# SDC Table 1. Detailed Study Characteristics

| **Author (Year);****Trial Name** | **Study Characteristics** | **Study Population** | **Audio Intervention(s)** | **Comparator(s)** | **Sample Characteristics** |
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| Audio Interventions for Depression |  |  |  |  |  |
| Kivelitz (2017)[13](#_ENREF_13" \o "Kivelitz, 2017 #758) | Provider: Inpatient treatment therapistsSetting: Psychotherapeutic inpatient units Country: GermanyFunders: Germany’s Federal Ministry of Education and Research and the German Federal Pension Fund Risk of bias: Some concerns | Condition: **Major Depressive Disorder or Dysthymia** (ICD-10 diagnosis [F32.x,F33.x,F34.1], validated with the Mini Diagnostic Interview for Mental Disorders)Other inclusion criteria: A recommendation of outpatient psychotherapy after discharge from the inpatient unit; at least 18 years oldExclusion criteria: Patients who received concurrent outpatient psychotherapeutic treatment before their admission that was planned to be continued after inpatient treatment, acute risk of suicide, acute psychosis or psychotic symptoms, insufficient German language skills, and an inpatient treatment duration of less than 3 days | Intervention (G2): Aftercare case managementN=99Intervention type: Audio- only for transitioning care (supplement with audio care)Audio intervention: Aftercare phone contacts performed by participants’ inpatient treatment therapists who were to support and guide them in making plans and generating goals regarding the coordination oftheir aftercare treatment; participants could utilize other care as desiredAudio frequency: 6 total calls every 2 weeksAudio duration: 20–30 minutes each  | Comparator (G1): Usual careN=100Comparator type: Referred or directed to seek health care as neededDescription: Participants did not receive any contact with their therapist from the clinic after being discharged from inpatient treatment; participants could use other care as desired | Mean age (SD):44.0 (11.0)Female:144 (73.8%)Race:Not reportedHispanic or Latino:Not reportedBachelor’s degree or higher:Not reportedComorbidities:Psychiatric comorbidities (1+ psychiatric diagnoses other than depression)196 (99.0%)Anxiety disorders 49 (24.7%)Somatoform disorders 16 (8.1%)Adjustment disorders 13 (6.6%)Eating disorders 9 (4.5%)Personality disorders9 (4.5%)Medications:Not reported |
| Bombardier (2013)[14](#_ENREF_14), [15](#_ENREF_15)Bombardier (2013)[14](#_ENREF_14), [15](#_ENREF_15)(continued)Bombardier (2013)[14](#_ENREF_14), [15](#_ENREF_15)(continued) | Provider: Master’s-level counselors who received 2- to 3-day training in motivational interviewing and ongoing supervision from clinical psychologistSetting: Community, multiple sclerosis service and care organizationsCountry: United StatesFunder: Department of Education, National Institute on Disability and Rehabilitation ResearchRisk of bias: Some concerns | Condition: **Major Depressive Disorder or Dysthymia** (based on Structured Clinical Interview for DSM–IV administered by phone) **and Multiple Sclerosis** Other inclusion criteria: Ages 18–70 years, having an Expanded Disability Severity Scale score of 5.5 or less, and currently not meeting physical activity guidelinesExclusion criteria: Having a cardiovascular, balance, or bone/joint problem that would make exercise unsafe; having extreme heat intolerance or experiencing Uhthoff effect; receiving a prior diagnosis of schizophrenia, paranoid disorder, or bipolar disorder; having active suicidal ideation; having current alcohol dependence; and being unable to complete forms without assistance | Intervention (G2): Telephone-counseling-based physical activity promotion N=44Intervention type: Audio- only with supports for monitoring (supplement with audio care) Intake: Initial in-person, 40- to 60-minute motivational interviewing and goal-setting session to develop a participant-tailored activity programAudio intervention: Scheduled telephone counseling calls designed to promote motivation and commitment to the activity plan as well as monitor progress toward goals, adjusting goals, and resolving barriers using the principles of motivational interviewing; participants could also initiate contact with counselors between sessions via a toll-free number to receive direct assistance, such as referrals, information, and resourcesAudio frequency: Weekly for first four sessions, biweekly for final three sessions (seven total sessions)Audio duration: 30 minutesOther resources: Educational information and resources such as exercise tapes provided upon request  | Comparator (G1): Wait-listN=48Comparator type: No careDescription: N/A | Mean age (SD):G1: 49.7 (7.9)G2: 47.1 (8.9)Female:G1: 40 (83%)G2: 39 (89%)Race: White (not Hispanic) G1: 43 (90%)G2: 42 (95%)African American, Hispanic/Latino, multiracial, or other~5%Native American2 (2%)Hispanic or Latino:Not reportedBachelor’s degree or higher:G1: 26 (54%)G2: 19 (43%)Comorbidities:Not reportedMedications:AntidepressantsG1: 17 (35%)G2: 22 (50%) |
| Pihlaja (2020);[16](#_ENREF_16" \o "Pihlaja, 2020 #309) The Helsinki University Hospital Finnish-language internet-delivered cognitive behavioral therapy programs (HUS-iCBTs) | Provider: Clinical psychologists who had at least 2 years of work experience with depressed patientsSetting: Hospital psychiatry departmentCountry: FinlandFunders: Finnish Cultural Foundation, Government of Finland, Hospital Region of Helsinki and UusimaaRisk of bias: High | Condition: **Depression** (ICD-10 diagnosis of depression [F32-F33] verified by referring physician)Other inclusion criteria: Aged 18 years or olderExclusion criteria: Current alcohol misuse as judged by the referring physician; known diagnosis of schizophrenia or other psychotic disorder, bipolar disorder, serious personality disorder, or neurological or neuropsychiatric disorder that adversely affects the patient’s cognitive performance; or demonstrated, reported, or observed suicidal intentions | Intervention (G2): HUS-iCBT plus scheduled telephone supportN=50Intervention type: Audio- only with supports for monitoring (supplement with audio care) Audio intervention: Individually tailored calls to select individual goals, discuss tasks and themes of each module Audio frequency: Weekly for 8 weeksAudio duration: 15 minutes/callAsynchronous communication: Therapists sent participants messages at the beginning, mid-treatment, at the sixth module, and post-treatment; participants were encouraged to write to therapists at any time with questions or concerns; participants received automatic messages recapping module content and email prompts if they had not logged into system for 2 weeks or when they received a new message Other resources: iCBT modules | Comparator (G1): HUS-iCBT N=50Comparator type: Asynchronous messagingDescription: iCBT modules; therapists sent participants messages at the beginning, mid-treatment, at the sixth module, and post-treatment and participants were encouraged to write to therapists at any time with questions or concerns; participants received automatic messages recapping module content and email prompts if they had not logged into system for 2 weeks or when they received a new message | Mean age (SD):36.11 (11.10)Female:66 (66.0%)Race:Not reportedHispanic or Latino:Not reportedBachelor’s degree or higher:10 (26.0%) of 28 with information availableComorbidities:Not reportedMedications:Anxiolytics or antidepressants, 19 (67.9%) of 28 with information available  |
| Lindner (2014)[17](#_ENREF_17" \o "Lindner, 2014 #1964) | Provider: Master’s students in clinical psychology supervised by a psychotherapistSetting: Not reportedCountry: SwedenFunder: Swedish Research Council for Health, Working Life and Welfare (FORTE) and Swedish Research CouncilRisk of bias: High or some concerns depending on outcome | Condition: **Major Depressive Disorder** (based on DSM-IV criteria, validated by a diagnostic screening interview conducted via telephone)Other inclusion criteria: At least 18 years old Exclusion criteria: None reported | Intervention (G2): iCBT with telephone supportN=19Intervention type: Audio- only with supports for monitoring (supplement with audio care) Audio intervention: Communication focused on module summary with personal reflections and questionsAudio frequency: Weekly for 7 weeksAudio duration: 10 minutes/callAsynchronous communication: Participant-submitted personal reflections and questions by emailOther resources: Internet-based self-help program consisting of seven modules that focused on behavioral activation with some influences from acceptance and commitment therapy | Comparator (G1): iCBT with e-mail supportN=19Comparator type: Asynchronous messagingDescription: Received the same internet-based self-help program as the intervention; participants submitted personal reflections and questions by email; received reply from therapist within 24 hours; reminders and encouragement were sent if they failed to submit a weekly module summary | Mean age (SD):G1: 40.47 (11.91) G2: 49.95 (11.89)Female:G1: 14 (94.7%) G2: 18 (73.7%)Race:Not reportedHispanic or Latino:Not reportedBachelor’s degree or higher:Not reportedComorbidities:DysthymiaG1: 4 (21.1%) G2: 2 (10.5%)Medications:Psychotropic medication G1: 5 (26.3%) G2: 2 (10.5%) |
| Anderson (2018)[18](#_ENREF_18" \o "Anderson, 2018 #819)Anderson (2018)[18](#_ENREF_18" \o "Anderson, 2018 #819) (continued) | Provider: PhD-level psychologistsSetting: AIDS service organizationsCountry: United StatesFunder: Not reportedRisk of bias: High or low depending on outcome | Condition: **Major Depressive Disorder or Dysthymic Disorder** (DSM-IV criteria for major depressive disorder, major depressive disorder in partial remission, or dysthymic disorder based on the Mood Module of the Primary Care Evaluation of Mental Disorders) **and HIV/AIDS** Other inclusion criteria: At least 18 years of age, residing in a county with a rural-urban commuting code of “4” through “9,” patient intention to stay in their current residence for at least 1 yearExclusion criteria: Not reportedPopulations at risk for disparities: More than 25% Black, indigenous, and people of color100% rural dwelling | Intervention (G2): Standard careplus telephone-administered interpersonal psychotherapy (IPT) N=75Intervention type: Audio- only for treating (supplement with audio care) Audio intervention: Tele-IPT with an interpersonal focusAudio frequency: Weekly for 9 weeksAudio duration: 1 hour/sessionOther resources: Access to community-based support services (e.g., AIDS-related support groups, antidepressant medications as prescribed) | Comparator (G1): Standard careN=72Comparator type: Referred or directed to seek health care as neededDescription: Access to community-based support services (e.g., AIDS-related support groups, antidepressant medications as prescribed) | Mean age (SD):51.9 (10.3)Female:56\* (38%\*)Race:Asian/Pacific Islander1\* (0.6%)African American26\* (17.7%)White108\* (73.4%)Native American4\* (2.5%)Multiracial and others6\* (3.8%)Hispanic or Latino:4\* (2.5%)Bachelor’s degree or higher:Not reportedComorbidities:HIV/AIDS100%Medications:Not reported |
| Naik (2019)[19](#_ENREF_19" \o "Naik, 2019 #455) Healthy Outcomes through Patient Empowerment (HOPE)Naik (2019)[19](#_ENREF_19" \o "Naik, 2019 #455) HOPE(continued) | Provider: Psychologists, nurses, pharmacists, and social workersSetting: Veterans Affairs Medical Center and affiliated community-based outpatient clinicsCountry: United StatesFunder: Veterans Health Administration Health Services Research and Development Office, National Institute of Diabetes and Digestive and Kidney DiseasesRisk of bias: Some concerns | Condition: **Depression** (PHQ-9 score ≥10) **and Diabetes**Other inclusion criteria: Veterans who live at least 20 miles from the Veterans Health Administration hospital in Houston; receive primary care services within a satellite community-based clinicExclusion criteria: Severe cognitive impairment or mental health condition; hearing or visual impairment; active suicidal ideation; presence of significant hypoglycemic events or substance abusePopulations at risk for disparities:More than 25% Black, indigenous, and people of colorMore than 25% older adultsMore than 25% physical, intellectual, or developmental disabilitiesMore than 25% low-income100% veterans | Intervention (G2): Usual care plus HOPEN=136Intervention type: Audio-only with supports for treating (supplement with audio care)Audio intervention: Coaching sessions that build skills to improve diabetes- and depression-related outcomes while stressing the importance of coach–patient relationship to improvement participant physical and emotional self-managementAudio frequency: Biweekly in months 1 to 3 and monthly in months 4 to 6 (9 sessions total); no contact from HOPE providers in months 7 to 12Audio duration: 30–40 minutes in months 1 to 3 and 15 minutes in months 4 to 6Other resources: Workbooks to guide conversations for participants to define and track their progress; participants continued to see their usual primary care provider  | Comparator (G2): Enhanced usual care N=89Comparator type: Educational or community-based resourceDescription: Participants were informed of their high-risk status, given educational materials, and encouraged to address these results with their primary care provider | Mean Age (SD):61.9 (8.3)Female:23 (10.2%)Race:White124 (55.1%)Non-Hispanic Black57 (25.3%)Other (Unspecified)21 (9.3%)Hispanic:23 (10.2%)Some college or higher:155 (68.9%)Comorbidities:Mean (SD) Deyo comorbidity score 2.1 (1.6)Medications:Insulin only60 (26.7%)Oral agents61 (27.1%)Insulin and oral agents62 (27.6%)  |
| Lerner (2020)[20](#_ENREF_20" \o "Lerner, 2020 #1802)Lerner (2020)[20](#_ENREF_20" \o "Lerner, 2020 #1802)(continued)  | Provider: Doctoral-level psychologists, supervised by a psychiatrist and workplace health specialist, who received an intensive 2.5-day training session, followed by weekly telephone supervision involving in-depth case reviewsSetting: Veterans Health Administration FacilitiesCountry: United StatesFunder: United States Department of Veterans Affairs, Health Services Research and Development ServiceRisk of bias: Some concerns  | Condition: **Major Depressive Disorder** **or Persistent Depressive Disorder** (based on DSM‑V criteria, validated by a structured clinical interview)Other inclusion criteria: Veterans 18 years or older, worked at least 15 hours per week in jobs they had occupied for at least 6 months, and had work limitations resulting in at least 5% at-work productivity loss Exclusion criteria: Inability to speak or read English, planned maternity leave, or a history of bipolar disorder or psychosisPopulations at risk for disparities: More than 25% Black, indigenous, and people of color100% veterans | Intervention (G2): Integrated care plus Be Well at WorkN=139Intervention type: Hybrid with supports for treating (supplement with audio care) Audio intervention: Calls to address issues related to coping with depression treatment using motivational enhancement and psychoeducational strategies, provide work-focused cognitive-behavioral therapy strategy training, identify and address workplace barriers to effective functioning and potential work-appropriate coping strategies, and develop a customized self-care plan; self-care progress is reviewed at booster session, and the plan is adjusted as necessaryAudio frequency: Eight visits occurring biweekly for 4 months and one booster session approximately 4 months laterAudio duration: 50 minutes/sessionOther resources: In between sessions, participants were assigned homework to test new strategies and integrate their useIn-person component: All participants received integrated primary and mental health care as described for the comparator | Comparator (G1): Integrated care N=114Comparator type: In-person careDescription: Mild to moderate disorders treated in primary care in collaboration with primary care clinician and an integrated mental health care practitioner; those with more severe symptoms were encouraged to engage in the appropriate Veterans Health Administration specialty care; treatment plans promoted adherence to prescribed antidepressants as well as activities to increase positive social interactions, healthy living, and self-esteem | Mean age (SD): 45.7 (11.6)Female:35 (13.8%)Race:White 135 (53.4%)Hispanic or Latino:Not reportedBachelor’s degree or higher:70 (27.9%)Comorbidities:PTSD 151 (59.7%)Medications:Antidepressant 68 (26.9%) |
| Alegria (2014);[21-23](#_ENREF_21" \o "Alegría, 2014 #1289) Comparando Estrategias para Reducir el Estres y la Depresion (CERED) StudyAlegria (2014);[21-23](#_ENREF_21" \o "Alegría, 2014 #1289) CERED Study(continued) | Provider: Various types of clinicians (e.g., master’s-level psychologists, licensed social workers, licensed PhD psychologists) who participated in at least 12 hours of CBT training and recorded observations of at least six sessions with two cases; clinicians received weekly supervision by psychiatristsSetting: Community-based clinics Country: United StatesFunder: Not reportedRisk of bias: Some concerns | Condition: **Depression** (PHQ-9 score ≥10 and met at least one essential criteria for major depressive disorder)Other inclusion criteria: Latino, at least 18 years of ageExclusion criteria: Psychosis history, use of specialty care within the 3 months prior to baseline or a mental health appointment within the next 2 months, inability to demonstrate capacity to consent, or evidence of suicidal thoughts or ideation Populations at risk for disparities: More than 50% low incomeMore than 50% immigrants or refugees | Intervention (G2): Telephone Engagement and Counseling for LatinosN=87Intervention type: Audio- only with supports for treating (supplement or replace other care with audio care, depending on comparator) Audio intervention: Focused on identifying and correcting negative cognitions; promoting behavioral activation, motivational interviewing to remain in care; and developing supportive relationshipsAudio frequency: First four sessions were weekly, sessions five and six were biweekly unless more immediate care was needed (six to eight total sessions)Audio duration: 45–50 minutes/session Other resources: Workbook and CBT exercises | Comparator (G1): Usual careN=86Comparator type: Referred or directed to seek health care as neededDescription: Typical standard of care determined by the provider the participant was already seeing including watchful waiting, prescription of antidepressants/anxiolytics, or referral to a mental health clinician for psychotherapy or medication management, depending on severity and clinical opinion Comparator (G3): Face-to-face Engagement and Counseling for LatinosN=84Comparator type: In-person careDescription: Same as audio intervention but delivered face-to-face | Age category:18–34: 64 (25%)35–49: 94 (37%)50–64: 89 (35%)>65: 10 (4%)Female:210 (82%)Race: Black/dark skinned86 (33%)Unreported (only indicated Latino) 82 (32%)White73 (28%)Mixed race/American Indian 16 (6%) Hispanic or Latino:257 (100%)Bachelor’s degree or higher:Not reportedComorbidities:Not reportedMedications:Antidepressants 44 (17.1%) |
| Kirkness (2017);[24](#_ENREF_24" \o "Kirkness, 2017 #763) Living Well with Stroke 2 (LWWS 2)Kirkness (2017);[24](#_ENREF_24" \o "Kirkness, 2017 #763) LWWS 2(continued)Kirkness (2017);[24](#_ENREF_24" \o "Kirkness, 2017 #763) LWWS 2(continued) | Provider: Psychosocial nurse practitioner therapistSetting: University and community hospitals Country: United StatesFunder: National Institute of Nursing ResearchRisk of bias: Low | Condition: **Depression** (Geriatric Depression Scale score ≥ 11 verified by the Diagnostic Interview and Structured Hamilton) **and within 4 months of an Ischemic or Hemorrhagic Stroke** Other inclusion criteria: None reportedExclusion criteria: Low depressive symptoms, no stroke, stroke took place more than 4 months before participation in the study | Intervention (G2): Brief telephone psychosocial-behavioral interventionN=37Intervention type: Audio- only with supports for treating (supplement or replace other care with audio care, depending on comparator) Intake: One in-person orientation session either in their home or at the study offices to receive the participant manuals, discuss goals and expectations of each session, and learn how to fill out the homework sectionsAudio intervention: Telephone sessions covering introduction to behavioral therapy for depression after stroke, and pleasant events; scheduling pleasant events; managing depression behaviors; changing negative thoughts and behaviors; problem-solving in depth; review of skills; and generalization and strategies for maintenance of skills; family members or informal caregivers could participate and provide data with the participant’s agreementAudio frequency: Six total sessionsAudio duration: Range of 10–80 minutes/sessionOther resources: Participant manual outlining intervention content; participants saw their primary care or stroke provider for stroke follow-up care and were provided antidepressants as prescribed by their providers | Comparator (G1): Usual careN=28Comparator type: Referred or directed to seek health care as neededDescription: Provided antidepressants as prescribed by the participant’s usual care provider Comparator (G3): Brief in-person psychosocial–behavioral interventionN=35Comparator type: In-person care Description: Same as intervention but delivered in-person | Mean age (range):G1: 60.7 (32–88)G2: 61.7 (31–85)G3: 58.5 (23–83)Female:G1: 14 (50%)G2: 18 (48.6%)G3: 18 (51.4%)Race: White onlyG1: 24 (85.7%)G2: 30 (81.1%)G3: 25 (71.4%)More than one raceG1: 2 (7.1%)G2: 4 (10.8%) G3: 8 (22.9%)Black onlyG1: 1 (3.1%)G2: 2 (5.4%) G3: 2 (5.7%)Asian onlyG1: 1 (3.1%)G2: 1 (2.7%) G3: 0 (0.0%)Hispanic or Latino:G1: 3 (10.7%)G2: 1 (2.7%)G3: 1 (2.9%)Bachelor’s degree or higher:Not reportedComorbidities:History of depressionG1: 20 (71%)G2: 32 (86%) G3: 27 (77%) Ischemic strokeG1: 22 (79%)G2: 32 (86%) G3: 31 (89%) Intraparenchymal hemorrhagic strokeG1: 3 (11%)G2: 4 (11%) G3: 4 (11%) Subarachnoid hemorrhageG1: 3 (11%)G2: 1 (2%)G3: 0 (0.0%)Heart failureG1: 2 (7%)G2: 0 (0.0%)G3: 6 (17%) DiabetesG1: 5 (17%)G2: 11 (30%) G3: 12 (34%)Medications:AntidepressantsG1: 12 (43%)G2: 19 (51%) G3: 16 (46%) |
| Himelhoch (2013)[25](#_ENREF_25" \o "Himelhoch, 2013 #1499)Himelhoch (2013)[25](#_ENREF_25" \o "Himelhoch, 2013 #1499)(continued) | Provider: Master’s level therapists experienced in delivering cognitive-behavioral interventions who received 12 hours of didactic training and subsequently completed one supervised case using the adapted telephone-administered CBT (T-CBT) interventionSetting: Urban HIV clinics affiliated with a large urban medical centerCountry: United StatesFunder: National Institute of Mental HealthRisk of bias: High | Condition: **Major Depressive Disorder** (met criteria based on the Mini International Neuropsychiatric Interview) **and HIV/AIDS** Other inclusion criteria: English-speaking adults who had access to a working telephone and were able to read at a 4th-grade reading level Exclusion criteria: Endorsing suicidal ideation, receiving concurrent psychotherapy, life expectancy less than 6 months as determined by their HIV clinician, having HIV-related dementia as determined by the HIV dementia scale, initiating antidepressant treatment targeting depression or having an antidepressant medication dose change within 6 weeks of the consent process, and/or having current drug or alcohol dependence, severe psychiatric pathology for whom participation in the study might be considered dangerous or unethicalPopulations at risk for disparities: More than 50% Black, indigenous, and people of color100% low income | Intervention (G2): T-CBTN=16Intervention type: Audio- only with supports for treating (replace other care with audio care) Audio intervention: Manualized T-CBT targeting depression, including one initial evaluation session, five behavioral activation sessions, and five cognitive restructuring sessionsAudio frequency: 11 sessions delivered weekly over up to 14 weeks, with the 3 additional weeks available in case of missed sessionsAudio duration: 45 minutesOther resources: Study workbook | Comparator (G1): Face-to-face psychotherapyN=18Comparator type: In-person careDescription: Usual care within the HIV clinic consisting of 11 non-manualized sessions of CBT provided by clinic therapist without study supervision; sessions were scheduled for 60-minute blocks with number of appointments left to therapists’ judgment | Mean age (SD):45.12 (8.33)Female:25 (73.5 %)Race: Black32 (94.1%)American Indian 1 (2.9%)Other 1 (2.9%)Hispanic or Latino:2 (5.7%)Bachelor’s degree or higher:Not reportedComorbidities:History of drug dependence 19 (55.8 %)Medications:Not reported |
| Mohr (2012);[26-30](#_ENREF_26" \o "Mohr, 2012 #2174)Telephone Versus Face-to-Face Administration of CBT for Depression Mohr (2012);[26-30](#_ENREF_26" \o "Mohr, 2012 #2174)Telephone Versus Face-to-Face Administration of CBT for Depression (continued) | Provider: PhD-level psychologists with 2 days of initial training followed by weekly supervised training until competence criterion reachedSetting: General internal medicine or primary care clinicsCountry: United StatesFunder: National Institute of Mental Health Risk of bias: High or some concerns depending on outcome | Condition: **Major Depressive Disorder** (Hamilton Depression Rating Scale score ≥16)Other inclusion criteria: Aged 18 years or older, can speak and read English, able to participate in face-to-face or telephone therapyExclusion criteria: Visual or hearing impairments that would prevent participation; meets diagnostic criteria for a severe psychiatric disorder or depression of organic etiology or reported alcohol or substance abuse severe enough that psychotherapy would be inappropriate; meets criteria for dementia; exhibits severe suicidality; receiving or planning to receive individual psychotherapy; or initiated antidepressant pharmacotherapy in the previous 10 daysPopulations at risk for disparitiies:More than 25% Black, indigenous, and people of color | Intervention (G2): Telephone-administered CBTN=163Intervention type: Audio- only with supports for treating (replace other care with audio care) Audio intervention: T-CBTAudio frequency: Two sessions weekly for first 2 weeks, followed by 12 weekly sessions, with two final booster sessions over 4 weeks (18 total sessions)Audio duration: 45 minutes/sessionOther resources: Patient workbook with eight chapters that covered CBT concepts, including behavioral activation, cognitive restructuring, and social support, along with five optional modules that covered common comorbidities and treatment content, including anxiety and worry, relaxation training, communication and assertiveness training, anger management, and insomnia | Comparator (G1): Face-to-face CBTN=162Comparator type: In-person care Description: The same care as the intervention group delivered in-person  | Mean age (SD):G1: 47.5 (13.5)G2: 47.8 (12.6)Female:G1: 127 (78.4%)G2: 125 (76.7%)Race:White G1: 98 (65.3%) G2: 89 (60.1%)African AmericanG1: 36 (24.0%)G2: 36 (24.3%)More than one raceG1: 12 (8.0%)G2: 18 (12.2%)American Indian or Alaska Native, Asian, and Native Hawaiian or Pacific Islander G1: 4 (2.7%)G2: 5 (3.4%)Hispanic or Latino:G1: 21 (13.0%) G2: 23 (14.1%)Bachelor’s degree or higher:G1: 107 (66.0%)G2: 103 (63.1%)Comorbidities:Not reportedMedications:Receiving an active dose of antidepressant medication G1: 56 (34.6%) G2: 54 (33.1%) |
| Audio Interventions for PTSD |  |  |  |  |  |
| Rosen (2013)[31](#_ENREF_31" \o "Rosen, 2013 #1561)Rosen (2013)[31](#_ENREF_31" \o "Rosen, 2013 #1561) (continued) | Provider: Clinical psychology graduate students supervised by clinical psychologistsSetting: Veterans Affairs residential post-traumatic stress disorder (PTSD) treatment programsCountry: United StatesFunder: Not reportedRisk of bias: Some concerns | Condition: **PTSD** (entering residential PTSD treatment programs)Other inclusion criteria: Veterans Exclusion criteria: Cognitive impairment precluded informed consent, discharged from treatment in less than 15 days, transferred from residential treatment directly to another inpatient treatment program, or active-duty military personnelPopulations at risk for disparities: More than 25% Black, Indigenous, and people of color100% veterans | Intervention (G2): Standard aftercare plus telephone monitoring and support N=412Intervention type: Audio-only with supports for transitioning (supplement with audio care)Audio intervention: After standard referral, providers used a scripted protocol to assess outpatient treatment attendance, medication compliance, symptom severity and coping, substance use, suicidality, and risk for violence as well as verbally reinforced positive behaviors and provided problem-solving support or brief motivation enhancementAudio frequency: Biweekly during the first 3 months after discharge (six planned calls)Audio duration: Average 16.4 minutes/call (SD 10.8, range 2–113)Referral: Standard referral to outpatient counselors or psychiatrists upon discharge | Comparator (G1): Standard aftercareN=425Comparator type: Referred or directed to seek health care as neededDescription: Standard referral to outpatient counselors or psychiatrists upon discharge | Mean age (SE):G1: 49.9 (0.86)G2: 50.2 (0.62)Female:G1: 368 (13.4%)G2: 357 (13.3%)Race: CaucasianG1: 256 (62.0%)G2: 263 (64.8%)African AmericanG1: 93 (22.5%)G2: 87 (21.4%)Native AmericanG1: 8 (1.9%)G2: 11 (2.7%)Pacific IslanderG1: 2 (0.5%)G2: 2 (0.5%)Asian AmericanG1: 0 (0.0%)G2: 2 (0.5%)OtherG1: 28 (6.8%)G2: 22 (5.4%)Hispanic or Latino: G1: 26 (6.3%)G2: 19 (4.7%)Bachelor’s degree or higher:Not reportedComorbidities:DepressionG1: 349 (82.1%)G2: 328 (79.6%) Anxiety (other than PTSD)G1: 135 (31.8%)G2: 123 (29.9%)Substance use disorder G1: 240 (56.5%)G2: 224 (54.4%) Schizophrenia G1: 18 (4.2%)G2: 20 (4.9%)Bipolar disorder G1: 58 (13.6%)G2: 49 (11.9%)Service-connected disabilityG1: 282 (66.4%)G2: 285 (69.2%)Medications:Not reported |
| Rosen (2017)[32](#_ENREF_32" \o "Rosen, 2017 #949)Rosen (2017)[32](#_ENREF_32" \o "Rosen, 2017 #949) (continued)Rosen (2017)[32](#_ENREF_32" \o "Rosen, 2017 #949) (continued) | Provider: Clinical psychology graduate students supervised by a clinical psychologistSetting: Outpatient mental health programs at Department of Veterans Affairs medical centers Country: United StatesFunder: Congressionally Directed Medical Research ProgramRisk of bias: Some concerns | Condition: **PTSD** (newly entering outpatient PTSD treatment or beginning a new phase of treatment)Other inclusion criteria: Veterans Exclusion criteria: Continuing patients, dropped out of care before completing enrollment, starting residential or inpatient treatment, active-duty military personnel, or too cognitively impaired to consentPopulations at risk for disparities:More than 50% Black, indigenous, and people of color100% veterans | Intervention (G2): Usual care plus telephone care management N=193Intervention type: Hybrid for transitioning care (supplement synchronous care interaction via audio) Audio intervention: Providers used a semi-scripted protocol to assess treatment attendance, medication compliance and side effects, symptom severity, self-efficacy for coping with symptoms, substance use, suicidality, and risk for violence as well as verbally reinforced positive behaviors and provided brief problem-solving support or motivation enhancement to help address behaviors that could interfere with treatmentAudio frequency: Every 2 weeks during the first 3 months of treatmentAudio duration: Average 25.1 minutes/call (SD: 11.1; range: 1–92)In-person component: Outpatient PTSD treatment from usual counselor or psychiatrist according to treatment plan and were provided medication as prescribed by their provider | Comparator (G1): Usual care N=165Comparator type: In-person careDescription: Outpatient PTSD treatment from usual counselor or psychiatrist according to treatment plan  | Mean age (SD):G1: 48.4 (1.1)G2: 47.7 (1.1)Female:G1: 22 (13%)G2: 31 (16%)Race:White G1: 89\* (54%\*)G2: 117\* (61%\*)African American G1: 53\* (32%\*)G2: 49\* (26%\*)AsianG1: 4 (3%)G2: 4 (2%)Pacific IslanderG1: 3 (2%)G2: 5 (3%)American IndianG1: 4 (3%)G2: 1 (1%)Other (not specified)G1: 9 (6%)G2: 11 (6%)Hispanic or Latino:G1: 19\* (12%\*)G2: 26\* (6%\*)Bachelor’s degree or higher:Not reportedComorbidities:DepressionG1: 88 (53%)G2: 108 (57%)Anxiety (other than PTSD)G1: 33 (20%)G2: 59 (31%)Substance use disorder G1: 35 (6%)G2: 31 (16%)Psychotic disorderG1: 1 (1%)G2: 1 (1%) Bipolar disorderG1: 5 (3%)G2: 12 (6%)Service-connected disabilityG1: 109 (66%)G2: 131 (69%)Medications:Selective serotonin reuptake inhibitors or serotonin and norepinephrine reuptake inhibitorsContinuing during the study period200 (56%)Newly prescribed during the study period 40 (11%)Prazosin Continuing during the study period60 (17%)Newly prescribed during the study period20 (8%) |
| Gallegos (2015)[33](#_ENREF_33" \o "Gallegos, 2015 #1178)Gallegos (2015)[33](#_ENREF_33" \o "Gallegos, 2015 #1178) (continued) | Provider: Doctoral-level interventionists trained in the CBT engagement interventionSetting: Not reportedCountry: United StatesFunder: Not reportedRisk of bias: High | Condition: **PTSD** (validated using the Mini-International Neuropsychiatric Interview-PTSD subscale)Other inclusion criteria: Served in the wars in Iraq or Afghanistan, specifically Operation Enduring Freedom/Operation Iraqi Freedom and thus could be active or separated, and have never initiated any treatment for PTSDExclusion criteria: Not reportedPopulations at risk for disparities: More than 25% rural dwelling100% veterans | Intervention (G2): Telephone-administered CBTN=123Intervention type: Audio- only for transitioning care (supplement with audio care)Audio intervention: CBT sessions focused on thoughts, feelings, and behaviors to influence treatment-seeking behaviorAudio frequency: Four total sessions (at baseline, 1, 3, and 6 months)Audio duration: 45–60 minutes/session | Comparator (G1): Wait-listN=150Comparator type: No careDescription: Wait-list | Mean age:Female: 32.0Male: 28.9Female:35 (12.8%)Race:BlackFemale: 34%Male: 11%WhiteFemale: 54%Male: 72%Other raceFemale: 9%Male: 6%Hispanic or Latino:Not reportedBachelor’s degree or higher:Not reportedComorbidities:Not reportedMedications:Not reported |
| Audio Interventions for Insomnia |  |  |  |  |  |
| Sunnhed (2020)[34](#_ENREF_34" \o "Sunnhed, 2020 #431)Sunnhed (2020)[34](#_ENREF_34" \o "Sunnhed, 2020 #431) (continued) | Provider: Licensed clinical psychologist and master’s student at the end of their clinical training who were required to read all internet modules, a therapist manual, and participate in a therapist workshop and allowed supervision on a need-to basisSetting: Not reportedCountry: SwedenFunder: VetenskapsrådetRisk of bias: Some concerns | Condition: **Insomnia** (occurrence of sleeping difficulties ≥3 nights per week during at least 3 months and the following scores on the Insomnia Sleep Index: a total score ≥ 11, a score of at least 2 on items 1–3, and a score of ≥ 2 on items 5 and 7)Other inclusion criteria: Time and opportunity to participate in therapy for 10 weeks, read approximately 15 pages per week, and execute homework on a daily to weekly basis; access to a computer, a cell phone, email, and the Internet; stable reported somatic conditions or receiving treatment for the condition; if sleep medication was used it had to be relatively stable for past 3 months; selective serotonin reuptake inhibitor change or initiation should be at least 3 months prior to phone interviewExclusion criteria: Severe depression and high suicidal ideation; sleeping problems due to obvious environmental conditions; participation in CBT for insomnia in past 5 years; regularly consuming sleep-disturbing medications; history of psychotic or bipolar disorders, sleep apnea, restless legs syndrome, periodic limb movement disorder, circadian rhythm disorder, and parasomnias | Intervention (G2): Telephone-administered cognitive therapyN=72Intervention type: Audio- only with supports for monitoring (supplement with audio care)Audio intervention: Telephone support for cognitive therapy consisting of feedback on registered homework, problem-solving issues related to the homework, and initiation of subsequent modules Audio frequency: Weekly for 10 weeksAudio duration: 15 minutes/call Other resources: Internet-delivered self-help program containing one module per week with corresponding exercises on PDF filesIntervention (G3): Telephone-administered behavioral therapy N=73Intervention type: Audio-only with supports for monitoring (supplement with audio care)Audio intervention: Telephone support for behavioral therapy consisting of feedback on registered homework, problem solving issues related to the homework, and initiation of subsequent modules Audio frequency: Weekly for 10 weeksAudio duration: 15 minutes/call Other resources: Internet-delivered self-help program containing one module per week with corresponding exercises on PDF files | Comparator (G1): Wait-listN=74Comparator type: No careDescription: Wait-list | Mean age (SD):G1: 54.2 (14.6)G2: 51.5 (12.5)G3: 51.8 (14.5)Female:G1: 54 (73.0%)G2: 55 (76.4%)G3: 51 (69.9%)Race:Not reportedHispanic or Latino:Not reportedBachelor’s degree or higher:G1: 57 (77.0%)G2: 58 (80.6%)G3: 57 (78.1%)Comorbidities:Somatic comorbidityG1: 17 (23.0%)G2: 24 (33.3%)G3: 12 (16.4%)Psychiatric comorbidity:G1: 14 (18.9%)G2: 12 (16.7%)G3: 10 (13.7%)Medications:Hypnotic medicationG1: 30 (40.5%)G2: 29 (40.3%)G3: 34 (46.4%)Other medicationG1: 33 (46.6%)G2: 33 (45.8%)G3: 34 (46.6%) |
| Arnedt (2013)[35](#_ENREF_35" \o "Arnedt, 2013 #1524)Arnedt (2013)[35](#_ENREF_35" \o "Arnedt, 2013 #1524)(continued) | Provider: Clinical psychologists with expertise in CBT for insomnia (CBT-I)Setting: Primary care outpatient clinicsCountry: United StatesFunder: National Center for Research ResourcesRisk of bias: High | Condition: **Insomnia** (met research diagnostic criteria for chronic insomnia with documented symptoms on 3 or more nights per week)Other inclusion criteria: Aged 18–65 yearsExclusion criteria: Diagnosis or high clinical suspicion of a sleep disorder other than insomnia; poorly controlled Axis I psychiatric disorder; uncontrolled medical disorder or pain syndrome that interfered with sleep, caused daytime sleepiness, or was likely to be causally related to the insomnia; current nonpharmacologic insomnia treatment or previous failed trial of CBT-I; routine overnight shift workPopulations at risk for disparities: More than 25% Black, indigenous, and people of color | Intervention (G2): Telephone-based CBT-I N=18 (3 withdrew prior to treatment)Intervention type: Audio- only with supports for treating (supplement with audio care)Audio intervention: Each session began with a sleep diary review and assessment of severity, then covered the treatment modulesAudio frequency: 4–8 weekly sessionsAudio duration: 15–60 minutes/sessionOther resources: Participants were mailed treatment modules that covered behavioral strategies, sleep hygiene, cognitive therapy, and relapse prevention | Comparator (G1): Information pamphlet N=15Comparator type: Educational resourceDescription: Participants were mailed a pamphlet with instructions to review and implement the recommendations, which was briefly reviewed with the participants by a study therapist | Mean age (SD):39.1 (14.4)Female:27 (90.0%)Race:White 22 (73.3%)Black 5 (16.7%)Other 3 (10.0%)Hispanic or Latino:Not reportedBachelor’s degree or higher:Not reportedComorbidities:Medical comorbidity11 (36.7%)Psychiatric comorbidity6 (20.0%)Medications:Hypnotic drug usage7 (23.3%) |
| Audio Interventions for Schizophrenia Spectrum Disorder |  |  |  |  |  |
| Beebe (2017)[36](#_ENREF_36" \o "Beebe, 2017 #888)Beebe (2017)[36](#_ENREF_36" \o "Beebe, 2017 #888) (continued) | Provider: Graduate-prepared psychiatric nurse with experience providing the intervention, supervised by principal investigator Setting: Community mental health center Country: United StatesFunder: Not reportedRisk of bias: High | Condition: **Schizophrenia Spectrum Disorder** (chart diagnosis of schizophrenia or schizoaffective disorder, any subtype, according to DSM-IV criteria)Other inclusion criteria: Not hospitalized for psychiatric illness within the past 6 months, English speakingExclusion criteria: Chart diagnosis of coexisting mental retardation, neurological disorders, or head injuryPopulations at risk for disparities: More than 25% Black, indigenous, and people of color | Intervention (G2): Telephone intervention problem solving (TIPS)N=Not reportedIntervention type: Audio- only for monitoring (replace other care with audio care)Audio intervention: Support to problem solve difficulties in community living that affect medication adherence, addresses knowledge of medication, attending appointments, coping with symptoms, abstaining from substances, and social supportAudio frequency: WeeklyAudio duration: Not reported | Comparator (G1): Treatment as usualN=Not reportedComparator type: In-person careDescription: Medication follow-up appointments with a psychiatrist approximately every 4–6 weeks along with case management appointments approximately every 6–8 weeks | Mean age (SD): 46.8 (12.9)Female:46 (43.8%)Race:Caucasian71 (67.6%)African American32 (30.5%)Asian2 (1.9%)Hispanic or Latino:Not reportedBachelor’s degree or higher:Not reportedComorbidities:Not reportedMedications:105 (100%) |
| Audio Interventions for Any Substance Use Disorder (SUD) |  |  |  |  |  |
| Timko (2019)[37](#_ENREF_37" \o "Timko, 2019 #587)Timko (2019)[37](#_ENREF_37" \o "Timko, 2019 #587) (continued) | Provider: Licensed master’s-level clinical social workersSetting: Inpatient psychiatry facilities Country: United StatesFunder: United States Department of Veterans AffairsRisk of bias: High | Condition: **Dual Diagnosis of any Mental Health and any SUD** (as documented in patient medical records)Other inclusion criteria: Having sufficient cognitive functioning to understand study procedures and self-reported having access to a cell or landline telephone when not hospitalizedExclusion criteria: Refusal, ineligibility, or other reason (e.g., discharged before baseline was complete) | Intervention (G2): Usual care plus telephone monitoringN=207Intervention type: Audio- only for transitioning care (supplement with audio care)Intake: A 30- to 50-minute in-person session during hospitalization to raise possible discrepancies between using substances and meeting goals, introduce the idea of a change plan, discuss post-discharge engagement in care, and review how calls would workAudio intervention: During each telephone session, participants answered a risk assessment covering behaviors since the previous call, compliance with substance use and mental health treatment, and participation in 12-step groups; providers positively reinforced steps toward recovery and reacted in a non-judgmental fashion to setbacksAudio frequency: One call per week for 3 monthsAudio duration: Approximately 15 minutes/sessionOther resources: Audio intervention preceded by inpatient psychiatry treatment including psychopharmacology | Comparator (G1): Usual care N=199Comparator type: In-person careDescription: Inpatient psychiatry treatment including psychopharmacology; care after discharge from inpatient psychiatry treatment not specified  | Mean age (SD):G1: 45.2 (12.6) G2: 45.1 (12.6)Female:G1: 16 (8.0%)G2: 19 (9.1%)Race:WhiteG1: 127 (64.1%) G2: 128 (62.0%)Hispanic or Latino:Not reportedBachelor’s degree or higher:Not reportedComorbidities:Not reportedMedications:Not reported |
| Timko (2019)[38](#_ENREF_38" \o "Timko, 2019 #542)Timko (2019)[38](#_ENREF_38" \o "Timko, 2019 #542) (continued) | Provider: Master’s-level telecoaches with regular supervision from doctoral-level, licensed clinicians, all with formal motivational interviewing training and experienceSetting: Psychiatry unitsCountry: United StatesFunder: Department of Veterans Affairs, Health Services Research and Development ServiceRisk of Bias: High or low depending on outcome | Condition: **Alcohol or Opioid Use Disorder** (undergoing detoxification for alcohol or opioid dependence)Other inclusion criteria: Having sufficient cognitive functioning to understand study procedures; access to a cell or land line telephone when not hospitalized; and at least one person who would know of their whereabouts after discharge, for whom contact information was availableExclusion criteria: Not reportedPopulations at risk for disparities: 100% veteran | Intervention (G2): Usual care plus enhanced telephone monitoringN=148Intervention type: Audio- only for transitioning care (supplement with audio care)Intake: One 50-minute individual session during the inpatient stay before the audio sessions began to provide an orientation to the telephone monitoring protocol; coach provided support and addressed post-detoxification engagement in addiction treatment; participants completed a contract including an intent to attend addiction treatment and/or mutual helpAudio intervention: Patients completed a worksheet about substance use and compliance with treatment and mutual help since the last call; coach provided prompts and reinforcements regarding patients’ attendance at treatment sessions and mutual-help meetingsAudio frequency: Weekly for 12 weeksAudio duration: 15 minutes/callOther resources: Audio intervention preceded by inpatient detoxification with post-detoxification addiction outpatient and residential specialty care and pharmacotherapy available; offered referral to or an appointment with addiction treatment services | Comparator (G1): Usual care N=150Comparator type: In-person careDescription: Inpatient detoxification with post-detoxification addiction outpatient and residential specialty care and pharmacotherapy available; offered referral to or an appointment with addiction treatment services  | Mean age (SD):50.1 (13.2)Female:15 (5%)Race:White225 (76%)Hispanic or Latino:Not reportedBachelor’s degree or higher:Not reportedComorbidities:Not reportedMedications:Not reported |
| McKellar (2012)[39](#_ENREF_39" \o "McKellar, 2012 #1597)McKellar (2012)[39](#_ENREF_39" \o "McKellar, 2012 #1597)(continued) | Provider: Postdoctoral fellows in clinical psychologySetting: United States Department of Veterans Affairs intensive outpatient substance use disorder (SUD) treatment sitesCountry: United StatesFunder: United States Department of Veterans AffairsRisk of bias: High | Condition: **Any SUD** (ICD-9 diagnosis of alcohol or drug dependence)Other inclusion criteria: English-speaking adult patients who were receiving intensive outpatient SUD treatment Exclusion criteria: Psychiatric or medical condition that precluded involvement in outpatient carePopulations at risk for disparities: More than 25% Black, indigenous, and people of colorMore than 25% rural dwellingMore than 50% veterans | Intervention (G2): Telephone case monitoring N=213Intervention type: Audio- only with supports for transitioning care (replace other care with audio care) Intake: One face-to-face contact with case monitor before intensive outpatient discharge to orient participants to the protocol, patient manual, and expectationsAudio intervention: Brief review of participants’ responses to counseling workbook questions and their progress toward primary goals chosen with counselors, positive reinforcement of patient’s progress toward their therapeutic goals, non-judgmental responses to setbacks, assistance to help participants at high risk of relapse or who had relapsed to re-engage with providers in stepped care fashionAudio frequency: Weekly for 12 weeksAudio duration: 10–15 minutes/callOther resources: Participant workbook with questions about past week behavior and progress toward primary goals | Comparator (G1): In-person continuing care as usual N=454Comparator type: In-person group-based careDescription: One to two face-to-face group sessions per week, usually in groups of 10–20 patients, that focused on maintaining treatment gains achieved in intensive outpatient and preventing relapse to substance use | Mean age (SD): 51.3 (8.2)Female:31\* (4.6%\*)Race:White, non-Hispanic333\* (49.9%)Black292\* (43.8%)Other (not specified)43\* (6.4%)Hispanic or Latino:Not reportedBachelor’s degree or higher:Not reportedComorbidities:Axis I diagnosis in 2 years prior to randomization409\* (61.3%)Medications:Not reported |
| Audio Interventions for Alcohol Use Disorder |  |  |  |  |  |
| Lucht (2021);[40](#_ENREF_40)Continuity of Care Among Alcohol‐Dependent Patients via Mobile Phone SMS Study (CAPS)Lucht (2021);[40](#_ENREF_40" \o "Lucht, 2021 #252)CAPS(continued) | Provider: Psychiatrists, psychologists, nurses, or medical assistants with no specific training except for an introduction to the interactive systemSetting: Inpatient addiction disorder units at psychiatric hospitalsCountry: GermanyFunder: German Research CouncilRisk of bias: Some concerns | Condition: **Alcohol Use Disorder** (ICD-10 diagnosis of alcohol dependence)Other inclusion criteria: Ongoing inpatient alcohol detoxification, aged ≥18 years, ability to send and receive short messaging service (SMS) messages and written informed consentExclusion criteria: Acute withdrawal from illegal drugs within the last 6 months, participation in a drug substitution program for opioid use disorders, expected nonadherence to the planned assessments, dementia or acute psychosis, life expectancy <12 months, or participation in other clinical trials | Intervention (G2): Treatment as usual plus SMS interventionN=230Intervention type: Audio- only with supports for transitioning care (supplement with audio care) Audio intervention: The interactive system automatically generated e‐mails to inform therapists about patient’s text message responses that required follow-up via phone; calls were intended to be supportive, including telephone counseling Audio frequency: Dependent on responses to SMS messages Audio duration: Not reported (intended to be brief)Asynchronous communication: The interactive system automatically sent SMS messages to patient’s mobile phones inquiring if they needed help (twice per week in months 1–2, once per week in month 3, twice per month in months 4–12 [40 total messages over 12 months]); the system informed therapists of participants needing assistance or did not respond and responded with a supportive message if no assistance was neededReferral: Providers could refer participants to an outpatient service or readmission to the hospital | Comparator (G1): Treatment as usualN=233Comparator type: Referred or directed to seek health care as neededDescription: All usual health care services, such as general practitioners and psychiatrists, emergency services, addiction counselling, outpatient psychotherapy, day clinic and inpatient treatment, and 3-month inpatient rehabilitation programs | Mean age (SD):G1: 44.5 (9.7) G2: 45.4 (9.2)Female:G1: 53 (22.8%) G2: 52 (22.6%)Race:Not reportedHispanic or Latino:Not reportedBachelor’s degree or higher:Not reportedComorbidities:ObesityG1: 36 (15.5%) G2: 27 (11.7%)Medications:None reported |
| McKay (2022)[41](#_ENREF_41" \o "McKay, 2022 #82)McKay (2022)[41](#_ENREF_41" \o "McKay, 2022 #82) (continued)McKay (2022)[41](#_ENREF_41" \o "McKay, 2022 #82) (continued) | Provider: Therapists with 2–25 years of experience treating substance use disorders and supervised by a licensed psychologistSetting: Publicly funded intensive outpatient programsCountry: United StatesFunder: National Institute on Alcohol Abuse and AlcoholismRisk of bias: High | Condition: **Alcohol Use Disorder** (DSM-V diagnosis of current, moderate to severe alcohol use disorder)Other inclusion criteria: Completed 3 weeks of intensive outpatient; aged 18–75 years; able to provide the name, verified telephone number, and address of two or more contacts willing to provide participant locator information to aid in follow-up; and functionally literateExclusion criteria: No current psychotic disorder or dementia; no acute medical problem requiring inpatient treatment; not receiving other addiction treatmentPopulations at risk for disparities: More than 50% Black, indigenous, and people of color | Intervention (G2): Treatment as usual plus telephone monitoring and counselingN=59Intervention type: Hybrid for monitoring (supplement with audio care)Intake: One face-to-face session to develop rapport with counselorsAudio intervention: CBT-based counseling addressing anticipated risky situations, based on a brief assessment of substance use and risk and protective factors at the beginning of each call (participants without reliable access to a telephone were given a non-smart mobile phone)Audio frequency: Weekly phone calls in month 1, twice-weekly calls in months 2–4, monthly calls in months 5–7, and calls every other month in months 8–12 (16 possible calls; average of 8.1 calls)Audio duration: 15–30 minutes/call In-person component: Weekly clinic-based intensive outpatient continuing care for 2–3 monthsIntervention (G4): Treatment as usual plus telephone monitoring and counseling plus A-CHESSN=70 Intervention type: Hybrid with supports for monitoring (supplement with audio care)Audio intervention: Same as aboveOther resources: Participants received a smartphone, data plan, and A-CHESS smartphone program for 12 months, which collected information daily or weekly to estimate relapse risk and sent text messages to participants encouraging them to seek additional support when relapse risk was high; included smartphone-based activities to support participants and information on where to find self-help resourcesIn-person component: Weekly, clinic-based intensive outpatient continuing care for 2–3 months | Comparator (G1): Treatment as usualN=65Comparator type: In-person careDescription: Weekly clinic-based intensive outpatient continuing care for 2-3 months Comparator (G3): Treatment as usual plus Addiction Comprehensive Health Enhancement Support System (A-CHESS)N=68Comparator type: In-person care with supportsDescription: Participants in weekly, clinic-based intensive outpatient continuing care for 2–3 months received a smartphone, data plan, and A-CHESS smartphone program for 12 months, which collected information daily or weekly to estimate relapse risk and sent text messages to participants encouraging them to seek additional support when relapse risk was high; included smartphone-based activities to support participants and information on where to find self-help resources | Mean age (SD): 46.9 (7.4)Female:77\* (29.39%)Race:African American 46\* (82.44%)Hispanic or Latino:Not reportedBachelor’s degree or higher:Not reportedComorbidities:Cocaine use disorder111\* (42.25%)Cannabis use disorder78\* (29.62%)Anxiety disorder 93\* (35.50%)Major depression69\* (26.34%)Medications:Not reported |
| Audio Interventions for Cocaine Use Disorder |  |  |  |  |  |
| McKay (2013)[42-44](#_ENREF_42" \o "McKay, 2013 #1454)McKay (2013)[42-44](#_ENREF_42" \o "McKay, 2013 #1454) (continued)McKay (2013)[42-44](#_ENREF_42" \o "McKay, 2013 #1454) (continued) | Provider: Therapists (BA, MA, and PhD levels) with prior experience providing outpatient treatment for substance use disordersSetting: Intensive outpatient programsCountry: United StatesFunder: National Institute on Drug AbuseRisk of bias: Some concerns | Condition: **Cocaine Use Disorder** (lifetime DSM-IV cocaine dependence)Other inclusion criteria: Between the ages of 18–65; willingness to participate in research and be randomly assigned to a treatment condition; completion of 2 weeks of intensive outpatient; ability to read at approximately the 4th-grade level; and at least a minimum degree of stability in living situation Exclusion criteria: No psychiatric or medical condition that precluded outpatient treatment, no regular IV heroin use within the past 12 monthsPopulations at risk for disparities: More than 50% Black, indigenous, and people of color100% veterans  | Intervention (G2): Treatment as usual plus telephone monitoring and counseling N=106Intervention type: Hybrid for monitoring (supplement with audio care)Intake: Participants had 1–2 initial face-to-face sessions in the first week (i.e., week 3 of intensive outpatient) to orient them to the protocolAudio intervention: Brief phone call including an assessment of current substance use, HIV risk behaviors, and intensive outpatient attendance; CBT-based counseling linked to the results of the assessment and addressing anticipated risky situations (participants had the option of completing some sessions in-person)Audio frequency: Weekly for first 8 weeks, every other week for the next 44 weeks, once per month for 6 months, and every other month for final 6 months (39 scheduled calls over 24 months)Audio duration: 20 minutes/call In-person component: Intensive outpatient program consisting of approximately 9 hours of group-based treatment per week, typically attended for 3–4 months; participants who completed the program were subsequently offered 2–3 months standard outpatient treatment (total of up to 6 months of treatment) Intervention (G3): Treatment as usual plus telephone monitoring and counseling plus incentivesN=107Intervention type: Hybrid with supports for monitoring (supplement with audio care)Audio intervention: Same as aboveOther resources: $10 gift coupon for each regularly scheduled or step care session attended in the first year and a bonus $10 gift coupons every three consecutively scheduled sessions were completedIn-person component: Same as above | Comparator (G1): Treatment as usualN=108Comparator type: In-person careDescription: Intensive outpatient program consisting of approximately 9 hours of group-based treatment per week, typically attended for 3–4 months; participants who completed the program were subsequently offered 2–3 months standard outpatient treatment (total of up to 6 months of treatment) | Mean age (SD):G1: 42.9 (8.0)G2: 43.3 (7.8)G3: 43.4 (6.5)Female:G1: 26 (24.1%) G2: 26 (24.5%)G3: 24 (22.4%)Race:African AmericanG1: 97 (90.7%) G2: 89 (84.0%)G3: 98 (91.6%)White G1: 8 (7.5%) G2: 10 (9.4%)G3: 6 (5.6%)Other (not specified)G1: 2 (1.9%) G2: 7 (6.6%)G3: 3 (2.8%)Hispanic or Latino:Not reportedBachelor’s degree or higher:Not reportedComorbidities:Not reportedMedications:Not reported |

\* Calculated by data abstractor based on information reported.

A-CHESS, Addiction Comprehensive Health Enhancement Support System; CAPS, Continuity of Care Among Alcohol‐Dependent Patients via Mobile Phone SMS Study; CBT, cognitive behavioral therapy; CBT-I, CBT for insomnia; CERED, Comparando Estrategias para Reducir el Estres y la Depresion; DSM, *Diagnostic and Statistical Manual of Mental Disorders*; G, group; HOPE, Healthy Outcomes through Patient Empowerment; HUS, Helsinki University Hospital; iCBT, internet-based CBT; ICD, *International Classification of Diseases*; LWWS, Living Well With Stroke; N, number; N/A, not applicable; PHQ, Patient Health Questionnaire; PTSD, post-traumatic stress disorder; SD, standard deviation; SE, standard error; SMS, short messaging service; SUD, substance use disorder; T-CBT, telephone-administered CBT.

# SDC Table 2. Risk of Bias

| **Author (Year);****Trial Name** | **Domain 1** | **Domain 2** | **Domain 3\*** | **Domain 4\*** | **Domain 5\*** | **Overall\*** |
| --- | --- | --- | --- | --- | --- | --- |
| **Depression** |  |  |  |  |  |  |
| Kivelitz (2017)[13](#_ENREF_13" \o "Kivelitz, 2017 #758) | Low | Some concerns | Low | Some concerns | Some concerns | Some concerns |
| Bombardier (2013)[14](#_ENREF_14), [15](#_ENREF_15) | Low | Low | Some concerns | Low | Low | Some concerns |
| Pihlaja (2020);[16](#_ENREF_16" \o "Pihlaja, 2020 #309) The Helsinki University Hospital Finnish-Language Internet-Delivered Cognitive Behavioral Therapy Programs  | High | Some concerns | Low | Low | Low | High |
| Lindner (2014)[17](#_ENREF_17" \o "Lindner, 2014 #1964) | Some concerns | Low | High for clinically meaningful change; some concerns for quality-of-life | Low | Low | High for clinically meaningful change;some concerns for quality-of-life |
| Anderson (2018)[18](#_ENREF_18) | Some concerns | High | High  | Low | Low | High  |
| Naik (2019);[19](#_ENREF_19) Healthy Outcomes through Patient Empowerment | Low | Some concerns | Some concerns | Low  | Low  | Some concerns |
| Lerner (2020)[20](#_ENREF_20" \o "Lerner, 2020 #1802) | Some concerns | Low | Some concerns  | Low | Some concerns | Some concerns |
| Alegria (2014);[21-23](#_ENREF_21" \o "Alegría, 2014 #1289)Comparando Estrategias para Reducir el Estres y la Depresion Study | Some concerns | Low | Low | Low | Low | Some concerns |
| Kirkness (2017);[24](#_ENREF_24" \o "Kirkness, 2017 #763) Living Well with Stroke 2 | Low | Low | Low | Low | Low | Low |
| Himelhoch (2013)[25](#_ENREF_25" \o "Himelhoch, 2013 #1499) | Low | Some concerns | Low | High | Low | High |
| Mohr (2012);[26-30](#_ENREF_26) Telephone Versus Face-to-Face Administration of CBT for Depression | Low | Low | High for clinically meaningful change; low for health care access and utilization and adverse events | Low | Some concerns  | High for clinically meaningful change; some concerns for health care access and utilization and adverse events |
| **Post-traumatic stress disorder** |  |  |  |  |  |  |
| Rosen (2013)[31](#_ENREF_31" \o "Rosen, 2013 #1561) | Low | Low | Some concerns for quality-of-life; low for health care access and utilization and patient safety and harms  | Some concerns for quality-of-life;Low for health care access and utilization and patient safety and harms | Some concerns | Some concerns |
| Rosen (2017)[32](#_ENREF_32" \o "Rosen, 2017 #949) | Low | Low | Some concerns for quality-of-life;low for health care access and utilization and adverse events | Some concerns for quality-of-life;low for health care access and utilization and adverse events | Some concerns | Some concerns |
| Gallegos (2015)[33](#_ENREF_33" \o "Gallegos, 2015 #1178) | High | Low | Low | Some concerns | Low | High |
| **Insomnia** |  |  |  |  |  |  |
| Sunnhed (2020)[34](#_ENREF_34" \o "Sunnhed, 2020 #431) | Some concerns | Low | Low | Low | Low | Some concerns |
| Arnedt (2013)[35](#_ENREF_35" \o "Arnedt, 2013 #1524) | Some concerns | Some concerns | High | Some concerns | Some concerns | High |
| **Schizophrenia Spectrum Disorder** |  |  |  |  |  |  |
| Beebe (2017)[36](#_ENREF_36) | Low | Some concerns | High | Low | Some concerns | High |
| **Any Substance Use Disorder** |  |  |  |  |  |  |
| Timko (2019)[37](#_ENREF_37" \o "Timko, 2019 #587) | Low | Some concerns | High | Low | Low | High |
| Timko (2019)[38](#_ENREF_38" \o "Timko, 2019 #542) | Some concerns | Low | High | Low | Low | High |
| McKellar (2012)[39](#_ENREF_39" \o "McKellar, 2012 #1597) | Some concerns | High | Some concerns | Some concerns | Some concerns | High |
| **Alcohol Use Disorder** |  |  |  |  |  |  |
| Lucht (2021);[40](#_ENREF_40" \o "Lucht, 2021 #252)Continuity of Care Among Alcohol‐Dependent Patients via Mobile Phone SMS Study  | Low | Low | Some concerns | Low | Low | Some concerns |
| McKay (2022)[41](#_ENREF_41" \o "McKay, 2022 #82) | Low | Some concerns | High | Some concerns  | Some concerns | High |
| **Cocaine Use Disorder** |  |  |  |  |  |  |
| McKay (2013)[42-44](#_ENREF_42" \o "McKay, 2013 #1454) | Low | Low | Low | Low | Some concerns | Some concerns |

\*Risk of bias was not assessed separately for outcomes reflecting symptom severity unless no other outcome comparison was reported (i.e., Anderson [2018],[18](#_ENREF_18) Gallegos [2015],[33](#_ENREF_33) and Timko [2019][38](#_ENREF_38), [38](#_ENREF_38)).

# SDC Table 3. Detailed Evidence from Studies Targeting Depression

| **Author (Year);****Trial Name** | **Study Characteristics** | **Intervention and Comparator Arms** | **Clinical Outcomes** | **Patient-Reported Health/Quality-of-Life** | **Care Access/ Utilization** | **Care Quality/ Experience** | **Patient Safety** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Kivelitz (2017)[13](#_ENREF_13" \o "Kivelitz, 2017 #758)Kivelitz (2017)[13](#_ENREF_13" \o "Kivelitz, 2017 #758) (continued) | Condition: Major depressive disorder or dysthymiaProvider: Inpatient treatment therapistsSetting: Psychotherapeutic inpatient units Country: GermanyFunders: Germany’s Federal Ministry of Education and Research and the German Federal Pension Fund Risk of bias: Some concerns | Comparator (G1): Usual careN=100Comparator type: Referred or directed to seek health care as neededIntervention (G2): Aftercare case managementN=99Intervention type: Audio-only for transitioning care (supplement with audio care) | Depression severity post-treatment (3 months), follow-up (9 months):Assessed using Beck’s Depression Inventory-Second Edition (BDI-II) Baseline:No difference between groups (p=0.917), scores reflected moderate-to-severe depression Post-treatment (3 months):No difference between groups (p=0.132), scores reflected moderate-to-severe depressionFollow-up (9 months):No difference between groups (p=0.284), scores reflected moderate-to-severe depression | Health-related quality-of-life post-treatment (3 months), follow-up (9 months):Assessed using the EuroQol-5D; full health is represented by the EuroQol-5D by a value of 1Mean (SD) score (3 months): G1: 0.63 (0.22)G2: 0.65 (0.21)Estimated mean difference0.025 (95% CI, ‑0.10 to 0.05), p=0.492Mean (SD) score (9 months): G1: 0.65 (0.19)G2: 0.62 (0.25)Estimated mean difference-0.012 (95% CI, ‑0.06 to 0.09), p=0.760Health-related quality-of-life (3 months, 9 months):Assessed using the Short-Form 8 Health Survey (SF-8); scores for the SF-8 range from 0 to 100 with higher scores indicating better statusesMean (SD) score (3 months): G1: 34.9 (11.3) G2: 37.8 (11.1)Estimated mean difference2.84 (95% CI, -6.72 to 1.04), p=0.151Mean (SD) score (9 months):G1: 36.9 (10.8)G2: 38.7 (11.2)Estimated mean difference2.12 (95% CI, -6.32 to 2.07), p=0.320 | Number of phone contacts post-treatment (3 months; intervention arm only): Assessed using the phone call recordsReceived only one contact7.5%Received two contacts2.2%Received four contacts5.4%Received six contacts78.5% | NR | NR |
| Bombardier (2013)[14](#_ENREF_14), [15](#_ENREF_15)Bombardier (2013)[14](#_ENREF_14), [15](#_ENREF_15)(continued)Bombardier (2013)[14](#_ENREF_14), [15](#_ENREF_15)(continued) | Condition: **Major Depressive Disorder and Multiple Sclerosis**Provider: Master’s-level counselors who received 2- to 3-day training in motivational interviewing (MI) and ongoing supervision from clinical psychologistSetting: Community, multiple sclerosis service and care organizationsCountry: United StatesFunder: Department of Education, National Institute on Disability and Rehabilitation ResearchRisk of bias: Some concerns  | Comparator (G1): Wait-listN=48Comparator type: No careIntervention (G2): Telephone-counseling based physical activity promotionN=44Intervention type: Audio-only with supports for monitoring (supplement with audio care)  | Depression severity post-treatment (12 weeks):[14](#_ENREF_14" \o "Bombardier, 2013 #1534)Assessed using Hamilton Depression rating Scale (HAM-D) Baseline:Significantly higher in G2 (p=0.03), scores reflected moderate depression for G2 and mild depression for G1 Post-treatment (12 weeks):Mean score favored G2 (p=0.0001), although the mean scores for both G1 and G2 reflected mild depression Mediation analysis:[15](#_ENREF_15" \o "Kratz, 2014 #1394)No significant direct effect of group on depressive symptoms (0.68), significant indirect pathway of group > physical activity > positive affect > depressive symptoms (p=0.04)Clinically significant response in depression symptoms post-treatment (12 weeks):Assessed using the HAM-D; participants who achieved a 50% decrease in the total score from baseline to post-treatmentG1: 9 (19%)G2: 15 (34%)Between-group difference p=0.10Number needed to treat to respond compared with controls: 6.5No longer meet Diagnostic and Statistical Manual of Mental Disorders-4th Edition (DSM-IV) diagnostic criteria for major depression or dysthymia post-treatment (12 weeks from baseline):[14](#_ENREF_14" \o "Bombardier, 2013 #1534)Assessed using the Structured Clinical Interview for DSM-IV G1: 13\* (27%)G2: 26\* (59%)Between-groupp=0.0029Remission at post-treatment (12 weeks):[14](#_ENREF_14" \o "Bombardier, 2013 #1534)Assessed using the HAM-D; participants who achieved a score <8G1: 11 (23%)G2: 13 (30%)Between-group difference p=not significantNumber needed to treat to remit compared with controls: 15.1 | NR | NR | Fidelity post-treatment (12 weeks; intervention arm only):[14](#_ENREF_14), [15](#_ENREF_15) Assessed using the checklist; 20% of recorded sessions were coded for key indicators of MI fidelityOpen-ended questions 72% (exceeded MI competency standards)Reflections-to-questions ratio2.9:1 (exceeded MI competency standards)MI inconsistent behaviors 0.26 (0.57) per session (rare)Frequency of observed client-resistive behavior0.28 (0.76) per session (rare)MI spirit ratingsMeans 5.73–5.88; Range 4–7 (satisfactory) | NR |
| Pihlaja (2020);[16](#_ENREF_16" \o "Pihlaja, 2020 #309) The Helsinki University Hospital Finnish-Language Internet-Delivered Cognitive Behavioral Therapy Programs (HUS-iCBT) | Condition: DepressionProvider: Clinical psychologists who had at least 2 years of work experience with depressed patientsSetting: Hospital psychiatry departmentCountry: FinlandFunders: Finnish Cultural Foundation, Government of Finland, Hospital Region of Helsinki and UusimaaRisk of bias: High | Comparator (G1): HUS-iCBTN=50Comparator type: Asynchronous messagingIntervention (G2): HUS-iCBT plus scheduled telephone supportN=50Intervention type: Audio-only with supports for monitoring (supplement with audio care) | Depression severity post-treatment (8 weeks) Assessed using Beck Depression Inventory (BDI) BaselineNo difference between groups (p=0.30), scores reflected moderate-to-severe depressionPost-treatment (8 weeks)Mean change in score from baseline favored G2 (p=0.049) | NR | Completed modules (6 months) Assessed using the iCBT platform; number of modules reached by participantsMean (SD)G1: 2.46 (1.88)G2: 3.54 (2.57)All seven modules reachedG1: 3 (6%) G2: 13 (26%)Treatment completion (6 months)Assessed using the iCBT platform; Participants who completed the program G1: 3 (6%) G2: 12 (24%)X2=6.4 (df=1), p=0.02 | NR | Adverse events reported (6 months) Events such as hospitalization or serious illnessNo adverse events occurred |
| Lindner (2014)[17](#_ENREF_17" \o "Lindner, 2014 #1964)Lindner (2014)[17](#_ENREF_17" \o "Lindner, 2014 #1964) (continued) | Condition: **Major Depressive Disorder**Provider: MSc students in clinical psychology supervised by a psychotherapistSetting: Not reportedCountry: SwedenFunder: Swedish Research Council for Health, Working Life and Welfare (FORTE) and Swedish Research CouncilRisk of bias: High or some concerns depending on outcome | Comparator (G1): Internet-based cognitive behavioral therapy (iCBT) with e-mail supportN=19Comparator type: Asynchronous messagingIntervention (G2): iCBT with telephone supportN=19Intervention type: Audio-only with supports for monitoring (supplement with audio care) | Depression severity post-treatment (7 weeks), follow-up (3 months)Assessed using Beck Depression Inventory-Second Edition (BDI-II) BaselineSimilar (no test of significance), scores reflected moderate-to-severe depressionPost-treatment (7 weeks)No group effect (p=0.703), scores reflected mild-to-moderate depressionFollow-up (3 months)No time x group effect (p=0.710), scores reflected mild-to-moderate depressionClinical change in depression post-treatment (7 weeks), follow-up (3 months)Assessed using the BDI-II; relevant clinical change was defined as having a BDI-II score of >10 pre-treatment, and ≤10 post-treatment and at follow-up; results were not stratified by groupPost-treatment (7 weeks)G1/G2: X2=0.11, p=1.00Follow-up (3 months)G1/G2: X2=0.358, p=0.730 | Quality-of-life post-treatment (7 weeks), follow-up (3 months)Assessed using the Quality-of-Life IndexMean score (SD) posttreatment (7 weeks)G1: 1.71 (1.9)G2: 1.52 (2.38)Group effect 0.001, p=0.972Follow-up (3 months)G1: 2.11 (1.94)G2: 1.90 (2.5)Time x group effect1.203, p=0.295 | NR | NR | NR |
| Anderson (2018)[18](#_ENREF_18" \o "Anderson, 2018 #819) | Condition: **Major Depressive Disorder or Dysthymic Disorder and HIV/AIDS**Provider: PhD-level psychologistsSetting: AIDS service organizationsCountry: United StatesFunder: Not reportedRisk of bias: High or low depending on outcome  | Comparator (G1): Standard CareN=72Comparator type: Referred or directed to seek health care as neededIntervention (G2): Tele-administered interpersonal psychotherapyN=75Intervention type: Audio-only for treating (supplement with audio care) | Depression severity post-treatment (9 weeks)Assessed using BDI-II BaselineNRPost-treatment (9 weeks)Direct effect of G2 to reduce depression (p<0.05) | NR | NR | NR | Adverse events post-treatment (9 weeks)No adverse events were reported during the trial |
| Naik (2019)[19](#_ENREF_19" \o "Naik, 2019 #455) Healthy Outcomes through Patient Empowerment (HOPE)Naik (2019)[19](#_ENREF_19" \o "Naik, 2019 #455) HOPE(continued)Naik (2019)[19](#_ENREF_19" \o "Naik, 2019 #455) HOPE(continued) | Provider: Psychologists, nurses, pharmacists, and social workersSetting: Veterans Affairs Medical Center and affiliated community-based outpatient clinicsCountry: United StatesFunder: Veterans Health Administration Health Services Research and Development Office, National Institute of Diabetes and Digestive and Kidney DiseasesRisk of bias: Some concerns | Comparator (G1): Enhanced usual careN=89Comparator type: Educational or community-based resourceIntervention (G2): Usual care plus HOPEN=136Intervention type: Audio-only with supports for treating (supplement with audio care) | Depressive symptom severity post-treatment (6 months), follow-up (12 months) Assessed using Patient Health Questionaire-9 (PHQ-9)BaselineNo difference between groups (p=NR), scores reflected moderately severe depression symptomsPost-treatment (6 months)Mean difference in score from baseline favored G2 (p=0.03), although mean score for both groups reflected moderate symptomsFollow-up (12 months)Mean difference in score from baseline favored G2 (p=0.03), although mean score for both groups reflected moderate symptoms Clinical response post-treatment (6 months), follow-up (12 months)Assessed using PHQ-9;participants who achieved a 50% decrease from baseline or a PHQ‑9 value <10Post-treatment (6 months)G1: 35.0%G2: 47.2%Success rate difference (95% CI)0.12 (-0.02 to 0.26), p=0.09Follow-up (12 months)G1: 32.9%G2: 52.1%Success rate difference (95% CI)0.19 (0.04 to 0.33), p=0.01 | NR | Completed treatment follow-up (12 months; intervention arm only)Assessed using trial dataAttended 3+ sessions G2: 73%Attended 6+ sessionsG2: 51% | NR | NR |
| Lerner (2020)[20](#_ENREF_20" \o "Lerner, 2020 #1802)Lerner (2020)[20](#_ENREF_20" \o "Lerner, 2020 #1802)(continued) | Condition: Major Depressive DisorderProvider: Doctoral-level psychologists, supervised by a psychiatrist and workplace health specialist, who received an intensive 2.5-day training session, followed by weekly telephone supervision involving in-depth case reviewsSetting: Veterans Health Administration FacilitiesCountry: United StatesFunder: United States Department of Veterans Affairs, Health Services Research and Development ServiceRisk of bias: Some concerns  | Comparator (G1): Integrated care N=114Comparator type: In-person careIntervention (G2): Integrated care plus Be Well at Work N=139Intervention type: Hybrid with supports for treating (supplement with audio care) | Depressive symptom severity post-treatment (4 months), follow-up (8 months)Assessed using Patient Health Questionnaire-9 (PHQ-9) BaselineNo difference between groups (p=0.25), scores reflected moderate symptomsPost-treatment (4 months)Mean change in score from baseline favored G2 (p=0.003), although both groups had significant improvements (p=0.001 and p<0.001)Follow-up (8 months)No significant loss of initial improvement (p=0.44), scores reflected moderate symptoms | NR | Sessions attended post-treatment (4 months; intervention arm only)Assessed using a counselor data system; number of sessions out of eight planned Mean (SD)5.2 (2.9)Treatment completion follow-up (8 months; intervention arm only)Assessed using a counselor data system; completion of booster session27 (22.1%)Mental health office visits post-treatment (4 months) Assessed using electronic health records; intervention is hypothesized to increase utilizationMean (SD)G1 (n=NR): 3.9 (3.9) G2 (n=NR): 3.8 (5.4) p=0.2  | NR | NR |
| Alegria (2014);[21-23](#_ENREF_21) Comparando Estrategias para Reducir el Estres y la Depresion (CERED) Study | Condition: **Depression**Provider: Various types of clinicians (e.g., master’s-level psychologists, licensed social workers, licensed PhD psychologists) who participated in at least 12 hours of CBT training and recorded observations of at least six sessions with two cases; clinicians received weekly supervision by psychiatristsSetting: Community-based clinics Country: United StatesFunder: Not reportedRisk of bias: Some concerns | Comparator (G1): UCN=86Comparator type: Referred or directed to seek health care as neededIntervention (G2): Telephone-based Engagement and Counseling for Latinos (ECLA-T)N=87Intervention type: Audio-only with supports for treating (supplement or replace other care with audio care, depending on comparator) Comparator (G3): Face-to-face Engagement and Counseling for Latinos (ELCA-F)N=84Comparator type: In-person careDescription: Same as audio intervention but delivered face-to-face | Depressive symptom severity follow-up (4 months)[21](#_ENREF_21), [22](#_ENREF_22) Assessed using Patient Health Questionnaire-9 (PHQ-9) BaselineNo difference between groups (p=0.08), reflected moderately severe symptomsFollow-up (4 months)Favored G2 over G1 for lowering symptoms (p=0.01); no difference in impact between G2 and G3 (p=0.69) | Health status follow-up (4 months)[21](#_ENREF_21" \o "Alegría, 2014 #1289)Assessed using the World Health Organization Disability Assessment Schedule (WHO-DAS 2); past 30-day functioningResults not reported by groupG2 compared with G1: p<.07, effect size=.23G2 compared with G3: p=.91 | Treatment completion post-treatment (8 weeks; ECLA arms only)[21](#_ENREF_21" \o "Alegría, 2014 #1289) Assessed using trial dataOnly completed sessions 1–3G2: 18 (20.7%)G3: 13 (15.5%)Completed sessions 4–6G2: 60 (69%)G3: 53 (63%) | Fidelity follow-up (4 months; ECLA arms only)[21](#_ENREF_21), [23](#_ENREF_23)Assessed using checklist; 20% of recorded sessions were evaluated by supervisory clinicians Results not reported by group “Clinicians exhibited substantial fidelity to the intervention and covered on average 84.55% and 80.23% of the required tasks at the two sites” (Page 7) | NR |
| Kirkness (2017);[24](#_ENREF_24" \o "Kirkness, 2017 #763)Living Well with Stroke 2 (LWWS 2)Kirkness (2017);[24](#_ENREF_24" \o "Kirkness, 2017 #763)LWWS 2 (continued) | Condition: **Depression and within 4 months of an Ischemic or Hemorrhagic Stroke**Provider: Psychosocial nurse practitioner therapistSetting: University and community hospitals Country: United StatesFunder: National Institute of Nursing ResearchRisk of bias: Low  | Comparator (G1): Usual careN=28Comparator type: Referred or directed to seek health care as neededIntervention (G2): Brief telephone psychosocial-behavioral interventionN=37Intervention type: Audio-only with supports for treating (supplement or replace other care with audio care, depending on comparator) Comparator (G3): Brief in-person psychosocial behavioral interventionN=35Comparator type: In-person care | Depression Severity post-treatment (8 weeks), follow-up (12 months)Assessed using Hamilton Depression Rating Scale (HDRS, also known as Hamilton Depression Scale [HAM-D])Not available for eligible comparisonsRemission post-treatment (8 weeks), follow-up (12 months)Assessed using HDRS; defined as HRSD score ≤10 (no longer meeting depression criteria)Post-treatment (8 weeks)G1: 7 (27%)G2/G3: 24 (37%)Follow-up (12 months)G1: 9 (36%)G2/G3: 28 (44%)Unspecified time pointThere was no statistically significant difference between G2 and G3 (combined G2/G3 compared with G1 is not an eligible comparison) | NR | NR | NR | Adverse events follow-up (12 months)No harms attributable to the study were identified |
| Himelhoch (2013)[25](#_ENREF_25" \o "Himelhoch, 2013 #1499)Himelhoch (2013)[25](#_ENREF_25" \o "Himelhoch, 2013 #1499)(continued) | Condition: **Major Depressive Disorder and HIV/AIDS**Provider: Master’s-level therapists experienced in delivering cognitive-behavioral interventions who received 12 hours of didactic training and subsequently completed one supervised case using the adapted telephone-administered CBT (T-CBT) interventionSetting: Urban HIV clinics affiliated with a large urban medical centerCountry: United StatesFunder: National Institute of Mental HealthRisk of bias: High  | Comparator (G1): Face-to-face psychotherapyN=18Comparator type: In-person careIntervention (G2): T-CBTN=16Intervention type: Audio-only with supports for treating (replace other care with audio care) | Depression severity at midpoint (7 weeks), post-treatment (14 weeks) Assessed using Hamilton Depression Scale BaselineNo difference between groups (p=0.297), although the mean score for G1 was at the bottom of the range for severe depression and the mean score for G2 was at the top of the range for moderate depressionMidpoint (7 weeks)No difference between groups (p=0.41), scores reflected moderate depressionPost-treatment (14 weeks)While both groups had significant reductions (p=0.04 and p=0.001), no difference between groups (p=0.32) with scores reflecting mild depression  | NR | Kept appointments post-treatment (14 weeks)Assessed using trial data; number of sessions attended out of 11 plannedMean (SD)G1: 6.3 (3.1)G2: 4.1 (2.7)Between-group p=0.20Adherence to Highly Active Antiretroviral Therapy during and post-treatment (1 week, 14 weeks) Assessed using a validated telephone-based pill counting method; Calculated as the difference between pills counted at two timepoints divided by the pills prescribed, accounting for the number of pills dispensed, pills lost, gained, and taken that dayMean % (SD) 1 weekG1: 77% (33%)G2: 82% (23%)Between-groupEffect size=NR, p=0.56Post-treatment (14 weeks)G1: 68% (21%)G2: 83% (27%)Between-groupEffect size=0.60, p=0.04 | Satisfaction with therapy post-treatment (14 weeks)Assessed using the Satisfaction Index-Mental Health; 12-item scale that scores each item on a 6-point scale; scores can range from 0 to 72, with a higher total score indicating higher satisfaction with mental health care Mean (SD)G1: 65.6 (5.7)G2: 63.0 (8.6)Between-group p=0.38 | Adverse events post-treatment (14 weeks)No adverse events occurred;none of the participants discontinued treatment due to adverse events |
| Mohr (2012); [26-29](#_ENREF_26" \o "Mohr, 2012 #2174)Telephone Versus Face-to-Face Administration of CBT for Depression Mohr (2012); [26-29](#_ENREF_26" \o "Mohr, 2012 #2174)Telephone Versus Face-to-Face Administration of CBT for Depression(continued)Mohr (2012); [26-29](#_ENREF_26" \o "Mohr, 2012 #2174)Telephone Versus Face-to-Face Administration of CBT for Depression(continued)Mohr (2012); [26-29](#_ENREF_26" \o "Mohr, 2012 #2174)Telephone Versus Face-to-Face Administration of CBT for Depression(continued)Mohr (2012); [26-29](#_ENREF_26" \o "Mohr, 2012 #2174)Telephone Versus Face-to-Face Administration of CBT for Depression(continued)Mohr (2012); [26-29](#_ENREF_26" \o "Mohr, 2012 #2174)Telephone Versus Face-to-Face Administration of CBT for Depression(continued)Mohr (2012); [26-29](#_ENREF_26" \o "Mohr, 2012 #2174)Telephone Versus Face-to-Face Administration of CBT for Depression(continued)Mohr (2012); [26-29](#_ENREF_26" \o "Mohr, 2012 #2174)Telephone Versus Face-to-Face Administration of CBT for Depression(continued) | Condition: **Major Depressive Disorder**Provider: PhD-level psychologists with 2 days of initial training followed by weekly supervised training until competence criterion reachedSetting: General internal medicine or primary care clinicsCountry: United StatesFunder: National Institute of Mental Health Risk of bias: High or some concerns depending on outcome | Comparator (G1): Face-to-face CBTN=162Comparator type: In-person careIntervention (G2): T-CBTN=163Intervention type: Audio-only with supports for treating (replace other care with audio care) | Depressive symptom severity post-treatment (18 weeks), follow-up (6 months)[2](#_ENREF_26" \o "Mohr, 2012 #2174)[6](#_ENREF_26" \o "Mohr, 2012 #2174)Assessed using Patient Health Questionnaire-9 (PHQ-9) and a noninferiority analysisBaselineNo difference between groups (p=0.12), scores reflected moderately severe symptomsPost-treatment (18 weeks)No difference between groups (p=0.89), scores reflected mild symptoms; effect size d=‑0.02 (90% CI, -‑0.20 to 0.17) within the inferiority margin of d=0.41 (i.e., G2 noninferior to G1)Follow-up (6 months)Mean score favored G1 (p=0.004), although the mean score for both G1 and G2 reflected mild symptomsAmong those with problematic alcohol use[28](#_ENREF_28" \o "Kalapatapu, 2014 #1329)BaselineNo difference between groups (p=0.38), scores reflected moderately severe symptomsPost-treatment (18 weeks)No difference between groups (p=0.97), scores reflected mild symptoms Follow-up (6 months)No difference between groups (p=0.19), scores reflected mild symptoms Among those with baseline comorbid anxiety[29](#_ENREF_29" \o "Stiles-Shields, 2014 #1275)BaselineNo difference between groups (p>0.15), scores reflected moderately severe symptomsPost-treatment (18 weeks)Significant two-way interaction of treatment assignment and presence or absence of baseline comorbid anxiety (p=0.002), scores reflected mild symptoms Depression severity post-treatment (18 weeks), follow-up (6 months)[26](#_ENREF_26" \o "Mohr, 2012 #2174)Assessed using Hamilton Depression Scale (HAM-D) and a noninferiority analysisBaselineNo difference between groups (p=0.77), scores reflected moderate depressionPost-treatment (18 weeks)No difference between groups (p=0.22), scores reflected mild depression; effect size d=0.14 (90% CI, -0.05 to 0.33) within the inferiority margin of d=0.41 (i.e., G2 noninferior to G1)Follow-up (6 months)Mean score favored G1 (p<0.001), although the mean scores for both G1 and G2 reflected mild depression Among those with problematic alcohol use[28](#_ENREF_28" \o "Kalapatapu, 2014 #1329)BaselineNo difference between groups (p=0.96), scores reflected moderate depressionPost-treatment (18 weeks)No difference between groups (p=0.93), scores reflected mild depressionFollow-up (6 months)No difference between groups (p=0.15), scores reflected mild depressionAmong those with baseline comorbid anxiety[29](#_ENREF_29" \o "Stiles-Shields, 2014 #1275)BaselineNo difference between groups (p>0.15), although the mean score for G1 reflected the top of the moderate depression range and the mean score for G2 reflected the bottom of the severe depression rangePost-treatment (18 weeks)Significant two-way interaction of treatment assignment and presence or absence of baseline comorbid anxiety (p=0.001), scores reflected mild depressionTreatment response post-treatment (18 weeks)[26](#_ENREF_26), [27](#_ENREF_27)Assessed using the Abbreviated HAM-D 7-item scale; participants who achieved a 50% decrease in symptomsG1 (n=141): 49.0%G2 (n=152): 44.0%p=0.40Baseline HAM-D scores <23 predicted treatment response[27](#_ENREF_27" \o "Stiles-Shields, 2015 #1174)Baseline PHQ-9 scores of <17 predicted treatment response[27](#_ENREF_27" \o "Stiles-Shields, 2015 #1174)Subgroup of participants with problematic alcohol use[28](#_ENREF_28" \o "Kalapatapu, 2014 #1329)G1 (n=47): 53.2%G2 (n=45): 48.9%X2=0.17 (df=1), p=0.68Meet diagnostic criteria[26](#_ENREF_26" \o "Mohr, 2012 #2174) post-treatment (18 weeks from baseline), follow-up (6 months)Assessed using the Mini International Neuropsychiatric InterviewPost-treatment (18 weeks)G1 (n=141): 25.0%G2 (n=152): 23.0%p=0.69Follow-up (6 months)G1 (n=133): 26.0%G2 (n=134): 29.0%p=0.57Subgroup of participants with problematic alcohol use[28](#_ENREF_28" \o "Kalapatapu, 2014 #1329)Post-treatment (18 weeks)G1 (n=47): 14.9%G2 (n=45): 20.0%X1=0.42 (df=1), p=0.52Remission[26](#_ENREF_26) post-treatment (18 weeks), follow-up (6 months)Assessed using the Abbreviated Ham-D 7-item scale criterion Post-treatment (18 weeks)G1 (n=141): 27.0%G2 (n=152): 27.0%p=0.95Follow-up (6 months)G1 (n=133): 32.0%G2 (n=134): 19.0%p=0.009Subgroup of participants with problematic alcohol use[28](#_ENREF_28" \o "Kalapatapu, 2014 #1329)Post-treatment (18 weeks)G1 (n=53): 41.5%G2 (n=50): 44.0%X1=0.07 (df=1), p=0.80 | NR | Discontinued treatment during and post-treatment (5 weeks, 18 weeks)[26](#_ENREF_26" \o "Mohr, 2012 #2174)Assessed using trial data; discontinued treatment before session 5 or did not complete all 18 sessions Before session 5G1 (n=141): 21 (13.0%)G2 (n=152): 7 (4.3%)G2 compared with G1: p=0.006Before session 18 G1 (n=141): 53 (32.7%)G2 (n=152): 34 (20.9%)G2 compared with G1: p=0.02Subgroup of participants with problematic alcohol use[28](#_ENREF_28" \o "Kalapatapu, 2014 #1329)G1 (n=53): 24.5%G2 (n=50): 26.0%X2=0.03 (df=1), p=0.86Sessions attended post-treatment (18 weeks)[26](#_ENREF_26), [29](#_ENREF_29)Assessed using trial data; number of sessions attended Mean (SD), median (interquartile range)G1 (n=141): 13.7 (6.1), 17 (11–18)G2 (n=152): 15.5 (4.4), 17 (16–18)G2 compared with G1: p=0.003Subgroup of participants with problematic alcohol use[28](#_ENREF_28" \o "Kalapatapu, 2014 #1329)Mean (SD), medianG1 (n=53): 15.0 (4.8), 17G2 (n=50): 14.7 (5.2), 17Ws=2,610.0, z=0.07, p=0.95 | NR | Adverse events during the study[26](#_ENREF_26)Events such as suicide, suicide attempt, psychiatric hospitalizationG1 (N=162): 0G2 (N=163): 0 |

CERED, Comparando Estrategias para Reducir el Estres y la Depresion; DSM-IV, *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition; ECLA-F, face-to-face Engagement and Counseling for Latinos; ECLA-T, telephone based ECLA; G, group; HAM-D/HDRS, Hamilton Depression Rating Scale; HOPE, Healthy Outcomes through Patient Empowerment; iCBT, internet-based cognitive behavioral therapy; LWWS, Living Well with Stroke; MI, motivational interviewing; NR, not reported; PHQ, Patient Health Questionnaire; SD, standard deviation; SF, short form; T-CBT, telephone-administered CBT.

# SDC Table 4. Detailed Evidence from Studies Targeting Post-Traumatic Stress Disorder

| **Author (Year);****Trial Name** | **Study Characteristics** | **Intervention and Comparator Arms** | **Clinical Outcomes** | **Patient-Reported Health/Quality-of-Life** | **Care Access/ Utilization** | **Care Quality/ Experience** | **Patient Safety** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Rosen (2013)[31](#_ENREF_31)Rosen (2013)[31](#_ENREF_31" \o "Rosen, 2013 #1561) (continued)Rosen (2013)[31](#_ENREF_31" \o "Rosen, 2013 #1561) (continued)Rosen (2013)[31](#_ENREF_31" \o "Rosen, 2013 #1561) (continued) | Condition: Post-traumatic Stress Disorder (PTSD)Provider: Clinical psychology graduate students supervised by clinical psychologistsSetting: Veterans Affairs residential PTSD treatment programsCountry: United StatesFunder: Not reportedRisk of bias: Some concerns | Comparator (G1): Standard aftercareN=425Comparator type: Referred or directed toIntervention (G2): Standard aftercare plus telephone monitoring and support N=412Intervention type: Audio-only with supports for transitioning care (supplement with audio care) | PTSD severity follow-up (4 months, 12 months) Assessed using PTSD Checklist BaselineSimilar scores (no test of significance) reflected probable PTSDFollow-up (4 months)No difference between groups (p=NR), scores reflected probable PTSDFollow-up (12 months)No difference between groups (p=NR), scores reflected probable PTSD | Quality-of-life follow-up (4 months, 12 months)Assessed using the 10-item Veterans Affairs Military Stress Treatment Assessment quality-of-life subscale; scores range from 1 to 7, with higher scores indicating greater satisfactionMean (SD) follow-up (4 months)G1 (n=NR): 3.2 (1.1)G2 (n=NR): 3.2 (1.1) d=-0.03Follow-up (12 months)G1 (n=NR): 3.3 (1.1)G2 (n=NR): 3.3 (1.1)d=0.00 | Call completion post-treatment (3 months; intervention arm only) Assessed using trial data; calls completed out of six planned callsCompleted at least 1 call355 (86%)Mean (SD)4.5 (1.6)Medication possession ratio follow-up (12 months)Assessed using the National Data Extracts for Pharmacy Database; for participants prescribed antidepressants, ratios were calculated as days’ supply of medications divided by total days; participants receiving telephone monitoring and support were expected to have higher medication possession ratios than those receiving standard referrals only Mean (SD) Among 758 participants prescribed antidepressantsG1: 0.62 (0.27)G2: 0.60 (0.26)Time to first outpatient mental health appointment (within 30 days of discharge)Assessed using the National Patient Care Database; number of participants completing a mental health visit within 30 days of discharge; participants receiving telephone monitoring and support were expected to have fewer days between discharge and attending a first outpatient mental health appointment than those receiving standard referrals onlyG1: 370 (87%)G2: 354 (86%)Mental health telephone visits (within 90-days of discharge)Assessed using the National Patient Care Database; telephone visits with mental health providers not delivered as part of the study; participants receiving telephone monitoring and support are expected to have more mental health visits than those receiving standard referrals only Mean (SD)G1: 1.3 (2.8)G2: 3.2 (4.1)t=8.0 (df=1,831), p<0.001Outpatient treatment visits follow-up (1 year) Assessed using the National Patient Care Database; number of in-person mental health or addiction treatment visits; participants receiving telephone monitoring and support were expected to have more mental health visits than those receiving standard referrals only Mean (SD)G1: 34.4 (39.9)G2: 37.8 (46.6)Re-hospitalizations follow-up (1 year)Assessed using the National Patient Care Database; re-hospitalizations in a psychiatric or substance use bed section and mental health and substance use outpatient treatment visits in the year after discharge; participants receiving telephone monitoring and support are hypothesized to have longer time to re-hospitalization than those receiving standard referrals onlyG1: 55 (13%)G2: 46 (11%)Time to rehospitalization was similar in both conditions | NR | Unintended effects or harms during the studyNone occurred |
| Rosen (2017)[32](#_ENREF_32" \o "Rosen, 2017 #949)Rosen (2017)[32](#_ENREF_32" \o "Rosen, 2017 #949) (continued)Rosen (2017)[32](#_ENREF_32" \o "Rosen, 2017 #949) (continued)Rosen (2017)[32](#_ENREF_32" \o "Rosen, 2017 #949) (continued)Rosen (2017)[32](#_ENREF_32" \o "Rosen, 2017 #949) (continued)Rosen (2017)[32](#_ENREF_32" \o "Rosen, 2017 #949) (continued) | Condition: Post-traumatic Stress Disorder (PTSD)Provider: Clinical psychology graduate students supervised by a clinical psychologistSetting: Outpatient mental health programs at Department of Veterans Affairs medical centers Country: United StatesFunder: Congressionally Directed Medical Research ProgramRisk of bias: Some concerns | Comparator (G1): UC N=165Comparator type: Synchronous in-person careIntervention (G2): Usual care plus telephone care management N=193Intervention type: Hybrid for transitioning care (supplement synchronous care interaction via audio) | PTSD severity follow-up (4 months, 12 months) Assessed using PTSD Checklist BaselineSimilar scores (no test of significance) reflected probable PTSDFollow-up (4 months)Similar scores (no test of significance) reflected probable PTSDFollow-up (12 months)Did not improve significantly over time and did not differ by group (p=NR) | Quality-of-life follow-up (4 months, 12 months)Assessed using 10-item Veterans Affairs Military Stress Treatment Assessment quality-of-life subscale; scores range from 1 to 7 with higher scores indicating greater satisfaction Mean (SD) follow-up (4 months)G1: 3.43 (1.10)G2: 3.34 (1.11) Follow-up (12 months)G1: 3.43 (1.12)G2: 3.48 (1.06)Regression estimate of incremental change over 12 monthsG2 compared with G1: 0.30, p=not significant | Medication possession ratio follow-up (12 months) Assessed using the Decision Support System Pharmacy National Data Extracts; for participants prescribed psychiatric medications, ratios were calculated as days’ supply of medication divided by total days; compared with participants receiving usual care only, those also receiving telephone care managementwere hypothesized to have higher medication possession ratios over the 3-month intervention period and 9 months follow-upSelective serotonin reuptake inhibitor or serotonin and norepinephrine reuptake inhibitor, Mean (SD)G1 (n=116): 0.57 (0.27)G2 (n=124): 0.54 (0.30)Incident rate ratio-0.03 (X2=0.58), p=0.45Prazosin, Mean (SD)G1 (n=51): 0.45 (0.27)G2 (n=36): 0.45 (0.29)Incident rate ratio-0.02 (X2=0.16), p=0.69Mental health visits post-treatment (3 months)Assessed using the National Patient Care Database; PTSD psychotherapy or other mental health visits; compared with participants receiving usual care only, those also receiving telephone care managementwere hypothesized to attend more mental health appointments over the 3-month intervention period and 9 months follow-upMean (SD)G1 (n=165): 4.1 (4.2)G2 (n=189): 5.9 (6.8)Incident rate ratio 1.36 (X2=6.56, df=1), p<0.01PTSD psychotherapy visits post-treatment (3 months), follow-up (12 months) Assessed using the National Patient Care Database; encounters with both a PTSD diagnosis and a psychotherapy procedure code; compared with participants receiving usual care only, those also receiving telephone care management were hypothesized to attend more mental health appointments over the 3-month intervention period and 9 months follow-upPost-treatment (3 months)No PTSD psychotherapy visitsG1 (n=165): 77 (47%)G2 (n=192): 67 (35%) Completed 8+ sessions of PTSD psychotherapy G1 (n=165): 16 (10%)G2 (n=192): 29 (15%)Mean (SD) G1 (n=165): 2.18 (3.26)G2 (n=189): 3.32 (5.24)Incident rate ratio 1.45 (X2=8.40, df=1), p<0.01Risk factors for low attendance (prior-year treatment visits, distance to care, treatment expectancies, therapeutic alliance, or being a veteran of Iraq or Afghanistan conflicts) did not moderate the effect of telephone care management on number of PTSD psychotherapy visits during the intervention periodFollow-up (12 months)G1 (n=165): 4.85 (7.99)G2 (n=189): 5.41 (11.83)Incident rate ratio1.10 (X2=0.59, df=1), p=0.44Other mental health visits post-treatment (3 months) follow-up (12 months)Assessed using the National Patient Care Database; defined as mental health visits without a PTSD diagnosis or visits for PTSD which did not include psychotherapy; compared with participants receiving usual care only, those also receiving telephone care management are hypothesized to attend more mental health appointments over the 3-month intervention period and 9 months follow-up Post-treatment (3 months)Mean (SD) G1 (n=165): 1.90 (2.10)G2 (n=189): 2.54 (2.96)Incident rate ratio1.26 (X2=3.14, df=1), p=0.07Risk factors for low attendance (prior-year treatment visits, distance to care, treatment expectancies, therapeutic alliance, or being a veteran of Iraq or Afghanistan conflicts) did not moderate the effect of telephone care management on number of other mental health visits during the intervention periodFollow-up (12 months)G1: 4.19 (5.32)G2: 5.71 (8.61)Incident rate ratio1.12 (X2=0.91, df=1), p=0.34 | NR | Adverse events follow-up (12 months)13 non-study related adverse events reported:1 hospitalized for alcohol withdrawal1 voluntarily entered residential alcohol treatment program2 had a psychiatric hospitalization for suicidal ideation5 hospitalized for medical reasons2 incarcerated2 were in car accidents |
| Gallegos (2015)[33](#_ENREF_33" \o "Gallegos, 2015 #1178)Gallegos (2015)[33](#_ENREF_33" \o "Gallegos, 2015 #1178)(continued) | Condition: Post-traumatic Stress Disorder (PTSD)Provider: Doctoral-level interventionists trained in the cognitive behavioral therapy (CBT) engagementSetting: Not reportedCountry: United StatesFunder: Not reportedRisk of bias: High | Comparator (G1): Wait-listN=150Comparator type: No careIntervention (G2): Telephone-administered CBTIntervention type: Audio-only for transitioning care (supplement with audio care) | PTSD severity during and post-treatment (1 month, 6 months) Assessed using PTSD Checklist Military Version BaselineSimilar scores (p=NR), reflected probable PTSD for all groupsDuring treatment (1 month)No significant group-by-gender effects (p=NR), scores reflected probable PTSDPost-treatment (6 months)Significant group-by-gender effects (p=0.0083) with significant reductions for females in G1 compared with females in G2 (p=0.048), males in G1 (p=0.036), and males in G2 (p=0.0057), although scores still reflected probably PTSD across groups and gender | NR | NR | NR | NR |

G, group; CBT, cognitive behavioral therapy; N, number; NR, not reported; PTSD, post-traumatic stress disorder; SD, standard deviation.

# SDC Table 5. Detailed Evidence from Studies Targeting Insomnia

| **Author (Year);****Trial Name** | **Study Characteristics** | **Intervention and Comparator Arms** | **Clinical Outcomes** | **Patient-Reported Health/QOL** | **Care Access/ Utilization** | **Care Quality/ Experience** | **Patient Safety** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Sunnhed (2020)[34](#_ENREF_34" \o "Sunnhed, 2020 #431)Sunnhed (2020)[34](#_ENREF_34" \o "Sunnhed, 2020 #431) (continued) | Condition: InsomniaProvider: Licensed clinical psychologist and master’s student at the end of their clinical training who were required to read all internet modules and a therapist manual and participate in a therapist workshop and allowed supervision on a need-to basisSetting: Not reportedCountry: SwedenFunder: VetenskapsrådetRisk of bias: Some concerns | Comparator (G1): Wait-listN=74Comparator type: No careIntervention (G2): Telephone-administered cognitive therapy N=72Intervention type: Audio-only with supports for monitoring (supplement with audio care)Intervention (G3): Telephone-administered behavioral therapy N=73Intervention type: Audio-only with supports for monitoring (supplement with audio care) | Insomnia severity post-treatment (10 weeks)Assessed using the Insomnia Severity Index (ISI)BaselineSimilar scores (no test of significance) reflected moderately severe clinical insomniaPost-treatment (10 weeks)Differential change favored G2 (p<0.001) and G3 (p<0.001) over G1, with scores for G2 and G3 reflecting subthreshold insomnia and scores for the G1 reflecting moderately severe clinical insomniaTreatment response post-treatment (10 weeks)Assessed using ISI; defined as achieving a change of 8 points or moreN (%)G1 (n=74): 8 (10.8%)G2 (n=67): 50 (74.6%)G3 (n=70): 41 (58.6%)G1/G2, estimate (SE)=3.34 (0.49), p<0.001, OR: 28.34G1/G3, estimate (SE)=2.73 (0.47), p<0.001, OR: 15.27 Treatment remission post-treatment (10 weeks)Assessed using ISI; defined as achieving a final score below 8N (%)G1 (n=74): 2 (2.7%)G2 (n=67): 24 (35.8%)G3 (n=70): 28 (40.0%)G1/G2, estimate (SE)=3.12 (0.74), p<0.001, OR: 22.57G1/G3, estimate (SE)=3.19 (0.74), p<0.001, OR: 24.26 | Functional impairment post-treatment (10 weeks)Assessed using the Work and Social Adjustment Scale; higher scores indicate higher severityMean (SD)G1 (n=74): 17.2 (9.5)G2 (n=66): 9.4 (7.8)G3 (n=70): 9.7 (8.4)Mean difference (95% CI), effect sizeG1/G2: -7.529 (‑10.469, -4.589), 0.879, p<0.001G1/G3: -7.844 (‑10.644, -5.044), 0.915, p<0.001Quality-of-life post-treatment (10 weeks)Assessed using the Brunnsviken Brief Quality of Life (BBQ); higher score indicate higher quality-of-lifeMean (SD)G1 (n=74): 52.1 (21.8)G2 (n=65): 59.8 (18.2)G3 (n=70): 59.6 (21.7)Mean difference (95% CI), effect sizeG1/G2: 7.735 (1.234, 14.237), 0.388, p<0.001G1/G3: 7.793 (0.759, 14.827), 0.391, p=not significant | Treatment dropout post-intervention (10 weeks; intervention arms only)Assessed using trial dataG2 (n=71): 12 (16.9%)G3 (n=73): 10 (13.7%)Adherence to treatment post-intervention (10 weeks; intervention arms only)Assessed using the trial dataMean (SD) modules reachedG2: 8.89 (2.5)G3: 9.05 (2.5)Mean (SD) support callsG2: 8.41 (2.6)G3: 8.86 (2.6)Percent exercises completedG2: 77.1%G3: 81.6% | Treatment satisfaction post-intervention (10 weeks; intervention arms only)Assessed using the Client Satisfaction Questionnaire-8; higher scores indicate higher satisfactionMean (SD)G2 (n=71): 25.7 (4.6)G3 (n=73): 25.2 (5.7)“Both therapies were rated with high credibility, expectancy, and client satisfaction” (Page 7) | Adverse events due to therapy post-treatment (10 weeks) Such as low mood, fatigue/exhaustion, and feeling irritableG2 (N=72): 14.1% G3 (N=73): 43.2%  |
| Arnedt (2013)[35](#_ENREF_35" \o "Arnedt, 2013 #1524)Arnedt (2013)[35](#_ENREF_35" \o "Arnedt, 2013 #1524) (continued)Arnedt (2013)[35](#_ENREF_35" \o "Arnedt, 2013 #1524) (continued)Arnedt (2013)[35](#_ENREF_35" \o "Arnedt, 2013 #1524) (continued) | Condition: **Insomnia**Provider: Clinical psychologists with expertise in cognitive behavioral therapy for insomnia (CBT‑I)Setting: Primary care outpatient clinicsCountry: United StatesFunder: National Center for Research ResourcesRisk of bias: High | Comparator (G1): Information pamphletN=15Comparator type: Educational resourceIntervention (G2): Telephone-based CBT-IN=18 (3 withdrew prior to treatment)Intervention type: Audio-only with supports for treating (supplement with audio care) | Insomnia severity post-treatment (8 weeks), follow-up (12 weeks [20 weeks from baseline]) Assessed using Insomnia Severity Index (ISI)BaselineSimilar scores (no test of significance) reflected moderately severe clinical insomniaPost-treatment (8 weeks)Mean scores reflected subthreshold insomnia for G1 and no clinical insomnia for G2 (no test of significance between groups)Follow-up (12 weeks)While significant time effects (p<0.001), no group-by-time interaction (p=0.23) with mean scores reflecting subthreshold insomnia for G1 and no clinical insomnia for G2Treatment response post-treatment (8 weeks), follow-up (12 weeks [20 weeks from baseline])Assessed using ISI; participants who achieved a score that was >8 points less than their pretreatment scorePost-treatment (8 weeks)G1 (n=15): 7 (46.7%)G2 (n=15): 13 (86.7% )G2 (n=15) compared with G1 (n=15): 5.40, p<0.02Follow-up (12 weeks)G1 (n=12): 6 (50.0%)G2 (n=15): 9 (60.0%)G2 (n=15) compared with G1 (n=12): 1.20, p=not significantRemission post-treatment (8 weeks from baseline), follow-up (12 weeks [20 weeks from baseline])Assessed using ISI; participants who achieved a score ≤7Post-treatment (8 weeks)G1 (n=15): 6 (40.0%)G2 (n=15): 11 (73.3%)G2 (n=15) compared with G1 (n=15): 3.39, p<0.06Follow-up (12 weeks) G1 (n=12): 5 (41.7%)G2 (n=15): 12 (80.0%)G2 (n=15) compared with G1 (n=12): 6.65, p<0.01 | Quality-of-life post-treatment (8 weeks from baseline), follow-up (12 weeks [20 weeks from baseline])Assessed using the Short Form Health Survey Mean physical health composite (SD) post-treatment (8 weeks)G1 (n=15): 40.9 (7.7)G2 (n=15): 42.7 (3.2)Follow-up (12 weeks)G1 (n=12): 42.2 (5.6)G2 (n=15): 42.7 (3.0)Group-by-time interactionp=0.65Mean mental health composite (SD) post-treatment (8 weeks)G1 (n=15): 48.8 (4.4)G2 (n=15): 47.4 (5.7)Follow-up (12 weeks)G1 (n=12): 45.0 (8.0)G2 (n=15): 49.2 (3.6)Group-by-time interactionp=0.09 | Call completion post-treatment (8 weeks; intervention arm only)Assessed using trial data; calls completed out of a possible 4–8 sessionsMean (SD)5.1 (1.7) | Fidelity post-treatment (8 weeks; intervention arm only)Assessed using the trial checklist; 10% of treatment sessions were randomly selected for independent review“Sessions were rated as being 100% pure and meeting all of the requirements for each session” (Page 358) | NR |

BBQ, Brunnsviken Brief Quality of Life; CBT-I, cognitive behavioral therapy for insomnia; G, group; ISI, Insomnia Severity Index; NR, not reported; OR, odds ratio; SD, standard deviation; SE, standard error; SF, short form.

# SDC Table 6. Detailed Evidence from Studies Targeting Schizophrenia

| **Author (Year);****Trial Name** | **Study Characteristics** | **Intervention and Comparator Arms** | **Clinical Outcomes** | **Patient-Reported Health/Quality-of-Life** | **Care Access/ Utilization** | **Care Quality/ Experience** | **Patient Safety** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Beebe (2017)[36](#_ENREF_36)Beebe (2017)[36](#_ENREF_36) (continued)Beebe (2017)[36](#_ENREF_36) (continued) | Condition: **Schizophrenia Spectrum Disorder**Provider: Graduate-prepared psychiatric nurse who provided telephone intervention problem solving (TIPS) in prior work, supervised by principal investigator Setting: Community mental health center Country: United StatesFunder: Not reportedRisk of bias: High  | Comparator (G1): Treatment as usualN=NRComparator type: In-person careIntervention (G2): TIPSN=NRIntervention type: Audio-only for monitoring (replace other care with audio care) | NR | NR | Medication adherence (6 months)Assessed using record review and pill counts in patient homes; pill measure of adherence was generated by dividing the number of pills missing from the bottle(s) by the number of pills prescribed within the time period covered by the current prescription; depot adherence percentage was the percentage of injections documented of the total injections ordered during the study period; if multiple medications were prescribed (psychiatric or nonpsychiatric), overall adherence was calculated by averaging the percentage adherence of all medications within that category; those receiving TIPS were hypothesized to have improved medication adherence% (SD) psychiatric medication adherenceG1: 63.9% (31.1)G2: 68.7% (27.2)G2 compared with G1: p=not significant% (SD) nonpsychiatric medication adherenceG1: 71.63% (26.2)G2: 66.6% (26.3)G2 compared with G1: p=not significantAntipsychotic medication adherence (6 months)Assessed via labs; participants with serum antipsychotic medication levels within therapeutic range; those receiving TIPS were hypothesized to have improved medication adherenceG1: 32.7%G2: 54.7%G2 compared with G1: X2=5.2,p=0.023 | NR | NR |

G, group; NR, not reported; SD, standard deviation; TIPS, telephone intervention problem solving.

# SDC **Table 7. Detailed Evidence from Studies Targeting Substance Use Disorders**

| **Author (Year);****Trial Name** | **Study Characteristics** | **Intervention and Comparator Arms** | **Clinical Outcomes** | **Patient-Reported Health/Quality-of-Life** | **Care Access/ Utilization** | **Care Quality/ Experience** | **Patient Safety** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Timko (2019)[37](#_ENREF_37) | Condition: Dual Diagnosis of any Mental Health and any Substance Use DisorderProvider: Licensed, master’s-level clinical social workersSetting: Inpatient psychiatry facilities Country: United StatesFunder: U.S. Department of Veterans AffairsRisk of bias: High | Comparator (G1): Usual careN=199Comparator type: Synchronous in-person visitsIntervention (G2): Usual care plus telephone monitoringN=207Intervention type: Audio-only for transitioning care (supplement with audio care) | Alcohol use, drug use, and psychological problem days (past 30 days) post-treatment (3 months), follow-up (15 months)Assessed using Addiction Severity Index (ASI) BaselineSimilar (no test of significance)Post-treatment (3 months)No difference between groups (overlapping confidence intervals)Follow-up (15 months)No difference between groups (p>0.05) | NR | Calls completed post-treatment (12 weeks; intervention arm only)Assessed using trial data Completed at least one call180 (87%)Mean (SD, range) calls completed7.6 (3.2, 0–12)Completed 12 calls26 (14%) | NR | NR |
| Timko (2019)[38](#_ENREF_38)Timko (2019)[38](#_ENREF_38) (continued)Timko (2019)[38](#_ENREF_38) (continued) | Condition: Alcohol or Opioid Use DisorderProvider: Masters-level telecoaches with regular supervision from doctoral-level, licensed clinicians, all with formal motivational interviewing training and experienceSetting: Psychiatry unitsCountry: United StatesFunder: Department of Veterans Affairs, Health Services Research and Development ServiceRisk of Bias: High or low depending on outcome | Comparator (G1): Usual careN=150Comparator type: In-person careIntervention (G2): Usual care plus Enhanced Telephone Monitoring N=148Intervention type: Audio-only for transitioning care (supplement with audio care) | Alcohol use days (past 30 days) post-treatment (3 months), follow-up (6 months)Assessed using ASI BaselineNo difference between groups (p=0.612)Post-treatment (3 months)Fewer days for G2 (p=0.029)Follow-up (6 months)No difference between groups (p=0.377)Alcohol severity post-treatment (3 months), follow-up (6 months)Assessed using ASI BaselineNo difference between groups (p=0.966)Post-treatment (3 months)Mean scores favored G2 (p=0.048)Follow-up (6 months)No difference between groups (p=0.851)Opioid use days (past 30 days) post-treatment (3 months), follow-up (6 months)Assessed using ASI BaselineNo difference between groups (p=0.671)Post-treatment (3 months)Fewer days for G2 (p=0.032)Follow-up (6 months)No difference between groups (p=0.438)Drug severity post-treatment (3 months), follow-up (6 months)Assessed using ASI BaselineNo difference between groups (p=0.613)Post-treatment (3 months)Mean scores favor G2 (p=0.024)Follow-up (6 months)No difference between groups (p=0.150) | NR | Calls completed post-treatment (12 weeks; intervention arm only)Assessed using appointment recordsMean (SD)G2 (n=148): 7.5 (3.2) | Provider fidelity post-treatment (12 weeks; intervention arm only) Assessed using the Motivational Interviewing Treatment Integrity Code; scores ranged from 1–5 with higher scores indicating better fidelityMean (SD) Softening Sustain Talk: 3.6 (0.6)Partnership: 4.1 (0.5) Empathy: 4.1 (0.2)Cultivating Change Talk: 4.3 (0.4) | NR |
| McKellar (2012)[39](#_ENREF_39)McKellar (2012)[39](#_ENREF_39)(continued) | Condition: Any Substance Use DisorderProvider: Postdoctoral fellows in clinical psychologySetting: Department of Veterans Affairs intensive outpatient substance use disorder treatment siteCountry: United StatesFunder: United States Department of Veterans AffairsRisk of bias: High  | Comparator (G1): In-person continuing care as usual N=454Comparator type: In-person group-based careIntervention (G2): Telephone case monitoringN=213Intervention type: Audio-only with supports for transitioning care (replace other care with audio care) | Percentage days abstinent from alcohol post-treatment (3 months), follow-up (1 year)Assessed using ASI BaselineNo difference between groups (p=0.99)Post-treatment (3 months)No difference between groups (p>0.05)Each call was associated with 0.43 increase in days abstinent (p=0.05)Follow-up (1 year)No difference between groups (p>0.05)Percentage days abstinent from drugs post-treatment (3 months), follow-up (1 year)Assessed using ASI BaselineNo difference between groups (p=0.76)Post-treatment (3 months)Higher percentage of days abstinent for G2 (p<0.05)Each call was associated with about 0.42 increase in days abstinent (p<0.05)Follow-up (1 year)No difference between groups (p>0.05) | Quality-of-life post-treatment (3 months), follow-up (1 year)Assessed using the Short Form Health Survey (SF-12); higher scores indicate better quality-of-lifeMean physical health composite post-treatment (3 months)G1: 44.9 G2: 45.6No effect of telephone care Follow-up (1 year)G1: 42.7G2: 43.2No effect of telephone careMean mental health composite post-treatment (3 months)G1: 35.1 G2: 36.2No effect of telephone care Follow-up (1 year)G1: 40.1G2: 40.8No effect of telephone care | NR | Satisfaction post-treatment (3 months)Assessed using the Client Satisfaction Questionnaire; scores ranged from 8 to 32, with higher scores indicating higher satisfaction MeanG1: 26.5 G2: 27.3No effect of telephone care | NR |
| Lucht (2021);[40](#_ENREF_40) Continuity of Care among Alcohol‐Dependent Patients via Mobile Phone SMS Study (CAPS)Lucht (2021);[40](#_ENREF_40) CAPS (continued) | Condition: **Alcohol Use Disorder**Provider: Psychiatrists, psychologists, nurses, or medical assistants with no specific training except for an introduction to the interactive systemSetting: Inpatient addiction disorder units at psychiatric hospitalsCountry: GermanyFunder: German Research CouncilRisk of bias: Some concerns  | Comparator (G1): Treatment as usualN=233Comparator type: Referred or directed to seek health care as neededIntervention (G2): Treatment as usual plus short messaging service interventionN=230Intervention type: Audio-only with supports for transitioning care (supplement with audio care) | Heavy drinking days (past 360 days) follow-up (12 months)Assessed using FORM-90 BaselineNRFollow-up (12 months)No difference between groups (p=0.68)Level of alcohol consumption follow up (12 months)Assessed using the FORM-90 Quick Drinking Assessment Interview and Subject Telephone Assessment of Drinking and Related Behaviors; consumption during the last 3 months categorized as:Heavy drinking (men >60 g/day, women >40 g/day), nonheavy drinking (men <60 g/day, women <40 g/day), or abstinenceFollow-up (12 months)G1: Abstinent: 98 (42.2)Nonheavy drinking: 59 (25.4)Heavy drinking: 75 (32.3)G2:Abstinent: 104 (45.2)Nonheavy drinking: 75 (32.6)Heavy drinking: 51 (22.2)Adjusted OR (95% CI) for G1 (n=232) compared with G2 (n=230)Heavy drinking vs. nonheavy drinking or abstinence: 1.78 (1.17 to 2.69)Drinking vs. abstinence: 1.11 (0.77 to 1.61) | NR | NR | NR | Serious events follow-up (12 months) Assessed “relative to the definition in the study protocol” (Page 116)G1 (n=232): 0G2 (n=230): 0 |
| McKay (2022)[41](#_ENREF_41)McKay (2022)[41](#_ENREF_41) (continued)McKay (2022)[41](#_ENREF_41) (continued)McKay (2022)[41](#_ENREF_41) (continued) | Condition: **Alcohol Use Disorder**Provider: Therapists with 2–25 years of experience treating substance use disorders and supervised by a licensed psychologistSetting: Publicly funded intensive outpatientCountry: United StatesFunder: National Institute on Alcohol Abuse and AlcoholismRisk of bias: High  | Comparator (G1): Treatment as usualN=65Comparator type: In-person careIntervention (G2): Treatment as usual plus telephone monitoring and counselingN=59Intervention type: Hybrid for monitoring (supplement with audio care)Comparator (G3): Treatment as usual plus Addiction Comprehensive Health Enhancement Support System (A-CHESS)N=68Comparator type: In-person care with supportsIntervention (G4): Treatment as usual plus telephone monitoring and counseling plus A-CHESSN=70Intervention type: Hybrid with supports for monitoring (supplement with audio care) | Percentage of days heavy drinking at post-treatment (12-month), follow-up (18 months) Assessed using the time-line follow-back (TLFB) BaselineSimilar (no test of significance)Post-treatment (12 months)Favored G2 over G1 (p=0.018) and G4 over G1 (p=0.009), no difference between G2 and G3 (p=0.732) or between G3 and G4 (p=0.661)Follow-up (18 months)No difference between G1 and G2 (p=0.576), G1 and G4 (p=0.434), G2 and G3 (p=0.405), or G3 and G4 (p=0.663)Any alcohol use post-treatment (12 months, 18 months)Assessed using TLFB; percentage of participants reporting alcohol usePost-treatment (12 months)Mean % (SE)G1 63.83 (7.08)G2 46.15 (8.09) G3 47.92 (7.29)G4 53.19 (7.36)Adjusted log OR (95% CI) G1/G2: 1.10 (0.26 to 1.94), p=0.010G1/G4: 0.89 (0.13 to 1.65), p=0.025G2/G3: -0.46 (‑1.30 to 0.38), p=0.276G3/G4: 0.25 (‑0.51 to 1.01), p=0.526Follow-up (18 months), mean % (SE)G1 51.02 (7.22)G2 50.00 (8.70) G3 44.19 (7.66)G4 43.14 (7.00) Adjusted log OR (95% CI)G1/G2: -0.17 (‑1.09 to 0.75), p=0.715G1/G4: -0.48 (‑1.34 to 0.38), p=0.275G2/G3: -0.31 (‑1.25 to 0.63), p=0.520G3/G4: -0.00 (‑0.88 to 0.88), p=0.996Any drug use (cocaine, amphetamines, opiates, barbiturates, benzodiazepines, or tetrahydrocanna-binol) post-treatment (12 months), follow-up (18 months)Assessed using TLFB, ASI, and urine drug screens; percentage of participants reporting or testing positive for drug use Post-treatment (12 months)Mean % (SE)G1 68.09 (6.87)G2 61.54 (7.89)G3 54.17 (7.27)G4 44.68 (7.33) Adjusted log OR (95% CI)G1/G2: -0.03 (‑0.87 to 0.81), p=0.938G1/G4: 0.38 (‑0.40 to 1.16), p=0.340G2/G3: 0.24 (‑0.58 to 1.06), p=0.573 G3/G4: 0.18 (‑0.60 to 0.96), p=0.651Follow-up (18 months), mean % (SE)G1: 65.31 (6.87)G2: 61.76 (8.46)G3: 55.81 (7.56)G4: 49.02 (7.07)Adjusted log OR (95% CI)G1/G2: 0.23 (‑0.75 to 1.21), p=0.653G1/G4: -0.48 (‑1.34 to 0.38), p=0.281G2/G3: -0.67 (‑1.69 to 0.35), p=0.200G3/G4: -0.03 (‑0.95 to 0.89), p=0.945 | Negative consequences of alcohol use post-treatment (12 months), follow-up (18 months)Assessed using the Short Inventory of Problems total score; higher scores indicate more negative consequences for drinkingPost-treatment (12 months)Mean % (SE)G1 12.55 (2.01)G2 10.46 (2.37) G3 10.04 (1.91)G4 12.15 (2.24)Adjusted log OR (95% CI)G1/G2: 1.82 (‑2.16 to 5.80), p=0.370G1/G4: 1.35 (‑2.37 to 5.07), p=0.478G2/G3: -0.23 (‑4.21 to 3.75), p=0.910G3/G4: -0.24 (‑3.96 to 3.48), p=0.900Follow-up (18 months), mean % (SE)G1 12.58 (1.98)G2 13.00 (2.70)G3 12.30 (2.27)G4 12.69 (2.09)Adjusted log OR (95% CI)G1/G2: -1.37 (‑7.49 to 4.75), p=0.661G1/G4: 0.42 (‑5.17 to 6.01), p=0.882G2/G3: 2.61 (‑4.23 to 9.45), p=0.454G3/G4: -0.82 (‑6.94 to 5.30), p=0.793Quality-of-life post-treatment (12 months, follow-up (18 months)Assessed using the SF-12; higher scores indicate worse quality-of-lifeMental health composite post-treatment (12 months)Mean % (SE) G1 65.96 (3.26)G2 61.22 (3.78)G3 63.80 (3.19)G4 60.11 (4.03)Adjusted log OR (95% CI)G1/G2: 4.31 (‑1.84 to 10.46), p=0.170G1/G4: 3.58 (‑2.10–9.26), p=0.217G2/G3: -1.36 (‑7.48 to 4.76), p=0.663G3/G4: 0.64 (‑5.08 to 6.36), p=0.827Follow-up (18 months)G1 67.75 (3.16)G2 61.43 (4.39)G3 64.49 (3.33)G4 61.76 (3.44)Adjusted log OR (95% CI)G1/G2: 8.62 (‑1.30 to 18.54), p=0.088G1/G4: 5.95 (‑3.03 to 14.93), p=0.194G2/G3: -4.78 (‑14.72 to 5.16), p=0.347G3/G4: 2.10 (‑7.13 to 11.33), p=0.656Physical health composite post-treatment (12 months)Mean % (SE)G1 63.83 (5.26)G2 64.10 (4.64)G3 64.58 (4.76)G4 57.98 (5.38)Adjusted log OR (95% CI)G1/G2: 2.93 (‑5.95 to 11.81), p=0.518G1/G4: 5.45 (‑2.74 to 13.64), p=0.193G2/G3: -3.54 (‑12.40 to 5.32), p=0.434G3/G4: 6.05 (‑2.14 to 14.24), p=0.148Follow-up (18 months)G1: 65.50 (4.51)G2: 73.57 (4.69)G3: 63.64 (5.17)G4: 67.65 (4.71)Adjusted log OR (95% CI) G1/G2: -4.04 (‑16.68 to 8.60), p=0.531G1/G4: -1.72 (‑12.52 to 9.08), p=0.755G2/G3: 5.67 (‑7.72 to 19.06), p=0.407G3/G4: -3.35 (‑15.09 to 8.39), p=0.576 | Sessions attended post-treatment (12 months, intervention arms only)Assessed using trial data; mean number of sessions completed G2: 8.1 sessions G4: 10.7 sessions | NR | NR |
| McKay (2013)[42-44](#_ENREF_42)McKay (2013)[42-44](#_ENREF_42) (continued)McKay (2013)[42-44](#_ENREF_42) (continued)McKay (2013)[42-44](#_ENREF_42) (continued)McKay (2013)[42-44](#_ENREF_42) (continued)McKay (2013)[42-44](#_ENREF_42) (continued) | Condition: **Cocaine Use Disorder**Provider: Therapists (BA, MA, and PhD levels) with prior experience providing outpatient treatment for substance use disordersSetting: Intensive outpatient programsCountry: United StatesFunder: National Institute on Drug AbuseRisk of bias: Some concerns  | Comparator (G1): Treatment as usualN=108Comparator type: In-person careIntervention (G2): Treatment as usual plus telephone monitoring and counseling N=106Intervention type: Hybrid for monitoring (supplement with audio care)Intervention (G3): Treatment as usual plus telephone monitoring and counseling plus incentives N=107Intervention type: Hybrid with supports for monitoring (supplement with audio care) | Days abstinent at post-treatment (24 months)[44](#_ENREF_44)Assessed using ASIBaselineNRPost-treatment (24 months)More days abstinent in G2 compared with G1 and similar between G3 and G1 (no test of significance)Positive urine screen during and post-treatment (3 months, 24 months)[42](#_ENREF_42)Assessed using urine toxicology; established cutoffs for drug positive resultsDuring treatment (3 months)G1 (n=89): 28 (31.0%)G2 (n=76): 17 (22.0%)G3 (n=83): 17 (20.0%)Post-treatment (24 months)G1 (n=69): 26 (38.0%)G2 (n=80): 21 (26.0%)G3 (n=75): 26 (35.0%)Treatment condition main effects G2 vs. G1: z= ‑1.31, p=0.19G3 vs. G1: z= ‑0.95, p=0.34Subgroup of participants with current cocaine use at baseline: G2 vs. G1: z=‑1.23, p=0.218G3 vs. G1: z=‑2.13, p=0.33Subgroup of participants without current cocaine use at baseline:G2 vs. G1: z=‑0.58, p=0.562G3 vs. G1: z=0.76, p=0.448Subgroup of participants with current alcohol use at baseline: G2 vs. G1: z=-0.84, p=0.401G3 vs. G1: z= ‑0.88, p=0.376Subgroup of participants without current alcohol use at baseline: G2 vs. G1: z=‑1.10, p=0.271G3 vs. G1: z= ‑0.73, p=0.468No moderator-by-treatment interaction effect for gender, controlled environment prior to intensive outpatient, prior drug treatments, cognitive and motivational factors, psychiatric factors, and family-social factors[43](#_ENREF_43) Abstinence composite (no cocaine use, no use of other drugs of abuse, no heavy alcohol use) during and post-treatment (3 months, 24 months)[42](#_ENREF_42)Assessed TLFB, ASI, and urine drug screens; percentage of participants reporting or testing positive for drug use During treatment (3 months)G1 (n=99): 44 (44.0%)G2 (n=97): 56 (58.0%)G3 (n=97): 46 (47.0%)Post-treatment (24 months)G1 (n=77): 25 (32.0%)G2 (n=82): 34 (41.0%)G3 (n=80): 29 (36.0%)Treatment condition main effectsG2 vs. G1: z= 0.44, p=0.66G3 vs. G1: z= 0.22, p=0.83Subgroup of participants with current cocaine use at baseline: G2 vs. G1: z=2.03, p=0.042G3 vs. G1: z=1.48, p=0.139Subgroup of participants without current cocaine use at baseline:G2 vs. G1: z=-0.87, p=0.385G3 vs. G1: z=-1.04, p=0.297Subgroup of participants with current alcohol use at baseline:G2 vs. G1: z=2.69, p=0.007G3 vs. G1: z=1.69, p=0.091Subgroup of participants without current alcohol use at baseline:G2 vs. G1: z=-0.68, p=0.500G3 vs. G1: z=-0.47, p=0.641No moderator-by-treatment interaction effect for gender, controlled environment prior to intensive outpatient, prior drug treatments, cognitive and motivational factors, psychiatric factors, and family-social factors[43](#_ENREF_43) | NR | Sessions attended post-treatment (24 months; intervention arms only)[42](#_ENREF_42), [44](#_ENREF_44)Assessed using trial data; number of continuing care sessions completed among those who completed their orientation sessionMean (SD)G2: 15.5 (14.1)G3: 26.0 (12.8)(G2 compared with G3 is not an eligible comparison) | Adherence to treatment post-treatment (24 months; intervention arms only)[42](#_ENREF_42)Assessed using the 12-item checklist; 5% of sessions were randomly selected and scored by trained clinicians “Overall, the treatments were provided in a manner highly consistent with the protocol” (Page 8)(G2 compared with G3 is not an eligible comparison) | NR |

A-CHESS, Addiction Comprehensive Health Enhancement Support System; ASI, Addiction Severity Index; CAPS, Continuity of Care Among Alcohol‐Dependent Patients via Mobile Phone SMS Study; CI, confidence interval; G, group; N, number; NR, not reported; OR, odds ratio; SD, standard deviation; SE, standard error; SF, Short-Form Health Survey; TLFB, timeline follow-back.