospital Anxiety and Depression Scale – Depression (-) Thai Mini-Mental State Examination</p>

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Chan, Immink & Hillier, 2012 PEDro score: 6 Country: Australia	17 patients with chronic stroke	<p>Yoga + exercise (n=9) vs. Exercise (n=8) Treatment details: 90 minutes/session, 1 session/week for 6 weeks (group) + 24 x 40-minutes sessions (home practice) Yoga was delivered in groups by a accredited yoga teacher/exercise physiologist and consisted of modified asana practice involving gentle and slow movements, pranayama practice involving gentle breathing with concentrated attention, meditation practice (brief relaxation, awareness of body region sensations), and group discussions. Home practice consisted of hatha yoga, Satyananda yoga nidra as per provided manual instructions. Exercises were provided by the exercise physiologist and consisted of resistance training for upper and lower extremities and cardiovascular type exercises. Delivered for 50 minutes/session, 1 session/week for 6 weeks.</p>	<p>At 6 weeks (post-treatment): (-) Geriatric Depression Scale Short Form 15 (-) State Trait Anxiety Inventory (STAI) – State anxiety (-) STAI – Trait anxiety</p>
Chang et al., 2011 PEDro score: 4 Country: USA & China	77 patients with acute/subacute/chronic stroke	<p>Knowledge and behavior therapy (n=39) vs. No treatment (n=38) Treatment details: 1-2-hours/session, 1 session/week for 1 month Knowledge and behavior therapy consisted of individually provided education about health psychology and recovery from stroke (e.g. lifestyle risks and changes post-stroke); and behavioral training component including belief changes, forgiveness training and anger management.</p>	<p>At 1 month (post-treatment): (+) State-Trait Anger Expression Inventory (STAXI) – State anger (-) STAXI – Hostility (-) STAXI – Anger-in* (+) STAXI – Anger-out (+) STAXI – Anger control (-) Hamilton Anxiety Scale (+) Hamilton Depression Rating Scale</p>

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<p>Chun et al., 2017 PEDro score: 4 Country: Republic of Korea</p>	<p>59 patients with chronic stroke</p>	<p>Both groups received conventional rehabilitation consisting of physical therapy + standard medical treatment (medications, nursing care); and was provided daily while in the hospital.</p> <p>Forest therapy (n=30) vs. Urban therapy (n=29) Treatment details: Provided over 4 days/3 nights. Forest therapy consisted of group therapy at a recreation forest area in Korea, promoting positive emotion through meditation, experiencing the forest through all five senses, and walking in the forest. Urban therapy consisted of group therapy in an urban hotel where participants performed in-house meditation and walking activities similar to those performed by the forest therapy group.</p>	<p>(+) Stroke Specific Quality of Life Scale (+) Barthel Index * significant between-group differences in favor of no CBT vs. CBT. Note: All significant between-group differences refer to changes in scores from baseline to post-treatment.</p> <p>At 4 days (post-treatment): (+) Beck Depression Inventory (+) Hamilton Depression Rating Scale (+) Spielberger State-Trait Anxiety Inventory (-) Oxidative stress – d-ROMs test (+) Anti-oxidative capacity – BAP test</p>
<p>Claiborne, 2006 PEDro score: 4 Country: USA</p>	<p>33 patients with acute/subacute stroke</p>	<p>Care coordination (n=17) vs. No treatment (n=16) Treatment details: Care coordination was provided by a social worker; services included ongoing monitoring of patient progress related to the patients’ biopsychosocial issues, service needs, and adherence to self-care practices, using</p>	<p>At 3 months post-discharge (follow-up): (-) Short-Form 36 (SF-36) – Physical component summary (+) SF-36 – Mental component summary (+) Geriatric Depression Scale (+) Adherence to self-management practices</p>

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<p>Faulkner et al., 2015 PEDro score: 7 Country: New Zealand</p>	<p>60 patients with acute transient ischemic attack or mild/non-disabling stroke</p>	<p>problem-solving approach, involving caregivers, recommendations of care and necessary services. Both groups received standard follow-up treatments as determined by physician (physical, occupational, speech therapy, physicians visits).</p> <p>Exercise and education program (n=30) vs. Standard secondary prevention and education (n=30)</p> <p>Treatment details: 2 x 90-minute exercise session + 1 x 30-minute education session per week for 8 weeks. The exercise and education program consisted of aerobic exercise, resistance training, core-stability and postural exercises with increase in intensity every week; didactic group discussions aimed at behavioral change and focused on risk factors, stroke prevention, nutrition, blood pressure, adherence to medication, stress management, and emotional/behavioral changes after stroke or transient ischemic attack. Standard secondary prevention and education consisted of providing information from the hospital ((e.g. leaflets from Stroke Foundation on discharge)</p>	<p>At 8 weeks (post-treatment): (+) Short-Form 36 (SF-36) – Physical component (-) SF-36 – Mental component (-) SF-36 – Mental health (-) SF-36 – Social functioning (+) SF-36 – Global health (+) SF-36 – Role physical (-) SF-36 – Role emotional (+) SF-36 – Vitality (-) SF-36 – Bodily pain (+) SF-36 – Physical functioning (-) Hospital Anxiety and Depress Scale (HADS) – Anxiety (-) HADS – Depression (-) Profile of Mood States (PMS) – Vigor (-) PMS – Depression (-) PMS – Confusion (-) PMS – Tension (-) PMS – Anger (-) PMS – Fatigue (+) Stroke Awareness Questionnaire (-) International Physical Activity Questionnaire</p>

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<p>Graven et al., 2016 PEDro score: 8 Country: Australia</p>	<p>110 patients with acute/subacute stroke</p>	<p>Multimodal case management (n=54) vs. Standard management (n=56) Treatment details: Type and intensity of the intervention were determined</p>	<p>At 12 months (follow-up): (-) SF-36 – Physical component (-) SF-36 – Mental component (-) SF-36 – Mental health (-) SF-36 – Social functioning (-) SF-36 – Global health (-) SF-36 – Role physical (-) SF-36 – Role emotional (-) SF-36 – Vitality (-) SF-36 – Bodily pain (-) SF-36 – Physical functioning (-) HADS – Anxiety (-) HADS – Depression (-) PMS – Vigor (-) PMS – Depression (-) PMS – Confusion (-) PMS – Tension (-) PMS – Anger (+) PMS – Fatigue (-) Stroke Awareness Questionnaire (-) International Physical Activity Questionnaire Differences refer to change in scores from baseline to post-treatment and from post-treatment to follow-up (adjusted for baseline).</p> <p>At 1 year post-stroke (follow-up): (+) Geriatric Depression Scale – 15</p>

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<p>Golding et al., 2016; 2017a; 2017b PEDro score: 6 Country: UK</p>	<p>21 patients with chronic stroke</p>	<p>on a needs basis with the aim to facilitate goal achievement and community reintegration and to address relevant emerging issues. Multimodal case management was comprised a multifactorial, integrated, community-based rehabilitation approach that consisted of monitoring, liaising with services, additional referrals, advice and information provision, review of progress, and identification of potential barriers to recovery, teaching patients to adopt a self-management approach to arising issues (self-review, identification of strategies/solutions, effective communication with health professionals). It included telephone contacts and 1 home visit. Standard care consisted of 2 post-discharge phone calls at 2 and 6 weeks post-discharge to ensure that post-discharge services had started.</p> <p>Autogenic relaxation program (n=11) vs. Waiting list for 3 months (n=10) Treatment details: 20-minutes/sessions, 5 times/week for 1 month Autogenic relaxation program consisted of listening to a relaxation CD (asking participants to be aware of their body and experience body aspects in particular ways, such as heavy, warm, refreshed, etc.) at home and filling in a diary sheet. Participants in on the waiting list receive the CD after 3 months.</p>	<p>At 1 month (post-treatment): (+) Hospital Anxiety and Depression Scale (HADS) – Anxiety (-) HADS – Depression At 2 and 3 months (follow-up): (+) HADS – Anxiety (-) HADS – Depression At 12 months (follow-up, N=15): (-) HADS - Anxiety* (-) HADS – Depression * between-group analysis of anxiety was not performed at this timepoint; significant gains</p>

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<p>Hoffman et al., 2015 PEDro score: 8 Country: Australia</p>	<p>36 patients with stroke (stage of stroke recovery is “during early discharge period after stroke”; specifics not available)</p>	<p>Coping-skills intervention (n=11) vs. Self-management intervention (n=12) vs. No treatment (n=10) Treatment details: 8 x 1-hour sessions (frequency per week unspecified) Coping-skills intervention was delivered by a clinical psychologist and included cognitive and behavioral exercises designed to improve self-awareness and coping skills (e.g. psychoeducation, self monitoring, graduated activity participation, and cognitive restructuring). Self-management intervention was delivered by an occupational therapist and included provision and reinforcement of individualized written information, and activities that were aimed at assisting individuals to learn problem-solving skills, communicate with health professionals and adjust to life post-stroke. All groups received standard care comprised of multidisciplinary assessment and treatment (medicine, nursing, physical and occupational therapy, speech pathology), education and advice during discharge process.</p>	<p>from baseline to 12-month follow-up were noted for all participants.</p> <p>At 8 sessions/~2 months post-discharge from hospital (post-treatment): Coping-skills vs. self-management intervention:</p> <p>(-) Montgomery and Asberg Depression Rating Scale (MADRS) (-) Hospital Anxiety and Depression Scale (HADS) – Depression (-) HADS – Anxiety (-) Stroke Self-Efficacy Questionnaire (SSE Questionnaire) (-) Nottingham Extended Activities of Daily Living Scale (NEADL Scale) (-) Stroke Knowledge Questionnaire (SKQ) (-) Stroke and Aphasia Quality of Life Scale (SAQoL) – General (-) SAQoL – Psychosocial (-) SAQoL – Physical (-) SAQoL – Communication (-) Modified Barthel Index (mBI) (-) State-Trait Anxiety Inventory (STAI) – Trait anxiety (-) STAI – State anxiety</p> <p>Coping-skills intervention vs. no treatment (-) MADRS (+) HADS – Depression</p>

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			<p>(-) HADS – Anxiety (-) SSE Questionnaire (-) NEADL Scale (+) SKQ (-) SAQoL – General (-) SAQoL – Psychosocial (-) SAQoL – Physical (-) SAQoL – Communication (-) mBI (-) STAI – Trait anxiety (-) STAI – State anxiety</p> <p>Self-management intervention vs. no treatment: (-) MADRS (-) HADS – Depression (-) HADS – Anxiety (-) SSE Questionnaire (-) NEADL Scale (-) SKQ (-) SAQoL – General (-) SAQoL – Psychosocial (-) SAQoL – Physical (-) SAQoL – Communication (-) mBI (-) STAI – Trait anxiety (-) STAI – State anxiety</p> <p>At 3 months (follow-up): Coping-skills vs. self-management</p>

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			<p>intervention:</p> <ul style="list-style-type: none"> (-) MADRS (-) HADS – Depression (-) HADS – Anxiety (-) SSE Questionnaire (-) NEADL Scale (-) SKQ (-) SAQoL – General (-) SAQoL – Psychosocial (-) SAQoL – Physical (-) SAQoL – Communication (-) mBI (-) STAI – Trait anxiety (-) STAI – State anxiety <p>Coping-skills intervention vs. no treatment</p> <ul style="list-style-type: none"> (-) MADRS (-) HADS – Depression (-) HADS – Anxiety (-) SSE Questionnaire (-) NEADL Scale (-) SKQ (-) SAQoL – General (-) SAQoL – Psychosocial (-) SAQoL – Physical (-) SAQoL – Communication (-) mBI (-) STAI – Trait anxiety (-) STAI – State anxiety

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<p>Holmgren et al., 2010 PEDro score: 7 Country: Sweden</p>	<p>34 patients with subacute stroke</p>	<p>High-intensity functional exercises + group discussions (n=15) Vs. Group discussions (n=19) Treatment details: 7 sessions/week provided over 3 times/week for 5 weeks (duration of sessions not provided). High-intensity functional exercises focused on physical activity and functional performance and was supervised by a physical therapist. Group discussion consisted of talking about different themes such as fall risk and security, stroke, how to cope with post-stroke difficulties aspects, and was provided for 1-hour session, 1 time/week for 5 weeks.</p>	<p>Self-management intervention vs. no treatment: (-) MADRS (-) HADS – Depression (-) HADS – Anxiety (-) SSE Questionnaire (-) NEADL Scale (-) SKQ (-) SAQoL – General (-) SAQoL – Psychosocial (-) SAQoL – Physical (-) SAQoL – Communication (-) mBI (-) STAI – Trait anxiety (-) STAI – State anxiety</p> <p>At 5 weeks (post-treatment): (-) Short Form-36 (SF-36) – Physical component scale (-) SF-36 – Mental component scale (-) SF-36 – Physical functioning (-) SF-36 – Role functioning physical (-) SF-36 – Bodily pain (-) SF-36 – General health (-) SF-36 – Vitality (-) SF-36 – Social functioning (-) SF-36 – Role functional emotional (-) SF-36 – Mental health (-) Geriatric Depression Scale-15 GDS-15)</p>

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			<p>At 3 months (follow-up 1): (-) SF-36 – Physical component scale (-) SF-36 – Mental component scale* (-) SF-36 – Physical functioning (-) SF-36 – Role functioning physical (-) SF-36 – Bodily pain (-) SF-36 – General health (-) SF-36 – Vitality (-) SF-36 – Social functioning (-) SF-36 – Role functional emotional (-) SF-36 – Mental health* (-) GDS-15</p> <p>At 6 months (follow-up 2): (-) SF-36 – Physical component scale (-) SF-36 – Mental component scale (-) SF-36 – Physical functioning (-) SF-36 – Role functioning physical (-) SF-36 – Bodily pain (-) SF-36 – General health (-) SF-36 – Vitality (-) SF-36 – Social functioning (-) SF-36 – Role functional emotional (-) SF-36 – Mental health (-) GDS-15</p> <p>*Significant between-group difference in favour of the control group.</p>

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Ihle-Hansen et al., 2014 PEDro score: 6 Country: Norway	195 patients with acute stroke or transient ischemic attack	<p>Health lifestyle promotion program (n=98) vs. Standard care (n=97)</p> <p>Treatment details: 2 visits at 3 and 6 months post-stroke. Healthy lifestyle promotion program consisted of outpatient consultation with study stroke nurse, physician, physical/occupational therapists, social worker (as needed) where education on stroke, prognosis, and rehabilitation was provided; an individualized treatment plan was set in place based on recommendations regarding secondary prevention (e.g. smoking, diabetes, physical activity, strength/balance training, obesity, diet, alcohol, etc.). Standard care involved consultation with general practitioner and following treatment as per the discretion of the general practitioner.</p>	<p>At 1 year post-stroke (follow-up): (-) Hospital Depression and Anxiety Scale (HADS) – Total (-) HADS – Depression (-) HADS – Anxiety</p>
Immink et al., 2014 PEDro score: 6 Country: Australia	25 patients with chronic stroke	<p>Yoga (n=12) vs. No treatment (waiting list) (n=13)</p> <p>Treatment details: 90-minute group sessions, 1 time/week for 10 weeks +40-minute individual home practice sessions, daily for 10 weeks. Yoga consisted of yoga practices provided in group for participants at beginner-level and included a range of adaptations and modifications to accommodate all participants (e.g. balance assistive support, practices while seated in chair, etc.). Included 10-minute lecture on</p>	<p>At 10 weeks (post-treatment): (-) Motor Assessment Scale (-) Berg Balance Scale (-) Two-minute Walk Distance Test (-) Comfortable Gait Speed Test (-) Geriatric Depression Scale – Short Form 15 (-) State Trait Anxiety Inventory – State anxiety (-) State Trait Anxiety Inventory – Trait anxiety (-) Stroke Impact Scale (SIS) – Physical (-) SIS – Emotion (+) SIS – Memory (-) SIS – Communication</p>

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<p>Khan et al., 2016 PEDro score: 8 Country: Australia</p>	<p>103 patients with various neurological conditions (n=53 patients with acute/subacute/chronic stroke)</p>	<p>yoga concepts, 30 minutes of yoga asana and 10-12 minutes of pranayama and 20-30 minutes of Satyananda Yoga Nidra. Daily home exercises consisted of 10-20-minute yoga asana and pranayama and 25-minute of Satyananda Yoga Nidra, was supported by an illustrated guide book and compact disk containing audio recordings to verbally guide the participants through the yoga practices. Participants in the wait-list control group did not receive any treatment for the 10 weeks intervention period, and were offered participants to the yoga intervention following postintervention time point assessment.</p> <p>Environmental enrichment programme during in-patient neuro-rehabilitation (n=28/52 with stroke) vs. Usual ward activity (n=25/51 with stroke) Treatment details: Mean duration of enriched program was 14 days (range: 9-21 days) Environmental enrichment programme during in-patient neurorehabilitation consisted of facilitating physical, cognitive and social activity by providing equipment and organization of a stimulating environment as well as activities (e.g. computers with internet connection, Skype access, Gaming Therapy, library with reading material, music station, life-size mirrors, simulated shopping corner with groceries, electronic payment machine, automatic back teller machine, board games, puzzles, chess, painting, wood workshop, etc.</p>	<p>(-) SIS – Social participation (-) SIS – Stroke recovery</p> <p>At discharge from the ward (post-treatment): (+) Depression Anxiety Stress Scale (DASS) – Total (+) DASS – Depression (+) DASS – Anxiety (+) DASS – Stress (+) Multidimensional Health Locus of Control (MHLC) – Internal (-) MHLC – Chance (-) MHLC – Doctors (-) MHLC – Other people (-) Montreal Cognitive Assessment (-) Rosenberg Self-Esteem Scale (+) Functional Independence Measure (FIM) – Motor Total (+) FIM – Self-care (-) FIM – Sphincter</p>

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		Usual ward activity consisted of television, radio, reading materials, internet, skype and games that are consistent with usual practice.	(+) FIM – Mobility (-) FIM – Locomotion (-) FIM – Cognition Total (-) FIM – Communication (-) FIM – Psychosocial (-) FIM – Cognition (-) EQ-5D – Mobility (-) EQ-5D – Self-care (-) EQ-5D – Daily activity (-) EQ-5D – Pain/discomfort (-) EQ-5D – Anxiety/depression (+) EQ-5D – Index value (-) EQ-5D – Overall health At 3 months post-discharge from the ward (follow-up): (-) DASS – Total (-) DASS – Depression (-) DASS – Anxiety (-) DASS – Stress (-) MHLC – Internal (-) MHLC – Chance (-) MHLC – Doctors (-) MHLC – Other people (-) Rosenberg Self-Esteem Scale (-) FIM – Motor Total (-) FIM – Self-care (-) FIM – Sphincter (-) FIM – Mobility

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			(-) FIM – Cognition Total (-) FIM – Communication (-) FIM – Psychosocial (-) FIM – Cognition (-) EQ-5D – Mobility (-) EQ-5D – Self-care (-) EQ-5D – Daily activity (-) EQ-5D – Pain/discomfort (-) EQ-5D – Anxiety/depression (-) EQ-5D – Index value (+) EQ-5D – Overall health NOTE: changes refer to difference in scores from baseline to assessment point, and only for those with stroke (i.e. based on diagnosis).
Kootker et al., 2017 PEDro score: 7 Country: Netherlands	61 patients with subacute/chronic stroke	Cognitive-behavioral therapy (n=31) vs. Computerized cognitive therapy (n=30) Treatment details: 13-16 x 1-hour sessions over 4 months. Cognitive-behavioral therapy consisted of goal setting and attainment using meaningful activities and social participation. Relaxation techniques and communication strategies were incorporated. Goal setting was performed with an occupational therapist. Computerized cognitive therapy consisted of self-administered training of attention, memory, executive functioning, visual attention using the Cogniplus program on a computer.	At 4 months (post-treatment): (-) Hospital Anxiety and Depression Scale (HADS) – Anxiety (-) HADS – Depression (-) Post-Stroke Depression Rating Scale (-) Utrecht Proactive Coping Competence Life Scale (-) Utrecht Scale for Evaluation of Rehabilitation – Participation (-) Life Satisfaction Questionnaire (-) Stroke Specific Quality of Life Scale At 8 and 12 months (follow-up): (-) HADS – Anxiety (-) HADS – Depression (-) Post-Stroke Depression Rating Scale

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Kongkasuwan et al., 2016 PEDro score: 7 Country: Thailand	118 patients with stroke (stage of stroke recovery not specified)	Creative art therapy (n=59) vs. No treatment (n=59) Treatment details: 1.5 – 2 hours/session, 2 sessions/week for 4 weeks Creative art therapy consisted of group (5-10 patients) activities to stimulate cognition, physical state, emotion, communication, social relation and spiritual dimensions (e.g. meditation with music, singing activity, group-healing circle, positive thinking, story sharing, etc.) Both groups received conventional physical therapy which consisted of range of motion exercises for the affected limb(s), strengthening exercises for the unaffected limb, balance and mobility training and was provided for 1-2-hours/session, 5 times/week for 4 weeks.	(-) Utrecht Proactive Coping Competence Life Scale (-) Utrecht Scale for Evaluation of Rehabilitation – Participation (-) Life Satisfaction Questionnaire (-) Stroke Specific Quality of Life Scale At 4 weeks (post-treatment): (-) Abbreviated Mental Test (-) Hospital Anxiety and Depression Scale (HADS) – Anxiety (+) HADS – Depression (+) Pictorial Thai Quality of Life Questionnaire
Lai et al., 2006 PEDro score: 6 Country: USA	100 patients with subacute stroke	Exercise training (n=50) vs. Standard care (n=50) Treatment details: 36 x 90-minute session over 12-14 weeks. Exercise training was provided in patients’ homes, supervised by a physical or an occupational therapist and	At 3 months (post-treatment): (+) Geriatric Depression Scale-15 (GDS-15) – mean score (+) GDS-15 - score ≥ 6 (+) Short-Form 36 (SF-36) – Emotion score (+) Stroke Impact Scale (SIS) – Emotion score (-) Orpington Prognostic Score

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<p>Lincoln, Jones & Mulley, 1985 PEDro score: 5 Country: UK</p>	<p>191 patients with subacute stroke</p>	<p>included strength, balance, endurance and affected limbs exercises. Standard care consisted of receiving services as prescribed by the physician. Usual care participants received home visits by research staff every 2 weeks for health education, vital signs, and a test of oxygen saturation.</p> <p>Speech therapy (n=104) vs. No treatment (n=87) Treatment details: 1-hour session, 2 times/week for 24 weeks Speech therapy was delivered in the hospital and then at home (details regarding constituents of treatment were not provided). Both groups received conventional rehabilitation.</p>	<p>(-) Pearlin Expressive Social Support Scale (-) Duke Comorbidity Scale At 9 months (follow-up): (-) GDS-15 – mean score (+) GDS-15 – score ≥ 6 (-) SF-36 – Emotion score (-) SIS – Emotion score (-) Orpington Prognostic Score (-) Pearlin Expressive Social Support Scale (-) Duke Comorbidity Scale</p> <p>At 12 weeks (mid-treatment): (-) Mood Rating Scale – Angry-calm (-) Mood Rating Scale – Sad-happy (-) Mood Rating Scale – Afraid-secure (-) Mood Rating Scale – Anxious-relaxed (-) Mood Rating Scale – Depressed-cheerful (-) Mood Rating Scale – Frustrated-contented (-) Multiple Adjective Checklist – Anxiety (-) Multiple Adjective Checklist – Depression (-) Multiple Adjective Checklist – Hostility (-) Goldberg General Health Questionnaire (spouse) (-) Wakefield Depression Inventory (spouse)</p> <p>At 24 weeks (post-treatment): (-) Mood Rating Scale – Angry-calm (-) Mood Rating Scale – Sad-happy (-) Mood Rating Scale – Afraid-secure (-) Mood Rating Scale – Anxious-relaxed (-) Mood Rating Scale – Depressed-cheerful</p>

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Lincoln & Flannaghan, 2003 PEDro score: 7 Country: UK	123 patients with subacute/chronic stroke	Cognitive behavioral therapy (n=39) vs. Attention placebo (n=43) vs. No intervention (n=41) Treatment details: 10 x 1-hour sessions over 3 months Cognitive behavioral therapy consisted of education, graded task assignment, activity scheduling, and identification and modification of unhelpful thoughts and beliefs. Attention placebo consisted of discussing physical effects of stroke and life changes with research personnel.	(-) Mood Rating Scale – Frustrated-contented (-) Multiple Adjective Checklist – Anxiety (-) Multiple Adjective Checklist – Depression (-) Multiple Adjective Checklist – Hostility (-) Goldberg General Health Questionnaire (spouse) (-) Wakefield Depression Inventory (spouse) At 3 months (post-treatment): (-) Beck Depression Inventory (-) Wakefield Self-Assessment of Depression Inventory (-) Extended Activities of Daily Living Scale (-) London Handicap Scale At 6 months (follow-up): (-) Beck Depression Inventory (-) Wakefield Self-Assessment of Depression Inventory (-) Extended Activities of Daily Living Scale (-) London Handicap Scale
Mead et al., 2007 PEDro score: 7 Country: UK	66 patients with subacute/chronic stroke	Relaxation intervention (n=34) vs. Exercise intervention (n=32) Treatment details: 1 hour/session, 3 times/week for 12 weeks. Relaxation intervention consisted of deep breathing and muscular relaxation techniques.	At 3 months (post-treatment): (-) Functional Independence Measure (FIM) (-) Nottingham Extended Activities of Daily Living Scale (NEADL) (-) Rivermead Mobility Index (RMI) (-) Functional Reach Test (-) Short-Form (SF) -36 – Physical functioning (-) SF-36 – Role physical*

Author, Year PEDro Score, Country	Sample size	Intervention	Outcome and significance: (+) significant (-) not significant
		Exercise intervention consisted of endurance and resistance training.	(-) SF-36 – General health (-) SF-36 – Vitality (-) SF-36 – Mental health (-) Hospital Anxiety and Depression Scale (HADS) – Anxiety (-) HADS – Depression (-) Nottingham Power Rig – Leg extensor power (affected side, unaffected side) (-) Walking speed (-) Walking economy* (-) Timed Up and Go test (TUG)* (-) Sit-to-Stand At 7 months (follow-up): (-) FIM (-) NEADL (-) RMI (-) Functional Reach Test (-) SF-36 – Physical functioning (-) SF-36 – Role physical* (-) SF-36 – General health (-) SF-36 – Vitality (-) SF-36 – Mental health (-) HADS – Anxiety (-) HADS – Depression (-) Nottingham Power Rig – Leg extensor power (affected side, unaffected side) (-) Walking speed (-) Walking economy

Author, Year PEDro Score, Country	Sample size	Intervention	Outcome and significance: (+) significant (-) not significant
			(-) TUG (-) Sit-to-Stand * significant between-group differences in favor of exercise vs. relaxation.
Ostwald et al., 2014 PEDro score: 6 Country: USA	156 patients with acute/subacute/chronic stroke and their caregivers	Home-based psychosocial education + mailed intervention (n=79) vs. Mailed intervention (n=80) Treatment details: ~ 16 visits of 70-minutes with a mean total of 36.7 hours of education per dyad (patient + caregiver), provided over 6 months. Home-based intervention consisted of home visits in the first 6 months post-discharge by rehabilitation team members (e.g .nurse, physical and occupational therapists) who provided information, education, support, skill training, counseling and links to social and community resources. Themes included stroke recovery, stress of stroke, promotion of a healthy lifestyle, special problems, therapeutic skill training, coping strategies, community networks. Mailed intervention consisted of monthly mailed personalized letters with information on signs and symptoms of stroke, stroke prevention, stress reduction strategies, diet and exercise guidelines, links to support groups and advocacy organizations, and tips for leisure activity adaptations. Mailed intervention was provided over a 12-month period.	At 6 months post-discharge (post-treatment): Patients and caregivers: (+) SF-36 (-) Brief Geriatric Depression Scale (-) 10-item Perceived Stress Scale (-) Mutuality Scale Caregivers only: (-) Zarit Burden Inventory (-) 4-item Caregiver Preparedness Scale (-) Medical Outcome Study Social Support Survey (-) Family Crisis Oriented Personal Evaluation Scales (F-COPES) – Mobilising family support (-) F-COPES – Acquiring social support (-) F-COPES – Reframing (-) F-COPES – Seeking spiritual support (-) F-COPES – Passive appraisal Patients only: (-) Stroke Impact Scale (-) Functional Independence Measure (FIM) – Motor subtotal (+) FIM – Cognitive subtotal At 12 months post-discharge (follow-up): Patients and caregivers: (-) SF-36

Author, Year PEDro Score, Country	Sample size	Intervention	Outcome and significance: (+) significant (-) not significant
			(-) Brief Geriatric Depression Scale (-) 10-item Perceived Stress Scale (-) Mutuality Scale Caregivers only: (-) Zarit Burden Inventory (-) 4-item Caregiver Preparedness Scale (-) Medical Outcome Study Social Support Survey (+) F-COPES – Mobilising family support (+) F-COPES – Acquiring social support (-) F-COPES – Reframing (-) F-COPES – Seeking spiritual support (-) F-COPES – Passive appraisal Patients only: (-) Stroke Impact Scale (-) Functional Independence Measure (FIM) – Motor subtotal (-) FIM – Cognitive subtotal Note: significant differences refer to change in scores over time. Measurements were also taken at 3 and 9 months post-discharge; however, no between-group analyses are provided for these measurement points.
Peng et al., 2015 PEDro score: 8 Country: China	180 patients with acute stroke	Neuro-Linguistic Programming (NLP) brief therapy + health education (n=90) vs. No treatment (n=90)	At 2 weeks (post-treatment): (+) Hamilton-17 Depression Scale (+) Hamilton Anxiety Scale (+) Stroke Knowledge Questionnaire

Author, Year PEDro Score, Country	Sample size	Intervention	Outcome and significance: (+) significant (-) not significant
<p>Saal et al., 2015 PEDro score 7 Country: Germany</p>	<p>265 patients with acute/subacute stroke</p>	<p>Treatment details: 60-120-minutes/session, 2 sessions/week for 2 weeks. NLP brief therapy + health education consisted of NLP techniques aimed at shifting negative thoughts or beliefs, banishing bad moods, increasing mental energy, releasing pressure and relaxation; and healthy education on stroke risk factors and warning signs, healthier lifestyle, stroke prevention. Both groups also received standard care consisting of medical, nursing, and therapy treatment provided as needed.</p> <p>Stroke education and support (n=130) vs. Mailed information alone (n=135)</p> <p>Treatment details: ~12 contacts (31% via telephone, 61% face-to-face, 8% by email/post/educational sessions) + 6 educational sessions/year. Delivered over 12 months. Stroke education and support consisted of stroke outreach support, educational sessions, written patient information directed at both, patient + caregiver; and included home visits with telephone contacts as necessary. Educational sessions included topics of stroke warning signs and symptoms, risk factors and risk management, ambient assisted living, coping strategies, outpatient therapies, self-help after stroke; and advance care planning. Mailed information alone consisted of two patient information brochures on general information, risk factors</p>	<p>(+) Quality of Life Index (+) Barthel Index</p> <p>At 6 months (follow-up): (-) Hamilton-17 Depression Scale (+) Quality of Life Index (+) Barthel Index</p> <p>At 1 year (post-treatment): (-) Stroke Impact Scale – Physical domain* (-) World Health Organisation Quality of Life short version (WHOQOL-BREF) (-) Geriatric Depression Scale (-) Symptom Checklist 90 revised – Somatization subscale (-) Number of recurrent strokes (+) Mortality (-) Use frequency of health services * significant between-group differences favoring standard care vs. stroke support service intervention.</p>

Author, Year PEDro Score, Country	Sample size	Intervention	Outcome and significance: (+) significant (-) not significant
		and warning signs of stroke; coordination of outpatient services was to the discretion of the physician + patient/caregivers.	
Smith et al., 2012 PEDro score: 7 Country: USA	38 dyads of patients with stroke (stage of recovery unspecified) and their caregivers	<p>Web-based psychoeducational intervention (n=19 dyads) vs. No treatment (n=19 dyads) Treatment details: 9 online modules, 1 module/week for 9 weeks. Web-based psychoeducational intervention consisted of 9 online learning modules based on Stress Process Model, providing caregivers with knowledge, resources, and skills to help them both reduce their personal distress and to provide optimal emotional care to the stroke patient and included the following topics: intervention overview, getting in touch with your feelings as a caregiver, understanding what its like to be a caregiver, being a good listener, nonverbal behavior, choice, control and predictability, relaxation and positive imagery to control stress, pleasant activities, saying goodbye. Each module had its goals and homework to be completed by the caregivers. The web-platform included the following: professional guide, educational videos, online chat sessions, email and message board, and resource room. The control group were given access to a resource room in order to access online information on their own terms.</p>	<p>At 9 weeks (post-treatment): Caregivers: (+) 20-item Center for Epidemiological Studies (CES) – Depression (-) Patient Health Questionnaire (PHQ)-9 (-) Pearlin & Schooler Mastery Scale (-) Rosenberg Self-Esteem Scale (-) Medical Outcome Study (MOS) Social Support Survey Patients with stroke: (-) 20-item CES – Depression (-) PHQ-9 (-) Pearlin & Schooler Mastery Scale (-) Rosenberg Self-Esteem Scale (-) MOS Social Support Survey At 1 month (follow-up): Caregivers: (+) 20-item CES – Depression (-) PHQ-9 (-) Pearlin & Schooler Mastery Scale (-) Rosenberg Self-Esteem Scale (-) MOS Social Support Survey Patients with stroke: (-) 20-item CES – Depression (-) PHQ-9</p>

Author, Year PEDro Score, Country	Sample size	Intervention	Outcome and significance: (+) significant (-) not significant
			(-) Pearlin & Schooler Mastery Scale (-) Rosenberg Self-Esteem Scale (-) MOS Social Support Survey
Taylor-Piliae et al., 2014 PEDro score: 8 Country: USA	145 patients with subacute/chronic stroke	Tai Chi training (n=53) vs. SilverSneakers national fitness program (n=44) vs. Standard care (n=48) Treatment details: 1-hour/session, 3x/week for 12 weeks Tai Chi training consisted of learning the Yang style 24 posture program, replicating motions, postures, and speed of the instructor, included 10-minute warm-up period, 40-minute Tai Chi exercise period, and 10-minute cool-down period; the program was administered by a tai chi practitioner. SilverSneakers national fitness program consisted of different types of ground-based exercise classes such as aerobics, strength and range of motion, water aerobics and yoga; it is administered by a fitness instructor. Standard care consisted of providing participants with written materials and resources for participating in community-based physical activity suitable for older adults, weekly phone call to inquire on health status and to provide individual attention.	At 12 weeks (post-treatment): Tai Chi vs. SilverSneakers fitness program: (-) Short Physical Performance Battery (SPPB) – Total (-) SPPB – Balance (-) SPPB – Strength (-) SPPB – Gait (-) Falls rate (-) 2-minute Step Test (-) 36-Item Short-Form Survey (SF-36) – Physical Component Score (PCS) (-) SF-36 – Mental Component Score (MCS) (-) Center for Epidemiologic Studies Depression Scale (-) Pittsburgh Sleep Quality Index Tai Chi vs. Standard care: (-) SPPB – Total (-) SPPB – Balance (-) SPPB – Strength (-) SPPB – Gait (+) Falls rate (+) 2-minute Step Test (-) SF-36 – PCS (-) SF-36 – MCS (-) Center for Epidemiologic Studies Depression

Author, Year PEDro Score, Country	Sample size	Intervention	Outcome and significance: (+) significant (-) not significant
<p>Thomas et al., 2012 PEDro score: 8 Country: UK</p>	<p>105 patients with subacute/chronic stroke and low mood related to aphasia</p>	<p>Behavioral therapy (n=51) vs. No treatment (n=54) Treatment details: Up to 20 x 1-hr sessions, over 3 months Behavioral therapy was delivered by an assistant psychologist and supervised by a clinical psychologist on a weekly basis at the patient’s place of residence. It included strategies, education, activity monitoring, activity scheduling, and graded task assignment, tailored to the patient’s needs and communication resources (e.g. using pictures, photographs, and letter charts).</p>	<p>Scale (-) Pittsburgh Sleep Quality Index SilverSneakers fitness program vs. Standard care: (-) SPPB – Total (-) SPPB – Balance (+) SPPB – Strength (-) SPPB – Gait (-) Falls rate (+) 2-minute Step Test (-) SF-36 – PCS (-) SF-36 – MCS (-) Center for Epidemiologic Studies Depression Scale (-) Pittsburgh Sleep Quality Index Note: differences refer to change in scores from baseline to post-treatment.</p> <p>At 3 months (post-treatment): (-) Stroke Aphasic Depression Questionnaire 21-item hospital version (+) Visual Analogue Mood Scale “Sad” Item (+) Visual Analogue Self-Esteem Scale (-) Nottingham Leisure Questionnaire At 6 months (follow-up): (+) Stroke Aphasic Depression Questionnaire 21-item hospital version (+) Visual Analogue Mood Scale “Sad” Item (+) Visual Analogue Self-Esteem Scale (+) Nottingham Leisure Questionnaire</p>

Author, Year PEDro Score, Country	Sample size	Intervention	Outcome and significance: (+) significant (-) not significant
<p>Watkins et al., 2007; 2011 PEDro score: 6 Country: UK</p>	<p>411 patients with acute stroke</p>	<p>Both groups received usual care consisting of all services that were available to them as local practice.</p> <p>Motivational interviewing (n=204) vs. No treatment (n=207)</p> <p>Treatment details: 30-60 minutes/session, 1 session/week for 4 weeks. Motivational interviewing was conducted by a therapist, where patients talked about adjustments to having had a stroke, their concerns, goals for recovery, perceived barriers to recovery, finding solutions. All patients received usual stroke care comprised of medical, nursing, and therapy input, inpatient care, discharge planning, and follow-up.</p>	<p>(-) Carer Strain Index (-) Visual Analogue Satisfaction with Care Rating (patient) (-) Visual Analogue Satisfaction with Care Rating (caregiver)</p> <p>At 3 months post-stroke (follow-up): (+) General Health Questionnaire -28 (GHQ-28) (-) Stroke Expectations Questionnaire (SEQ) – Beliefs (-) SEQ – Expectations (-) SEQ – Differences between beliefs and expectations (-) Barthel Index (+) Yale Single Question</p> <p>At 12 months post-stroke (follow-up): (+) GHQ-28 (-) SEQ – Beliefs (-) SEQ – Expectations (-) SEQ – Differences between beliefs and expectations (-) Barthel Index (-) Nottingham Extended Activities of Daily Living (-) Yale Single Question (+) Mortality rates</p>
<p>Wu et al., 2012 PEDro score: 4 Country: China</p>	<p>120 patients with acute stroke</p>	<p>Psychological intervention + comprehensive rehabilitation training (n=60) vs.</p>	<p>At day 3 of treatment: (-) Taita Symptom Checklist (TSCL-90) – Somatization</p>

Author, Year PEDro Score, Country	Sample size	Intervention	Outcome and significance: (+) significant (-) not significant
		<p>No treatment (n=60)</p> <p>Treatment details: 20-minutes session, 5 sessions/week (psychological intervention, duration of intervention not specified) + 30-minutes sessions, 2 sessions/day (comprehensive rehabilitation training, duration of intervention not specified)</p> <p>Psychological intervention was provided by a professional psychologist where open-ended questions were used to provide the patients with positive regards and response. Comprehensive rehabilitation training consisted of positioning, passive range of motion, sitting balance training, transfers training, and mobility training. Both groups also received corresponding drug therapy, medical basic and conventional nursing.</p>	<p>(-) TSCL-90 – Obsession (-) TSCL-90 – Interpersonal sensitivity (-) TSCL-90 – Depression (-) TSCL-90 – Anxiety (-) TSCL-90 – Hostility (-) TSCL-90 – Fear (-) TSCL-90 – Paranoia (-) TSCL-90 – Mental disease (-) European Stroke Scale At day 21 of treatment: (+) TSCL-90 – Somatization (+) TSCL-90 – Obsession (-) TSCL-90 – Interpersonal sensitivity (+) TSCL-90 – Depression (+) TSCL-90 – Anxiety (+) TSCL-90 – Hostility (+) TSCL-90 – Fear (-) TSCL-90 – Paranoia (+) TSCL-90 – Mental disease (+) European Stroke Scale At day 90 (follow-up): (+) Barthel Index</p>