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AREA**

**More Behavioral Recommendations Produce More Change:  
A Meta-Analysis of Efficacy of Multi-Behavior Recommendations to Reduce  
Non-Medical Substance Use<sup>1</sup>**

Wenhao Dai<sup>1</sup>,

Ryan Palmer<sup>1</sup>,

Aashna Sunderrajan<sup>1</sup>,

Marta Durantini<sup>1</sup>

Flor Sánchez<sup>2</sup>,

Laura R. Glasman<sup>3</sup>,

Fan Xuan Chen<sup>1</sup>,

Dolores Albarracín<sup>1</sup>

<sup>1</sup> Department of Psychology, University of Illinois, Urbana-Champaign

<sup>2</sup> Departamento de Psicología Social, Universidad Autónoma de Madrid

<sup>3</sup> Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin

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### Abstract

**Objective:** Death and morbidity associated with substance use have risen continuously over the last few decades, increasing the need for rigorous examination of promising programs.

Interventions attempting to change multiple behaviors have been designed to address interconnected problems such as use of both alcohol and drugs. This meta-analysis aimed to examine the efficacy of multi-behavior interventions to curb non-medical substance use in relation to the theoretical relation among different substance use behaviors. Specifically, our synthesis aimed to estimate the optimal number of recommendations for intervention efficacy and evaluate the impact of different combinations of recommendations on intervention efficacy.

**Methods:** A synthesis of multi-behavior interventions addressing non-medical substance use was conducted to measure behavioral changes between the pretest and the follow-up. These changes were then compared across different numbers of recommendations.

**Results:** Sixty-nine reports and 233 effect sizes ( $k$  of conditions = 155,  $n$  = 28,295) were included. A positive linear relation was found between the number of targeted behaviors and intervention efficacy, which was stronger for drug use than alcohol use. Furthermore, recommendations on drug use worked better when paired with recommendations targeting other behaviors, whereas recommendations on alcohol use worked more independently. Lastly, multi-behavior interventions were especially efficacious when delivered by experts.

**Conclusions:** Overall, our synthesis indicated that targeting multiple substances is beneficial for changing drug use outcomes, but less so for alcohol use outcomes. Therefore, in the current substance use epidemic, innovative multi-behavior programs appear to hold promise, especially to combat non-medical drug use.

**Keywords:** Meta-analysis, substance use, alcohol, multi-behavior interventions

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Substance Use**

The detrimental effects of non-medical substance use are well documented. According to the Centers for Disease Control, between 2006 and 2010, alcohol was responsible for an average of 88,000 deaths and 2.5 million years of potential life lost each year in the United States (Centers for Disease Control and Prevention, 2016). Deaths from illicit drug overdoses (heroin, natural and semisynthetic opioids, methadone, synthetic opioids, cocaine, etc.) in the United States are currently at a record high in both sheer numbers and prevalence per 100,000 people (Hedegaard et al., 2017). In 2015, 16.3 per 100,000 people died of a drug overdose, which represented over 2.5 times the 6.1 per 100,000 rate in 1999 (Hedegaard et al., 2017). Fortunately, many treatments and programs have been created to address non-medical substance use and addiction, including multi-behavior interventions, which are interventions geared towards changing two or more behaviors.

The efficacy of interventions aimed at reducing substance use has often been underwhelming. For example, nine prior meta-analyses estimated efficacy across populations and interventions. The sources, number of studies, critical comparisons, and effect sizes of these nine syntheses appear in Table 1. The syntheses spanned several decades with no apparent changes in efficacy, leading to the question of whether the newest generation of more complex interventions is ready to reduce substance use.

It is noteworthy that many of the programs included in Table 1 have addressed drug or alcohol use as relatively independent of other related behaviors or contextual factors that are likely to maintain the behavior. But in fact, research has shown that substance use often stems

from a plethora of biological, psychological, and social factors, all working in tandem (Borrell-Carrió et al., 2004). Substance use is often interdependent with other disorders and behaviors. For example, a number of underlying factors that affect a person's propensity to alcohol dependence may also lead to a propensity to tobacco dependency (Dawson, 2000; Friedman et al., 1991). Moreover, different forms of substance use are often interrelated. For example, alcohol and drug use are strongly correlated and using alcohol is often a precursor to drug use (Regier et al., 1990; Agosti, Nunes, & Levin, 2002). Relative to people who do not use alcohol, people who use alcohol are 35 times more likely to use cocaine, 17 times more likely to use sedatives, and 13 times more likely to use opioids (Helzer & Pryzbeck, 1988; Agosti, Nunes, & Levin, 2002; Stinson et al., 2005).

Recognizing the interrelation among different behaviors, cutting-edge intervention approaches often attempt to target multiple behaviors by making multiple recommendations. These interventions that attempt to change two or more behaviors are known as integrated interventions (Prochaska et al., 2008) or multi-behavior programs (Wilson et al., 2015), and can be implemented in several ways. First of all, interventions can promote multiple principal goals regarding substance use or other risks, based on knowledge of comorbid risks in the population, or programs and behaviors that the population needs. For example, an intervention tested by Haller et al. (2014) provided two main recommendations, namely to reduce alcohol use and to reduce cannabis consumption. Besides directly targeting risky behaviors, multi-behavior interventions can also address multiple behaviors that are often disrupted by the use of substances and can improve the outlook and lifestyle of people who use non-medical substances. For example, an intervention tested by Kypri and McAnally (2005) recommended increasing physical activity, increasing fruit intake, and increasing vegetable intake, besides reducing

hazardous drinking. Both types of recommendations discussed above are the goals of these programs and are considered to be main recommendations.

Interventions can also promote multiple auxiliary recommendations, which are skills or behaviors that are prerequisite for recipients to implement the main recommendations. For example, the intervention tested by Deady, Mills, Teesson, & Kay-Lambkin (2016) provided three auxiliary recommendations, including to monitor drinking behaviors, to monitor thoughts, and to plan for activities, besides the main recommendation to reduce alcohol use. These recommendations concern behaviors that, if implemented, can help participants to be successful at implementing the main recommendation.

Given the demonstrated existence of clusters of harmful behaviors and the antagonistic effects between drug use and health promoting behaviors, multi-behavior programs are the most logical solution to addressing the complex problem of substance use. Before our meta-analysis, some evidence suggested that multi-behavior interventions are effective in the domain of lifestyle behaviors (Wilson et al., 2015). Although these results are auspicious, it is still unclear whether similar models will improve substance-related interventions over and above prior generations of programs, and whether these programs apply differently to drug and alcohol outcomes. Therefore, the primary purpose of this meta-analysis was to examine the efficacy of these multi-behavior interventions in the domain of substance use.

### **Commonly Used Recommendations and Combinations of Recommendations in Multi-Behavior Programs for Non-Medical Substance Use**

Besides recommending a reduction in alcohol use and drug use, multi-behavior interventions often provide recommendations to change other related behaviors. These behaviors can range from major goals, such as maintaining a healthy lifestyle and preventing transmission

of sexually transmitted infections, to ones such as seeking social support and making better use of community services. To better understand the efficacy of multi-behavior interventions in the substance use domain, it is thus crucial to first describe combinations of recommendations that are most commonly used in multi-behavior programs for non-medical substance use. Therefore, another goal of this meta-analysis was to provide this description and further investigate the efficacy of such combinations of recommendations.

### **Optimal Number of Recommendations to Reduce Drug and Alcohol Use: Facilitating, Independent, and Antagonistic Relations among Behaviors**

Besides the type of recommendations to include, the number of recommendations to include in an intervention is also an important question to consider when aiming for the most efficacious intervention program. Whereas too few recommendations may not be stimulating enough to elicit change, an excessive number of recommendations can create burden and undermine the motivation to change (Wilson et al., 2015; Albarracín et al., 2018; Albarracín et al., 2019). Therefore, our meta-analysis also investigated the optimal number of recommendations to produce the greatest behavioral change.

The optimal number of recommendations to include in an intervention should depend on the relations among the target behaviors. Although previous research has shown a high intercorrelation among the use of multiple substances, the use of some substances may still be relatively more independent than the use of other substances. Better knowledge of the relative independence among the network of different behavior can help better predict the optimal number of recommendations targeting the use of each specific substance. To achieve this goal, in this paper, we proposed two models of relations among behaviors (see Figure 1). On the one hand, a Relative Interdependence Model represents behaviors that are causally associated. For

example, a person may experience cocaine cravings each time he drinks alcohol, or not seek health care during periods of heavy drug use (Behavior A causally related with Behavior B). Therefore, alcohol use increases the probability of drug use and drug use decreases the probability of seeking health care. On the other hand, a Relative Independence Model represents behaviors that are relatively independent from each other. For example, a person may drink alcohol (Behavior A) without having a craving for cocaine (Behavior A not causally related with Behavior B) (see e.g., Livingston, Oost, Heck, & Cochran, 2015). Thus, the Relative Interdependence model should be associated with stronger correlations among these two behaviors than the relative independence model, although neither model is likely to lead to either a perfect correlation or a 0 correlation and correlations among behaviors may also occur due to other factors.

In the current meta-analysis, we tested our theoretical hypothesis by comparing the efficacy of multi-behavior interventions targeting alcohol use, drug use, or both. In summary, if behaviors follow the Relative Interdependence Model, such as alcohol use facilitating drug use, or drug recovery requiring a cluster of support and health care services, then an intervention should be more efficacious when it targets both alcohol use and drug use, compared to targeting drug use alone. If behaviors follow the Relative Independence Model, such as alcohol use being independent from drug use, then an intervention should be equally efficacious when it targets both alcohol use and drug use, compared to targeting alcohol use alone.

A related important question is whether adding behavioral recommendations increases efficacy in a monotonic fashion. If the behaviors contribute to positive outcomes because they are mutually facilitating, then more recommendations should be better than fewer. However, if behaviors contribute to a positive outcome but compete for resources and cause fatigue, then

more recommendations should add only up to a point (Baumeister & Heatherton, 1996; Muraven et al., 1998; Vohs & Heatherton, 2000). In the domain of lifestyle (smoking, exercise, and diet), Wilson et al. (2015) showed that the improvements in efficacy resulting from adding recommendations flattened out or even decreased after 3 recommendations. However, the pattern may be different in the substance use domain. Whereas quitting smoking can make dieting more difficult, quitting alcohol can make quitting drugs easier. Likewise, protecting one's child, completing drug treatment, maintaining drug abstinence, and complying with court orders act synergistically, so that protecting a child is generally not possible without maintaining drug abstinence, complying with court orders, and completing drug treatment. Therefore, we hypothesized that in the substance use domain, there should be a linear relation between number of recommendations and intervention efficacy, such that more recommendations generally lead to more behavioral changes.

### **The Current Meta-Analysis**

The synthesis included 69 research reports ( $k$  of conditions = 155), which looked at the outcomes of interventions related to both alcohol and drug use. The list of the articles and its description can be found in Supplementary Table 1. We determined the change between the baseline and first follow-up and compared change across interventions with different numbers of recommendations, with passive controls coded as providing zero recommendations. The average gap between the baseline and first follow-up was two and a half weeks.

Importantly, the prior meta-analysis of multi-behavior interventions in the lifestyle domain identified several factors such as targeting a specific population and delivery format, as moderators of the effects of these multi-behavior interventions (Wilson et al., 2015). Often, targeting a specific population (e.g., specific ethnic group, vulnerable population) leads to more



efficacious programs than not targeting (Ammerman et al., 2002; Ebrahim et al., 2006; Hardcastle et al., 2013), and group delivery format is associated with higher efficacy than individual delivery format (Ayala, 2006; Wright et al., 2011). Besides these features, we also coded a variety of study settings and methodological moderators that have been commonly studied in intervention research (Albarracín et al., 2005), as well as the expertise of the facilitator of the intervention as represented by professional training in health or substance use issues (Durantini et al., 2006; Amaro et al., 2007; Burton et al., 1995). We also coded whether the intervention was designed to be culturally specific or generic (Dushay et al., 2001; Fogel et al., 2015), whether the intervention made use of active (e.g., behavioral skills training) vs. passive (e.g., informational arguments) strategies (Albarracín et al., 2005; Grossbard et al., 2010), whether the intervention relied on attitudinal elements (e.g., attitudinal arguments, threat arguments; Albarracín et al., 2005; Burke et al., 2005), motivational elements (e.g., feedback, encouragement, a written contract; Jungerman et al., 2007; Latkin et al., 2009), and/or skills training (e.g., role-playing, goal setting; Albarracín et al., 2005; Calsyn et al., 2010; Kaner et al., 2013), as well as whether the intervention included biological methods (e.g., use of nicotine patches, methadone; Hanson et al., 2008; Penberthy et al., 2013). A last moderator we included was whether the intervention targeted an alcohol / drug dependent population. This moderator was added to distinguish prevention of alcohol or drug use increase from treatment in dependent populations, which are often different in efficacy and characteristics (Nemoto et al., 2002; Volkow & Li, 2005; Fischer et al., 2015). The present meta-analysis explored the influence of all these factors in the domain of substance use.

Critical to our objectives, we described the synthesized multiple-behavior interventions in terms of whether they targeted drug use, alcohol use, and any additional behaviors, such as using

available community services, seeking social support, and developing behavioral skills to combat non-medical substance use. We then analyzed the impact of the number of all recommendations, as well as the number of main recommendations only, and considered this impact in the context of the types of behaviors that were combined. These analyses controlled for other factors identified as having an impact on change.

## **Method**

### **Literature Search**

We conducted an internet search of six research databases (EBSCO, Scopus, Web of Science, PubMed, JSTOR, and Crossref). The search terms used were as follows: *intervention, health education, persuasion, recommendation, treatment, educational program, rehabilitation, counseling outcomes, treatment outcomes, treatment effectiveness evaluation, treatment compliance, health promotion, behavior change, and randomized trial*. To specifically find articles related to multiple alcohol and/or drug use behaviors, we used the syntax ((alcohol or drug or substance) AND ((intervention or randomized trial)) NOT ((review or meta-analysis or campaign or cost-effectiveness or theoretical))). This search yielded a total of 2,022 articles. In an attempt to include as many pertinent articles as possible, we searched through the reference list of related meta-analyses, conference titles, and emailed the researchers who appeared most frequently in the database search, requesting any unpublished works. Article searches were performed iteratively in 2014, 2015, 2017, and 2019.

### **Inclusion Criteria**

After finding research reports, we screened the articles with our inclusion criteria, which led to a total of 69 eligible articles (see Figure 2). The inclusion criteria were as follows:

1. **Existence of at least two groups, including at least one multi-behavior group.** To be considered eligible, all reports had to have at least two groups to allow for comparison of change across conditions. They also had to have at least one multi-behavior intervention group that provided at least one substance use recommendation.
2. **Existence of at least one behavioral or clinical outcome.** To be included, all reports had to include at least one behavioral or clinical outcome variable. For example, if a paper reported behavioral intentions only, it was excluded.
3. **Number of recommendations available.** To be included in this meta-analysis, all reports had to include information that allowed us to count the number of recommendations. Reports were excluded if the number of recommendations could not be ascertained.
4. **Presence of sufficient statistical information.** All reports that did not include enough statistical information to calculate effect sizes for change over time were excluded. Therefore, to be included, articles had to report outcome values at both baseline and at least one follow-up, or other statistics (e.g., a paired *t*-test) to calculate change effect sizes. Reports that only included a follow-up outcome value were excluded, due to the fact that they disallowed us to calculate effect sizes to represent change over time.

### **Measuring Change in Overall Outcomes, Drug use Outcomes, and Alcohol use Outcomes**

Similar to the coding process used in Wilson et al. (2015), we recorded both behavioral and clinical intervention outcomes. The most frequent outcomes were alcohol consumption and drug consumption. The most frequent measures for alcohol consumption were the amount of alcohol consumed in a specific period (e.g., in a day, in a week), the frequency of excessive alcohol use (e.g., number of days of excessive drinking in a month), the proportion of abstinence days, and the number of drunk days. The most frequent measures for drug consumption were the amount of drug use (heroin, opioids, methadone, cocaine, crack, etc.) in a specific period (e.g., in the past week), the frequency of ecstasy use, the frequency of excessive drug use, the proportion of abstinence days, and the number of times having sex while under the influence of drugs.

Behaviors that help to reduce the risk from non-medical substance use were measured as well. These variables included adherence to medications, managing negative consequence of substance use, and counseling attendance. Clinical outcomes were measured infrequently. Clinical outcomes for alcohol use were urine test results, the number of medical conditions related to alcohol use, and diagnoses of alcohol use disorder or dependence. Clinical outcomes for substance use were urine test results, the number of drug use disorders diagnosed, and the number of dependence symptoms.

We obtained each effect size by representing the change from the pretest to the posttest (e.g.,  $d = (M_{\text{posttest}} - M_{\text{pretest}}) / SD_{\text{pretest}}$ ) for each of the outcome variables in a sample, including drug use outcomes, alcohol use outcomes, and any auxiliary behavioral outcomes, such as medical adherence and counseling attendance. For example, we obtained 5 effect sizes from Reback et al. (2010), including one alcohol-use outcome (i.e. percentage of people free of alcohol in a urine test), three drug-use outcomes (i.e. percentage of people free of cocaine / amphetamine / methamphetamine in a urine test), and one auxiliary outcome (i.e. intervention attendance).

Importantly, the decision to analyze change over time was based on the fact that performing post-test comparisons across conditions would typically provide one or two effect sizes of the many possible comparisons across interventions with 0, 1, 2, 3, 4, 5, 6, 7, 8 recommendations, and so on. Such a situation would thus require abnormally high levels of imputation to estimate the impact of the number of recommendation count, much higher than is the norm for network meta-analysis (Lumley, 2002; Caldwell et al., 2005; Glenny et al., 2005). Thus, it seemed more appropriate to impute the correlation between measures than to model tons of differences based on the scarce data provided by the trials we synthesized.

When running analyses on drug use and alcohol use separately, we only included the outcomes that only pertained to drug use or alcohol use from each report, depending on what they reported. For example, in Reback et al. (2010), we obtained one effect size for alcohol use from the only reported alcohol-use outcome, and three effect sizes for drug use from each of the three drug-use outcomes. Outcomes that pertained only to alcohol use included alcohol consumption, sex and drinking, and managing harmful consequences of alcohol use. Outcomes that pertained only to drug use included drug consumption, exchanging drugs for sex, starting drug treatment, and sharing syringes or other equipment. In each case, effects were scored to reflect improvement. For example, a decrease in alcohol use and an increase in the percentage of a sample starting drug treatment were coded positive.

### **Coding of Number of Overall and Main Recommendations**

We coded the number of recommendations by counting the total number of behavioral goals, including both main and auxiliary goals. We also created a separate count of number of main recommendations for the purpose of some analyses. Main recommendations were defined as the main goals defined in an intervention which had a direct impact on clients' quality of life,

whereas auxiliary recommendations are those that can help clients to achieve the main goals of the intervention. For example, the intervention in Santa, LaRowe, Armeson, Lamb, and Hartwell (2016) was coded as providing four recommendations because the intervention encouraged participants to reduce substance use, stay clean and sober, attend treatment, and take medication for the substance use disorder. Among these recommendations, the first one was considered a main recommendation, because it directly targeted the risky behavior of substance use and was the intervention's focus. The other three were coded as auxiliary because they were introduced to help clients to achieve the main goal of reducing non-medical substance use.

### **Coding of Type of Recommendations**

In addition to understanding the impact of the number of recommendations, we were interested in describing the most commonly used recommendations and combinations of recommendations, and their influence on change. Therefore, for each intervention, we coded whether it included recommendations targeting alcohol use, drug use, and any other commonly targeted behaviors, including sexual behavior, lifestyle behavior, service use, support seeking, and development of behavioral skills. However, due to the small *ks* for each of these types of recommendations, we combined all these recommendations into the category of “other recommendations” and classified all interventions into seven categories based on whether they included recommendations targeting alcohol use, drug use, and at least one other domain: (a) neither alcohol nor drug use, (b) alcohol use only, (c) drug use only, (d) alcohol and drug use, (e) alcohol use and at least one other domain, (f) drug use and at least one other domain, and (g) drug use, alcohol use, and at least one other domain.

### **Coding of Exploratory Study Characteristics**

Relevant characteristics of the reports, as well as the methods used in the studies, were coded by two independent raters as described in Supplementary Materials. Disagreements between coders were resolved by discussion and further examination of the reports.

**Description of the report.** We coded report characteristics, including the (a) publication year, (b) first authors' institution (e.g., college, hospital, research center), (c) first authors' institutional area (e.g., psychology, public health, medicine), (d) source type (e.g., journal article, dissertation), (e) location of the intervention, and (f) language of the intervention.

**Demographic and other participant characteristics.** We also coded characteristics of the sample, including the (a) sample size, (b) percentage of males in each group, (c) mean age, (d) percentages of participants of European, African, Latin, Asian, and Native American descent, (e) percentage of participants who completed high school and their mean years of education, (f) percentages of participants who identified as heterosexual, gay and bisexual, and (g) percentage of participants with a pre-existing health condition (e.g., HIV, heart disease).

We further coded factors related to the intervention participants. We coded reports for (a) the specific sample targeted in the intervention (e.g., college students, people who inject drugs), and recoded this variable to indicate whether the intervention targeted a population that was alcohol / drug dependent, (b) whether the intervention was targeted to an ethnic minority group, (c) whether the intervention was targeted to a specific gender group, and (d) whether the sample was self-selected, indicated by whether participation in the intervention was voluntary or whether the study conducted with a captive audience (e.g., prison inmates).

**Intervention characteristics.** Finally, we coded for characteristics of the intervention programs, including (a) whether participants were randomly assigned and (b) the mean number of days between the intervention and posttest. We also coded for factors related to the

implementation of these interventions. Specifically, we classified each intervention group according to (a) where participants were recruited (e.g., drug treatment facility, social service agency), and recoded this variable to describe a hospital/clinic setting vs. a non-hospital/clinic setting, (b) whether the facilitator was a professional (e.g., physician, nurse, social workers, licensed counselors) or lay community member (e.g., community leaders and peers), (c) whether the intervention was delivered in a group setting, to individuals, or a combination of the two, (d) the exposure format (e.g., radio, brochure), which was recoded as face-to-face vs. other formats, (e) the exposure setting (e.g., school, community), and (f) clinic vs. non-clinic setting. We also determined (g) whether the intervention was designed to be culturally specific or generic, (h) whether the intervention made use of active (e.g., behavioral skills training) vs. passive (e.g., informational arguments) strategies, (i) whether the intervention relied on attitudinal elements (e.g., attitudinal arguments, threat arguments), motivational elements (e.g., feedback, encouragement), or skills training elements (e.g., role-playing, goal setting), (j) whether the intervention included biological methods (e.g., use of nicotine patches, methadone), and (k) whether the intervention include a written behavioral contract.

### **Data Analytic Plan**

To obtain effect sizes from the mean scores we subtracted the mean at posttest from the mean at pretest and divided it by the pooled standard deviation. To get effect sizes from proportions, we calculated the odds ratio and divided its natural log by 1.81 to convert it into Cohen's *d* as outlined by Chinn (2000). For cases in which the proportion was equal to 0 or 1 at either posttest or pretest, we applied the correction from Sweeting, Sutton, and Lambert (2004), which involved adding 0.005 to (or subtracting 0.005 from) both pretest and posttest scores. Because the correlation between the pre-test and post-test measures is not reported, we set this



correlation constantly as  $r = .5$ . We note, however, that supplementary analyses were conducted with  $r = .8$ , as a sensitivity analysis, and all our conclusions remained the same. Hedges and Olkin's (1985) correction factor was applied to all effect sizes to correct for small sample size bias. Reverse factors were applied to all the effect sizes so that a positive effect size always showed improvement, whereas a negative effect size showed worsening in the targeted health outcome.

For reports that included multiple outcomes or multiple measurements for one outcome (e.g., substance use, alcohol use), we kept all the effect sizes in the final analyses and used the robust variance estimate to deal with the dependency among correlated effect sizes obtained from the same study (Tanner-Smith et al., 2016).

Most data analysis was conducted using RVE (i.e. robust variance estimate) meta-regression in the statistical program R (Tanner-Smith & Tipton, 2014). R was also used to generate a funnel plot and run trim and fill analysis to gauge publication bias. Due to high levels of heterogeneity ( $I^2 = 0.953$ ), we used only random-effect models for all analyses. That is, the effect sizes were weighted by the inverse of their sampling variance plus a random variance component.

## **Results & Discussion**

### **Description of Sample**

We included 69 reports, resulting in 155 research groups and 233 effect sizes. Among the 155 research groups, 103 groups recommended multiple behaviors, 20 groups recommended a single behavior, and 22 groups did not recommend any behavior. The number of recommendations in the synthesized studies ranged from 0 to 11. When only counting the main recommendations, 87 groups included more than one main recommendation, 44 groups included

one main recommendation, and 24 groups did not include any main recommendation. Of the 155 groups, 106 included outcomes on alcohol use and 86 included outcomes on drug use. The total number of participants included in this meta-analysis was 28,295.

A summary of the demographic characteristics, intervention set-up details, and participants information appears in Supplementary Table 2. As can be seen, most of the reports included in this meta-analysis were journal articles, published around 2011, and conducted in the United States. The samples included both males (56%) and females (44%), who, on average, were in their mid-thirties. On average<sup>2</sup>, 37% of participants were gay or bisexual ( $k = 31$ ), 61% had completed high school ( $k = 80$ ), 57% had a risk factor or health condition at baseline ( $k = 51$ ), 48% were European-American ( $k = 121$ ), 28% were African-American ( $k = 112$ ), 86% were randomly assigned to conditions ( $k = 155$ ), and 85% voluntarily participated in the interventions ( $k = 151$ ). Among all interventions, 83% were delivered face-to-face ( $k = 126$ ), 25% were delivered to groups ( $k = 136$ ), 53% were delivered to individuals ( $k = 136$ ), 87% used professional experts as facilitators ( $k = 155$ ), 26% targeted alcohol / drug dependent populations ( $k = 155$ ), 6% targeted a specific at-risk ethnic group ( $k = 155$ ), 24% targeted a specific gender ( $k = 148$ ), and only 8% were described by the authors as culturally appropriate ( $k = 155$ ).

### **Average Intervention Effect Size**

Overall, there were significant improvements in the studied samples. The grand average for change over time was  $d = 0.42$  ( $CI = [0.34, 0.50]$ ,  $p < .001$ ,  $k = 233$ ,  $I^2 = 0.953$ ), which was close to a medium effect<sup>3</sup>. Comparing the efficacy of multi-behavior interventions to that of

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<sup>2</sup>  $k$  referred to the number of conditions in which relevant information was reported. For example, only 22 groups reported percentage of gay or bisexual man, and 56% was the average percentage among these 22 groups.

<sup>3</sup> According to Cohen's tradition (Chen et al., 2010),  $d = 0.2$  is considered a small effect,  $d = 0.5$  is considered a moderate effect,  $d = 0.8$  is considered a large effect. Therefore, the effect we found in the current meta is close to a moderate effect.

previous intervention programs on substance use (Table 1), multi-behavior interventions performed better than most of the intervention programs that have been examined in the past. When separating alcohol and drug use outcomes, the average change on alcohol use outcomes over time was  $d = 0.31$  ( $CI = [0.24, 0.38]$ ,  $p < .001$ ,  $k = 118$ ,  $I^2 = 0.892$ ). The average change on drug use outcomes over time was  $d = 0.53$  ( $CI = [0.39, 0.67]$ ,  $p < .001$ ,  $k = 91$ ,  $I^2 = 0.972$ ). Multi-behavior interventions led to significantly more change on drug use outcomes than on alcohol use outcomes ( $B = 0.245$ ,  $SE = 0.079$ ,  $p = .002$ ).

### **Optimal number of Recommendations**

Our objective was to estimate the association between number of recommendations and change. To test for the linear and quadratic predictions between number of behavioral recommendations and intervention efficacy, we first ran an RVE (i.e. robust variance estimate) meta-regression analysis of overall efficacy on number of recommendations, including mean-centered linear and quadratic terms in the model. As shown in Table 2a, the linear term was significant ( $B = 0.073$ ,  $SE = 0.016$ ,  $p < .001$ ) but the quadratic term was not ( $B = 0$ ,  $SE = 0.007$ ,  $p > .05$ ). This pattern replicated for both alcohol use outcomes alone (Linear:  $B = 0.046$ ,  $SE = 0.017$ ,  $p < .05$ ) and drug use outcomes alone (Linear:  $B = 0.085$ ,  $SE = 0.025$ ,  $p < .01$ ). To better understand the effect of the main intervention recommendations, we counted only the main recommendations and reran the above regression analysis. The patterns were mostly similar to the previous analysis. For overall outcomes, the linear term was significant ( $B = 0.129$ ,  $SE = 0.031$ ,  $p < .001$ ) but the quadratic term was not ( $B = 0.022$ ,  $SE = 0.023$ ,  $p > .05$ ). This pattern replicated for drug-use outcomes alone (Linear:  $B = 0.182$ ,  $SE = 0.080$ ,  $p < .05$ ) but not for alcohol-use outcomes alone (Linear:  $B = 0.042$ ,  $SE = 0.024$ ,  $p > .05$ ).

Knowing that underestimation of the pre-post correlation can lead to potential errors in estimation of the effect (Cuijpers et al., 2017), we changed the correlation between the pre and post measures from 0.5 to 0.8 and rerun the above meta-regression, as a sensitivity analysis. As shown in Table 2b, changing the correlation between the pre and post measures only changed the numerical value of the estimated effect but did not change the overall linear pattern between number of recommendation and the intervention efficacy. This pattern replicated for both alcohol and drug use outcomes and for both main and auxiliary recommendations.

To further describe an optimal number of recommendations, we calculated the mean change for each number of recommendations on all outcomes. Due to the small *ks* for interventions recommending 6 or more than 6 behaviors, we combined them all into one group as “6 & 6+ recommendations”. As shown in Panel A of Figure 3, the mean change steadily increased as the number of recommendations increased, with interventions recommending 6 or more than 6 recommendations bringing the largest change over time. The overall pattern of means is offered for descriptive purposes and further support the positive linear relation between number of recommendations and intervention efficacy that we formally tested in Table 2.

We then calculated the mean change for each number of recommendations for alcohol use outcomes and drug use outcomes separately. As shown in Panel B of Figure 3, the mean change for alcohol use outcomes did not change much as the number of recommendations increased beyond one, suggesting that a single recommendation might be sufficient in this case. In contrast, the mean change for drug use outcomes steadily increased as the number of recommendations increased and flattened out after 4, although the quadratic pattern was not significant (see Table 2). This pattern suggested that multiple recommendations were needed to maximize efficacy in drug interventions.

Overall, the results in Table 3 show a linear association between number of recommendations and intervention efficacy for our three measures of substance use outcomes. First, although the regression analysis shows a linear effect of number of recommendations on efficacy for alcohol use, Panel B of Figure 3 indicates little benefit in adding recommendations beyond one, suggesting that a single recommendation might be enough to change alcohol use behavior. In contrast, for drug use, recommending reducing drug use along with other behaviors is most efficacious. Regarding the number of included recommendations, intervention including four or more than four recommendations appeared to be most efficacious in changing drug use behavior. These patterns provide more support for the Relative Interdependence Model for drug use than for alcohol use.

### **Types of Recommendations**

To better understand the impact of different types of recommendations included in the interventions and further test our hypothesized models (i.e., Relative Interdependence Model and Relative Independence Model), we then calculated the mean change for different groups of interventions on overall outcomes based on the types of recommendations included.<sup>4</sup>

If drug use is more dependent on alcohol use than alcohol use is on drug use, then the effects of interventions targeting both alcohol and drug use may be larger than those targeting alcohol use only. As shown in Panel D of Figure 3, however, the effects of interventions targeting both alcohol and drug use appeared to be similar to those targeting alcohol or drug use only. Still, we found that intervention efficacy was especially high when it included interventions recommending reducing both drug use and another behavior compared to only drug use.

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<sup>4</sup> Due to the low power and low statistical efficiency, we were unable to examine the efficacy of different recommendations combinations on alcohol and drug use outcomes separately.

However, the efficacy of interventions recommending reducing alcohol use did not improve when paired with recommendations of other behaviors.

All in all, substance use outcomes improved more when drug recommendations were combined with at least one other recommendation, such as seeking service use and support seeking. This finding provides further support for the Relative Interdependence Model for drug use. Replicating the finding that alcohol-use outcomes changed equally in response to single- and multi-recommendation interventions, a single recommendation of alcohol use achieved roughly the same level of change as did combinations of alcohol use and other recommendations such as seeking service use or reducing drug use. This finding again supported the earlier finding (see Panels B and C at Figure 3) that alcohol use is relatively more independent from other related behaviors, compared to drug use.

### **Exploratory Moderator Analysis**

We then conducted exploratory moderator analyses to determine whether participant or intervention characteristics were associated with efficacy. All analyses were conducted with the overall samples of conditions except for those with intervention characteristics as moderators, which pertained only to intervention groups. These analyses appear in Table 3 and showed three major significant moderators. Specifically, interventions were more efficacious when they targeted an alcohol / drug dependent population ( $d = 0.59$ , 95% CI = [0.37, 0.80],  $k = 69$ ) than when they did not ( $d = 0.36$ , 95% CI = [0.28, 0.43],  $k = 164$ ); when they were delivered by experts ( $d = 0.57$ , 95% CI = [0.33, 0.80],  $k = 99$ ) than when they were not ( $d = 0.18$ , 95% CI = [0.00, 0.36],  $k = 11$ ); and when they included a behavioral contract ( $d = 1.02$ , 95% CI = [0.52, 1.72],  $k = 7$ ) than when they did not ( $d = 0.39$ , 95% CI = [0.32, 0.47],  $k = 226$ ). The rest of the described moderators had no significant effect.

### **Testing the Linearity between Number of Recommendations and Efficacy after Controlling for Significant Moderators**

We lastly tested whether number of recommendations predicted intervention efficacy above and beyond each of these predictors. Specifically, we conducted three multiple regression models, each including the number of recommendations and one of the three moderators above as the predictors. The linear term of number of recommendations was still significant after controlling for targeting drug / alcohol dependent population ( $B = 0.067$ ,  $SE = 0.020$ ,  $p < .01$ ), expert delivery ( $B = 0.136$ ,  $SE = 0.034$ ,  $p < .001$ ), and inclusion of behavioral contract ( $B = 0.067$ ,  $SE = 0.020$ ,  $p < .01$ ). However, only expert delivery remained as a significant predictor after controlling for the number of recommendations included ( $B = 0.249$ ,  $SE = 0.083$ ,  $p < .05$ ). Again, these findings confirmed the positive linear relationship between number of recommendations and intervention efficacy, showing the promising prospect of multi-behavior interventions in combating non-medical substance use.

### **Summary**

In conclusion, our analyses revealed that multi-behavior interventions were efficacious at reducing non-medical substance use behaviors, especially for drug use behaviors. The data also suggested a linear association between the number of recommendations and change, such that the more behaviors recommended, the more efficacious the interventions were, particularly for drug use outcomes. This pattern held even after controlling for alcohol / drug dependent subpopulations, facilitators' characteristics, and inclusion of behavioral contracts. Finally, we found strong support for the Relative Interdependence Model for drug use in relation to other behaviors, particularly seeking services that support recovery. In contrast, we found less support for the Relative Interdependence Model for alcohol use, which could be targeted more

independently of other outcomes and achieve the same level of success as in combination with other outcomes.

### **Inclusion Bias**

Finally, we assessed inclusion bias in multiple ways. First, we visually inspected the funnel plot of the effect size against the standard error (see Figure 4). If the distribution of effect sizes were unbiased, the plot should resemble a funnel, with studies with greater errors (assessed as smaller sample sizes) displaying greater variability (Sterne et al., 2006). Our plot revealed a bias suggesting that some positive effects were missing across different levels of precision. Therefore, we ran Egger's test of asymmetry (Egger et al., 1997). For our data, the intercept for Egger's test was 4.08 ( $p < .001$ ), which suggested that there is asymmetry in the distribution of effect sizes. To address the asymmetry, we ran Duval and Tweedie's (2000) trim and fill analysis. This method first fills in any missing effect sizes and then adds them to the analysis to recalculate an adjusted effect size corrected for observed biases (Rothstein, 2005). The trim and fill analysis (see Figure 4) added 43 studies to the right side, which moved our estimate from 0.42 ( $CI = [0.34, 0.50]$ ) to a new adjusted  $d = 0.53$  ( $CI = [0.47, 0.60]$ ) for the intervention groups, which remained significant. All the above analyses of bias indicated that our estimated effects were overly conservative and not affected by the usual publication bias that shows reluctance to publish negative effects. In this case, the synthesis appears to be missing positive effects.

Given the existing criticism of the above methods as lacking a statistical model and proper evaluation (McShane et al., 2016), we then applied the selection methods to further assess and adjust for publication biases relating to the statistical significance of effect sizes. Selection methods assume that the probability of publication depends on the  $p$ -value of its effect size. In other words, different  $p$ -values tend to have different chances of getting published and therefore



being included in a meta-analysis (Hedges & Vevea, 1996; Vevea & Woods, 2005). Given that our dataset showed an untraditional bias against positive effects, we run a two-tailed sensitivity analysis for our dataset. Assuming a moderate two-tailed selection bias, the adjusted effect dropped to 0.39, which is a 0.03 reduction from the original effect size. Assuming a severe two-tailed selection bias, the adjusted effect turned into 0.36, which is a 0.06 reduction from the original effect size. These sensitivity analyses did suggest some potential bias, but the bias should have very little impact on our estimated effect sizes.

Altogether, the distribution of effect sizes in our meta-analysis was asymmetric. However, the asymmetry does not suggest exclusion of negative or non-significant effects. Instead, the asymmetry indicates that positive effects might be missing, which would then lead to overly conservative estimates of the efficacy of multi-behavior interventions. The sensitivity analyses also showed that, even assuming a severe bias, the observed effect remains significant. All in all, the observed bias is most likely due to the heterogeneity in the current dataset created by different methodological variables and unlikely to nullify our conclusions.

## **Conclusions**

### **Overview of Findings**

Given the rising rates of alcohol-related deaths and drug overdoses in the United States, understanding intervention efficacy in this domain is critical. Our study is the first to describe the body of evidence on multiple-behavior interventions for substance use. The majority of multi behavior programs analyzed in the current meta-analysis involved 2 or 3 recommendations targeting more than one behavioral domain, either alcohol use plus drug use, alcohol use plus one other domain (e.g. lifestyle, sexual behavior, service use), or drug use plus one other domain.

Our study showed that multi-behavior interventions were overall effective in reducing non-medical substance use, more so for drug use than for alcohol use. Our results also showed a general positive linear relation between number of recommendations and overall change, which was stronger for drug use outcomes and weaker for alcohol use outcomes. Regarding the type of included recommendations, we found that inclusion of recommendations for other behaviors increases the efficacy of drug use interventions but does not seem to improve the efficacy of alcohol use interventions. Altogether, these findings supported the notion that drug use often accompanies alcohol use (i.e., Relative Interdependence Model; see Figure 1), whereas alcohol use is more independent from drug use and other related behaviors (i.e., Relative Independence Model, see Figure 1). All in all, although the heterogeneity of the data caution against broad generalizations, multi-behavior interventions seemed better for drug use, whereas single-behavior interventions might be sufficient for alcohol use.

It is important to note that this linear pattern is different from the curvilinear pattern found by Wilson et al. (2015) in the lifestyle domain, suggesting that the optimal number of recommendations to be included in intervention programs differs across domains. Although three recommendations might be sufficient to change lifestyle related behaviors (e.g. exercising, smoking) and single recommendation might be sufficient to decrease alcohol use, more recommendations are necessary to reduce drug use. These findings surrounding the domain-specific optimal number of recommendations have important implications for the design of future intervention programs. Based on our findings, alcohol use can be treated as a relatively independent problem and an alcohol intervention program can simply target the alcohol use behavior itself (i.e. aiming to reduce the amount of alcohol consumed in the target population). In contrast, intervention programs to curb non-medical drug use need to consider the

interconnections among the drug use behaviors and other related behaviors. For example, these interventions may benefit from determining all the substances that a patient is currently using and all the relevant behaviors that are leading to or relevant to the use of a specific substance (e.g., lack of social support, limited access to drug treatment program). Interventions may also benefit from including recommendations targeting all of these relevant behaviors, instead of just drug use. Accordingly, when reassessing patient behavior at a follow-up point, the interventionists should not limit the assessment to just drug use but instead measure the related behaviors and a more holistic improvement.

Lastly, our exploratory moderator analyses found participant and intervention characteristics that moderate the efficacy of interventions. Specifically, interventions were more efficacious when targeting an alcohol / drug dependent population, being delivered by experts, and including a behavioral contract. Number of recommendations still remained as a significant predictor after controlling for each of these predictors, but only expert delivery remained as a significant predictor after controlling for the number of recommendations. These results, if supported by further evidence from randomized controlled trials, may also provide important guideline for future interventions. For example, future intervention programs may invest more resources in the training of the facilitators to ensure their expertise in delivering the interventions.

### **Limitations and Future Work**

There are a few limitations to be noted for the current meta-analysis. First of all, although we included both behavioral and clinical outcomes, most of the outcome measurements included in the current meta-analyses were behavioral (roughly 90 percent), due to the fact that most studies in the substance use domain rely solely on behavioral outcomes. Since most of the

behavioral outcomes are measured through self-report, various problems can rise, such as social desirability bias and participants' lack of knowledge about health behaviors (Newell et al., 1999). To enhance the generalizability of the current findings, future research should examine the impact of multi-behavior programs on clinical outcomes.

Next, although the intervention programs included in our synthesis covered a wide range of number of recommendations (i.e., 0-11), they did not assess all possible numbers of recommendations. Past research suggests that related behavioral recommendations might compete for resources and lead to a fatigue effect (Baumeister & Heatherton, 1996; Muraven et al., 1998; Vohs & Heatherton, 2000). Although this fatigue effect does not seem to appear in our studies with up to 11 recommendations, a higher number of recommendations could still be problematic. Therefore, future research should replicate the current meta-analytic study findings by examining future multi-behavioral interventions with more than 11 recommendations to determine the effect of higher numbers of recommendations.

Lastly, there are conflicting opinions on use of effect sizes that reflect change over time as posed to treatment-control conditions, although those apply primarily to the use of pre-post designs without controls (Cuijpers et al., 2017). Despite the validity of these arguments, we believe that the problem at hand required the chosen effect size. In addition, our findings were robust to changes in the estimated correlation between the pre- and post- measures from 0.5 to 0.8 as a sensitivity analysis. The additional analyses showed that any uncertainty about this correlation could influence the point estimation of the effect but is very unlikely to alter the primary conclusions from our study. Secondly, although it is true that it is hard to separate the intervention effect from the effect coming from natural processes, we are always comparing across conditions rather than relying on a single effect.

## **Closing Remarks**

Designing more efficacious intervention programs is key to halting the current substance use crisis. This meta-analysis found a general positive linear relation between the number of recommendations and change, which was stronger for drug use programs than for alcohol use programs. This result ensures that multi-behavior interventions are promising methods to combat the current drug use epidemic and may be an effective solution through widespread implementation. Our analyses also showed that drug use interventions appeared to be more efficacious when also targeting other related behaviors, whereas alcohol use interventions can be efficacious enough when only targeting alcohol use itself. Additionally, this meta-analysis identified multiple moderators that can influence the efficacy of this particular type of promising intervention in the substance use domain. To maximize change, interventions should be delivered by experts, which imply the necessity of greater funding in the area of behavioral health and more training of health professionals. Lastly, the efficacy of multi-behavior programs seemed robust to differences in contexts and target populations, which makes the findings generalizable. Altogether, although more work still need to be done to reach confident conclusions about the optimal number and type of recommendations, our meta-analysis contributes to our understanding of multi-behavior programs in the substance use domain and has actionable implications for the development and implementation of future intervention programs, as well as policy surrounding them.

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Table 1. Summary of Prior Meta-Analyses of Substance Use Interventions.

	Title	<i>M</i> year	k of studies	Effect size	Comparison (& type of controls)
Prendergast, Podus, Chang, & Urada, (2002)	The effectiveness of drug abuse treatment: A meta-analysis of comparison group studies	1980	78	$g = 0.34$	Drug use treatment vs. active control
Prendergast, Podus, Finney, Greenwell, & Roll (2006)	Contingency management for treatment of substance misuse disorders: A meta-analysis	1986	47	$g = 0.42$	Contingency management vs. control
Magill & Ray (2009)	Cognitive-Behavioral Treatment with Adult Alcohol and Illicit Drug Users: A meta-analysis of randomized controlled trials	1994	53	$g = 0.154$	CBT vs. active control
				$g = 0.115$	CBT vs. active control,
Carney & Myers, (2012)	Effectiveness of early interventions for substance using adolescents: Findings from a systematic review and meta-analysis	2006	9	$g = 0.24$	Drug and alcohol treatment vs. control
Blodgett, Maisel, Fuh, Wilbourne, & Finney, (2014)	How effective is continuing care for substance misuse disorders? A meta-analytic review	1999	19	$g = 0.187$	Continuing care vs passive control

Title		<i>M</i> year	k of studies	Effect size	Comparison (& type of controls)
Benishek et al., (2014)	Prize-based contingency management for the treatment of substance abusers: A meta-analysis	2007	19	$g = 0.271$	Continuing care vs. passive control comparison
				$d = 0.46$	Contingency management vs. active control
				$d = 0.33$	Contingency management vs. active control
Tanner-Smith & Risser (2016)	A meta-analysis of brief alcohol interventions for adolescents and young adults: Variability in effects across alcohol measures	NR	190	$g = 0.25$	Brief intervention vs. passive control (adolescents)
				$g = 0.15$	Brief intervention vs. passive control (young adults)
Boumparis, Karyotaki, Schaub, Cuijpers, & Riper (2017)	Internet interventions for adult illicit substance misusers: A meta-analysis	2010	17	$g = 0.31$	Internet interventions vs. mostly active control
				$g = 0.22$	Internet interventions vs. mostly active control
Sayegh, Huey, Zara, & Jhaveri (2017)	Follow-up treatment effects of contingency management and motivational interviewing on substance misuse: A meta-analysis	NR	84	$d = 0.43$	Contingency management vs. control
				$d = 0.06$	Contingency management vs. control
				$d = 0.10$	Motivational interviewing vs. control
				$d = 0.22$	Motivational interviewing vs. control

$g$  = Hedge's  $g$ , corrected for small sample bias.  $d$  = Cohen's  $d$ , not corrected for small sample bias.

Table 2a. Summaries of the Meta-Regression Analysis for Change with Robust Variance Estimate (Correlation between Pre- and Post-Score Set as 0.5)

	Estimated coefficients $\beta$ (Standard error)		
	Overall Outcome Change ( $k = 233$ )	Alcohol Use Change ( $k = 118$ )	Drug Use Change ( $k = 91$ )
<i>All recommendations included</i>			
Recommendation number linear	0.073 (0.016) ***	0.046 (0.017) *	0.085 (0.025) **
Recommendation number squared	0.000 (0.007)	-0.002 (0.003)	-0.005 (0.011)
<i>Only main recommendations included</i>			
Recommendation number linear	0.129 (0.031) ***	0.042 (0.024)	0.182 (0.080) *
Recommendation number squared	0.022 (0.023)	0.021 (0.026)	-0.003 (0.074)

\*  $p < .05$  \*\*  $p < .01$  \*\*\*  $p < .001$ .  $k$  is the total number of effect sizes included.

Table 2b. Summaries of the Meta-Regression Analysis for Change with Robust Variance Estimate (Correlation between Pre- and Post-Score Set as 0.8)

	Estimated coefficients $\beta$ (Standard error)		
	Overall Outcome Change ( $k = 233$ )	Alcohol Use Change ( $k = 118$ )	Drug Use Change ( $k = 91$ )
<i>All recommendations included</i>			
Recommendation number linear	0.070 (0.015) ***	0.045 (0.016) **	0.080 (0.025) **
Recommendation number squared	0.000 (0.007)	-0.003 (0.003)	-0.005 (0.010)
<i>Only main recommendations included</i>			
Recommendation number linear	0.125 (0.030) ***	0.041 (0.023)	0.177 (0.078) *
Recommendation number squared	0.020 (0.022)	0.020 (0.026)	-0.007 (0.074)

\*  $p < .05$  \*\*  $p < .01$  \*\*\*  $p < .001$ .  $k$  is the total number of effect sizes included.

Table 3. Exploratory Moderator Analyses.

<i>Moderators</i>	<i>d [CI]</i>	<b>Estimated coefficients <i>B</i> (Standard error)</b>	<i>k</i>
Is the target group alcohol / drug dependent?		0.230 (0.106) *	233
Yes	0.59 [0.37, 0.80]		69
No	0.36 [0.28, 0.43]		164
Is the intervention delivered by experts?		0.385 (0.106) **	110
Yes	0.57 [0.33, 0.80]		99
No	0.18 [0.00, 0.36]		11
Is there behavioral contract?		0.726 (0.238) *	233
Yes	1.02 [0.52, 1.72]		7
No	0.39 [0.32, 0.47]		226

\*  $p < .05$  \*\*  $p < .01$ .  $k$  is the total number of effect sizes included.

Figure 1. Models of Relatively Interdependent and Relatively Independent Behaviors

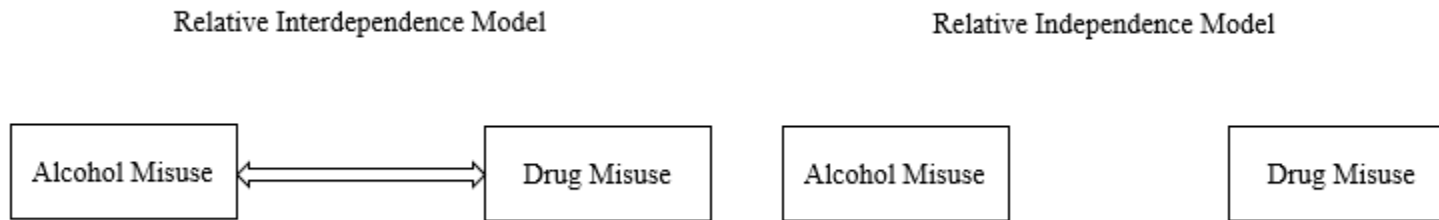
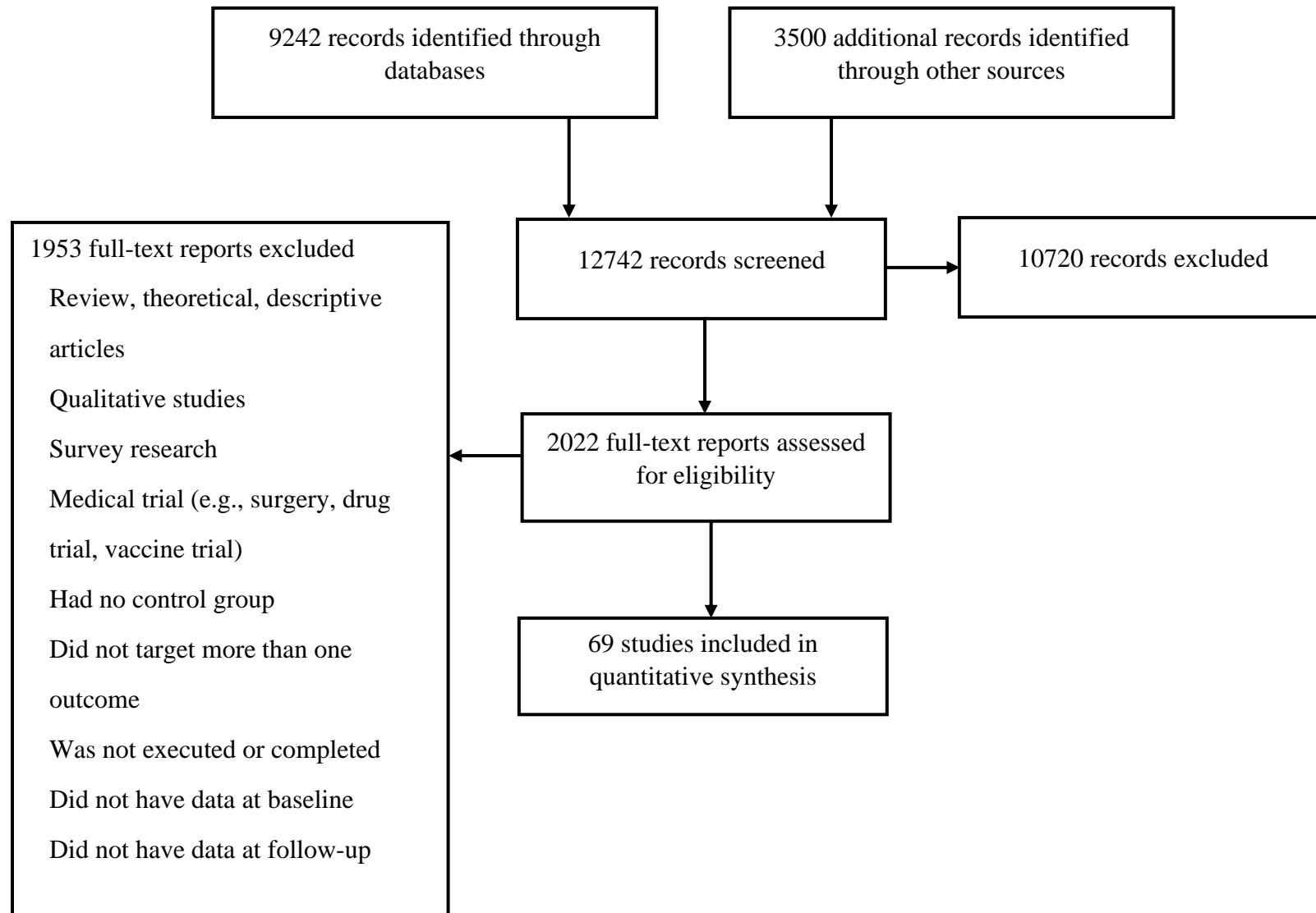
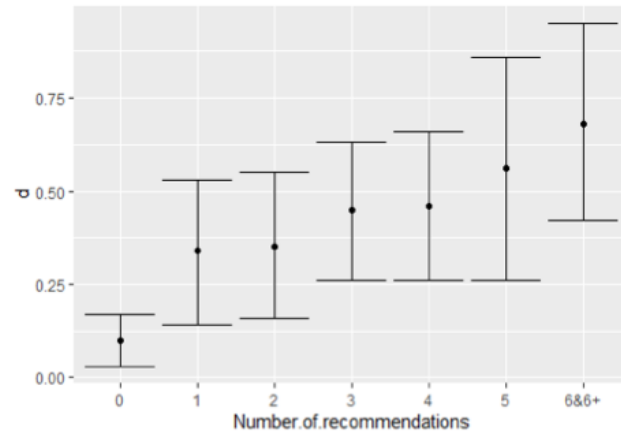




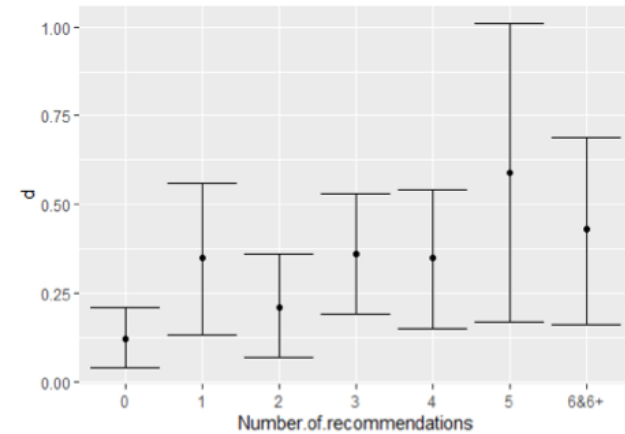
Figure 2. Flow of reports in this systematic review.



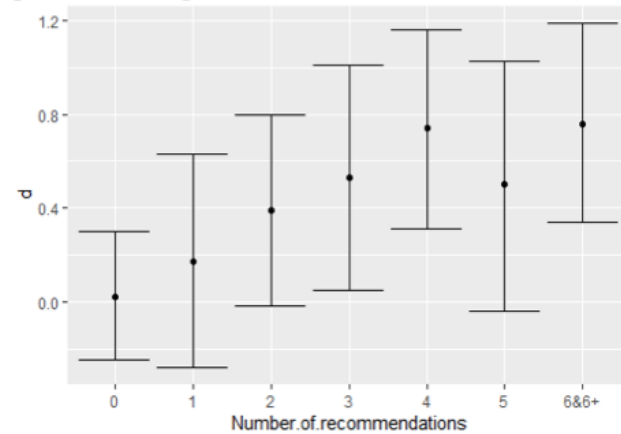
A. Overall Change as a Function of Recommendation Number



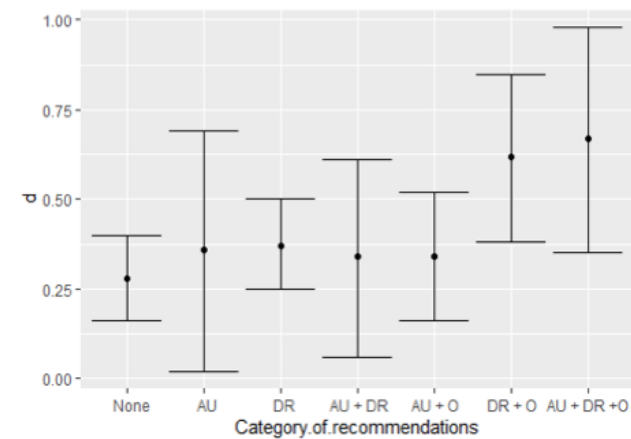
B. Alcohol Misuse Change as a Function of Recommendation Number



C. Drug Misuse Change as a Function of Recommendation Number



D. Overall Change as a Function of Recommendation Types.

Figure 3. Findings for Number and Type of Recommendations. *Note.* AU = Alcohol Use; DR = Drug Use; O = Other Category

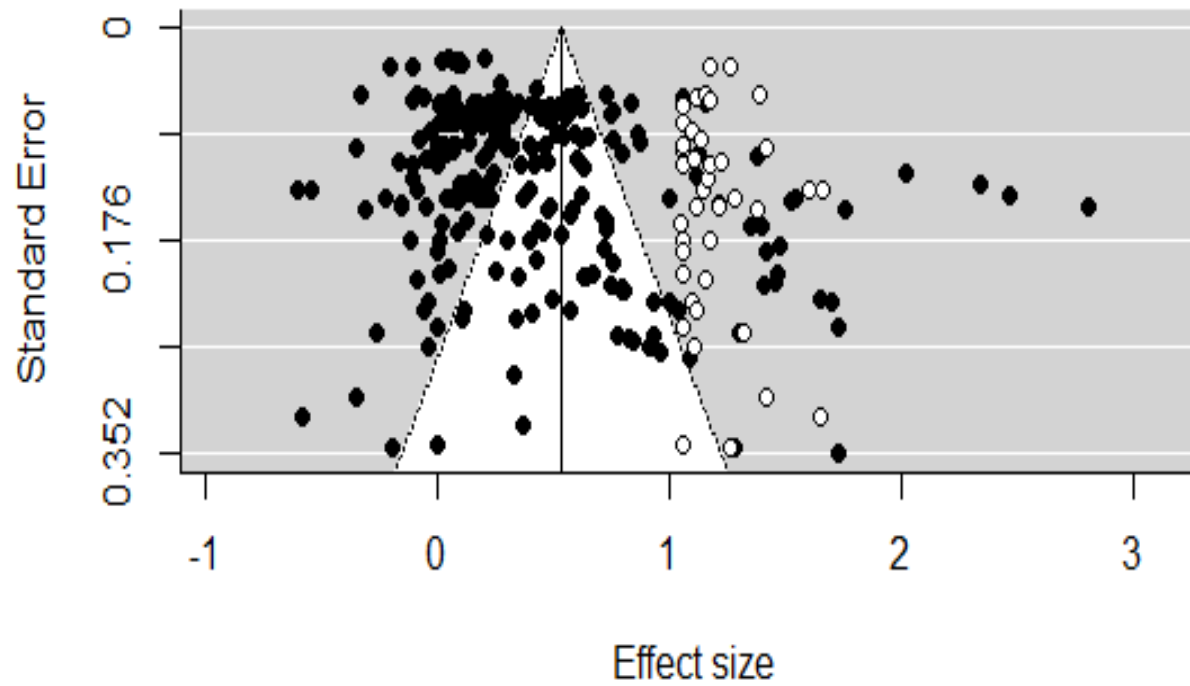


Figure 4. Funnel plot for inclusion bias analysis (dots added by trim and fill methods are shown in white).

Supplementary Table 1. Summaries of All Studies Included in The Current Meta-Analysis

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Aharonovich et al.,2017	This study examined the feasibility and efficacy of MI + HealthCall as adapted for smartphone technology on reducing non-injection drug and alcohol use.	6	2	Reduce drug use; reduce alcohol use	4	Set goals to reduce alcohol use; set goals to reduce drug use; continue alcohol use care; continue drug use care	21	0.88
Aharonovich et al.,2017	This study examined the feasibility and efficacy of MI + HealthCall as adapted for smartphone technology on reducing non-injection drug and alcohol use.	5	3	Reduce alcohol use; reduce drug use; achieve abstinence;	2	Continue alcohol use care; continue substance use care	21	0.89
Amaro et al., 2007	This study examined the efficacy of trauma-enhanced substance abuse treatment combined with HIV/AIDS prevention on reducing sexual risk behaviors compared to treatment with services-as-usual.	2	2	Reduce sexual risk for HIV; decrease substance abuse	0	/	110	-0.1
Amaro et al., 2007	This study examined the efficacy of trauma-enhanced substance abuse treatment combined with HIV/AIDS prevention on reducing sexual risk behaviors compared to treatment with services-as-	6	2	Reduce sexual risk for HIV; decrease substance abuse	4	Implement interpersonal skills (sexual negotiation, sexual safety); implement money and finances skills; implement child custody skills;	122	0.36

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	usual.					implement parenting skills and family communication		
Arnaud, 2017	This study examined the efficacy of a brief motivational intervention to reduce drinking and associated problems within pediatric emergency department in Germany.	1	0	/	1	Seek counseling service	145	0.62
Arnaud, 2017	This study examined the efficacy of a brief motivational intervention to reduce drinking and associated problems within pediatric emergency department in Germany.	4	1	Reduce alcohol use	3	Seek family-related service; seek substance-use related services; reflect on previous AAI episodes	124	0.8
Avants et al., 2004	This study examined the efficacy of a 12-session harm reduction group intervention for injection drug users, based upon the Information-Motivation-Behavioral skills model of behavior change, which focused on reducing both drug and sex risk.	2	2	Reduce drug use, increase condom use	0	/	112	1.12

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Avants et al., 2004	This study examined the efficacy of a 12-session harm reduction group intervention for injection drug users, based upon the Information-Motivation-Behavioral skills model of behavior change, which focused on reducing both drug and sex risk.	7	2	Reduce drug use, increase condom use	5	Implement safe sex skills (correct use of condom, eroticizing condom use); implement skills for negotiating safe sex with partner; implement drug-safety skills (cleaning needle/syringe); implement a healthy lifestyle; implement healthy social relationship and activities	107	1.53
Bachanas et al., 2016	This study examined the feasibility and efficacy of a multi-component, clinic-based HIV prevention intervention for HIV-positive patients attending clinical care in Namibia, Kenya, and Tanzania.	0	0	/	0	/	1573	0.05
Bachanas et al., 2016	This study examined the feasibility and efficacy of a multi-component, clinic-based HIV prevention intervention for HIV-positive patients attending	0	0	/	0	/	1539	0.21

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	clinical care in Namibia, Kenya, and Tanzania.							
Boyer, Shafer & Tschann, 1997	This study evaluated the efficacy of a school-based knowledge- and cognitive-behavioral skills-building STD/HIV prevention intervention.	2	2	Prevent STD/HIV; avoid alcohol use	0	/	106	0.03
Boyer, Shafer & Tschann, 1997	This study evaluated the efficacy of a school-based knowledge- and cognitive-behavioral skills-building STD/HIV prevention intervention.	8	2	Prevent STD/HIV; avoid alcohol use	6	Implement skills of prevention STDs and HIV; problem-solving and communication skills; steps to maintaining abstinence; skills to recognize antecedent of risk; skills for identify health-promoting behaviors; make clinic appointments	106	0
Brendryen, 2017	This study compared the efficacy of a brief and an intensive self-help alcohol intervention.	0	0	/	0	/	30	0
Brendryen, 2017	This study compared the efficacy of a brief and an intensive self-help alcohol intervention.	3	1	Reduce alcohol use;	2	Set reminders for the self; monitor alcohol consumption	26	0.35

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Burke et al., 2005; 2007;2008	This study examined the efficacy of multifactorial lifestyle modification on antihypertensive drug needs in treated hypertensive individuals.	1	1	Read materials regarding health care	0	/	98	0.07
Burke et al., 2005; 2007;2008	This study examined the efficacy of multifactorial lifestyle modification on antihypertensive drug needs in treated hypertensive individuals.	5	4	Follow a diet; increase physical activity; reduce alcohol intake; quit smoking	1	Increase social support from partners	106	0.3
Burton et al., 1995	This study examined the efficacy of the John Hopkins Medicare Preventive Services Demonstration over a period of 2 years on smoking, problem alcohol use, and sedentary lifestyle.	1	1	Read good health practices	0	/	92	0.63
Burton et al., 1995	This study examined the efficacy of the John Hopkins Medicare Preventive Services Demonstration over a period of 2 years on smoking, problem alcohol use, and sedentary lifestyle.	3	3	Reduce smoking; reduce alcohol use; reduce sedentary lifestyle	0	/	92	0.48



Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Calsyn et al., 2010	This study examined the efficacy of the Real Men Are Safe (REMAS) intervention on reducing the frequency with which men engage in sex under the influence of drug or alcohol.	2	1	Reduce sex under the influence	1	Read educational materials	141	0
Calsyn et al., 2010	This study examined the efficacy of the Real Men Are Safe (REMAS) intervention on reducing the frequency with which men engage in sex under the influence of drug or alcohol.	1	1	Reduce sex under the influence	0	/	136	0.28
Carrico, 2015	This study compared the efficacy of a positive-affect intervention plus contingency management with contingency management alone for methamphetamine using men who have sex with men.	3	1	Abstain from stimulant use	2	Attend support group; seek substance use treatment	9	-0.1
Carrico, 2015	This study compared the efficacy of a positive-affect intervention plus contingency management with contingency management alone for	5	1	Abstain from stimulant use	4	Attend support group; seek substance use treatment; conduct acts of kindness; meditate	12	-0.5

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	methamphetamine using men who have sex with men.							
Choo, 2016	This study examined the acceptability and feasibility of BSAFER, a brief Web-based program and booster phone call addressing violence and drug use.	0	0	/	0	/	19	0.11
Choo, 2016	This study examined the acceptability and feasibility of BSAFER, a brief Web-based program and booster phone call addressing violence and drug use.	4	2	Reduce drug use; reduce intimate partner violence	2	Seek help for relationship safety; seek help from substance-use expert	15	-0
Dakof, 2010	This study examined the efficacy of "Engaging Moms program" vs. intensive care management on drug use, child abuse potential, and psychological symptoms, for mothers enrolled in family drug court.	9	4	Protect child welfare; complete drug treatment; maintain drug abstinence; comply with court orders	5	Complete parenting classes; demonstrate good parenting skills; participate in educational/vocational training; attend necessary counseling services; study or maintain employment	29	0.8

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Dakof, 2010	This study examined the efficacy of "Engaging Moms program" vs. intensive care management on drug use, child abuse potential, and psychological symptoms, for mothers enrolled in family drug court.	11	4	Protect child welfare; complete drug treatment; maintain drug abstinence; comply with court orders	7	Complete parenting classes; demonstrate good parenting skills; develop communication skills; participate in educational/vocational training; attend necessary counseling services; study or maintain employment; develop a workable everyday routine	29	0.79
Deady, 2016	This study examined the feasibility and preliminary efficacy of an automated Web-based self-help intervention (DEAL Project) in treating co-occurring depressive symptoms and problematic alcohol use in young people.	0	0	/	0	/	26	0.15
Deady, 2016	This study examined the feasibility and preliminary efficacy of an automated Web-based self-help intervention (DEAL	4	1	Reduce alcohol use	3	Monitor their drinking; plan their activities; monitor their thoughts	30	0.83

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	Project) in treating co-occurring depressive symptoms and problematic alcohol use in young people.							
Doumas, 2017	This study examined the efficacy of a brief, web-based personalized feedback intervention (the eCHECKUP TO GO) on alcohol use and alcohol-related consequences among high school seniors.	0	0	/	0	/	52	0.04
Doumas, 2017	This study examined the efficacy of a brief, web-based personalized feedback intervention (the eCHECKUP TO GO) on alcohol use and alcohol-related consequences among high school seniors.	0	0	/	0	/	18	0.11
Doumas, 2017	This study examined the efficacy of a brief, web-based personalized feedback intervention (the eCHECKUP TO GO) on alcohol use and alcohol-related consequences among high school seniors.	3	1	Reduce alcohol use	2	Seek professional helps; use services in the local community	61	0.1

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Doumas, 2017	This study examined the efficacy of a brief, web-based personalized feedback intervention (the eCHECKUP TO GO) on alcohol use and alcohol-related consequences among high school seniors.	3	1	Reduce alcohol use	2	Seek professional helps; use services in the local community	20	0.41
Doumas, 2011	This study examined the efficacy of two brief personalized feedback interventions on reducing heavy drinking among mandated college students.	1	1	Reduce heavy drinking	0	/	47	-0.3
Doumas, 2011	This study examined the efficacy of two brief personalized feedback interventions on reducing heavy drinking among mandated college students.	1	1	Reduce heavy drinking	0	/	36	0.09
Dushay et al., 2001	This study compared the efficacy of a standard intervention with a culturally competent enhanced intervention.	5	3	Seek HIV testing; use condoms; implement needle bleaching	2	Engage in HIV preventive behavior; reduce drug use	86	0.42
Dushay et al., 2001	This study compared the efficacy of a standard intervention with a culturally competent enhanced intervention.	5	3	Seek HIV testing; use condoms; implement needle	2	Engage in HIV preventive behavior; reduce drug use	453	0.42

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
				bleaching				
Fogel et al., 2015	This study examined the efficacy of an HIV/STI prevention intervention compared with a standard STI education session among women in 2 correctional facilities.	2	2	Use condoms; abstain from sex	0	/	155	1
Fogel et al., 2015	This study examined the efficacy of an HIV/STI prevention intervention compared with a standard STI education session among women in 2 correctional facilities.	7	2	Use condoms; clean drug paraphernalia	5	Implement condom-use skills; communicate/negotiate with partners about sex; avoid violence; identify/contact a support person; search for resources	179	1.12
Fromme, 2004	This study examined the efficacy of the peer- versus professional- led Lifestyle Management Class Alcohol Prevention Program among voluntary and mandated college students.	0	0	/	0	/	164	0.01
Fromme, 2004	This study examined the efficacy of the peer- versus professional- led Lifestyle Management Class Alcohol Prevention Program among voluntary and mandated	3	2	Moderate alcohol use; reduce behavioral risks associated	1	Implement harm reduction strategies	194	0.09

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	college students.			with college drinking				
Fromme, 2004	This study examined the efficacy of the peer- versus professional- led Lifestyle Management Class Alcohol Prevention Program among voluntary and mandated college students.	3	2	Moderate alcohol use; reduce behavioral risks associated with college drinking	1	Implement harm reduction strategies	159	0.16
Go et al., 2015	This study examined the efficacy of a multi-level intervention to reduce injection and sexual risk behaviors among HIV-infected people who inject drugs in Vietnam.	2	2	Reduce drug injection; reduce sexual HIV risk behaviors	0	/	75	1.39
Go et al., 2015	This study examined the efficacy of a multi-level intervention to reduce injection and sexual risk behaviors among HIV-infected people who inject drugs in Vietnam.	3	2	Reduce drug injection; reduce sexual HIV risk behaviors	1	Look for social support	113	1.54
Go et al., 2015	This study examined the efficacy of a multi-level intervention to reduce injection and sexual risk behaviors among HIV-infected people who inject	5	2	Reduce drug injection; reduce sexual HIV risk behaviors	3	Look for social support; ask partner to test; disclose HIV status	76	1

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	drugs in Vietnam.							
Go et al., 2015	This study examined the efficacy of a multi-level intervention to reduce injection and sexual risk behaviors among HIV-infected people who inject drugs in Vietnam.	5	2	Reduce drug injection; reduce sexual HIV risk behaviors	3	Look for social support; ask partner to test; disclose HIV status	113	1.76
Grossbard, 2010	This study examined the efficacy of a parent-delivered intervention on reducing alcohol use among incoming college students.	0	0	/	0	/	340	-0.1
Grossbard, 2010	This study examined the efficacy of a parent-delivered intervention on reducing alcohol use among incoming college students.	2	1	Reduce alcohol use	1	Resist peer pressure	277	-0.1
Grossbard, 2010	This study examined the efficacy of a parent-delivered intervention on reducing alcohol use among incoming college students.	2	1	Reduce alcohol use	1	Implement protective behavioral strategies to reduce negative consequences of alcohol use	316	-0.1
Grossbard, 2010	This study examined the efficacy of a parent-delivered intervention on reducing alcohol use among	3	1	Reduce alcohol use	2	Implement protective behavioral strategies to reduce	342	0.06



Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	incoming college students.					negative consequences of alcohol use; resist peer pressure		
Hadley et al., 2016	This study examined the efficacy of an interactive DVD and workbook specifically designed for African-American parents and adolescents (ages 13–18), based on an efficacious face-to-face intervention, to address key factors associated with risk.	0	0	/	0	/	85	-0.2
Hadley et al., 2016	This study examined the efficacy of an interactive DVD and workbook specifically designed for African-American parents and adolescents (ages 13–18), based on an efficacious face-to-face intervention, to address key factors associated with risk.	4	3	Abstinence, condom use, substance use	1	Parent-child communication	80	-0.1
Haller et al., 2014	This study examined the efficacy of brief interventions delivered by family physicians on reducing binge drinking and excessive cannabis use among young people.	2	2	Reduce alcohol; reduce cannabis consumption	0	/	232	0.06

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Haller et al., 2014	This study examined the efficacy of brief interventions delivered by family physicians on reducing binge drinking and excessive cannabis use among young people.	2	2	Reduce alcohol; reduce cannabis consumption	0	/	249	0.04
Hanson et al., 2008	This study examined the efficacy of contingency management on reducing HIV risk behaviors and tested whether this was mediated by longest duration.	6	3	Abstain from drugs; take daily methadone dose; attend counseling	3	Perform urinalysis; have discussion with counselors; participate in HIV testing competition	65	0.68
Hanson et al., 2008	This study examined the efficacy of contingency management on reducing HIV risk behaviors and tested whether this was mediated by longest duration.	6	3	Abstain from drugs; take daily methadone dose; attend counseling	3	Perform urinalysis; have discussion with counselors; participate in HIV testing competition	100	0.3
Hershberger, Wood & Fisher, 2003	This study compared the efficacy a cognitive-behavioral intervention with a two-session standard counseling with respect to drug and sex-related risk behaviors among crack and injection users.	2	2	Reduce injection risk; reduce sex risk behavior	0	/	487	0.27

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Hershberger, Wood & Fisher, 2003	This study compared the efficacy a cognitive-behavioral intervention with a two-session standard counseling with respect to drug and sex-related risk behaviors among crack and injection users.	2	2	Reduce injection risk; reduce sex risk behavior	0	/	281	0.34
Hien et al., 2009	This study compared the efficacy of a cognitive-behavioral treatment for substance use disorder and posttraumatic stress disorder (PTSD), with an active comparison health education group.	2	2	Reduce alcohol use; reduce drug consumption	0	/	113	0.27
Hien et al., 2009	This study compared the efficacy of a cognitive-behavioral treatment for substance use disorder and posttraumatic stress disorder (PTSD), with an active comparison health education group.	2	2	Reduce alcohol use; reduce drug consumption	0	/	108	0.19
Ingersoll et al., 2011	This study examined the efficacy of two interventions to improve adherence and drug problems among people with crack cocaine use and poor adherence to HAART.	3	3	Reduce alcohol use; take medication; reduce drug use	0	/	23	0.71

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Ingersoll et al., 2011	This study examined the efficacy of two interventions to improve adherence and drug problems among people with crack cocaine use and poor adherence to HAART.	6	3	Reduce alcohol use; take medication; reduce drug use	3	Improve nutrition; increase exercise; implement behaviors to cope with stress	22	0.83
Jones et al., 2018	This study examined the efficacy of different inhibitory control trainings (associative no-go, associative stop signal, general inhibition, and control) on alcohol-related outcomes (volume consumed, abstinent days, etc.).	1	1	Reduce alcohol use	0	/	50	0.73
Jones et al., 2018	This study examined the efficacy of different inhibitory control trainings (associative no-go, associative stop signal, general inhibition, and control) on alcohol-related outcomes (volume consumed, abstinent days, etc.).	1	1	Reduce alcohol use	0	/	54	0.71
Jones et al., 2018	This study examined the efficacy of different inhibitory control trainings (associative no-go,	1	1	Reduce alcohol use	0	/	51	0.48

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Jones et al., 2018	associative stop signal, general inhibition, and control) on alcohol-related outcomes (volume consumed, abstinent days, etc.). This study examined the efficacy of different inhibitory control trainings (associative no-go, associative stop signal, general inhibition, and control) on alcohol-related outcomes (volume consumed, abstinent days, etc.).	1	1	Reduce alcohol use	0	/	52	0.58
Jungerman et al., 2007	This study examined the efficacy of a brief intervention for cannabis users.	1	1	Abstain from using cannabis	0	/	52	0.13
Jungerman et al., 2007	This study examined the efficacy of a brief intervention for cannabis users.	3	1	Abstain from using cannabis	2	Implement feasible and realistic consumption goals; implement skills to face and manage high risk consumption situations	55.8	0.13
Jungerman et al., 2007	This study examined the efficacy of a brief intervention for cannabis	3	1	Abstain from using cannabis	2	Implement feasible and realistic consumption goals;	52	0.16

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	users.					implement skills to face and manage high risk consumption situations		
Kaner et al., 2013	This study examined the efficacy of different brief intervention strategies at reducing hazardous or harmful drinking in primary care.	1	1	Reduce alcohol consumption	0	/	202	0.3
Kaner et al., 2013	This study examined the efficacy of different brief intervention strategies at reducing hazardous or harmful drinking in primary care.	2	1	Reduce alcohol consumption	1	Implement techniques to reduce drinking	207	0.24
Kaner et al., 2013	This study examined the efficacy of different brief intervention strategies at reducing hazardous or harmful drinking in primary care.	3	2	Reduce alcohol consumption; positive changes in lifestyle	1	Implement techniques to reduce drinking	205	0.39
Kulesza, 2010	This study examined the efficacy of different duration of brief interventions on reducing the amount of alcohol consumed by college alcohol drinkers, as well as their number of alcohol-	0	0	/	0	/	40	0.29

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	related problems.							
Kulesza, 2010	This study examined the efficacy of different duration of brief interventions on reducing the amount of alcohol consumed by college alcohol drinkers, as well as their number of alcohol-related problems.	3	1	Reduce alcohol use	2	Change drinking patterns; use strategies to moderate drinking	39	0.36
Kulesza, 2010	This study examined the efficacy of different duration of brief interventions on reducing the amount of alcohol consumed by college alcohol drinkers, as well as their number of alcohol-related problems.	3	1	Reduce alcohol use	2	Change drinking patterns; use strategies to moderate drinking	35	0.53
Kypri et al., 2005	This study examined the efficacy of a brief web-based intervention for multiple risk behaviors in a primary care setting for young people.	0	0	/	0	/	61	0.21
Kypri et al., 2005	This study examined the efficacy of a brief web-based intervention for multiple risk behaviors in a	0	0	/	0	/	65	0.15

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Kypri et al., 2005	primary care setting for young people. This study examined the efficacy of a brief web-based intervention for multiple risk behaviors in a primary care setting for young people.	4	4	Reduce hazardous drinking; increase physical activity; increase fruit; increase vegetable intake	0	/	72	0.24
Latkin et al., 2008	This study evaluated the efficacy of a network-orientated peer education intervention for drug users and their drug and sexual members.	5	2	Engage in protective sexual behaviors; reduce injection risk behavior	2	Keep cookers handy; keep condoms handy	488	1.06
Latkin et al., 2008	This study evaluated the efficacy of a network-orientated peer education intervention for drug users and their drug and sexual members.	4	2	Engage in protective sexual behaviors; reduce injection risk behavior	2	Keep cookers handy; keep condoms handy	425	1.15
Leeman, 2013	This study examined the efficacy of multiple iterations of automatic action tendency retraining,	0	0	/	0	/	19	-0.1



Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Leeman, 2013	followed by laboratory alcohol self-administration, on reducing young adults' heavy drinking. This study examined the efficacy of multiple iterations of automatic action tendency retraining, followed by laboratory alcohol self-administration, on reducing young adults' heavy drinking.	1	1	Moderate alcohol use	0	/	20	-0
Letourneau, 2017	This study examined the efficacy of Risk Reduction Therapy for Adolescents (RRTA) on addressing youth substance use disorders (SUD) and sexual risk behaviors.	2	1	Substance use	1	Peer influence	60	1.42
Letourneau, 2017	This study examined the efficacy of Risk Reduction Therapy for Adolescents (RRTA) on addressing youth substance use disorders (SUD) and sexual risk behaviors.	9	5	Substance use, condom use, abstinence, STI testing, no sex on substances	4	Drug refusal skills; avoid unhealthy peers; avoid parties; make condoms more available	42	1.73
Lewis et al., 2015	This study examined the efficacy of a pharmacy-randomized intervention on reducing injection risk among PWID in New York	1	1	Reduce drug injection	0	/	255	0.37

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	City.							
Lewis et al., 2015	This study examined the efficacy of a pharmacy-randomized intervention on reducing injection risk among PWID in New York City.	8	1	Reduce drug injection	7	Use a pharmacy as primary syringe source; use a sterile syringes; reduce drug injection; avoid sharing syringes; use safe syringe disposal; test for HIV; access drug treatment	227	0.31
Litt, 2009	This study compared the efficacy of a comprehensive CBT program versus an individualized assessment and treatment program among participants with alcohol abuse/dependence.	3	1	Reduce alcohol misuse	2	Manage social pressure/conflict; implement self-management skills	45	1.41
Litt, 2009	This study compared the efficacy of a comprehensive CBT program versus an individualized assessment and treatment program among participants with alcohol abuse/dependence.	5	1	Reduce alcohol misuse	4	Avoid alcohol settings; escape alcohol settings; modify alcohol settings; implement self-management skills	48	1.46
Martin et al., 2001	This study compared the efficacy of a standard intervention with a focused intervention for people on probation.	2	2	Reduce drug use; reduce risky sex behavior	0	/	213	0.55

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Martin et al., 2001	This study compared the efficacy of a standard intervention with a focused intervention for people on probation.	5	2	Reduce drug use; reduce risky sex behavior	3	Reduce selling sex; reduce paying for sex; reduce number of sexual partners	213	0.5
McCusker et al., 1997	This study compared the efficacy of a traditional therapeutic community program, and a modified therapeutic community program with relapse prevention.	5	3	Stop using drugs; prevent relapse; reduce risk for HIV	2	Implement behavioral coping skills to confront triggers; avoid situations that trigger drug use	362	0.7
McCusker et al., 1997	This study compared the efficacy of a traditional therapeutic community program, and a modified therapeutic community program with relapse prevention.	7	2	Stop using drugs; reduce risk for HIV	5	Assume responsibilities; implement social skills; help peers; rely on others; be honest	155	0.43
McMahon, Malow, Jennings & Gomez, 2001	This study compared the efficacy of a cognitive-behavioral HIV risk reduction intervention with standard care condition in modifying HIV risk related knowledge, beliefs, attitudes, and behaviors among HIV seronegative males.	3	3	Reduce drug consumption; prevent HIV; reduce risky sex	0	/	152	0.76

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
McMahon, Malow, Jennings & Gomez, 2001	This study compared the efficacy of a cognitive-behavioral HIV risk reduction intervention with standard care condition in modifying HIV risk related knowledge, beliefs, attitudes, and behaviors among HIV seronegative males.	7	3	Reduce drug consumption; prevent HIV; reduce risky sex	4	Implement communication and negotiation skills about safe sex (condom use, sexual practices, partner attitudes); implement skills for managing social situations that trigger drug use; implement skills for managing social situations risky sex; safe syringe use (avoid share needles, clean needles)	149	0.64
Meade et al., 2010	This study examined the efficacy of a group intervention addressing coping with HIV and sex trauma in reducing alcohol and cocaine use.	2	2	Reduce alcohol use; reduce cocaine use	0	/	88	-0.1
Meade et al., 2010	This study examined the efficacy of a group intervention addressing coping with HIV and sex trauma in reducing alcohol and cocaine use.	2	2	Reduce alcohol use; reduce cocaine use	0	/	95	0.46

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Monti, 2016	This study examined the efficacy of a single session MI compared to Brief Advice (BA) for reducing heavy drinking and condomless sex in adult ED patients screening positive for both.	2	2	Reduce alcohol use; use condom	0	/	161	0.28
Monti, 2016	This study examined the efficacy of a single session MI compared to Brief Advice (BA) for reducing heavy drinking and condomless sex in adult ED patients screening positive for both.	3	3	Reduce alcohol use; use condom; increase drinking abstinence;	0	/	141	0.54
Mouttapa et al., 2009	This study compared the efficacy of the SUHIP (substance use and HIV prevention) intervention with a control group in adolescents.	4	4	Avoid use of drugs; avoid use of alcohol; avoid stimulant use; practice safe sex	0	/	14	0.33
Mouttapa et al., 2009	This study compared the efficacy of the SUHIP (substance use and HIV prevention) intervention with a control group in adolescents.	10	4	Avoid use of drugs; avoid use of alcohol; avoid stimulant use; practice	6	Implement decision making skills; implement effective communication skills (refuse drugs, alcohol, unsafe sex); implement	11	0.37

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
				safe sex		correct and effective condom use; implement skills for negotiating safe sex; increase skills to assess the partner risk; implement skills to identify and manage antecedents to risk behaviors and barriers		
Murphy, 2001	This study compared the efficacy of an educational intervention with an assessment-only control group among college student drinkers.	0	0	/	0	/	24	-0.1
Murphy, 2001	This study compared the efficacy of an educational intervention with an assessment-only control group among college student drinkers.	1	1	Reduce alcohol use	0	/	25	0
Murphy, 2001	This study compared the efficacy of an educational intervention with an assessment-only control group among college student drinkers.	1	1	Reduce alcohol use	0	/	30	0.42

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
O'Farrell, 2016	This study compared the efficacy of group-based behavioral couple therapies to standard behavioral couple therapy on its effect on substance and relationship outcomes.	2	1	To stay abstinent	1	Engage in constructive couple communications	51	1.47
O'Farrell, 2016	This study compared the efficacy of group-based behavioral couple therapies to standard behavioral couple therapy on its effect on substance and relationship outcomes.	3	2	To stay abstinent; to reinforce sobriety	1	Engage in constructive couple communications	48	1.65
Parsons, Lelutiu-Weinberger, Botsko & Golub, 2014	This study compared the efficacy of an intervention combining motivational interviewing and cognitive-behavioral skills building versus a time- and content-equivalent educational condition among hazardous drinkers.	2	2	Reduce sexual risk; reduce drug use	0	/	62	0.11
Parsons, Lelutiu-Weinberger, Botsko & Golub, 2014	This study compared the efficacy of an intervention combining motivational interviewing and cognitive-behavioral skills building versus a time- and content-equivalent educational condition among hazardous	2	2	Reduce sexual risk; reduce drug use	0	/	61	0.4

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	drinkers.							
Penberthy et al., 2013	This study examined the efficacy of a motivational interviewing plus feedback condition against a video information condition and an informational brochure condition in women with depression related drinking.	4	2	Reduce alcohol misuse; use contraception	2	Explore community health resources; explore substance abuse resources	59	0.16
Penberthy et al., 2013	This study examined the efficacy of a motivational interviewing plus feedback condition against a video information condition and an informational brochure condition in women with depression related drinking.	2	2	Reduce alcohol misuse; use contraception	0	/	64	0.16
Penberthy et al., 2013	This study examined the efficacy of a motivational interviewing plus feedback condition against a video information condition and an informational brochure condition in women with depression related drinking.	0	0	/	0	/	58	0.2
Perry et al., 2003	This study examined the efficacy of D.A.R.E. and D.A.R.E. plus with middle	0	0	/	0	/	1093	0.08



Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	and junior high school students.							
Perry et al., 2003	This study examined the efficacy of D.A.R.E. and D.A.R.E. plus with middle and junior high school students.	3	3	Resist social influence to use drugs; resist social influence to use tobacco; handle violent situations effectively	0	/	1269	0.09
Perry et al., 2003	This study examined the efficacy of D.A.R.E. and D.A.R.E. plus with middle and junior high school students.	6	3	Resist social influence to use drugs; resist social influence to use tobacco; handle violent situations effectively	3	Participate in school activities; participate in team activities at home; participate in community activities	1381	0.07
Prado et al., 2012	This study examined the efficacy of family therapy in reducing substance use, illicit drug use, and alcohol dependence diagnosis, relative to a control community practice.	2	2	Increase parental support; increase parental participation	0	/	119	0.16

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Prado et al., 2012	This study examined the efficacy of family therapy in reducing substance use, illicit drug use, and alcohol dependence diagnosis, relative to a control community practice.	3	2	Increase parental support; increase parental participation	1	Transfer competencies learned in the group to their children (e.g. how to use female condom)	113	0.18
Purcell et al., 2007	This study examined the efficacy of a peer mentoring intervention on sexual behaviors, injection behaviors, utilization of HIV care, and adherence, among HIV-positive IDUs recruited in 4 US cities.	4	2	Prevent HIV; prevent drug overdose	2	Seek employment; implement Red Cross safety tips	314	0.34
Purcell et al., 2007	This study examined the efficacy of a peer mentoring intervention on sexual behaviors, injection behaviors, utilization of HIV care, and adherence, among HIV-positive IDUs recruited in 4 US cities.	6	4	Use HIV care; maintain adherence to HIV treatment; reduce sexual risk behaviors; reduce injection risk behaviors	2	Mentor peers; implement skills for behavior change	312.5	0.39
Reback et al., 2010	This study examined the efficacy of a contingency management intervention to reduce substance use and	2	1	Reduce HIV risk	1	Attend HIV prevention activities	67	-0.2

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	increase health-promoting behaviors among homeless MSM.							
Reback et al., 2010	This study examined the efficacy of a contingency management intervention to reduce substance use and increase health-promoting behaviors among homeless MSM.	5	4	Abstain from stimulants; abstain from other drugs; reduce HIV risk; participate in health promotion activities	1	Attend HIV prevention activities	64	0.04
Robles et al., 2004	This study examined the efficacy of an intervention to engage Hispanic injection drug users in treatment and reduce their drug use and injection-related HIV risk.	7	4	Reduce injection risk for HIV; reduce sexual risk for HIV; receive HIV testing; receive HIV testing results	3	Implement safer sex skills; implement safer injection skills; receive drug use treatment.	203	2.24
Robles et al., 2004	This study examined the efficacy of an intervention to engage Hispanic injection drug users in treatment and reduce their drug use and injection-related HIV risk.	11	5	Reduce injection risk for HIV; reduce sexual risk for HIV; receive HIV	6	Implement safer sex skills; implement safer injection skills; receive primary care; receive drug use treatment;	207	2.58

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
				testing; receive HIV testing results; prevent relapse		negotiate safer sex; refuse to use drugs		
Rongkavilit et al., 2013	This study examined the efficacy of a four-session motivational interviewing intervention aimed at decreasing sexual risk and alcohol use, and increasing medication adherence among youth living with HIV in Thailand.	4	4	Diet; exercise; stop smoking; develop healthy sleep habits	0	/	47	0.17
Rongkavilit et al., 2013	This study examined the efficacy of a four-session motivational interviewing intervention aimed at decreasing sexual risk and alcohol use, and increasing medication adherence among youth living with HIV in Thailand.	4	2	Reduce sexual HIV transmission risk; change one of the following behaviors: reduce alcohol use or maintain anti-retroviral treatment adherence	2	Monitor change progress; implement strategies to maintain healthy behaviors	49	0.17
Saitz et al., 2013	This study examined the efficacy of motivational	1	1	Get addiction treatment	0	/	262	0.46

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Saitz et al., 2013	enhancement therapy on drug and alcohol use. This study examined the efficacy of motivational enhancement therapy on drug and alcohol use.	4	2	Attend health care visits; receive relapse prevention counseling	2	Take medication; attend mental health counseling	270	0.54
Sakane, 2015	This study examined the efficacy of telephone-delivered lifestyle coaching on preventing the development of type 2 diabetes mellitus (T2DM) in participants with impaired fasting glucose (IFG).	6	6	Exercise, maintain weight, diet fiber, diet vegetables, less alcohol, undergo check ups	2	Set and monitor goals of body weight and number of daily steps	1367	0.02
Sakane, 2015	This study examined the efficacy of telephone-delivered lifestyle coaching on preventing the development of type 2 diabetes mellitus (T2DM) in participants with impaired fasting glucose (IFG).	6	6	Exercise, maintain weight, diet fiber, diet vegetables, less alcohol, undergo check ups	2	Set and monitor goals of body weight and number of daily steps	1240	0.1
Samet et al., 2015	This study examined the efficacy of an HIV prevention intervention compared with an attention control condition in	3	2	Improve nutrition; reduce stress	1	Seek social support	259	0.4

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Samet et al., 2015	decreasing sexually transmitted infections and sex and drug risk behaviors among Russian HIV-infected heavy drinkers. This study examined the efficacy of an HIV prevention intervention compared with an attention control condition in decreasing sexually transmitted infections and sex and drug risk behaviors among Russian HIV-infected heavy drinkers.	7	1	Reduce sexual STI risk behaviors	6	Disclose HIV status, reduce alcohol use; reduce drug use; communicate about condom use; implement condom use skills; receive substance use treatment	264	0.29
Santa, 2016	This study examined the efficacy of a novel GMI protocol that included tobacco-specific components (referred to as 'Tobacco GMI or T-GMI') targeting enhanced engagement in smoking cessation treatment.	4	1	Reduce substance use	3	Staying clean and sober; attend treatment; take medication for the substance use disorders	16	1.28
Santa, 2016	This study examined the efficacy of a novel GMI protocol that included tobacco-specific components (referred to as 'Tobacco GMI or T-GMI') targeting enhanced	6	2	Reduce substance use; quit smoking	4	Staying clean and sober; attend treatment; take medication for the substance use disorders; join quit smoking treatment	21	1.25

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	engagement in smoking cessation treatment.							
Santos et al., 2014	This study examined the efficacy of adapting Personalized Cognitive Counseling and rapid HIV testing on abstinence from substances and reducing alcohol intoxication frequency and high-risk sexual behaviors.	0	0	/	0	/	164	0.15
Santos et al., 2014	This study examined the efficacy of adapting Personalized Cognitive Counseling and rapid HIV testing on abstinence from substances and reducing alcohol intoxication frequency and high-risk sexual behaviors.	2	1	Reduce HIV risk behaviors	1	Avoid similar high-risk situations in the future	162	0.14
Satre, 2016	This study examined the efficacy of Motivational Interviewing (MI) to reduce hazardous drinking and drug use among adults in treatment for depression.	0	0	/	0	/	148	0.51
Satre, 2016	This study examined the efficacy of Motivational Interviewing (MI) to reduce hazardous drinking and	3	3	Reduce alcohol use; reduce illegal drug use;	0	/	148	0.64

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
	drug use among adults in treatment for depression.			reduce misuse of prescription drugs				
St. Lawrence, Jefferson, Alleyne & Brasfield, 1995	This study examined the efficacy of a behavioral skill training intervention among youth in substance dependence residential treatment.	1	1	Reduce sexual HIV risk	0	/	17	-0.3
St. Lawrence, Jefferson, Alleyne & Brasfield, 1995	This study examined the efficacy of a behavioral skill training intervention among youth in substance dependence residential treatment.	5	2	Reduce sexual HIV risk; abstain from sex	3	Develop condom use skills; implement interpersonal skills; implement self-management skills	17	0
Surratt & Inciardi, 2010	This study compared the efficacy of two HIV and hepatitis prevention interventions on changes in risk behavior among drug using women sex workers.	3	3	Reduce sexual risk for HIV; reduce injection risk for HIV and hepatitis B/C; reduce HIV risk associated with stimulant use	0	/	274	0.32



Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Surratt & Inciardi, 2010	This study compared the efficacy of two HIV and hepatitis prevention interventions on changes in risk behavior among drug using women sex workers.	6	4	Reduce sexual risk for HIV; reduce injection risk for HIV and hepatitis B/C; test for HIV; test for hepatitis B/C	2	Implement tips to reduce the risk of violence; receive services including drug treatment	272	0.28
Tucker, 2017	This study examined the efficacy of AWARE, a voluntary four session group- based motivational interviewing (MI) intervention to reduce AOD use and sexual risk behavior.	0	0	/	0	/	95	0.13
Tucker, 2017	This study examined the efficacy of AWARE, a voluntary four session group- based motivational interviewing (MI) intervention to reduce AOD use and sexual risk behavior.	6	3	Reduce alcohol use; reduce drug use; reduce risky sexual behaviors	3	Avoid high-risk situations; protect oneself when drinking; protect oneself when having sex;	86	0.27
Wechsberg et al., 2006	This study compared the efficacy of a modified Standard HIV intervention and a Woman-Focused HIV prevention intervention.	5	2	Reduce risk; use condoms properly	3	Implement skills to talk to one's partner; test for HIV; prevent spread of HIV	40	0.43

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Wechsberg et al., 2006	This study compared the efficacy of a modified Standard HIV intervention and a Woman-Focused HIV prevention intervention.	4	0	/	4	Negotiate risk reduction; communicate better with partners; prevent violence; seek community resources	40	0.53
Wechsberg et al., 2016	This study examined the efficacy of the Couples Health CoOp intervention on heavy drinking, condom use, and HIV incidence.	4	2	Condom use, alcohol/drug use	2	Stress management, relationship communication skills	162	0.15
Wechsberg et al., 2016	This study examined the efficacy of the Couples Health CoOp intervention on heavy drinking, condom use, and HIV incidence.	4	2	Condom use, alcohol/drug use	2	Stress management, relationship communication skills	191	0.25
Wechsberg et al., 2016	This study examined the efficacy of the Couples Health CoOp intervention on heavy drinking, condom use, and HIV incidence.	4	2	Condom use, alcohol/drug use	2	Stress management, relationship communication skills	198	0.47
Wernett et al., 2018	This study examined the efficacy of a computer-delivered, single-session brief motivational intervention plus booster session on addressing both substance use and STI risk.	0	0	/	0	/	19	0.34

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Wernett et al., 2018	This study examined the efficacy of a computer-delivered, single-session brief motivational intervention plus booster session on addressing both substance use and STI risk.	2	2	Reduce unprotected sex, reduce substance use	0	/	30	1.3
Williams et al., 2009	This study examined the efficacy of an electronic clinical reminder for brief alcohol counseling.	0	0	/	0	/	345	-0
Williams et al., 2009	This study examined the efficacy of an electronic clinical reminder for brief alcohol counseling.	1	1	Reducing drinking	0	/	957	-0.2
Woolf et al., 2006	This study examined the efficacy of a tailored web site that provides health information on behavior change.	1	1	Reduce drinking	0	/	49	1.7
Woolf et al., 2006	This study examined the efficacy of a tailored web site that provides health information on behavior change.	6	6	Reduce drinking; increase vegetable/fruit consumption; increase grain consumption; decrease fat consumption;	0	/	73	1.35

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
				increase exercise; stop smoking				
Yonkers et al., 2012	This study examined the efficacy of motivational enhancement therapy coupled with cognitive behavioral therapy (MET-CBT) to brief advice for treatment of substance use in pregnancy.	3	3	Abstain from sex; practice safe sex behavior; practice relapse prevention	0	/	35	0.11
Yonkers et al., 2012	This study examined the efficacy of motivational enhancement therapy coupled with cognitive behavioral therapy (MET-CBT) to brief advice for treatment of substance use in pregnancy.	5	3	Abstain from sex; practice safe sex behavior; practice relapse prevention	2	Implement communication skills; implement problem solving skills	34	0.14
Zule, Costenbader, Coornes & Wechsberg, 2009	This study examined the efficacy of a motivational intervention versus an educational intervention on use of a new syringe at last injection, and condom use at last sexual encounter in a community sample of injection drug users.	9	3	Reduce sexual risk; reduce injection risk; reduce alcohol use	6	Test for HIV; test for hepatitis B and C; clean syringes; apply condoms correctly; seek addiction treatment and necessary services; seek vaccine or treatment	286	0.18

Article reference	Description	Number of recommendations	Number of main recommendations	Main recommendation(s)	Number of auxiliary recommendations	Auxiliary recommendation(s)	Sample size	Average Effect size
Zule, Costenbader, Coornes & Wechsberg, 2009	This study examined the efficacy of a motivational intervention versus an educational intervention on use of a new syringe at last injection, and condom use at last sexual encounter in a community sample of injection drug users.	11	3	Reduce sexual risk; reduce injection risk; reduce alcohol use	8	Test for HIV; test for hepatitis B and C; clean syringes; apply condoms correctly; seek addiction treatment and necessary services; seek vaccine or treatment; monitor progress; develop strategies to overcome obstacles	265	0.4

Supplementary Table 2. Descriptive Statistics

<i>Variable</i>	<i>Multiple behavior groups (k = 113)</i>	<i>Other groups (k = 42)</i>
General characteristics		
Publication year ( $r = 1$ )		
M	2010	2011
Mdn	2010	2013
SD	6.70	6.41
$k$	113	42
Source type ( $\kappa = 1$ )		
Journal article	97.3 (110)	97.6 (41)
Not specified	2.7 (3)	2.4 (1)
Academic affiliation ( $\kappa = .91$ )		
University	48.1 (37)	56.0 (14)
College	29.9 (23)	20.0 (5)
Research center	18.2 (14)	12.0 (3)
Hospital / health cent	3.9 (3)	12.0 (3)
Institutional area ( $\kappa = 1$ )		
Psychology	21.6 (19)	35.1 (13)
Epidemiology	3.4 (3)	2.8 (1)
Community / Health	29.5 (26)	0.0 (0)
Medicine	43.2 (38)	48.6 (18)
Public Health	0.0 (0)	13.5 (5)
Sociology	2.3 (2)	0 (0)
Country ( $\kappa = 1$ )		
United States	83.2 (94)	71.4 (30)
Other	16.8 (19)	28.6 (12)
Participant characteristics		
Sample size (N) ( $r = 1$ )		
Sum total	19689	8606
M	174.24	204.91
Mdn	106.67	56.00
SD	245.02	375.76

<i>Variable</i>	<i>Multiple behavior groups (k = 113)</i>	<i>Other groups (k = 42)</i>
k	113	42
Age in years ( $r = 1$ )		
M	34.04	30.69
Mdn	36.2	32.20
SD	12.04	14.49
k	85	29
% men ( $r = 1$ )		
M	56.06	53.62
Mdn	59.80	53.00
SD	31.27	24.29
k	111	39
% women ( $r = 1$ )		
M	43.82	45.76
Mdn	40.20	47.00
SD	31.46	24.69
k	111	39
% gay / bisexual ( $r = 1$ )		
M	36.31	50.00
Mdn	9.6	50.00
SD	42.43	70.71
k	29	2
% high school graduates ( $r = 1$ )		
M	58.00	70.91
Mdn	61.30	91.90
SD	31.78	37.91
k	60	20

<i>Variable</i>	<i>Multiple behavior groups (k = 113)</i>	<i>Other groups (k = 42)</i>
% with risk factors or a health condition at pretest ( $r = 1$ )		
M	53.35	56.84
Mdn	47.70	57.5
SD	43.39	46.15
k	43	8
Ethnic descent		
% European - American ( $r = 1$ )		
M	42.48	64.64
Mdn	33.30	76.97
SD	34.01	30.07
K	91	30
% Africa – American ( $r = 1$ )		
M	29.86	21.19
Mdn	23.90	10
SD	28.58	30.10
k	89	23
% Latin – American ( $r = 1$ )		
M	16.69	7.79
Mdn	10.00	4.05
SD	22.97	10.73
k	85	22
% Asian – American ( $r = 1$ )		
M	7.30	3.97
Mdn	0.00	2.7
SD	19.65	4.43



<i>Variable</i>	<i>Multiple behavior groups (k = 113)</i>	<i>Other groups (k = 42)</i>
k	71	18
% Native American ( $r = 1$ )		
M	0.41	0.75
Mdn	0.00	0.00
SD	1.18	1.41
k	72	21
Types of intervention strategies		
Passive strategies		
Attitudinal arguments ( $\kappa = 1$ )		
Yes	64.0 (55)	25.0 (4)
No	36.0 (31)	75.0 (12)
Normative arguments ( $\kappa = 1$ )		
Yes	41.3 (31)	26.7 (4)
No	58.7 (44)	73.3 (11)
Control arguments ( $\kappa = .85$ )		
Yes	57.3 (47)	6.7 (1)
No	42.7 (35)	93.3 (14)
Threat argument ( $\kappa = 1$ )		
Yes	32.8 (20)	18.8 (3)
No	67.2 (41)	81.2 (13)
Informational arguments ( $\kappa = 1$ )		
Yes	90.5 (96)	68.2 (15)
No	9.5 (10)	31.8 (7)
Active strategies		
Behavioral skills training ( $\kappa = 1$ )		
Yes	50.4 (57)	16.7 (7)

<i>Variable</i>	<i>Multiple behavior groups (k = 113)</i>	<i>Other groups (k = 42)</i>
No	49.6 (56)	83.3 (35)
Communication skills training ( $\kappa = 1$ )		
Yes	42.9 (40)	0.0 (0)
No	57.1 (30)	100.0 (16)
Setting / reviews of goals ( $\kappa = 1$ )		
Yes	54.4 (43)	0.0 (0)
No	45.6 (36)	100.0 (17)
Role playing exercises ( $\kappa = 1$ )		
Yes	26.1 (18)	0 (0)
No	73.9 (51)	100.0 (18)
Teaches cues to engage in behavior ( $\kappa = 1$ )		
Yes	16.4 (10)	0.0 (0)
No	83.6 (51)	100.0 (16)
Training on coping with barriers ( $\kappa = 1$ )		
Yes	49.3 (35)	0.0 (0)
No	50.7 (36)	100.0 (15)
Relapse prevention training ( $\kappa = 1$ )		
Yes	32.9 (23)	0.0 (0)
No	67.1 (47)	100.0 (15)
Relaxation training ( $\kappa = 1$ )		
Yes	8.2 (6)	0.0 (0)
No	91.8 (67)	100.0 (17)
Teaches self-monitoring prompts ( $\kappa = 1$ )		
Yes	25.8 (17)	25.0 (4)
No	74.2 (49)	75.0 (12)

<i>Variable</i>	<i>Multiple behavior groups (k = 113)</i>	<i>Other groups (k = 42)</i>
Stress management skills training ( $\kappa = 1$ )		
Yes	17.4 (12)	0 (0)
No	82.6 (57)	100 (17)
Strategies in both intervention types		
Biological methods ( $\kappa = 1$ )		
Yes	7.7 (7)	0 (0)
No	92.3 (84)	100 (18)
Behavioral contract ( $\kappa = 1$ )		
Yes	6.8 (6)	0 (0)
No	93.2 (82)	100 (19)
Intervention set-up		
Domains targeted		
Alcohol use ( $\kappa = 1$ )		
Yes	37.5 (21)	47.4 (9)
No	62.5 (35)	52.6 (10)
Drug use ( $\kappa = 1$ )		
Yes	61.5 (32)	23.1 (3)
No	28.5 (20)	76.9 (13)
Tobacco use ( $\kappa = 1$ )		
Yes	4.3 (2)	0.0 (0)
No	95.7(47)	100.0 (12)
Number of recommendations ( $r = 1$ )		
M	4.24	0.48
Mdn	4.00	1
SD	2.20	0.51

<i>Variable</i>	<i>Multiple behavior groups (k = 113)</i>	<i>Other groups (k = 42)</i>
k	113	42
Medium of delivery		
Face to face ( $\kappa = .97$ )		
Yes	88.1 (89)	60.0 (15)
No	11.9 (12)	40.0 (10)
Delivery format ( $\kappa = 1$ )		
Groups	27.5 (30)	14.8 (4)
Individuals	46.8 (51)	81.5 (22)
Both	25.7 (28)	3.7 (1)
Facilitator ( $\kappa = .93$ )		
Professional expert	88.5 (54)	80.0 (8)
Lay community member	11.5 (7)	20.0 (2)
Culturally appropriateness ( $\kappa = .89$ )		
Yes	9.7 (11)	2.4 (1)
No	90.3 (102)	97.6 (41)
Duration of intervention in minutes ( $r = 1$ )		
M	62.83	42.50
Mdn	60.00	39.75
SD	42.70	45.17
k	68	18
Research design and implementation		
Random assignment to conditions ( $\kappa = .97$ )		
Yes	84.1 (95)	92.9 (39)
No	15.9 (18)	7.1 (3)
Payment received (US dollars) ( $r = 0.93$ )		
M	85.08	56.12

<i>Variable</i>	<i>Multiple behavior groups (k = 113)</i>	<i>Other groups (k = 42)</i>
Mdn	30.00	0
SD	123.91	83.62
k	85	26
Days between intervention and posttest ( $r = 0.88$ )		
M	17.80	0
Mdn	0.00	0
SD	61.61	0
k	25	5
Targeting an alcohol / drug dependent population ( $\kappa = 1$ )		
Yes	28.3 (32)	21.4 (9)
No	71.7 (81)	78.6 (33)
Sample targeted by ethnicity ( $\kappa = 1$ )		
Yes	8.0 (9)	2.4 (1)
No	92.0 (104)	97.6 (41)
Sample targeted by gender ( $\kappa = 1$ )		
Yes	27.7 (31)	13.9 (5)
No	62.3 (81)	86.1 (31)
Self-selected sample ( $\kappa = 1$ )		
Yes	83.1 (93)	82.1 (32)
No	16.9 (19)	17.9 (7)

