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Comparative efficacy and acceptability of antidepressants, psychological interventions, and their combination for depressive disorder in children and adolescents: protocol for a network meta-analysis



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	analysis, systematic review

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3 **Comparative efficacy and acceptability of antidepressants, psychological interventions, and their**
4 **combination for depressive disorder in children and adolescents: protocol for a network meta-**
5 **analysis**
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18 review
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ABSTRACT

Introduction: Depressive disorder is common in children and adolescents, with important consequences and serious impairments in terms of personal and social functioning. While both pharmacological and psychological interventions have been shown to be effective, there is still uncertainty about the balance between these and what treatment strategy should be preferred in clinical practice. Therefore, we aim to compare and rank in a network meta-analysis (NMA) the commonly used psychological, pharmacological and combined interventions for depressive disorder in young people.

Methods and analysis: We will update the literature search of two previous NMAs for the identification of trials of antidepressant and psychotherapy alone for depressive disorder in children and adolescents. For identification of trials of combination interventions, seven databases (PubMed, EMBASE, CENTRAL (Cochrane Central Register of Controlled Trials), Web of Science, PsycINFO, CINAHL, LiLACS) will be searched from date of inception. We will also search ClinicalTrials.gov, the World Health Organization International Clinical Trials Registry Platform, and check relevant reports on the US FDA website for unpublished data. Building on our previous findings in the field, we will include any commonly prescribed oral antidepressants, and any manualised or structured psychotherapies, as well as their combinations. Randomised controlled trials assessing any active intervention against active comparator or pill placebo/psychological controls in acute treatment for depressive disorder in children and adolescents will be included. The primary outcomes will be efficacy (mean change in depressive symptoms), and acceptability of treatment (dropout rate due to any cause). The secondary outcomes will be remission rate, tolerability of treatment (dropouts for adverse events), as well as suicide-related outcomes (suicidal behavior or ideation). We will perform Bayesian NMAs for all relative outcome measures. Subgroup analyses and sensitivity analyses will be conducted to assess the robustness of the findings.

Dissemination: This NMA will provide the most up to date and clinically useful information about the comparative efficacy and acceptability of antidepressants, psychological intervention and their combination in

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the acute treatment of children and adolescents with depressive disorder. The results will be disseminated through peer-reviewed publication.

Protocol registration: PROSPERO CRD42015020841

For peer review only

Strengths and limitations of this study

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1. The network meta-analysis can integrate direct evidence with indirect evidence from multiple treatment comparisons and multiple control approaches to estimate the interrelations across all treatments, which can guide treatment decisions and guideline development.

2. For the first time the efficacy, acceptability, tolerability, and suicide-related outcomes of pharmacological and psychological interventions, alone or in combination for depressive disorder in children and adolescents will be comprehensively assessed in a network meta-analysis.

3. We will employ validated local and global methods to evaluate consistency and we will explore whether treatment effects are robust in network subgroup analyses and sensitivity analyses. The quality of evidence for network estimates of the primary outcomes will be assessed with the GRADE framework, which characterises the quality of a body of evidence on the basis of the study limitations, imprecision, heterogeneity or inconsistency, indirectness, and publication bias.

Background

Depressive disorder in children and adolescents is a major public health problem, affecting 1% to 2% of children (6–12 years old) and 2% to 5% of adolescents (13–18 years old), with a peak incidence around puberty.^{1,2} The course of depressive disorder in young people is often characterised by protracted episodes, frequent recurrence, and comorbid psychiatric disorders.³ Compared with adults, the identification and diagnosis of depressive disorder in children and adolescents may be more often missed by clinicians⁴ due to undifferentiated signs and symptoms and atypical presentations. Thus, many such patients exhibit serious impairments in social functioning (e.g., poor school achievement; relational problems with family members and peers),⁵ and are significantly increased risk for suicide behaviors and ideation.⁶ For example, a report from the American Academy of Child and Adolescent Psychiatry (AACAP) suggested that depressive disorder is responsible for over 500,000 suicide attempts by children and adolescents a year.⁷

The past two decades have seen significant increases in the data for children and adolescents with depression and both pharmacological and psychological therapies have been effective. Among current psychological interventions, based on our previous findings, CBT and IPT seem to be the best available psychotherapies for depression in children and adolescents.^{8,9} Multiple pharmacological therapies have also been studied for the treatment of depressive disorder in children and adolescents.^{10–12} The controversy about the use of antidepressants in this age group, due the potentially increased risk of suicidality, has not been fully resolved.¹³ Recently, the findings of our previous studies showed most antidepressants do not seem to offer a clear benefit for children and adolescents, and fluoxetine is probably the best option to consider when a pharmacological treatment is indicated.¹⁰

Several clinical practice guidelines recommend that in children and adolescents, psychotherapy should be considered as the first-line intervention for the management of depressive disorder, while pharmacological treatments are often reserved for more severe illness or when psychotherapy does not work or is not available.^{14,15} Nevertheless, the evidence-base for psychotherapy to be more effective and safer than antidepressants in the treatment of child and adolescent depressive disorder is not well established. A large, non-industry funded trial reported superior efficacy for fluoxetine compared to CBT in adolescents with

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3 major depression.¹⁶ Literature supports the notion that psychotherapy has its own side-effects.¹⁷ However,
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5 unlike with antidepressants, they are rarely measured systematically, making the comparison of safety and
6
7 tolerability harder.¹⁸ Moreover, data from the adult studies showed that combination antidepressants and
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9 psychotherapy is superior to either intervention alone.^{19,20} Recently, a Cochrane conventional meta-analysis,
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11 on the basis of the very limited evidence, reported that the effectiveness of psychological interventions,
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13 antidepressant medication and a combination of these interventions for treating depressive disorders in
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15 children and adolescents cannot be established.²¹
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19 Network meta-analysis has the advantage that all interventions that have been tested in randomised
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21 controlled trials (RCTs) can be simultaneously compared, without requiring direct within-study treatment vs.
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23 treatment comparisons. Thus effects of the different treatments can be estimated relative to each other as well
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25 as to a common reference condition (e.g., pill placebo or psychological controls).²² Network meta-analysis thus
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27 overcomes some of the limitations of traditional meta-analysis, in which conclusions are largely restricted to
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29 comparisons between treatments that have been directly compared in RCTs.²³ In our two previous network
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31 meta-analyses the comparative efficacy and acceptability of psychotherapies and antidepressants for
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33 depressive disorder in children and adolescents have been separately investigated.^{8,10} The aim of the current
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35 protocol is to synthesise all this evidence and provide clinicians with a reliable treatment algorithm of the
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37 commonly used psychological, and pharmacological interventions, as well as their combinations for the acute
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39 treatment of depressive disorder in children and adolescents.
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45 **Methods**

46 *Criteria for included studies*

47 **Types of studies**

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49 Any randomised controlled trials (RCTs), including the first phase of cross-over trials as well as cluster-
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51 randomised trials, will be included. Quasi-randomised trials (e.g., those allocating participants using alternate
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53 days of the week) will be excluded. For trials of antidepressants alone, only double-blind RCTs (patients and
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55 raters blinded) will be included. As it is difficult to utilise a double-blind design for patients in trials of
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psychotherapy alone or the combination of antidepressant and psychotherapy, we will only include trials in which raters were blinded or participants were assessed by self-rating depression scales.

Types of participants

We will include studies that enrolled participants aged less than 18 years of age when they are initially enrolled in the studies, of both sexes with a diagnosis of depressive disorder based on standardised diagnostic criteria (e.g., the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases).²⁴⁻²⁹ While it is accepted that subclinical depression still has a significant impact on an individuals' social and educational functioning, we will not include studies of this population. Similarly, studies where depressive disorder was not formally diagnosed will also be excluded for the same rationale that its clinical heterogeneity could violate the transitivity assumption in NMA (i.e. one can compare indirectly intervention B and C via intervention A).³⁰ We will also exclude trials in which participants are described as having psychotic depression or treatment-resistant depression, as their treatment response differs from patients without treatment resistance or symptoms of psychosis. Trials focusing on child or adolescent bipolar disorder will also be excluded, but not those involving patients with other comorbid psychiatric disorders (e.g., anxiety disorder). Where a study includes both adults and children/adolescents and the randomisation had been stratified according this variable, the data will be included if data on the depressed youths can be separately extracted from the manuscript, or can be obtained from the authors. Studies conducted in both inpatient and outpatient settings will be included. RCTs recruiting participants with an overall sample size of fewer than ten patients will be excluded.

Types of interventions

For pharmacological interventions, we will include any commonly prescribed oral antidepressants (fixed or flexible doses). These will include tricyclic antidepressants (TCAs; amitriptyline, clomipramine, nortriptyline, desipramine, imipramine, etc.), selective serotonin reuptake inhibitors (SSRIs; escitalopram, fluoxetine, paroxetine, sertraline, etc.), and serotonin-norepinephrine reuptake inhibitors (SNRIs; venlafaxine,

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4 duloxetine), as well as novel agents mirtazapine and nefazodone. In terms of psychological interventions, we
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6 will include any manualised or structured psychotherapies, e.g., behavioral therapy, cognitive-behavioral
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8 therapy, cognitive therapy, family therapy, interpersonal therapy, play therapy, problem-solving therapy,
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10 psychodynamic therapy, and supportive therapy. Table 1 provides the detailed description of
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12 psychotherapies. Also, we will include the combination of both above-mentioned psychological interventions
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14 and pharmacological interventions. For the pharmacological interventions, the control condition always is pill
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16 placebo, and these for psychological control conditions will include waiting-list (WL), treatment as usual
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18 (TAU), psychological placebo or attention placebo, as well as no-treatment (NT).
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23 All RCTs comparing any active intervention (psychological interventions, pharmacological interventions,
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25 or their combinations) with either active comparators or control conditions for acute treatment of depressive
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27 disorder in children and adolescents will be included. The acute phase will be defined as from 4 to 16 week.
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29 We will exclude trials with treatment duration of less than 4 weeks, because the onset of benefit for most
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31 antidepressants often takes at least 4 weeks. If a study present data for more than one time point within our
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33 pre-defined acute phase window or beyond 16 weeks, the 8-week (or the closest to 8-week) will be taken as
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35 the time. Trials comparing the same antidepressant at different therapeutic doses will be merged in the same
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37 node in the network analysis so long as they are within the dose range licensed by drug regulatory agencies.
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39 Also, trials comparing the same type of psychological interventions but at different numbers of therapeutic
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41 sessions, different delivery format (group, individual), different treatment medium (face-to-face, internet-
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43 based), and different treatment conditions (with or without family involvement) will be considered as the
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45 same node in the network analysis. We anticipate that any patient who meets all inclusion criteria, in
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47 principal, is equally likely to be randomised to any of the interventions in the synthesis comparator set.
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51 We have generated an ideal network plot that is a fully connected network with all expected
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53 interventions (Figure 1).
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56 57 58 **Types of outcome measures** 59 60

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Primary outcomes

- (1) Efficacy (as a continuous outcome), measured by the overall mean change scores on depressive symptom scales (self- or assessor-rated), e.g., Children's Depression Rating Scale (CDRS-R)³¹ and Hamilton Depression Rating Scale (HAMD)³² from baseline to endpoint.
- (2) Acceptability of treatment, defined as the proportion of patients who drop out of the study by any cause during the delivery of the intervention.

Secondary outcomes

- (1) Efficacy (as dichotomous outcome), measured by the total number of patients who achieved the criteria of remission, defined as being below the threshold in depression rating score (e.g., less than 28 for CDRS-R),³³ while these thresholds are different across trials.
- (2) Tolerability of treatment, defined as the proportion of patients who discontinued treatment due to any adverse events during the delivery of the intervention.
- (3) Suicide-related outcome, estimated by the reported cases of definitive suicidal behavior or suicidal ideation during the acute phase of treatment. The definition of suicide-related outcome is based on the Columbia Classification Algorithm of Suicide Assessment (C-CASA).³⁴ For the antidepressants trials, the data on suicidality mainly referred to the Columbia re-analysis data reported in the FDA report.³⁵ If trials are not included in this report, we will attempt to extract the data on suicide-related outcome from the Medicines and Healthcare products Regulatory Agency database or the pharmaceutical company website. For the psychological trials and the combination trials, we will mainly extract the data on suicidality from original text, and from related reviews.
- (4) Global functional improvement, estimated by overall change scores on global assessment of functioning scales, e.g., Children's Global Assessment Scale (CGAS)³⁶ and Global Assessment of Functioning Scale (GAF),³⁷ or quality of life scales, e.g., Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q).³⁸ When data are reported on more than one measure, we will first chose data from the CGAS, then the GAF, and finally the Q-LES-Q and others.

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6 Where depression symptoms are measured using more than one depression scale in a trial, we will
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8 extract data from the depressive scales on the basis of a hierarchy of rating scales. The hierarchy will be based
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10 on psychometric properties and appropriateness for use with children and adolescents and for consistency of
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12 use across trials (referred from the Zhou et al study³⁹, Table 2). We will also establish a hierarchy of
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14 informants of depressive rating scales, with the clinician report first in the hierarchy, and then the child or
15
16 adolescent self-report.
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18 **Data Sources and Search strategy**

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20 For the identification of trials of antidepressant and psychotherapy alone for depressive disorder in
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22 children and adolescents, we will update the literature search of our two previous network meta-analyses.^{8,10}
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24 Other eligible trials of the combinations of antidepressant and psychotherapy will be identified by searching
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26 PubMed, EMBASE, CENTRAL (Cochrane Central Register of Controlled Trials), Web of Science, PsycINFO,
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28 ProQuest, CINAHL, LiLACS from date of inception with Medical Subject Headings (MeSH) and text words:
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30 (depress* or dysthymi* or mood disorder* or affective disorder*) and (adolesc* or child* or boy* or girl* or
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32 juvenil* or minors or paediatric* or pediatric* or pubescen* or school* or student* or teen* or young or youth*)
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34 and (“selective serotonin reuptake inhibitor*” or SSRIs or “serotonin norepinephrine reuptake inhibitor*” or
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36 SNRIs or citalopram or fluoxetine or paroxetine or sertraline or escitalopram or fluvoxamine or venlafaxine or
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38 duloxetine “noradrenergic and specific serotonergic antidepressants” or NaSSA or mirtazapine or TCA or
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40 tricyclic or amitriptyline or clomipramine or desipramine or imipramine or nortriptyline) and
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42 (psychotherapy* or behavio* or “family therap*” or CBT or cognitive or interpersonal or IPT or “play therap*”
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44 or supportive or problem-solving or psychodynamic). We will also search ClinicalTrials.gov in USA and other
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46 international trial registers via the International Clinical Trials Registry Platform (ICTRP) in WHO. We will
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48 also check relevant reports on the US Food and Drug Administration (FDA) website, and hand-search key
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50 journals, conference proceedings, such as, *J Child Adolesc Psychopharmacol*, *J Am Acad Child Adolesc Psychiatry*,
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52 *Child Adolesc Psychiatry Ment Health*, *Psychopharmacol Bull*, *Arch Gen Psychiatry*, *Am J Psychiatry*, *Eur Psychiatry*,
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54 *Depress Anxiety*. There will be no restrictions on language, or publication year. Additional relevant studies
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3 will be obtained by scanning reference lists of trials identified in the initial searches and relevant review
4 papers. We will also inquire at the relative pharmaceutical companies (e.g., GlaxoSmithKline, Lilly, Organon,
5 Forest Pharmaceuticals, Bristol-Myers Squibb) and search their websites for unpublished data. All relevant
6 experts and principal manufacturers will be contacted to supplement incomplete reports of the original
7 papers or to provide new data for unpublished studies.
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10 11 12 13 14 15 16 17 **Study selection and data extraction**

18 *Selection of trials*

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20 Titles and abstracts identified from the search strategies will be independently examined by two
21 reviewers (XZ and YZ). If both reviewers judge that the trial does not meet eligibility criteria, we will exclude
22 it. Then, we will obtain the full-texts of all remaining articles and determine whether to include them
23 according to inclusion criteria described above. We will calculate the inter-rater reliability of the two raters.
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25 Any disagreements will be resolved by a third review author (AC or PX) or by consultation with the authors
26 of the articles. The reasons for exclusion of trials will be reported in the characteristics of excluded studies list.
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36 *Data extraction*

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38 Two independent reviewers (XZ and YZ) will extract the data from each included trial using
39 standardised data extraction forms, including study characteristics (e.g., first listed author, publication year,
40 title, publication type, publication journal, country, and sponsor), patient characteristics (e.g., diagnostic
41 criteria, comorbidities, the age of patients, patient setting, the number of patients, the gender of patients, and
42 severity of depression at baseline), intervention details (e.g., the type of intervention, the treatment duration,
43 the dose of antidepressant agent, the length and number of sessions of psychotherapy, treatment delivery and
44 treatment medium of psychotherapy) and outcome measures (primary outcomes and secondary outcomes).
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46 We will assess and report the reliability of the reviewers' data extraction on each coded variable. Any
47 disagreements will be resolved by a third review author (AC or PX). Where necessary, the authors of the
48 studies will be contacted for further information.
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Risk of bias assessment

We will assess risk of bias as “low risk”, “unclear risk”, or “high risk”, in accordance with the Cochrane Collaboration’s Risk of bias tool as described in the Cochrane Hand book for Systematic Reviews of Interventions.⁴⁰ The following items will be assessed: sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessors, incomplete outcome data, selective outcome reporting, and other sources of bias (e.g., sponsorship bias/researcher allegiance bias). Two independent review authors (XZ and YZ) will assess the risk of bias in selected studies. Degree of agreement between the two independent raters will be reported. Any disagreements will be resolved by a third review author (AC or PX). Where necessary, the authors of the studies will be contacted for further information. Studies will be classified as having high risk of bias if two or more domains were rated as high risk of bias; low if five or more were rated as low risk of bias and none was rated as high risk of bias, and all other cases will be assumed to pertain to moderate risk.

Statistical analysis

Network meta-analysis combines direct and indirect evidence for all relative treatment effects and provides estimates with maximum power.²³ First, we will perform pairwise meta-analyses of direct evidence using the random-effects model with STATA version 14.0. Second, we will also perform a random-effects network meta-analysis (NMA) within a Bayesian framework using Markov chain Monte Carlo in WinBUGS version 1.4.3. Where different measures are used to assess the same outcome, continuous outcomes data will be pooled with standardised mean difference (SMD), and dichotomous outcomes will be analysed by calculating the odds ratio (OR). In the presence of minimally informative priors, Credible Intervals (CrIs) can be interpreted similarly to confidence intervals (CIs).

Missing dichotomous outcome data will be managed according to the intention to treat (ITT) principle, and all the dropouts after randomisation will be considered to be non-responders. Missing continuous outcome data will be analysed using the completer data. When p-values, t-values, confidence intervals or

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3 standard errors are reported in articles, SD will be calculated from their values.⁴¹ Where SDs are missing,
4 attempts will be made to obtain these data through contacting trial authors. When this fails, they will be
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6 borrowed from the other trials in the network or from other published reports.⁴¹
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10 In the analysis of network meta-analysis, the pooled estimates will be obtained using the Markov Chains
11 Monte Carlo method. Two Markov chains will be run simultaneously with different arbitrarily chosen initial
12 values and non-informative priors will be used for the parameters. To ensure convergence, trace plots and the
13 Brooks-Gelman-Rubin statistic will be assessed.⁴² We will also estimate the ranking probabilities for all
14 treatments of being at each possible rank for each intervention. Then, we will obtain a treatment hierarchy
15 using the surface under the cumulative ranking curve (SUCRA) and mean ranks. SUCRA can also be
16 interpreted as the percentage of efficacy/safety of a treatment that would be ranked first without
17 uncertainty.⁴³
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30 *Measures for transitivity assumption*

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32 We will assess whether the included interventions are similar when they are evaluated in RCTs with
33 different designs; and whether the distributions of clinical and methodological variables that can act as effect
34 modifiers across treatment comparison are balanced across comparisons. The clinical features, which have
35 been demonstrated to date to moderate efficacy of antidepressants and psychotherapy in children and
36 adolescents include bipolarity,⁴⁴ psychotic features,⁴⁵ subthreshold depression.⁴⁶ We have assured transitivity
37 in our network with regard to these variables by limiting our samples to participants with non-psychotic
38 unipolar depressive disorders. Other clinical or methodological variables that may influence our primary
39 outcomes of treatment efficacy or acceptability include: age, sex, depressive severity at baseline, and the
40 treatment duration.
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51 *Measures for heterogeneity*

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53 In standard pairwise meta-analyses we will estimate a different heterogeneity variance for each pairwise
54 comparisons; in network meta-analysis we will assume a common estimate for the heterogeneity variance
55 across the different comparisons. We will assess statistically the presence of heterogeneity within each
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3 pairwise comparison using the I-squared statistic⁴⁷ and its 95% confidence interval that measures the
4 percentage of variability that cannot be attributed to random error. The assessment for the presence of
5 statistical heterogeneity in the entire network will be based on the magnitude of the heterogeneity variance
6 parameter (τ^2) estimated from the NMA models. We will also estimate a total I-squared value and predictive
7 intervals for heterogeneity in the network.⁴⁸
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10 11 12 13 14 15 16 17 *Measures for inconsistency*

18 NMA assumes that there is consistency in the network (i.e. direct and indirect evidence are in
19 agreement). However, the assumption of consistency can be violated either in the entire network or in certain
20 parts (i.e. loops of evidence) of the network.⁴⁹ Therefore, consistency needs to be checked. We will evaluate
21 the presence of local inconsistency and global inconsistency in STATA version 14.0 and will be duplicated in
22 R software.⁵⁰
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32 *Measures for publication bias*

33 We will use the contour-enhanced funnel plot and Egger's test to assess risk of publication bias within
34 each pairwise comparison.⁵¹ We will also use the comparison-adjusted funnel plots of all trials with placebo
35 controls or inactive controls to investigate whether results in imprecise trials differ from those in more precise
36 trials in network meta-analysis.⁵²
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45 *Subgroup analyses and sensitivity analyses*

46 Where possible, we will conduct the network meta-regression meta-analyses of data on primary
47 outcomes for the: (i) age of participants (children vs. adolescents); (ii) sex ratio; (iii) the severity of depressive
48 symptoms at baseline; and (iv) the treatment duration. If possible, we will do some extra subgroup analyses
49 according to the results of heterogeneity and inconsistency. In the sensitivity analysis, trials where missing
50 data have been imputed will be excluded, and trials where high risk of bias rating have been assessed will be
51 excluded. And, we will not only test whether the results change but also if transitivity (consistency/model fit)
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3 is affected. We will also examine some variables (e.g., sample size of trials⁵³), as continuous measure in meta-
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5 regression analyses.
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8 9 10 *GRADE quality assessment*

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12 We will also assess the quality of evidence contributing to primary outcomes with the GRADE
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14 framework, which characterises the quality of a body of evidence on the basis of the study limitations,
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16 imprecision, heterogeneity or inconsistency, indirectness, and publication bias.⁵⁴ The starting point for
17
18 confidence in each network estimate is high, but will be downgraded according to the assessments of these
19
20 five aspects.
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23 24 25 *Ethics and dissemination*

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28 This network meta-analysis does not need ethical approval, as data used here are based on aggregated
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30 data in the public domain. Findings from the analysis will provide an overview and information on the
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32 relative efficacy and acceptability of antidepressant medications, psychological therapies, and their
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34 combination for depressive disorder in children and adolescents. It is suggested that the findings will have
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36 significant implications for clinical practice and further research.
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4 **Contributors** PX, AC, and XZ conceived the study and drafted the protocol. PX, AC and XZ wrote the first
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6
7 draft of the manuscript. PC, SEH, JRW, CDG, TAF, JB, DC, SL, AVR assisted in protocol design and revision.
8
9
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25
26
27 about quetiapine extended release. SEH is an Editor of the Cochrane Common Mental Disorders Group, an
28
29
30 author of the Cochrane systematic review of newer generation antidepressants for depression in children and
31
32
33 adolescents, and an author (senior) on the Cochrane review of psychological, pharmacological and their
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36 combination for child/adoles depression. DC reports grants and personal fees from Shire; personal fees from
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TABLES

Table 1 Description of Psychotherapeutic interventions and control conditions

Interventions	Abbreviation	Description
<i>Psychotherapeutic Intervention:</i>		
Behavioral therapy	BT	BT uses some kind of behavioral training and psychoeducation. BT programs provide parents and youths information about MDD and interventions; teach youths to monitor their mood, thoughts and behaviors; proposed pleasant activity scheduling and behavioral activation.
Cognitive-behavioral therapy	CBT	CBT is a combination of BT and CT. Additional CBT skill-building techniques are used in many programs by teaching relaxation techniques to cope with environmental stressors, providing social skills and resolution training, and teaching general problem-solving.
Cognitive therapy	CT	CT uses some kind of cognitive restructuring training. CT programs ask youths to examine their automatic thoughts and core schemas and to assess the accuracy and affective consequences of their views. They aim to teach youths to engage in "rational" thinking about themselves, the world and their possibilities for the future.
Family therapy	FT	FT works with families to nurture change and development. FT tends to view change in terms of the systems of interaction between family members. In the case of youth with MDD, FT aims at helping the family to answer the child's needs for completing age-appropriate developmental tasks to relieve depression.
Interpersonal therapy	IPT	IPT aim at educating patients as to how their depression and the quality of interpersonal relationships affect one another and at addressing interpersonal problems that may be contributing to the depression (e.g. grief, disputes, role transitions, social deficits). Compared to its adult version, IPT in youths is shorter, involves parents, and adds a liaison role for the therapist between schools and families.
Play therapy	PT	PT used techniques to engage participants in recreational activities to help them cope with their problems and fears.
Problem-solving therapy	PST	PST focus on the problems participants are currently facing and on helping them find solutions to those problems.
Psychodynamic therapy	DYN	DYN proposed patients to help understand the origin and nature of long standing problems by investigating both conscious and non-conscious thoughts and emotional feelings. DYN uses free associations and interpretation of dreams (or drawing in children), and addresses how personal history and experience may alter the patient/therapist transference. In youth MDD, a particular interest is given to psychological trauma, early

parent/child relationships, narcissistic organization and experiences of loss.

Supportive therapy SUP
 SUP is an unstructured therapy without specific psychological techniques that it helped people to ventilate their experiences and emotions and offering empathy. These therapies are commonly described in the literature as either counseling or supportive therapy.

Control conditions:

No-treatment NT
 NT is a control condition in which the participants receive no active treatment during the study and in which they do not expect to receive such after the study is over.

Psychological placebo PBO
 PBO is a control condition that was regarded as inactive by the researchers but was to be the participants.

Treatment-as-usual TAU
 TAU is not considered to be structured psychotherapy but may have some treatment effects.

Waitlist WL
 WL is a control condition in which the participants receive no active treatment during the study but are forewarned that they can receive one after the study period is over.

Table 2 Hierarchy of depression symptom severity measurement scales

Hierarchy	Depression symptom severity measurement scales	Abbreviation
1	Children's Depression Rating Scale	CDRS
2	Hamilton Depression Rating Scale	HAMD
3	Montgomery Asberg Depression Rating Scale	MADRS
4	Beck Depression Inventory	BDI
5	Children's Depression Inventory	CDI
6	Schedule for Affective Disorders and Schizophrenia for School Aged Children	K-SADS
7	Mood and Feeling Questionnaire	MFQ
8	Reynolds Adolescent Depression Scale	RADS
9	Bellevue Index of Depression	BID
10	Child Depression Scale	CDS
11	Centre for Epidemiologic Studies Depression Scale	CESD
12	Child Assessment Schedule	CAS
13	Child Behavior Checklist-Depression	CBCL-D

Figure 1. Possible interventions eligible for the ideal network plot

For peer review only

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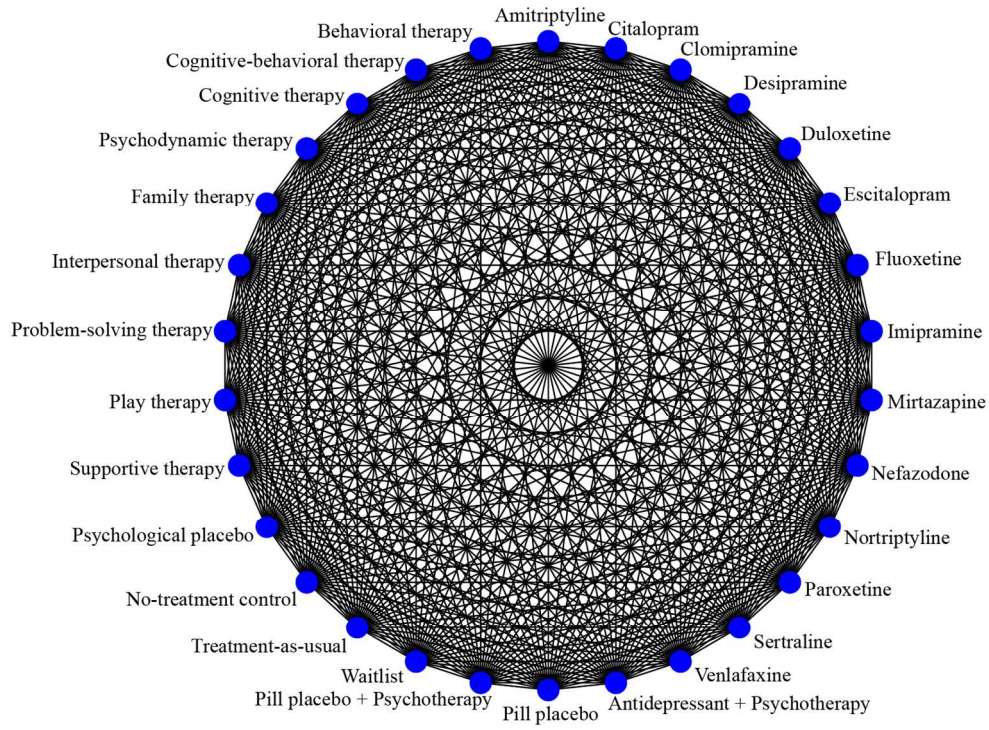


Figure 1. Possible interventions eligible for the ideal network plot

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Review only

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

Section and topic	Item No	Checklist item	Reported on Page #
ADMINISTRATIVE INFORMATION			
Title:			
Identification	1a	Comparative efficacy and acceptability of antidepressants, psychological interventions, and their combination for depressive disorder in children and adolescents: protocol for a network meta-analysis	1
Update	1b	None	
Registration	2	PROSPERO CRD42015020841	4
Authors:			
Contact	3a	Xinyu Zhou, Yuqing Zhang, Juncai Pu, Lining Yang, Peng Xie (Department of Neurology and Psychiatry, The First Affiliated Hospital of Chongqing Medical University, Chongqing, China; Institute of Neuroscience and the Collaborative Innovation Center for Brain Science, Chongqing Medical University, Chongqing, China) Andrea Cipriani (Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford, UK) Pim Cuijpers (Department of Clinical, Neuro and Developmental Psychology, Amsterdam Public Health research institute, Vrije Universiteit Amsterdam, The Netherlands) Sarah E. Hetrick (Orygen, The National Centre of Excellence in Youth Mental Health, and the Centre of Youth Mental Health, University of Melbourne, Melbourne, Australia) John R. Weisz (Department of Psychology, Harvard University, Cambridge, MA, USA) Cinzia Del Giovane (Department of Diagnostic, Clinical and Public Health Medicine, University of Modena and Reggio Emilia, Modena, Italy) Toshiaki A. Furukawa (Department of Health Promotion and Human Behavior, Kyoto University Graduate School of Medicine and School of Public Health, Kyoto, Japan) Jürgen Barth (Institute of Complementary and Integrative Medicine, University Hospital and University of Zurich, Zurich, Switzerland) David Coghill (Departments of Paediatrics and Psychiatry, University of Melbourne, Melbourne, Australia) Stefan Leucht (Department of Psychiatry and Psychotherapy, Technische Universität München, Munich, Germany) Arun V Ravindran (Department of Psychiatry, University of Toronto, Toronto, ON, Canada) Corresponding author :Peng Xie, Department of Neurology and Psychiatry, The First Affiliated Hospital of Chongqing Medical University, 1 Youyi Road, Yuzhong District, Chongqing 400016, China; E-mail: xiepeng973@126.com	1-2
Contributions	3b	PX, AC, and XZ conceived the study and drafted the protocol. PX, AC and XZ wrote the first draft of the manuscript. PC, SEH, JRW, CDG, TAF, JB, DC, AVR assisted in protocol design and revision. XZ, YZ, and LY participated in the search strategy	17

development. CDG, and JP participated in the design of data synthesis and analysis. All the authors have approved the publication of the protocol.

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Sponsor 5b This work is supported by the National Basic Research Program of China (973 Program) (Grant No. 2009CB918300).

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INTRODUCTION

Rationale 6 Depressive disorder in children and adolescents is a major public health problem. The course of depressive disorder in young people is often characterised by protracted episodes, frequent recurrence, and comorbid psychiatric disorders. Several clinical practice guidelines recommend that in children and adolescents, psychotherapy should be considered as the first-line intervention for the management of depressive disorder, while pharmacological treatments are often reserved for more severe illness or when psychotherapy does not work or is not available. Nevertheless, the evidence-base for psychotherapy to be more effective and safer than antidepressants in the treatment of child and adolescent depressive disorder is not well established. In our two previous network meta-analyses the comparative efficacy and acceptability of psychotherapies and antidepressants for depressive disorder in children and adolescents have been separately investigated 6

Objectives 7 The aim of the current protocol is to synthesise all this evidence and provide clinicians with a reliable treatment algorithm of the commonly used psychological, and pharmacological interventions, as well as their combinations for the acute treatment of depressive disorder in children and adolescents. 7

METHODS

Eligibility criteria 8 **Types of participants**
We will include studies that enrolled participants aged less than 18 years of age when they are initially enrolled in the studies, of both sexes with a diagnosis of depressive disorder based on standardised diagnostic criteria (e.g., the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases). While it is accepted that subclinical depression still has a significant impact on an individuals' social and educational functioning, we will not include studies of this population. Similarly, studies where depressive disorder was not formally diagnosed will also be excluded for the same rationale that its clinical heterogeneity could violate the transitivity assumption in NMA (i.e. one can compare indirectly intervention B and C via intervention A). We will also exclude trials in which participants are described as having psychotic depression or treatment-resistant depression, as their treatment response differs from patients without treatment resistance or symptoms of psychosis. Trials focusing on child or adolescent bipolar disorder will also be excluded, but not those involving patients with other comorbid psychiatric disorders (e.g., anxiety disorder). Where a study includes both adults and children/adolescents and the randomisation had been stratified according this variable, the data will be included if data on the depressed youths can be separately extracted from the manuscript, or can be obtained from the authors. Studies conducted in both inpatient and outpatient settings will be included. RCTs recruiting participants with an overall sample size of fewer than ten patients will be excluded. 7-10

Types of studies

Any randomised controlled trials (RCTs), including the first phase of cross-over trials as well as cluster-randomised trials, will be included. Quasi-randomised trials (e.g., those allocating participants using alternate days of the week) will be excluded. For trials of antidepressants alone, only double-blind RCTs (patients and raters blinded) will be included. As it is difficult to utilise a double-blind design for patients in trials of psychotherapy alone or the combination of antidepressant and psychotherapy, we will only include trials in which raters were blinded or participants were assessed by self-rating depression scales.

Types of interventions

For pharmacological interventions, we will include any commonly prescribed oral antidepressants (fixed or flexible doses). These will include tricyclic antidepressants (TCAs; amitriptyline, clomipramine, nortriptyline, desipramine, imipramine, etc.), selective serotonin reuptake inhibitors (SSRIs; escitalopram, fluoxetine, paroxetine, sertraline, etc.), and serotonin-norepinephrine reuptake inhibitors (SNRIs; venlafaxine, duloxetine), as well as novel agents mirtazapine and nefazodone. In terms of psychological interventions, we will include any manualised or structured psychotherapies, e.g., behavioral therapy, cognitive-behavioral therapy, cognitive therapy, family therapy, interpersonal therapy, play therapy, problem-solving therapy, psychodynamic therapy, and supportive therapy. Also, we will include the combination of both psychological interventions and pharmacological interventions. For the pharmacological interventions, the control condition always is pill placebo, and these for psychological control conditions will include waiting-list (WL), treatment as usual (TAU), psychological placebo or attention placebo, as well as no-treatment (NT). All RCTs comparing any active intervention (psychological interventions, pharmacological interventions, or their combinations) with either active comparators or control conditions for acute treatment of depressive disorder in children and adolescents will be included. The acute phase will be defined as from 4 to 16 week. We will exclude trials with treatment duration of less than 4 weeks, because the onset of benefit for most antidepressants often takes at least 4 weeks. If a study present data for more than one time point within our pre-defined acute phase window or beyond 16 weeks, the 8-week (or the closest to 8-week) will be taken as the time. Trials comparing the same antidepressant at different therapeutic doses will be merged in the same node in the network analysis so long as they are within the dose range licensed by drug regulatory agencies. Also, trials comparing the same type of psychological interventions but at different numbers of therapeutic sessions, different delivery format (group, individual), different treatment medium (face-to-face, internet-based), and different treatment conditions (with or without family involvement) will be considered as the same node in the network analysis. We anticipate that any patient who meets all inclusion criteria, in principal, is equally likely to be randomised to any of the interventions in the synthesis comparator set.

Types of outcome measures

Primary outcomes

- (1) Efficacy (as a continuous outcome), measured by the overall mean change scores on depressive symptom scales (self- or assessor-rated), e.g., Children's Depression Rating Scale (CDRS-R) and Hamilton Depression Rating Scale (HAMD) from baseline to endpoint.
- (2) Acceptability of treatment, defined as the proportion of patients who drop out of the study by any cause during the delivery of the intervention.

Secondary outcomes

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(1) Efficacy (as dichotomous outcome), measured by the total number of patients who achieved the criteria of remission, defined as being below the threshold in depression rating score (e.g., less than 28 for CDRS-R), while these thresholds are different across trials.

(2) Tolerability of treatment, defined as the proportion of patients who discontinued treatment due to any adverse events during the delivery of the intervention.

(3) Suicide-related outcome, estimated by the reported cases of definitive suicidal behavior or suicidal ideation during the acute phase of treatment. The definition of suicide-related outcome is based on the Columbia Classification Algorithm of Suicide Assessment (C-CASA). For the antidepressants trials, the data on suicidality mainly referred to the Columbia re-analysis data reported in the FDA report. If trials are not included in this report, we will attempt to extract the data on suicide-related outcome from the Medicines and Healthcare products Regulatory Agency database or the pharmaceutical company website. For the psychological trials and the combination trials, we will mainly extract the data on suicidality from original text, and from related reviews.

(4) Global functional improvement, estimated by overall change scores on global assessment of functioning scales, e.g., Children's Global Assessment Scale (CGAS) and Global Assessment of Functioning Scale (GAF), or quality of life scales, e.g., Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q). When data are reported on more than one measure, we will first chose data from the CGAS, then the GAF, and finally the Q-LES-Q and others.

Information sources	9	For the identification of trials of antidepressant and psychotherapy alone for depressive disorder in children and adolescents, we will update the literature search of our two previous network meta-analyses. ^{8,10} Other eligible trials of the combinations of antidepressant and psychotherapy will be identified by searching PubMed, EMBASE, CENTRAL (Cochrane Central Register of Controlled Trials), Web of Science, PsycINFO, ProQuest, CINAHL, LiLACS from date of inception with Medical Subject Headings (MeSH) and text words. We will also search ClinicalTrials.gov in USA and other international trial registers via the International Clinical Trials Registry Platform (ICTRP) in WHO. We will also check relevant reports on the US Food and Drug Administration (FDA) website, and hand-search key journals, conference proceedings, such as, J Child Adolesc Psychopharmacol, J Am Acad Child Adolesc Psychiatry, Child Adolesc Psychiatry Ment Health, Psychopharmacol Bull, Arch Gen Psychiatry, Am J Psychiatry, Eur Psychiatry, Depress Anxiety. There will be no restrictions on language, or publication year. Additional relevant studies will be obtained by scanning reference lists of trials identified in the initial searches and relevant review papers. We will also inquire at the relative pharmaceutical companies (e.g., GlaxoSmithKline, Lilly, Organon, Forest Pharmaceuticals, Bristol-Myers Squibb) and search their websites for unpublished data. All relevant experts and principal manufacturers will be contacted to supplement incomplete reports of the original papers or to provide new data for unpublished studies.	11-12
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Search strategy	10	(depress* or dysthymi* or mood disorder* or affective disorder*) and (adolesc* or child* or boy* or girl* or juvenil* or minors or paediatric* or pediatri* or pubescen* or school* or student* or teen* or young or youth*) and (“selective serotonin reuptake inhibitor*” or SSRIs or “serotonin norepinephrine reuptake inhibitor*” or SNRIs or citalopram or fluoxetine or paroxetine or sertraline or escitalopram or fluvoxamine or venlafaxine or duloxetine “noradrenergic and specific serotonergic antidepressants” or NaSSA or mirtazapine or TCA or tricyclic or amitriptyline or clomipramine or desipramine or imipramine or nortriptyline) and (psychotherapy* or behavio* or “family therap*” or CBT or cognitive or interpersonal or IPT or “play therap*” or supportive or problem-solving or psychodynamic).	11
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Study records:

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5	Data management	11a	Literature search results will be imported to Endnote and the duplicates will be removed during the study selection process. We will screening citations based on the inclusion and exclusion criteria.	12
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7	Selection process	11b	Titles and abstracts identified from the search strategies will be independently examined by two reviewers (XZ and YZ). If both reviewers judge that the trial does not meet eligibility criteria, we will exclude it. Then, we will obtain the full-texts of all remaining articles and determine whether to include them according to inclusion criteria described above. We will calculate the inter-rater reliability of the two raters. Any disagreements will be resolved by a third review author (AC or PX) or by consultation with the authors of the articles. The reasons for exclusion of trials will be reported in the characteristics of excluded studies list.	12
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12	Data collection process	11c	Two independent reviewers (XZ and YZ) will extract the data from each included trial using standardised data extraction forms. We will assess and report the reliability of the reviewers' data extraction on each coded variable. Any disagreements will be resolved by a third review author (AC or PX). Where necessary, the authors of the studies will be contacted for further information.	12-13
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14	Data items	12	Study characteristics (e.g., first listed author, publication year, title, publication type, publication journal, country, and sponsor), patient characteristics (e.g., diagnostic criteria, comorbidities, the age of patients, patient setting, the number of patients, the gender of patients, and severity of depression at baseline), intervention details (e.g., the type of intervention, the treatment duration, the dose of antidepressant agent, the length and number of sessions of psychotherapy, treatment delivery and treatment medium of psychotherapy) and outcome measures (primary outcomes and secondary outcomes).	12
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20	Outcomes and prioritization	13	Primary outcomes (1) Efficacy (as a continuous outcome), measured by the overall mean change scores on depressive symptom scales (self- or assessor-rated), e.g., Children's Depression Rating Scale (CDRS-R) and Hamilton Depression Rating Scale (HAMD) from baseline to endpoint. (2) Acceptability of treatment, defined as the proportion of patients who drop out of the study by any cause during the delivery of the intervention. Secondary outcomes (1) Efficacy (as dichotomous outcome), measured by the total number of patients who achieved the criteria of remission, defined as being below the threshold in depression rating score (e.g., less than 28 for CDRS-R), while these thresholds are different across trials. (2) Tolerability of treatment, defined as the proportion of patients who discontinued treatment due to any adverse events during the delivery of the intervention. (3) Suicide-related outcome, estimated by the reported cases of definitive suicidal behavior or suicidal ideation during the acute phase of treatment. The definition of suicide-related outcome is based on the Columbia Classification Algorithm of Suicide Assessment (C-CASA). For the antidepressants trials, the data on suicidality mainly referred to the Columbia re-analysis data reported in the FDA report. If trials are not included in this report, we will attempt to extract the data on suicide-related outcome from the Medicines and Healthcare products Regulatory Agency database or the pharmaceutical company website. For the psychological trials and the combination trials, we will mainly extract the data on suicidality from original text, and from related reviews. (4) Global functional improvement, estimated by overall change scores on global assessment of functioning scales, e.g., Children's Global Assessment Scale (CGAS) and Global Assessment of Functioning Scale (GAF), or quality of life scales, e.g., Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q). When data are reported on more than one measure, we will first chose	10-11
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		data from the CGAS, then the GAF, and finally the Q-LES-Q and others. Where depression symptoms are measured using more than one depression scale in a trial, we will extract data from the depressive scales on the basis of a hierarchy of rating scales. The hierarchy will be based on psychometric properties and appropriateness for use with children and adolescents and for consistency of use across trials (referred from the Zhou et al study). We will also establish a hierarchy of informants of depressive rating scales, with the clinician report first in the hierarchy, and then the child or adolescent self-report.	
Risk of bias in individual studies	14	We will assess risk of bias as “low risk”, “unclear risk”, or “high risk”, in accordance with the Cochrane Collaboration’s Risk of bias tool as described in the Cochrane Hand book for Systematic Reviews of Interventions. The following items will be assessed: sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessors, incomplete outcome data, selective outcome reporting, and other sources of bias (e.g., sponsorship bias/researcher allegiance bias). Two independent review authors (XZ and YZ) will assess the risk of bias in selected studies. Degree of agreement between the two independent raters will be reported. Any disagreements will be resolved by a third review author (AC or PX). Where necessary, the authors of the studies will be contacted for further information. Studies will be classified as having high risk of bias if two or more domains were rated as high risk of bias; low if five or more were rated as low risk of bias and none was rated as high risk of bias, and all other cases will be assumed to pertain to moderate risk.	13
Data synthesis	15a	We will perform Bayesian network meta-analysis to compare the relative outcomes of different antidepressant medications, psychotherapies or their combination from the median of the posterior distribution.	13
	15b	Network meta-analysis combines direct and indirect evidence for all relative treatment effects and provides estimates with maximum power. First, we will perform pairwise meta-analyses of direct evidence using the random-effects model with STATA version 14.0. Second, we will also perform a random-effects network meta-analysis (NMA) within a Bayesian framework using Markov chain Monte Carlo in WinBUGS version 1.4.3. Where different measures are used to assess the same outcome, continuous outcomes data will be pooled with standardised mean difference (SMD), and dichotomous outcomes will be analysed by calculating the odds ratio (OR). In the presence of minimally informative priors, Credible Intervals (CrIs) can be interpreted similarly to confidence intervals (CIs). Missing dichotomous outcome data will be managed according to the intention to treat (ITT) principle, and all the dropouts after randomisation will be considered to be non-responders. Missing continuous outcome data will be analysed using the completer data. When p-values, t-values, confidence intervals or standard errors are reported in articles, SD will be calculated from their values. Where SDs are missing, attempts will be made to obtain these data through contacting trial authors. When this fails, they will be borrowed from the other trials in the network or from other published reports. In the analysis of network meta-analysis, the pooled estimates will be obtained using the Markov Chains Monte Carlo method. Two Markov chains will be run simultaneously with different arbitrarily chosen initial values and non-informative priors will be used for the parameters. To ensure convergence, trace plots and the Brooks-Gelman-Rubin statistic will be assessed. We will also estimate the ranking probabilities for all treatments of being at each possible rank for each intervention. Then, we will obtain a treatment hierarchy using the surface under the cumulative ranking curve (SUCRA) and mean ranks. SUCRA can also be interpreted as the percentage of efficacy/safety of a treatment that would be ranked first without uncertainty.	13-14
	15c	Where possible, we will conduct the network meta-regression meta-analyses of data on primary outcomes for the: (i) age of participants (children vs. adolescents); (ii) sex ratio; (iii) the severity of depressive symptoms at baseline; and (iv) the treatment duration. If possible, we will do some extra subgroup analyses according to the results of heterogeneity and inconsistency. In the	15-16

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		sensitivity analysis, trials where missing data have been imputed will be excluded, and trials where high risk of bias rating have been assessed will be excluded. And, we will not only test whether the results change but also if transitivity (consistency/model fit) is affected. We will also examine some variables (e.g., sample size of trials ⁵³), as continuous measure in meta-regression analyses.	
	15d	A systematic narrative synthesis will be provided with information presented in the text and tables to summarize and explain the characteristics and findings of the included studies.	15
Meta-bias(es)	16	We will use the contour-enhanced funnel plot and Egger's test to assess risk of publication bias within each pairwise comparison. We will also use the comparison-adjusted funnel plots of all trials with placebo controls or inactive controls to investigate whether results in imprecise trials differ from those in more precise trials in network meta-analysis.	15
Confidence in cumulative evidence	17	We will also assess the quality of evidence contributing to primary outcomes with the GRADE framework, which characterises the quality of a body of evidence on the basis of the study limitations, imprecision, heterogeneity or inconsistency, indirectness, and publication bias. The starting point for confidence in each network estimate is high, but will be downgraded according to the assessments of these five aspects.	16

*** It is strongly recommended that this checklist be read in conjunction with the PRISMA-P Explanation and Elaboration (cite when available) for important clarification on the items. Amendments to a review protocol should be tracked and dated. The copyright for PRISMA-P (including checklist) is held by the PRISMA-P Group and is distributed under a Creative Commons Attribution Licence 4.0.**

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Comparative efficacy and acceptability of antidepressants, psychological interventions, and their combination for depressive disorder in children and adolescents: protocol for a network meta-analysis



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4 **Comparative efficacy and acceptability of antidepressants, psychological interventions, and their**
5 **combination for depressive disorder in children and adolescents: protocol for a network meta-**
6 **analysis**
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18 Xinyu Zhou and Andrea Cipriani contributed equally to this work.

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23 Keywords: depression, child, adolescent, antidepressant, psychotherapy, network meta-analysis, systematic
24 review

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26 Word count: 3509.

ABSTRACT

Introduction: Depressive disorder is common in children and adolescents, with important consequences and serious impairments in terms of personal and social functioning. While both pharmacological and psychological interventions have been shown to be effective, there is still uncertainty about the balance between these and what treatment strategy should be preferred in clinical practice. Therefore, we aim to compare and rank in a network meta-analysis (NMA) the commonly used psychological, pharmacological and combined interventions for depressive disorder in children and adolescents.

Methods and analysis: We will update the literature search of two previous NMAs for the identification of trials of antidepressant and psychotherapy alone for depressive disorder in children and adolescents. For identification of trials of combination interventions, seven databases (PubMed, EMBASE, CENTRAL (Cochrane Central Register of Controlled Trials), Web of Science, PsycINFO, CINAHL, LiLACS) will be searched from date of inception. We will also search ClinicalTrials.gov, the World Health Organization International Clinical Trials Registry Platform, and check relevant reports on the US FDA website for unpublished data. Building on our previous findings in the field, we will include any commonly prescribed oral antidepressants, and any manualised or structured psychotherapies, as well as their combinations. Randomised controlled trials assessing any active intervention against active comparator or pill placebo/psychological controls in acute treatment for depressive disorder in children and adolescents will be included. The primary outcomes will be efficacy (mean change in depressive symptoms), and acceptability of treatment (dropout rate due to any cause). The secondary outcomes will be remission rate, tolerability of treatment (dropouts for adverse events), as well as suicide-related outcomes (suicidal behavior or ideation). We will perform Bayesian NMAs for all relative outcome measures. Subgroup analyses and sensitivity analyses will be conducted to assess the robustness of the findings.

Dissemination: This NMA will provide the most up to date and clinically useful information about the comparative efficacy and acceptability of antidepressants, psychological intervention and their combination in the acute treatment of children and adolescents with depressive disorder. This is the newest network meta-

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analysis and therefore these results are very important in terms of evidence-based medicine. The results will be disseminated through peer-reviewed publication.

Protocol registration: PROSPERO CRD42015020841

For peer review only

Strengths and limitations of this study

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1. The network meta-analysis can integrate direct evidence with indirect evidence from multiple treatment comparisons and multiple control approaches to estimate the interrelations across all treatments, which can guide treatment decisions and guideline development.

2. For the first time the efficacy, acceptability, tolerability, and suicide-related outcomes of pharmacological and psychological interventions, alone or in combination for depressive disorder in children and adolescents will be comprehensively assessed in a network meta-analysis.

3. We will employ validated local and global methods to evaluate consistency and we will explore whether treatment effects are robust in network subgroup analyses and sensitivity analyses. The quality of evidence for network estimates of the primary outcomes will be assessed with the GRADE framework, which characterises the quality of a body of evidence on the basis of the study limitations, imprecision, heterogeneity or inconsistency, indirectness, and publication bias.

Background

Depressive disorder in children and adolescents is a major public health problem, affecting 1% to 2% of children (6–12 years old) and 2% to 5% of adolescents (13–18 years old), with a peak incidence around puberty.^{1,2} The course of depressive disorder in children and adolescents is often characterised by protracted episodes, frequent recurrence, and comorbid psychiatric disorders.³ Compared with adults, the identification and diagnosis of depressive disorder in children and adolescents may be more often missed by clinicians⁴ due to undifferentiated signs and symptoms and atypical presentations. Thus, many such patients exhibit serious impairments in social functioning (e.g., poor school achievement; relational problems with family members and peers),⁵ and are significantly increased risk for suicide behaviors and ideation.⁶ For example, a report from the American Academy of Child and Adolescent Psychiatry (AACAP) suggested that depressive disorder is contributed to over 500,000 suicide attempts by children and adolescents a year.⁷

The past two decades have seen significant increases in the data for children and adolescents with depression and both pharmacological and psychological therapies have been effective. Among current psychological interventions, based on our previous findings, cognitive behavior therapy (CBT) and interpersonal psychotherapy (IPT) seem to be the best available psychotherapies for depression in children and adolescents.^{8,9} Multiple pharmacological therapies have also been studied for the treatment of depressive disorder in children and adolescents.^{10–12} The controversy about the use of antidepressants in this age group, due the potentially increased risk of suicidality, has not been fully resolved.¹³ Recently, the findings of our previous studies showed most antidepressants do not seem to offer a clear benefit for children and adolescents, and fluoxetine is probably the best option to consider when a pharmacological treatment is indicated.¹⁰

Several clinical practice guidelines recommend that in children and adolescents, psychotherapy should be considered as the first-line intervention for the management of depressive disorder, while pharmacological treatments are often reserved for more severe illness or when psychotherapy does not work or is not available.^{14,15} Nevertheless, the evidence-base for psychotherapy to be more effective and safer than antidepressants in the treatment of child and adolescent depressive disorder is not well established. A large,

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3 non-industry funded trial reported superior efficacy for fluoxetine compared to CBT in adolescents with
4 major depression.¹⁶ Previous research supports the notion that psychotherapy has its own side-effects, such as
5 dependency on the therapist, and leading to distress for the patients' family.¹⁷ However, unlike with
6 antidepressants, they are rarely measured systematically, making the comparison of safety and tolerability
7 harder.¹⁸ Moreover, data from the adult studies showed that combination antidepressants and psychotherapy
8 is superior to either intervention alone.^{19,20} Recently, a Cochrane conventional meta-analysis, on the basis of
9 the very limited evidence, reported that the effectiveness of psychological interventions, antidepressant
10 medication and a combination of these interventions for treating depressive disorders in children and
11 adolescents cannot be established.²¹

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23 Network meta-analysis has the advantage that all interventions that have been tested in randomised
24 controlled trials (RCTs) can be simultaneously compared, without requiring direct within-study treatment vs.
25 treatment comparisons. Thus effects of the different treatments can be estimated relative to each other as well
26 as to a common reference condition (e.g., pill placebo or psychological controls).²² Network meta-analysis thus
27 overcomes some of the limitations of traditional meta-analysis, in which conclusions are largely restricted to
28 comparisons between treatments that have been directly compared in RCTs.²³ In our two previous network
29 meta-analyses the comparative efficacy and acceptability of psychotherapies and antidepressants for
30 depressive disorder in children and adolescents have been separately investigated^{8,10} The aim of the current
31 protocol is to synthesise all this evidence and provide clinicians with a reliable treatment algorithm of the
32 commonly used psychological, and pharmacological interventions, as well as their combinations for the acute
33 treatment of depressive disorder in children and adolescents.

48 **Methods**

49 *Criteria for included studies*

50 **Types of studies**

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52 Any randomised controlled trials (RCTs), including the first phase of cross-over trials as well as cluster-
53 randomised trials, will be included. Quasi-randomised trials (e.g., those allocating participants using alternate
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3 days of the week) will be excluded. For trials of antidepressants alone, only double-blind RCTs (patients and
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5 raters blinded) will be included. As it is difficult to utilise a double-blind design for patients in trials of
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7 psychotherapy alone or the combination of antidepressant and psychotherapy, we will only include trials in
8
9 which raters were blinded or participants were assessed by self-rating depression scales.
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12 13 14 **Types of participants**

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16 We will include studies that enrolled participants aged less than 18 years of age when they are initially
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18 enrolled in the studies, of both sexes with a diagnosis of depressive disorder, including of major depressive
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20 disorder (MDD), dysthymia, and other specified types, based on standardised diagnostic criteria (e.g., the
21
22 Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases).²⁴⁻²⁹
23
24 While it is accepted that subclinical depression still has a significant impact on an individuals' social and
25
26 educational functioning, we will not include studies of this population. Similarly, studies where depressive
27
28 disorder was not formally diagnosed will also be excluded for the same rationale that its clinical
29
30 heterogeneity could violate the transitivity assumption in NMA (i.e. one can compare indirectly intervention
31
32 B and C via intervention A).³⁰ We will also exclude trials in which participants are described as having
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34 psychotic depression or treatment-resistant depression, as their treatment response differs from patients
35
36 without treatment resistance or symptoms of psychosis. Trials focusing on child or adolescent bipolar
37
38 disorder will also be excluded, but not those involving patients with other comorbid psychiatric disorders as
39
40 diagnosed according to standardised criteria (e.g., anxiety disorder, or attention deficit hyperactivity
41
42 disorder). Where a study includes both adults and children/adolescents and the randomisation had been
43
44 stratified according this variable, the data will be included if data on the depressed youths can be separately
45
46 extracted from the manuscript, or can be obtained from the authors. Studies conducted in both inpatient and
47
48 outpatient settings will be included. RCTs recruiting participants with an overall sample size of fewer than
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50 ten patients will be excluded.
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55 56 57 58 **Types of interventions**

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4 For pharmacological interventions, we will include any commonly prescribed oral antidepressants (fixed
5 or flexible doses). These will include tricyclic antidepressants (TCAs; amitriptyline, clomipramine,
6 nortriptyline, desipramine, imipramine, etc.), selective serotonin reuptake inhibitors (SSRIs; escitalopram,
7 fluoxetine, paroxetine, sertraline, etc.), and serotonin-norepinephrine reuptake inhibitors (SNRIs; venlafaxine,
8 duloxetine), as well as novel agents mirtazapine and nefazodone. In terms of psychological interventions, we
9 will include any manualised or structured psychotherapies, e.g., behavioral therapy, cognitive-behavioral
10 therapy, cognitive therapy, family therapy, interpersonal therapy, play therapy, problem-solving therapy,
11 psychodynamic therapy, and supportive therapy. Table 1 provides the detailed description of
12 psychotherapies. Also, we will include the combination of both above-mentioned psychological interventions
13 and pharmacological interventions. For the pharmacological interventions, the control condition is always a
14 pill placebo, whilst the psychological control conditions are waiting-list (WL), treatment as usual (TAU),
15 psychological placebo or attention placebo, or no-treatment (NT).
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32 All RCTs comparing any active intervention (psychological interventions, pharmacological interventions,
33 or their combinations) with either active comparators or control conditions for acute treatment of depressive
34 disorder in children and adolescents will be included. The acute phase will be defined as from 4 to 16 week.
35 We will exclude trials with treatment duration of less than 4 weeks, because the onset of benefit for most
36 antidepressants often takes at least 4 weeks.³¹ If a study present data for more than one time point within our
37 pre-defined acute phase window or beyond 16 weeks, the 8-week (or the closest to 8-week) will be taken as
38 the time. Trials comparing the same antidepressant at different therapeutic doses will be merged in the same
39 node in the network analysis so long as they are within the dose range licensed by drug regulatory agencies.
40 Also, trials comparing the same type of psychological interventions but at different numbers of therapeutic
41 sessions, different delivery format (group, individual), different treatment medium (face-to-face, internet-
42 based), and different treatment conditions (with or without family involvement) will be considered as the
43 same node in the network analysis. We anticipate that any patient who meets all inclusion criteria, in
44 principal, is equally likely to be randomised to any of the interventions in the synthesis comparator set.
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3 We have generated an ideal network plot that is a fully connected network with all expected
4 interventions (Figure 1).
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10 **Types of outcome measures**

11 *Primary outcomes*

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14 (1) Efficacy (as a continuous outcome), measured by the overall mean change scores on depressive symptom
15 scales (self- or assessor-rated), e.g., Children's Depression Rating Scale (CDRS-R)³² and Hamilton
16 Depression Rating Scale (HAMD)³³ from baseline to endpoint.
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21 (2) Acceptability of treatment, defined as the proportion of patients who drop out of the study by any cause
22 during the delivery of the intervention.
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27 *Secondary outcomes*

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30 (1) Efficacy (as dichotomous outcome), measured by the total number of patients who achieved the criteria of
31 remission, defined as being below the threshold in depression rating score (e.g., less than 28 for CDRS-
32 R),³⁴ while these thresholds are different across trials.
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36 (2) Tolerability of treatment, defined as the proportion of patients who discontinued treatment due to any
37 adverse events during the delivery of the intervention.
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41 (3) Suicide-related outcome, estimated by the reported cases of definitive suicidal behavior or suicidal
42 ideation during the acute phase of treatment. The definition of suicide-related outcome is based on the
43 Columbia Classification Algorithm of Suicide Assessment (C-CASA).³⁵ For the antidepressants trials,
44 the data on suicidality mainly referred to the Columbia re-analysis data reported in the FDA report.³⁶ If
45 trials are not included in this report, we will attempt to extract the data on suicide-related outcome
46 from the Medicines and Healthcare products Regulatory Agency database or the pharmaceutical
47 company website. For the psychological trials and the combination trials, we will mainly extract the
48 data on suicidality from original text, and from related reviews.
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4 (4) Global functional improvement, estimated by overall change scores on global assessment of functioning
5 scales, e.g., Children's Global Assessment Scale (CGAS)³⁷ and Global Assessment of Functioning Scale
6 (GAF),³⁸ or quality of life scales, e.g., Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-
7 Q).³⁹ When data are reported on more than one measure, we will first chose data from the CGAS, then
8 the GAF, and finally the Q-LES-Q and others.
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16 Where depression symptoms are measured using more than one depression scale in a trial, we will
17 extract data from the depressive scales on the basis of a hierarchy of rating scales. The hierarchy will be based
18 on psychometric properties and appropriateness for use with children and adolescents and for consistency of
19 use across trials (referred from the Zhou et al study⁴⁰, Table 2). We will also establish a hierarchy of
20 informants of depressive rating scales, with the clinician report first in the hierarchy, and then the child or
21 adolescent self-report.
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32 **Data Sources and Search strategy**

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34 For the identification of trials of antidepressant and psychotherapy alone for depressive disorder in
35 children and adolescents, we will update the literature search of our two previous network meta-analyses.^{8,10}
36 Other eligible trials of the combinations of antidepressant and psychotherapy will be identified by searching
37 PubMed, EMBASE, CENTRAL (Cochrane Central Register of Controlled Trials), Web of Science, PsycINFO,
38 ProQuest, CINAHL, LiLACS from date of inception with Medical Subject Headings (MeSH) and text words:
39 (depress* or dysthymi* or mood disorder* or affective disorder*) and (adolesc* or child* or boy* or girl* or
40 juvenil* or minors or paediatric* or pediatric* or pubescen* or school* or student* or teen* or young or youth*)
41 and ("selective serotonin reuptake inhibitor*" or SSRIs or "serotonin norepinephrine reuptake inhibitor*" or
42 SNRIs or citalopram or fluoxetine or paroxetine or sertraline or escitalopram or fluvoxamine or venlafaxine or
43 duloxetine "noradrenergic and specific serotonergic antidepressants" or NaSSA or mirtazapine or TCA or
44 tricyclic or amitriptyline or clomipramine or desipramine or imipramine or nortriptyline) and
45 (psychotherapy* or behavio* or "family therap*" or CBT or cognitive or interpersonal or IPT or "play therap*")
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3 or supportive or problem-solving or psychodynamic). We will also search ClinicalTrials.gov in USA and other
4 international trial registers via the International Clinical Trials Registry Platform (ICTRP) in WHO. We will
5 also check relevant reports on the US Food and Drug Administration (FDA) website, and hand-search key
6 journals, conference proceedings, such as, *J Child Adolesc Psychopharmacol*, *J Am Acad Child Adolesc Psychiatry*,
7 *Child Adolesc Psychiatry Ment Health*, *Psychopharmacol Bull*, *Arch Gen Psychiatry*, *Am J Psychiatry*, *Eur Psychiatry*,
8 *Depress Anxiety*. There will be no restrictions on language, or publication year. Additional relevant studies
9 will be obtained by scanning reference lists of trials identified in the initial searches and relevant review
10 papers. We will also inquire at the relative pharmaceutical companies (e.g., GlaxoSmithKline, Lilly, Organon,
11 Forest Pharmaceuticals, Bristol-Myers Squibb) and search their websites for unpublished data. All relevant
12 experts and principal manufacturers will be contacted to supplement incomplete reports of the original
13 papers or to provide new data for unpublished studies.
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30 **Study selection and data extraction**

31 *Selection of trials*

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34 Titles and abstracts identified from the search strategies will be independently examined by two
35 reviewers (XZ and YZ). If both reviewers judge that the trial does not meet eligibility criteria, we will exclude
36 it. Then, we will obtain the full-texts of all remaining articles and determine whether to include them
37 according to inclusion criteria described above. We will calculate the inter-rater reliability of the two raters.
38 Any disagreements will be resolved by a third review author (AC or PX) or by consultation with the authors
39 of the articles. The reasons for exclusion of trials will be reported in the characteristics of excluded studies list.
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49 *Data extraction*

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51 Two independent reviewers (XZ and YZ) will extract the data from each included trial using
52 standardised data extraction forms, including study characteristics (e.g., first listed author, publication year,
53 title, publication type, publication journal, country, and sponsor), patient characteristics (e.g., diagnostic
54 criteria, comorbidities, the age of patients, patient setting, the number of patients, the gender of patients, and
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3 severity of depression at baseline), intervention details (e.g., the type of intervention, the treatment duration,
4 the dose of antidepressant agent, the length and number of sessions of psychotherapy, treatment delivery and
5 treatment medium of psychotherapy) and outcome measures (primary outcomes and secondary outcomes).
6
7 We will assess and report the reliability of the reviewers' data extraction on each coded variable. Any
8 disagreements will be resolved by a third review author (AC or PX). Where necessary, the authors of the
9 studies will be contacted for further information.
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19 *Risk of bias assessment*

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21 We will assess risk of bias as "low risk", "unclear risk", or "high risk", in accordance with the Cochrane
22 Collaboration's Risk of bias tool as described in the Cochrane Hand book for Systematic Reviews of
23 Interventions.⁴¹ The following items will be assessed: sequence generation, allocation concealment, blinding of
24 participants and personnel, blinding of outcome assessors, incomplete outcome data, selective outcome
25 reporting, and other sources of bias (e.g., sponsorship bias/researcher allegiance bias). Two independent
26 review authors (XZ and YZ) will assess the risk of bias in selected studies. Degree of agreement between the
27 two independent raters will be reported. Any disagreements will be resolved by a third review author (AC or
28 PX). Where necessary, the authors of the studies will be contacted for further information. Studies will be
29 classified as having high risk of bias if two or more domains were rated as high risk of bias; low if five or
30 more were rated as low risk of bias and none was rated as high risk of bias, and all other cases will be
31 assumed to pertain to moderate risk.
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47 **Statistical analysis**

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49 Network meta-analysis combines direct and indirect evidence for all relative treatment effects and
50 provides estimates with maximum power.²³ First, we will perform pairwise meta-analyses of direct evidence
51 using the random-effects model with STATA version 14.0. Second, we will also perform a random-effects
52 network meta-analysis (NMA) within a Bayesian framework using Markov chain Monte Carlo in WinBUGS
53 version 1.4.3. Where different measures are used to assess the same outcome, continuous outcomes data will
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3 be pooled with standardised mean difference (SMD), and dichotomous outcomes will be analysed by
4
5 calculating the odds ratio (OR). In the presence of minimally informative priors, Credible Intervals (CrIs) can
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7 be interpreted similarly to confidence intervals (CIs).
8
9

10 Missing dichotomous outcome data will be managed according to the intention to treat (ITT) principle,
11
12 and all the dropouts after randomisation will be considered to be non-responders. Missing continuous
13
14 outcome data will be analysed using the completer data. When p-values, t-values, confidence intervals or
15
16 standard errors are reported in articles, SD will be calculated from their values.⁴² Where SDs are missing,
17
18 attempts will be made to obtain these data through contacting trial authors. When this fails, they will be
19
20 borrowed from the other trials in the network or from other published reports.⁴²
21
22

23 In the analysis of network meta-analysis, the pooled estimates will be obtained using the Markov Chains
24
25 Monte Carlo method. Two Markov chains will be run simultaneously with different arbitrarily chosen initial
26
27 values and non-informative priors will be used for the parameters. To ensure convergence, trace plots and the
28
29 Brooks-Gelman-Rubin statistic will be assessed.⁴³ We will also estimate the ranking probabilities for all
30
31 treatments of being at each possible rank for each intervention. Then, we will obtain a treatment hierarchy
32
33 using the surface under the cumulative ranking curve (SUCRA) and mean ranks. SUCRA can also be
34
35 interpreted as the percentage of efficacy/safety of a treatment that would be ranked first without
36
37 uncertainty.⁴⁴
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40 41 42 *Measures for transitivity assumption*

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44 We will assess whether the included interventions are similar when they are evaluated in RCTs with
45
46 different designs; and whether the distributions of clinical and methodological variables that can act as effect
47
48 modifiers across treatment comparison are balanced across comparisons. The clinical features, which have
49
50 been demonstrated to date to moderate efficacy of antidepressants and psychotherapy in children and
51
52 adolescents include bipolarity,⁴⁵ psychotic features,⁴⁶ subthreshold depression.⁴⁷ We have assured transitivity
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54 in our network with regard to these variables by limiting our samples to participants with non-psychotic
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56 unipolar depressive disorders. Other clinical or methodological variables that may influence our primary
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3 outcomes of treatment efficacy or acceptability include: age, sex, depressive severity at baseline, and the
4
5 treatment duration.
6

7 *Measures for heterogeneity*

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10 In standard pairwise meta-analyses we will estimate a different heterogeneity variance for each pairwise
11
12 comparisons; in network meta-analysis we will assume a common estimate for the heterogeneity variance
13
14 across the different comparisons. We will assess statistically the presence of heterogeneity within each
15
16 pairwise comparison using the I-squared statistic⁴⁸ and its 95% confidence interval that measures the
17
18 percentage of variability that cannot be attributed to random error. The assessment for the presence of
19
20 statistical heterogeneity in the entire network will be based on the magnitude of the heterogeneity variance
21
22 parameter (τ^2) estimated from the NMA models. We will also estimate a total I-squared value and predictive
23
24 intervals for heterogeneity in the network.⁴⁹
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29 *Measures for inconsistency*

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32 NMA assumes that there is consistency in the network (i.e. direct and indirect evidence are in
33
34 agreement). However, the assumption of consistency can be violated either in the entire network or in certain
35
36 parts (i.e. loops of evidence) of the network.⁵⁰ Therefore, consistency needs to be checked. We will evaluate
37
38 the presence of local inconsistency and global inconsistency in STATA version 14.0 and will be duplicated in
39
40 R software.⁵¹
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45 *Measures for publication bias*

46
47 We will use the contour-enhanced funnel plot and Egger's test to assess risk of publication bias within
48
49 each pairwise comparison.⁵² We will also use the comparison-adjusted funnel plots of all trials with placebo
50
51 controls or inactive controls to investigate whether results in imprecise trials differ from those in more precise
52
53 trials in network meta-analysis.⁵³
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58 *Subgroup analyses and sensitivity analyses*

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4 Where possible, we will conduct the network meta-regression meta-analyses of data on primary
5
6 outcomes for the: (i) age of participants (children vs. adolescents); (ii) sex ratio; (iii) the severity of depressive
7
8 symptoms at baseline; (iv) the treatment duration; (v) the dosing schedule (fixed or flexible doses). If possible,
9
10 we will do some extra subgroup analyses according to the results of heterogeneity and inconsistency. In the
11
12 sensitivity analysis, trials where missing data have been imputed will be excluded, trials where high risk of
13
14 bias rating have been assessed, and trials where only included patients comorbidity with other psychiatric
15
16 disorders will be excluded. And, we will not only test whether the results change but also if transitivity
17
18 (consistency/model fit) is affected. We will also examine some variables (e.g., sample size of trials⁵⁴), as
19
20 continuous measure in meta-regression analyses.
21

22 23 24 25 *GRADE quality assessment*

26
27 We will also assess the quality of evidence contributing to primary outcomes with the GRADE
28
29 framework, which characterises the quality of a body of evidence on the basis of the study limitations,
30
31 imprecision, heterogeneity or inconsistency, indirectness, and publication bias.⁵⁵ The starting point for
32
33 confidence in each network estimate is high, but will be downgraded according to the assessments of these
34
35 five aspects.
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38 39 40 41 *Ethics and dissemination*

42
43 This network meta-analysis does not need ethical approval, as data used here are based on aggregated
44
45 data in the public domain. Findings from the analysis will provide an overview and information on the
46
47 relative efficacy and acceptability of antidepressant medications, psychological therapies, and their
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49 combination for depressive disorder in children and adolescents. It is suggested that the findings will have
50
51 significant implications for clinical practice and further research.
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4 **Contributors** PX, AC, and XZ conceived the study and drafted the protocol. PX, AC and XZ wrote the first
5
6
7 draft of the manuscript. PC, SEH, JRW, CDG, TAF, JB, DC, SL, AVR assisted in protocol design and revision.
8
9
10 XZ, YZ, and LY participated in the search strategy development. CDG, and JP participated in the design of
11
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13
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19
20
21 submit the protocol for publication.

22
23
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25
26
27 about quetiapine extended release. SEH is an Editor of the Cochrane Common Mental Disorders Group, an
28
29
30 author of the Cochrane systematic review of newer generation antidepressants for depression in children and
31
32
33 adolescents, and an author (senior) on the Cochrane review of psychological, pharmacological and their
34
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8

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34 upon this work non-commercially, and license their derivative works on different terms, provided the
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36 original work is properly cited and the use is non-commercial. See: See:
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TABLES

Table 1 Description of Psychotherapeutic interventions and control conditions

Interventions	Abbreviation	Description
<i>Psychotherapeutic Intervention:</i>		
Behavioral therapy	BT	BT uses some kind of behavioral training and psychoeducation. BT programs provide parents and youths information about MDD and interventions; teach youths to monitor their mood, thoughts and behaviors; proposed pleasant activity scheduling and behavioral activation.
Cognitive-behavioral therapy	CBT	CBT is a combination of BT and CT. Additional CBT skill-building techniques are used in many programs by teaching relaxation techniques to cope with environmental stressors, providing social skills and resolution training, and teaching general problem-solving.
Cognitive therapy	CT	CT uses some kind of cognitive restructuring training. CT programs ask youths to examine their automatic thoughts and core schemas and to assess the accuracy and affective consequences of their views. They aim to teach youths to engage in "rational" thinking about themselves, the world and their possibilities for the future.
Family therapy	FT	FT works with families to nurture change and development. FT tends to view change in terms of the systems of interaction between family members. In the case of youth with MDD, FT aims at helping the family to answer the child's needs for completing age-appropriate developmental tasks to relieve depression.
Interpersonal therapy	IPT	IPT aim at educating patients as to how their depression and the quality of interpersonal relationships affect one another and at addressing interpersonal problems that may be contributing to the depression (e.g. grief, disputes, role transitions, social deficits). Compared to its adult version, IPT in youths is shorter, involves parents, and adds a liaison role for the therapist between schools and families.
Play therapy	PT	PT used techniques to engage participants in recreational activities to help them cope with their problems and fears.
Problem-solving therapy	PST	PST focus on the problems participants are currently facing and on helping them find solutions to those problems.
Psychodynamic therapy	DYN	DYN proposed patients to help understand the origin and nature of long standing problems by investigating both conscious and non-conscious thoughts and emotional feelings. DYN uses free associations and interpretation of dreams (or drawing in children), and addresses how personal history and experience may alter the patient/therapist transference. In youth MDD, a particular interest is given to psychological trauma, early

parent/child relationships, narcissistic organization and experiences of loss.

Supportive therapy SUP
 SUP is an unstructured therapy without specific psychological techniques that it helped people to ventilate their experiences and emotions and offering empathy. These therapies are commonly described in the literature as either counseling or supportive therapy.

Control conditions:

No-treatment NT
 NT is a control condition in which the participants receive no active treatment during the study and in which they do not expect to receive such after the study is over.

Psychological placebo PBO
 PBO is a control condition that was regarded as inactive by the researchers but was to be the participants.

Treatment-as-usual TAU
 TAU is not considered to be structured psychotherapy but may have some treatment effects.

Waitlist WL
 WL is a control condition in which the participants receive no active treatment during the study but are forewarned that they can receive one after the study period is over.

Table 2 Hierarchy of depression symptom severity measurement scales

Hierarchy	Depression symptom severity measurement scales	Abbreviation
1	Children's Depression Rating Scale	CDRS
2	Hamilton Depression Rating Scale	HAMD
3	Montgomery Asberg Depression Rating Scale	MADRS
4	Beck Depression Inventory	BDI
5	Children's Depression Inventory	CDI
6	Schedule for Affective Disorders and Schizophrenia for School Aged Children	K-SADS
7	Mood and Feeling Questionnaire	MFQ
8	Reynolds Adolescent Depression Scale	RADS
9	Bellevue Index of Depression	BID
10	Child Depression Scale	CDS
11	Centre for Epidemiologic Studies Depression Scale	CESD
12	Child Assessment Schedule	CAS
13	Child Behavior Checklist-Depression	CBCL-D

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Figure 1. Possible interventions eligible for the ideal network plot

For peer review only

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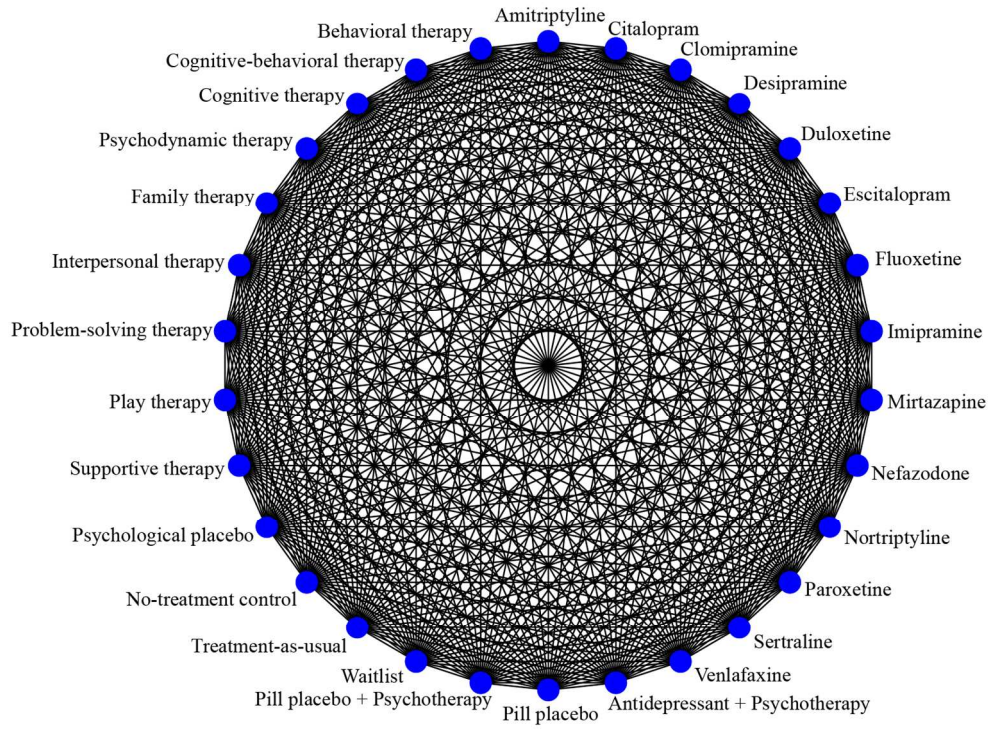


Figure 1. Possible interventions eligible for the ideal network plot

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Review only

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

Section and topic	Item No	Checklist item	Reported on Page #
ADMINISTRATIVE INFORMATION			
Title:			
Identification	1a	Comparative efficacy and acceptability of antidepressants, psychological interventions, and their combination for depressive disorder in children and adolescents: protocol for a network meta-analysis	1
Update	1b	None	
Registration	2	PROSPERO CRD42015020841	4
Authors:			
Contact	3a	Xinyu Zhou, Yuqing Zhang, Juncai Pu, Lining Yang, Peng Xie (Department of Neurology and Psychiatry, The First Affiliated Hospital of Chongqing Medical University, Chongqing, China; Institute of Neuroscience and the Collaborative Innovation Center for Brain Science, Chongqing Medical University, Chongqing, China) Andrea Cipriani (Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford, UK) Pim Cuijpers (Department of Clinical, Neuro and Developmental Psychology, Amsterdam Public Health research institute, Vrije Universiteit Amsterdam, The Netherlands) Sarah E. Hetrick (Orygen, The National Centre of Excellence in Youth Mental Health, and the Centre of Youth Mental Health, University of Melbourne, Melbourne, Australia) John R. Weisz (Department of Psychology, Harvard University, Cambridge, MA, USA) Cinzia Del Giovane (Department of Diagnostic, Clinical and Public Health Medicine, University of Modena and Reggio Emilia, Modena, Italy) Toshiaki A. Furukawa (Department of Health Promotion and Human Behavior, Kyoto University Graduate School of Medicine and School of Public Health, Kyoto, Japan) Jürgen Barth (Institute of Complementary and Integrative Medicine, University Hospital and University of Zurich, Zurich, Switzerland) David Coghill (Departments of Paediatrics and Psychiatry, University of Melbourne, Melbourne, Australia) Stefan Leucht (Department of Psychiatry and Psychotherapy, Technische Universität München, Munich, Germany) Arun V Ravindran (Department of Psychiatry, University of Toronto, Toronto, ON, Canada) Corresponding author :Peng Xie, Department of Neurology and Psychiatry, The First Affiliated Hospital of Chongqing Medical University, 1 Youyi Road, Yuzhong District, Chongqing 400016, China; E-mail: xiepeng973@126.com	1-2
Contributions	3b	PX, AC, and XZ conceived the study and drafted the protocol. PX, AC and XZ wrote the first draft of the manuscript. PC, SEH, JRW, CDG, TAF, JB, DC, AVR assisted in protocol design and revision. XZ, YZ, and LY participated in the search strategy	17

development. CDG, and JP participated in the design of data synthesis and analysis. All the authors have approved the publication of the protocol.

Amendments	4	None	
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Support:

Sources	5a	ational Basic Research Program of China (973 Program) (Grant No. 2009CB918300)	
Sponsor	5b	This work is supported by the National Basic Research Program of China (973 Program) (Grant No. 2009CB918300).	
Role of sponsor or funder	5c	The funders had no role in the protocol design; the writing of the protocol; or the decision to submit the protocol for publication.	

INTRODUCTION

Rationale	6	Depressive disorder in children and adolescents is a major public health problem. The course of depressive disorder in young people is often characterised by protracted episodes, frequent recurrence, and comorbid psychiatric disorders. Several clinical practice guidelines recommend that in children and adolescents, psychotherapy should be considered as the first-line intervention for the management of depressive disorder, while pharmacological treatments are often reserved for more severe illness or when psychotherapy does not work or is not available. Nevertheless, the evidence-base for psychotherapy to be more effective and safer than antidepressants in the treatment of child and adolescent depressive disorder is not well established. In our two previous network meta-analyses the comparative efficacy and acceptability of psychotherapies and antidepressants for depressive disorder in children and adolescents have been separately investigated	6
Objectives	7	The aim of the current protocol is to synthesise all this evidence and provide clinicians with a reliable treatment algorithm of the commonly used psychological, and pharmacological interventions, as well as their combinations for the acute treatment of depressive disorder in children and adolescents.	7

METHODS

Eligibility criteria	8	<p>Types of participants</p> <p>We will include studies that enrolled participants aged less than 18 years of age when they are initially enrolled in the studies, of both sexes with a diagnosis of depressive disorder based on standardised diagnostic criteria (e.g., the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases). While it is accepted that subclinical depression still has a significant impact on an individuals’ social and educational functioning, we will not include studies of this population. Similarly, studies where depressive disorder was not formally diagnosed will also be excluded for the same rationale that its clinical heterogeneity could violate the transitivity assumption in NMA (i.e. one can compare indirectly intervention B and C via intervention A). We will also exclude trials in which participants are described as having psychotic depression or treatment-resistant depression, as their treatment response differs from patients without treatment resistance or symptoms of psychosis. Trials focusing on child or adolescent bipolar disorder will also be excluded, but not those involving patients with other comorbid psychiatric disorders (e.g., anxiety disorder). Where a study includes both adults and children/adolescents and the randomisation had been stratified according this variable, the data will be included if data on the depressed youths can be separately extracted from the manuscript, or can be obtained from the authors. Studies conducted in both inpatient and outpatient settings will be included. RCTs recruiting participants with an overall sample size of fewer than ten patients will be excluded.</p>	7-10
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Types of studies

Any randomised controlled trials (RCTs), including the first phase of cross-over trials as well as cluster-randomised trials, will be included. Quasi-randomised trials (e.g., those allocating participants using alternate days of the week) will be excluded. For trials of antidepressants alone, only double-blind RCTs (patients and raters blinded) will be included. As it is difficult to utilise a double-blind design for patients in trials of psychotherapy alone or the combination of antidepressant and psychotherapy, we will only include trials in which raters were blinded or participants were assessed by self-rating depression scales.

Types of interventions

For pharmacological interventions, we will include any commonly prescribed oral antidepressants (fixed or flexible doses). These will include tricyclic antidepressants (TCAs; amitriptyline, clomipramine, nortriptyline, desipramine, imipramine, etc.), selective serotonin reuptake inhibitors (SSRIs; escitalopram, fluoxetine, paroxetine, sertraline, etc.), and serotonin-norepinephrine reuptake inhibitors (SNRIs; venlafaxine, duloxetine), as well as novel agents mirtazapine and nefazodone. In terms of psychological interventions, we will include any manualised or structured psychotherapies, e.g., behavioral therapy, cognitive-behavioral therapy, cognitive therapy, family therapy, interpersonal therapy, play therapy, problem-solving therapy, psychodynamic therapy, and supportive therapy. Also, we will include the combination of both psychological interventions and pharmacological interventions. For the pharmacological interventions, the control condition always is pill placebo, and these for psychological control conditions will include waiting-list (WL), treatment as usual (TAU), psychological placebo or attention placebo, as well as no-treatment (NT). All RCTs comparing any active intervention (psychological interventions, pharmacological interventions, or their combinations) with either active comparators or control conditions for acute treatment of depressive disorder in children and adolescents will be included. The acute phase will be defined as from 4 to 16 week. We will exclude trials with treatment duration of less than 4 weeks, because the onset of benefit for most antidepressants often takes at least 4 weeks. If a study present data for more than one time point within our pre-defined acute phase window or beyond 16 weeks, the 8-week (or the closest to 8-week) will be taken as the time. Trials comparing the same antidepressant at different therapeutic doses will be merged in the same node in the network analysis so long as they are within the dose range licensed by drug regulatory agencies. Also, trials comparing the same type of psychological interventions but at different numbers of therapeutic sessions, different delivery format (group, individual), different treatment medium (face-to-face, internet-based), and different treatment conditions (with or without family involvement) will be considered as the same node in the network analysis. We anticipate that any patient who meets all inclusion criteria, in principal, is equally likely to be randomised to any of the interventions in the synthesis comparator set.

Types of outcome measures

Primary outcomes

- (1) Efficacy (as a continuous outcome), measured by the overall mean change scores on depressive symptom scales (self- or assessor-rated), e.g., Children's Depression Rating Scale (CDRS-R) and Hamilton Depression Rating Scale (HAMD) from baseline to endpoint.
- (2) Acceptability of treatment, defined as the proportion of patients who drop out of the study by any cause during the delivery of the intervention.

Secondary outcomes

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(1) Efficacy (as dichotomous outcome), measured by the total number of patients who achieved the criteria of remission, defined as being below the threshold in depression rating score (e.g., less than 28 for CDRS-R), while these thresholds are different across trials.

(2) Tolerability of treatment, defined as the proportion of patients who discontinued treatment due to any adverse events during the delivery of the intervention.

(3) Suicide-related outcome, estimated by the reported cases of definitive suicidal behavior or suicidal ideation during the acute phase of treatment. The definition of suicide-related outcome is based on the Columbia Classification Algorithm of Suicide Assessment (C-CASA). For the antidepressants trials, the data on suicidality mainly referred to the Columbia re-analysis data reported in the FDA report. If trials are not included in this report, we will attempt to extract the data on suicide-related outcome from the Medicines and Healthcare products Regulatory Agency database or the pharmaceutical company website. For the psychological trials and the combination trials, we will mainly extract the data on suicidality from original text, and from related reviews.

(4) Global functional improvement, estimated by overall change scores on global assessment of functioning scales, e.g., Children's Global Assessment Scale (CGAS) and Global Assessment of Functioning Scale (GAF), or quality of life scales, e.g., Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q). When data are reported on more than one measure, we will first chose data from the CGAS, then the GAF, and finally the Q-LES-Q and others.

Information sources	9	For the identification of trials of antidepressant and psychotherapy alone for depressive disorder in children and adolescents, we will update the literature search of our two previous network meta-analyses. ^{8,10} Other eligible trials of the combinations of antidepressant and psychotherapy will be identified by searching PubMed, EMBASE, CENTRAL (Cochrane Central Register of Controlled Trials), Web of Science, PsycINFO, ProQuest, CINAHL, LiLACS from date of inception with Medical Subject Headings (MeSH) and text words. We will also search ClinicalTrials.gov in USA and other international trial registers via the International Clinical Trials Registry Platform (ICTRP) in WHO. We will also check relevant reports on the US Food and Drug Administration (FDA) website, and hand-search key journals, conference proceedings, such as, J Child Adolesc Psychopharmacol, J Am Acad Child Adolesc Psychiatry, Child Adolesc Psychiatry Ment Health, Psychopharmacol Bull, Arch Gen Psychiatry, Am J Psychiatry, Eur Psychiatry, Depress Anxiety. There will be no restrictions on language, or publication year. Additional relevant studies will be obtained by scanning reference lists of trials identified in the initial searches and relevant review papers. We will also inquire at the relative pharmaceutical companies (e.g., GlaxoSmithKline, Lilly, Organon, Forest Pharmaceuticals, Bristol-Myers Squibb) and search their websites for unpublished data. All relevant experts and principal manufacturers will be contacted to supplement incomplete reports of the original papers or to provide new data for unpublished studies.	11-12
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Search strategy	10	(depress* or dysthymi* or mood disorder* or affective disorder*) and (adolesc* or child* or boy* or girl* or juvenil* or minors or paediatric* or pediatri* or pubescen* or school* or student* or teen* or young or youth*) and (“selective serotonin reuptake inhibitor*” or SSRIs or “serotonin norepinephrine reuptake inhibitor*” or SNRIs or citalopram or fluoxetine or paroxetine or sertraline or escitalopram or fluvoxamine or venlafaxine or duloxetine “noradrenergic and specific serotonergic antidepressants” or NaSSA or mirtazapine or TCA or tricyclic or amitriptyline or clomipramine or desipramine or imipramine or nortriptyline) and (psychotherapy* or behavio* or “family therap*” or CBT or cognitive or interpersonal or IPT or “play therap*” or supportive or problem-solving or psychodynamic).	11
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Study records:

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5	Data management	11a	Literature search results will be imported to Endnote and the duplicates will be removed during the study selection process. We will screening citations based on the inclusion and exclusion criteria.	12
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7	Selection process	11b	Titles and abstracts identified from the search strategies will be independently examined by two reviewers (XZ and YZ). If both reviewers judge that the trial does not meet eligibility criteria, we will exclude it. Then, we will obtain the full-texts of all remaining articles and determine whether to include them according to inclusion criteria described above. We will calculate the inter-rater reliability of the two raters. Any disagreements will be resolved by a third review author (AC or PX) or by consultation with the authors of the articles. The reasons for exclusion of trials will be reported in the characteristics of excluded studies list.	12
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12	Data collection process	11c	Two independent reviewers (XZ and YZ) will extract the data from each included trial using standardised data extraction forms. We will assess and report the reliability of the reviewers' data extraction on each coded variable. Any disagreements will be resolved by a third review author (AC or PX). Where necessary, the authors of the studies will be contacted for further information.	12-13
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14	Data items	12	Study characteristics (e.g., first listed author, publication year, title, publication type, publication journal, country, and sponsor), patient characteristics (e.g., diagnostic criteria, comorbidities, the age of patients, patient setting, the number of patients, the gender of patients, and severity of depression at baseline), intervention details (e.g., the type of intervention, the treatment duration, the dose of antidepressant agent, the length and number of sessions of psychotherapy, treatment delivery and treatment medium of psychotherapy) and outcome measures (primary outcomes and secondary outcomes).	12
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20	Outcomes and prioritization	13	Primary outcomes (1) Efficacy (as a continuous outcome), measured by the overall mean change scores on depressive symptom scales (self- or assessor-rated), e.g., Children's Depression Rating Scale (CDRS-R) and Hamilton Depression Rating Scale (HAMD) from baseline to endpoint. (2) Acceptability of treatment, defined as the proportion of patients who drop out of the study by any cause during the delivery of the intervention. Secondary outcomes (1) Efficacy (as dichotomous outcome), measured by the total number of patients who achieved the criteria of remission, defined as being below the threshold in depression rating score (e.g., less than 28 for CDRS-R), while these thresholds are different across trials. (2) Tolerability of treatment, defined as the proportion of patients who discontinued treatment due to any adverse events during the delivery of the intervention. (3) Suicide-related outcome, estimated by the reported cases of definitive suicidal behavior or suicidal ideation during the acute phase of treatment. The definition of suicide-related outcome is based on the Columbia Classification Algorithm of Suicide Assessment (C-CASA). For the antidepressants trials, the data on suicidality mainly referred to the Columbia re-analysis data reported in the FDA report. If trials are not included in this report, we will attempt to extract the data on suicide-related outcome from the Medicines and Healthcare products Regulatory Agency database or the pharmaceutical company website. For the psychological trials and the combination trials, we will mainly extract the data on suicidality from original text, and from related reviews. (4) Global functional improvement, estimated by overall change scores on global assessment of functioning scales, e.g., Children's Global Assessment Scale (CGAS) and Global Assessment of Functioning Scale (GAF), or quality of life scales, e.g., Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q). When data are reported on more than one measure, we will first chose	10-11
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		data from the CGAS, then the GAF, and finally the Q-LES-Q and others. Where depression symptoms are measured using more than one depression scale in a trial, we will extract data from the depressive scales on the basis of a hierarchy of rating scales. The hierarchy will be based on psychometric properties and appropriateness for use with children and adolescents and for consistency of use across trials (referred from the Zhou et al study). We will also establish a hierarchy of informants of depressive rating scales, with the clinician report first in the hierarchy, and then the child or adolescent self-report.	
Risk of bias in individual studies	14	We will assess risk of bias as “low risk”, “unclear risk”, or “high risk”, in accordance with the Cochrane Collaboration’s Risk of bias tool as described in the Cochrane Hand book for Systematic Reviews of Interventions. The following items will be assessed: sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessors, incomplete outcome data, selective outcome reporting, and other sources of bias (e.g., sponsorship bias/researcher allegiance bias). Two independent review authors (XZ and YZ) will assess the risk of bias in selected studies. Degree of agreement between the two independent raters will be reported. Any disagreements will be resolved by a third review author (AC or PX). Where necessary, the authors of the studies will be contacted for further information. Studies will be classified as having high risk of bias if two or more domains were rated as high risk of bias; low if five or more were rated as low risk of bias and none was rated as high risk of bias, and all other cases will be assumed to pertain to moderate risk.	13
Data synthesis	15a	We will perform Bayesian network meta-analysis to compare the relative outcomes of different antidepressant medications, psychotherapies or their combination from the median of the posterior distribution.	13
	15b	Network meta-analysis combines direct and indirect evidence for all relative treatment effects and provides estimates with maximum power. First, we will perform pairwise meta-analyses of direct evidence using the random-effects model with STATA version 14.0. Second, we will also perform a random-effects network meta-analysis (NMA) within a Bayesian framework using Markov chain Monte Carlo in WinBUGS version 1.4.3. Where different measures are used to assess the same outcome, continuous outcomes data will be pooled with standardised mean difference (SMD), and dichotomous outcomes will be analysed by calculating the odds ratio (OR). In the presence of minimally informative priors, Credible Intervals (CrIs) can be interpreted similarly to confidence intervals (CIs). Missing dichotomous outcome data will be managed according to the intention to treat (ITT) principle, and all the dropouts after randomisation will be considered to be non-responders. Missing continuous outcome data will be analysed using the completer data. When p-values, t-values, confidence intervals or standard errors are reported in articles, SD will be calculated from their values. Where SDs are missing, attempts will be made to obtain these data through contacting trial authors. When this fails, they will be borrowed from the other trials in the network or from other published reports. In the analysis of network meta-analysis, the pooled estimates will be obtained using the Markov Chains Monte Carlo method. Two Markov chains will be run simultaneously with different arbitrarily chosen initial values and non-informative priors will be used for the parameters. To ensure convergence, trace plots and the Brooks-Gelman-Rubin statistic will be assessed. We will also estimate the ranking probabilities for all treatments of being at each possible rank for each intervention. Then, we will obtain a treatment hierarchy using the surface under the cumulative ranking curve (SUCRA) and mean ranks. SUCRA can also be interpreted as the percentage of efficacy/safety of a treatment that would be ranked first without uncertainty.	13-14
	15c	Where possible, we will conduct the network meta-regression meta-analyses of data on primary outcomes for the: (i) age of participants (children vs. adolescents); (ii) sex ratio; (iii) the severity of depressive symptoms at baseline; and (iv) the treatment duration. If possible, we will do some extra subgroup analyses according to the results of heterogeneity and inconsistency. In the	15-16

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		sensitivity analysis, trials where missing data have been imputed will be excluded, and trials where high risk of bias rating have been assessed will be excluded. And, we will not only test whether the results change but also if transitivity (consistency/model fit) is affected. We will also examine some variables (e.g., sample size of trials ⁵³), as continuous measure in meta-regression analyses.	
	15d	A systematic narrative synthesis will be provided with information presented in the text and tables to summarize and explain the characteristics and findings of the included studies.	15
Meta-bias(es)	16	We will use the contour-enhanced funnel plot and Egger's test to assess risk of publication bias within each pairwise comparison. We will also use the comparison-adjusted funnel plots of all trials with placebo controls or inactive controls to investigate whether results in imprecise trials differ from those in more precise trials in network meta-analysis.	15
Confidence in cumulative evidence	17	We will also assess the quality of evidence contributing to primary outcomes with the GRADE framework, which characterises the quality of a body of evidence on the basis of the study limitations, imprecision, heterogeneity or inconsistency, indirectness, and publication bias. The starting point for confidence in each network estimate is high, but will be downgraded according to the assessments of these five aspects.	16

*** It is strongly recommended that this checklist be read in conjunction with the PRISMA-P Explanation and Elaboration (cite when available) for important clarification on the items. Amendments to a review protocol should be tracked and dated. The copyright for PRISMA-P (including checklist) is held by the PRISMA-P Group and is distributed under a Creative Commons Attribution Licence 4.0.**

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Comparative efficacy and acceptability of antidepressants, psychological interventions, and their combination for depressive disorder in children and adolescents: protocol for a network meta-analysis



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4 **Comparative efficacy and acceptability of antidepressants, psychological interventions, and their**
5 **combination for depressive disorder in children and adolescents: protocol for a network meta-**
6 **analysis**
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18 Xinyu Zhou and Andrea Cipriani contributed equally to this work.

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24 review

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26 Word count: 3509.

ABSTRACT

Introduction: Depressive disorder is common in children and adolescents, with important consequences and serious impairments in terms of personal and social functioning. While both pharmacological and psychological interventions have been shown to be effective, there is still uncertainty about the balance between these and what treatment strategy should be preferred in clinical practice. Therefore, we aim to compare and rank in a network meta-analysis (NMA) the commonly used psychological, pharmacological and combined interventions for depressive disorder in children and adolescents.

Methods and analysis: We will update the literature search of two previous NMAs for the identification of trials of antidepressant and psychotherapy alone for depressive disorder in children and adolescents. For identification of trials of combination interventions, seven databases (PubMed, EMBASE, CENTRAL (Cochrane Central Register of Controlled Trials), Web of Science, PsycINFO, CINAHL, LiLACS) will be searched from date of inception. We will also search ClinicalTrials.gov, the World Health Organization International Clinical Trials Registry Platform, and check relevant reports on the US FDA website for unpublished data. Building on our previous findings in the field, we will include any commonly prescribed oral antidepressants, and any manualised or structured psychotherapies, as well as their combinations. Randomised controlled trials assessing any active intervention against active comparator or pill placebo/psychological controls in acute treatment for depressive disorder in children and adolescents will be included. The primary outcomes will be efficacy (mean change in depressive symptoms), and acceptability of treatment (dropout rate due to any cause). The secondary outcomes will be remission rate, tolerability of treatment (dropouts for adverse events), as well as suicide-related outcomes (suicidal behavior or ideation). We will perform Bayesian NMAs for all relative outcome measures. Subgroup analyses and sensitivity analyses will be conducted to assess the robustness of the findings.

Dissemination: This NMA will provide the most up to date and clinically useful information about the comparative efficacy and acceptability of antidepressants, psychological intervention and their combination in the acute treatment of children and adolescents with depressive disorder. This is the newest network meta-

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analysis and therefore these results are very important in terms of evidence-based medicine. The results will be disseminated through peer-reviewed publication.

Protocol registration: PROSPERO CRD42015020841

For peer review only

Strengths and limitations of this study

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1. The network meta-analysis can integrate direct evidence with indirect evidence from multiple treatment comparisons and multiple control approaches to estimate the interrelations across all treatments, which can guide treatment decisions and guideline development.

2. For the first time the efficacy, acceptability, tolerability, and suicide-related outcomes of pharmacological and psychological interventions, alone or in combination for depressive disorder in children and adolescents will be comprehensively assessed in a network meta-analysis.

3. We will employ validated local and global methods to evaluate consistency and we will explore whether treatment effects are robust in network subgroup analyses and sensitivity analyses. The quality of evidence for network estimates of the primary outcomes will be assessed with the GRADE framework, which characterises the quality of a body of evidence on the basis of the study limitations, imprecision, heterogeneity or inconsistency, indirectness, and publication bias.

Background

Depressive disorder in children and adolescents is a major public health problem, affecting 1% to 2% of children (6–12 years old) and 2% to 5% of adolescents (13–18 years old), with a peak incidence around puberty.^{1,2} The course of depressive disorder in children and adolescents is often characterised by protracted episodes, frequent recurrence, and comorbid psychiatric disorders.³ Compared with adults, the identification and diagnosis of depressive disorder in children and adolescents may be more often missed by clinicians⁴ due to undifferentiated signs and symptoms and atypical presentations. Thus, many such patients exhibit serious impairments in social functioning (e.g., poor school achievement; relational problems with family members and peers),⁵ and are significantly increased risk for suicide behaviors and ideation.⁶ For example, a report from the American Academy of Child and Adolescent Psychiatry (AACAP) suggested that depressive disorder is contributed to over 500,000 suicide attempts by children and adolescents a year.⁷

The past two decades have seen significant increases in the data for children and adolescents with depression and both pharmacological and psychological therapies have been effective. Among current psychological interventions, based on our previous findings, cognitive behavior therapy (CBT) and interpersonal psychotherapy (IPT) seem to be the best available psychotherapies for depression in children and adolescents.^{8,9} Multiple pharmacological therapies have also been studied for the treatment of depressive disorder in children and adolescents.^{10–12} The controversy about the use of antidepressants in this age group, due the potentially increased risk of suicidality, has not been fully resolved.¹³ Recently, the findings of our previous studies showed most antidepressants do not seem to offer a clear benefit for children and adolescents, and fluoxetine is probably the best option to consider when a pharmacological treatment is indicated.¹⁰

Several clinical practice guidelines recommend that in children and adolescents, psychotherapy should be considered as the first-line intervention for the management of depressive disorder, while pharmacological treatments are often reserved for more severe illness or when psychotherapy does not work or is not available.^{14,15} Nevertheless, the evidence-base for psychotherapy to be more effective and safer than antidepressants in the treatment of child and adolescent depressive disorder is not well established. A large,

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3 non-industry funded trial reported superior efficacy for fluoxetine compared to CBT in adolescents with
4 major depression.¹⁶ Previous research supports the notion that psychotherapy has its own side-effects, such as
5 dependency on the therapist, and leading to distress for the patients' family.¹⁷ However, unlike with
6 antidepressants, they are rarely measured systematically, making the comparison of safety and tolerability
7 harder.¹⁸ Moreover, data from the adult studies showed that combination antidepressants and psychotherapy
8 is superior to either intervention alone.^{19,20} Recently, a Cochrane conventional meta-analysis, on the basis of
9 the very limited evidence, reported that the effectiveness of psychological interventions, antidepressant
10 medication and a combination of these interventions for treating depressive disorders in children and
11 adolescents cannot be established.²¹

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23 Network meta-analysis has the advantage that all interventions that have been tested in randomised
24 controlled trials (RCTs) can be simultaneously compared, without requiring direct within-study treatment vs.
25 treatment comparisons. Thus effects of the different treatments can be estimated relative to each other as well
26 as to a common reference condition (e.g., pill placebo or psychological controls).²² Network meta-analysis thus
27 overcomes some of the limitations of traditional meta-analysis, in which conclusions are largely restricted to
28 comparisons between treatments that have been directly compared in RCTs.²³ In our two previous network
29 meta-analyses the comparative efficacy and acceptability of psychotherapies and antidepressants for
30 depressive disorder in children and adolescents have been separately investigated^{8,10} The aim of the current
31 protocol is to synthesise all this evidence and provide clinicians with a reliable treatment algorithm of the
32 commonly used psychological, and pharmacological interventions, as well as their combinations for the acute
33 treatment of depressive disorder in children and adolescents.

48 **Methods**

49 *Criteria for included studies*

50 **Types of studies**

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52 Any randomised controlled trials (RCTs), including the first phase of cross-over trials as well as cluster-
53 randomised trials, will be included. Quasi-randomised trials (e.g., those allocating participants using alternate
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3 days of the week) will be excluded. For trials of antidepressants alone, only double-blind RCTs (patients and
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5 raters blinded) will be included. As it is difficult to utilise a double-blind design for patients in trials of
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7 psychotherapy alone or the combination of antidepressant and psychotherapy, we will only include trials in
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9 which raters were blinded or participants were assessed by self-rating depression scales.
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12 13 14 **Types of participants**

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16 We will include studies that enrolled participants aged less than 18 years of age when they are initially
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18 enrolled in the studies, of both sexes with a diagnosis of depressive disorder, including of major depressive
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20 disorder (MDD), dysthymia, and other specified types, based on standardised diagnostic criteria (e.g., the
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22 Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases).²⁴⁻²⁹
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24 While it is accepted that subclinical depression still has a significant impact on an individuals' social and
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26 educational functioning, we will not include studies of this population. Similarly, studies where depressive
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28 disorder was not formally diagnosed will also be excluded for the same rationale that its clinical
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30 heterogeneity could violate the transitivity assumption in NMA (i.e. one can compare indirectly intervention
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32 B and C via intervention A).³⁰ We will also exclude trials in which participants are described as having
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34 psychotic depression or treatment-resistant depression, as their treatment response differs from patients
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36 without treatment resistance or symptoms of psychosis. Trials focusing on child or adolescent bipolar
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38 disorder will also be excluded, but not those involving patients with other comorbid psychiatric disorders as
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40 diagnosed according to standardised criteria (e.g., anxiety disorder, or attention deficit hyperactivity
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42 disorder). Where a study includes both adults and children/adolescents and the randomisation had been
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44 stratified according this variable, the data will be included if data on the depressed youths can be separately
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46 extracted from the manuscript, or can be obtained from the authors. Studies conducted in both inpatient and
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48 outpatient settings will be included. RCTs recruiting participants with an overall sample size of fewer than
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50 ten patients will be excluded.
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58 **Types of interventions**

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4 For pharmacological interventions, we will include any commonly prescribed oral antidepressants (fixed
5 or flexible doses). These will include tricyclic antidepressants (TCAs; amitriptyline, clomipramine,
6 nortriptyline, desipramine, imipramine, etc.), selective serotonin reuptake inhibitors (SSRIs; escitalopram,
7 fluoxetine, paroxetine, sertraline, etc.), and serotonin-norepinephrine reuptake inhibitors (SNRIs; venlafaxine,
8 duloxetine), as well as novel agents mirtazapine and nefazodone. In terms of psychological interventions, we
9 will include any manualised or structured psychotherapies, e.g., behavioral therapy, cognitive-behavioral
10 therapy, cognitive therapy, family therapy, interpersonal therapy, play therapy, problem-solving therapy,
11 psychodynamic therapy, and supportive therapy. Table 1 provides the detailed description of
12 psychotherapies. Also, we will include the combination of both above-mentioned psychological interventions
13 and pharmacological interventions. For the pharmacological interventions, the control condition is always a
14 pill placebo, whilst the psychological control conditions are waiting-list (WL), treatment as usual (TAU),
15 psychological placebo or attention placebo, or no-treatment (NT).
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32 All RCTs comparing any active intervention (psychological interventions, pharmacological interventions,
33 or their combinations) with either active comparators or control conditions for acute treatment of depressive
34 disorder in children and adolescents will be included. The acute phase will be defined as from 4 to 16 week.
35 We will exclude trials with treatment duration of less than 4 weeks, because the onset of benefit for most
36 antidepressants often takes at least 4 weeks.³¹ If a study present data for more than one time point within our
37 pre-defined acute phase window or beyond 16 weeks, the 8-week (or the closest to 8-week) will be taken as
38 the time. Trials comparing the same antidepressant at different therapeutic doses will be merged in the same
39 node in the network analysis so long as they are within the dose range licensed by drug regulatory agencies.
40 Also, trials comparing the same type of psychological interventions but at different numbers of therapeutic
41 sessions, different delivery format (group, individual), different treatment medium (face-to-face, internet-
42 based), and different treatment conditions (with or without family involvement) will be considered as the
43 same node in the network analysis. We anticipate that any patient who meets all inclusion criteria, in
44 principal, is equally likely to be randomised to any of the interventions in the synthesis comparator set.
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3 We have generated an ideal network plot that is a fully connected network with all expected
4 interventions (Figure 1).
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10 **Types of outcome measures**

11 *Primary outcomes*

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14 (1) Efficacy (as a continuous outcome), measured by the overall mean change scores on depressive symptom
15 scales (self- or assessor-rated), e.g., Children's Depression Rating Scale (CDRS-R)³² and Hamilton
16 Depression Rating Scale (HAMD)³³ from baseline to endpoint.
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21 (2) Acceptability of treatment, defined as the proportion of patients who drop out of the study by any cause
22 during the delivery of the intervention.
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27 *Secondary outcomes*

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30 (1) Efficacy (as dichotomous outcome), measured by the total number of patients who achieved the criteria of
31 remission, defined as being below the threshold in depression rating score (e.g., less than 28 for CDRS-
32 R),³⁴ while these thresholds are different across trials.
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36 (2) Tolerability of treatment, defined as the proportion of patients who discontinued treatment due to any
37 adverse events during the delivery of the intervention.
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41 (3) Suicide-related outcome, estimated by the reported cases of definitive suicidal behavior or suicidal
42 ideation during the acute phase of treatment. The definition of suicide-related outcome is based on the
43 Columbia Classification Algorithm of Suicide Assessment (C-CASA).³⁵ For the antidepressants trials,
44 the data on suicidality mainly referred to the Columbia re-analysis data reported in the FDA report.³⁶ If
45 trials are not included in this report, we will attempt to extract the data on suicide-related outcome
46 from the Medicines and Healthcare products Regulatory Agency database or the pharmaceutical
47 company website. For the psychological trials and the combination trials, we will mainly extract the
48 data on suicidality from original text, and from related reviews.
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4 (4) Global functional improvement, estimated by overall change scores on global assessment of functioning
5 scales, e.g., Children's Global Assessment Scale (CGAS)³⁷ and Global Assessment of Functioning Scale
6 (GAF),³⁸ or quality of life scales, e.g., Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-
7 Q).³⁹ When data are reported on more than one measure, we will first chose data from the CGAS, then
8 the GAF, and finally the Q-LES-Q and others.
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17 Where depression symptoms are measured using more than one depression scale in a trial, we will
18 extract data from the depressive scales on the basis of a hierarchy of rating scales. The hierarchy will be based
19 on psychometric properties and appropriateness for use with children and adolescents and for consistency of
20 use across trials (referred from the Zhou et al study⁴⁰, Table 2). We will also establish a hierarchy of
21 informants of depressive rating scales, with the clinician report first in the hierarchy, and then the child or
22 adolescent self-report.
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32 **Data Sources and Search strategy**

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34 For the identification of trials of antidepressant and psychotherapy alone for depressive disorder in
35 children and adolescents, we will update the literature search of our two previous network meta-analyses.^{8,10}
36 Other eligible trials of the combinations of antidepressant and psychotherapy will be identified by searching
37 PubMed, EMBASE, CENTRAL (Cochrane Central Register of Controlled Trials), Web of Science, PsycINFO,
38 ProQuest, CINAHL, LiLACS from date of inception with Medical Subject Headings (MeSH) and text words:
39 (depress* or dysthymi* or mood disorder* or affective disorder*) and (adolesc* or child* or boy* or girl* or
40 juvenil* or minors or paediatric* or pediatric* or pubescen* or school* or student* or teen* or young or youth*)
41 and ("selective serotonin reuptake inhibitor*" or SSRIs or "serotonin norepinephrine reuptake inhibitor*" or
42 SNRIs or citalopram or fluoxetine or paroxetine or sertraline or escitalopram or fluvoxamine or venlafaxine or
43 duloxetine "noradrenergic and specific serotonergic antidepressants" or NaSSA or mirtazapine or TCA or
44 tricyclic or amitriptyline or clomipramine or desipramine or imipramine or nortriptyline) and
45 (psychotherapy* or behavio* or "family therap*" or CBT or cognitive or interpersonal or IPT or "play therap*")
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3 or supportive or problem-solving or psychodynamic). We will also search ClinicalTrials.gov in USA and other
4 international trial registers via the International Clinical Trials Registry Platform (ICTRP) in WHO. We will
5 also check relevant reports on the US Food and Drug Administration (FDA) website, and hand-search key
6 journals, conference proceedings, such as, *J Child Adolesc Psychopharmacol*, *J Am Acad Child Adolesc Psychiatry*,
7 *Child Adolesc Psychiatry Ment Health*, *Psychopharmacol Bull*, *Arch Gen Psychiatry*, *Am J Psychiatry*, *Eur Psychiatry*,
8 *Depress Anxiety*. There will be no restrictions on language, or publication year. Additional relevant studies
9 will be obtained by scanning reference lists of trials identified in the initial searches and relevant review
10 papers. We will also inquire at the relative pharmaceutical companies (e.g., GlaxoSmithKline, Lilly, Organon,
11 Forest Pharmaceuticals, Bristol-Myers Squibb) and search their websites for unpublished data. All relevant
12 experts and principal manufacturers will be contacted to supplement incomplete reports of the original
13 papers or to provide new data for unpublished studies.
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30 **Study selection and data extraction**

31 *Selection of trials*

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34 Titles and abstracts identified from the search strategies will be independently examined by two
35 reviewers (XZ and YZ). If both reviewers judge that the trial does not meet eligibility criteria, we will exclude
36 it. Then, we will obtain the full-texts of all remaining articles and determine whether to include them
37 according to inclusion criteria described above. We will calculate the inter-rater reliability of the two raters.
38 Any disagreements will be resolved by a third review author (AC or PX) or by consultation with the authors
39 of the articles. The reasons for exclusion of trials will be reported in the characteristics of excluded studies list.
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49 *Data extraction*

50
51 Two independent reviewers (XZ and YZ) will extract the data from each included trial using
52 standardised data extraction forms, including study characteristics (e.g., first listed author, publication year,
53 title, publication type, publication journal, country, and sponsor), patient characteristics (e.g., diagnostic
54 criteria, comorbidities, the age of patients, patient setting, the number of patients, the gender of patients, and
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3 severity of depression at baseline), intervention details (e.g., the type of intervention, the treatment duration,
4 the dose of antidepressant agent, the length and number of sessions of psychotherapy, treatment delivery and
5 treatment medium of psychotherapy) and outcome measures (primary outcomes and secondary outcomes).
6
7 We will assess and report the reliability of the reviewers' data extraction on each coded variable. Any
8
9 disagreements will be resolved by a third review author (AC or PX). Where necessary, the authors of the
10
11 studies will be contacted for further information.
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19 *Risk of bias assessment*

20
21 We will assess risk of bias as "low risk", "unclear risk", or "high risk", in accordance with the Cochrane
22
23 Collaboration's Risk of bias tool as described in the Cochrane Hand book for Systematic Reviews of
24
25 Interventions.⁴¹ The following items will be assessed: sequence generation, allocation concealment, blinding of
26
27 participants and personnel, blinding of outcome assessors, incomplete outcome data, selective outcome
28
29 reporting, and other sources of bias (e.g., sponsorship bias/researcher allegiance bias). Two independent
30
31 review authors (XZ and YZ) will assess the risk of bias in selected studies. Degree of agreement between the
32
33 two independent raters will be reported. Any disagreements will be resolved by a third review author (AC or
34
35 PX). Where necessary, the authors of the studies will be contacted for further information. Studies will be
36
37 classified as having high risk of bias if two or more domains were rated as high risk of bias; low if five or
38
39 more were rated as low risk of bias and none was rated as high risk of bias, and all other cases will be
40
41 assumed to pertain to moderate risk.
42
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45
46

47 **Statistical analysis**

48
49 Network meta-analysis combines direct and indirect evidence for all relative treatment effects and
50
51 provides estimates with maximum power.²³ First, we will perform pairwise meta-analyses of direct evidence
52
53 using the random-effects model with STATA version 14.0. Second, we will also perform a random-effects
54
55 network meta-analysis (NMA) within a Bayesian framework using Markov chain Monte Carlo in WinBUGS
56
57 version 1.4.3. Where different measures are used to assess the same outcome, continuous outcomes data will
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1
2
3 be pooled with standardised mean difference (SMD), and dichotomous outcomes will be analysed by
4
5 calculating the odds ratio (OR). In the presence of minimally informative priors, Credible Intervals (CrIs) can
6
7 be interpreted similarly to confidence intervals (CIs).
8
9

10 Missing dichotomous outcome data will be managed according to the intention to treat (ITT) principle,
11
12 and all the dropouts after randomisation will be considered to be non-responders. Missing continuous
13
14 outcome data will be analysed using the completer data. When p-values, t-values, confidence intervals or
15
16 standard errors are reported in articles, SD will be calculated from their values.⁴² Where SDs are missing,
17
18 attempts will be made to obtain these data through contacting trial authors. When this fails, they will be
19
20 borrowed from the other trials in the network or from other published reports.⁴²
21
22

23 In the analysis of network meta-analysis, the pooled estimates will be obtained using the Markov Chains
24
25 Monte Carlo method. Two Markov chains will be run simultaneously with different arbitrarily chosen initial
26
27 values and non-informative priors will be used for the parameters. To ensure convergence, trace plots and the
28
29 Brooks-Gelman-Rubin statistic will be assessed.⁴³ We will also estimate the ranking probabilities for all
30
31 treatments of being at each possible rank for each intervention. Then, we will obtain a treatment hierarchy
32
33 using the surface under the cumulative ranking curve (SUCRA) and mean ranks. SUCRA can also be
34
35 interpreted as the percentage of efficacy/safety of a treatment that would be ranked first without
36
37 uncertainty.⁴⁴
38
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40 41 42 *Measures for transitivity assumption*

43
44 We will assess whether the included interventions are similar when they are evaluated in RCTs with
45
46 different designs; and whether the distributions of clinical and methodological variables that can act as effect
47
48 modifiers across treatment comparison are balanced across comparisons. The clinical features, which have
49
50 been demonstrated to date to moderate efficacy of antidepressants and psychotherapy in children and
51
52 adolescents include bipolarity,⁴⁵ psychotic features,⁴⁶ subthreshold depression.⁴⁷ We have assured transitivity
53
54 in our network with regard to these variables by limiting our samples to participants with non-psychotic
55
56 unipolar depressive disorders. Other clinical or methodological variables that may influence our primary
57
58
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1
2
3 outcomes of treatment efficacy or acceptability include: age, sex, depressive severity at baseline, and the
4
5 treatment duration.
6

7 *Measures for heterogeneity*

8
9
10 In standard pairwise meta-analyses we will estimate a different heterogeneity variance for each pairwise
11
12 comparisons; in network meta-analysis we will assume a common estimate for the heterogeneity variance
13
14 across the different comparisons. We will assess statistically the presence of heterogeneity within each
15
16 pairwise comparison using the I-squared statistic⁴⁸ and its 95% confidence interval that measures the
17
18 percentage of variability that cannot be attributed to random error. The assessment for the presence of
19
20 statistical heterogeneity in the entire network will be based on the magnitude of the heterogeneity variance
21
22 parameter (τ^2) estimated from the NMA models. We will also estimate a total I-squared value and predictive
23
24 intervals for heterogeneity in the network.⁴⁹
25
26
27
28

29 *Measures for inconsistency*

30
31
32 NMA assumes that there is consistency in the network (i.e. direct and indirect evidence are in
33
34 agreement). However, the assumption of consistency can be violated either in the entire network or in certain
35
36 parts (i.e. loops of evidence) of the network.⁵⁰ Therefore, consistency needs to be checked. We will evaluate
37
38 the presence of local inconsistency and global inconsistency in STATA version 14.0 and will be duplicated in
39
40 R software.⁵¹
41
42
43
44

45 *Measures for publication bias*

46
47 We will use the contour-enhanced funnel plot and Egger's test to assess risk of publication bias within
48
49 each pairwise comparison.⁵² We will also use the comparison-adjusted funnel plots of all trials with placebo
50
51 controls or inactive controls to investigate whether results in imprecise trials differ from those in more precise
52
53 trials in network meta-analysis.⁵³
54
55
56
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58 *Subgroup analyses and sensitivity analyses*

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3
4 Where possible, we will conduct the network meta-regression meta-analyses of data on primary
5
6 outcomes for the: (i) age of participants (children vs. adolescents); (ii) sex ratio; (iii) the severity of depressive
7
8 symptoms at baseline; (iv) the treatment duration; (v) severity of depressive symptom at baseline. If possible,
9
10 we will do some extra subgroup analyses according to the results of heterogeneity and inconsistency. In the
11
12 sensitivity analysis, trials where missing data have been imputed will be excluded, trials where high risk of
13
14 bias rating have been assessed, and trials where only included patients comorbidity with other psychiatric
15
16 disorders will be excluded. And, we will not only test whether the results change but also if transitivity
17
18 (consistency/model fit) is affected. We will also examine some variables (e.g., sample size of trials⁵⁴), as
19
20 continuous measure in meta-regression analyses.
21

22 23 24 25 *GRADE quality assessment*

26
27 We will also assess the quality of evidence contributing to primary outcomes with the GRADE
28
29 framework, which characterises the quality of a body of evidence on the basis of the study limitations,
30
31 imprecision, heterogeneity or inconsistency, indirectness, and publication bias.⁵⁵ The starting point for
32
33 confidence in each network estimate is high, but will be downgraded according to the assessments of these
34
35 five aspects.
36
37

38 39 40 41 *Ethics and dissemination*

42
43
44 This network meta-analysis does not need ethical approval, as data used here are based on aggregated
45
46 data in the public domain. Findings from the analysis will provide an overview and information on the
47
48 relative efficacy and acceptability of antidepressant medications, psychological therapies, and their
49
50 combination for depressive disorder in children and adolescents. It is suggested that the findings will have
51
52 significant implications for clinical practice and further research.
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3
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5
6
7 draft of the manuscript. PC, SEH, JRW, CDG, TAF, JB, DC, SL, AVR assisted in protocol design and revision.
8
9
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11
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22
23
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25
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28
29
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31
32
33 adolescents, and an author (senior) on the Cochrane review of psychological, pharmacological and their
34
35
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41
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43
44
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8

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TABLES

Table 1 Description of Psychotherapeutic interventions and control conditions

Interventions	Abbreviation	Description
<i>Psychotherapeutic Intervention:</i>		
Behavioral therapy	BT	BT uses some kind of behavioral training and psychoeducation. BT programs provide parents and youths information about MDD and interventions; teach youths to monitor their mood, thoughts and behaviors; proposed pleasant activity scheduling and behavioral activation.
Cognitive-behavioral therapy	CBT	CBT is a combination of BT and CT. Additional CBT skill-building techniques are used in many programs by teaching relaxation techniques to cope with environmental stressors, providing social skills and resolution training, and teaching general problem-solving.
Cognitive therapy	CT	CT uses some kind of cognitive restructuring training. CT programs ask youths to examine their automatic thoughts and core schemas and to assess the accuracy and affective consequences of their views. They aim to teach youths to engage in "rational" thinking about themselves, the world and their possibilities for the future.
Family therapy	FT	FT works with families to nurture change and development. FT tends to view change in terms of the systems of interaction between family members. In the case of youth with MDD, FT aims at helping the family to answer the child's needs for completing age-appropriate developmental tasks to relieve depression.
Interpersonal therapy	IPT	IPT aim at educating patients as to how their depression and the quality of interpersonal relationships affect one another and at addressing interpersonal problems that may be contributing to the depression (e.g. grief, disputes, role transitions, social deficits). Compared to its adult version, IPT in youths is shorter, involves parents, and adds a liaison role for the therapist between schools and families.
Play therapy	PT	PT used techniques to engage participants in recreational activities to help them cope with their problems and fears.
Problem-solving therapy	PST	PST focus on the problems participants are currently facing and on helping them find solutions to those problems.
Psychodynamic therapy	DYN	DYN proposed patients to help understand the origin and nature of long standing problems by investigating both conscious and non-conscious thoughts and emotional feelings. DYN uses free associations and interpretation of dreams (or drawing in children), and addresses how personal history and experience may alter the patient/therapist transference. In youth MDD, a particular interest is given to psychological trauma, early

parent/child relationships, narcissistic organization and experiences of loss.

Supportive therapy SUP
 SUP is an unstructured therapy without specific psychological techniques that it helped people to ventilate their experiences and emotions and offering empathy. These therapies are commonly described in the literature as either counseling or supportive therapy.

Control conditions:

No-treatment NT
 NT is a control condition in which the participants receive no active treatment during the study and in which they do not expect to receive such after the study is over.

Psychological placebo PBO
 PBO is a control condition that was regarded as inactive by the researchers but was to be the participants.

Treatment-as-usual TAU
 TAU is not considered to be structured psychotherapy but may have some treatment effects.

Waitlist WL
 WL is a control condition in which the participants receive no active treatment during the study but are forewarned that they can receive one after the study period is over.

Table 2 Hierarchy of depression symptom severity measurement scales

Hierarchy	Depression symptom severity measurement scales	Abbreviation
1	Children's Depression Rating Scale	CDRS
2	Hamilton Depression Rating Scale	HAMD
3	Montgomery Asberg Depression Rating Scale	MADRS
4	Beck Depression Inventory	BDI
5	Children's Depression Inventory	CDI
6	Schedule for Affective Disorders and Schizophrenia for School Aged Children	K-SADS
7	Mood and Feeling Questionnaire	MFQ
8	Reynolds Adolescent Depression Scale	RADS
9	Bellevue Index of Depression	BID
10	Child Depression Scale	CDS
11	Centre for Epidemiologic Studies Depression Scale	CESD
12	Child Assessment Schedule	CAS
13	Child Behavior Checklist-Depression	CBCL-D

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Figure 1. Possible interventions eligible for the ideal network plot

For peer review only

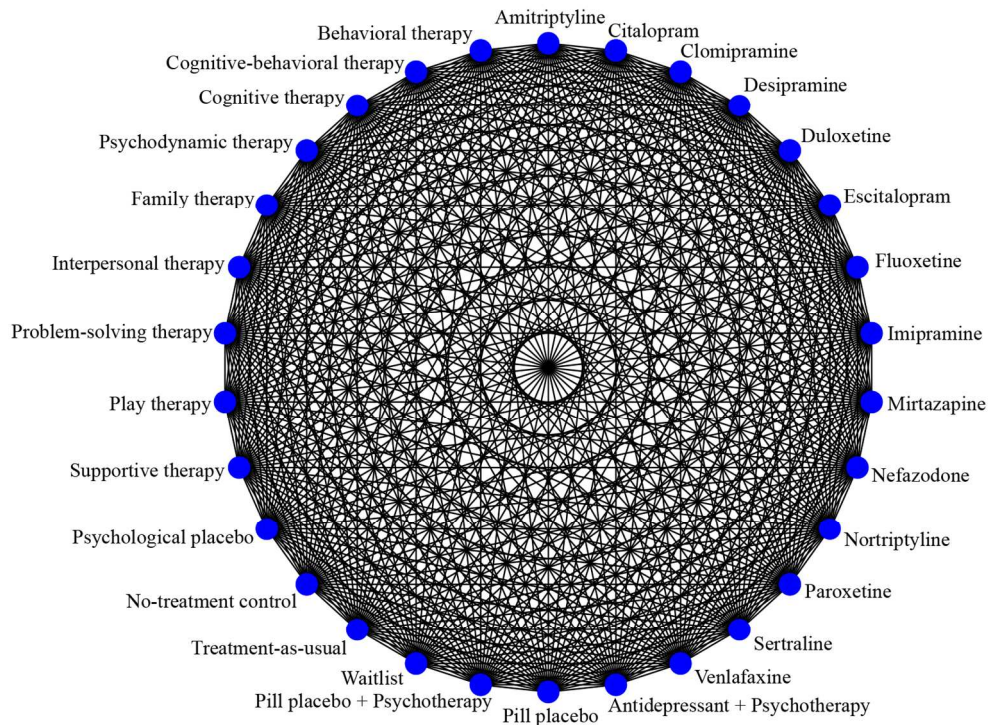


Figure 1. Possible interventions eligible for the ideal network plot

139x102mm (300 x 300 DPI)

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

Section and topic	Item No	Checklist item	Reported on Page #
ADMINISTRATIVE INFORMATION			
Title:			
Identification	1a	Comparative efficacy and acceptability of antidepressants, psychological interventions, and their combination for depressive disorder in children and adolescents: protocol for a network meta-analysis	1
Update	1b	None	
Registration	2	PROSPERO CRD42015020841	4
Authors:			
Contact	3a	Xinyu Zhou, Yuqing Zhang, Juncai Pu, Lining Yang, Peng Xie (Department of Neurology and Psychiatry, The First Affiliated Hospital of Chongqing Medical University, Chongqing, China; Institute of Neuroscience and the Collaborative Innovation Center for Brain Science, Chongqing Medical University, Chongqing, China) Andrea Cipriani (Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford, UK) Pim Cuijpers (Department of Clinical, Neuro and Developmental Psychology, Amsterdam Public Health research institute, Vrije Universiteit Amsterdam, The Netherlands) Sarah E. Hetrick (Orygen, The National Centre of Excellence in Youth Mental Health, and the Centre of Youth Mental Health, University of Melbourne, Melbourne, Australia) John R. Weisz (Department of Psychology, Harvard University, Cambridge, MA, USA) Cinzia Del Giovane (Department of Diagnostic, Clinical and Public Health Medicine, University of Modena and Reggio Emilia, Modena, Italy) Toshiaki A. Furukawa (Department of Health Promotion and Human Behavior, Kyoto University Graduate School of Medicine and School of Public Health, Kyoto, Japan) Jürgen Barth (Institute of Complementary and Integrative Medicine, University Hospital and University of Zurich, Zurich, Switzerland) David Coghill (Departments of Paediatrics and Psychiatry, University of Melbourne, Melbourne, Australia) Stefan Leucht (Department of Psychiatry and Psychotherapy, Technische Universität München, Munich, Germany) Arun V Ravindran (Department of Psychiatry, University of Toronto, Toronto, ON, Canada) Corresponding author :Peng Xie, Department of Neurology and Psychiatry, The First Affiliated Hospital of Chongqing Medical University, 1 Youyi Road, Yuzhong District, Chongqing 400016, China; E-mail: xiepeng973@126.com	1-2
Contributions	3b	PX, AC, and XZ conceived the study and drafted the protocol. PX, AC and XZ wrote the first draft of the manuscript. PC, SEH, JRW, CDG, TAF, JB, DC, AVR assisted in protocol design and revision. XZ, YZ, and LY participated in the search strategy	17

development. CDG, and JP participated in the design of data synthesis and analysis. All the authors have approved the publication of the protocol.

Amendments 4 None

Support:

Sources 5a ational Basic Research Program of China (973 Program) (Grant No. 2009CB918300)

Sponsor 5b This work is supported by the National Basic Research Program of China (973 Program) (Grant No. 2009CB918300).

Role of sponsor or funder 5c The funders had no role in the protocol design; the writing of the protocol; or the decision to submit the protocol for publication.

INTRODUCTION

Rationale 6 Depressive disorder in children and adolescents is a major public health problem. The course of depressive disorder in young people is often characterised by protracted episodes, frequent recurrence, and comorbid psychiatric disorders. Several clinical practice guidelines recommend that in children and adolescents, psychotherapy should be considered as the first-line intervention for the management of depressive disorder, while pharmacological treatments are often reserved for more severe illness or when psychotherapy does not work or is not available. Nevertheless, the evidence-base for psychotherapy to be more effective and safer than antidepressants in the treatment of child and adolescent depressive disorder is not well established. In our two previous network meta-analyses the comparative efficacy and acceptability of psychotherapies and antidepressants for depressive disorder in children and adolescents have been separately investigated 6

Objectives 7 The aim of the current protocol is to synthesise all this evidence and provide clinicians with a reliable treatment algorithm of the commonly used psychological, and pharmacological interventions, as well as their combinations for the acute treatment of depressive disorder in children and adolescents. 7

METHODS

Eligibility criteria 8 **Types of participants**
We will include studies that enrolled participants aged less than 18 years of age when they are initially enrolled in the studies, of both sexes with a diagnosis of depressive disorder based on standardised diagnostic criteria (e.g., the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases). While it is accepted that subclinical depression still has a significant impact on an individuals' social and educational functioning, we will not include studies of this population. Similarly, studies where depressive disorder was not formally diagnosed will also be excluded for the same rationale that its clinical heterogeneity could violate the transitivity assumption in NMA (i.e. one can compare indirectly intervention B and C via intervention A). We will also exclude trials in which participants are described as having psychotic depression or treatment-resistant depression, as their treatment response differs from patients without treatment resistance or symptoms of psychosis. Trials focusing on child or adolescent bipolar disorder will also be excluded, but not those involving patients with other comorbid psychiatric disorders (e.g., anxiety disorder). Where a study includes both adults and children/adolescents and the randomisation had been stratified according this variable, the data will be included if data on the depressed youths can be separately extracted from the manuscript, or can be obtained from the authors. Studies conducted in both inpatient and outpatient settings will be included. RCTs recruiting participants with an overall sample size of fewer than ten patients will be excluded. 7-10

Types of studies

Any randomised controlled trials (RCTs), including the first phase of cross-over trials as well as cluster-randomised trials, will be included. Quasi-randomised trials (e.g., those allocating participants using alternate days of the week) will be excluded. For trials of antidepressants alone, only double-blind RCTs (patients and raters blinded) will be included. As it is difficult to utilise a double-blind design for patients in trials of psychotherapy alone or the combination of antidepressant and psychotherapy, we will only include trials in which raters were blinded or participants were assessed by self-rating depression scales.

Types of interventions

For pharmacological interventions, we will include any commonly prescribed oral antidepressants (fixed or flexible doses). These will include tricyclic antidepressants (TCAs; amitriptyline, clomipramine, nortriptyline, desipramine, imipramine, etc.), selective serotonin reuptake inhibitors (SSRIs; escitalopram, fluoxetine, paroxetine, sertraline, etc.), and serotonin-norepinephrine reuptake inhibitors (SNRIs; venlafaxine, duloxetine), as well as novel agents mirtazapine and nefazodone. In terms of psychological interventions, we will include any manualised or structured psychotherapies, e.g., behavioral therapy, cognitive-behavioral therapy, cognitive therapy, family therapy, interpersonal therapy, play therapy, problem-solving therapy, psychodynamic therapy, and supportive therapy. Also, we will include the combination of both psychological interventions and pharmacological interventions. For the pharmacological interventions, the control condition always is pill placebo, and these for psychological control conditions will include waiting-list (WL), treatment as usual (TAU), psychological placebo or attention placebo, as well as no-treatment (NT). All RCTs comparing any active intervention (psychological interventions, pharmacological interventions, or their combinations) with either active comparators or control conditions for acute treatment of depressive disorder in children and adolescents will be included. The acute phase will be defined as from 4 to 16 week. We will exclude trials with treatment duration of less than 4 weeks, because the onset of benefit for most antidepressants often takes at least 4 weeks. If a study present data for more than one time point within our pre-defined acute phase window or beyond 16 weeks, the 8-week (or the closest to 8-week) will be taken as the time. Trials comparing the same antidepressant at different therapeutic doses will be merged in the same node in the network analysis so long as they are within the dose range licensed by drug regulatory agencies. Also, trials comparing the same type of psychological interventions but at different numbers of therapeutic sessions, different delivery format (group, individual), different treatment medium (face-to-face, internet-based), and different treatment conditions (with or without family involvement) will be considered as the same node in the network analysis. We anticipate that any patient who meets all inclusion criteria, in principal, is equally likely to be randomised to any of the interventions in the synthesis comparator set.

Types of outcome measures

Primary outcomes

- (1) Efficacy (as a continuous outcome), measured by the overall mean change scores on depressive symptom scales (self- or assessor-rated), e.g., Children's Depression Rating Scale (CDRS-R) and Hamilton Depression Rating Scale (HAMD) from baseline to endpoint.
- (2) Acceptability of treatment, defined as the proportion of patients who drop out of the study by any cause during the delivery of the intervention.

Secondary outcomes

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(1) Efficacy (as dichotomous outcome), measured by the total number of patients who achieved the criteria of remission, defined as being below the threshold in depression rating score (e.g., less than 28 for CDRS-R), while these thresholds are different across trials.

(2) Tolerability of treatment, defined as the proportion of patients who discontinued treatment due to any adverse events during the delivery of the intervention.

(3) Suicide-related outcome, estimated by the reported cases of definitive suicidal behavior or suicidal ideation during the acute phase of treatment. The definition of suicide-related outcome is based on the Columbia Classification Algorithm of Suicide Assessment (C-CASA). For the antidepressants trials, the data on suicidality mainly referred to the Columbia re-analysis data reported in the FDA report. If trials are not included in this report, we will attempt to extract the data on suicide-related outcome from the Medicines and Healthcare products Regulatory Agency database or the pharmaceutical company website. For the psychological trials and the combination trials, we will mainly extract the data on suicidality from original text, and from related reviews.

(4) Global functional improvement, estimated by overall change scores on global assessment of functioning scales, e.g., Children's Global Assessment Scale (CGAS) and Global Assessment of Functioning Scale (GAF), or quality of life scales, e.g., Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q). When data are reported on more than one measure, we will first chose data from the CGAS, then the GAF, and finally the Q-LES-Q and others.

Information sources	9	For the identification of trials of antidepressant and psychotherapy alone for depressive disorder in children and adolescents, we will update the literature search of our two previous network meta-analyses. ^{8,10} Other eligible trials of the combinations of antidepressant and psychotherapy will be identified by searching PubMed, EMBASE, CENTRAL (Cochrane Central Register of Controlled Trials), Web of Science, PsycINFO, ProQuest, CINAHL, LiLACS from date of inception with Medical Subject Headings (MeSH) and text words. We will also search ClinicalTrials.gov in USA and other international trial registers via the International Clinical Trials Registry Platform (ICTRP) in WHO. We will also check relevant reports on the US Food and Drug Administration (FDA) website, and hand-search key journals, conference proceedings, such as, J Child Adolesc Psychopharmacol, J Am Acad Child Adolesc Psychiatry, Child Adolesc Psychiatry Ment Health, Psychopharmacol Bull, Arch Gen Psychiatry, Am J Psychiatry, Eur Psychiatry, Depress Anxiety. There will be no restrictions on language, or publication year. Additional relevant studies will be obtained by scanning reference lists of trials identified in the initial searches and relevant review papers. We will also inquire at the relative pharmaceutical companies (e.g., GlaxoSmithKline, Lilly, Organon, Forest Pharmaceuticals, Bristol-Myers Squibb) and search their websites for unpublished data. All relevant experts and principal manufacturers will be contacted to supplement incomplete reports of the original papers or to provide new data for unpublished studies.	11-12
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Search strategy	10	(depress* or dysthymi* or mood disorder* or affective disorder*) and (adolesc* or child* or boy* or girl* or juvenil* or minors or paediatric* or pediatri* or pubescen* or school* or student* or teen* or young or youth*) and (“selective serotonin reuptake inhibitor*” or SSRIs or “serotonin norepinephrine reuptake inhibitor*” or SNRIs or citalopram or fluoxetine or paroxetine or sertraline or escitalopram or fluvoxamine or venlafaxine or duloxetine “noradrenergic and specific serotonergic antidepressants” or NaSSA or mirtazapine or TCA or tricyclic or amitriptyline or clomipramine or desipramine or imipramine or nortriptyline) and (psychotherapy* or behavio* or “family therap*” or CBT or cognitive or interpersonal or IPT or “play therap*” or supportive or problem-solving or psychodynamic).	11
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Study records:

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5	Data management	11a	Literature search results will be imported to Endnote and the duplicates will be removed during the study selection process. We will screening citations based on the inclusion and exclusion criteria. 12
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7	Selection process	11b	Titles and abstracts identified from the search strategies will be independently examined by two reviewers (XZ and YZ). If both reviewers judge that the trial does not meet eligibility criteria, we will exclude it. Then, we will obtain the full-texts of all remaining articles and determine whether to include them according to inclusion criteria described above. We will calculate the inter-rater reliability of the two raters. Any disagreements will be resolved by a third review author (AC or PX) or by consultation with the authors of the articles. The reasons for exclusion of trials will be reported in the characteristics of excluded studies list. 12
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9	Data collection process	11c	Two independent reviewers (XZ and YZ) will extract the data from each included trial using standardised data extraction forms. We will assess and report the reliability of the reviewers' data extraction on each coded variable. Any disagreements will be resolved by a third review author (AC or PX). Where necessary, the authors of the studies will be contacted for further information. 12-13
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11	Data items	12	Study characteristics (e.g., first listed author, publication year, title, publication type, publication journal, country, and sponsor), patient characteristics (e.g., diagnostic criteria, comorbidities, the age of patients, patient setting, the number of patients, the gender of patients, and severity of depression at baseline), intervention details (e.g., the type of intervention, the treatment duration, the dose of antidepressant agent, the length and number of sessions of psychotherapy, treatment delivery and treatment medium of psychotherapy) and outcome measures (primary outcomes and secondary outcomes). 12
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13	Outcomes and prioritization	13	Primary outcomes (1) Efficacy (as a continuous outcome), measured by the overall mean change scores on depressive symptom scales (self- or assessor-rated), e.g., Children's Depression Rating Scale (CDRS-R) and Hamilton Depression Rating Scale (HAMD) from baseline to endpoint. (2) Acceptability of treatment, defined as the proportion of patients who drop out of the study by any cause during the delivery of the intervention. Secondary outcomes (1) Efficacy (as dichotomous outcome), measured by the total number of patients who achieved the criteria of remission, defined as being below the threshold in depression rating score (e.g., less than 28 for CDRS-R), while these thresholds are different across trials. (2) Tolerability of treatment, defined as the proportion of patients who discontinued treatment due to any adverse events during the delivery of the intervention. 10-11 (3) Suicide-related outcome, estimated by the reported cases of definitive suicidal behavior or suicidal ideation during the acute phase of treatment. The definition of suicide-related outcome is based on the Columbia Classification Algorithm of Suicide Assessment (C-CASA). For the antidepressants trials, the data on suicidality mainly referred to the Columbia re-analysis data reported in the FDA report. If trials are not included in this report, we will attempt to extract the data on suicide-related outcome from the Medicines and Healthcare products Regulatory Agency database or the pharmaceutical company website. For the psychological trials and the combination trials, we will mainly extract the data on suicidality from original text, and from related reviews. (4) Global functional improvement, estimated by overall change scores on global assessment of functioning scales, e.g., Children's Global Assessment Scale (CGAS) and Global Assessment of Functioning Scale (GAF), or quality of life scales, e.g., Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q). When data are reported on more than one measure, we will first chose
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		<p>data from the CGAS, then the GAF, and finally the Q-LES-Q and others.</p> <p>Where depression symptoms are measured using more than one depression scale in a trial, we will extract data from the depressive scales on the basis of a hierarchy of rating scales. The hierarchy will be based on psychometric properties and appropriateness for use with children and adolescents and for consistency of use across trials (referred from the Zhou et al study). We will also establish a hierarchy of informants of depressive rating scales, with the clinician report first in the hierarchy, and then the child or adolescent self-report.</p>	
Risk of bias in individual studies	14	<p>We will assess risk of bias as “low risk”, “unclear risk”, or “high risk”, in accordance with the Cochrane Collaboration’s Risk of bias tool as described in the Cochrane Hand book for Systematic Reviews of Interventions. The following items will be assessed: sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessors, incomplete outcome data, selective outcome reporting, and other sources of bias (e.g., sponsorship bias/researcher allegiance bias). Two independent review authors (XZ and YZ) will assess the risk of bias in selected studies. Degree of agreement between the two independent raters will be reported. Any disagreements will be resolved by a third review author (AC or PX). Where necessary, the authors of the studies will be contacted for further information. Studies will be classified as having high risk of bias if two or more domains were rated as high risk of bias; low if five or more were rated as low risk of bias and none was rated as high risk of bias, and all other cases will be assumed to pertain to moderate risk.</p>	13
Data synthesis	15a	<p>We will perform Bayesian network meta-analysis to compare the relative outcomes of different antidepressant medications, psychotherapies or their combination from the median of the posterior distribution.</p>	13
	15b	<p>Network meta-analysis combines direct and indirect evidence for all relative treatment effects and provides estimates with maximum power. First, we will perform pairwise meta-analyses of direct evidence using the random-effects model with STATA version 14.0. Second, we will also perform a random-effects network meta-analysis (NMA) within a Bayesian framework using Markov chain Monte Carlo in WinBUGS version 1.4.3. Where different measures are used to assess the same outcome, continuous outcomes data will be pooled with standardised mean difference (SMD), and dichotomous outcomes will be analysed by calculating the odds ratio (OR). In the presence of minimally informative priors, Credible Intervals (CrIs) can be interpreted similarly to confidence intervals (CIs).</p> <p>Missing dichotomous outcome data will be managed according to the intention to treat (ITT) principle, and all the dropouts after randomisation will be considered to be non-responders. Missing continuous outcome data will be analysed using the completer data. When p-values, t-values, confidence intervals or standard errors are reported in articles, SD will be calculated from their values. Where SDs are missing, attempts will be made to obtain these data through contacting trial authors. When this fails, they will be borrowed from the other trials in the network or from other published reports.</p> <p>In the analysis of network meta-analysis, the pooled estimates will be obtained using the Markov Chains Monte Carlo method. Two Markov chains will be run simultaneously with different arbitrarily chosen initial values and non-informative priors will be used for the parameters. To ensure convergence, trace plots and the Brooks-Gelman-Rubin statistic will be assessed. We will also estimate the ranking probabilities for all treatments of being at each possible rank for each intervention. Then, we will obtain a treatment hierarchy using the surface under the cumulative ranking curve (SUCRA) and mean ranks. SUCRA can also be interpreted as the percentage of efficacy/safety of a treatment that would be ranked first without uncertainty.</p>	13-14
	15c	<p>Where possible, we will conduct the network meta-regression meta-analyses of data on primary outcomes for the: (i) age of participants (children vs. adolescents); (ii) sex ratio; (iii) the severity of depressive symptoms at baseline; and (iv) the treatment duration. If possible, we will do some extra subgroup analyses according to the results of heterogeneity and inconsistency. In the</p>	15-16

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		sensitivity analysis, trials where missing data have been imputed will be excluded, and trials where high risk of bias rating have been assessed will be excluded. And, we will not only test whether the results change but also if transitivity (consistency/model fit) is affected. We will also examine some variables (e.g., sample size of trials ⁵³), as continuous measure in meta-regression analyses.	
	15d	A systematic narrative synthesis will be provided with information presented in the text and tables to summarize and explain the characteristics and findings of the included studies.	15
Meta-bias(es)	16	We will use the contour-enhanced funnel plot and Egger's test to assess risk of publication bias within each pairwise comparison. We will also use the comparison-adjusted funnel plots of all trials with placebo controls or inactive controls to investigate whether results in imprecise trials differ from those in more precise trials in network meta-analysis.	15
Confidence in cumulative evidence	17	We will also assess the quality of evidence contributing to primary outcomes with the GRADE framework, which characterises the quality of a body of evidence on the basis of the study limitations, imprecision, heterogeneity or inconsistency, indirectness, and publication bias. The starting point for confidence in each network estimate is high, but will be downgraded according to the assessments of these five aspects.	16

*** It is strongly recommended that this checklist be read in conjunction with the PRISMA-P Explanation and Elaboration (cite when available) for important clarification on the items. Amendments to a review protocol should be tracked and dated. The copyright for PRISMA-P (including checklist) is held by the PRISMA-P Group and is distributed under a Creative Commons Attribution Licence 4.0.**

From: Shamseer L, Moher D, Clarke M, Ghersi D, Liberati A, Petticrew M, Shekelle P, Stewart L, PRISMA-P Group. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015: elaboration and explanation. BMJ. 2015 Jan 2;349(jan02 1):g7647.