

GRADE assessments general population

Assessors and date: PJ, ML, November 2021, December 2021, April 2022

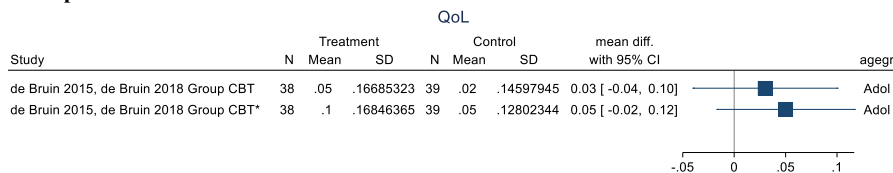
Outcome: Health-related quality-of-life

Result:

Can sleep interventions increase health-related quality-of-life among children and adolescents?

One study (de Bruin, 2015) that compares EQ-5D-3L (www.euroqol.org) values between the two active arms, i.e. cognitive-behaviour therapy delivered over the internet versus group format. Post-treatment data but also longer follow-up.

Forest plot



Result in text:

Both intervention formats increase health-related quality-of-life among adolescents to some extent, but the internet format led to a larger increase that is reinforced over the longer follow-up.

Conclusion: Sleep interventions increase health-related quality-of-life slightly among children and adolescents.

Outcome	Health-related quality-of-life is a composite measure from the questionnaire EQ-5D-3L with a max value of 1 (ref).		
Design	Alternatives	GRADE value	Comments
Study design	(⊕⊕⊕⊕)	⊕⊕⊕⊕	1RCT, n = 115
Kriterier	Alternatives	Mark possible deductions	Comments
Risk of bias	No concerns (no deduction)		Some concerns of risk of bias in the study.
	Some concerns (possible deduction)	x	
	Serious concerns (-1)		
	Very serious concerns (-2)		
Inconsistency	No concerns (no deduction)		As only one study consistency not possible to assess, so -2 deduction.
	Some concerns (possible deduction)		
	Serious concerns (-1)		
	Very serious concerns (-2)	-2	
Indirectness	No concerns (no deduction)		Deduction as only one study.
	Some concerns (possible deduction)		
	Serious concerns (-1)	-1	
	Very serious concerns (-2)		
Imprecision	No concerns (no deduction)		

	Some concerns (possible deduction)	x	No statistically significant difference between study arms, but difference maintained over longer follow-up.
	Serious concerns (-1)		
	Very serious concerns (-2)		
Other considerations (e.g. publication bias)	No concerns (no deduction)	x	No indications of publication bias.
	Some concerns (possible deduction)		
	Serious concerns (-1)		
Does the number of Some concerns imply downrating?	No (no deduction)	x	Further downrating not warranted.
	Yes (-1)		
Other comments			
Summary			Comments
Certainty of evidence	High (⊕⊕⊕⊕)		-3 in downratings.
	Moderate (⊕⊕⊕○)		
	Low (⊕⊕○○)		
	Very low (⊕○○○)	Very low (⊕○○○)	

Statement: Sleep interventions may increase health-related quality-of-life slightly among children and adolescents but the evidence is very uncertain.

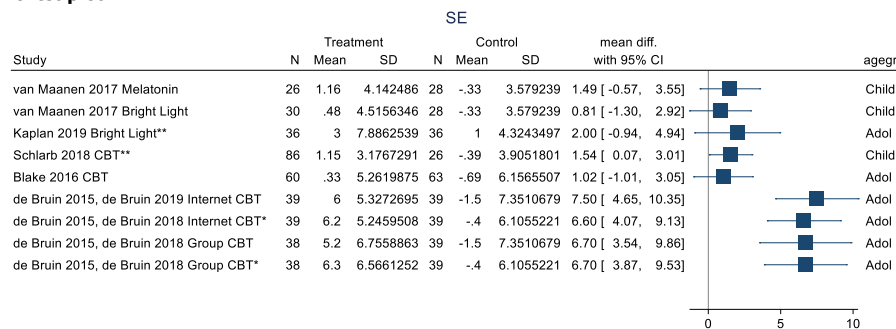
Outcome: Sleep efficiency, SE

Result:

Can sleep interventions increase sleep efficiency among children and adolescents?

Six studies, of which one study with mixed population (healthy children and children with ADHD and ASD) (van Maanen, 2017) and two studies with sleep diary data (Kaplan, 2019; Schlarb, 2018). Post-treatment measurements but two studies with longer-term follow-up (de Bruin 2018; Paine, 2011).

Forest plot



One additional study is not reported in the forest plot. Paine, 2011 reported cognitive-behaviour therapy (CBT) for school-aged children resulting in a Cohen's d value of 1.75 for the intervention group vs 0.03 for the control group, and 1.85 vs 0.19 at 1 month follow-up.

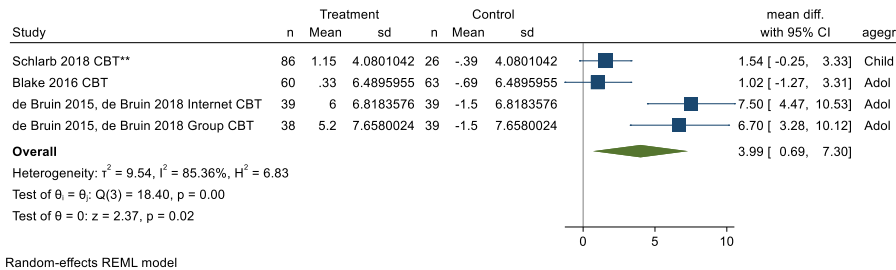
All studies report increases in sleep efficiency, but the only statistically significant increases are found in the study on two formats of CBT for adolescents compared with a wait-list control group (de Bruin, 2015; de Bruin, 2018); both group and internet CBT increases sleep efficiency more than 6 percent, also at 2 months follow-up. The other four studies report increases of 1-2 percent.

Meta-analysis

Can cognitive-behaviour therapy (CBT) for children and adolescents increase SE?

The meta-analysis contains three studies on cognitive behavior therapy, of which two studies were conducted with adolescents (De Bruin 2015, Blake, 2016) and one study with sleep diary data (Schlarb, 2018). The de Bruin study (de Bruin, 2015) includes two study arms, where two formats of CBT is compared with a waitlist group.

Meta-analysis, SE



Result in text:

The meta-analysis reports a statistically significant increase in sleep efficiency of 4 percent from CBT for children and adolescents, but the statistical heterogeneity in the studies is high, with a I^2 over 85 percent.

Conclusion:

Sleep interventions and particularly cognitive-behavior therapy (CBT) for children and adolescents increase sleep efficiency.

Outcome	Sleep efficiency (SE) is the percentage of total sleep time in relation to time in bed		
Design	Alternatives	GRADE value	Comments
Study design	(⊕⊕⊕⊕)	⊕⊕⊕⊕	6 RCTs, n = 549 Meta-analysis, n = 351
Kriterier	Alternatives	Mark possible deductions	Comments
Risk of bias	No concerns (no deduction)		Five of the six studies are assessed as having some concerns of risk bias.
	Some concerns (possible deduction)	x	
	Serious concerns (-1)		
	Very serious concerns (-2)		
Inconsistency	No concerns (no deduction)		The results from the studies point in the same direction, however differences in effect size. The meta-analysis on CBT reports a high statistical heterogeneity.
	Some concerns (possible deduction)		
	Serious concerns (-1)	-1	
	Very serious concerns (-2)		
Indirectness	No concerns (no deduction)		The studies include both young children and adolescents. Some studies have recruited participants from schools, some use sample from clinic. Different types of interventions but only CBT in meta-analysis.
	Some concerns (possible deduction)		
	Serious concerns (-1)	-1	
	Very serious concerns (-2)		
Imprecision	No concerns (no deduction)		Imprecision in estimates, ranging from 1 to 7 % increases; meta-analysis statistically significant at 4 %, but with a confidence interval of 7 %.
	Some concerns (possible deduction)		
	Serious concerns (-1)	-1	
	Very serious concerns (-2)		

Other considerations (e.g. publication bias)	No concerns (no deduction)	x	
	Some concerns (possible deduction)		
	Serious concerns (-1)		
Does the number of Some concerns imply downrating?	No (no deduction)	x	
	Yes (-1)		
Other comments			
Summary			Comments
Certainty of evidence	High (⊕⊕⊕⊕)		-3 in downratings. Very low certainty of evidence.
	Moderate (⊕⊕⊕○)		
	Low (⊕⊕○○)		
	Very low (⊕○○○)	⊕○○○	

Statement:

Sleep interventions for children and adolescents may increase sleep efficiency, but the evidence is very uncertain.

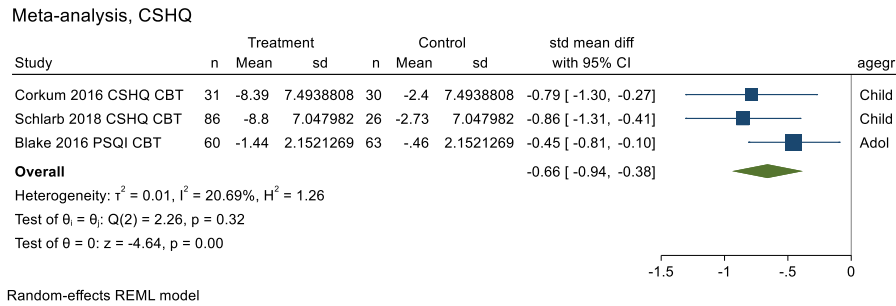
Outcome: Sleep disturbances

Result:

Meta-analysis

Can cognitive behavior therapy for children and adolescents decrease sleep disturbances?

Three studies, of which one study with a mixed population (healthy children and children with ADHD) (Corkum, 2016). Two studies report data from the questionnaire CSHQ (Children's Sleep Habits Questionnaire, total score, ref) (Corkum, 2016; Schlarb, 2018) and one from the questionnaire PSQI (Pittsburgh Sleep Quality Index, global score, ref) (Blake, 2016). Post-treatment measurements and results reported as Cohen's d.



Kommenterad [PJ1]: Owens J, Spirito A, McGuinn M. The Children's Sleep Habits Questionnaire (CSHQ): psychometric properties of a survey instrument for school aged children. *Sleep* 2000;23:1043-5

Kommenterad [PJ2]: Buysse, Daniel J.; Reynolds, Charles F.; Monk, Timothy H.; Berman, Susan R.; Kupfer, David J. (May 1989). "The Pittsburgh sleep quality index: A new instrument for psychiatric practice and research". *Psychiatry Research*. **28** (2): 193–213. doi:10.1016/0165-1781(89)90047-4.

Result in text:

All studies report statistically significant decreases in sleep disturbances from cognitive behavior therapy (CBT) compared with the control group, more pronounced in the two studies with wait-list controls (Corkum, 2016; Schlarb, 2018) than in the study with adolescents (Blake, 2016) where the control group received an alternative study-skills intervention. The meta-analysis shows a statistically significant decrease in disturbances, with a Cohen's d of 0.66 which is considered a large effect size.

Conclusion:

Cognitive behavior therapy for children and adolescents results in large decreases in sleep disturbances.

Outcome	Sleep quality is a composite measure of different sleep aspects that is often reported as the total score from sleep questionnaires. In this study the outcome consists of data from two sleep questionnaires: CSHQ (Children's Sleep Habits Questionnaire, total score) and PSQI (Pittsburgh Sleep Quality Index, global score, max value 21)		
Design	Alternatives	GRADE value	Comments
Study design	(⊕⊕⊕⊕)	⊕⊕⊕⊕	3 RCTs, n = 270 Meta-analysis, n = 270
Kriterier	Alternatives	Mark possible deductions	Comments
Risk of bias	No concerns (no deduction)		Two of the three studies are assessed as having some concerns of risk bias.
	Some concerns (possible deduction)	x	
	Serious concerns (-1)		
	Very serious concerns (-2)		
Inconsistency	No concerns (no deduction)	x	All studies, and the meta-analysis, report a
	Some concerns (possible deduction)		

	Serious concerns (-1)		statistically significant effect. The meta-analysis shows a low heterogeneity.
	Very serious concerns (-2)		
Indirectness	No concerns (no deduction)		Two different instruments of sleep difficulties used. The studies include both young children and adolescents.
	Some concerns (possible deduction)	x	
	Serious concerns (-1)		
	Very serious concerns (-2)		
Imprecision	No concerns (no deduction)		Fairly wide confidence intervals in the studies as well as in the meta-analysis.
	Some concerns (possible deduction)	x	
	Serious concerns (-1)		
	Very serious concerns (-2)		
Other considerations (e.g. publication bias)	No concerns (no deduction)	x	
	Some concerns (possible deduction)		
	Serious concerns (-1)		
Does the number of Some concerns imply downrating?	No (no deduction)		
	Yes (-1)	-1	
Other comments			
Summary			Comments
Certainty of evidence	High (⊕⊕⊕⊕)		-1 in downratings.
	Moderate (⊕⊕⊕○)	⊕⊕⊕○	Moderate certainty of evidence.
	Low (⊕⊕○○)		
	Very low (⊕○○○)		

Statement:

Cognitive behavior therapy for children and adolescents likely results in large decreases in sleep disturbances.

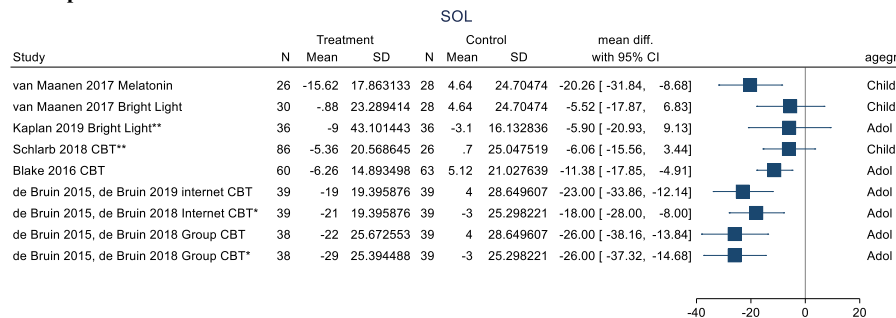
Outcome: Sleep onset latency, SOL

Result:

Can sleep interventions decrease SOL among children and adolescents?

Six studies, of which one study with mixed population (healthy children and children with ADHD and ASD) (van Maanen, 2017) and two studies with sleep diary data (Kaplan, 2019; Schlarb, 2018). Post-treatment measurements but two studies with longer-term follow-up (de Bruin, 2018; Paine, 2011).

Forest plot



One study is not included in the forest plot. Paine, 2011 reported cognitive-behaviour therapy (CBT) for school-aged children resulting in a Cohen's d value of 1.62 for the intervention group vs 0.34 for the control group, and 1.54 vs -0.06 at 1 month follow-up.

Result in text:

All interventions are reported to decrease SOL and some studies report statistically significant differences in change for the intervention compared with the comparator. Among the interventions for children, however only melatonin compared to placebo (van Maanen, 2017) reports a considerable and statistically significant difference in change of SOL, 20 minutes. For the adolescents, the two studies on cognitive-behaviour therapy report (De Bruin 2015; Blake, 2016) a decrease in SOL for 10-25 minutes, that is maintained after 2-month follow-up (de Bruin, 2015), while the study on bright light (Kaplan, 2019) reports a minor and not statistically significant difference in change compared to the sham light.

Conclusion: Sleep interventions decrease SOL among children and adolescents.

Outcome	Sleep onset latency is the time it takes to fall asleep (after turning the lights out), in minutes. It is most frequently measured by actigraph.		
Design	Alternatives	GRADE value	Comments
Study design	(⊕⊕⊕⊕)	⊕⊕⊕⊕	6 RCTs, n = 549
Kriterier	Alternatives	Mark possible deductions	Comments
Risk of bias	No concerns (no deduction)		Five of the six studies are assessed as having some concerns of risk bias.
	Some concerns (possible deduction)	x	
	Serious concerns (-1)		
	Very serious concerns (-2)		
Inconsistency	No concerns (no deduction)	x	

	Some concerns (possible deduction)		The results from the studies point in the same direction, however some differences in effect size (three studies with statistically non-significant effects).
	Serious concerns (-1)		
	Very serious concerns (-2)		
Indirectness	No concerns (no deduction)		The studies investigate different types of interventions. The studies include both young children and adolescents. Some studies have recruited participants from schools, some use sample from clinic.
	Some concerns (possible deduction)		
	Serious concerns (-1)	-1	
	Very serious concerns (-2)		
Imprecision	No concerns (no deduction)		Several of the studies have few participants, and wide confidence intervals.
	Some concerns (possible deduction)	x	
	Serious concerns (-1)		
	Very serious concerns (-2)		
Other considerations (e.g. publication bias)	No concerns (no deduction)	x	No indications of publication bias.
	Some concerns (possible deduction)		
	Serious concerns (-1)		
Does the number of Some concerns imply downrating?	No (no deduction)	x	
	Yes (-1)		
Other comments			
Summary			Comments
Certainty of evidence	High (⊕⊕⊕⊕)		-1 in downratings. Moderate certainty of evidence.
	Moderate (⊕⊕⊕○)	Moderate (⊕⊕⊕○)	
	Low (⊕⊕○○)		
	Very low (⊕○○○)		

Statement: Sleep interventions probably decrease SOL among children and adolescents.

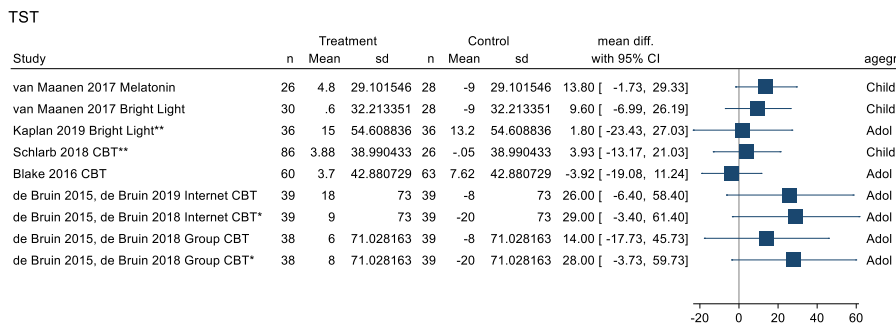
Outcome: Total sleep time, TST

Result:

Can sleep interventions increase TST among children and adolescents?

Six studies, of which one study with mixed population (healthy children and children with ADHD and ASD) (van Maanen, 2017) and two studies with sleep diary data (Kaplan, 2019; Schlarb, 2018). Post-treatment measurements but two studies with longer-term follow-up (de Bruin 2018; Paine 2011).

Forest plot:



One additional study is not reported in the forest plot. Paine, 2011 reported cognitive-behaviour therapy (CBT) for school-aged children resulting in a Cohen's d value of 0.14 for the intervention group vs 0.39 for the control group, and 0.77 vs 0.07 at 1 month follow-up.

Result

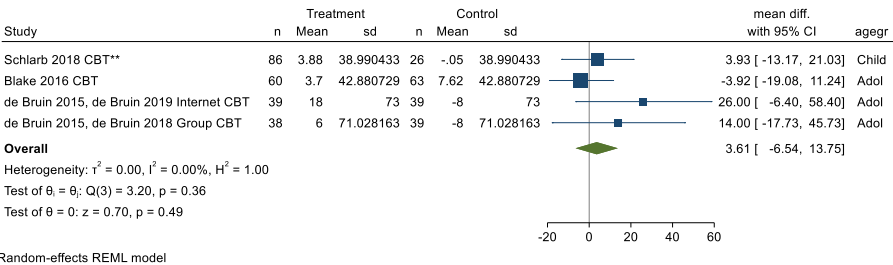
Most of the studies report some increases in total sleep time (TST) in the intervention groups compared with the control groups, except two of the cognitive behavior therapy (CBT) studies (Blake, 2016; Paine, 2011). Another CBT study (de Bruin, 2015) reports considerable increases in TST, of 15-30 minutes, that is further increased at two months follow-up and almost reach statistical significance for both study arms, compared with the wait-list group. The melatonin study (van Maanen, 2017) for children increased TST with 14 minutes, which is close to a statistically significant increase. The two studies on bright light (van Maanen, 2017; Kaplan, 2019) report minor increases in TST.

Meta-analysis

Can cognitive behaviour therapy (CBT) for children and adolescents increase TST?

The meta-analysis contains three studies on cognitive behavior therapy (CBT), of which one study included parents in the therapy (Schlarb, 2018) and one study with sleep diary data (Schlarb, 2018). Post-treatment measurements.

Meta-analysis, TST



Result meta-analysis

The meta-analysis shows a minor and statistically non-significant increase in total sleep time of 3 minutes from the three CBT studies for children and adolescents.

Conclusion:

Sleep interventions make little or no difference in total sleep time among children and adolescents.

Outcome	Total sleep time (TST) measures the total amount of sleep time during the total time in bed, in minutes.		
Design	Alternatives	GRADE value	Comments
Study design	(⊕⊕⊕⊕)	⊕⊕⊕⊕	6 RCTs, n = 549 Meta-analysis, n = 351
Kriterier	Alternatives	Mark possible deductions	Comments
Risk of bias	No concerns (no deduction)		Five of the six studies are assessed as having some concerns of risk bias.
	Some concerns (possible deduction)	x	
	Serious concerns (-1)		
	Very serious concerns (-2)		
Inconsistency	No concerns (no deduction)		Differing effect estimates and no statistically significant estimates.
	Some concerns (possible deduction)	x	
	Serious concerns (-1)		
	Very serious concerns (-2)		
Indirectness	No concerns (no deduction)		The studies include both young children and adolescents. Some studies have recruited participants from schools, some use sample from clinic. Different types of interventions but only CBT in meta-analysis.
	Some concerns (possible deduction)		
	Serious concerns (-1)	-1	
	Very serious concerns (-2)		
Imprecision	No concerns (no deduction)		Several of the studies have few participants, and wide confidence intervals. The meta-analysis reports a statistically non-significant minor effect
	Some concerns (possible deduction)		
	Serious concerns (-1)	-1	
	Very serious concerns (-2)		
Other considerations (e.g. publication bias)	No concerns (no deduction)	x	
	Some concerns (possible deduction)		

	Serious concerns (-1)		
Does the number of Some concerns imply downrating?	No (no deduction)		
	Yes (-1)	-1	
Other comments			
Summary			Comments
Certainty of evidence	High (⊕⊕⊕⊕)		-3 in downratings.
	Moderate (⊕⊕⊕○)		Very low certainty of evidence.
	Low (⊕⊕○○)		
	Very low (⊕○○○)	⊕○○○	

Statement:

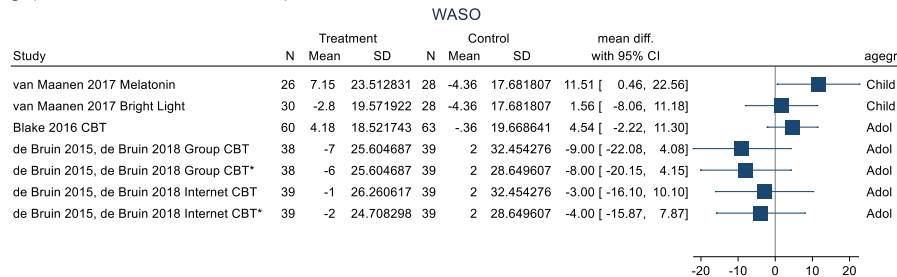
Sleep interventions make little or no difference in total sleep time among children and adolescents, but the evidence is very uncertain.

Outcome: Wake after sleep onset, WASO

Result:

Can sleep interventions increase WASO among children and adolescents?

Five studies, of which one study with mixed population (healthy children and children with ADHD and ASD) (van Maanen, 2017). Post-treatment measurements but two studies with longer-term follow-up (de Bruin, 2015; Paine, 2011).



Two additional studies are not reported in the forest plot. One is Paine, 2011 that reported cognitive-behaviour therapy (CBT) for school-aged children resulting in a Cohen's d value of 1.10 for the intervention group vs 0.50 for the control group, and 0.98 vs 0.58 at 6 months follow-up. Another study, Schlarb, 2018 also reports results from a CBT intervention for school-aged children in the number of awakenings recorded from sleep diary, with a decrease from 5.17 to 2.96 (Cohen's d = 0.33) for the intervention group vs from 5.44 to 5.36 (Cohen's d = 0.15) for the waitlist control group.

Result in text: Only three of the five studies report a positive effect on WASO; de Bruin, 2015; Paine, 2011 and Schlarb, 2018. In the two studies with a longer follow-up, the decrease in WASO is maintained. Blake, 2016 reports results from a similar intervention to de Bruin 2015, i.e CBT for adolescents, but without any effect in comparison with an active control arm. Van Maanen, 2017 reports no effect from either melatonin nor bright light compared with placebo. All comparisons with control group results are statistically non-significant and of a small magnitude, and the largest decrease in wake time after sleep onset is 9 minutes (De Bruin, 2015).

Conclusion: Sleep interventions have no effect on WASO among children and adolescents.

Outcome	Wake after sleep onset measures the time awake after first falling asleep, in minutes. It is most frequently measured by actigraph.		
Design	Alternatives	GRADE value	Comments
Study design	(⊕⊕⊕⊕)	⊕⊕⊕⊕	5 RCTs, n = 477
Kriterier	Alternatives	Mark possible deductions	Comments
Risk of bias	No concerns (no deduction)		Moderate risk of bias as four studier has some concerns for bias.
	Some concerns (possible deduction)	x	
	Serious concerns (-1)		
	Very serious concerns (-2)		
Inconsistency	No concerns (no deduction)		The studies point in different directions. The heterogeneity can be partly explained with differing populations. de
	Some concerns (possible deduction)		
	Serious concerns (-1)	-1	
	Very serious concerns (-2)		

			Bruin and Blake have the same type of intervention for adolescents but in one study the target group is adolescents at-risk for Major depression. One study's interventions are different and with a mixed population of children. Four out of five studies have statistically non-significant results.
Indirectness	No concerns (no deduction)		Populations include both children and adolescents. Some studies have recruited participants from schools, some use sample from clinic.
	Some concerns (possible deduction)		
	Serious concerns (-1)	-1	
	Very serious concerns (-2)		
Imprecision	No concerns (no deduction)		Broad confidence intervals that overlap limit for no effect (0).
	Some concerns (possible deduction)		
	Serious concerns (-1)	-1	
	Very serious concerns (-2)		
Other considerations (e.g. publication bias)	No concerns (no deduction)		Publication bias can be present. WASO can be measured with actigraphs, but several studies with other actigraph measurements do not report WASO.
	Some concerns (possible deduction)	x	
	Serious concerns (-1)		
Does the number of Some concerns imply downrating?	No (no deduction)	x	
	Yes (-1)		
Other comments			
Summary			Comments
Certainty of evidence	High (⊕⊕⊕⊕)		-3 in downratings.
	Moderate (⊕⊕⊕○)		
	Low (⊕⊕○○)		
	Very low (⊕○○○)	Very low (⊕○○○)	

Statement: Sleep interventions have no effect on WASO among children and adolescents but the evidence is very uncertain.

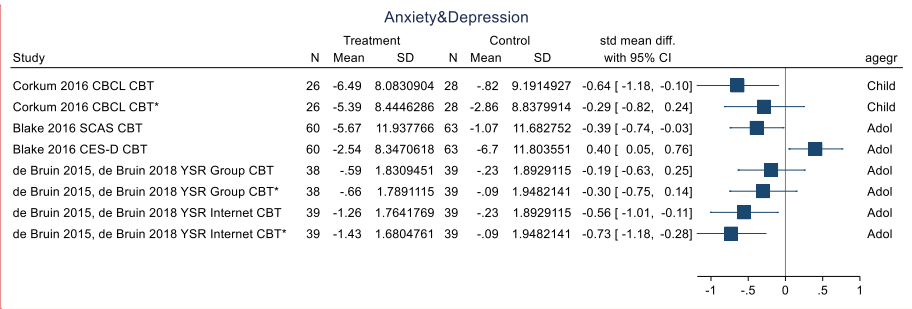
Outcome: Anxiety and depression

Result:

Can sleep interventions decrease anxiety and/or depression among children and adolescents?

Three studies, of which one study with a mixed population (healthy children and children with ADHD) (Corkum, 2016). Post-measurements data but two studies with longer follow-up (Corkum, 2016; de Bruin, 2015). One study uses the questionnaire CBCL (Child Behavior Checklist; ref) (Corkum, 2016), one study uses the two questionnaires SCAS (Spence Children's Anxiety Scale, ref) and CES-D (Center for Epidemiologic Studies Depression Scale, ref) (Blake, 2016), and one study uses the questionnaire YSR (Youth Self-Report, ref) de Bruin). Results reported as SMD.

Forest plot



Result in text:

All studies report decreases in scores for anxiety/depression for the intervention group. In one study (Blake, 2016), however the decrease in depression scores was larger in the control group, leading to a positive difference in changes. All differences, measured as SMD, are small and only a few are statistically significant. The study on children (Corkum, 2016) showed statistically significant difference between groups at a SMD value of 0.64 but the effects decreased in the longer follow-up. Among the two studies that report anxiety scores following cognitive-behaviour therapy (CBT) for adolescents, internet CBT (De bruin, 2015) reports a considerable change that is reinforced over time, while the intervention for at-risk youths (Blake, 2016) reports a less pronounced but statistically significant difference.

Conclusion: Sleep interventions decrease anxiety/depression among children and adolescents.

Outcome	The outcome Anxiety/depression is composed of results from several questionnaires that measure internalizing mental health issues; CBCL (Child Behavior Checklist, age 6-18 yrs, internalizing subscale) SCAS (Spence Children's Anxiety Scale, total score) CES-D (Center for Epidemiologic Studies Depression Scale, total score), and YSR (Youth Self-Report, subscale anxiety).		
Design	Alternatives	GRADE value	Comments
Study design	(⊕⊕⊕⊕)	⊕⊕⊕⊕	3 RCTs, n = 293
Kriterier	Alternatives	Mark possible deductions	Comments
Risk of bias	No concerns (no deduction)		

Kommenterad [PJ3]: Achenbach, T. M., & Rescorla, L. (2001). ASEBA schoolage forms & profiles. Retrieved from aseba.com/ordering/ASEBA%20Reliability%20and%20Validity-School%20Age.pdf

Kommenterad [PJ4]: Spence, SH; Barrett, PM; Turner, CM (2003). "Psychometric properties of the Spence Children's Anxiety Scale with young adolescents". *Journal of Anxiety Disorders*. 17 (6): 605–25. doi:10.1016/S0887-6185(02)00236-0. PMID 14624814.

Kommenterad [PJ5]: Radloff, Lenore Sawyer (June 1977). "The CES-D Scale: A Self-Report Depression Scale for Research in the General Population". *Applied Psychological Measurement*. 1 (3): 385–401. doi:10.1177/014662167700100306.

Kommenterad [PJ6]: Achenbach, T. M. (1991). Manual for the Youth Self-Report and 1991 profile. Burlington, VT: University of Vermont, Department of Psychiatry.

Kommenterad [PJ7]: Maria: ändra gäma måttet till SMD (istället för std mean diff.)

	Some concerns (possible deduction)	x	Two of the three studies are assessed as having some concerns for risk of bias, while one is assessed as no concern.
	Serious concerns (-1)		
	Very serious concerns (-2)		
Inconsistency	No concerns (no deduction)		Fairly high consistency in results except for the report of depression scores in one study. Some statistically non-significant effects.
	Some concerns (possible deduction)	x	
	Serious concerns (-1)		
	Very serious concerns (-2)		
Indirectness	No concerns (no deduction)		All studies use different instruments, that include both anxiety and depression. The studies include both young children and adolescents. Participants in two of the three studies are adolescents, but in one study at risk for Major depression. Some studies have recruited participants from schools, some use sample from clinic.
	Some concerns (possible deduction)		
	Serious concerns (-1)	-1	
	Very serious concerns (-2)		
Imprecision	No concerns (no deduction)		Although most studies point in the same direction, few differences are statistically significant.
	Some concerns (possible deduction)		
	Serious concerns (-1)	-1	
	Very serious concerns (-2)		
Other considerations (e.g. publication bias)	No concerns (no deduction)	x	No indications of publication bias.
	Some concerns (possible deduction)		
	Serious concerns (-1)		
Does the number of Some concerns imply downrating?	No (no deduction)	x	Further downrating not warranted.
	Yes (-1)		
Other comments			
Summary			Comments
Certainty of evidence	High (⊕⊕⊕⊕)		-2 in downratings
	Moderate (⊕⊕⊕○)		
	Low (⊕⊕○○)	Low (⊕⊕○○)	
	Very low (⊕○○○)		

Statement: Sleep interventions may decrease anxiety/depression among children and adolescents.