Bilaga 1. Tabeller över beskrivning av inkluderade studier (hög eller medelhög kvalitet)

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence **Amato et al (2011) [21]** **Study quality: High**	**Objectives:** To evaluate the effectiveness of any psychosocial plus any agonist maintenance treatment versus standard agonist treatment for opiate dependence	**Population:** Opiate addicts undergoing any psychosocial associated with any agonist maintenance intervention Patients with polysubstance abuse were included provided that they were also opioid dependent **Interventions:** Psychosocial plus agonist maintenance interventions of any kind (any psychosocial and any drug) **Comparison/control:** Any agonist treatments alone for opiate maintenance therapy **Outcomes:** *Primary outcomes* 1. Retention in treatment 2. Abstinence by primary substance measured as number of participants with consecutive	**Characteristics of included studies:** 35 studies **Country of origin:** 31 studies were conducted in USA, one in Germany and one in Malaysia, one in China, one in Scotland **Population:** 4,319 opiate addicts: 73% were male, one study did not report information on gender Average age was 35 years (range 27 to 45) **DSM/ICD:** Not reported **Substance use:** Opiate **Comorbidity or factors that may affect the substance use:** Not reported **Interventions:** 13 different psychosocial interventions	“For the considered outcomes, it seems that adding any psychosocial support to standard maintenance treatments do not add additional benefits. Data do not show differences also for contingency approaches, contrary to all expectations. Duration of the studies was too short to analyse relevant outcomes such as mortality. It should be noted that the control intervention used in the studies included in the review on maintenance treatments, is a program that routinely offers counselling sessions in addition to methadone; thus the review, actually, did not evaluate the question of whether any ancillary psychosocial intervention is needed when methadone maintenance is provided, but the narrower question of whether a specific

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		negative urinalysis for at least three weeks 3. Results at follow-up as number of participants still in treatment at the end of follow-up or opioid abstinent at the end of follow-up *Secondary outcomes* 1. Compliance as number of psychosocial sessions attended 2. Craving 3. Psychiatric symptoms/psychological distress 4. Quality of life 5. Severity of dependence 6. Death **Study design:** RCT's and CCT's **Settings:** Not specified **Other criteria:** People less than 18 years of age and pregnant women were excluded because the pharmacological treatments for these people are often different from those offered to the general population, no restrictions for people with physical or psychological illness **Studies published**: Up to 2011	comparing any psychosocial plus any maintenance pharmacological treatment to standard maintenance treatment **Outcomes:** 1. Abstinence by opiate during the treatment 2. Compliance 3. Psychiatric symptoms 4. Depression 5. Participants still in treatment 6. Abstinent by opioid **Follow-up time**: Not specified **Settings:** Outpatients **Number of participants:** 4,319	more structured intervention provides any additional benefit to a standard psychosocial support. These interventions probably can be measured and evaluated by employing diverse criteria for evaluating treatment outcomes, aimed to rigorously assess changes in emotional, interpersonal, vocational and physical health areas of life functioning."
Peer-Delivered Recovery Support Services for	**Objectives:** To identify, appraise, and summarize the evidence of the effectiveness of	**Population:** People in recovery from addiction from alcohol and/or drugs	**Characteristics of included studies:** In total 9 studies focusing on peer-delivered	"This systematic review suggests the positive impact of peer-delivered recovery support

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Addictions in the United States: A Systematic Review **Bassuk et al (2016) [38]** **Study quality: Moderate**	peer-delivered recovery support services for individuals in recovery from addictions using strict scientific criteria	**Interventions:** Any intervention delivered by peers, recovery coaches, or other peer recovery support providers to help people in recovery from addiction was included, intervention types including telephone-based peer support, recovery programs, recovery centers, peer-run drop in centers, and access to recovery programs were included **Comparison/control:** A comparison group or multiple time points comparing the same group **Outcomes:** *Primary outcome* Substance use *Secondary outcomes* Other recovery-related outcomes, such as housing status, health, mental health, criminal justice status, quality of life, and service utilization **Study design:** Primary empirical quantitative studies (including mixed methods) conducted in the USA that used a randomised, experimental, quasi-experimental or controlled observational design, published in English **Settings:** Not specified	services by an individual peer support worker, 4 RCT's, 3 quasi-experimental studies, 1 comparison group study, and 1 program evaluation with no comparison group **Country of origin:** All studies were carried out in the USA **Population:** All studies focused on adults and reported the gender of participants, with a majority consisting of males **DSM/ICD:** Not reported **Substance use:** All studies focused on adults with alcohol or drug use problems, not specific to a certain substance, except for one study focusing on outpatient users of heroin or cocaine **Comorbidity or factors that may affect the substance use:** The majority of the studies focused on individuals with varying combinations of complex needs and challenges in addition to substance use disorders. 5 of the studies specifically focused on individuals with co-occurring substance use and mental health disorders. Several studies included or focused on individuals experiencing homelessness in addition to	services. As indicated by our findings, this is a promising area for the development of innovative program models involving peers as well as for future investigation. It is imperative that future studies address the methodological limitations described in this review so that we can develop a robust evidence base supporting peer-delivered recovery services."

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		Other criteria: Cross-sectional studies were excluded as were studies conducted among samples of fewer than 50 participants **Studies published:** Between 1998 and 2014	addiction and other challenges: one study targeted unemployed homeless veterans, another study noted that 46% of participants experienced homelessness and 3 studies focused on individuals transitioning back to the community from psychiatric inpatient treatment or criminal justice settings. **Interventions:** Both the interventions and the role of the peers varied widely across the studies. Some did not include detailed descriptions of the intervention or services provided by the peer. The intensity of the peer intervention ranged from a brief one-time motivational intervention delivered by a substance abuse outreach worker in recovery to a trained peer support worker who made home visits and accompanied individuals to community mutual aid groups. **Follow-up time**: Studies ranged in duration and outcomes were assessed at varying time intervals, ranging from 3 months to 3 years, with most studies following participants for 6 months to a year **Settings:** The setting in which services were delivered varied widely. The programs described	

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			in this set of studies were located in diverse settings including peer-run drop-in centers, peer-run recovery community organizations, and medical outpatient clinics, while others focused on individuals transitioning from residential or psychiatric inpatient care. **Number of participants:** The sample sizes of the studies ranged from 52 to 4,420 (mean = 765, median = 137)	
Systematic Review of Self-Management and Recovery Training (SMART) Recovery: Outcomes, Process Variables, and Implications for Research **Beck et al (2017) [39]** **Study quality: Moderate**	**Objectives:** To explore whether, for adults with experience of substance and/or behavioral addiction(s), SMART Recovery results in changes in the severity of addiction and its consequences and whether any observed changes are influenced by process variables (e.g. treatment engagement)	**Population:** Adults (ages ≥18) attending SMART Recovery with current or past problematic experience of at least one addictive behavior (substance and/or behavioral) **Interventions:** SMART Recovery delivered in a group format, of any intensity or frequency (including stand alone and/or as an adjunct), by a lay or professional facilitator **Comparison/control:** No control or could be compared to inactive and/or active conditions of any intensity, frequency, and delivery method **Outcomes:** SMART Recovery participants for at least one of the following: 1. severity of addiction and its consequences	**Characteristics of included studies:** 12 studies of which 8 were cross-sectional The effectiveness of SMART Recovery was explored in one RCT, one pre- and posttreatment (prepost) design, and one quasi-experimental pseudoprospective study Concurrent mental illness and substance use disorder was the focus of only one study **Country of origin:** Not specified **Population:** Mean age ranged from 34.2 to 51 The gender distribution (% male) ranged from 39% to 71%	"Although positive effects were found, the modest sample and diversity of methods prevent us from making conclusive remarks about efficacy. Further research is needed to understand the clinical and public health utility of SMART as a viable recovery support option."

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		2. process variables (e.g. treatment engagement) 3. feasibility. **Study design:** RCT's (cluster and parallel design), crossover trials, case series or case controls, one-arm trials, nonrandomised trials, cross-sectional or cohort studies, and case reports **Settings:** Community, rehabilitation, treatment, and/or correctional settings **Other criteria:** Not specified **Studies published**: Up to April 2016	The majority of participants were Caucasian Between 25% and 82% attained at least a college- or graduate-degree level of certification Employment (full- or part-time) ranged from 30.7% to 63% The proportion of individuals who were single or divorced ranged from 23% to 63.9% Average years of alcohol use ranged from 10 to 19.25 years The majority of participants reported prior treatment and/or multiple quit attempts. **DSM/ICD:** Not reported **Substance use:** The 2 studies that used AUDIT at baseline both reported scores >20 consistent with hazardous alcohol use and likely dependence Amphetamines (7.3%) and marijuana (3.3%) were variously identified as the most common self-reported primary nonalcohol substance of abuse. Self-reported multidrug use was as high as 70%	

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			Comorbidity or factors that may affect the substance use: From the data available, mental health problems and impairment were common **Intervention:** SMART Recovery **Outcomes:** Severity of addiction and its consequences, process variables, feasibility **Follow-up time**: Not specified **Settings:** Not specified for each study **Number of participants:** 7,655	
12-step programs for reducing illicit drug use **Bøg et al (2017) [22]** **Study quality: High**	**Objectives:** To systematically evaluate and synthesize effects of 12-step interventions for participants with illicit drug dependence against no intervention, treatment as usual, and alternative interventions	**Population:** Participants who have used one or more types of illicit drugs, regardless of gender and ethnic background **Interventions:** 12-step interventions **Comparison/control:** No intervention or other interventions **Outcomes:** *Primary outcome* The use of illicit drugs *Secondary outcomes* 1. Criminal behavior 2. Prostitution 3. Psychiatric symptoms	**Characteristics of included studies:** 10 studies of which 7 used an RCT design, 2 studies used a QRCT design, and 1 study used a QES design **Country of origin:** 9 of the studies were conducted in the USA, and 1 in the UK **Population:** Participants in the included studies had overall a long history of drug use, ranging from 5 to 19 years of drug addiction The mean age varied between 29 and 43 years	"The results of this review suggest that 12-step interventions to support illicit drug users are as effective as alternative psychosocial interventions in reducing drug use. This conclusion should be seen against the weight of evidence. A total of seven studies contributed data to analyses comparing 12-step interventions and alternative psychosocial interventions. The power to detect differences was low, and estimated effect sizes were small. In addition, most studies delivered treatment as group therapy, but did not correct the analysis for the dependence between

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		4. Social functioning 5. Employment status 6. Homelessness 7. Treatment retention **Study design:** RCT's and quasi-experimental studies **Settings:** Inpatient, outpatient, or self-help groups **Other criteria:** Not specified **Studies published**: Until September 2016	The number of males and females were approximately equal in 3 studies In 5 studies the participants were predominantly white Caucasian, in 3 studies most participants were African American, and 2 studies reported a combination of ethnic groups **DSM/ICD:** Not specified **Substance use:** Drug dependence in some studies specified as opioid abuse or cocaine or methadone dependence **Comorbidity or factors that may affect the substance use:** 5 studies reported that minimum a third of the participants had some kind of mental disorder, including depression, personality disorder, and antisocial personality disorder, 1 study reported that 24% of the participants met the criteria for current major depression disorder, and 2 studies reported psychiatric problem severity using the ASI Composite Score **Interventions:** 12-step program compared to alternative interventions that were manual-based and delivered by trained therapists	participants assigned to the same group. Given the preponderance with which self-help 12-step interventions are delivered in practice, further evidence regarding the effectiveness of this type of intervention is needed."

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			In 7 studies, treatment was partially or fully delivered in group therapy sessions **Outcomes:** 1. Drug use 2. Treatment retention **Follow-up time**: Post treatment, and at 6- and 12 month follow-ups **Settings:** Outpatient settings **Number of participants:** 1,071	
Psychosocial interventions for benzodiazepine harmful use, abuse or dependence (Review) **Darker et al (2015) [23]** **Study quality: High**	**Objectives:** To evaluate the effectiveness of psychosocial interventions for treating benzodiazepine (BZD) harmful use, abuse or dependence compared to pharmacological interventions, no intervention, placebo or a different psychosocial intervention on reducing the use of BZDs in opiate dependent and non-opiate dependent groups	**Population:** Opiate dependent populations and non-opiate dependent populations, people with a dual diagnosis, referring to comorbidity or the cooccurrence in the same individual suffering from both a substance problem and another mental health issue such as depression or an anxiety disorder **Interventions:** Psychosocial intervention **Comparison/control:** Pharmacological interventions, no intervention, placebo or a different psychosocial intervention **Outcomes:**	**Characteristics of included studies:** 25 studies of which 11 utilised CBT plus taper and 2 studies utilized CBT without taper, 4 studies utilized motivational interviewing (MI), 2 studies utilised letters, 4 studies utilised relaxation orientated interventions 1 study used e-counselling, and 1 study used advice from a general practitioner (GP) **Country of origin:** 6 studies were conducted in Canada, 6 in the USA, 3 in Germany, 2 in Australia, 2 in the Netherlands and 1 in Finland, Norway, the Czech Republic, Scotland, and Spain, respectively	"CBT plus taper is effective in the short term (three-month time period) in reducing BZD use. However, this is not sustained at six months and subsequently. Currently there is insufficient evidence to support the use of MI to reduce BZD use. There is emerging evidence to suggest that a tailored GP letter versus a generic GP letter, a standardised interview versus TAU, and relaxation versus TAU could be effective for BZD reduction. There is currently insufficient evidence for other approaches to reduce BZD use."

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		1. Reduction of BZD use classified as either successful discontinuation of BZD use or reduction of BZD use by >50% 2. Use of BZDs at the end of treatment was measured by: • any biological marker of BZD metabolites provided in original studies (e.g. urine drug screen or hair analysis) • self-reported use of BZDs • degree of effective dose reduction (e.g. frequency of BZD intake) • abstinence rates • time to relapse • drop-outs/loss to follow-up **Study design:** RCT **Settings:** Residential and outpatient facilities in primary and secondary care settings **Other criteria:** People 15 years of age or younger were excluded **Studies published**: Up to December 2014	**Population:** Patients with BZD harmful use, abuse or dependence Age and number is unclear for all the studies, but for 11 studies on which meta-analysis were performed the following information was given: These studies included a total of 575 participants, 368 women and 207 men Mean ages in various studies were 55, 42, 39, 36, all over 50' **DSM/ICD:** Reported in some studies **Substance use:** Long term BZDs, opiate-dependent, amphetamine, illicit drug users, chronic BZD users, BZD dependence, opiate addicts, BZDs for more than a year **Comorbidity or factors that may affect the substance use:** Not specified **Interventions:** The studies tested many different psychosocial interventions including CBT (some studies with taper, other studies with no taper), MI, letters to patients advising them to reduce or quit BZD use, relaxation studies, counselling delivered electronically, and advice	

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			provided by a general practitioner, on the data of which the authors of the review performed 2 meta-analyses: one assessing the effectiveness of CBT plus taper versus taper only (575 participants), and one assessing MI versus treatment as usual (80 participants) **Outcome:** 1. Successful discontinuation of BZDs 2. Reduce BZDs >50% **Follow-up time**: Not specified **Settings:** Opiate dependency clinics, acute hospital setting, gynecology, and psychiatry **Number of participants:** Unclear	
Alcoholics Anonymous and other 12-step programs for alcohol dependence **Ferri et al (2006) [24]** **Study quality: Moderate**	**Objectives:** To assess the effectiveness of AA or TSF programs compared to other psychosocial interventions in reducing alcohol intake, achieving abstinence, maintaining abstinence, improving the quality of life of affected people and their families, and reducing alcohol associated accidents and health problems	**Population:** Adults (>18) of both genders with alcohol dependence **Interventions:** A voluntary or coerced basis AA or TSF programs **Comparison/control:** No treatment, other psychological interventions, 12-step variants **Outcomes:** 1. Severity of dependence and its consequences measured	**Characteristics of included studies:** 8 trials involving 3,417 participants **Country of origin:** Not reported **Population:** Participants who had completed an inpatient detoxification treatment, applied for outpatient rehabilitation without passing through in-patient treatment, or were in outpatient therapy or aftercare, men with alcohol problems and their wives, people in their work	"No experimental studies unequivocally demonstrated the effectiveness of AA or TSF approaches for reducing alcohol dependence or problems. One large study focused on the prognostic factors associated with interventions that were assumed to be successful rather than on the effectiveness of interventions themselves, so more efficacy studies are needed."

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		2. Retention in, or drop-out from, treatment 3. Reduction of drinking, self-reported 4. Abstinence, self-reported 5. Qualitative outcomes regarding patients' and relatives' satisfaction reported as described in the included studies **Study design:** RCT's **Settings:** Not specified **Other criteria:** None **Studies published**: No limitation	setting who considered compulsory participation in inpatient programs or compulsory Alcoholic Anonymous meetings, hospital-based program combining medical and behavioral interventions or community based 12-steps program **DSM/ICD:** Only in 2 of the included studies (DSM-III-R and DSM III) **Substance use:** Alcohol **Comorbidity or factors that may affect the substance use:** Not reported **Interventions:** AA versus other self-help programs, brief advice to attend AA versus MET for 12-steps involvement, TSF versus other self-help programs, and hospital based 12-step principles versus community-based programs **Outcomes:** 1. ASI 2. Drop-out 3. Reduction of drinking 4. Abstinence 5. DrInC **Follow-up time**: 4 studies lasted 6 months, 1 study lasted 1 year, 1 study lasted 15 weeks,	

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			1 other study lasted 2 years, and Project Match lasted 3 years **Settings:** Not specified **Number of participants:** 3,417	
Psychosocial interventions for cannabis use disorder **Gates et al (2016) [25]** **Study quality: High**	**Objectives:** To evaluate the efficacy of psychosocial interventions for cannabis use disorder (compared with inactive control and/or alternative treatment) delivered to adults in an outpatient or community setting	**Population:** Participants who received treatment in outpatient or community settings if they were 18 years of age or older and met diagnostic criteria for cannabis abuse or dependence by clinical assessment (per criteria of the Diagnostic and Statistical Manual of Menta l Disorders, 5th Edition, or the 10th Revision of the International Statistical Classification of Diseases and Related Health Problems) or were at least near daily cannabis users or were seeking treatment for their cannabis use **Interventions**: *Psychosocial interventions* 1. CBT 2. MI/MET 3. Components of cognitive and motivational approaches delivered with focus on the importance of obtaining SS 4. Drug counselling and/or education 5. CM	**Characteristics of included studies:** 23 RCT's involving 4,045 participants of which 18 studies detailed therapists' experience and training **Country of origin:** A total of 15 studies in the USA, 2 in Australia, 2 in Germany and 1 each in Switzerland, Canada, Brazil and Ireland **Population:** Averaging across study groups, mean age was 28.2 years (SD = 5.4), and total number of participants in the review was 4,045 **DSM/ICD:** A clear majority of participants from 13 studies met diagnostic criteria for cannabis use disorder **Substance use:** Cannabis **Comorbidity or factors that may affect the substance use:** Some studies report comorbidity such as PTSD, and depression, anxiety, depressive or personality disorder,	"Included studies were heterogeneous in many aspects, and important questions regarding the most effective duration, intensity and type of intervention were raised and partially resolved. Generalisability of findings was unclear, most notably because of the limited number of localities and homogeneous samples of treatment seekers. The rate of abstinence was low and unstable although comparable with treatments for other substance use. Psychosocial intervention was shown, in comparison with minimal treatment controls, to reduce frequency of use and severity of dependence in a fairly durable manner, at least in the short term. Among the included intervention types, an intensive intervention provided over more than four sessions based on the combination of MET and CBT with abstinence-based incentives was most consistently supported for treatment of cannabis use disorder."

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		6. MM 7. Relapse prevention 8. Combination of the above **Comparison/control:** Inactive (including untreated/ minimally treated control or DTC) or a second active psychosocial intervention **Outcomes:** *Primary* outcomes 1. Self-reported use of cannabis with or without confirmation by objective means 2. Severity of cannabis use disorder observed as an index measured by a standardized questionnaire or as a count of symptoms of dependence following clinical assessment 3. Level of cannabis-related problems such as medical problems, legal problems, social and family relations, employment and support 4. Retention in treatment *Secondary outcomes* 1. Motivation to change cannabis use measured by a standardised questionnaire 2. Frequency of self-reported other substance intake 3. Mental health and symptoms of affective	schizophrenia, or mental health disorders **Interventions:** Across studies, investigators compared 7 different therapeutic modalities: CBT, motivational intervention (MET), a combination of MET and CBT, CM, SS, MM and drug education and counselling (DC). **Outcomes:** 1. Cannabis use 2. Abstinence 3. Symptoms of dependence 4. Cannabis-related problems 5. Retention in treatment **Follow-up time**: Investigators delivered treatments over approximately 7 sessions (range 1 to 14) for approximately 12 weeks (range 1 to 56) **Setting:** Outpatient design **Number of participants:** 4,045	

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		disorder measured by a standardised questionnaire **Study design:** RCT **Settings:** Outpatient or community settings (excluding mail, phone and computer-based treatments) **Other criteria:** Exclusion criteria were: 1. current dependence on alcohol or any other drug (except nicotine) 2. near daily use of other substances (excluding nicotine) **Studies published**: Before July 2015		
Psychosocial interventions for people with both severe mental illness and substance misuse (Review) **Hunt et al (2013) [26]** **Study quality: High**	**Objectives:** To assess the effects of psychosocial interventions for reduction in substance use in people with a serious mental illness compared with standard care	**Population**: People with both severe mental illness (defined as those with a chronic mental illness like schizophrenia who present to adult services for long-term care) and substance misuse **Interventions:** *Psychosocial interventions for substance misuse* 1. Provider-oriented long-term interventions: integrated and non-integrated care by community mental health teams for dual diagnosis populations	**Characteristics of included studies:** 32 trials **Country of origin:** 19 studies from the USA, 3 from the UK, 6 from Australia, 1 from Switzerland, Denmark and Ireland, respectively **Population:** All participants were adults (aged 18 to 65 years) who were “severely mentally ill”, with the majority having a diagnosis of schizophrenia, schizoaffective disorder or psychosis, and a current diagnosis of SUD or	“We included 32 RCT’s and found no compelling evidence to support any one psychosocial treatment over another for people to remain in treatment or to reduce substance use or improve mental state in people with serious mental illnesses. Furthermore, methodological difficulties exist which hinder pooling and interpreting results. Further high-quality trials are required which address these concerns and improve the evidence in this important area.”

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		2. Patient or client focused short-term interventions for substance misuse 3. Standard care or treatment as usual **Comparison/control:** Standard care **Outcomes:** *Primary outcomes* 1. Numbers lost to treatment (this is a measure of stability and engagement) 2. Change in substance use as defined by each of the studies 3. Changes in symptoms as defined by each of the studies *Secondary outcomes* 1. Numbers lost to evaluation 2. Death (all causes) 3. Substance use (alcohol or drugs, or both) 4. Mental state 5. Global functioning 6. Social functioning 7. Quality of life and life satisfaction 8. Hospital readmissions (and days in the community) 9. Homelessness 10. Compliance with treatment and medication **Study design:** RCT **Settings:** Not specified	documented evidence of substance misuse Some were homeless or had a history of unstable accommodation and some were incarcerated at the time of the study **DSM/ICD:** CD-10, DSM or SCID-1 **Substance use:** Alcohol, cannabis, drugs (not specified), cocaine, opiates, amphetamine, benzodiazepine, substance abuse or dependence, SUD **Comorbidity or factors that may affect the substance use:** The majority having a diagnosis of schizophrenia, schizoaffective disorder or psychosis **Interventions:** 1. Integrated models of care (4 RCT's) 2. Non-integrated models of care (4 RCT's) 3. Combined CBT and MI (7 RCT's) 4. Cognitive behavioural therapy (2 RCT's) 5. Motivational interviewing (8 RCT's) 6. CM (2 RCT's) 7. Skills training (2 RCT's)	**Comments:** We believe that they have been too generous when grading a comparison that only includes one small study to low quality of evidence.

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		Other criteria: Those with an organic disorder, non-severe mental illness (for example, personality disorder, PTSD, anxiety disorders, depressive symptoms based on scores from a scale) or those who solely abused tobacco was, if possible, excluded. Trials that included a mixture of patients with a severe mental diagnosis were included if a large proportion had a schizophrenia-like illness or psychosis. **Studies published**: Up to 15 February 2013	**Outcome:** 1. Substance use scales 2. Mental state assessment 3. Quality of life and client satisfaction 4. Social functioning **Follow-up time**: Not specified **Settings**: Psychiatric hospital, community, residential, inpatient, outpatient, Veterans Affairs medical center, jail, hospital, early intervention services **Number of participants:** 3,165	
Beyond face-to-face individual counseling: A systematic review on alternative modes of motivational interviewing in substance abuse treatment and prevention **Jiang et al (2017) [27]** **Study quality: Moderate**	**Objectives:** To synthesize the evidence on the effectiveness of MI, delivered in modes other than face-to-face individual counseling, in preventing and treating substance abuse related behaviors	**Population:** Individuals with substance abuse **Interventions:** MI was included in at least one of the intervention groups and the intervention included at least one alternative mode of MI that is beyond face-to-face individual counseling **Comparison/control:** Not reported **Outcomes:** Prevention or treatment of at least one type of substance abuse	**Characteristics of included studies:** 22 RCT's with the most common target behaviors being smoking (11 studies), followed by alcohol (9 studies), illicit drugs (6 studies) and medication overuse (1 study), and 4 trials targeting more than one substance abuse behavior **Country of origin:** Not reported **Population:** Adults and adolescents (age and relation female/male are unclear) **DSM/ICD:** No reported	"Collectively, the studies reviewed indicate that telephone MI is a promising mode of intervention in treating and preventing substance abuse. The effectiveness of other alternative modes (SMS-based MI, Internet-based MI and group MI) remains inconclusive given the controversial findings and a limited number of studies. By synthesizing the currently available evidence, this systematic review suggested that telephone MI might be considered as an alternative to face-to-face MI for treating and preventing substance abuse.

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		Study design: Interventional study using an RCT design **Settings:** Not specified **Other criteria:** If family members or other people are involved in the MI session, which however was only for changing one individual participant's behavior, the study was excluded. Also, if the alternative media (e.g. internet and telephone) were used only as a supplement after face-to-face MI or as a "booster" after face-to-face counseling, this study was excluded. **Studies published**: Between January 1983 and January 2016	**Substance use:** Smoking, alcohol, illicit drugs, medication overuse **Comorbidity or factors that may affect the substance use:** Not reported **Interventions:** Telephone appeared to be the most commonly used alternative medium for MI (11 studies) followed by internet (4 studies) and SMS (2 studies). Group MI was tested in 5 studies. In 8 studies, other behavioral interventions were combined with MI. The MI counselors included nurses or nurse health educator, clinicians, psychologists, psychiatrist, students in related areas (health sciences, public health or psychology), research assistant, and social worker. The number of main MI sessions ranged from 1 to 24 and each MI session lasted for 10–90 min. **Outcomes:** 1. Preventing and quitting smoking 2. Controlling alcohol consumption 3. Abstinence from illicit drugs 4. Reducing medication (analgesics) overuse	Further research is needed to investigate the effectiveness of SMS-based MI, Internet MI, group MI and other alternative modes. Studies with methodological rigor and incorporating MI fidelity measures have great potential to advance the understanding in this field."

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			Follow-up time: Varied from 8 weeks to 1 year, with 15 trials reporting 6-month follow-up or longer **Settings**: Not specified for each study **Number of participants:** Sample size of the trials varied from 57 to 2,151, with a total of 9,920 participants	
Psychosocial interventions to reduce alcohol consumption in concurrent problem alcohol and illicit drug users (Review) **Klimas et al (2014) [28]** **Study quality: High**	**Objectives:** To assess the effects of psychosocial interventions for problem alcohol use in illicit drug users (principally problem drug users of opiates and stimulants)	**Population:** Adult (aged ≥18 years) problem drug users attending a range of services (i.e. community, inpatient or residential, including opiate substitution treatment) with problem drug use defined according to the definition of the European Monitoring Centre for Drugs and Drug Addiction, as "injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines" **Interventions:** Any psychosocial intervention that was described by the study's author as such **Comparison/control:** Other psychosocial interventions that will allow for comparisons between different types of interventions (e.g. CBT, CM, family therapy, etc.), standard care, no intervention, waiting list, placebo or any other	**Characteristics of included studies:** 4 RCT's, involving 594 participants **Country of origin:** 3 studies were conducted in the USA and 1 in Switzerland **Population:** 33% were female, mean age was 38.3 years **DSM/ICD:** DSM, ASI, AUDIT **Substance use:** Alcohol, cocaine **Comorbidity or factors that may affect the substance use:** One study reported psychiatric disorders, and one depressive symptoms **Interventions:** • 6 different psychosocial interventions grouped into four comparisons:	"There is low-quality evidence to suggest that there is no difference in effectiveness between different types of interventions to reduce alcohol consumption in concurrent problem alcohol and illicit drug users and that brief interventions are not superior to assessment- only or to treatment as usual. No firm conclusions can be made because of the paucity of the data and the low quality of the retrieved studies." **Comments:** We believe that they have been too generous when grading a comparison that only includes one small study to low quality of evidence.

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		nonpharmacological therapy (including moderate drinking, assessment-only) **Outcomes:** *Primary outcome* Alcohol use (reduction or stabilisation), as measured by either biological markers or self-report tests *Secondary outcomes* 1. Illicit drug use (changes in illicit drug use), as measured by either biological markers or self-report test 2. Engagement in further treatment (i.e. drop-out rates, utilisation of health services) 3. Alcohol-related problems or harms, as represented by physical or mental health outcomes associated with problem alcohol use **Study design:** RCT's and CCT's **Settings:** Not specified **Other criteria:** Only studies that defined participants as problem drug and alcohol users at randomisation were included. Studies including problem drug users without concurrent problem alcohol use were excluded. People whose	• Cognitive-behavioral coping skills training versus TSF (1 study, 41 participants) • Brief intervention versus treatment as usual (1 study, 110 participants) Group or individual MI versus hepatitis health promotion (1 study, 256 participants) BMI versus assessment-only (1 study, 187 participants) **Outcomes:** 1. Maximum number of weeks of consecutive alcohol abstinence during treatment 2. Maximum number of weeks of consecutive abstinence from cocaine during treatment 3. Number of people achieving 3 or more weeks of consecutive alcohol abstinence during treatment, 4. Alcohol abstinence **Follow-up time**: Not specified **Settings:** Outpatient clinic and opioid substitution clinic **Number of participants:** 594	

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
		primary drug of use was alcohol were excluded from this review. **Studies published**: Up to June 2014		
Continuing care for patients with alcohol use disorders: A systematic review **Lenaerts et al (2014) [29]** **Study quality: Moderate**	**Objectives:** To identify effective continuing care interventions for patients with AUD	**Population:** Adult patients (≥18 years) with an AUD as their main problem, without specification of the type or severity of the disorder **Interventions:** Continuing care defined as the phase after completing an inpatient or intensive outpatient alcohol rehabilitation program of at least seven days, not just detoxification The interventions had to focus primarily on the treatment of AUD **Comparison/control:** Not specified **Outcomes:** Drinking and treatment engagement outcomes were considered **Study design:** RCT's **Settings:** An outpatient, continuing care setting **Other criteria:** Data on the individuals drinking related outcomes or treatment	**Characteristics of included studies:** 6 RCT's, 1,479 patients **Country of origin:** 5 of the studies were conducted in the USA and 1 study was conducted in the UK **Population:** Participants were mostly male (63–100%), with an average age of 40, and had a reasonable degree of education, and had previously followed an inpatient or outpatient rehabilitation program, ranging from 7 days to 6 weeks **DSM/ICD:** DSM-III-R, DSM-IV, Michigan Alcoholism Screening Test, Iowa alcoholic stages index score, alcohol dependence, alcohol abuse **Substance use:** Alcohol **Comorbidity or factors that may affect the substance use:** None **Interventions:** Interventions varied in duration (10 weeks to 1 year), frequency of scheduled contacts (3 sessions a week to	"In this systematic review, we observe a trend of better outcomes in favor of continuing care interventions actively involving the patient, compared to 'usual care.' The lack of convincing evidence in continuing care research should not discourage clinicians or researchers. Considering the severe consequences of this disorder, even small improvements in outcomes can be important for the individual patient and for society."

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
		engagement had to be available, with a follow-up duration of at least 12 weeks after the beginning of the continuing care phase. Studies were excluded if patients were inmates or parolees or suffered from a comorbid psychotic illness or other co-occurring SUD (except for nicotine). **Studies published**: Up to February 2013	4 sessions in 12 weeks) and type of continuing care (telephone calls, behavioral marital therapy, interactional couples therapy, cognitive behavioral coping skills therapy, MET, TSF, relapse prevention, standard continuing care, early warning signs relapse prevention training, community nurse follow-up, usual continuing care). The therapists were all experienced and trained in the treatment of AUD's. **Outcomes:** Drinking outcomes including percentage of days abstinent and drinking severity, and treatment engagement **Follow-up time**: 6 months after trial entry to 2 years after the continuing care treatment **Settings**: Outpatient **Number of participants:** 1,479	
Mindfulness treatment for substance misuse: A systematic review and meta-analysis **Li et al (2017) [30]** **Study quality: Moderate**	**Objectives:** To evaluate the methodological characteristics and substantive findings of recent studies evaluating effects of mindfulness treatment for substance misuse	**Population:** Clients with substance misuse problems (alcohol, drugs, and tobacco) **Interventions:** Mindfulness treatment **Comparison/control:** Treatment as usual or alternative treatments	**Characteristics of included studies:** 8 studies using quasi-experimental designs, and 34 studies using RCT designs Of the 42 identified studies, 33 were original studies and the remaining 9 studies were secondary analyses of original studies	"Mindfulness treatment for substance misuse is a promising intervention for substance misuse and relapse preventiom, although more research is needed examining the mechanisms by which mindfulness interventions exert their effects

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
		Outcomes: *Primary outcomes* Decreases in substance misuse-related behaviors and problems, including severity of substance misuse, craving for substances, and substance use-related problems at posttreatment and follow-up assessments *Secondary outcomes* Improvements in affective and behavioral functioning, increases in mindfulness and nonjudgment of thoughts and treatment adherence and completion rate **Study design:** Quasi-experimental designs with repeated-measures, or RCT designs with repeated-measures, published in English **Settings:** Not specified **Other criteria:** Studies were excluded if they only reported qualitative results, used pre-experimental designs, did not assess substance use-related outcomes and examined interventions that did not teach formal mindfulness practices (e.g. Acceptance and Commitment Therapy, Dialectical Behavior Therapy, and Spiritual Self-Schema Therapy).	**Country of origin:** Not reported **Population:** 1 study investigated adolescents and 41 studies investigated adults, 7 studies evaluated mindfulness treatment for people involved with the criminal justice system **DSM/ICD:** Not reported **Substance use:** Polysubstance misuse, alcohol abuse/dependence, cigarette smoking, and other illicit drug misuse **Comorbidity or factors that may affect the substance use:** Not specified **Intervention:** Mindfulness training **Outcomes:** *Primary outcome* Substance misuse *Secondary outcomes* For example: • suppressing unwanted thoughts and urges for substance use • psychiatric distress • negative emotions and moods • stress • substance use-related locus-of-control	and the effectiveness of mindfulness treatments in diverse treatment settings.”

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
		Studies published: Up to December 2015	• optimism • neuropsychological functions such as working memory, response inhibition, and decision-making ability at posttreatment and follow-up assessments **Follow-up time**: Not specified **Settings**: Not specified for each study Community treatment and laboratory setting are two examples **Number of participants:** Sample sizes ranged from 24 to 459	
Computer-based interventions for drug use disorders: A systematic review **Moore et al (2011) [31]** **Study quality: Moderate**	**Objectives:** To conduct a systematic review of computer-based interventions for illicit drug use disorders	**Population:** Patients with a substance-related disorder that was not alcohol or tobacco **Interventions:** Computer-based interventions defined as a those in which the primary treatment was provided by an automated, computer-based system **Comparison/control:** Treatment as usual or other comparisons **Outcomes:** Not specified **Study design:** Research study (not a review, letter, etc.)	**Characteristics of included studies:** 12 studies, all but one study used a randomised design with a control group **Country of origin:** 2 included studies were conducted in Australia and 10 in the USA **Population:** Men and woman (mostly white men), generally in their 20's to early 30's, composed of individuals from different racial/ethnic groups **DSM/ICD:** Not reported	"Computer-based interventions for drug use disorders show initial evidence of efficacy during treatment and some evidence effects continue after treatment. Despite heterogeneity of samples, methods, and intervention types, studies evaluated showed improved self-reported and urinalysis outcomes for computer-based interventions compared to control conditions."

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
		Settings: Not specified **Other criteria:** Not specified **Studies published**: From 1966 to November 19, 2009	**Substance use:** 4 studies evaluated opioid users exclusively, whereas the other studies included more than one type of drug user (5 cocaine, 8 cannabis, 6 alcohol and 5 other). **Comorbidity or factors that may affect the substance use:** Not reported **Interventions:** Characteristics of the computer-based interventions varied in presentation modality, length, number of sessions, and therapist involvement **Outcomes:** Drug use outcomes were evaluated in 6 studies, with 4 including urinalysis data, 5 studies evaluated retention, 5 studies evaluated treatment retention and 5 studies evaluated ratings of satisfaction with the computer-based system **Follow-up time**: Not specified **Settings:** Prison (drug treatment unit), outpatient clinic, residential substance abuse treatment program, research setting, hospital, unsupervised at home **Number of participants:** 1,966	

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
			Sample sizes of the studies ranged from 19 to 909 (mean = 163, median = 102)	
Effectiveness of current treatment approaches for benzodiazepine discontinuation: a meta-analysis **Parr et al (2008) [32]** **Study quality: Moderate**	**Objectives:** To assess the effectiveness of current treatment approaches to assist BZD discontinuation	**Population:** Outpatients who had used BZD continuously for 3 months or longer prior to the commencement of the study **Interventions:** Adjunctive treatment **Comparison/control:** Routine care or GDR **Outcomes:** Proportions of participants ceasing BZD use in each condition were the key outcome variables, as the goal of dose reduction is complete cessation **Study design:** RCT's **Settings:** Not specified **Other criteria:** Trials had at least 10 participants in each condition at baseline, and reported information had to allow calculation of cessation rates for each condition based on intention-to-treat **Studies published**: Up to 2005	**Characteristics of included studies:** 11 RCT's **Country of origin:** Not specified **Population:** Age between 40 and 61 **DSM/ICD:** Not specified **Substance use:** BZD **Comorbidity or factors that may affect the substance use:** Not reported **Interventions:** Psychological interventions (relaxation training, psychoeducation, for BZD withdrawal or teaching strategies to address insomnia) versus routine care **Outcomes:** 1. BZD cessation rate 2. Insomnia **Follow-up time**: Not specified **Settings:** Outpatient setting **Number of participants:** 850	"Brief interventions were more effective than routine care in increasing benzodiazepine cessation rates. Adding psychological interventions to gradual dose reduction may have increased cessation rates compared to gradual dose reduction alone. There was insufficient evidence to support substitutive pharmacotherapies." **Comment:** Only part of the review suited this report
Psychological therapies for post-traumatic stress disorder and comorbid	**Objectives:** To find out whether psychological therapies aimed at treating traumatic stress	**Population:** People with comorbid PTSD and SUD	**Characteristics of included studies:** 14 studies which were either RCT's or pilot RCT's	"We assessed the evidence in this review as mostly low to very low quality. Evidence showed

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substance use disorder (Review) **Roberts et al (2016) [33]** **Study quality: High**	symptoms, substance misuse symptoms, or both are effective in treating people with PTSD and SUD in comparison to control conditions and other psychological therapies	**Interventions:** Psychological therapies aimed at treating traumatic stress symptoms, substance misuse symptoms, or both **Comparison/control:** Control conditions (usual care, waiting-list conditions, and no treatment) and other psychological therapies **Outcomes:** *Primary outcome* Severity of traumatic stress symptoms using a standardised measure, reduction in drug use, alcohol use, or both as measured by a standardised measure, treatment completion as measured by number of participants who were identified as treatment completers by study authors *Secondary outcomes* PTSD or SUD diagnosis after treatment, adverse events, compliance, general functioning, including quality of life measures and the use of health-related resources **Study design:** RCT or cluster-RCT **Settings:** No limitations reported **Other criteria:** Not specified	**Country of origin:** 12 studies were conducted in the USA, the remaining 2 studies in Australia **Population:** Adults in 11 studies, 1 study investigated intervention for adolescent girls with a mean age of 16.06 years 1 study recruited from veteran populations with an all-male cohort, 1 study recruited female prisoners and 4 studies studied female-only cohorts, all other studies were of mixed gender and from community groups **DSM/ICD:** Not specified **Substance use:** Alcohol dependence, AUD, drug dependent substance, typically polydrug use None of the included studies targeted one specific substance other than alcohol **Comorbidity or factors that may affect the substance use:** PTSD or subthreshold PTSD, 1 study focused on severe mental illness, and 1 study included participants who had been out of an abusive relationship for at least a month	that individual trauma-focused psychological therapy delivered alongside SUD therapy did better than TAU/minimal intervention in reducing PTSD severity post-treatment and at long-term follow-up, but only reduced SUD at long-term follow-up. All effects were small, and follow-up periods were generally quite short. There was evidence that fewer participants receiving trauma-focused therapy completed treatment. There was very little evidence to support use of non-trauma-focused individual- or group-based integrated therapies. Individuals with more severe and complex presentations (e.g. serious mental illness, individuals with cognitive impairment, and suicidal individuals) were excluded from most studies in this review, and so the findings from this review are not generalisable to such individuals.”

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
		Studies published: Up to March 2015	**Interventions:** All of the experimental interventions included in the review were based on some form of CBT. These interventions can perhaps best be summarised and divided into trauma-focused approaches (some of which included combined interventions for SUD) and non-trauma-focused interventions (which mainly involved integrated treatment of PTSD and SUD) **Outcomes:** A range of measures were used to assess outcomes for SUD. Many of the included studies recognised high levels of treatment drop-out as a pervasive problem in the field. Of the 14 studies, 10 used a clinician-administered measure of PTSD. **Follow-up time**: Not specified **Settings:** All participants were seen on an outpatient basis, apart in 1 study where they received most of their intervention in prison, with some follow-up on release **Number of participants:** 1,506 The number of participants ranged from 29 to 353	
Motivational interviewing for substance abuse	**Objectives:** To assess the effectiveness of MI for	**Population:** Persons defined as having either substance abuse,	**Characteristics of included studies:** 59 studies of which	"MI can reduce the extent of substance abuse compared to

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Smedslund et al (2011) [34] **(This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in The Cochrane Library 2011, Issue 5.)** **Study quality: High**	substance abuse on drug use, retention in treatment, readiness to change, and number of repeat convictions.	dependency or addiction, but not misuse, no limitations on age or other participant characteristics The term substance refers to a drug of abuse, a medication, a toxin or alcohol, excluding nicotine **Interventions:** MI or MET The intervention could basically be offered in three ways: 1. as a standalone therapy 2. MI integrated with another therapy 3. MI as a prelude to another therapy (e.g. CBT) Only individual, face-to-face interventions were included **Comparison/control:** No intervention, waiting list control, placebo psychotherapy or other active therapy **Outcomes:** *Primary outcome* Substance abuse such as cease of substance use or reduction in substance abuse measured as above, both measured by self-report, report by collaterals, urine analysis, or blood samples, etc.) *Secondary outcomes*	57 studies were RCT's, and 2 studies were quasi-RCT's **Country of origin:** 44 studies from the USA, 5 from Australia, 3 each from the Netherlands and UK, 2 from Canada, and 1 each from Germany and New Zealand **Population:** In 29 studies the participants seemed to be exclusively alcohol abusers, in 8 studies they were cannabis abusers, in 4 studies the participants were exclusively cocaine abusers, and in the remaining 18 studies the participants were abusing more than one substance **DSM/ICD:** Not reported **Substance use:** Alcohol, cannabis, cocaine **Comorbidity or factors that may affect the substance use:** Not reported **Intervention:** MI versus no intervention, treatment as usual, other active intervention or assessment and feedback **Outcomes:** 1. Extent of substance use 2. Readiness for change	no intervention. The evidence is mostly of low quality, so further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate."

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
		Retention in treatment, improve motivation for change, e.g. measured by the Readiness to Change Questionnaire (RCQ; Heather 1993), number of repeat convictions (for convicted substance abusers) **Study design:** Studies where units (persons, therapists, institutions) were allocated randomly or quasi-randomly to MI or other conditions **Settings:** Face-to-face **Other criteria:** Not specified **Studies published**: In or after 1983, which was the year that MI was introduced	3. Retention in treatment **Follow-up time**: Not specified **Settings**: Face-to-face **Number of participants:** 13,342	
Therapeutic communities for substance related disorder (Review) **Smith et al (2006) [35]** **Study quality: Moderate**	**Objectives:** To determine the effectiveness of Therapeutic Communities (TC) versus other treatments for substance dependents, and to investigate whether effectiveness is modified by client or treatment characteristics	**Population:** People who sought treatment or were ordered by the court to obtain treatment with any substance misuse or dependency problem, including people with a range of substance abuse problems, multiple drug addictions, co-morbidities (e.g. mental health problems), and people with prior substance misuse treatment experience **Interventions:** TC **Comparison/control:** Other treatments, no treatment or another TC	**Characteristics of included studies**: 7 RCT's **Country of origin:** Unclear **Population:** Not specified **DSM/ICD:** Reported for some studies **Substance use:** Reported for some studies as cocaine, crack, heroin, alcohol or a combination of different drugs **Comorbidity or factors that may affect the substance use:** Serious mental illness and	"There is little evidence that TCs offer significant benefits in comparison with other residential treatment, or that one type of TC is better than another. Prison TC may be better than prison on its own or Mental Health Treatment Programmes to prevent re-offending post-release for in-mates. However, methodological limitations of the studies may have introduced bias and firm conclusions cannot be drawn due to limitations of the existing evidence."

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
		Outcomes: Illicit drug use measured by self-report or urinalysis during treatment or follow-up, alcohol use measured by self-report or urinalysis during treatment or follow-up, retention in treatment, reasons for withdrawal from treatment, ASI composite scores during treatment or follow-up, imprisonment, employment, drug use arrests, overdoses, death due to all causes or drug related **Study design:** RCT's with parallel group or cluster design **Settings:** No limitation **Other criteria:** Not specified **Studies published**: Up to October 2004	chemical abuse reported in some studies **Intervention:** TC **Outcomes:** 1. Drug use – urinalysis 2. Treatment completion 3. ASI 4. Withdrawal severity 5. Abstinent at follow-up 6. Employment 7. Criminal activity 8. Time to first drug use (days from admission) 9. Time to first drug use (days from treatment exit) **Follow-up time**: Not specified **Settings**: Inpatient, outpatient, therapeutic community, jail, hospital, residential etc. **Number of participants:** Not specified	
Psychosocial interventions for pregnant women in outpatient illicit drug treatment programs compared to other interventions (Review) **Terplan et al (2015) [36]** **Study quality: Moderate**	**Objectives:** To evaluate the effectiveness of psychosocial interventions in pregnant women enrolled in illicit drug treatment programs on birth and neonatal outcomes, on attendance and retention in treatment, as well as on maternal and neonatal drug abstinence	**Population:** Pregnant women enrolled in illicit drug treatment programs for any treatment of substance abuse or dependence of any drug including illegal substances such as cannabis, heroin, cocaine, amphetamines, etc. also including women on methadone treatment	**Characteristics of included studies:** 14 RCT's where 9 studies compared CM versus control, and 5 studies compared MI interventions versus control **Country of origin:** 13 studies were from the USA and 1 from Australia	"The present evidence suggests that there is no difference in treatment outcomes to address drug use in pregnant women with use of psychosocial interventions, when taken in the presence of other comprehensive care options. However, few studies evaluated obstetrical or neonatal outcomes and rarely did so in a systematic way, making it

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	In short, do psychosocial interventions translate into less illicit drug use, greater abstinence, better birth outcomes, or greater clinic attendance?	**Interventions:** Any psychosocial intervention **Comparison/control:** Control intervention that could include pharmacological treatment, such as methadone maintenance, a different psychosocial intervention, counselling, prenatal care, STD counselling and testing, transportation, or childcare **Outcomes:** *Primary outcomes* Neonatal outcomes, maternal drug use (measured by maternal toxicology or maternal self-reported drug use), and adverse events for the mother of the child *Secondary outcome* Retention in treatment **Study design:** RCT's **Settings:** Not specified **Other criteria:** Not specified **Studies published**: Up to January 2015	**Population:** 13 trials reported age and the mean age for those was 28.8 years. Overall, 88.6% of the trial participants were unemployed. Of the trials that reported ethnicity, on average 63.12% of participants were African American. Among 11 studies, most participants had at least some high school education, either measured as a proportion (>50%) or >10 mean years of education. Most trials did not mention gestational age at enrolment. **DSM/ICD:** All but 4 studies used DSM-III-R or DSM-IV-R criteria in the assessment of substance use **Substance use:** Cocaine, heroin, methadone, opiate dependent, marijuana, alcohol and nicotine **Comorbidity or factors that may affect the substance use:** Not specified **Interventions:** CM and MI based **Outcomes:** 1. Preterm birth 2. Positive neonatal toxicology at delivery 3. Low birth weight	difficult to assess the effect of psychosocial interventions on these clinically important outcomes. It is important to develop a better evidence base to evaluate psychosocial modalities of treatment in this important population".

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
			4. Days hospitalized after delivery 5. Adverse events 6. Maternal drug use measured by maternal toxicology 7. Retention at treatment completion 8. Short term treatment retention **Follow-up time**: Ranged from 14 days to 24 weeks **Settings:** All trials took place in drug treatment facilities that were either academic-based, hospital-based, or both All included trials were predominately in the outpatient setting **Number of participants:** 1,298 Study sizes ranged from 12 to 168	
Integrated treatment programs for individuals with concurrent substance use disorders and trauma experiences: A systematic review and meta-analysis **Torchalla et al (2012) [37]** **Study quality: Moderate**	**Objectives:** To examine the evidence of psychotherapeutic IT programs for individuals with concurrent SUD and trauma histories	**Population:** Individuals that meet diagnostic criteria for substance abuse or dependence and/or seek SUD treatment and report a history of psychological trauma and/or show presence of PTSD symptoms	**Characteristics of included studies:** 17 studies, 9 controlled studies (1 RCT) and 8 cohort studies **Country of origin:** Not reported **Population:** 9 studies had women-only samples, 2 had	"Overall, IT appears to effectively reduce trauma and SUD symptoms, but there is insufficient evidence to support its superiority over nonintegrated programs. Well-designed randomized controlled trials are clearly needed, particularly large sample studies evaluating understudied IT

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
		Interventions: Integrated psychotherapeutic treatment defined as a coordinated and simultaneous focus on both substance use and trauma issues within the same service and by the same (team of) clinicians **Comparison/control:** No treatment or other treatment **Outcomes:** Quantitative substance use and/or trauma symptom severity outcomes **Study design:** All English-language studies that quantitatively evaluated the outcome of psychotherapeutic integrated substance use and trauma programs **Settings:** Not specified **Other criteria:** Not specified **Studies published**: Up to June 2010	men only samples, and 6 had mixed-gender samples A few studies targeted specific subgroups, including veterans, incarcerated women, and adolescents **DSM/ICD:** Not reported **Substance use:** Tobacco, alcohol, drugs alone or in combination **Comorbidity or factors that may affect the substance use:** PTSD **Interventions:** Interventions were primarily based in SUD treatment facilities in the USA, and treatment providers were predominantly master's level addiction or mental health counselors or graduate/postdoctoral students **Outcomes:** Most of the studies found that IT programs effectively reduced substance use and PTSD and other mental health symptoms from baseline through follow-up, with symptoms remaining stable or continuing to improve posttreatment **Follow-up time**: 3–12 months	programs and exposure-based approaches”.

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
			Settings: Interventions were primarily based in SUD treatment facilities in the USA, and treatment providers were predominantly master's level addiction or mental health counselors or graduate/postdoctoral students **Number of participants:** 3,817 Baseline sample sizes ranged from 19 to 2,729 in studies that included a control group and from 5 to 107 in cohort studies	
Home visits during pregnancy and after birth for women with an alcohol or drug problem (Review) **Turnbull and Osborn (2012) [40]** **Study quality: High**	**Objectives:** To determine the effects of home visits during pregnancy and/or after birth for women with a drug or alcohol problem	**Population:** Pregnant or postpartum women with a drug or alcohol problem **Interventions:** Home visits that commenced during pregnancy and/or after birth by teams or individuals consisting of doctors (obstetricians, general practitioners or paediatricians), nurses (midwives, drug and alcohol workers or early childhood nurses), social workers, counsellors or trained lay people **Comparison/control:** Not specified **Outcomes:** 1. Drug and alcohol related outcomes such as	**Characteristics of included studies:** 7 studies **Country of origin:** Not specified **Population:** Pregnant or postpartum women The enrolled women were generally at high psychosocial risk and had a high rate of alcohol and drug use (greater than 50%) **DSM/ICD:** Not reported **Substance use:** Drugs or alcohol **Comorbidity or factors that may affect the substance use:** Not reported	"There is insufficient evidence to recommend the routine use of home visits for pregnant or postpartum women with a drug or alcohol problem. Further large, high-quality trials are needed".

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
		• continued alcohol or drug misuse in pregnancy and/or after birth • not stabilised on methadone if opiate dependent • maternal acquisition of HIV or hepatitis B or C • neonatal abstinence syndrome • enrolled and retained in drug treatment program 2. Pregnancy and puerperium outcomes 3. Infant/child outcomes 4. Psychosocial outcomes **Study design:** Studies using random or quasi-random allocation **Settings:** Home visits **Other criteria:** Trials enrolling high-risk women of whom more than 50% were reported to use drugs or alcohol were also eligible **Studies published**: Up to 2011	**Intervention:** Home visits mostly after birth Visitors included community health nurses, paediatric nurses, trained counsellors, paraprofessional advocates, midwives and lay African-American women **Outcomes:** 1. Continued illicit drug use or alcohol use 2. Failure to enroll in a drug treatment program 3. Not breastfeeding at six months 4. Incomplete six-month infant vaccination schedule 5. The Bayley Mental Development Index 6. Psychomotor Index 7. Child behavioral problems 8. Infants not in care of biological mother 9. Non-accidental injury and non-voluntary foster care or infant death 10. Involvement with child protective services 11. Failure touse postpartum contraception **Follow-up time**: Not reported **Settings**: Home visits	

Reference, the systematic review, study quality	Objectives of the systematic review	Inclusion criteria for the systematic review	Characteristics of the studies included in the systematic review	The conclusions of the systematic review´s author
			Number of participants: 803 mother-infant pairs Study sizes ranged from 30–227 mother-infant pairs	

AA = Alcoholic Anonymous; ASI = Addiction Severity Index; AUD = Alcohol Use Disorder; AUDIT = Alcohol Use Disorder Identification Test; BMI = Brief Motivational Intervention; BZD = Benzodiazepine; CBT = Cognitive Behavioral Therapy; CCT = Controlled Clinical Trial; CM = Contingency Management; DC = Drug Education and Counselling; DSM = Diagnostic and Statistical Manual for Mental disorders; DTC = Delayed Treatment Control; GDR = Gradual Dose Reduction; ICD = International Classification of Diseases; IT = Integrated Treatment; MET = Motivational Enhancement Therapy; MI = Motivational Interviewing; MM = Mindfulness-Based Meditation; PTSD = Post-Traumatic Stress Disorder; RCT = Randomised Controlled Trial; SMS = Short Message Service; STD = Sexually Transtmitted Disease; SS = Social Support; SUD = Substance Use Disorder; TSF = Twelve-Step Facilitation; QES = Quality Education Study; QRCT = Quasi Randomised Controlled Trial