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**Does a brief, behavioural intervention, delivered by
paediatricians or psychologists improve sleep problems for
children with ADHD?
A cluster-randomised, translational trial**

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3 **Does a brief, behavioural intervention, delivered by paediatricians or psychologists**
4 **improve sleep problems for children with ADHD?**
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6 **A cluster-randomised, translational trial**
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10
11 All authors have completed the Unified Competing Interest form at
12 www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and
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14 financial relationships with companies that may be relevant to the submitted work to declare.
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17 18 **Author contribution**

19
20 ES, HH, HH, NR and LG conceived the study. MM and NH coordinated the study. ES
21 drafted the current manuscript. TS contributed to the design and analytic components of the
22 study. All authors contributed, read and approved the final manuscript.
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ABSTRACT

Introduction: Up to 70% of children with Attention-Deficit/Hyperactivity Disorder (ADHD) suffer from behavioural sleep problems. We have demonstrated the efficacy of a brief behavioural intervention in improving sleep for children with ADHD. We now aim to examine whether this intervention is effective in real-life clinical settings when delivered by paediatricians or psychologists in improving child sleep and child and family wellbeing. We will also assess the cost-effectiveness of the intervention.

Methods and analysis: Children aged 5-12 years with ADHD (n=320) are being recruited for this translational cluster randomised controlled trial (RCT) through paediatrician practices in Victoria and Queensland, Australia. Children are eligible if they meet DSM-5 criteria for ADHD, have a moderate/severe sleep problem, and meet American Academy of Sleep Medicine criteria for a behavioural sleep disorder. Clinicians are randomly allocated to either receive the sleep training or not. The behavioural intervention comprises two consultations covering sleep hygiene and standardized behavioural strategies. The primary outcome is change in the proportion of children with moderate/severe sleep problems from moderate/severe to no/mild by parent report at 3 months post-intervention. Secondary outcomes include a range of child (sleep severity, ADHD symptoms, quality of life, behaviour, working memory, executive functioning, learning, academic achievement, school attendance) and primary caregiver (mental health, parenting, work attendance) outcome domains. Analyses will address clustering at the level of the paediatrician using linear mixed effect models adjusting for potential a priori confounding variables.

Ethics and dissemination: Ethics approval has been granted. Findings will determine whether the benefits of an efficacy trial can be realised more broadly at the population level and will inform the development of clinical guidelines for managing sleep problems in this

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2
3 population. We will seek to publish in leading international paediatric journals, present at
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5 major conferences and through established clinician networks.
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7 **Registration details:** Current Controlled Trials ISRCTN50834814
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For peer review only

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3 Behavioural sleep problems are common and more persistent in children with ADHD, and
4 associated with poorer child and family well-being.¹⁻⁴ Although randomised controlled trials
5 (RCTs) have shown that melatonin is associated with improved sleep onset latency for
6 children with ADHD,⁵⁻⁷ broader benefits for daily functioning including ADHD symptom
7 severity have yet to be shown. More recently, efficacy RCTs have shown that sleep problems
8 are amenable to behavioural intervention in children with ADHD.⁸⁻¹⁰ However, it is unknown
9 whether the same benefits will be observed when such interventions are delivered by
10 practitioners in 'real life' clinical settings. This article describes the protocol for the Sleeping
11 Sound with ADHD Translational RCT, which aims to assess the effectiveness of a
12 behavioural sleep intervention designed for children with ADHD, when delivered by
13 psychologists or paediatricians in their daily clinical practice.

27 **Sleep problems in children with ADHD**

28
29 Up to 70% of children with ADHD experience sleep problems,^{1,2} compared with 20-30% of
30 children in the general population.¹¹ Sleep problems experienced by children with ADHD
31 comprise difficulties initiating and/or maintaining sleep, with the most common sleep
32 problems being difficulty falling asleep (reported by 84% of parents of children who report a
33 sleep problem for their child with ADHD), bedtime resistance (68%), tiredness upon waking
34 (62%) and difficulty waking in the morning (56%).² Medical conditions such as obstructive
35 sleep apnoea (OSA) can also affect sleep in children with ADHD, although behavioural sleep
36 problems appear more common.¹² Sleep problems have been associated with worse
37 functioning for children with ADHD including poorer QoL, behaviour, daily functioning, and
38 working memory, as well as increased school absenteeism.^{2,4,13} They thus represent an
39 important modifiable target for intervention.

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41 A number of factors have been associated with sleep problems in children with
42 ADHD. Insomnia can be a side-effect of stimulant medication,^{1,14} although unmedicated
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3 children with ADHD also experience higher rates of sleep problems relative to non-ADHD
4 controls.¹⁵ Comorbid externalising and internalising comorbidities are each associated with a
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7 2-fold increase in moderate/severe sleep problems in children with ADHD, while co-
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9
10 occurring internalising and externalising comorbidities are associated with a 3-fold
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12 increase.¹⁶ Parenting inconsistency in daily household routines has also been associated with
13
14 increased bedtime resistance in this group.¹⁷ Biologically, there is overlap in the brain regions
15
16 and genetic factors (e.g., catecholaminergic system, CLOCK genes) associated with both
17
18 ADHD and sleep disorders/arousal regulation.¹ ADHD is also a highly genetic condition and
19
20 parents likely are affected by symptoms such as disorganisation and impulsivity, which may
21
22 impact on child sleep.
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24 **Treating sleep problems in children with ADHD using behavioural strategies**

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26 We recently published our efficacy RCT evaluating the impact of a behavioural sleep
27
28 program in children with ADHD and moderate/severe sleep problems (n=244 5-12 year old
29
30 children with ADHD).⁸ Children were recruited from 21 paediatric practices across Victoria,
31
32 Australia and randomised to either a behavioural sleep intervention (n=122) or a usual care
33
34 comparison group (n=122). Intervention families attended two x 50 minute individual
35
36 sessions (held two weeks apart) with a trained clinician (psychologist or trainee
37
38 paediatrician), comprising a standardised yet flexible intervention, tailored to the child's
39
40 sleep problems and family preferences.
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45 The intervention was associated with improved child outcomes at three and six
46
47 months post-randomisation including improved parent-reported child sleep, ADHD symptom
48
49 severity, QoL, daily functioning and behavior.⁸ Intervention children also had improved
50
51 teacher-reported classroom behavior, as well as improved school attendance and working
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53 memory assessed via blinded assessment.⁸ There were small improvements in sleep duration
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55 for a subsample that completed actigraphy.⁸ Although the intervention was associated with
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3 improved caregiver work attendance and mental health three months later, these benefits
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5 were not observed at six months.⁸
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8 Similarly, two additional randomised controlled trials have demonstrated the efficacy
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10 of improving sleep problems in children with ADHD. Keshavarzi et al. reported that a 12-
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12 week sleep-training program for children with ADHD aged 10 years (n=40) had beneficial
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14 effects for sleep and psychosocial functioning when compared to controls with ADHD who
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16 did not receive the intervention (n=20) and typically developing children (n=20).⁹ Corkum
17
18 and colleagues also recently reported the beneficial effects of their distance sleep intervention
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20 for childhood insomnia in a mixed sample of children with and without ADHD (n=61).¹⁰
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22 Improvements were identified at 2 and 6 months for sleep assessed using parent report as
23
24 well as actigraphy, and benefits were also reported for broader child psychosocial health.¹⁰
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28 **Managing sleep problems in children with ADHD through existing clinical services**

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30 Although three trials have now shown that it is possible to improve sleep problems in
31
32 children with ADHD using behavioural approaches, it remains to be seen whether it is
33
34 possible to replicate such approaches and improve outcomes for children with ADHD in 'real
35
36 life' clinical settings when delivered by clinicians rather than trained researchers. We are now
37
38 testing the translation of this program at the population level by training community
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40 paediatricians and psychologists to deliver this sleep intervention to children with ADHD and
41
42 sleep problems. If this intervention can be translated successfully to the population level
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44 within existing workforces, then this would have the real potential to improve outcomes for
45
46 children with ADHD and their families. If cost-effective, it could be readily incorporated into
47
48 the existing health system.
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52 Paediatricians are the main care providers for ADHD in Australia.¹⁸ The
53
54 paediatrician's role includes both the assessment and treatment (behavioural and medication-
55
56 based) of ADHD and associated comorbidities (including sleep problems, if identified).
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3 Visits to a paediatrician are subsidised by Australia's Medicare scheme, however, families
4 may experience out of pockets costs for these visits. Paediatricians (and general practitioners)
5 may also refer children to a psychologist in the community to manage comorbid behaviours.¹⁹
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10 In Australia, this referral is facilitated by the Medicare Better Access to Mental Health
11 Scheme, which provides subsidised access to up to 10 psychology sessions in a calendar year,
12 provided the criteria for a DSM condition are met. We have deliberately designed our sleep
13 intervention so that it is feasible for both paediatricians and psychologists to deliver within
14 the Australian Medicare scheme and within their typical consultation durations.
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20 21 **Aims and hypotheses**

22 Building on our efficacy trial, we aim to determine whether the Sleeping Sound with ADHD
23 intervention, delivered by paediatricians or psychologists in their usual work setting can
24 replicate the benefits of the efficacy trial. Therefore, in this translational, cluster-randomised
25 trial we aim to determine whether a brief sleep intervention delivered by paediatricians or
26 psychologists:
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34 1. Decreases the proportion of children with moderate/severe sleep problems from
35 moderate/severe to no/mild by parent report at 3 months post-intervention (**primary**
36 **outcome**).
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38 2. Improves child and family functioning at 3 and 6 months post-intervention
39 (**secondary outcome**).
- 40
41 3. Is cost-effective (**secondary outcome**).

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47 We hypothesise that, compared to the control children at 3 (primary outcome timepoint) and
48 6 months post-intervention, a brief behavioural sleep intervention will:
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52 1. Decrease prevalence of child sleep problems from moderate/severe to no/mild;
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54 2. Improve functioning in other child (sleep severity, ADHD symptoms, QoL,
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56 behaviour, working memory, executive functioning, learning, academic achievement,
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3 school attendance) and primary caregiver (mental health, parenting, work attendance)
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5 outcome domains.
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8 3. Be cost-effective.
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10 11 **Methods**

12 13 **Overall Study Design**

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15 This is a cluster RCT of a behavioural sleep intervention versus usual care conducted in
16
17 Victoria and Queensland, Australia (see Figure 1). The trial will be reported according to
18
19 Consolidated Standards of Reporting Trials guidelines and the extension report of non-
20
21 pharmacological interventions.²⁰ This project has been funded by the National Health and
22
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24
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26
27 Hospital (RG-14-349), Deakin University (2015-211), Victorian Department of Education &
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29 Training (2014_002519), The Queensland Department of Education & Training
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31 (550/27/1570), and the Catholic Education Office (Ballarat; Brisbane; Melbourne;
32
33 Toowoomba) Human Research Ethics Committees.
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38 39 **Participants**

40
41 Participants include families of children aged 5-12 years at the time of recruitment with
42
43 paediatrician-diagnosed and DSM-5 confirmed ADHD and a moderate to severe sleep
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45 problem as defined by the American Academy of Sleep Medicine diagnostic criteria²¹:
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47 chronic insomnia disorder, delayed sleep-wake phase disorder, or sleep related anxiety.
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50 51 **Recruitment of health professionals**

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53 Paediatricians are recruited via the Australian Paediatric Research Network or through
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55 clinical contacts.¹⁸ Interested paediatricians are invited to attend a briefing session in which
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57 the study requirements and timetable is presented and clinicians have the opportunity to ask
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3 questions. Interested paediatricians are sent a follow up email thanking them for their interest,
4 asking them to sign an individual Memorandum of Understanding (MOU) if they consent to
5 participation, and asking them to provide a list of psychologists to whom they refer patients.
6
7 By signing the MOU, paediatricians agree to: (1) participate in training if randomised to the
8 intervention arm; (2) deliver the sleep program to intervention families *or* refer the child to a
9 psychologist to deliver the sleep program; (3) not share the intervention materials with
10 control group paediatricians; and (4) allocate time for intervention session bookings.
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20 Once paediatricians have been recruited, psychologists are invited to whom the
21 paediatricians have indicated they refer patients. The research team then informs
22 psychologists about the study via email or phone. The researchers then send psychologists
23 who express interest in participating a follow up email thanking them for their interest and
24 asking them to sign an individual MOU, agreeing to: (1) participate in training; (2) deliver the
25 sleep program to intervention families referred by paediatricians; (3) use intervention
26 materials only with children enrolled in the study; and (4) not share the intervention materials
27 with any other families they see during the study period. This approach has worked well to
28 minimise contamination in our previous RCTs.²²⁻²⁴
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39 **Screening children for sleep problems and recruiting families**

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41 This translational trial uses, where possible, the same procedures that were used in our
42 efficacy trial.⁸ Paediatricians pre-identify their patients with ADHD, aged between 5-12
43 years, seen within the last 12 months, either through their medical software or through case
44 notes. Paediatricians then send a letter to the child's primary caregiver inviting them to take
45 part. The letter advises families that the research team will ask them about their child's sleep
46 and ADHD symptoms. An 'opt out' approach is used, whereby parents are asked to contact
47 the paediatrician if they *do not* wish to learn more about the study. If parents do not opt out
48 within a two-week period, the paediatrician provides the research team with the contact
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3 details of the families. Only 9% of families opted out in our efficacy trial.⁸ Paediatricians
4 also have the option to use an active consent process. In these cases paediatricians send an
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7 'opt in' version of the study invitation letter.
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11 The research team then contacts interested (or not opted-out) families via telephone to
12 ascertain if the child meets inclusion/exclusion criteria. Eligible families are sent a parent
13 information statement and consent form and a baseline survey. Families have the option to
14 complete hard copy surveys or online surveys (via REDCap - a secure, web-based
15 application).²⁵ Surveys are completed by the child's primary caregiver. Parents have the
16 option to consent to have their child's school teacher complete a survey about their child's
17 behaviour. If consent is provided by the primary caregiver and school, a link to an online
18 survey is sent to teachers. Parents also have the option to consent to being contacted for
19 ethically approved future research, for the research team to keep their de-identified data to be
20 shared with future ethically approved research, and to allow the research team to link with
21 their child's *National Assessment Program – Literacy and Numeracy* (NAPLAN) results.
22 NAPLAN is a national assessment of literacy and numeracy Australian children complete in
23 Grades 3 and 5, and Years 7 and 9.²⁶
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40 Once caregivers provide consent, the research team contacts them to complete the
41 Anxiety Disorders Interview Schedule for Children (ADIS-C) over the telephone to assess
42 comorbid internalising and externalising diagnoses in children with ADHD.²⁷ To ensure we
43 administer the telephone interviews consistently we are recording 10% of the sample to test
44 inter-rater reliability.
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50 **Inclusion/exclusion criteria (all assessed via telephone)**

51 *Inclusion criteria*

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56 a. Child aged between 5-12 years at the time of the recruitment call.
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- b. Child's sleep is a moderate-severe problem for the caregiver ascertained using the following question: Has your child's sleep been a problem for you over the past 4 weeks? If 'yes', they are asked to rate severity (mild, moderate or severe). This measure has been used in studies of children with and without ADHD and has good agreement with the Children's Sleep Habits Questionnaire.^{2,28,29}
 - c. Child sleep problem meets the International Classification of Sleep Disorders – Third Edition criteria²¹ for an eligible sleep disorder (chronic insomnia disorder, delayed sleep-wake phase disorder) or sleep-related anxiety assessed using study-designed questions.
 - d. Child meets DSM 5 criteria for ADHD assessed via the 18-item ADHD Rating Scale IV - a validated scale measuring the core symptoms of ADHD.³⁰ Caregivers need to rate at least 6 of 9 of the inattention and/or hyperactivity/impulsivity items as occurring 'often' or 'very often' in order to meet current symptom criteria. Caregivers are asked to rate symptoms off stimulant medication. Additional questions are then asked to ensure symptoms have been present for at least 6 months, contribute to cross-situational impairment and have age of onset prior to the age of 12.

40 Children are eligible to participate if they are taking melatonin or any other sleep
41 inducing medication, as long as the inclusion criteria are still met despite medication use.

42 *Exclusion criteria*

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- a. Suspected OSA identified using three OSA items from the Children's Sleep Habits Questionnaire.³¹ Paediatrician investigators Hiscock and Heussler telephone caregivers of children with suspected OSA to ask further about their symptoms and if OSA is suspected, these children are excluded and referred to appropriate clinical services as per usual clinical care (1% in our efficacy trial).⁸

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- 3 *b.* No longer meeting criteria for ADHD at the time of recruitment.
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- 6 *c.* Major illness or disability (e.g., intellectual disability). Common comorbidities
- 7 including internalising/externalising disorder and autism spectrum disorder (ASD) are
- 8 not excluded.
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- 13 *d.* Parents with insufficient English language proficiency to complete study
- 14 documentation and/or participate in the intervention.
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- 19 *e.* Participated in our original efficacy trial.
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21 **Sample size**

22 Sample size planning is based on the primary outcome, the proportion of children for whom
23 parents no longer report moderate/severe sleep problems at 3 months. In the efficacy study, at
24 3 months, 56% and 30% of parents in the intervention and control group, respectively,
25 reported that their child's sleep was still a moderate/severe problem i.e. a difference of 26%.
26 We conservatively assume a smaller difference of 20%, i.e. 56% vs 36% to be observed in
27 this trial. In order to have 80% power in detecting this difference at a two-sided type one
28 error level of 5%, a group sample size of 107 individuals (total sample size $n=214$) is
29 required. As this is a cluster controlled trial (clustered at the level of the paediatrician to
30 minimise contamination), we will inflate our sample size by a design effect of 1.2 where the
31 design effect = $1+(n-1) \cdot r$ with $n=3$ (the number of children seen by each paediatrician) and
32 $r=0.1$ (the conservatively assumed intra-cluster correlation coefficient, based on our efficacy
33 RCT). Allowing for 20% drop out to 3 months and accounting for clustering, we need to
34 recruit 160 children in each study arm (total sample size $n=320$).

52 **Randomisation**

53 Paediatricians are randomly allocated to either receive the sleep training or not by an
54 independent researcher, thereby avoiding potential contamination if all paediatricians were to
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3 be trained in the program. Randomisation is based on a pre-generated group allocation
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be trained in the program. Randomisation is based on a pre-generated group allocation sequence from the Murdoch Childrens Research Institute's Clinical Epidemiology and Biostatistics Unit and is stratified by location of the paediatrician (regional or metropolitan area). The randomisation is also stratified by the predicted number of enrolled patients (less than 10 and 10 or more). Paediatricians, families and researchers are blind to group allocation at the time of recruitment.

If the paediatrician is assigned to the intervention group and has more than four patients enrolled, families are randomised to receive the intervention from either the paediatrician or psychologist. This second step of randomisation takes place after family recruitment is complete. The research team then sends the paediatrician a letter informing them of whether they will be receiving the sleep training or not. In addition, participating families are also sent a letter informing them of whether they will be receiving the sleep intervention or not.

Families of children attending a paediatrician randomised to the control group receive 'usual care' which involves seeing their paediatrician as per usual regarding their child's ADHD. Our research has shown that this does not routinely include addressing sleep issues.² In Australia, paediatricians typically see children with ADHD every 6 months to check their height, weight, blood pressure and re-issue a script for medication (valid for 6 months), where necessary.

Intervention training

The intervention is designed to be feasible to deliver in paediatricians' and psychologists' practice. Intervention group paediatricians and all psychologists are trained to deliver the same program described for our efficacy trial⁸ in one 3.5-hour session. Training occurs conjointly for paediatricians and psychologists, where possible, with investigators Hiscock, Sciberras and Heussler to maximise fidelity. Training addresses normal sleep

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3 patterns in school-aged children and highlights the importance of sleep hygiene practices
4 such as consistent bedtime routines and keeping bedrooms media-free. The intervention
5 includes verbal and written information of standard sleep intervention strategies as
6 recommended by the American Sleep Association³² and addresses common behavioural sleep
7 problems experienced at the beginning of, and during, the night. A summary of sleep
8 problems addressed and management strategies are provided in Table 1. Training focuses on
9 how these strategies can be individualised for families and includes evidence-based
10 instructional strategies such as role play, feedback, modelling practice, and use of checklists.
11 Training is supported by a manual and written parent education materials.
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24 Prior to training, paediatricians and psychologists complete a “pre-quiz” to establish
25 their baseline knowledge, skills and attitudes in relation to child sleep problems and their
26 management. A “post-quiz” following training is used to assess changes in knowledge,
27 confidence, and perceived competence in the management of child sleep problems.
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32 **Intervention delivery**

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34 Paediatricians and psychologists are sent an intervention package for each child allocated to
35 them containing the child’s contact details, a clinical checklist to complete after each
36 appointment and parent education materials. Families contact the clinician to make an
37 appointment (up to 30 minutes for paediatricians, up to 50 minutes for a psychologist) to
38 discuss their child’s sleep, with a follow-up session (up to 30 minutes for paediatricians, up to
39 50 minutes for a psychologist) approximately two weeks later and if needed, a final 15-20
40 minute phone call a further two weeks after that. Children are present at all face to face
41 appointments. The first session focuses on an assessment of the child’s sleep problem,
42 providing information about normal sleep and sleep cycles, giving the family a sleep diary to
43 complete, advice about sleep hygiene, and a plan specifically tailored to the child’s particular
44 sleep disorder. The second session and follow-up phone call include a review of the sleep
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3 diary, re-enforcement/trouble shooting of existing strategies and the introduction of new
4
5 strategies, where appropriate.
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7 The research team contacts families within one month post-randomisation to ensure
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9 an appointment has been made with either their paediatrician or a psychologist and to
10
11 encourage them to make the appointment if they have not yet done so.
12

13 **Follow-up**

14 We mail/email follow-up surveys to families and teachers at 3 and 6 months post-intervention
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16 (measured from first intended intervention session for intervention families with controls
17
18 followed up at the median date of intervention follow-up) to determine both short and longer
19
20 term changes in primary and secondary outcomes. Teachers are not informed of the child's
21
22 intervention group status. For intervention families only, the 3 month survey also asks about
23
24 the behavioural intervention components received, usefulness of the intervention, ease of use
25
26 of strategies, and costs experienced by families in accessing the program. At 6 months a
27
28 trained research assistant completes a blinded direct assessment of child executive
29
30 functioning, learning, working memory, academic functioning, sleep and QoL via home visits
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32 (of 45 minutes duration).
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38 **Measures**

39 All measures administered at baseline, 3 and 6 months are summarised in Table 2. The
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41 majority of measures were used in our efficacy trial. We now additionally measure academic
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43 functioning given that our efficacy trial showed a trend towards improvement in working
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45 memory, which is a key determinant of academic functioning. For similar reasons we also
46
47 include a more detailed assessment of cognitive and executive functioning. The baseline
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49 questionnaire includes family (e.g., family composition, parental education and age, language
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51 spoken at home, annual household income) and child demographic and medical (e.g.,
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53 medication, diagnosed comorbidities etc.) characteristics.
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3 The research team prospectively records resources used to administer all program
4 components to facilitate economic analyses. Families also report time, travel and out-of-
5 pocket costs associated with visits as well as those costs associated with child ADHD
6 medication/prescriptions.
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10 11 **Data analysis**

12 Analyses will be based on the ‘intention to treat’ population at the level of the individual
13 child and will adjust for clustering at the level of the paediatrician using a generalised linear
14 mixed effect model (logit link function) for the binary outcome. In the primary efficacy
15 analysis, the stratification variable ‘*location of study site (practice)*’ as well as an indicator
16 variable for the *type of health care professional* who delivered the intervention (paediatrician
17 or psychologist) will be considered as adjustments variables. Model-based effect estimates
18 (risk differences and risk ratios) will be reported along with 95% confidence intervals.
19 Because of the range of outcomes and time-points, the results will be considered in their
20 totality and interpreted with suitable caution regarding formal conclusions of “statistical
21 significance”. In order to reduce potential confounding bias due to differential patient-drop
22 out over time, multiple imputation methodology will be applied to replace missing outcome
23 data in the primary efficacy analysis. All secondary analyses will be adjusted for baseline
24 scores and stratification variables wherever possible, in order to increase precision of
25 comparisons.³³ We will present results of analyses both unadjusted and adjusted for further
26 potential outcome predictor variables (child age, medication use, comorbidities, and family
27 socio-demographic characteristics (Socioeconomic Index for Advantage linked to the
28 family’s postcode),³⁴ parent high school completion, and parent age). A comprehensive
29 statistical analysis plan, finalized before database lock, will specify the details of the primary
30 and secondary analyses.
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56 57 **Cost-effectiveness analyses**

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3 The economic analysis will first present cost-consequences analysis, then proceed to cost-
4 effectiveness analysis against the primary outcome (*prevalence of sleep problems*) measure
5 as the primary economic analysis. Secondary economic analyses will include cost-utility
6 analysis against CHU9D-based QALYs.^{35,36} These analyses will be conducted from both the
7 health care and broader societal perspectives (as cost-effectiveness can vary significantly by
8 perspective)³⁷ and will include extensive sensitivity analyses to test the impact of uncertainty
9 in data and sensitivity to evaluation approach.
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18 **Dissemination**

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20 Findings will determine whether the benefits of an efficacy trial can be realised more broadly
21 at the population level and whether it is cost-effective to do so. Findings will inform the
22 development of clinical guidelines for managing sleep problems in this population. We will
23 seek to publish in leading international paediatric journals, present at major conferences and
24 disseminate findings through established clinician networks.
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32 **Discussion**

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34 ADHD affects approximately 5% of school-aged children³⁸ and is frequently associated with
35 sleep problems, which worsen child and family outcomes.² The development of effective
36 behavioural interventions that can be rolled out in routine clinical practice for children with
37 ADHD and sleep problems may improve a host of child and family outcomes, as suggested
38 by recent efficacy trials.⁸⁻¹⁰
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46 It is essential to now take the next steps to translate these findings to everyday
47 practice. To do this, we have deliberately designed our intervention so that it can be readily
48 delivered by children's treating paediatricians or psychologists in the community. No such
49 trial has been previously reported, either in Australia or internationally. If cost-effective, we
50 expect the following outcomes: 1) the best evidence yet that addressing sleep problems
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3 improves outcomes for children with ADHD; and 2) a ready-to-use intervention that is
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5 tailored to the Australian health system, and can be replicated internationally.
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8 **Article summary**

9 **Strengths and limitations**

- 10 • First translational trial to determine whether a brief, behavioural sleep intervention
11
12 has benefits for children with ADHD when delivered in ‘real-life’ clinical settings by
13
14 paediatricians and psychologists.
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16
- 17 • The inclusion of blinded teacher reports, as well as blinded direct assessment
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19 measures to minimise bias.
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21
- 22 • Inclusion of economic analyses, which provide data on the cost-effectiveness of the
23
24 program.
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26
- 27 • Limited generalisability to non-English speaking families and children with ADHD
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29 presenting with serious medical conditions and/or intellectual disability.
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- 32 • Sleep problems assessed using unblinded parent report as opposed to objective
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34 measures.
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Table 1. Key behavioural sleep management strategies

Sleep disorder	Definition	Examples of behavioural strategies
Sleep onset association disorder	Child associates falling asleep with a person or object (e.g., television) and is unable to fall asleep without its presence.	<ul style="list-style-type: none"> • Adult fading (i.e. graduated extinction) using ‘camping out’ - gradual withdrawal of parental presence from the child’s bedroom over 7-10 days. • ‘Checking method’ – parent checks on the child at regular time intervals (2, 5, or 10 minutes, with intervals increasing over time).
Delayed sleep phase	Shift in the child’s sleep-wake cycle, in which the child cannot fall asleep until late and then wakes late in the morning.	<ul style="list-style-type: none"> • Bedtime fading - child’s bedtime is temporarily set later to when they are usually falling asleep and gradually brought forward. The child is then woken at a pre-set time in the morning. • Early morning light exposure.
Limit setting sleep disorder	Child refusal to go to bed and general non-compliant behaviour at bedtime. Parent struggles to set appropriate and consistent bedtime limits.	<ul style="list-style-type: none"> • Parent management strategies - ignoring child protests, rewarding compliance with bedtime routines. A ‘bedtime pass’, whereby the child can only leave the bedroom one time before sleep, can be used to promote compliant behaviour. • Consideration of bedtime fading or the checking method.
Primary insomnia	Child has substantial difficulty initiating and/or maintaining sleep even if they go to bed at a later time.	<ul style="list-style-type: none"> • Visual imagery and relaxation. • Basic cognitive restructuring. • Restricting time in bed (e.g., temporarily setting the bedtime later as per delayed sleep phase or getting out of bed and doing a relaxing activity if the child cannot

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		sleep).
Night time anxiety	Specific night time fears including fear of the dark and/or child worrying about other things while in bed.	<ul style="list-style-type: none"> • Visual imagery and relaxation training. • Discussing fears during the day rather than just before bedtime. • Rewarding brave behaviour. • Other - use of a security object, avoiding scary television shows, use of a book to record worries.

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Table 2. Summary of measures

Construct	Measures	Source ^a	T1	T2	T3
Child Outcomes					
Sleep	Sleep problem prevalence (primary outcome) - Primary caregiver report of child sleep problem (none/mild vs moderate/severe). ²	P	●	●	●
	Children's Sleep Habits Questionnaire (CSHQ) - 33-item validated measure of disorders of initiating and maintaining sleep. ³¹ Child Sleep Self Report collected at 6 months only. ¹⁵	P	●	●	●
	Teacher Daytime Sleepiness Questionnaire - 10-item validated scale of daytime sleepiness at school. ³⁹	T	●	●	●
	Sleep Hygiene scale - 7-item measure assessing sleep hygiene. ²⁴	P	●		●
Comorbidity	Anxiety Disorders Interview Schedule for DSM-IV (ADIS-C) - diagnostic interview assessing mental health disorders according to DSM-IV criteria. This is completed with parents over the telephone and has been validated for this purpose. ²⁷	P	●		
ADHD	ADHD Rating Scale IV - 18-item validated scale measuring the core symptoms of ADHD. ³⁰	P, T	●	●	●
Behaviour	Strengths and Difficulties Questionnaire – 25 items assessing the following subscales: hyperactivity/inattention, conduct problems, emotional symptoms, peer relationship problems, and prosocial behavior. ⁴⁰	P, T	●	●	●
Irritability	Affective reactivity index (ARI) - 6-item validated measure assessing child irritability. ⁴¹	P	●	●	●
School attendance	School attendance over the preceding 3 months. ²	P	●	●	●
Quality of Life	Child Health Utility-9D (CHU-9D) - 9 item measure of child quality of life used to calculate quality adjusted life years. Child report is collected at the 6 month follow up only. ⁴²	P, C	●		●
	Pediatrics Quality of Life Inventory 4.0 – 23-item measure of child total, physical and psychosocial QoL. ⁴³	P	●		●

Memory	Sleep Suite App – An animated iPad application that includes a continuous performance test to measure sustained attention, and 2 tests of memory consolidation and learning. ⁴⁴	C			●
Working Memory	Working Memory Test Battery for Children – The Backward digit span recall subtest is administered as a measure of child working memory. ⁴⁵	C			●
Academic functioning	Wide Range Achievement Test 4 (WRAT) – word reading and math computation subtests. ⁴⁶	C			●
	NAPLAN – standardised academic tests of reading, writing, language conventions and numeracy. Results can be compared to National or State population results and against the national minimum standard. ²⁶	L			●
Autism	Social Responsiveness Scale (SRS) Brief – 16-item measure of autism spectrum disorder symptoms. ⁴⁷	P			●
Parent Outcomes					
Mental health	Kessler 6 (K6) - 6-item validated measure of adult psychological stress. ⁴⁸	P	●	●	●
Work attendance	Work attendance over the previous 3 months. ²	P	●	●	●
Parenting	Parenting - validated scales developed for the Longitudinal Study of Australian Children assessing parenting consistency (6-items) and parental warmth (5-items). ⁴⁹	P	●		●
Family costs	Service use and costs - families report service use over previous 3 months as well as time, travel and out-of-pocket costs associated	P		●	●

^a P = Parent-report, T = teacher-report, C = child-report, L = data linkage; T1 = baseline; T2 = 3 months post-intervention; T3 = 6 months post-intervention.

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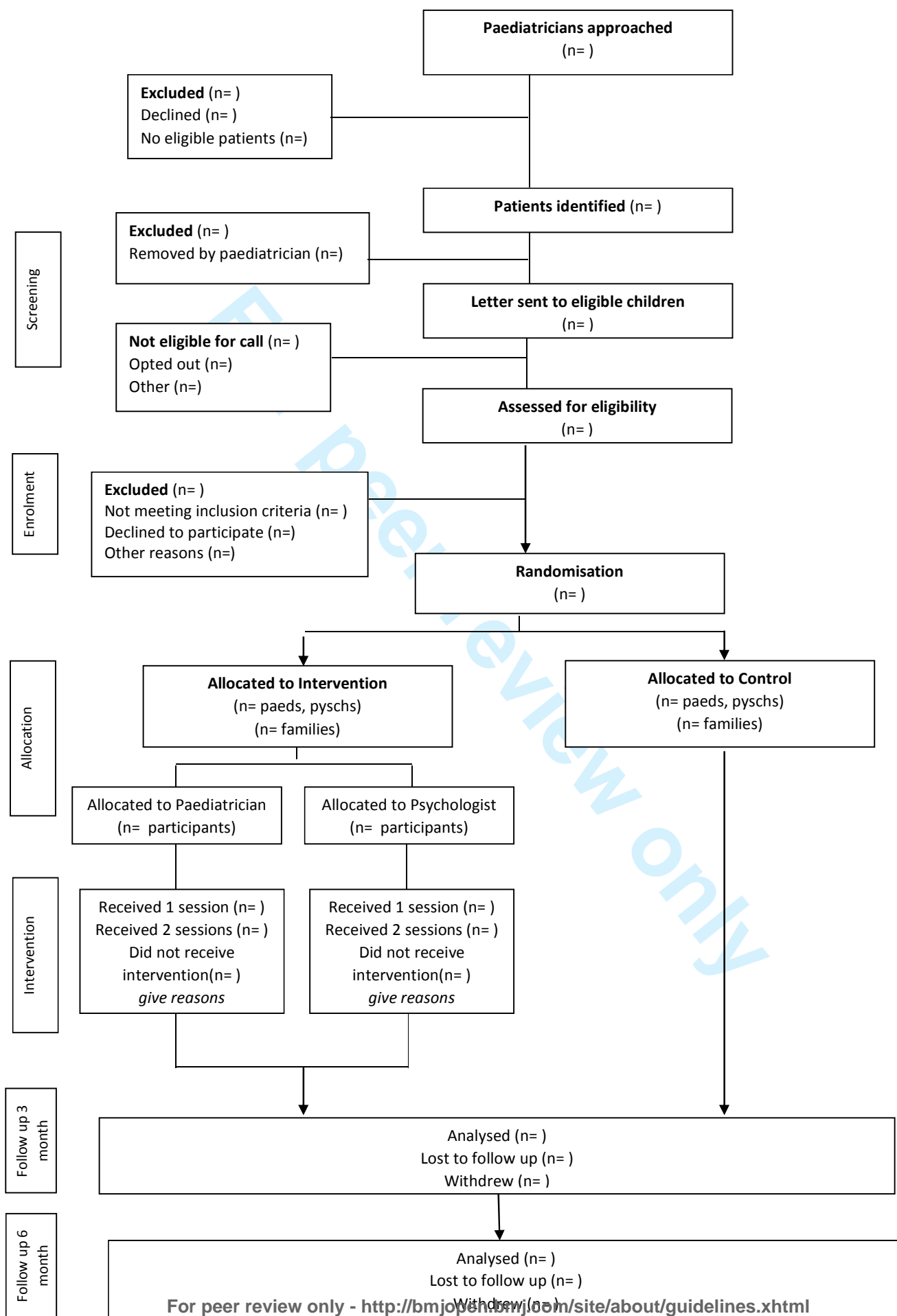
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BMJ Open

**Does a brief, behavioural intervention, delivered by
paediatricians or psychologists improve sleep problems for
children with ADHD?
Protocol for a cluster-randomised, translational trial**

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2016-014158.R1
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Date Submitted by the Author:	01-Dec-2016
Complete List of Authors:	Sciberras, Emma; Murdoch Childrens Research Institute, Centre for Community Child Health Mulraney, Melissa; Murdoch Childrens Research Institute Heussler, Honey; Mater Medical Research Institute Rinehart, Nicole; Deakin University Schuster, Tibor; Murdoch Childrens Research Institute, Medical Statistics Gold, Lisa; Deakin University, Deakin Health Economics Hayes, Nicole; Mater Medical Research Institute Hiscock, Harriet; The Royal Children's Hospital, Centre for Community Child Health
Primary Subject Heading:	Mental health
Secondary Subject Heading:	Public health
Keywords:	attention deficit disorder with hyperactivity, randomised controlled trial, effectiveness, treatment, sleep, child

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3 **Does a brief, behavioural intervention, delivered by paediatricians or psychologists**
4 **improve sleep problems for children with ADHD?**
5
6 **Protocol for a cluster-randomised, translational trial**
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23 **Running title** Behavioural sleep intervention for children with ADHD
24

25 **Key words** attention deficit disorder with hyperactivity, sleep, child, randomised
26 controlled trial, effectiveness, treatment
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ABSTRACT

Introduction: Up to 70% of children with Attention-Deficit/Hyperactivity Disorder (ADHD) experience sleep problems. We have demonstrated the efficacy of a brief behavioural intervention for children with ADHD in a large randomised controlled trial (RCT) and now aim to examine whether this intervention is effective in real-life clinical settings when delivered by paediatricians or psychologists. We will also assess the cost-effectiveness of the intervention.

Methods and analysis: Children aged 5-12 years with ADHD (n=320) are being recruited for this translational cluster RCT through paediatrician practices in Victoria and Queensland, Australia. Children are eligible if they meet criteria for ADHD, have a moderate/severe sleep problem, and meet American Academy of Sleep Medicine criteria for either chronic insomnia disorder or delayed sleep-wake phase disorder; or are experiencing sleep-related anxiety. Clinicians are randomly allocated at the level of the paediatrician to either receive the sleep training or not. The behavioural intervention comprises two consultations covering sleep hygiene and standardized behavioural strategies. The primary outcome is change in the proportion of children with moderate/severe sleep problems from moderate/severe to no/mild by parent report at 3 months post-intervention. Secondary outcomes include a range of child (e.g., sleep severity, ADHD symptoms, quality of life, behaviour, working memory, executive functioning, learning, academic achievement) and primary caregiver (mental health, parenting, work attendance) measures. Analyses will address clustering at the level of the paediatrician using linear mixed effect models adjusting for potential a priori confounding variables.

Ethics and dissemination: Ethics approval has been granted. Findings will determine whether the benefits of an efficacy trial can be realised more broadly at the population level and will inform the development of clinical guidelines for managing sleep problems in this

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3 population. We will seek to publish in leading international paediatric journals, present at
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5 major conferences and through established clinician networks.
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7 **Registration details:** Current Controlled Trials ISRCTN50834814
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9 **Article summary**
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11 **Strengths and limitations**
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- 14 • First translational trial to determine whether a brief, behavioural sleep intervention
15 has benefits for children with ADHD when delivered in ‘real-life’ clinical settings by
16 paediatricians and psychologists.
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 - 18 • The inclusion of blinded teacher reports, as well as blinded direct assessment
19 measures to minimise bias.
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 - 21 • Inclusion of economic analyses, which provide data on the cost-effectiveness of the
22 program.
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 - 24 • Limited generalisability to non-English speaking families and children with ADHD
25 presenting with serious medical conditions and/or intellectual disability.
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 - 27 • Sleep problems assessed using unblinded parent report as opposed to objective
28 measures.
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INTRODUCTION

Sleep problems are common and more persistent in children with ADHD, and associated with poorer child and family well-being.¹⁻⁴ Efficacy Randomised Controlled Trials (RCTs) have shown that sleep problems are amenable to intervention⁵⁻¹⁰ in children with ADHD, particularly behavioural interventions.⁸⁻¹⁰ However, it is unknown whether the same benefits will be observed when such interventions are delivered by practitioners in 'real life' clinical settings. This article describes the protocol for the Sleeping Sound with ADHD Translational RCT, which aims to assess the effectiveness of a behavioural sleep intervention designed for children with ADHD, when delivered by psychologists or paediatricians in their daily clinical practice.

Sleep problems in children with ADHD

Up to 70% of children with ADHD experience sleep problems,^{1,2} compared with 20-30% of children in the general population.¹¹ Sleep problems experienced by children with ADHD are largely comprise difficulties initiating and/or maintaining sleep, with the most common sleep problems being difficulty falling asleep (reported by 84% of parents of children who report a sleep problem for their child with ADHD), bedtime resistance (68%), tiredness upon waking (62%) and difficulty waking in the morning (56%).² Medical conditions such as obstructive sleep apnoea (OSA) can also affect sleep in children with ADHD, although behavioural sleep problems appear more common.¹² In this study we use the term sleep problems to denote those difficulties that can be addressed using behavioural intervention. Sleep problems have been associated with worse functioning for children with ADHD including poorer quality of life (QoL), behaviour, daily functioning, and working memory, as well as increased school absenteeism.^{2,4,13} They thus represent an important modifiable target for intervention.

A number of factors have been associated with sleep problems in children with ADHD and it is possible that biological sleep problems such as restless legs syndrome,

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3 obstructive sleep apnoea and narcolepsy can lead to continued sleep disruptions.¹² Insomnia
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5 can be a side-effect of stimulant medication,^{1,14} although unmedicated children with ADHD
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7 also experience higher rates of sleep problems relative to non-ADHD controls.¹⁵ Comorbid
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9 externalising and internalising comorbidities are each associated with a 2-fold increase in
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11 moderate/severe sleep problems in children with ADHD, while co-occurring internalising and
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13 externalising comorbidities are associated with a 3-fold increase.¹⁶ Parenting inconsistency in
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15 daily household routines has also been associated with increased bedtime resistance in this
16
17 group.¹⁷ Biologically, there is overlap in the brain regions and genetic factors (e.g.,
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19 catecholaminergic system, CLOCK genes) associated with both ADHD and sleep
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21 disorders/arousal regulation.¹ ADHD is also a highly genetic condition and parents likely are
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23 affected by symptoms such as disorganisation and impulsivity, which may impact on child
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25 sleep.
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29 **Treating sleep problems in children with ADHD using behavioural strategies**

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31 We recently published our efficacy RCT evaluating the impact of a behavioural sleep
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33 program in children with ADHD and moderate/severe sleep problems (n=244 5-12 year old
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35 children with ADHD).⁸ Children were recruited from 21 paediatric practices across Victoria,
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37 Australia and randomised to either a behavioural sleep intervention (n=122) or a usual care
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39 comparison group (n=122). Intervention families attended two x 50 minute individual
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41 sessions (held two weeks apart) with a clinician trained in the intervention (psychologist or
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43 trainee paediatrician), comprising a standardised yet flexible intervention, tailored to the
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45 child's sleep problems and family preferences.
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50 The intervention was associated with improved child outcomes at three and six
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52 months post-randomisation including improved parent-reported child sleep, ADHD symptom
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54 severity, QoL, daily functioning and behavior.⁸ Intervention children also had improved
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56 teacher-reported classroom behavior, as well as improved school attendance and working
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3 memory assessed via blinded assessment.⁸ There were small improvements in sleep duration
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5 for a subsample that completed actigraphy.⁸ Although the intervention was associated with
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7 improved caregiver work attendance and mental health three months later, these benefits
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9 were not observed at six months.⁸
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12 Similarly, two additional randomised controlled trials have demonstrated the efficacy
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14 of improving sleep problems in children with ADHD. Keshavarzi et al. reported that a 12-
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16 week sleep-training program for children with ADHD aged 10 years (n=40) had beneficial
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18 effects for sleep and psychosocial functioning when compared to controls with ADHD who
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20 did not receive the intervention (n=20) and typically developing children (n=20).⁹ However
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22 the professional group responsible for delivering the intervention was not reported. Corkum
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24 and colleagues also recently reported the beneficial effects of their distance sleep intervention
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26 delivered by paraprofessionals for childhood insomnia in a mixed sample of children with
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28 and without ADHD (n=61).¹⁰ Improvements were identified at 2 and 6 months for sleep
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30 assessed using parent report as well as actigraphy, and benefits were also reported for broader
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32 child psychosocial health.¹⁰
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37 Although RCTs have shown that melatonin is associated with improved sleep onset
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39 latency for children with ADHD,⁵⁻⁷ broader benefits for daily functioning including ADHD
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41 symptom severity have yet to be shown.
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43 **Managing sleep problems in children with ADHD through existing clinical services**

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45 Although three trials have now shown that it is possible to improve sleep problems in
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47 children with ADHD using behavioural approaches, it remains to be seen whether it is
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49 possible to replicate such approaches and improve outcomes for children with ADHD in ‘real
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51 life’ clinical settings when delivered by their treating clinicians (e.g., community
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53 paediatricians or psychologists) rather than by clinicians hired to deliver interventions in
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55 tightly controlled research trials. We are now testing the translation of this program at the
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3 population level by training community paediatricians and psychologists to deliver this sleep
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5 intervention to children with ADHD and sleep problems. If this intervention can be translated
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7 successfully to the population level within existing workforces, then this would have the real
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9 potential to improve outcomes for children with ADHD and their families. If cost-effective, it
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11 could be readily incorporated into the existing health system.
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14 Paediatricians are the main care providers for ADHD in Australia.¹⁸ The
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16 paediatrician's role includes both the assessment and treatment (behavioural and medication-
17
18 based) of ADHD and associated comorbidities (including sleep problems, if identified).
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20 Visits to a paediatrician are subsidised by Australia's Medicare scheme, however, families
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22 may experience out of pockets costs for these visits. Paediatricians (and general practitioners)
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24 may also refer children to a psychologist in the community to manage comorbid behaviours.¹⁹
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26 In Australia, this referral is facilitated by the Medicare Better Access to Mental Health
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28 Scheme, which provides subsidised access to up to 10 psychology sessions in a calendar year,
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30 provided the criteria for a DSM condition are met. We have deliberately designed our sleep
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32 intervention so that it is feasible for both paediatricians and psychologists to deliver within
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34 the Australian Medicare scheme and within their typical consultation durations.
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38 **Aims and hypotheses**

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40 Building on our efficacy trial, we aim to determine whether the Sleeping Sound with ADHD
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42 intervention, delivered by paediatricians or psychologists in their usual work setting can
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44 replicate the benefits of the efficacy trial. Therefore, in this translational, cluster-randomised
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46 trial we aim to determine whether a brief sleep intervention delivered by paediatricians or
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48 psychologists:
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- 51 1. Decreases the proportion of children with moderate/severe sleep problems from
52 moderate/severe to no/mild by parent report at 3 months post-intervention (**primary**
53
54 **outcome**).

2. Improves child and family functioning at 3 and 6 months post-intervention
(secondary outcome).
3. Is cost-effective (secondary outcome).

We hypothesise that, compared to the control children at 3 (primary outcome timepoint) and 6 months post-intervention, a brief behavioural sleep intervention will:

1. Decrease prevalence of child sleep problems from moderate/severe to no/mild;
2. Improve functioning in other child (sleep severity, ADHD symptoms, QoL, behaviour, working memory, executive functioning, learning, academic achievement, school attendance) and primary caregiver (mental health, parenting, work attendance) outcome domains.
3. Be cost-effective.

METHODS AND ANALYSIS

Overall Study Design

This is a cluster RCT of a behavioural sleep intervention versus usual care conducted in Victoria and Queensland, Australia (see Figure 1). The trial will be reported according to Consolidated Standards of Reporting Trials guidelines and the extension report of non-pharmacological interventions.²⁰

Participants

Participants include parents of children aged 5-12 years at the time of recruitment with paediatrician-diagnosed and DSM-5 confirmed ADHD and a moderate to severe sleep problem as defined by the American Academy of Sleep Medicine diagnostic criteria²¹: chronic insomnia disorder, delayed sleep-wake phase disorder, or sleep related anxiety.

Recruitment of health professionals

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3 Given that paediatricians are the main healthcare provider for children with ADHD,
4 recruitment and randomisation occurs at the level of the paediatrician. Paediatricians are
5 recruited via the Australian Paediatric Research Network or through clinical contacts.¹⁸
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7 Interested paediatricians are invited to attend a briefing session in which the study
8 requirements and timetable is presented and paediatricians have the opportunity to ask
9 questions. Interested paediatricians are sent a follow up email thanking them for their interest,
10 asking them to sign an individual Memorandum of Understanding (MOU) if they consent to
11 participation, and asking them to provide a list of psychologists to whom they refer patients.
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13 By signing the MOU, paediatricians agree to: (1) participate in training if randomised to the
14 intervention arm; (2) deliver the sleep program to intervention families *or* refer the child to a
15 psychologist to deliver the sleep program; (3) not share the intervention materials with
16 control group paediatricians; and (4) allocate time for intervention session bookings.
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31 Once paediatricians have been recruited, psychologists are invited to whom the
32 paediatricians have indicated they refer patients. Psychologists are only recruited for the
33 intervention arm of the project and have no contact with control participants. The research
34 team then informs psychologists about the study via email or phone. The researchers then
35 send psychologists who express interest in participating a follow up email thanking them for
36 their interest and asking them to sign an individual MOU, agreeing to: (1) participate in
37 training; (2) deliver the sleep program to intervention families referred by paediatricians; (3)
38 use intervention materials only with children enrolled in the study; and (4) not share the
39 intervention materials with any other families they see during the study period. This approach
40 has worked well to minimise contamination in our previous RCTs.²²⁻²⁴
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52 **Screening children for sleep problems and recruiting families**

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54 This translational trial uses, where possible, the same procedures that were used in our
55 efficacy trial.⁸ Paediatricians pre-identify their patients with ADHD, aged between 5-12
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3 years, seen within the last 12 months, either through their medical software or through case
4 notes. Paediatricians then send a letter to the child's primary caregiver inviting them to take
5 part. The letter advises families that the research team will ask them about their child's sleep
6 and ADHD symptoms. An 'opt out' approach is used, whereby parents are asked to contact
7 the paediatrician if they *do not* wish to learn more about the study. If parents do not opt out
8 within a two-week period, the paediatrician provides the research team with the contact
9 details of the families. Only 9% of families opted out in our efficacy trial.⁸ Paediatricians
10 also have the option to use an active consent process. In these cases paediatricians send an
11 'opt in' version of the study invitation letter.
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24 The research team then contacts interested (or not opted-out) families via telephone to
25 ascertain if the child meets inclusion/exclusion criteria. Eligible families are sent a parent
26 information statement and consent form and a baseline survey. Families have the option to
27 complete hard copy surveys or online surveys (via REDCap - a secure, web-based
28 application).²⁵ Surveys are completed by the child's primary caregiver. Parents have the
29 option to consent to have their child's school teacher complete a survey about their child's
30 behaviour. If consent is provided by the primary caregiver and school, a link to an online
31 survey is sent to teachers. Parents also have the option to consent to being contacted for
32 ethically approved future research, for the research team to keep their de-identified data to be
33 shared with future ethically approved research, and to allow the research team to link with
34 their child's *National Assessment Program – Literacy and Numeracy* (NAPLAN) results.
35 NAPLAN is a national assessment of literacy and numeracy Australian children complete in
36 Grades 3 and 5, and Years 7 and 9.²⁶
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53 Once caregivers provide written consent, the research team contacts them to complete
54 the Anxiety Disorders Interview Schedule for Children (ADIS-C) over the telephone to assess
55 comorbid internalising and externalising diagnoses in children with ADHD.²⁷ To ensure we
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administer the telephone interviews consistently we are recording 10% of the sample to test inter-rater reliability.

Inclusion/exclusion criteria (all assessed via telephone)

Inclusion criteria

- a. Child aged between 5-12 years at the time of the recruitment call.
- b. Child's sleep is a moderate-severe problem for the caregiver ascertained using the following question: Has your child's sleep been a problem for you over the past 4 weeks? If 'yes', they are asked to rate severity (mild, moderate or severe). This measure has been used in studies of children with and without ADHD and has good agreement with the Children's Sleep Habits Questionnaire.^{2,28,29}
- c. Child sleep problem meets the International Classification of Sleep Disorders – Third Edition criteria²¹ for an eligible sleep disorder (chronic insomnia disorder, delayed sleep-wake phase disorder) or sleep-related anxiety assessed using study-designed questions. To meet criteria for *chronic insomnia disorder* in this study children needed to meet criterion A (one or more of the following: difficulty initiating sleep, difficulty maintaining sleep, waking earlier than desired, resistance going to bed, difficulty sleeping without a caregiver), B (evidence of impairments related to the sleep difficulty such as daytime sleepiness, impaired social, family, or academic performance etc), C (sleep problem not be explained by inadequate sleep opportunity or circumstances) and D and E (symptoms and associated impairment must have been present 3 times a week or more for at least 3 months) needed to be met.²¹ To meet criteria for *delayed sleep-wake phase disorder* in this study, criterion A (significant phase delay as shown by difficulty initiating sleep and awakening at a required time), B (delayed sleep-wake phase must have been present for at least 3 months), and C (improved sleep quality and duration when allowed to choose their own schedule)

needed to be satisfied.²¹ Children were accepted into the study on the basis of experiencing sleep-related anxiety if the caregiver endorses significant difficulty falling asleep at night, in addition to anxious behaviour at bedtime (e.g., fearful behaviours such as crying, asking for reassurance or lying in bed worrying).

- d. Child meets DSM 5 criteria for ADHD assessed via the 18-item ADHD Rating Scale IV - a validated scale measuring the core symptoms of ADHD.³⁰ Caregivers need to rate at least 6 of 9 of the inattention and/or hyperactivity/impulsivity items as occurring 'often' or 'very often' in order to meet current symptom criteria. Caregivers are asked to rate symptoms off stimulant medication. Additional questions are then asked to ensure symptoms have been present for at least 6 months ('Did your child have these symptoms for at least 6 months before being diagnosed with ADHD?'), and contribute to cross-situational impairment ('Are these symptoms present at home, school and/or when out socially?') Given the included age range all participants met age of onset criteria. We did not assess whether the symptoms were not better explained by another mental disorder.

Children are eligible to participate if they are taking melatonin or any other sleep inducing medication, as long as the inclusion criteria are still met despite medication use.

Exclusion criteria

- a. Suspected OSA identified using three OSA items from the Children's Sleep Habits Questionnaire.³¹ Paediatrician investigators Hiscock and Heussler telephone caregivers of children with suspected OSA to ask further about their symptoms and if OSA is suspected, these children are excluded and referred to appropriate clinical services as per usual clinical care (1% in our efficacy trial).⁸
- b. No longer meeting criteria for ADHD at the time of recruitment.

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3 c. Major illness or disability (e.g., intellectual disability). Parents are asked if their child
4 has ever been diagnosed with an intellectual disability or serious medical condition. If
5 has ever been diagnosed with an intellectual disability or serious medical condition. If
6 yes, parents are asked to provide further details (e.g., IQ score, diagnosis). If
7 clarification is needed permission is sought to recontact the paediatrician to obtain
8 relevant information from the child's medical record. Common comorbidities
9 including internalising/externalising disorder and autism spectrum disorder (ASD) are
10 not excluded.
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12 d. Parents with insufficient English language proficiency to complete study
13 documentation and/or participate in the intervention.
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15 e. Participated in our original efficacy trial.
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27 **Sample size**

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29 Sample size planning is based on the primary outcome, the proportion of children for whom
30 parents no longer report moderate/severe sleep problems at 3 months. In the efficacy study, at
31 3 months, 56% and 30% of parents in the intervention and control group, respectively,
32 reported that their child's sleep was still a moderate/severe problem i.e. a difference of 26%.
33 We conservatively assume a smaller difference of 20%, i.e. 56% vs 36% to be observed in
34 this trial. In order to have 80% power in detecting this difference at a two-sided type one
35 error level of 5%, a group sample size of 107 individuals (total sample size n=214) is
36 required. As this is a cluster controlled trial (clustered at the level of the paediatrician to
37 minimise contamination), we will inflate our sample size by a design effect of 1.2 where the
38 design effect = $1+(n-1)r$ with n=3 (the number of children seen by each paediatrician) and
39 r=0.1 (the conservatively assumed intra-cluster correlation coefficient, based on our efficacy
40 RCT). Allowing for 20% drop out to 3 months and accounting for clustering, we need to
41 recruit 160 children in each study arm (total sample size n=320). All recruitment procedures
42 described have been used in our previous trials to achieve similar recruitment numbers.
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Randomisation

Randomisation occurs at the level of the paediatrician. Paediatricians are randomly allocated to either receive the sleep training or not by an independent researcher, thereby avoiding potential contamination if all paediatricians were to be trained in the program. Randomisation is based on a pre-generated group allocation sequence from the Murdoch Childrens Research Institute's Clinical Epidemiology and Biostatistics Unit and is stratified by location of the paediatrician (regional or metropolitan area). The randomisation is also stratified by the predicted number of enrolled patients (less than 10 and 10 or more). Paediatricians, families and researchers are blind to group allocation at the time of recruitment.

If the paediatrician is assigned to the intervention group and has more than four patients enrolled, families are randomised to receive the intervention from either the paediatrician or psychologist. This second step of randomisation takes place after family recruitment is complete. The research team then sends the paediatrician a letter informing them of whether they will be receiving the sleep training or not. In addition, participating families are also sent a letter informing them of whether they will be receiving the sleep intervention or not.

Families of children attending a paediatrician randomised to the control group receive 'usual care' which involves seeing their paediatrician as per usual regarding their child's ADHD. Our research has shown that this does not routinely include addressing sleep issues.² In Australia, paediatricians typically see children with ADHD every 6 months to check their height, weight, blood pressure and re-issue a script for medication (valid for 6 months), where necessary.

Intervention training

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3 The intervention is designed to be feasible to deliver in paediatricians' and
4 psychologists' practice. Intervention group paediatricians and psychologists are trained to
5 deliver the same program described for our efficacy trial⁸ in one 3.5-hour session. Training
6 occurs conjointly for paediatricians and psychologists, where possible, with investigators
7 Hiscock, Sciberras and Heussler to maximise fidelity. Training addresses normal sleep
8 patterns in school-aged children and highlights the importance of sleep hygiene practices
9 such as consistent bedtime routines and keeping bedrooms media-free. The intervention
10 includes verbal and written information of standard sleep intervention strategies as
11 recommended by the American Sleep Association³² and addresses common sleep problems
12 experienced at the beginning of, and during, the night. A summary of sleep problems
13 addressed and management strategies are provided in Table 1. Training focuses on how these
14 strategies can be individualised for families and includes evidence-based instructional
15 strategies such as role play, feedback, modelling practice, and use of checklists. Training is
16 supported by a manual and written parent education materials.

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Prior to training, paediatricians and psychologists complete a “pre-quiz” to establish their baseline knowledge, skills and attitudes in relation to child sleep problems and their management. A “post-quiz” following training is used to assess changes in knowledge, confidence, and perceived competence in the management of child sleep problems.

Intervention delivery

Paediatricians and psychologists are sent an intervention package for each child allocated to them containing the child's contact details, a clinical checklist to complete after each appointment and parent education materials. Families contact the clinician they have been allocated to make an appointment (up to 30 minutes for paediatricians, up to 50 minutes for a psychologist) to discuss their child's sleep, with a follow-up session (up to 30 minutes for paediatricians, up to 50 minutes for a psychologist) approximately two weeks later and if

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3 needed, a final 15-20 minute phone call a further two weeks after that. The differences in
4
5 consultation duration reflect real life clinical practice. We record the actual duration of all
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7 consultations, which will enable us to examine the relationship between intervention dose and
8
9 outcomes. Children are present at all face to face appointments. The first session focuses on
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11 an assessment of the child's sleep problem, providing information about normal sleep and
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13 sleep cycles, giving the family a sleep diary to complete, advice about sleep hygiene, and a
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15 plan specifically tailored to the child's particular sleep disorder. The second session and
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17 follow-up phone call include a review of the sleep diary, re-enforcement/trouble shooting of
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19 existing strategies and the introduction of new strategies, where appropriate.
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23 The research team contacts families within one month post-randomisation to ensure
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25 an appointment has been made with either their paediatrician or a psychologist and to
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27 encourage them to make the appointment if they have not yet done so.
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29 **Follow-up**

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31 We mail/email follow-up surveys to families and teachers at 3 and 6 months post-intervention
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33 (measured from first intended intervention session for intervention families with controls
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35 followed up at the median date of intervention follow-up) to determine both short and longer
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37 term changes in primary and secondary outcomes. Teachers are not informed of the child's
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39 intervention group status. For intervention families only, the 3 month survey also asks about
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41 the behavioural intervention components received, usefulness of the intervention, ease of use
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43 of strategies, and costs experienced by families in accessing the program. At 6 months a
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45 trained research assistant completes a blinded direct assessment of child executive
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47 functioning, learning, working memory, academic functioning, sleep and QoL via home visits
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49 (of 45 minutes duration).
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52 **Measures**

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3 All measures administered at baseline, 3 and 6 months are summarised in Table 2. The
4 majority of measures were used in our efficacy trial. We now additionally measure academic
5 functioning given that our efficacy trial showed a trend towards improvement in working
6 memory, which is a key determinant of academic functioning. For similar reasons we also
7 include a more detailed assessment of cognitive and executive functioning. The baseline
8 questionnaire includes family (e.g., family composition, parental education and age, language
9 spoken at home, annual household income) and child demographic and medical (e.g.,
10 medication, diagnosed comorbidities etc.) characteristics.
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21 The research team prospectively records resources used to administer all program
22 components to facilitate economic analyses. Families also report time, travel and out-of-
23 pocket costs associated with visits as well as those costs associated with child ADHD
24 medication/prescriptions.
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30 **Data analysis**

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32 Analyses will be based on the ‘intention to treat’ population at the level of the individual
33 child and will adjust for clustering at the level of the paediatrician using a generalised linear
34 mixed effect model (logit link function) for the binary outcome. In the primary efficacy
35 analysis, the stratification variable ‘*location of study site (practice)*’ as well as an indicator
36 variable for the *type of health care professional* who delivered the intervention (paediatrician
37 or psychologist) will be considered as adjustments variables. Model-based effect estimates
38 (risk differences and risk ratios) will be reported along with 95% confidence intervals.
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40 Because of the range of outcomes and time-points, the results will be considered in their
41 totality and interpreted with suitable caution regarding formal conclusions of “statistical
42 significance”. In order to reduce potential confounding bias due to differential patient-drop
43 out over time, multiple imputation methodology will be applied to replace missing outcome
44 data in the primary efficacy analysis. All secondary analyses will be adjusted for baseline
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3 scores and stratification variables wherever possible, in order to increase precision of
4 comparisons.³³ We will present results of analyses both unadjusted and adjusted for further
5 potential outcome predictor variables (child age, medication use, comorbidities, and family
6 socio-demographic characteristics (Socioeconomic Index for Advantage linked to the
7 family's postcode),³⁴ parent high school completion, and parent age). A comprehensive
8 statistical analysis plan, finalized before database lock, will specify the details of the primary
9 and secondary analyses.
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19 **Cost-effectiveness analyses**

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21 The economic analysis will first present cost-consequences analysis, then proceed to cost-
22 effectiveness analysis against the primary outcome (*prevalence of sleep problems*) measure
23 as the primary economic analysis. Secondary economic analyses will include cost-utility
24 analysis against CHU9D-based QALYs.^{35,36} These analyses will be conducted from both the
25 health care and broader societal perspectives (as cost-effectiveness can vary significantly by
26 perspective)³⁷ and will include extensive sensitivity analyses to test the impact of uncertainty
27 in data and sensitivity to evaluation approach.
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37 **ETHICS AND DISSEMINATION**

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39 ADHD affects approximately 5% of school-aged children³⁸ and is frequently associated with
40 sleep problems, which worsen child and family outcomes.² Findings will determine whether
41 the benefits of an efficacy trial can be realised more broadly at the population level and
42 whether it is cost-effective to do so. If cost-effective, we expect the following outcomes: 1)
43 the best evidence yet that addressing sleep problems improves outcomes for children with
44 ADHD; and 2) a ready-to-use intervention that is tailored to the Australian health system, and
45 can be replicated internationally. Findings will inform the development of clinical guidelines
46 for managing sleep problems in this population. We will seek to publish in leading
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3 international paediatric journals, present at major conferences and disseminate findings
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5 through established clinician networks.
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8 This project has been funded by the National Health and Medical Research Council of
9
10 Australia (1106427) and has been granted ethics approval from The Royal Children's
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12 Hospital (34072), University of Queensland (2014001555), Mater Hospital (RG-14-349),
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18 the Catholic Education Office (Ballarat; Brisbane; Melbourne; Toowoomba) Human
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20 Research Ethics Committees.
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Table 1. Key behavioural sleep management strategies

Sleep disorder	Definition	Examples of behavioural strategies
Sleep onset association disorder	Child associates falling asleep with a person or object (e.g., television) and is unable to fall asleep without its presence.	<ul style="list-style-type: none"> • Adult fading (i.e. graduated extinction) using ‘camping out’ - gradual withdrawal of parental presence from the child’s bedroom over 7-10 days. • ‘Checking method’ – parent checks on the child at regular time intervals (2, 5, or 10 minutes, with intervals increasing over time).
Delayed sleep phase	Shift in the child’s sleep-wake cycle, in which the child cannot fall asleep until late and then wakes late in the morning.	<ul style="list-style-type: none"> • Bedtime fading - child’s bedtime is temporarily set later to when they are usually falling asleep and gradually brought forward. The child is then woken at a pre-set time in the morning. • Early morning light exposure.
Limit setting sleep disorder	Child refusal to go to bed and general non-compliant behaviour at bedtime. Parent struggles to set appropriate and consistent bedtime limits.	<ul style="list-style-type: none"> • Parent management strategies - ignoring child protests, rewarding compliance with bedtime routines. A ‘bedtime pass’, whereby the child can only leave the bedroom one time before sleep, can be used to promote compliant behaviour. • Consideration of bedtime fading or the checking method.
Primary insomnia	Child has substantial difficulty initiating and/or maintaining sleep even if they go to bed at a later time.	<ul style="list-style-type: none"> • Visual imagery and relaxation. • Basic cognitive restructuring. • Restricting time in bed (e.g., temporarily setting the bedtime later as per delayed sleep phase or getting out of bed and doing a relaxing activity if the child cannot

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		sleep).
Night time anxiety	Specific night time fears including fear of the dark and/or child worrying about other things while in bed.	<ul style="list-style-type: none"> • Visual imagery and relaxation training. • Discussing fears during the day rather than just before bedtime. • Rewarding brave behaviour. • Other - use of a security object, avoiding scary television shows, use of a book to record worries.

Table 2. Summary of measures

Construct	Measures	Source ^a	T1	T2	T3
Child Outcomes					
Sleep	Sleep problem prevalence (primary outcome) - Primary caregiver report of child sleep problem (none/mild vs moderate/severe). ²	P	●	●	●
	Children's Sleep Habits Questionnaire (CSHQ) - 33-item validated measure of disorders of initiating and maintaining sleep. ³¹ Child Sleep Self Report collected at 6 months only. ¹⁵	P	●	●	●
	Teacher Daytime Sleepiness Questionnaire - 10-item validated scale of daytime sleepiness at school. ³⁹	T	●	●	●
	Sleep Hygiene scale - 7-item measure assessing sleep hygiene. ²⁴	P	●		●
Comorbidity	Anxiety Disorders Interview Schedule for DSM-IV (ADIS-C) - diagnostic interview assessing mental health disorders according to DSM-IV criteria. This is completed with parents over the telephone and has been validated for this purpose. ²⁷	P	●		
ADHD	ADHD Rating Scale IV - 18-item validated scale measuring the core symptoms of ADHD. ³⁰	P, T	●	●	●
Behaviour	Strengths and Difficulties Questionnaire – 25 items assessing the following subscales: hyperactivity/inattention, conduct problems, emotional symptoms, peer relationship problems, and prosocial behavior. ⁴⁰	P, T	●	●	●
Irritability	Affective reactivity index (ARI) - 6-item validated measure assessing child irritability. ⁴¹	P	●	●	●
School attendance	School attendance over the preceding 3 months. ²	P	●	●	●
Quality of Life	Child Health Utility-9D (CHU-9D) - 9 item measure of child quality of life used to calculate quality adjusted life years. Child report is collected at the 6 month follow up only. ⁴²	P, C	●		●
	Pediatrics Quality of Life Inventory 4.0 – 23-item measure of child total, physical and psychosocial QoL. ⁴³	P	●		●

Memory	Sleep Suite App – An animated iPad application that includes a continuous performance test to measure sustained attention, and 2 tests of memory consolidation and learning. ⁴⁴	C			●
Working Memory	Working Memory Test Battery for Children – The Backward digit span recall subtest is administered as a measure of child working memory. ⁴⁵	C			●
Academic functioning	Wide Range Achievement Test 4 (WRAT) – word reading and math computation subtests. ⁴⁶	C			●
	NAPLAN – standardised academic tests of reading, writing, language conventions and numeracy. Results can be compared to National or State population results and against the national minimum standard. ²⁶	L			●
Autism	Social Responsiveness Scale (SRS) Brief – 16-item measure of autism spectrum disorder symptoms. ⁴⁷	P			●
Parent Outcomes					
Mental health	Kessler 6 (K6) - 6-item validated measure of adult psychological stress. ⁴⁸	P	●	●	●
Work attendance	Work attendance over the previous 3 months. ²	P	●	●	●
Parenting	Parenting - validated scales developed for the Longitudinal Study of Australian Children assessing parenting consistency (6-items) and parental warmth (5-items). ⁴⁹	P	●		●
Family costs	Service use and costs - families report service use over previous 3 months as well as time, travel and out-of-pocket costs associated	P		●	●

^a P = Parent-report, T = teacher-report, C = child-report, L = data linkage; T1 = baseline; T2 = 3 months post-intervention; T3 = 6 months post-intervention.

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AUTHORS' CONTRIBUTIONS:

ES, HH, HH, NR and LG conceived the study. MM and NH coordinated the study. ES drafted the current manuscript. TS contributed to the design and analytic components of the study. All authors contributed, read and approved the final manuscript.

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COMPETING INTERESTS STATEMENT:

All authors have completed the Unified Competing Interest form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare that they, their spouses, partners or children do not have any financial and non-financial relationships with companies that may be relevant to the submitted work to declare.

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Figure 1:
Participant Flow

For peer review only

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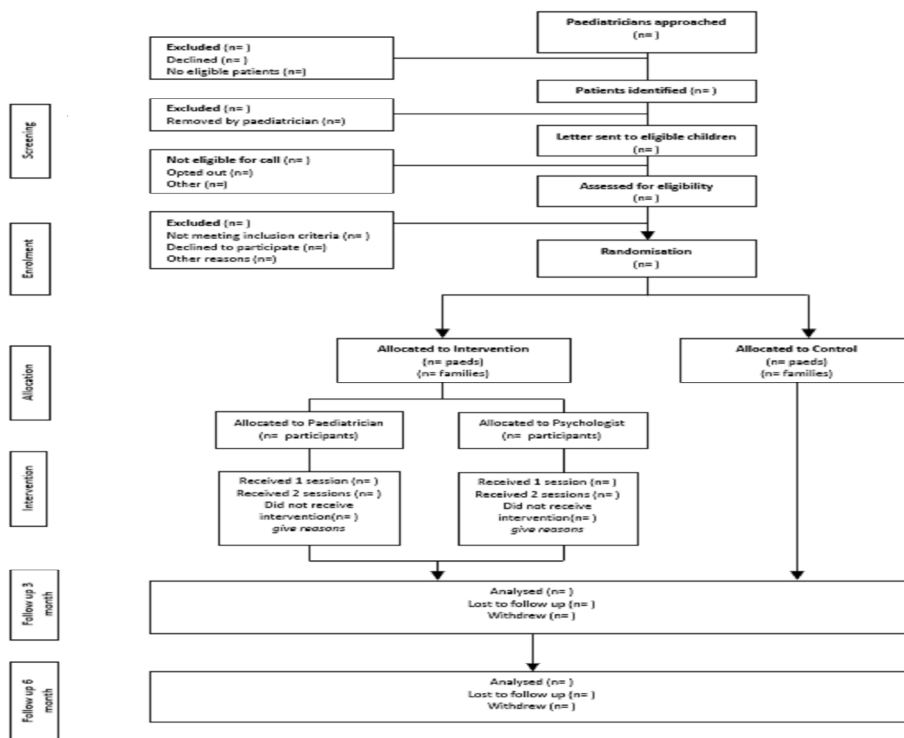


Figure 1: Participant Flow

219x165mm (300 x 300 DPI)



STANDARD PROTOCOL ITEMS: RECOMMENDATIONS FOR INTERVENTIONAL TRIALS

SPIRIT 2013 Checklist: Recommended items to address in a clinical trial protocol and related documents*

Section/item	Item No	Description
Administrative information		
Title	1	Descriptive title identifying the study design, population, interventions, and, if applicable, trial acronym PAGE 1
Trial registration	2a	Trial identifier and registry name. If not yet registered, name of intended registry PAGE 3
	2b	All items from the World Health Organization Trial Registration Data Set PAGE 3 + YES SEE TRIAL REGISTRY
Protocol version	3	Date and version identifier PAGE 3 + YES SEE TRIAL REGISTRY
Funding	4	Sources and types of financial, material, and other support PAGE 18, 29
Roles and responsibilities	5a	Names, affiliations, and roles of protocol contributors PAGE 1, 29
	5b	Name and contact information for the trial sponsor NA
	5c	Role of study sponsor and funders, if any, in study design; collection, management, analysis, and interpretation of data; writing of the report; and the decision to submit the report for publication, including whether they will have ultimate authority over any of these activities NA
	5d	Composition, roles, and responsibilities of the coordinating centre, steering committee, endpoint adjudication committee, data management team, and other individuals or groups overseeing the trial, if applicable (see Item 21a for data monitoring committee) NA
Introduction		
Background and rationale	6a	Description of research question and justification for undertaking the trial, including summary of relevant studies (published and unpublished) examining benefits and harms for each intervention PAGE 4-8
	6b	Explanation for choice of comparators PAGE 13-14
Objectives	7	Specific objectives or hypotheses PAGE 7-8
Trial design	8	Description of trial design including type of trial (eg, parallel group, crossover, factorial, single group), allocation ratio, and framework (eg, superiority, equivalence, noninferiority, exploratory) PAGE 8

Methods: Participants, interventions, and outcomes

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7	Study setting	9	Description of study settings (eg, community clinic, academic hospital) and list of countries where data will be collected. Reference to where list of study sites can be obtained <i>PAGE 8</i>
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11	Eligibility criteria	10	Inclusion and exclusion criteria for participants. If applicable, eligibility criteria for study centres and individuals who will perform the interventions (eg, surgeons, psychotherapists) <i>PAGE 11-13</i>
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15	Interventions	11a	Interventions for each group with sufficient detail to allow replication, including how and when they will be administered <i>PAGE 14-16, 20-21</i>
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18		11b	Criteria for discontinuing or modifying allocated interventions for a given trial participant (eg, drug dose change in response to harms, participant request, or improving/worsening disease) <i>NA</i>
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23		11c	Strategies to improve adherence to intervention protocols, and any procedures for monitoring adherence (eg, drug tablet return, laboratory tests) <i>NA</i>
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27		11d	Relevant concomitant care and interventions that are permitted or prohibited during the trial <i>PAGE 14</i>
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30	Outcomes	12	Primary, secondary, and other outcomes, including the specific measurement variable (eg, systolic blood pressure), analysis metric (eg, change from baseline, final value, time to event), method of aggregation (eg, median, proportion), and time point for each outcome. Explanation of the clinical relevance of chosen efficacy and harm outcomes is strongly recommended <i>PAGE 16-17, 22-23</i>
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38	Participant timeline	13	Time schedule of enrolment, interventions (including any run-ins and washouts), assessments, and visits for participants. A schematic diagram is highly recommended (see Figure) <i>PAGE 8-10, 14-16</i>
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43	Sample size	14	Estimated number of participants needed to achieve study objectives and how it was determined, including clinical and statistical assumptions supporting any sample size calculations <i>PAGE 13</i>
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47	Recruitment	15	Strategies for achieving adequate participant enrolment to reach target sample size <i>PAGE 13</i>
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Methods: Assignment of interventions (for controlled trials)

Allocation:

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54	Sequence generation	16a	Method of generating the allocation sequence (eg, computer-generated random numbers), and list of any factors for stratification. To reduce predictability of a random sequence, details of any planned restriction (eg, blocking) should be provided in a separate document that is unavailable to those who enrol participants or assign interventions <i>PAGE 14</i>
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4 Allocation 16b Mechanism of implementing the allocation sequence (eg, central
5 concealment telephone; sequentially numbered, opaque, sealed envelopes),
6 mechanism describing any steps to conceal the sequence until interventions are
7 assigned PAGE 14
8
9 Implementation 16c Who will generate the allocation sequence, who will enrol participants,
10 and who will assign participants to interventions PAGE 14
11
12 Blinding 17a Who will be blinded after assignment to interventions (eg, trial
13 (masking) participants, care providers, outcome assessors, data analysts), and
14 how PAGE 14, 16
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17 17b If blinded, circumstances under which unblinding is permissible, and
18 procedure for revealing a participant's allocated intervention during
19 the trial NA
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Methods: Data collection, management, and analysis

- 23 Data collection 18a Plans for assessment and collection of outcome, baseline, and other
24 methods trial data, including any related processes to promote data quality (eg,
25 duplicate measurements, training of assessors) and a description of
26 study instruments (eg, questionnaires, laboratory tests) along with
27 their reliability and validity, if known. Reference to where data
28 collection forms can be found, if not in the protocol PAGE 16-17, 22-23
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31 18b Plans to promote participant retention and complete follow-up,
32 including list of any outcome data to be collected for participants who
33 discontinue or deviate from intervention protocols PAGE 13, 11-17, 22-23
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35 Data 19 Plans for data entry, coding, security, and storage, including any
36 management related processes to promote data quality (eg, double data entry;
37 range checks for data values). Reference to where details of data
38 management procedures can be found, if not in the protocol PAGE 17
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41 Statistical 20a Statistical methods for analysing primary and secondary outcomes.
42 methods Reference to where other details of the statistical analysis plan can be
43 found, if not in the protocol PAGE 17-18
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45 20b Methods for any additional analyses (eg, subgroup and adjusted
46 analyses) PAGE 17-18
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48 20c Definition of analysis population relating to protocol non-adherence
49 (eg, as randomised analysis), and any statistical methods to handle
50 missing data (eg, multiple imputation) PAGE 17-18
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Methods: Monitoring

- 54 Data monitoring 21a Composition of data monitoring committee (DMC); summary of its role
55 and reporting structure; statement of whether it is independent from
56 the sponsor and competing interests; and reference to where further
57 details about its charter can be found, if not in the protocol.
58 Alternatively, an explanation of why a DMC is not needed NA
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4		21b	Description of any interim analyses and stopping guidelines, including who will have access to these interim results and make the final decision to terminate the trial NA
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9	Harms	22	Plans for collecting, assessing, reporting, and managing solicited and spontaneously reported adverse events and other unintended effects of trial interventions or trial conduct PAGE 16
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13	Auditing	23	Frequency and procedures for auditing trial conduct, if any, and whether the process will be independent from investigators and the sponsor NA
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18	Ethics and dissemination		
19	Research ethics approval	24	Plans for seeking research ethics committee/institutional review board (REC/IRB) approval PAGE 18
20			
21			
22	Protocol amendments	25	Plans for communicating important protocol modifications (eg, changes to eligibility criteria, outcomes, analyses) to relevant parties (eg, investigators, REC/IRBs, trial participants, trial registries, journals, regulators) NA
23			
24			
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26			
27			
28	Consent or assent	26a	Who will obtain informed consent or assent from potential trial participants or authorised surrogates, and how (see Item 32) PAGE 10
29			
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31			
32		26b	Additional consent provisions for collection and use of participant data and biological specimens in ancillary studies, if applicable PAGE 10
33			
34	Confidentiality	27	How personal information about potential and enrolled participants will be collected, shared, and maintained in order to protect confidentiality before, during, and after the trial PAGE 10
35			
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38			
39	Declaration of interests	28	Financial and other competing interests for principal investigators for the overall trial and each study site PAGE 29
40			
41			
42	Access to data	29	Statement of who will have access to the final trial dataset, and disclosure of contractual agreements that limit such access for investigators SEE TRIAL REGISTRY
43			
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46	Ancillary and post-trial care	30	Provisions, if any, for ancillary and post-trial care, and for compensation to those who suffer harm from trial participation NA
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50	Dissemination policy	31a	Plans for investigators and sponsor to communicate trial results to participants, healthcare professionals, the public, and other relevant groups (eg, via publication, reporting in results databases, or other data sharing arrangements), including any publication restrictions PAGE 18
51			
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56		31b	Authorship eligibility guidelines and any intended use of professional writers NA
57			
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59		31c	Plans, if any, for granting public access to the full protocol, participant-level dataset, and statistical code SEE TRIAL REGISTRY
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Appendices

Informed consent materials	32	Model consent form and other related documentation given to participants and authorised surrogates	SEE TRIAL REGISTRY
Biological specimens	33	Plans for collection, laboratory evaluation, and storage of biological specimens for genetic or molecular analysis in the current trial and for future use in ancillary studies, if applicable	NA

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BMJ Open

**Does a brief, behavioural intervention, delivered by
paediatricians or psychologists improve sleep problems for
children with ADHD?
Protocol for a cluster-randomised, translational trial**

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Primary Subject Heading:	Mental health
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Keywords:	attention deficit disorder with hyperactivity, randomised controlled trial, effectiveness, treatment, sleep, child

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3 **Does a brief, behavioural intervention, delivered by paediatricians or psychologists**
4 **improve sleep problems for children with ADHD?**
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6 **Protocol for a cluster-randomised, translational trial**
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ABSTRACT

Introduction: Up to 70% of children with Attention-Deficit/Hyperactivity Disorder (ADHD) experience sleep problems. We have demonstrated the efficacy of a brief behavioural intervention for children with ADHD in a large randomised controlled trial (RCT) and now aim to examine whether this intervention is effective in real-life clinical settings when delivered by paediatricians or psychologists. We will also assess the cost-effectiveness of the intervention.

Methods and analysis: Children aged 5-12 years with ADHD (n=320) are being recruited for this translational cluster RCT through paediatrician practices in Victoria and Queensland, Australia. Children are eligible if they meet criteria for ADHD, have a moderate/severe sleep problem, and meet American Academy of Sleep Medicine criteria for either chronic insomnia disorder or delayed sleep-wake phase disorder; or are experiencing sleep-related anxiety. Clinicians are randomly allocated at the level of the paediatrician to either receive the sleep training or not. The behavioural intervention comprises two consultations covering sleep hygiene and standardized behavioural strategies. The primary outcome is change in the proportion of children with moderate/severe sleep problems from moderate/severe to no/mild by parent report at 3 months post-intervention. Secondary outcomes include a range of child (e.g., sleep severity, ADHD symptoms, quality of life, behaviour, working memory, executive functioning, learning, academic achievement) and primary caregiver (mental health, parenting, work attendance) measures. Analyses will address clustering at the level of the paediatrician using linear mixed effect models adjusting for potential a priori confounding variables.

Ethics and dissemination: Ethics approval has been granted. Findings will determine whether the benefits of an efficacy trial can be realised more broadly at the population level and will inform the development of clinical guidelines for managing sleep problems in this

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2
3 population. We will seek to publish in leading international paediatric journals, present at
4
5 major conferences and through established clinician networks.
6

7 **Registration details:** Current Controlled Trials ISRCTN50834814
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10 **Article summary**

11
12 **Strengths and limitations**

- 13
14 • First translational trial to determine whether a brief, behavioural sleep intervention
15 has benefits for children with ADHD when delivered in ‘real-life’ clinical settings by
16 paediatricians and psychologists.
17
18 • The inclusion of blinded teacher reports, as well as blinded direct assessment
19 measures to minimise bias.
20
21 • Inclusion of economic analyses, which provide data on the cost-effectiveness of the
22 program.
23
24 • Limited generalisability to non-English speaking families and children with ADHD
25 presenting with serious medical conditions and/or intellectual disability.
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27 • Sleep problems assessed using unblinded parent report as opposed to objective
28 measures.
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INTRODUCTION

Sleep problems are common and more persistent in children with ADHD, and associated with poorer child and family well-being.¹⁻⁴ Efficacy Randomised Controlled Trials (RCTs) have shown that sleep problems are amenable to intervention⁵⁻¹⁰ in children with ADHD, particularly behavioural interventions.⁸⁻¹⁰ However, it is unknown whether the same benefits will be observed when such interventions are delivered by practitioners in 'real life' clinical settings. This article describes the protocol for the Sleeping Sound with ADHD Translational RCT, which aims to assess the effectiveness of a behavioural sleep intervention designed for children with ADHD, when delivered by psychologists or paediatricians in their daily clinical practice.

Sleep problems in children with ADHD

Up to 70% of children with ADHD experience sleep problems,^{1,2} compared with 20-30% of children in the general population.¹¹ Sleep problems experienced by children with ADHD largely comprise difficulties initiating and/or maintaining sleep, with the most common sleep problems being difficulty falling asleep (reported by 84% of parents of children who report a sleep problem for their child with ADHD), bedtime resistance (68%), tiredness upon waking (62%) and difficulty waking in the morning (56%).² Medical conditions such as obstructive sleep apnoea (OSA) can also affect sleep in children with ADHD, although behavioural sleep problems appear more common.¹² In this study we use the term sleep problems to denote those difficulties that can be addressed using behavioural intervention. Sleep problems have been associated with worse functioning for children with ADHD including poorer quality of life (QoL), behaviour, daily functioning, and working memory, as well as increased school absenteeism.^{2,4,13} They thus represent an important modifiable target for intervention.

A number of factors have been associated with sleep problems in children with ADHD and it is possible that biological sleep problems such as restless legs syndrome,

1
2
3 obstructive sleep apnoea and narcolepsy can lead to continued sleep disruptions.¹² Insomnia
4
5 can be a side-effect of stimulant medication,^{1,14} although unmedicated children with ADHD
6
7 also experience higher rates of sleep problems relative to non-ADHD controls.¹⁵ Comorbid
8
9 externalising and internalising comorbidities are each associated with a 2-fold increase in
10
11 moderate/severe sleep problems in children with ADHD, while co-occurring internalising and
12
13 externalising comorbidities are associated with a 3-fold increase.¹⁶ Parenting inconsistency in
14
15 daily household routines has also been associated with increased bedtime resistance in this
16
17 group.¹⁷ Biologically, there is overlap in the brain regions and genetic factors (e.g.,
18
19 catecholaminergic system, CLOCK genes) associated with both ADHD and sleep
20
21 disorders/arousal regulation.¹ ADHD is also a highly genetic condition and parents likely are
22
23 affected by symptoms such as disorganisation and impulsivity, which may impact on child
24
25 sleep.
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29 **Treating sleep problems in children with ADHD using behavioural strategies**

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31 We recently published our efficacy RCT evaluating the impact of a behavioural sleep
32
33 program in children with ADHD and moderate/severe sleep problems (n=244 5-12 year old
34
35 children with ADHD).⁸ Children were recruited from 21 paediatric practices across Victoria,
36
37 Australia and randomised to either a behavioural sleep intervention (n=122) or a usual care
38
39 comparison group (n=122). Intervention families attended two x 50 minute individual
40
41 sessions (held two weeks apart) with a clinician trained in the intervention (psychologist or
42
43 trainee paediatrician), comprising a standardised yet flexible intervention, tailored to the
44
45 child's sleep problems and family preferences.
46
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49
50 The intervention was associated with improved child outcomes at three and six
51
52 months post-randomisation including improved parent-reported child sleep, ADHD symptom
53
54 severity, QoL, daily functioning and behavior.⁸ Intervention children also had improved
55
56 teacher-reported classroom behavior, as well as improved school attendance and working
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3 memory assessed via blinded assessment.⁸ There were small improvements in sleep duration
4
5 for a subsample that completed actigraphy.⁸ Although the intervention was associated with
6
7 improved caregiver work attendance and mental health three months later, these benefits
8
9 were not observed at six months.⁸
10

11
12 Similarly, two additional randomised controlled trials have demonstrated the efficacy
13
14 of improving sleep problems in children with ADHD. Keshavarzi et al. reported that a 12-
15
16 week sleep-training program for children with ADHD aged 10 years (n=40) had beneficial
17
18 effects for sleep and psychosocial functioning when compared to controls with ADHD who
19
20 did not receive the intervention (n=20) and typically developing children (n=20).⁹ However
21
22 the professional group responsible for delivering the intervention was not reported. Corkum
23
24 and colleagues also recently reported the beneficial effects of their distance sleep intervention
25
26 delivered by paraprofessionals for childhood insomnia in a mixed sample of children with
27
28 and without ADHD (n=61).¹⁰ Improvements were identified at 2 and 6 months for sleep
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30 assessed using parent report as well as actigraphy, and benefits were also reported for broader
31
32 child psychosocial health.¹⁰
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37 Although RCTs have shown that melatonin is associated with improved sleep onset
38
39 latency for children with ADHD,⁵⁻⁷ broader benefits for daily functioning including ADHD
40
41 symptom severity have yet to be shown.
42

43 **Managing sleep problems in children with ADHD through existing clinical services**

44
45 Although three trials have now shown that it is possible to improve sleep problems in
46
47 children with ADHD using behavioural approaches, it remains to be seen whether it is
48
49 possible to replicate such approaches and improve outcomes for children with ADHD in 'real
50
51 life' clinical settings when delivered by their treating clinicians (e.g., community
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53 paediatricians or psychologists) rather than by clinicians hired to deliver interventions in
54
55 tightly controlled research trials. We are now testing the translation of this program at the
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2
3 population level by training community paediatricians and psychologists to deliver this sleep
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5 intervention to children with ADHD and sleep problems. If this intervention can be translated
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7 successfully to the population level within existing workforces, then this would have the real
8
9 potential to improve outcomes for children with ADHD and their families. If cost-effective, it
10
11 could be readily incorporated into the existing health system.
12
13

14 Paediatricians are the main care providers for ADHD in Australia.¹⁸ The
15
16 paediatrician's role includes both the assessment and treatment (behavioural and medication-
17
18 based) of ADHD and associated comorbidities (including sleep problems, if identified).
19
20 Visits to a paediatrician are subsidised by Australia's Medicare scheme, however, families
21
22 may experience out of pocket costs for these visits. Paediatricians (and general practitioners)
23
24 may also refer children to a psychologist in the community to manage comorbid behaviours.¹⁹
25
26 In Australia, this referral is facilitated by the Medicare Better Access to Mental Health
27
28 Scheme, which provides subsidised access to up to 10 psychology sessions in a calendar year,
29
30 provided the criteria for a DSM condition are met. We have deliberately designed our sleep
31
32 intervention so that it is feasible for both paediatricians and psychologists to deliver within
33
34 the Australian Medicare scheme and within their typical consultation durations.
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38 **Aims and hypotheses**

39
40 Building on our efficacy trial, we aim to determine whether the Sleeping Sound with ADHD
41
42 intervention, delivered by paediatricians or psychologists in their usual work setting can
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44 replicate the benefits of the efficacy trial. Therefore, in this translational, cluster-randomised
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46 trial we aim to determine whether a brief sleep intervention delivered by paediatricians or
47
48 psychologists:
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50

- 51 1. Decreases the prevalence of children with moderate/severe sleep problems from
52 moderate/severe to no/mild by parent report at 3 months post-intervention (**primary**
53
54 **outcome**).

2. Improves child and family functioning at 3 and 6 months post-intervention (secondary outcome).
3. Is cost-effective (secondary outcome).

We hypothesise that, compared to the control children at 3 (primary outcome timepoint) and 6 months post-intervention, a brief behavioural sleep intervention will:

1. Decrease prevalence of child sleep problems from moderate/severe to no/mild;
2. Improve functioning in other child (sleep severity, ADHD symptoms, QoL, behaviour, working memory, executive functioning, learning, academic achievement, school attendance) and primary caregiver (mental health, parenting, work attendance) outcome domains.
3. Be cost-effective.

METHODS AND ANALYSIS

Overall Study Design

This is a cluster RCT of a behavioural sleep intervention versus usual care conducted in Victoria and Queensland, Australia (see Figure 1). The trial will be reported according to Consolidated Standards of Reporting Trials guidelines and the extension report of non-pharmacological interventions.²⁰

Participants

Participants are parents of children aged 5-12 years at the time of recruitment with paediatrician-diagnosed and DSM-5 confirmed ADHD and a moderate to severe sleep problem as defined by the American Academy of Sleep Medicine diagnostic criteria²¹: chronic insomnia disorder, delayed sleep-wake phase disorder, or sleep related anxiety.

Recruitment of health professionals

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3 Given that paediatricians are the main healthcare provider for children with ADHD,
4 recruitment and randomisation occurs at the level of the paediatrician. Paediatricians are
5 recruited via the Australian Paediatric Research Network or through clinical contacts.¹⁸
6
7 Interested paediatricians are invited to attend a briefing session in which the study
8 requirements and timetable is presented and paediatricians have the opportunity to ask
9 questions. Interested paediatricians are sent a follow up email thanking them for their interest,
10 asking them to sign an individual Memorandum of Understanding (MOU) if they consent to
11 participation, and asking them to provide a list of psychologists to whom they refer patients.
12
13 By signing the MOU, paediatricians agree to: (1) participate in training if randomised to the
14 intervention arm; (2) deliver the sleep program to intervention families *or* refer the child to a
15 psychologist to deliver the sleep program if allocated to the intervention; (3) not share the
16 intervention materials with control group paediatricians if allocated to the intervention; and
17
18 (4) allocate time for intervention session bookings.
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33 Once paediatricians have been recruited, psychologists are invited to whom the
34 paediatricians have indicated they refer patients. Psychologists are only recruited for the
35 intervention arm of the project and have no contact with control participants. The research
36 team then informs psychologists about the study via email or phone. The researchers then
37 send psychologists who express interest in participating a follow up email thanking them for
38 their interest and asking them to sign an individual MOU, agreeing to: (1) participate in
39 training; (2) deliver the sleep program to intervention families referred by paediatricians; (3)
40 use intervention materials only with children enrolled in the study; and (4) not share the
41 intervention materials with any other families they see during the study period. This approach
42 has worked well to minimise contamination in our previous RCTs.²²⁻²⁴
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55 **Screening children for sleep problems and recruiting families**

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3 This translational trial uses, where possible, the same procedures that were used in our
4 efficacy trial.⁸ Paediatricians pre-identify their patients with ADHD, aged between 5-12
5 years, seen within the last 12 months, either through their medical software or through case
6 notes. Paediatricians then send a letter to the child's primary caregiver inviting them to take
7 part. The letter advises families that the research team will ask them about their child's sleep
8 and ADHD symptoms. An 'opt out' approach is used, whereby parents are asked to contact
9 the paediatrician if they *do not* wish to learn more about the study. If parents do not opt out
10 within a two-week period, the paediatrician provides the research team with the contact
11 details of the families. Only 9% of families opted out in our efficacy trial.⁸ Paediatricians
12 also have the option to use an active consent process. In these cases paediatricians send an
13 'opt in' version of the study invitation letter.
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28 The research team then contacts interested (or not opted-out) families via telephone to
29 ascertain if the child meets inclusion/exclusion criteria. Eligible families are sent a parent
30 information statement and consent form (to participate in the RCT and for optional consents
31 outlined below) as and a baseline survey. Families have the option to complete hard copy
32 surveys or online surveys (via REDCap - a secure, web-based application).²⁵ Surveys are
33 completed by the child's primary caregiver. Parents have the option to consent to have their
34 child's school teacher complete a survey about their child's behaviour. If consent is provided
35 by the primary caregiver and school, a link to an online survey is sent to teachers. Parents
36 also have the option to consent to being contacted for ethically approved future research, for
37 the research team to keep their de-identified data to be shared with future ethically approved
38 research, and to allow the research team to link with their child's *National Assessment*
39 *Program – Literacy and Numeracy* (NAPLAN) results. NAPLAN is a national assessment of
40 literacy and numeracy Australian children complete in Grades 3 and 5, and Years 7 and 9.²⁶
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3 Once caregivers provide written consent, the research team contacts them to complete
4 the Anxiety Disorders Interview Schedule for Children (ADIS-C) over the telephone to assess
5 comorbid internalising and externalising diagnoses in children with ADHD.²⁷ To ensure we
6 administer the telephone interviews consistently we are recording 10% of the sample to test
7 inter-rater reliability.
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13 **Inclusion/exclusion criteria (all assessed via telephone)**

14 *Inclusion criteria*

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19 a. Child aged between 5-12 years at the time of the recruitment call.
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21 b. Child's sleep is a moderate-severe problem for the caregiver ascertained using the
22 following question: Has your child's sleep been a problem for you over the past 4
23 weeks?' If 'yes', they are asked to rate severity (mild, moderate or severe). This
24 measure has been used in studies of children with and without ADHD and has good
25 agreement with the Children's Sleep Habits Questionnaire.^{2,28,29}
26
27
28 c. Child sleep problem meets the International Classification of Sleep Disorders – Third
29 Edition criteria²¹ for an eligible sleep disorder (chronic insomnia disorder, delayed
30 sleep-wake phase disorder) or sleep-related anxiety assessed using study-designed
31 questions. To meet criteria for *chronic insomnia disorder* in this study children need
32 to meet criterion A (one or more of the following: difficulty initiating sleep, difficulty
33 maintaining sleep, waking earlier than desired, resistance going to bed, difficulty
34 sleeping without a caregiver), B (evidence of impairments related to the sleep
35 difficulty such as daytime sleepiness, impaired social, family, or academic
36 performance etc.), C (sleep problem not be explained by inadequate sleep opportunity
37 or circumstances) and D and E (symptoms and associated impairment must have been
38 present 3 times a week or more for at least 3 months).²¹ To meet criteria for *delayed*
39 *sleep-wake phase disorder* in this study, criterion A (significant phase delay as shown
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3 by difficulty initiating sleep and awakening at a required time), B (delayed sleep-
4 wake phase must have been present for at least 3 months), and C (improved sleep
5 quality and duration when allowed to choose their own schedule) need to be
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by difficulty initiating sleep and awakening at a required time), B (delayed sleep-wake phase must have been present for at least 3 months), and C (improved sleep quality and duration when allowed to choose their own schedule) need to be satisfied.²¹ Children were accepted into the study on the basis of experiencing sleep-related anxiety if the caregiver endorses significant difficulty falling asleep at night, in addition to anxious behaviour at bedtime (e.g., fearful behaviours such as crying, asking for reassurance or lying in bed worrying).

- d. Child meets DSM 5 criteria for ADHD assessed via the 18-item ADHD Rating Scale IV - a validated scale measuring the core symptoms of ADHD.³⁰ Caregivers need to rate at least 6 of 9 of the inattention and/or hyperactivity/impulsivity items as occurring 'often' or 'very often' in order to meet current symptom criteria. Caregivers are asked to rate symptoms off stimulant medication. Additional questions are then asked to ensure symptoms have been present for at least 6 months ('Did your child have these symptoms for at least 6 months before being diagnosed with ADHD?'), and contribute to cross-situational impairment ('Are these symptoms present at home, school and/or when out socially?') Given the target age range all participants will meet age of onset criteria. We do not assess whether the symptoms were better explained by another mental disorder.

Children are eligible to participate if they are taking melatonin or any other sleep inducing medication, as long as the inclusion criteria are still met despite medication use.

Exclusion criteria

- a. Suspected OSA identified using three OSA items from the Children's Sleep Habits Questionnaire.³¹ Paediatrician investigators Hiscock and Heussler telephone caregivers of children with suspected OSA to ask further about their symptoms and if

OSA is suspected, these children are excluded and referred to appropriate clinical services as per usual clinical care (1% in our efficacy trial).⁸

- b. No longer meeting criteria for ADHD at the time of recruitment.
- c. Major illness or disability (e.g., intellectual disability). Parents are asked if their child has ever been diagnosed with an intellectual disability or serious medical condition. If yes, parents are asked to provide further details (e.g., IQ score, diagnosis). If clarification is needed permission is sought to recontact the paediatrician to obtain relevant information from the child's medical record. Common comorbidities including internalising/externalising disorder and autism spectrum disorder (ASD) are not excluded.
- d. Parents with insufficient English language proficiency to complete study documentation and/or participate in the intervention.
- e. Participated in our original efficacy trial.

Sample size

Sample size planning is based on the primary outcome, the proportion of children for whom parents no longer report moderate/severe sleep problems at 3 months. In the efficacy study, at 3 months, 56% and 30% of parents in the intervention and control group, respectively, reported that their child's sleep was still a moderate/severe problem i.e. a difference of 26%. We conservatively assume a smaller difference of 20%, i.e. 56% vs 36% to be observed in this trial. In order to have 80% power in detecting this difference at a two-sided type one error level of 5%, a group sample size of 107 individuals (total sample size n=214) is required. As this is a cluster controlled trial (clustered at the level of the paediatrician to minimise contamination), we will inflate our sample size by a design effect of 1.2 where the design effect = $1+(n-1) \cdot r$ with n=3 (the number of children seen by each paediatrician) and

1
2
3 $r=0.1$ (the conservatively assumed intra-cluster correlation coefficient, based on our efficacy
4 RCT). Allowing for 20% drop out to 3 months and accounting for clustering, we need to
5 recruit 160 children in each study arm (total sample size $n=320$). All recruitment procedures
6 described have been used in our previous trials to achieve similar recruitment numbers.
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10 11 **Randomisation**

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14 Randomisation occurs at the level of the paediatrician. Paediatricians are randomly
15 allocated to either receive the sleep training or not by an independent researcher, thereby
16 avoiding potential contamination if all paediatricians were to be trained in the program.
17
18 Randomisation is based on a pre-generated group allocation sequence from the Murdoch
19 Childrens Research Institute's Clinical Epidemiology and Biostatistics Unit and is stratified
20 by location of the paediatrician (regional or metropolitan area). The randomisation is also
21 stratified by the predicted number of enrolled patients (less than 10 and 10 or more).
22
23 Paediatricians, families and researchers are blind to group allocation at the time of
24 recruitment.
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35 If the paediatrician is assigned to the intervention group and has more than four
36 patients enrolled, families are randomised to receive the intervention from either the
37 paediatrician or psychologist. This second step of randomisation takes place after family
38 recruitment is complete. The research team then sends the paediatrician a letter informing
39 them of whether they will be receiving the sleep training or not. In addition, participating
40 families are also sent a letter informing them of whether they will be receiving the sleep
41 intervention or not.
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51 Families of children attending a paediatrician randomised to the control group receive
52 'usual care' which involves seeing their paediatrician as per usual regarding their child's
53 ADHD. Our research has shown that this does not routinely include addressing sleep issues.²
54
55 In Australia, paediatricians typically see children with ADHD every 6 months to check their
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3 height, weight, blood pressure and re-issue a script for medication (valid for 6 months),
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5 where necessary.
6

7 **Intervention training**

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9 The intervention is designed to be feasible to deliver in paediatricians' and
10
11 psychologists' practice. Intervention group paediatricians and psychologists are trained to
12
13 deliver the same program described for our efficacy trial⁸ in one 3.5-hour session. Training
14
15 occurs conjointly for paediatricians and psychologists, where possible, with investigators
16
17 Hiscock, Sciberras and Heussler to maximise fidelity. Training addresses normal sleep
18
19 patterns in school-aged children and highlights the importance of sleep hygiene practices
20
21 such as consistent bedtime routines and keeping bedrooms media-free. The intervention
22
23 includes verbal and written information of standard sleep intervention strategies as
24
25 recommended by the American Sleep Association³² and addresses common sleep problems
26
27 experienced at the beginning of, and during, the night. A summary of sleep problems
28
29 addressed and management strategies are provided in Table 1. Training focuses on how these
30
31 strategies can be individualised for families and includes evidence-based instructional
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33 strategies such as role play, feedback, modelling practice, and use of checklists. Training is
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35 supported by a manual and written parent education materials.
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42 Prior to training, paediatricians and psychologists complete a “pre-quiz” to establish
43
44 their baseline knowledge, skills and attitudes in relation to child sleep problems and their
45
46 management. A “post-quiz” following training is used to assess changes in knowledge,
47
48 confidence, and perceived competence in the management of child sleep problems.
49

50 **Intervention delivery**

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52 Paediatricians and psychologists are sent an intervention package for each child allocated to
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54 them containing the child's contact details, a clinical checklist to complete after each
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56 appointment and parent education materials. Families contact the clinician they have been
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3 allocated to make an appointment (up to 30 minutes for paediatricians, up to 50 minutes for a
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5 psychologist) to discuss their child's sleep, with a follow-up session (up to 30 minutes for
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7 paediatricians, up to 50 minutes for a psychologist) approximately two weeks later and if
8
9 needed, a final 15-20 minute phone call a further two weeks after that. The differences in
10
11 consultation duration reflect real life clinical practice. We record the actual duration of all
12
13 consultations, which will enable us to examine the relationship between intervention dose and
14
15 outcomes. Children are present at all face to face appointments. The first session focuses on
16
17 an assessment of the child's sleep problem, providing information about normal sleep and
18
19 sleep cycles, giving the family a sleep diary to complete, advice about sleep hygiene, and a
20
21 plan specifically tailored to the child's particular sleep disorder. The second session and
22
23 follow-up phone call include a review of the sleep diary, re-enforcement/trouble shooting of
24
25 existing strategies and the introduction of new strategies, where appropriate.
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29
30 The research team contacts families within one month post-randomisation to ensure
31
32 an appointment has been made with either their paediatrician or a psychologist and to
33
34 encourage them to make the appointment if they have not yet done so.
35

36 **Follow-up**

37
38 We mail/email follow-up surveys to families and teachers at 3 and 6 months post-intervention
39
40 (measured from first intended intervention session for intervention families with controls
41
42 followed up at the median date of intervention follow-up) to determine both short and longer
43
44 term changes in primary and secondary outcomes. Teachers are not informed of the child's
45
46 intervention group status. For intervention families only, the 3 month survey also asks about
47
48 the behavioural intervention components received, usefulness of the intervention, ease of use
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50 of strategies, costs experienced by families in accessing the program and any negative
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52 events/experienced. At 6 months a trained research assistant completes a blinded direct
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3 assessment of child executive functioning, learning, working memory, academic functioning,
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5 sleep and QoL via home visits (of 45 minutes duration).
6

7 **Measures**

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9 All measures administered at baseline, 3 and 6 months are summarised in Table 2. The
10 majority of measures were used in our efficacy trial. We now additionally measure academic
11 functioning given that our efficacy trial showed a trend towards improvement in working
12 memory, which is a key determinant of academic functioning. For similar reasons we also
13 include a more detailed assessment of cognitive and executive functioning. The baseline
14 questionnaire includes family (e.g., family composition, parental education and age, language
15 spoken at home, annual household income) and child demographic and medical (e.g.,
16 medication, diagnosed comorbidities etc.) characteristics.
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28 The research team prospectively records resources used to administer all program
29 components to facilitate economic analyses. Families also report time, travel and out-of-
30 pocket costs associated with visits as well as those costs associated with child ADHD
31 medication/prescriptions.
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37 **Data analysis**

38
39 Primary (aim 1) and secondary (aim 2) analyses will be based on the ‘intention to treat’
40 population at the level of the individual child and will adjust for clustering at the level of the
41 paediatrician using a generalised linear mixed effect model (logit link function) for the binary
42 primary outcome (proportion of children with moderate/severe sleep problems). For primary
43 and secondary analyses, the stratification variable ‘*location of study site (practice)*’ as well as
44 an indicator variable for the *type of health care professional* who delivered the intervention
45 (paediatrician or psychologist) will be considered as adjustments variables. For all analyses
46 model-based effect estimates (risk differences and risk ratios) will be reported along with
47 95% confidence intervals. Because of the range of outcomes and time-points, the results will
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3 be considered in their totality and interpreted with suitable caution regarding formal
4 conclusions of “statistical significance”. In order to reduce potential confounding bias due to
5 differential patient-drop out over time, multiple imputation methodology will be considered
6 to replace missing outcome data in the primary efficacy analysis. All secondary analyses (aim
7 2) will be adjusted for baseline scores and stratification variables wherever possible, in order
8 to increase precision of comparisons.³³ For primary and secondary analyses, we will present
9 results of analyses both unadjusted and adjusted for further potential outcome predictor
10 variables (child age, medication use, comorbidities, and family socio-demographic
11 characteristics (Socioeconomic Index for Advantage linked to the family’s postcode),³⁴
12 parent high school completion, and parent age). Syntax will be written before database lock,
13 which will cover the primary and secondary analyses. Participant level data is available on
14 request.
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29 30 **Cost-effectiveness analyses**

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32 The economic analysis (aim 3) will first present cost-consequences analysis, then proceed to
33 cost-effectiveness analysis against the primary outcome (*prevalence of sleep problems*)
34 measure as the primary economic analysis. Secondary economic analyses will include cost-
35 utility analysis against CHU9D-based QALYs.^{35,36} These analyses will be conducted from
36 both the health care and broader societal perspectives (as cost-effectiveness can vary
37 significantly by perspective)³⁷ and will include extensive sensitivity analyses to test the
38 impact of uncertainty in data and sensitivity to evaluation approach.
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48 **ETHICS AND DISSEMINATION**

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50 ADHD affects approximately 5% of school-aged children³⁸ and is frequently associated with
51 sleep problems, which worsen child and family outcomes.² Findings will determine whether
52 the benefits of an efficacy trial can be realised more broadly at the population level and
53 whether it is cost-effective to do so. If cost-effective, we expect the following outcomes: 1)
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3 the best evidence yet that addressing sleep problems improves outcomes for children with
4 ADHD; and 2) a ready-to-use intervention that is tailored to the Australian health system, and
5
6 can be replicated internationally. Findings will inform the development of clinical guidelines
7
8 for managing sleep problems in this population. We will seek to publish in leading
9
10 international paediatric journals, present at major conferences and disseminate findings
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12 through established clinician networks.
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17
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19
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21
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23
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26 the Catholic Education Office (Ballarat; Brisbane; Melbourne; Toowoomba) Human
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28 Research Ethics Committees.
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Table 1. Key behavioural sleep management strategies

Sleep disorder	Definition	Examples of behavioural strategies
Sleep onset association disorder	Child associates falling asleep with a person or object (e.g., television) and is unable to fall asleep without its presence.	<ul style="list-style-type: none"> • Adult fading (i.e. graduated extinction) using ‘camping out’ - gradual withdrawal of parental presence from the child’s bedroom over 7-10 days. • ‘Checking method’ – parent checks on the child at regular time intervals (2, 5, or 10 minutes, with intervals increasing over time).
Delayed sleep phase	Shift in the child’s sleep-wake cycle, in which the child cannot fall asleep until late and then wakes late in the morning.	<ul style="list-style-type: none"> • Bedtime fading - child’s bedtime is temporarily set later to when they are usually falling asleep and gradually brought forward. The child is then woken at a pre-set time in the morning. • Early morning light exposure.
Limit setting sleep disorder	Child refusal to go to bed and general non-compliant behaviour at bedtime. Parent struggles to set appropriate and consistent bedtime limits.	<ul style="list-style-type: none"> • Parent management strategies - ignoring child protests, rewarding compliance with bedtime routines. A ‘bedtime pass’, whereby the child can only leave the bedroom one time before sleep, can be used to promote compliant behaviour. • Consideration of bedtime fading or the checking method.
Primary insomnia	Child has substantial difficulty initiating and/or maintaining sleep even if they go to bed at a later time.	<ul style="list-style-type: none"> • Visual imagery and relaxation. • Basic cognitive restructuring. • Restricting time in bed (e.g., temporarily setting the bedtime later as per delayed sleep phase or getting out of bed and doing a relaxing activity if the child cannot

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		sleep).
Night time anxiety	Specific night time fears including fear of the dark and/or child worrying about other things while in bed.	<ul style="list-style-type: none"> • Visual imagery and relaxation training. • Discussing fears during the day rather than just before bedtime. • Rewarding brave behaviour. • Other - use of a security object, avoiding scary television shows, use of a book to record worries.

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Table 2. Summary of measures

Construct	Measures	Source ^a	T1	T2	T3
Child Outcomes					
Sleep	Sleep problem prevalence (primary outcome) - Primary caregiver report of child sleep problem (none/mild vs moderate/severe). ²	P	●	●	●
	Children's Sleep Habits Questionnaire (CSHQ) - 33-item validated measure of disorders of initiating and maintaining sleep. ³¹ Child Sleep Self Report collected at 6 months only. ¹⁵	P	●	●	●
	Teacher Daytime Sleepiness Questionnaire - 10-item validated scale of daytime sleepiness at school. ³⁹	T	●	●	●
	Sleep Hygiene scale - 7-item measure assessing sleep hygiene. ²⁴	P	●		●
Comorbidity	Anxiety Disorders Interview Schedule for DSM-IV (ADIS-C) - diagnostic interview assessing mental health disorders according to DSM-IV criteria. This is completed with parents over the telephone and has been validated for this purpose. ²⁷	P	●		
ADHD	ADHD Rating Scale IV - 18-item validated scale measuring the core symptoms of ADHD. ³⁰	P, T	●	●	●
Behaviour	Strengths and Difficulties Questionnaire – 25 items assessing the following subscales: hyperactivity/inattention, conduct problems, emotional symptoms, peer relationship problems, and prosocial behavior. ⁴⁰	P, T	●	●	●
Irritability	Affective reactivity index (ARI) - 6-item validated measure assessing child irritability. ⁴¹	P	●	●	●
School attendance	School attendance over the preceding 3 months. ²	P	●	●	●
Quality of Life	Child Health Utility-9D (CHU-9D) - 9 item measure of child quality of life used to calculate quality adjusted life years. Child report is collected at the 6 month follow up only. ⁴²	P, C	●		●
	Pediatrics Quality of Life Inventory 4.0 – 23-item measure of child total, physical and psychosocial QoL. ⁴³	P	●		●

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Memory	Sleep Suite App – An animated iPad application that includes a continuous performance test to measure sustained attention, and 2 tests of memory consolidation and learning. ⁴⁴	C			●
Working Memory	Working Memory Test Battery for Children – The Backward digit span recall subtest is administered as a measure of child working memory. ⁴⁵	C			●
Academic functioning	Wide Range Achievement Test 4 (WRAT) – word reading and math computation subtests. ⁴⁶	C			●
	NAPLAN – standardised academic tests of reading, writing, language conventions and numeracy. Results can be compared to National or State population results and against the national minimum standard. ²⁶	L			●
Autism	Social Responsiveness Scale (SRS) Brief – 16-item measure of autism spectrum disorder symptoms. ⁴⁷	P			●
Parent Outcomes					
Mental health	Kessler 6 (K6) - 6-item validated measure of adult psychological stress. ⁴⁸	P	●	●	●
Work attendance	Work attendance over the previous 3 months. ²	P	●	●	●
Parenting	Parenting - validated scales developed for the Longitudinal Study of Australian Children assessing parenting consistency (6-items) and parental warmth (5-items). ⁴⁹	P	●		●
Family costs	Service use and costs - families report service use over previous 3 months as well as time, travel and out-of-pocket costs associated	P		●	●

^a P = Parent-report, T = teacher-report, C = child-report, L = data linkage; T1 = baseline; T2 = 3 months post-intervention; T3 = 6 months post-intervention.

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AUTHORS' CONTRIBUTIONS:

ES, HH, HH, NR and LG conceived the study. MM and NH coordinated the study. ES drafted the current manuscript. TS contributed to the design and analytic components of the study. All authors contributed, read and approved the final manuscript.

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COMPETING INTERESTS STATEMENT:

All authors have completed the Unified Competing Interest form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare that they, their spouses, partners or children do not have any financial and non-financial relationships with companies that may be relevant to the submitted work to declare.

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Figure 1:
Participant Flow

For peer review only

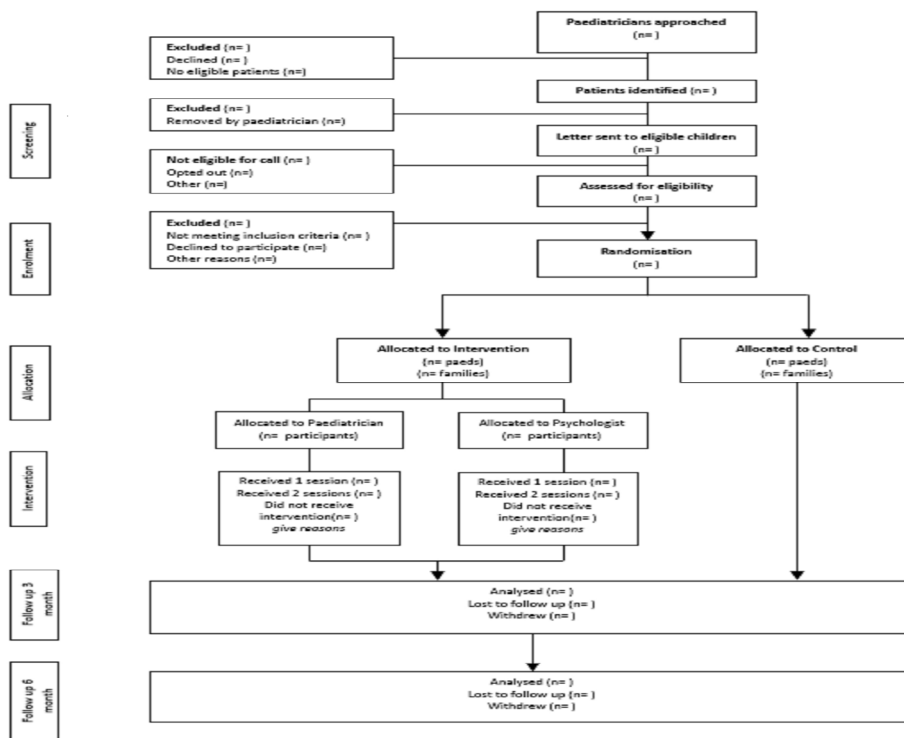


Figure 1: Participant Flow

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STANDARD PROTOCOL ITEMS: RECOMMENDATIONS FOR INTERVENTIONAL TRIALS

SPIRIT 2013 Checklist: Recommended items to address in a clinical trial protocol and related documents*

Section/item	Item No	Description
Administrative information		
Title	1	Descriptive title identifying the study design, population, interventions, and, if applicable, trial acronym <i>PAGE 1</i>
Trial registration	2a	Trial identifier and registry name. If not yet registered, name of intended registry <i>PAGE 3</i>
	2b	All items from the World Health Organization Trial Registration Data Set <i>PAGE 3 + YES SEE TRIAL REGISTER</i>
Protocol version	3	Date and version identifier <i>PAGE 3 + YES SEE TRIAL REGISTER</i>
Funding	4	Sources and types of financial, material, and other support <i>PAGE 16, 24</i>
Roles and responsibilities	5a	Names, affiliations, and roles of protocol contributors <i>PAGE 1, 29</i>
	5b	Name and contact information for the trial sponsor <i>NA</i>
	5c	Role of study sponsor and funders, if any, in study design; collection, management, analysis, and interpretation of data; writing of the report; and the decision to submit the report for publication, including whether they will have ultimate authority over any of these activities <i>NA</i>
	5d	Composition, roles, and responsibilities of the coordinating centre, steering committee, endpoint adjudication committee, data management team, and other individuals or groups overseeing the trial, if applicable (see Item 21a for data monitoring committee) <i>NA</i>
Introduction		
Background and rationale	6a	Description of research question and justification for undertaking the trial, including summary of relevant studies (published and unpublished) examining benefits and harms for each intervention <i>PAGE 4-8</i>
	6b	Explanation for choice of comparators <i>PAGE 13-14</i>
Objectives	7	Specific objectives or hypotheses <i>PAGE 7-8</i>
Trial design	8	Description of trial design including type of trial (eg, parallel group, crossover, factorial, single group), allocation ratio, and framework (eg, superiority, equivalence, noninferiority, exploratory) <i>PAGE 8</i>

Methods: Participants, interventions, and outcomes

Study setting	9	Description of study settings (eg, community clinic, academic hospital) and list of countries where data will be collected. Reference to where list of study sites can be obtained <i>PAGE 8</i>
Eligibility criteria	10	Inclusion and exclusion criteria for participants. If applicable, eligibility criteria for study centres and individuals who will perform the interventions (eg, surgeons, psychotherapists) <i>PAGE 11-13</i>
Interventions	11a	Interventions for each group with sufficient detail to allow replication, including how and when they will be administered <i>PAGE 14-16, 20-21</i>
	11b	Criteria for discontinuing or modifying allocated interventions for a given trial participant (eg, drug dose change in response to harms, participant request, or improving/worsening disease) <i>NA</i>
	11c	Strategies to improve adherence to intervention protocols, and any procedures for monitoring adherence (eg, drug tablet return, laboratory tests) <i>NA</i>
	11d	Relevant concomitant care and interventions that are permitted or prohibited during the trial <i>PAGE 14</i>
Outcomes	12	Primary, secondary, and other outcomes, including the specific measurement variable (eg, systolic blood pressure), analysis metric (eg, change from baseline, final value, time to event), method of aggregation (eg, median, proportion), and time point for each outcome. Explanation of the clinical relevance of chosen efficacy and harm outcomes is strongly recommended <i>PAGE 16-17, 22-23</i>
Participant timeline	13	Time schedule of enrolment, interventions (including any run-ins and washouts), assessments, and visits for participants. A schematic diagram is highly recommended (see Figure) <i>PAGE 8-10, 14-16</i>
Sample size	14	Estimated number of participants needed to achieve study objectives and how it was determined, including clinical and statistical assumptions supporting any sample size calculations <i>PAGE 13</i>
Recruitment	15	Strategies for achieving adequate participant enrolment to reach target sample size <i>PAGE 13</i>

Methods: Assignment of interventions (for controlled trials)

Allocation:

Sequence generation	16a	Method of generating the allocation sequence (eg, computer-generated random numbers), and list of any factors for stratification. To reduce predictability of a random sequence, details of any planned restriction (eg, blocking) should be provided in a separate document that is unavailable to those who enrol participants or assign interventions <i>PAGE 14</i>
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5	Allocation	16b	Mechanism of implementing the allocation sequence (eg, central
6	concealment		telephone; sequentially numbered, opaque, sealed envelopes),
7	mechanism		describing any steps to conceal the sequence until interventions are
8			assigned <i>PAGE 14</i>
9			
10	Implementation	16c	Who will generate the allocation sequence, who will enrol participants,
11			and who will assign participants to interventions <i>PAGE 14</i>
12			
13	Blinding	17a	Who will be blinded after assignment to interventions (eg, trial
14	(masking)		participants, care providers, outcome assessors, data analysts), and
15			how <i>PAGE 14, 16</i>
16			
17			
18		17b	If blinded, circumstances under which unblinding is permissible, and
19			procedure for revealing a participant's allocated intervention during
20			the trial <i>NA</i>

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Methods: Data collection, management, and analysis

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23	Data collection	18a	Plans for assessment and collection of outcome, baseline, and other
24	methods		trial data, including any related processes to promote data quality (eg,
25			duplicate measurements, training of assessors) and a description of
26			study instruments (eg, questionnaires, laboratory tests) along with
27			their reliability and validity, if known. Reference to where data
28			collection forms can be found, if not in the protocol <i>PAGE 16-17, 22-23</i>
29			
30		18b	Plans to promote participant retention and complete follow-up,
31			including list of any outcome data to be collected for participants who
32			discontinue or deviate from intervention protocols <i>PAGE 13, 11-17, 22-23</i>
33			
34	Data	19	Plans for data entry, coding, security, and storage, including any
35	management		related processes to promote data quality (eg, double data entry;
36			range checks for data values). Reference to where details of data
37			management procedures can be found, if not in the protocol <i>PAGE 17</i>
38			
39	Statistical	20a	Statistical methods for analysing primary and secondary outcomes.
40	methods		Reference to where other details of the statistical analysis plan can be
41			found, if not in the protocol <i>PAGE 17-18</i>
42			
43		20b	Methods for any additional analyses (eg, subgroup and adjusted
44			analyses) <i>PAGE 17-18</i>
45			
46		20c	Definition of analysis population relating to protocol non-adherence
47			(eg, as randomised analysis), and any statistical methods to handle
48			missing data (eg, multiple imputation) <i>PAGE 17-18</i>
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Methods: Monitoring

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54	Data monitoring	21a	Composition of data monitoring committee (DMC); summary of its role
55			and reporting structure; statement of whether it is independent from
56			the sponsor and competing interests; and reference to where further
57			details about its charter can be found, if not in the protocol.
58			Alternatively, an explanation of why a DMC is not needed <i>NA</i>
59			
60			

	21b	Description of any interim analyses and stopping guidelines, including who will have access to these interim results and make the final decision to terminate the trial	NA
Harms	22	Plans for collecting, assessing, reporting, and managing solicited and spontaneously reported adverse events and other unintended effects of trial interventions or trial conduct	PAGE 16
Auditing	23	Frequency and procedures for auditing trial conduct, if any, and whether the process will be independent from investigators and the sponsor	NA

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Ethics and dissemination

Research ethics approval	24	Plans for seeking research ethics committee/institutional review board (REC/IRB) approval	PAGE 18
Protocol amendments	25	Plans for communicating important protocol modifications (eg, changes to eligibility criteria, outcomes, analyses) to relevant parties (eg, investigators, REC/IRBs, trial participants, trial registries, journals, regulators)	NA
Consent or assent	26a	Who will obtain informed consent or assent from potential trial participants or authorised surrogates, and how (see Item 32)	PAGE 10
	26b	Additional consent provisions for collection and use of participant data and biological specimens in ancillary studies, if applicable	PAGE 10
Confidentiality	27	How personal information about potential and enrolled participants will be collected, shared, and maintained in order to protect confidentiality before, during, and after the trial	PAGE 9-10
Declaration of interests	28	Financial and other competing interests for principal investigators for the overall trial and each study site	PAGE 29
Access to data	29	Statement of who will have access to the final trial dataset, and disclosure of contractual agreements that limit such access for investigators	SEE TRIAL REGISTRY PAGE 18
Ancillary and post-trial care	30	Provisions, if any, for ancillary and post-trial care, and for compensation to those who suffer harm from trial participation	NA
Dissemination policy	31a	Plans for investigators and sponsor to communicate trial results to participants, healthcare professionals, the public, and other relevant groups (eg, via publication, reporting in results databases, or other data sharing arrangements), including any publication restrictions	PAGE 18
	31b	Authorship eligibility guidelines and any intended use of professional writers	NA
	31c	Plans, if any, for granting public access to the full protocol, participant-level dataset, and statistical code	SEE TRIAL REGISTRY

Appendices

Informed consent materials	32	Model consent form and other related documentation given to participants and authorised surrogates	SEE TRIAL REGISTRY
Biological specimens	33	Plans for collection, laboratory evaluation, and storage of biological specimens for genetic or molecular analysis in the current trial and for future use in ancillary studies, if applicable	NA

*It is strongly recommended that this checklist be read in conjunction with the SPIRIT 2013 Explanation & Elaboration for important clarification on the items. Amendments to the protocol should be tracked and dated. The SPIRIT checklist is copyrighted by the SPIRIT Group under the Creative Commons "Attribution-NonCommercial-NoDerivs 3.0 Unported" license.

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