**Supplementary Material**

**Supplementary 1 – PRISMA-P (Preferred Reporting Items for Systematic review and Meta-Analysis Protocols)**114 **2015 checklist: recommended items to address in a systematic review protocol**

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| --- | --- | --- | --- |
| Section and topic | Item No | Checklist item |  |
| ADMINISTRATIVE INFORMATION | | |  |
| Title: |  | Cognitive behavioural therapy for sleep problems in psychosis: A systematic review of effectiveness and acceptability |  |
| Identification | 1a | Identify the report as a protocol of a systematic review | V |
| Update | 1b | If the protocol is for an update of a previous systematic review, identify as such | V |
| Registration | 2 | If registered, provide the name of the registry (such as PROSPERO) and registration number | V |
| Authors: |  |  |  |
| Contact | 3a | Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author | V |
| Contributions | 3b | Describe contributions of protocol authors and identify the guarantor of the review | V |
| Amendments | 4 | If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments | V |
| Support: |  |  |  |
| Sources | 5a | Indicate sources of financial or other support for the review | V |
| Sponsor | 5b | Provide name for the review funder and/or sponsor | V |
| Role of sponsor or funder | 5c | Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol | V |
| INTRODUCTION | | |  |
| Rationale | 6 | Describe the rationale for the review in the context of what is already known | V |
| Objectives | 7 | Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO) | V |
| METHODS | | |  |
| Eligibility criteria | 8 | Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review | V |
| Information sources | 9 | Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage | V |
| Search strategy | 10 | Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated | V |
| Study records: |  |  |  |
| Data management | 11a | Describe the mechanism(s) that will be used to manage records and data throughout the review | V |
| Selection process | 11b | State the process that will be used for selecting studies (such as two independent reviewers) through each phase of the review (that is, screening, eligibility and inclusion in meta-analysis) | V |
| Data collection process | 11c | Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators | V |
| Data items | 12 | List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications | V |
| Outcomes and prioritization | 13 | List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale | V |
| Risk of bias in individual studies | 14 | Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis | V |
| Data synthesis | 15a | Describe criteria under which study data will be quantitatively synthesised | V |
| 15b | If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I2, Kendall’s τ) | V |
| 15c | Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression) | N/A |
| 15d | If quantitative synthesis is not appropriate, describe the type of summary planned | V |
| Meta-bias(es) | 16 | Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies) | N/A |
| Confidence in cumulative evidence | 17 | Describe how the strength of the body of evidence will be assessed (such as GRADE) | V |

**Supplementary 2 – PICO table**

|  |  |
| --- | --- |
| Table 2.1 *Inclusion criteria* | |
| Dimension | Inclusion Criteria |
| General | The study either (a) has an experimental design (i.e., a trial with a treatment arm delivering a CBT-based intervention and obtaining quantitative outcomes; the trial may be controlled or non-controlled); OR (b) uses qualitative research methods evaluating the subjective experiences of the CBT delivered in (a). |
| Published in a peer-reviewed journal (i.e. not a dissertation, non-peer reviewed conference abstract).  Published in English (the language spoken by the researchers). |
| Population | At least a third of participants have psychotic symptoms as assessed by either (a) formal diagnosis of a psychotic disorder, OR (b) meeting the criteria for 'at risk mental state' with the use of a comprehensive measure, such as the ‘Comprehensive Assessment of At-Risk Mental States’ (CAARMS)61. Of note, DSM-V and ICD-11 psychotic spectrum disorders include the following115,116:   * schizophreniform disorder * schizoaffective disorder * schizotypal disorders * brief psychotic disorder * acute and transient psychotic disorder * delusional disorder * psychosis not otherwise specified   Participants present with a level of sleep difficulties which are *not* in the context of a medical sleep disorder (e.g. narcolepsy or obstructive sleep apnoea) or neurodegenerative disease (e.g. dementia). |
| Intervention | Trials evaluate a CBT-based intervention that targets an aspect of sleep quality. This includes CBT directed at insomnia (i.e., difficulties with falling asleep, staying asleep, early waking), nightmares, or excessive sleeping.  Trials have a minimum of 10 participants per arm to test quantitative outcomes. For studies with a qualitative design, there is no minimum number of participants. |
| Comparator/control | All trials are required to report comparisons in clinical outcomes pre- and post-treatment. Randomised controlled trials should additionally report comparisons between a treatment and control group.  Qualitative studies are not required to have a comparator/control. |
| Outcome | Trials include quantitative outcomes of the following: sleep quality and/or psychotic symptoms. Overall intervention effects are reported.  Qualitative studies describe participant’s subjective experiences of engaging in treatment. |
| *Note. ‘DSM-V’ refers to the Diagnostic and Statistical Manual of Mental Disorders.*115 *‘ICD-11’ refers to International Classification of Diseases.*116 | |

**Supplementary 3 - Search terms**

***S.3.1 Search terms for Embase:***

|  |  |
| --- | --- |
| **Step** | **Search History** |
| 1 | ("cognitive behavio\* therapy" or CBT or CBT-I).ab,ti. |
| 2 | cognitive behavioral therapy/ |
| 3 | 1 or 2 |
| 4 | (sleep or nightmares or insomnia or asleep or hypersomnia).ab,ti. |
| 5 | insomnia/ |
| 6 | nightmare/ |
| 7 | 4 or 5 or 6 |
| 8 | (psychosis or psychotic or schizophren\* or bipolar or hallucinat\* or delusion\* or persecutory).ab,ti. |
| 9 | psychosis/ or affective psychosis/ or schizoaffective psychosis/ or paranoid psychosis/ |
| 10 | bipolar disorder/ |
| 11 | 8 or 9 or 10 |
| 12 | 3 and 7 and 11 |

***S.3.2 Search terms for Medline:***

|  |  |
| --- | --- |
| **Step** | **Search History** |
| 1 | ("cognitive behavio\* therapy" or CBT or CBT-I).ab,ti. |
| 2 | Cognitive Behavioral Therapy/ |
| 3 | 1 or 2 |
| 4 | (sleep\* or nightmares or insomnia or asleep or hypersomnia).ab,ti. |
| 5 | "Sleep Initiation and Maintenance Disorders"/ |
| 6 | 4 or 5 |
| 7 | (psychosis or psychotic or schizophren\* or bipolar or hallucinat\* or delusion\* or persecutory).ab,ti. |
| 8 | Psychotic Disorders/ |
| 9 | Bipolar Disorder/ or Affective Disorders, Psychotic/ |
| 10 | Schizophrenia, Paranoid/ |
| 11 | Schizophrenia/ |
| 12 | 8 or 9 or 10 or 11 |
| 13 | 7 or 12 |
| 14 | 3 or 6 or 13 |
| 15 | 3 and 6 and 13 |

***S.3.3 Search terms for PsycInfo:***

|  |  |
| --- | --- |
| **Step** | **Search History** |
| 1 | ("cognitive behavio\* therapy" or CBT or CBT-I).ab,ti. |
| 2 | Cognitive Behavior Therapy/ |
| 3 | 1 or 2 |
| 4 | (sleep or nightmares or insomnia or asleep or hypersomnia).ab,ti. |
| 5 | Insomnia/ |
| 6 | Nightmares/ |
| 7 | 4 or 5 or 6 |
| 8 | (psychosis or psychotic or schizophren\* or bipolar or hallucinat\* or delusion\* or persecutory).ab,ti. |
| 9 | psychosis/ or affective psychosis/ or delusional disorder/ or exp paranoid psychosis/ or exp schizophrenia/ |
| 10 | 8 or 9 |
| 11 | 3 and 7 and 10 |

***S.3.4 Search terms for PubMed:***

(("cognitive behavior therapy"[Title/Abstract] OR "cognitive behavioral therapy"[Title/Abstract] OR "cognitive behaviour therapy"[Title/Abstract] OR "cognitive behavioural therapy"[Title/Abstract] OR CBT[Title/Abstract] OR CBT-I[Title/Abstract]) OR ("cognitive behavioral therapy"[MeSH Terms])) AND ((sleep[Title/Abstract] OR nightmares[Title/Abstract] OR insomnia[Title/Abstract] OR asleep[Title/Abstract] OR hypersomnia[Title/Abstract]) OR (sleep quality[MeSH Terms]) OR ("sleep initiation and maintenance disorders"[MeSH Terms])) AND ((psychosis[Title/Abstract] OR psychotic[Title/Abstract] OR schizophren\*[Title/Abstract] OR bipolar[Title/Abstract] OR hallucinat\*[Title/Abstract] OR delusion\*[Title/Abstract] OR persecutory[Title/Abstract]) OR ("psychotic disorders"[MeSH Terms]) OR ("affective disorders, psychotic"[MeSH Terms]) OR ("bipolar and related disorders"[MeSH Terms]) OR ("schizophrenia"[MeSH Terms] OR "schizophrenia spectrum and other psychotic disorders"[MeSH Terms]))

**Supplementary 4 – Qualitative checklist ratings, developed from Braun and Clarke’s reviewing guidelines48**

***S.4.1 Quality ratings for Taylor et al. (2020)*35**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Evaluating the methods and methodology** | **Yes/ Probably yes** | **Maybe/**  **partly** | **No/ Probably no** | **Comments** |
| 1 | Is the use of TA explained (even if only briefly)? | V |  |  | Yes: “To explore patterns within the qualitative interview data” |
| 2 | Do the authors clearly specify and justify which type of TA they are using? |  |  | V | They reference Braun and Clarke’s paper but don’t actually say what type they are using |
| 3 | Is the use and justification of the specific type of TA consistent with the research questions or aims? |  |  | V | At a guess, they have used a fairly realist approach which fits with their aim of understanding the intervention acceptability, but it’s not clear what they have even done regarding use, and it’s not justified |
| 4 | Is there a good ‘fit’ between the theoretical and conceptual underpinnings of the research and the specific type of TA (conceptual coherence)? |  |  | V | No information about the kind of TA |
| 5 | Is there a good ‘fit’ between the methods of data collection and the specific type of TA? |  |  | V | No information about how data was collected |
| 6 | Is the specified type of TA consistently enacted throughout the paper? |  |  | V | No information about the type of TA |
| 7 | Is there evidence of problematic assumptions about TA? These commonly include (mark ‘yes’ if evidence of any of these errors, and indicate where they are):  -Treating TA as one, homogenous, entity, with one set of – widely agreed on – procedures.  -Assuming grounded theory concepts and procedures (e.g. saturation, constant comparative analysis, line-by-line coding) apply to TA without any explanation or justification.  -Assuming TA is essentialist or realist, or atheoretical.  -Assuming TA is only a data reduction or descriptive approach and thus has to be supplemented with other methods and procedures to achieve other ends. | V |  |  | Treat TA as one homogenous entity  Seem to assume it is only data reductionist approach  Seem to assume TA is atheoretical from the fact that they don’t mention a theoretical approach – they simply assume a realist position it seems  They don’t supplement TA with other methods |
| 8 | (Skip if not applicable) Are any supplementary procedures or methods justified and necessary or could the same results have been achieved simply by using TA more effectively? |  |  |  | N/A |
| 9 | Are the theoretical underpinnings of the use of TA clearly specified (e.g. ontological, epistemological assumptions, guiding theoretical framework(s)), even when using TA inductively (inductive TA does not equate to analysis in a theoretical vacuum)? |  |  | V |  |
| 10 | Do the researchers strive to ‘own their perspectives’ (even if only very briefly); their personal and social standpoint and positioning? (This is especially important when the researchers are engaged in social justice-oriented research and when representing the ‘voices’ of marginal and vulnerable groups, and groups to which the researcher does not belong.) |  |  | V | Not really  They mention that as a researcher they may have influenced outcomes by being involved in the other stages of research, but this is not their personal/social standpoint |
| 11 | Are the analytic procedures used clearly outlined? |  |  | V | No description |
| 12 | Is there evidence of conceptual and procedural confusion? For example, reflexive TA (Braun & Clarke, 2006) is the claimed approach but different procedures are outlined such as the use of a codebook or coding frame, multiple independent coders and consensus coding, inter-rater reliability measures, and/or themes are conceptualised as analytic inputs rather than outputs and therefore the analysis progresses from theme identification to coding (rather than coding to theme development). |  | V |  | Possibly…they cite Braun & Clarke but it’s very unclear |
| 13 | Have the authors fully understood their claimed approach to TA? |  |  | V | No evidence to suggest this |
| **Evaluating the analysis** | | | | | |
| 14 | Is it clear what and where the themes are in the report? Would the manuscript benefit from some kind of overview of the analysis: listing of themes, narrative overview, table of themes, thematic map? | V |  |  | Themes in a clear table |
| 15 | Are themes reported domain summaries rather than fully realised themes?  Have the data collection questions been used as themes?  Are domain summaries appropriate to the purpose of the research? (If so, if the authors are using reflexive TA, is this modification in the conceptualisation of themes explained and justified?)  Would the manuscript benefit from further analysis being undertaken and the reporting of fully realised themes?  Or, if the authors are claiming to use reflexive TA, would the manuscript benefit from claiming to use a different type of TA (e.g. coding reliability or codebook)? | V  V | V  V  V |  | They are domain summaries, and yes, it seems that the data collection questions are the themes |
| 16 | Is a non-thematic contextualising information presented as a theme? (e.g. the first theme is a domain summary providing contextualising information, but the rest of the themes reported are fully realised themes) Would the manuscript benefit from this being presented as non-thematic contextualising information? |  |  | V | Contextualising information isn’t presented as a theme, so this doesn’t really apply |
| 17 | In applied research, do the reported themes give rise to actionable outcomes? | V |  |  | Yes – clear implications for future interventions |
| 18 | Are there conceptual clashes and confusion in the paper? (e.g. claiming a social constructionist approach while also expressing concern for positivist notions of coding reliability, or claiming a constructionist approach while treating participants’ language as a transparent reflection of their experiences and behaviours) |  |  | V | No claims about conceptual standpoint – so no scope for contradiction |
| 19 | Is there evidence of weak or unconvincing analysis?  Too many or two few themes?  Too many theme levels?  Confusion between codes and themes?  Mismatch between data extracts and analytic claims?  Too few or too many data extracts?  Overlap between themes? |  | V |  | Relatively superficial analysis although the themes, extracts and analytic claims do largely overlap |
| 20 | Do authors make problematic statements about the lack of generalisability of their results, and implicitly conceptualise generalisability as statistical-generalisability? |  | V |  | They mention this, but it isn’t clear that it’s a problem given their research aims |

***S.4.2 Quality ratings for Waite et al. (2018)*53**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Evaluating the methods and methodology | Yes/ Probably yes | Maybe/  Partly | No/ Probably no | Comments |
| 1 | Is the use of TA explained (even if only briefly)? | V |  |  | Organising, encoding and identifying patterns |
| 2 | Do the authors clearly specify and justify which type of TA they are using? |  |  | V | They report using Braun & Clarke’s method but that isn’t a type of TA |
| 3 | Is the use and justification of the specific type of TA consistent with the research questions or aims? |  |  | V | No justification given |
| 4 | Is there a good ‘fit’ between the theoretical and conceptual underpinnings of the research and the specific type of TA (conceptual coherence)? |  | V |  | Seems to be a realist/essentialist approach – makes sense that they are concerned about accuracy and reliability |
| 5 | Is there a good ‘fit’ between the methods of data collection and the specific type of TA? |  | V |  | According with the above, yes, but difficult to say when they haven’t specified what type of TA they are using. If it is reflexive TA then no |
| 6 | Is the specified type of TA consistently enacted throughout the paper? |  | V |  | Not specified but there is potentially consistency |
| 7 | Is there evidence of problematic assumptions about TA? These commonly include:  -Treating TA as one, homogenous, entity, with one set of – widely agreed on – procedures.  -Assuming grounded theory concepts and procedures (e.g. saturation, constant comparative analysis, line-by-line coding) apply to TA without any explanation or justification.  -Assuming TA is essentialist or realist, or atheoretical.  -Assuming TA is only a data reduction or descriptive approach and thus has to be supplemented with other methods and procedures to achieve other ends. | V  V  V |  |  |  |
| 8 | (Skip is not applicable) Are any supplementary procedures or methods justified and necessary or could the same results have been achieved simply by using TA more effectively? |  |  |  |  |
| 9 | Are the theoretical underpinnings of the use of TA clearly specified (e.g. ontological, epistemological assumptions, guiding theoretical framework(s)), even when using TA inductively (inductive TA does not equate to analysis in a theoretical vacuum)? |  |  | V |  |
| 10 | Do the researchers strive to ‘own their perspectives’ (even if only very briefly); their personal and social standpoint and positioning? (This is especially important when the researchers are engaged in social justice-oriented research and when representing the ‘voices’ of marginal and vulnerable groups, and groups to which the researcher does not belong.) |  |  | V |  |
| 11 | Are the analytic procedures used clearly outlined? | V |  |  |  |
| 12 | Is there evidence of conceptual and procedural confusion? For example, reflexive TA (Braun & Clarke, 2006) is the claimed approach but different procedures are outlined such as the use of a codebook or coding frame, multiple independent coders and consensus coding, inter-rater reliability measures, and/or themes are conceptualised as analytic inputs rather than outputs and therefore the analysis progresses from theme identification to coding (rather than coding to theme development). |  |  | V |  |
| 13 | Have the authors fully understood their claimed approach to TA? |  | V |  |  |
| Evaluating the analysis | | | | | |
| 14 | Is it clear what and where the themes are in the report? Would the manuscript benefit from some kind of overview of the analysis: listing of themes, narrative overview, table of themes, thematic map? | V |  |  |  |
| 15 | Are themes reported domain summaries rather than fully realised themes?  -Have the data collection questions been used as themes?  -Are domain summaries appropriate to the purpose of the research? (If so, if the authors are using reflexive TA, is this modification in the conceptualisation of themes explained and justified?)  -Would the manuscript benefit from further analysis being undertaken and the reporting of fully realised themes?  -Or, if the authors are claiming to use reflexive TA, would the manuscript benefit from claiming to use a different type of TA (e.g. coding reliability or codebook)? | V | V  V  V  V  NA |  |  |
| 16 | Is a non-thematic contextualising information presented as a theme? (e.g. the first theme is a domain summary providing contextualising information, but the rest of the themes reported are fully realised themes). Would the manuscript benefit from this being presented as non-thematic contextualising information? |  |  | V | Contextualising information isn’t one of the theme so it doesn’t really apply |
| 17 | In applied research, do the reported themes give rise to actionable outcomes? | V |  |  |  |
| 18 | Are there conceptual clashes and confusion in the paper? (e.g. claiming a social constructionist approach while also expressing concern for positivist notions of coding reliability, or claiming a constructionist approach while treating participants’ language as a transparent reflection of their experiences and behaviours) |  | V |  | Difficult to judge as it doesn’t really claim a position |
| 19 | Is there evidence of weak or unconvincing analysis?  -Too many or two few themes?  -Too many theme levels?  -Confusion between codes and themes?  -Mismatch between data extracts and analytic claims?  -Too few or too many data extracts?  -Overlap between themes? |  | V |  | Perhaps some confusion between what is a code and what is a theme; it’s rather superficial and doesn’t ‘tell a story’ – it is broken down into what’s helpful/unhelpful etc. which suggests a superficial analysis. |
| 20 | Do authors make problematic statements about the lack of generalisability of their results, and implicitly conceptualise generalisability as statistical-generalisability? |  | V |  | They do make claims about this, but it isn’t fully problematic given their realist positions/aims |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Supplementary 5 - Means, standard deviations and numbers of participants for outcome measures**  ***S.5.1 Sleep problems*** | | | | |
| **Table S.5.1** *Primary sleep measure: means, standard deviations and participant numbers* | | | | |
| **Study** | **Primary Outcome** | **Time-point** | **Results** | |
|  | **Treatment** | **Control** |
| Batalla-Martin et al. (2023)37 | ISI | Baseline  Post-treatment  Three months | 15.0 (4.2); n = 20  8.1 (4.0); n = 20  6.7 (3.5); n = 20 | 15.6 (4.5); n = 20  15.3 (4.9); n = 20  15.8 (4.3); n = 20 |
| Freeman et al., (2015)24 | ISI | Baseline  Post-treatment  Three months | 18.6 (3.2); n = 24  9.3 (5.5); n = 22  11.0 (5.6); n = 23 | Pre: 18.8 (3.3); n = 26  Post: 15.4 (5.4); n = 25  15.0 (5.7); n = 25 |
| Sheaves et al., (2018)25 | ISI | Baseline  Post-treatment  Two weeks  Ten weeks | 17.1 (6.0); n = 20  8.5 (5.4); n = 20  6.8 (5.2); n = 19  5.8 (4.9); n = 16 | 16.1 (4.9); n = 20  12.5 (5.5); n = 20  10.1 (5.6); n = 20  8.6 (4.4); n = 18 |
| Sheaves et al., (2019)26 | DDNSI | Baseline  Post-treatment  Six months | 21.6 (6.9); n = 12  14.2 (8.8); n = 12  12.6 (8.6); n = 11 | 23.0 (6.4); n = 12  22.6 (7.1); n = 11  22.1 (8.2); n = 9 |
| Waite et al., (2023)27 | ISI | Baseline  Post-treatment  Six months | 19.2 (2.8); n = 21  6.3 (4.9); n = 21  8.3 (6.3); n = 21 | 18.7 (3.3); n = 19  14.3 (5.8); n = 18  13.9 (5.8); n = 18 |
| Hwang et al., (2019)28\* | ISI | Baseline  Post-treatment  One month | 17.7 (0.5); n = 31  12.2 (0.6); n = 31  11.4 (0.6); n = 31 | 18.5 (0.5); n = 32  18.2 (0.6); n = 32  17.7 (0.6); n = 32 |
| Bradley et al., (2018)29 | ISI | Baseline  Post-treatment  One month | 17.2 (1.2); n = 11  9.1 (5.1); n = 11  9.1 (4.6); n = 11 | None |
| Haynes et al., (2011)30 | ISI | Baseline  Post-treatment | 17.53 (7.33); n = 19  13.36 (7.52); n = 19 | None |
| Holmes et al., (1995)31 | Subjective sleep rating | Baseline  Post-treatment | Means and SDs not reported; simply state that repeated measures ANOVA, looking at change found a significant difference: subjective rating of sleep (E(1,16) = 6.12, p < .05); n = 18 | None |
| Myers et al., (2011)32 | ISI | Baseline  Post-treatment  One month | 20.93 (3.45); n = 15  9.13 (5.30); n = 15  10.20 (4.63); n = 15 | None |
| Novak et al., (2020)33 | ISI | Baseline  Post-treatment | 18 (no SD reported)  14 (no SD reported) | None |
| Waters et al., (2020)34 | PSQI | Baseline  Post-treatment | 13.4 (3.4); n = 50  10.3 (3.5); n = 40 | Not reported |
| Taylor et al., (2022)35 | ISI | Baseline  Post-treatment | 18.45 (4.99); n = 11  12.91 (5.75); n = 11 | None |
| *Note: This table reports data assessed by the primary sleep measure in the treatment and control groups at each time-point. Data are presented as mean, (SD), and number of participants completing the assessment measure.*  *For Hwang et al.'s study*28 *study, the asterisk (\*) indicates to treat their findings with caution given the unusually small standard deviations.*  *Primary measures include: ISI = Insomnia Severity Index,*55 *DDNSI = Disturbing Dream and Nightmare Severity Index,* 56 *and PSQI = Pittsburgh Sleep Quality Index.*57 *Holmes et al.* 31 *report a subjective sleep rating that is extracted from a sleep log published elsewhere*58 *but provide minimal further details. Where studies did not specify a single primary sleep measure, the most relevant measure to evaluate the intervention (e.g. an insomnia measure for a study of CBT-I) is reported.*   |  |  |  |  |  | | --- | --- | --- | --- | --- | | ***S.5.2 Psychotic outcomes*** | | | | | | **Table S.5.2** *Psychotic symptoms: means, standard deviations and participant numbers* | | | | | | **Study** | **Primary Outcome** |  | **Results** | | |  | **Treatment** | **Control** | | Batalla-Martin et al. (2023)37 | None |  |  |  | | Freeman et al., (2015)24 | PSYRATS (delusions)  PSYRATS (hallucinations)  GPTS  PANSS | Baseline  Post-treatment  Three months  Baseline  Post-treatment  Three months  Baseline  Post-treatment  Three months  Baseline  Post-treatment  Three months | 16.1 (3.2); n = 24  13.9 (4.8); n = 22  14.0 (4.7); n = 23  25.1 (12.1); n = 24  27.5 (9.2); n = 22  24.6 (11.6); n = 23  90.8 (28.7); n = 24  89.6 (36.8); n = 22  78.3 (34.8); n = 20  83.6 (16.2); n = 24  77.5 (12.1); n = 22  74.8 (14.7); n = 21 | 15.3 (4.9); n = 26  13.8 (4.1); n = 25  12.7 (5.7); n = 25  26.7 (9.2); n = 26  25.9 (8.1); n = 25  22.0 (10.2); n = 25  90·5 (29.8); n = 26  96.2 (37.3); n = 24  88·1 (35.0); n = 25  79.7 (14.1); n = 26  79.3 (14.6); n = 24  75.8 (11.8); n = 24 | | Sheaves et al., (2018)25 | PANSS Total  PANSS (positive symptoms)  PANSS (negative symptoms)  PANSS (psychopathology) | Baseline  Post-treatment  Two weeks  Ten weeks  Baseline  Post-treatment  Two weeks  Ten weeks  Baseline  Post-treatment  Two weeks  Ten weeks  Baseline  Post-treatment  Two weeks  Ten weeks | 68.3 (16.3); n = 20  56.4 (9.2); n = 20  53.9 (12.6); n = 19  50.4 (11.7); n = 16  15.3 (6.6); n = 20  12.2 (4.8); n = 20  11.2 (3.9); n = 19  9.4 (2.9); n = 16  14.7 (6.0); n = 20  12.8 (4.1); n = 20  11.9 (4.6); n = 19  11.9 (3.5); n = 16  38.4 (9.2); n = 20  31.4 (6.6); n = 20  30.8 (8.8); n = 19  29.1 (8.4); n = 16 | 68.4 (14.9); n = 20  61.1 (15.5); n = 20  54.9 (14.7); n = 20  55.8 (19.0); n = 18  15.4 (5.2); n = 20  12.5 (4.6); n = 20  11.2 (4.3); n = 20  10.4 (3.5); n = 18  13.9 (4.3); n = 20  13.8 (5.7); n = 20  13.6 (5.1); n = 20  14.9 (7.4); n = 18  39.2 (8.3); n = 20  34.7 (8.5); n = 20  30.2 (8.0); n = 20  30.5 (11.8); n = 18 | | Sheaves et al., (2019)26 | CAPS  GPTS | Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months | 17.7 (7.7); n = 12  15.5 (7.7); n = 12  15.8 (7.8); n = 11  101.2 (35.7); n = 12  75.3 (37.0); n = 12  68.5 (39.4); n = 11 | 18.8 (7.1); n = 12  16.8 (7.3); n = 10  16.7 (10.1); n = 9  109.8 (33.9); n = 12  109.0 (32.3); n = 10  100.7 (35.5); n = 9 | | Waite et al., (2023)27 | CAARMS  ČEFSA  GPTS-A  GPTS-B  SPEQ | Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months | 50.8 (11.2); n = 21  42.2 (20.9); n = 19  38.8 (21.4); n = 20  75.8 (41.2); n = 21  63.2 (37.0); n = 19  53.0 (41.2); n = 21  18.7 (8.9); n = 21  13.2 (8.9); n = 20  10.4 (9.5); n = 21  18.9 (11.7); n = 21  14.4 (11.7); n = 20  10.3 (10.1); n = 21  23.8 (9.6); n = 21  18.8 (12.2); n = 20  14.6 (10.5); n = 21 | 45.4 (12.1); n = 19  44.6 (21.6); n = 16  39.3 (26.6); n = 18  74.0 (31.8); n = 19  65.6 (38.4); n = 17  60.7 (41.4); n = 17  17.6 (9.5); n = 19  15.9 (11.1); n = 17  15.9 (11.2); n = 18  14.7 (11.9); n = 19  14.5 (13.3); n = 17  15.5 (15.5); n = 18  23.8 (9.2); n = 19  18.3 (12.4); n = 18  16.7 (14.0); n = 18 | | Hwang et al., (2019)28\* | PSYRATS Total  PSYRATS (hallucinations)  PSYRATS (delusions) | Baseline  Post-treatment  One month  Baseline  Post-treatment  One month  Baseline  Post-treatment  One month | 29.2 (1.3); n = 31  26.1 (1.3); n = 31  25.8 (1.3); n = 31  18.3 (1.4); n = 31  17.0 (1.3); n = 31  16.7 (1.3); n = 31  10.9 (0.8); n = 31  9.2 (0.8); n = 31  9.1 (0.8); n = 31 | 28.8 (1.3); n = 32  29.2 (1.3); n = 32  29.4 (1.3); n = 32  19.4 (1.4); n = 32  19.8 (1.3); n = 32  20.0 (1.3); n = 32  9.3 (0.8); n = 32  9.5 (0.8); n = 32  9.5 (0.7); n = 32 | | Bradley et al., (2018)29 | GPTS  SPEQ | Baseline  Post-treatment  One month  Baseline  Post-treatment  One month | 71.6 (22.7); n = 11  58.3 (24.1); n = 11  53.9 (21.3); n = 11  13.8 (5.5); n = 11  11.9 (5.8); n = 10  9.4 (6.6); n = 11 | None | | Haynes et al., (2011)30 | None |  |  |  | | Holmes et al., (1995)31 | None |  |  |  | | Myers et al., (2011)32 | GPTS-A  GPTS-B  PSYRATS  CAPS | Baseline  Post-treatment  One month  Baseline  Post-treatment  One month  Baseline  Post-treatment  One month  Baseline  Post-treatment  One month | 46.93 (13.27); n = 15  35.20 (16.89); n = 15  34.93 (15.60); n = 15  58.27 (15.93); n = 15  39.60 (18.80); n = 15  38.93 (20.80); n = 15  18.33 (2.72); n = 15  15.07 (3.06); n = 15  14.00 (4.11); n = 15  18.07 (10.69); n = 15  13.20 (9.68); n = 15  13.60 (9.24); n = 15 | None | | Novak et al., (2020)33 | None |  |  |  | | Waters et al., (2020)34 | MINI-p | Baseline  Post-treatment | 16.1 (7.3); n = 50  13.5 (6.6); n = 40 | Not reported | | Taylor et al., (2022)35 | R-GPTS-A  R-GPTS-B  SPEQ | Baseline  Post-treatment  Baseline  Post-treatment  Baseline  Post-treatment | 11.45 (10.14); n = 11  7.09 (7.62); n = 11  15.45 (14.17); n = 11  12.18 (13.90); n = 11  10.64 (11.05); n = 11  10.27 (11.44); n = 11 | None | | *Note: This table reports data assessed by psychotic outcome measures in the treatment and control groups at each time-point. Data are presented as mean, (SD), and number of participants completing the outcome measure.*  *For Hwang et al.'s study*28*, the asterisk (\*) indicates to treat their findings with caution given the unusually small standard deviations.*  *Psychotic measures include: Cardiff Anomalous Perceptions Scale (CAPS)* 59*; Černis Felt Sense of Anomaly (ČEFSA)* 60*; Comprehensive Assessment of At-Risk Mental States (CAARMs)* 61*; Green Paranoid Thoughts Scale (GTPS)* 62 *which contains subscales of ‘Ideas of Reference’ (GPTS-A) and ‘Ideas of Persecution’ (GPTS-B); Adapted Mini International Neuropsychiatric Interview – Psychosis section (MINI-p)* 63*; Positive and Negative Symptoms Scale (PANSS)* 64 *which contains subscales relating to positive symptoms, negative symptoms, and general psychopathology; Psychotic Symptom Rating Scale (PSYRATS)* 65 *which contains subscales relating to delusions and hallucinations, Revised-Green Paranoid Thoughts Scale (R-GPTS)* 66 *which contains subscales of ‘Ideas of Reference’ (GTPS-A) and ‘Ideas of Persecution’ (GPTS-B) subscales; Specific Psychotic Experiences Questionnaire (SPEQ)* 67*.*   |  |  |  |  |  | | --- | --- | --- | --- | --- | | ***S.5.3 Other clinical outcomes***  **Table S.5.3** *Other clinical outcomes: means, standard deviations and participant numbers* | | | | | | **Study** | **Primary Outcome** |  | **Results** | | |  | **Treatment** | **Control** | | Batalla-Martin et al. (2023)37 | Quality of life (ED-5Q VAS) | Baseline  Post-treatment  Three months | 54.8 (19.6); n = 20  64.1 (20.8); n = 20  66.9 (14.0); n = 20 | 56.9 (13.3); n = 20  49.6 (16.5); n = 20  47.8 (13.60); n = 20 | | Freeman et al., (2015)24 | Psychological recovery (CHOICE)  Quality of life (ED-5D-5L)  Fatigue (MFI)  Mental wellbeing (WEMWBS) | Baseline  Post-treatment  Three months  Baseline  Post-treatment  Three months  Baseline  Post-treatment  Three months  Baseline  Post-treatment  Three months | 52·2 (21·1); n = 23  58·0 (22·7); n = 22  60·0 (22·8); n = 21  0·55 (0·23); n = 24  0·63 (0·25); n = 22  0·63 (0·27); n = 22  43·8 (16·4); n = 23  29·1 (19·0); n = 22  25·9 (21·4); n = 21  35·3 (9·3); n = 24  36·1 (10·7); n = 22  39·4 (9·9); n = 21 | 55·0 (14·4); n = 26  49·9 (18·3); n = 24  57·5 (21·8); n = 23  0·60 (0·22); n = 26  0·55 (0·22); n = 24  0·58 (0·20); n = 25  47·6 (15·3); n = 26  45·4 (19·6); n = 24  38·4 (18·1); n = 25  37·0 (7·8); n = 26  34·0 (8·9); n = 24  34·7 (7·9); n = 25 | | Sheaves et al., (2018)25 | Suicidal ideation (BSS)  Psychological distress (CORE-10)  Quality of life (ED-5Q)  Mental wellbeing (WEMWBS)  Mania (YMRS) | Baseline  Post-treatment  Two weeks  Ten weeks  Baseline  Post-treatment  Two weeks  Ten weeks  Baseline  Post-treatment  Two weeks  Ten weeks  Baseline  Post-treatment  Two weeks  Ten weeks  Baseline  Post-treatment  Two weeks  Ten weeks | 4.6 (8.3); n = 20  0.8 (3.3); n = 20  1.1 (4.6); n = 19  1.3 (3.5); n = 16  19.9 (8.4); n = 20  10.4 (5.6); n = 20  9.9 (6.4); n = 19  11.7 (8.0); n = 16  4.4 (2.9); n = 20  2.3 (2.7); n = 20  2.3 (2.1); n = 19  2.6 (3.6); n = 16  39.8 (15.4); n = 20  47.4 (10.5); n = 20  48.3 (11.7); n = 19  48.3 (12.3); n = 16  14.6 (9.8); n = 20  9.4 (6.8); n = 20  8.1 (8.3); n = 19  5.4 (6.4); n = 16 | 6.7 (10.1); n = 20  3.6 (8.7); n = 20  3.0 (6.9); n = 20  2.0 (5.9); n = 18  17.2 (9.9); n = 20  13.3 (7.4); n = 20  10.9 (6.6); n = 20  11.3 (6.2); n = 18  3.8 (3.3); n = 20  2.9 (3.4); n = 20  1.7 (2.1); n = 20  1.8 (2.1); n = 18  42.3 (13.1); n = 20  44.8 (13.4); n = 20  45.6 (10.3); n = 20  44.4 (12.9); n = 18  13.9 (6.2); n = 20  11.2 (6.6); n = 20  7.8 (6.4); n = 20  7.8 (6.7); n = 18 | | Sheaves et al., (2019)26 | Suicidal ideation (BSS)  Anxiety (DASS-21 anxiety)  Depression (DASS-21 depression)  Stress (DASS-21 stress)  Dissociation (DES-B)  Mental wellbeing (WEMWBS) | Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months | 17.7 (7.7); n = 12  15.5 (7.7); n = 12  15.8 (7.8); n = 11  10.8 (5.1); n = 12  7.4 (5.8); n = 12  7.6 (5.3); n = 11  13.2 (5.5); n = 12  10.8 (7.0); n = 12  11.5 (5.8); n = 11  11.8 (4.0); n = 12  9.0 (5.6); n = 12  10.4 (6.2); n = 11  1.7 (0.7); n = 12  1.5 (0.9); n = 12  1.2 (1.0); n = 11  38.6 (7.5); n = 12  44.5 (12.2); n =12  44.1 (12.4); n = 11 | 18.8 (7.1); n = 12  16.8 (7.3); n = 10  16.7 (10.1); n = 9  14.5 (5.2); n = 12  13.3 (5.4); n = 10  11.0 (4.6); n = 9  14.3 (5.7); n = 12  13.8 (6.5); n = 10  10.6 (5.3); n = 9  15.5 (3.7); n = 12  15.9 (3.1); n = 10  13.3 (5.1); n = 9  2.1 (0.8; n =12  2.4 (0.6); n = 10  1.9 (0.8); n = 9  34.0 (9.7); n = 12  34.2 (10.4); n = 10  41.0 (9.9); n = 9 | | Waite et al., (2023)27 | Suicidal ideation (CSSRS)  Negative schemas (BCSS-negative)  Positive schemas (BCSS-positive)  Anxiety (DASS-21 anxiety)  Depression (DASS-21 depression)  Stress (DASS-21 stress)  Worry (DWQ)  Quality of life (EQ-5D-5L-Index)  Quality of life (EQ-5D-5L-VAS)  Agoraphobic avoidance (O-AS-A)  Agoraphobic distress (O-AS-D)  Depression (PHQ-15)  Recovery (QPR)  Quality of life (ReQol)  Functioning (WSAS) | Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months  Baseline  Post-treatment  Six months | 2·1 (1·5); n=21  1·2 (1·3); n=18  0·9 (1·3); n=18  15·2 (5·4); n=21  9·5 (6·8); n=19  7·9 (6·1); n=21  5·2 (4·2); n=21  9·8 (4·5); n=19  10·2 (5·6); n=21  26.0 (10.1); n = 21  15.9 (13.3); n = 19  15.9 (13.3); n = 19  30.4 (10.5); n = 21  19.5 (13.4); n = 19  14.7 (10.2); n = 21  29.1 (8.9); n = 21  19.5 (12.7); n = 19  20.3 (12.4); n = 21  34·8 (6·5); n=21  25·9 (12·3); n=19  21·4 (12·3); n=21  0.5 (0.3); n = 21  0.6 (0.3); n = 19  0.6 (0.3); n = 21  48.1 (24.3); n = 21  61.4 (24.4); n = 19  68.0 (22.6); n = 21  3·0 (2·4); n=21  2·2 (2·4); n=19  1·1 (1·9); n=20  42·8 (23·2); n=21  31·2 (23·9); n=19  20·4 (19·1); n=21  15.4 (4.4); n = 21  11.7 (7.1); n = 19  10.8 (5.5); n = 20  28·9 (13·5); n=21  34·7 (11·6); n=19  36·6 (10·7); n=21  20·3 (8·1); n=21  39·8 (18·8); n=19  44·6 (14·3); n=21  27·4 (6·0); n=21  18·3 (12·0); n=19  11·1 (9·2); n=20 | 1·5 (1·7); n=19  1·4 (1·9); n=16  1·0 (1·6); n=16  12·6 (8·0); n=19  10·4 (7·2); n=17  9·7 (6·6); n=17  6·7 (4·2); n=19  7·9 (5·2); n=17  9·1 (6·1); n=17  20.3 (12.6) n = 19  17.9 (14.0); n = 17  18.6 (11.4); n = 16  27.5 (12.4); n = 19  21.3 (14.6); n = 17  19.8 (14.8); n = 16  25.1 (9.6); n = 19  23.4 (12.3); n =17  22.4 (10.3); n = 16  29·8 (9·7); n=19  24·9 (13·5); n=17  26·2 (10·7); n=17  0.5 (0.3); n = 19  0.5 (0.3); n = 17  0.5 (0.3); n = 17  55.1 (24.8); n = 19  57.4 (27.8); n = 17  60.9 (18.6); n = 17  2·0 (2·2); n=17  2·4 (2·3); n=17  1·3 (1·6); n=17  35·9 (19·7); n=18  35·6 (20·5); n=17  30·9 (20·5); n=15  13.8 (6.1); n = 19  12.6 (6.0); n = 17  11.8 (6.4); n = 17  28·2 (13·5); n=19  31·2 (13·7); n=17  31·9 (11·1); n=17  28·5 (16·3); n=19  35·4 (17·4); n=16  32·1 (17·2); n=17  22·4 (9·5); n=19  22·4 (13·0); n=17  19·8 (9·5); n=19 | | Hwang et al., (2019)28\* | Anxiety (ASI)  Depression (BDI) | Baseline  Post-treatment  One month  Baseline  Post-treatment  One month | 18.4 (2.4); n = 31  15.2 (2.3); n = 31  13.0 (2.1); n = 31  16.4 (2.2); n = 31  10.9 (1.6); n = 31  9.0 (1.6); n = 31 | 15.3 (2.4); n = 32  16.0 (2.3); n = 32  16.1 (2.0); n = 32  12.2 (2.1); n = 32  13.3 (1.6); n = 32  13.4 (1.6); n = 32 | | Bradley et al., (2018)29 | Anxiety (DASS-21 anxiety)  Depression (DASS-21 depression)  Stress (DASS-21 stress)  Mental wellbeing (WEMWBS)  Functioning (WSAS) | Baseline  Post-treatment  One month  Baseline  Post-treatment  One month  Baseline  Post-treatment  One month  Baseline  Post-treatment  One month  Baseline  Post-treatment  One month | 8.2 (4.7); n = 11  6.2 (3.8); n = 10  7.3 (5.9); n = 11  12.0 (6.0); n = 11  8.3 (6.5); n = 10  7.8 (7.8); n = 11  12.2 (4.8); n = 11  8.2 (6.1); n = 11  8.2 (5.7); n = 11  35.4 (7.9); n = 11  41.1 (6.2); n = 11  42.1 (8.1); n = 11  24.2 (7.5); n = 11  18.6 (9.5); n = 11  16.6 (10.4); n = 11 | None | | Haynes et al., (2011)30 | None |  |  |  | | Holmes et al., (1995)31 | None |  |  |  | | Myers et al., (2011)32 | Anxiety (DASS-21 anxiety)  Depression (DASS-21 depression) | Baseline  Post-treatment  One month  Baseline  Post-treatment  One month | 21.80 (9.05); n = 15  11.73 (9.65); n = 15  13.47 (10.53); n = 15  23.13 (15.41); n = 15  12.87 (14.37); n = 15  16.07 (15.88); n = 15 | None | | Novak et al., (2020)33 | None |  |  |  | | Waters et al., (2020)34 | Impulsivity (BIS)  Quality of life (MANSA)  Anxiety and depression (PHQ-4) | Baseline  Post-treatment  Baseline  Post-treatment  Baseline  Post-treatment | 18.7 (18.5); n = 50  17.9 (3.6); n = 40  37.3 (9.5); n = 50  38.0 (8.7); n = 40  6.5 (6.6); n = 50  4.8 (3.3); n = 40 | Not reported | | Taylor et al., (2022)35 | Anxiety (DASS-21 anxiety)  Depression (DASS-21 depression)  Stress (DASS-21 stress)  Mental wellbeing  (WEMWBS)  Functioning (WSAS) | Baseline  Post-treatment  Baseline  Post-treatment  Baseline  Post-treatment  Baseline  Post-treatment  Baseline  Post-treatment | 10.36 (8.85); n = 11  7.64 (6.31); n = 11  19.82 (13.58); n = 11  14.18 (13.43); n = 11  18.55 (10.28); n = 11  16.00 (10.81); n = 11  40.18 (12.05); n = 11  43.36 (12.52); n = 11  23.18 (11.37); n = 11  20.18 (11.19); n = 11 | None | | *Note: This table reports data assessed by other clinical outcome measures in the treatment and control groups at each time-point. Data are presented as mean, (SD), and number of participants completing the outcome measure.*  *For Hwang et al.'s study* 28 *study, the asterisk (\*) indicates to treat their findings with caution given the unusually small standard deviations.*  *The Measures column in the table states the clinical symptom that was assessed, followed by the assessment measure in brackets. Assessment measures include: Anxiety Sensitivity Index (ASI)* 68*; Barratt Impulsiveness Scale - Brief (BIS)* 69*; Brief Core Schema Scale (BCS*  *S)* 70*; Beck Depression Inventory (BDI)* 71*; Beck Suicide Scale (BSS)* 72*; CHoice of Outcome In CBT for psychoses (CHOICE)* 73*; Clinical Outcomes in Routine Evaluation 10-item scale (CORE-10)* 74*; Columbia Suicide Severity Rating Scale (CSSRS)* 75*; Depression Anxiety and Stress Scale–21-item (DASS-21)* 76 *version with subscales for anxiety (DASS-21 anxiety), depression (DASS-21 depression) and stress (DASS-21 stress); Brief Dissociative Experiences Scale (DES-B)* 77*; Dunn Worry Questionnaire (DWQ)* 78*; Euroqol 5D questionnaire (E*  *D-5Q)* 79*; Euroqol 5D questionnaire visual analogue scale (ED-5Q VAS)* 79*; Euroqol 5D questionnaire 5 Level version (ED-5D-*  *5L)* 80*, Manchester Short Assessment of Quality of Life (MANSA)* 81*; Multidimensional Fatigue Inventory (MFI)* 82*; Oxford Agoraphobic Avoidance Scale (O-AS)* 83*; with subscales for avoidance (O-AS-A) and distress (O-AS-D)* 84*; Patient Health Questionnare 15-item version (PHQ-15)* 85*; Brief Patient Health Questionnaire (PHQ-4)* 84*; Questionnaire about the Process of Recovery (QPR)* 8*6; Recovering Quality of Life (ReQol)* 87*; Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)* 88*; Work and Social Adjustment Scale (WSAS)* 89*; Young Mania Rating Scale (YMRS)* 90*.*  ***Supplementary 6 – List of included papers***  Batalla-Martin D., Martorell-Poveda M.-A., Belzunegui-Eraso A., Marieges Gordo A., Batlle Lleal H., Pasqual Melendez R., et al. 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Front Psychiatry. 2018 Aug 24;9:375.  ***Supplementary 7 – Quality Assessment using ‘The Measurement Tool to Assess systematic Reviews 2’ (AMSTAR)*52**  The scoring indicates a ‘high’ rating of overall confidence in the review.  ***A close-up of a questionnaire  Description automatically generated***  **A close-up of a document  Description automatically generatedA close-up of a questionnaire  Description automatically generatedA close-up of a computer screen  Description automatically generated** | | | | | |  | | | | | | | | | | | | | | |