

Telephone-delivered interventions for loneliness and depression in older adults: A rapid review of randomized clinical trials

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ABSTRACT

Loneliness and depression impose significant health burdens on older adults, particularly those who are homebound or living in rural areas. While remote care has broadened access to healthcare services, it has also exposed equity gaps in which app and video-centered platforms often marginalize older adults with low digital literacy. As a resolution, telephone-delivery might be helpful to bridge this gap. This rapid review examines randomized clinical trials (RCTs) to examine whether telephone-delivered interventions reduce loneliness and/or depression in older adults and to identify which therapeutic contents produce consistent clinical benefits. A rapid review was conducted in line with updated Cochrane guidance for rapid reviews of effectiveness and PsycINFO, Medline, and CINAHL search, with criteria including RCTs of community-dwelling adults ≥ 60 years, telephone-delivered interventions, and validated loneliness or depression outcomes. Among 79 records, 11 RCTs met the criteria, of which 3 RCTs compared telephone with nontelephone-delivered interventions and 8 compared different telephone-delivered interventions. Most trials showed significant sustained improvement. Additionally, manualized protocols with supervision and outcome monitoring clearly outperformed the nonspecific support. The type of provider was also a key factor. Protocolized layperson-delivered programs reduced loneliness, whereas depression, a more severe condition, showed more pronounced improvements when a more structured or algorithm-guided care was delivered by clinicians or nurses. In sum, telephone-delivered interventions promote health equity by offering essential mental healthcare to digitally excluded older adults. The clinical benefits may be amplified when those calls deliver structured and manualized therapy under appropriate supervision.

Keywords: Depression, digital literacy, health equity, loneliness, telephone-delivered interventions

INTRODUCTION

Loneliness and depression, which frequently co-occur, were long regarded as mere social or personal issues. However, they are now increasingly recognized as significant determinants of health. Meta-analyses indicate that loneliness is associated with a higher risk of all-cause mortality.^[1] A strong association between loneliness and premature mortality, comparable to well-established factors such as smoking, was demonstrated by Holt-Lunstad *et al.*^[2] These findings on mortality prompted international attention: both the U. S. Surgeon General and the

World Health Organization declared loneliness as a “pressing health threat” in 2023.

In the wake of the coronavirus disease 2019 (COVID-19) pandemic, health systems rapidly expanded telehealth. While this expansion opened new possibilities, it also raised concerns regarding health equity gaps. The standard telehealth model, which depended heavily on videoconferencing, required

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devices with cameras, stable internet connectivity, and digital literacy. These prerequisites imposed considerable barriers for many older adults who often lack these resources or knowledge to use them.^[3] As a result, the older population that was already at higher risk of isolation and depression may have a greater chance of being excluded from essential mental healthcare as the world became more digitally intensive.

This raises a crucial question: How can remote mental health support reach all older adults regardless of their digital literacy? The telephone, a universally accessible device, can reach older adults who might otherwise be excluded from telehealth. However, access alone does not guarantee clinical benefits. As a voice-only modality, healthcare through telephone lacks visual cues, which are considered a core component of patient engagement. Therefore, without carefully structured protocols, its clinical effectiveness may be diminished.

Our primary aim is to examine randomized clinical trials (RCTs) to assess whether telephone-delivered interventions reduce loneliness and/or depression in older adults and to identify which therapeutic contents delivered through these telephone calls yield the most consistent outcome. Although several studies assessed additional outcomes such as worry, anxiety, insomnia, perceived stress, and quality of life, this rapid review mainly focuses on comparing the effects on loneliness and depression.

MATERIALS AND METHODS

Review methodology

We conducted a rapid review of RCTs following the updated Cochrane methods guidance for rapid reviews of effectiveness.^[4] The reporting follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement. A rapid review approach was selected to provide a timely synthesis of a heterogeneous evidence base at a point when digital and app-based mental health interventions are rapidly expanding, while concerns remain regarding the exclusion of older adults with limited internet access or digital literacy.

Study selection

We searched PsycINFO, Medline (with full text), and CINAHL, covering publications from January 2000 to September 2025 to capture contemporary interventions. The start year was selected to capture the period when digital and mobile health technologies began to influence mental healthcare delivery. This allowed telephone-delivered interventions to be examined within a contemporary care context, rather than as early or predigital models. Searches were limited to peer-reviewed articles published in English.

Eligibility criteria were guided by the PICO framework, as follows:

- Population (P): Community-dwelling adults aged 60 years and over with or without chronic diseases, who were experiencing loneliness or depression
- Intervention (I): Interventions delivered primarily via telephone or nonvideo mobile health. Any video or other digital modalities were excluded
- Comparison (C): Any comparator, including usual care or active control
- Outcome (O): Validated self-reported loneliness, social isolation, or depression as a primary or key secondary outcome, assessed with common measurement instruments (including but not limited to loneliness: University of California Los Angeles (UCLA) Loneliness Scale and De Jong Gierveld Loneliness Scale. Depression: Patient Health Questionnaire-9 [PHQ-9], the Beck Depression Inventory-II [BDI-II], the Hospital Anxiety and Depression Scale [HADS], and the Hamilton Rating Scale for Depression [HAM-D])
- Design: RCTs. Protocols, reviews, and secondary analyses were excluded.

Search terms

- Population: “older adults,” “elderly,” “seniors,” “geriatric,” or “aged”
- Intervention: “telephone,” “telephone-based,” “telephone-delivered,” “phone-based,” or “telephonic”
- Outcomes: “depression” or “loneliness”
- Study design: “randomized controlled trial,” “controlled clinical trial,” “randomized,” or “trial”
- Boolean logic: Search terms were combined using Boolean operators.
(telephone OR “telephone-based” OR “telephone-delivered” OR “phone-based” OR “telephonic”) AND (“older adults” OR elderly OR seniors OR geriatric OR aged) AND (depression OR loneliness) AND (“randomized controlled trial” OR “controlled clinical trial” OR randomized OR trial) NOT (video OR videoconference OR app OR telecare OR telemonitor).

Where available, database filters were applied to exclude protocols, guidelines, review articles and non-interventional studies.

Data extraction and synthesis

The systematic search identified 79 articles, of which 38 remained after duplicates were removed. Three-stage screening was employed to remove irrelevant articles such as study protocols, systemic reviews, and those that did not satisfy the PICO criteria. Thus, this review selected 11 studies that satisfied the criteria.

In these studies, depression was assessed with the PHQ-8/PHQ-9, BDI/BDI-II, HADS, the Montgomery–Asberg Depression Rating Scale, the Center for Epidemiologic Studies Depression Scale, or the Geriatric Depression Scale-15, and loneliness was assessed with the UCLA Loneliness Scale or the De Jong Gierveld Loneliness Scale. Some studies also assessed worry and anxiety using the Penn State Worry Questionnaire or the Hamilton Anxiety Rating Scale.

Study identification and screening

All records identified through database searching were collated, and duplicate records were removed prior to screening. Title and abstract screening were conducted to identify potentially eligible studies examining telephone-delivered interventions targeting loneliness or depression among older adults. Articles were screened by the reviewers using a three-stage process: title screening, abstract screening and full-text assessment. The extracted information included: first author, year of publication, geographical region, study design, sample size, baseline characteristics of participants, and effect sizes of the association between exposure and outcome. Full-text articles were retrieved for all records deemed potentially relevant during title and abstract screening. Full-text assessment was conducted to determine final eligibility based on predefined inclusion and exclusion criteria, including study population, intervention modality, outcome measures, and study design. Records that clearly did not meet the eligibility criteria were excluded at the title and abstract stage.

Studies were included if they evaluated a telephone-delivered intervention as the primary mode of delivery and assessed loneliness or depression as a primary or secondary outcome using a randomized or controlled clinical trial design. Studies in which these outcomes were reported only as tertiary outcomes or were not explicitly specified in the outcome hierarchy were excluded. Studies were also excluded if they primarily relied on video-based, app-based, or internet-based platforms, focused on protocol development, or did not report relevant mental health outcomes.

The findings of the review were presented as a narrative synthesis, providing a clear summary of the available evidence. Outcome measures used across included studies are summarized in Table 1.

Risk-of-bias (RoB) assessments were conducted in accordance with Cochrane guidance using the Cochrane RoB 2.0 tool [Table 2]. Most randomized controlled trials demonstrated some concerns of bias primarily related to lack of participant, therapist blinding, and reliance on self-reported outcomes, which are considered limitations of psychosocial interventions. One large RCT showed low RoB while high RoB was due to small sample sizes and attrition.

All included studies focused on telephone-delivered intervention that aimed to address loneliness or depression in older adults. The PRISMA flow diagram [Figure 1] illustrates the complete selection process.

Rationale for single-reviewer screening

Single-reviewer screening and selection were employed as part of the rapid review design to allow timely synthesis of evidence within a focused research scope. This approach reflects methodological streamlining commonly adopted in rapid reviews when resources or timelines preclude duplicate screening. To mitigate potential selection bias, eligibility

criteria were clearly predefined, applied consistently across all stages of screening, and transparently reported.

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RESULTS

Table 1 shows an overview of the included studies, with the sample sizes ranging from 38 to 1151. The studies were conducted in the United States, Sweden, and Hong Kong, offering a diverse perspective on interventions across different settings.

Protocolized, manualized therapies delivered by trained clinicians

Depression as primary outcome

Pellas *et al.* tested a brief, telephone-delivered behavioral activation with mental imagery (BA-MI) in isolated older adults during the COVID-19.^[5] The pilot RCT showed significant reductions in depressive symptoms compared to an attention-assessment control. Afterward, the control group also received BA-MI, and these improvements lasted for up to 6 months.^[6]

Depression as secondary outcome

Brenes *et al.* compared telephone cognitive behavioral therapy (CBT-T) to nondirective supportive therapy by phone for late-life GAD among older adults in rural areas.^[7,8] CBT-T produced a significant improvement in anxiety, worry, and depression at posttreatment. By the 15-month follow-up, sustained benefits were observed for the primary outcomes, worry, and anxiety, while the between-group advantage for depression was not maintained. Similarly, McCurry *et al.* demonstrated clear benefits for insomnia with CBT-I that were maintained at the 12-month follow-up. However, secondary outcomes such as depression remained unchanged in the long term (12 months), showing improvement only at 2 months.^[9]

Protocolized therapies delivered by lay providers

Kwok *et al.* tested telephone-delivered BA among low-income older adults in Hong Kong. While depressive symptoms did not differ between the groups, BA significantly reduced loneliness scores compared to telephone befriending at 3 months.^[10] This effect was maintained at 6 months after the initial treatment.^[11]

Algorithm-guided telephone care management by trained clinicians

Mavandadi *et al.* compared telephone symptom monitoring alone with the same monitoring with algorithm guided care management among low-income, community-dwelling older adults.^[12] The addition of algorithm guided care management produced results with greater reductions in depressive symptoms and anxiety over 6 months.

Telephone versus nontelephone interventions

Riegel *et al.* studied older Mexican American adults with heart failure and found no significant between-group differences in depressive symptoms (secondary outcome) over 6 months when

Table 1: An overview of the included studies, with the sample sizes ranging from 38 to 1151

Study	Country	Design	Sample (n)	Outcome	Primary/secondary	Findings
Brenes <i>et al.</i> , ^[13]	USA	RCT	60	Depression (BDI)	Secondary	No significant improvement
Brenes <i>et al.</i> , ^[7]	USA	RCT	141	Depression (BDI)	Secondary	Significant improvement
Brenes <i>et al.</i> , ^[8]	USA	Follow-up of 2015 RCT	141	Depression (BDI)	Secondary	Improvement not maintained at 15-month follow-up
Kornblith <i>et al.</i> , ^[14]	USA	RCT	192	Psychological distress (HADS total: depression and anxiety)	Primary	Significant improvement
Kwok <i>et al.</i> , ^[10]	Hong Kong	Three-arm RCT	1151	Loneliness (UCLA loneliness scale) Depression (PHQ-9)	Primary - Loneliness Secondary - Depression	Significant improvement on loneliness No significant improvement on depression
Jiang <i>et al.</i> , ^[11]	Hong Kong	Follow-up of 2024 RCT	1151	Loneliness (UCLA loneliness scale)	Primary - Loneliness	Improvement in loneliness maintained at 6-month follow-up
Mavandadi <i>et al.</i> , ^[12]	USA	RCT (SUSTAIN study)	1081	Depression (PHQ-9)	Secondary	Significant improvement at 3-month and 6-month follow-up
McCurry <i>et al.</i> , ^[9]	USA	RCT	327	Depression (PHQ-9)	Secondary	Significant improvement at 2 months; not maintained at 12-month follow-up
Pellas <i>et al.</i> , ^[5]	Sweden	RCT	41	Depressive symptoms (MADR-S)	Primary	Significant improvement
Pellas <i>et al.</i> , ^[6]	Sweden	Follow-up of 2021 RCT	38	Depressive symptoms (MADR-S)	Primary	Improvement maintained up to 6 months
Riegel <i>et al.</i> , ^[15]	USA	RCT	135	Depression (PHQ-9)	Secondary	No significant improvement

The studies were conducted in the United States, Sweden, and Hong Kong, offering a diverse perspective on interventions across different settings. BDI: Beck Depression Inventory, HADS: Hospital Anxiety and Depression Scale, MADR-S: Montgomery-Asberg Depression Rating Scale, PHQ-9: Patient Health Questionnaire-9, RCT: Randomized controlled trial

Table 2: Risk-of-bias assessment using the Cochrane Risk of Bias 2.0 tool

Study	Design	Tool	Overall risk	Brief justification
Brenes <i>et al.</i> , ^[13]	RCT	RoB 2	Some concerns	Adequate randomization No blinding Self-reported anxiety outcomes
Brenes <i>et al.</i> , ^[7]	RCT	RoB 2	Some concerns	Robust allocation Unblinded psychotherapy Partial reliance on self-report measures
Brenes <i>et al.</i> , ^[8]	Follow-up of 2015 RCT	RoB 2	Some concerns	Long-term follow-up increases attrition risk Self-report outcomes and unblinded participants remain concerns
Kornblith <i>et al.</i> , ^[14]	RCT	RoB 2	Some concerns	Adequate randomization Minimal missing data Possible performance bias due to nonblinded intervention delivery
Kwok <i>et al.</i> , ^[10]	RCT	RoB 2	Some concerns	Strong trial design Lack of blinding and self-reported depression outcomes lead to some risk of bias
Jiang <i>et al.</i> , ^[11]	Follow-up of 2024 RCT	RoB 2	Some concerns	Well-conducted randomization Layperson-delivered intervention and self-reported loneliness outcomes introduce potential performance and measurement bias
Mavandadi <i>et al.</i> , ^[12]	RCT (sustain study)	RoB 2	Some concerns	Large RCT Objective outcomes mitigate bias, but observed lack of participant blinding
McCurry <i>et al.</i> , ^[9]	RCT	RoB 2	Low risk	Strong randomization Low attrition Blinded outcome assessment and validated outcome measures cause minimal sources of bias
Pellas <i>et al.</i> , ^[5]	RCT	RoB 2	High risk	Small sample size High attrition Lack of blinding and imprecise effect estimates substantially increase risk of bias
Pellas <i>et al.</i> , ^[6]	Follow-up of 2021 RCT	RoB 2	High risk	Continuation of pilot limitations with additional attrition and reduced statistical power at long-term follow-up
Riegel <i>et al.</i> , ^[15]	RCT	RoB 2	Some concerns	Adequate randomization Attrition and lack of blinding introduce potential bias Outcomes are clinically objective

RoB assessments were conducted in accordance with Cochrane guidance. Most randomized controlled trials demonstrated some concerns of bias primarily related to lack of participant, therapist blinding, and reliance on self-reported outcomes, which are considered limitations of psychosocial interventions. One large RCT showed low risk of bias while high risk of bias was due to small sample sizes and attrition. RCT: Randomized controlled trial, RoB: Risk of bias

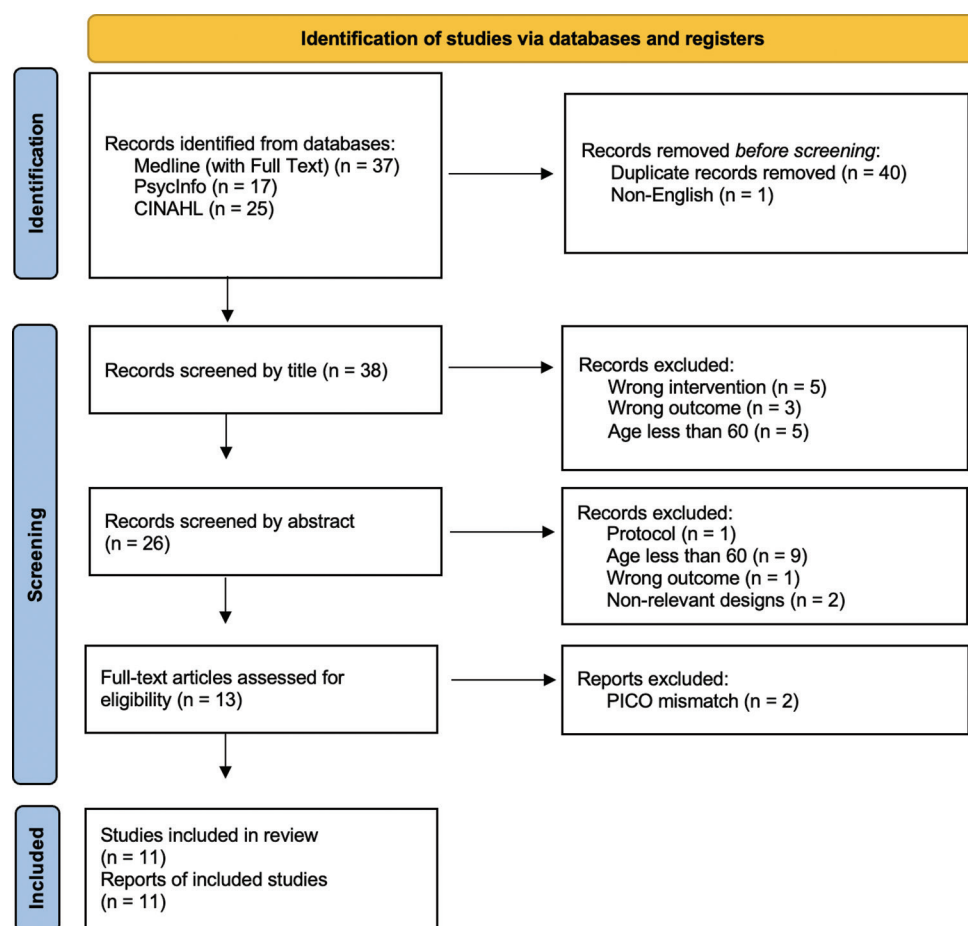


Figure 1: Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram

comparing nurse-led bilingual telephone case management with usual care.^[15] Brenes *et al.* compared CBT-T with an information-only intervention.^[13] CBT-T improved the primary outcomes, anxiety, and worry but produced no effect on additional outcomes including depressive symptoms. Finally, Kornblith *et al.* tested whether monthly telephone monitoring paired with education materials (TM + EM) could reduce psychological distress more effectively than EM alone to patients in advanced stage cancer.^[14] Psychological distress was the primary outcome measured with HADS total, comprising depression and anxiety, and depression was significantly lower in TM + EM than EM at 6 months.

DISCUSSION

This rapid review examined RCTs of telephone-delivered interventions targeting loneliness and depression among older adults. Overall, the findings indicate that telephone delivery can effectively support mental health in this population, particularly when interventions are clearly targeted, structured, and delivered with appropriate intensity and provider training. Importantly, the effectiveness of telephone-delivered interventions appears to depend less on the modality itself and more on the alignment between the therapeutic target and the intervention content and outcome prioritization.

Alignment between therapeutic targets and outcomes

A central finding of this review is that telephone-delivered interventions were most effective when the therapeutic target of the intervention aligned with the primary outcome assessed. Trials that explicitly targeted depression or loneliness as primary outcomes demonstrated more consistent and sustained improvements compared to trials in which these outcomes were assessed as secondary endpoints.^[5,7,9-15] Interventions designed specifically to reduce depressive symptoms produced meaningful and sustained reductions in depression when depression was the primary outcome.^[5,6,14] In contrast, trials in which depression was assessed as a secondary outcome^[9,13,15] often showed only short-term or modest improvements that were not maintained over longer follow-up periods. This pattern was further supported by long-term and secondary analyses of the same trial, which showed attenuation of between-group differences in depressive symptoms over time.^[7,8] A similar pattern was observed for loneliness, with trials that explicitly targeted loneliness as a primary outcome demonstrating consistent improvements.^[10,11]

This pattern suggests that telephone delivery is not inherently limited in its therapeutic potential. Rather, voice-only interventions require clear therapeutic intent and outcome prioritization to achieve meaningful clinical effects. The

distinction between primary and secondary outcomes is critical for interpreting heterogeneous findings across trials and underscores the importance of aligning intervention design with intended clinical targets. Telephone delivery appears to work best when the therapeutic target is clear and closely aligned with the intervention.

Implications for access and health equity

Across the 11 included trials, telephone delivery consistently functioned as a highly accessible modality for older adults. Unlike app- or video-based interventions, telephone-delivered care does not require broadband internet access, advanced digital literacy, or specialized devices. As a result, telephone-based interventions may help reach older adults who are homebound, living in rural areas, or otherwise digitally excluded.

However, these findings should be interpreted with caution. The evidence base is limited by restricted geographical diversity, as most trials were conducted in high-income settings, as well as modest sample sizes in several RCTs. In addition, none of the included studies specifically targeted older adults with severe depression, limiting the generalizability of findings to more complex clinical populations. Therefore, while telephone-delivered interventions have the potential to promote health equity by reducing access barriers, the current evidence does not support broad claims of effectiveness across all populations or levels of clinical severity.

Roles of intervention structure and provider background

Intervention structure and provider background further shaped observed outcomes. Structured and manualized interventions, such as behavioral activation or cognitive behavioral therapy, were associated with stronger and more consistent effects than nonspecific supportive approaches.^[5,10] This pattern was particularly evident for depressive symptoms, which appeared to require more directive and protocol-driven interventions.^[5,12] In contrast, trials in which depression was assessed as a secondary outcome showed limited or nonsignificant effects on depressive symptoms.^[10] Provider background also mattered. Clinician-led or algorithm-guided interventions demonstrated clearer benefits for depression, whereas structured interventions delivered by trained and supervised lay providers were effective in addressing loneliness and social connectedness.^[5,10,12] These findings suggest that intervention intensity and provider expertise should be matched to symptom severity and therapeutic goals. These findings point to a staged care model that begins with brief and structured support from trained laypersons for loneliness and engagement and escalates to clinician-led, measurement-based care when symptoms are severe or do not improve. This approach widens access while maintaining clinical benefits.

Practical considerations and limitations

Together, these findings support a staged or stepped-care approach in which telephone-delivered interventions are tailored according to clinical need, beginning with low-intensity, structured support for loneliness and engagement and escalating to clinician-led care for more severe or persistent

symptoms.^[10,12] Fundamentally, the telephone offers a quick and simple therapy to be delivered with short preparation time and low entry cost. These studies demonstrate advantages of telephone-delivered intervention, and its modality that removes barriers enables older adults to stay engaged and feel supported, amplifying the clinical benefits.

CONCLUSION

This rapid review highlights the role of telephone delivery in providing mental health support to adults who are often digitally excluded. Across randomized trials, telephone-based interventions were able to deliver care ranging from brief check-ins to structured CBT without videos or apps. Importantly, their impact was maximized when therapeutic targets were clearly defined, intervention content was structured, and intervention intensity was maintained.

Rather than suggesting that telephone delivery is universally effective, the findings indicate that its success depends on intentional intervention design and alignment between therapeutic goals and outcomes. Telephone-delivered interventions appear particularly well suited for addressing loneliness and engagement at scale, while more intensive, clinician-led, or algorithm-guided approaches may be required to achieve sustained improvements in depression and more complex clinical presentations.

These findings therefore position the telephone as a simple, scalable, and effective platform that fosters therapeutic alliance, engagement, and emotional support among digitally excluded older adults.

Further research is needed to address the limitations of the current evidence base, including heterogeneity across interventions, limited geography diversity, and the absence of trials targeting severe depression. Further studies should focus on standardizing intervention frameworks, evaluating longer-term effectiveness, and assessing feasibility and cost-effectiveness across diverse care settings.

Data availability statement

The datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

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Conflicts of interest

There are no conflicts of interest.

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