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Blues Programme

Review: January 2021

Note on provider involvement: This provider has agreed to EIF's terms of reference, and the assessment has been conducted and published with the full cooperation of the programme provider.

The Blues Programme is a school-based cognitive behavioural therapy programme. It is a targeted indicated group intervention programme for pupils between the age of 13 and 19. It is for adolescents who are experiencing depressive symptoms. It is delivered in secondary schools, and aims to support adolescents to identify negative thoughts, change their thinking patterns, increase their involvement in pleasant activities, and enhance their coping flexibility.

Evidence rating: **4+**

Cost rating: **1**

The intervention consists of six weekly one hour long group sessions that are cofacilitated by a Young Persons Practitioner and a Young Persons Support Worker.

The intervention is a talking therapy involving group discussion using live experiences from the group. There also is homework to reinforce the learning from the group sessions.

The recipients are identified through a screening questionnaire (CES-D) that assesses the frequency of negative thoughts and feelings over the previous 7–10 days. The screening questionnaire is typically given to larger groups of young people, such as whole year groups or multiple classes.

The screening questionnaire helps schools identify pupils with emerging or entrenched mental health difficulties who would benefit from participating in the intervention. This can involve but is not limited to young people feeling under pressure to achieve, those experiencing chaotic home life, parental mental health difficulties, low self-esteem and young people exploring their identity and sexuality. The intervention is not for adolescents with clinical depression.

EIF Programme Assessment

Blues Programme has **evidence of a long-term positive impact** on child outcomes through multiple rigorous evaluations.

Evidence rating: **4+**

What does the evidence rating mean?

Level 4 indicates **evidence of effectiveness**. This means the programme can be described as evidence-based: it has evidence from at least two rigorously conducted evaluations (RCT/QED) demonstrating positive impacts across populations and environments lasting a year or longer.

What does the plus mean?

The plus rating indicates that a programme's best evidence is level 4 standard, and there is at least one other study at level 4, and at least one of the level 4 studies has been conducted independently of the programme provider.

The evidence of long-term effects relates to the Blues Programme producing improvements relative to an alternative intervention (self-help book), rather than compared to a treatment as usual group.

Cost rating

A rating of 1 indicates that a programme has a low cost to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of less than£100.

Cost rating: **1**

Child outcomes

According to the best available evidence for this programme's impact, it can achieve the following positive outcomes for children:

Supporting children's mental health and wellbeing

Based on study 1

0.18-point improvement on the Structured Clinical Interview for DSM-IV Disorders

Improvement index: **+19**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 69% and worse outcomes than 31% of their peers, if they had received the intervention.

Immediately after the intervention

0.22-point improvement on the Center for Epidemiologic Studies-Depression (CES-D) screener

Improvement index: **+16**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 66% and worse outcomes than 34% of their peers, if they had received the intervention.

Immediately after the intervention

Decreased risk of developing major depressive disorder

Based on study 1

12-percentage point reduction in proportion of participants at risk of developing a major depressive disorder (measured using the Structured Clinical Interview for DSM-IV Disorders)

Improvement index: **+36**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 86% and worse outcomes than 14% of their peers, if they had received the intervention.

6 months later

Based on study 2

15-percentage point reduction in proportion of participants at risk of developing major depressive disorder (measured using the Schedule for Affective Disorders and Schizophrenia for School-Age Children)

Improvement index: **+27**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 77% and worse outcomes than 23% of their peers, if they had received the intervention.

Long-term 2 years later

Based on study 3a

6.3-percentage point reduction in proportion of participants at risk of developing major depressive disorder (measured using the Schedule for Affective Disorders and Schizophrenia)

Improvement index: **+21**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 71% and worse outcomes than 29% of their peers, if they had received the intervention.

6 months later

Based on study 3b

Reduction in risk of developing major depressive disorder (measured using the Schedule for Affective Disorders and Schizophrenia)

Long-term A year later

Decreased depressive symptoms

Based on study 2

0.10-point improvement on the Schedule for Affective Disorders and Schizophrenia for School-Age Children

Improvement index: **+12**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 62% and worse outcomes than 38% of their peers, if they had received the intervention.

Immediately after the intervention

Based on study 3a

0.17-point improvement on the Schedule for Affective Disorders and Schizophrenia

Improvement index: **+18**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 68% and worse outcomes than 32% of their peers, if they had received the intervention.

Immediately after the intervention

0.16-point improvement on the Schedule for Affective Disorders and Schizophrenia

Improvement index: **+16**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 66% and worse outcomes than 34% of their peers, if they had received the intervention.

6 months later

Based on study 3b

0.06-point improvement on the Schedule for Affective Disorders and Schizophrenia

Improvement index: **+15**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 65% and worse outcomes than 35% of their peers, if they had received the intervention.

Long-term A year later

Reduced depression symptom severity

Based on study 3a

4.51-point improvement on the Beck Depression Inventory

Improvement index: **+19**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 69% and worse outcomes than 31% of their peers, if they had received the intervention.

Immediately after the intervention

3.87-point improvement on the Beck Depression Inventory

Improvement index: **+15**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 65% and worse outcomes than 35% of their peers, if they had received the intervention.

6 months later

Preventing substance abuse

Decreased substance use

Based on study 3a

0.08-point improvement on a self-report measure on frequency of substance use

Improvement index: **+11**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 61% and worse outcomes than 39% of their peers, if they had received the intervention.

Immediately after the intervention

0.17-point improvement on a self-report measure on frequency of substance use

Improvement index: **+18**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 68% and worse outcomes than 32% of their peers, if they had received the intervention.

6 months later

Key programme characteristics

Who is it for?

The best available evidence for this programme relates to the following age-groups:

- Adolescents

How is it delivered?

The best available evidence for this programme relates to implementation through these delivery models:

- Group

Where is it delivered?

The best available evidence for this programme relates to its implementation in these settings:

- Secondary school

The programme may also be delivered in these settings:

How is it targeted?

The best available evidence for this programme relates to its implementation as:

- Targeted indicated

Where has it been implemented?

Canada, United Kingdom, United States, Ireland

UK provision

This programme has been implemented in the UK.

UK evaluation

This programme's best evidence does not include evaluation conducted in the UK.

Spotlight sets

EIF includes this programme in the following Spotlight sets:

- school based social emotional learning

About the programme

What happens during delivery?

How is it delivered?

- The Blues Programme is delivered in six sessions of one hour's duration each by two trained support workers. In evaluated implementations in the USA and Canada, the programme has been delivered by a range of professionals, including teachers and psychology students. It is delivered to groups of eight to 10 pupils.

What happens during the intervention?

- The sessions focus on building group rapport and increasing participant involvement in pleasant activities (sessions 1–6), learning and practising cognitive restructuring techniques (sessions 2–4), and developing response plans for future life stressors (sessions 5–6).
- In-session exercises require youth to apply the skills taught in the intervention.
- Homework is used to reinforce the skills taught in the sessions and help participants learn how to apply these skills to their daily life.
- Motivational enhancement exercises are used to maximise the willingness to use the new skills.
- Strategic self-presentation is used to facilitate internalisation of key principles.
- Behavioural techniques are used to reinforce the use of the new skills.
- Group activities are used to foster feelings of social support and group cohesion.

What are the implementation requirements?

Who can deliver it?

- The programme is co-facilitated by a Young Persons Practitioner with QCF-4 or 5qualifications and a Young Persons Support Worker.

What are the training requirements?

- The practitioners have two days of programme training. Booster training of practitioners is recommended. Practitioners receive 10 hours of booster training in the first year and fewer hours in the years thereafter.
- Initially, a quality performance coordinator reviews three two-hour recordings of delivery for fidelity checks.

How are the practitioners supervised?

Practitioner supervision is provided through the following processes:

- It is recommended that practitioners are supervised by one case management supervisor (qualified to QCF-6 level), with one hour of programme training.
- It is recommended that practitioners are additionally supervised by one fidelity & quality supervisor (qualified to QCF-4/5 level), with two days of programme training and who completed 12 two-hour fidelity recording checks.
- It is recommended that fidelity checks of the host trainer and quality performance coordinator are additionally conducted by one external supervisor (the developer) (qualified to QCF-7/8 level). Each year, three recorded two-hour sessions are reviewed by the developer to check the fidelity scoring of the quality performance coordinator.

What are the systems for maintaining fidelity?

Programme fidelity is maintained through the following processes:

- Training manual
- Other printed material
- Fidelity monitoring
- Face-to-face training
- Other (peer managers network within host organisation)

Is there a licensing requirement?

There is no licence required to run this programme.

How does it work? (Theory of Change)

How does it work?

- The Blues Programme is based on the assumption that thoughts, feelings, physical sensations and actions are interconnected, and that negative thoughts and feelings can create a vicious cycle.
- The programme aims to teach young people the connection of thoughts, feelings, and actions along with approaches to think in a more positive way by breaking overwhelming problems down into smaller parts.
- In the short term, the programme aims to support participants in learning how to identify negative thoughts, work towards cognitive restructuring, and increase their involvement in pleasant social or physical activity.
- In the longer term, the programme aims to prevent depressive symptoms worsening, or the development of clinical depressive disorders.

Intended outcomes

Supporting children's mental health and wellbeing Preventing substance abuse

Contact details

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https://www.actionforchildren.org.uk/our-work-and-impact/children-and-families/good-mental-health/blues-programme/

About the evidence

The Blues Programme's most rigorous evidence comes from three RCTs which were conducted in the US and in Canada.

All three studies identified a statistically significant impact on a number of child outcomes.

This programme has evidence from three rigorously conducted RCTs, with at least one study demonstrating long-term impact, and impact on assessment measures independent of study participants (not self-reports). In addition, at least one study has been conducted independently of the programme developer. Consequently, the programme receives a 4+ rating overall.

Study 1

Citation: Brière, Reigner, Yale-Soulière, & Turgeon, 2019

Design: RCT

Country: Canada

Sample: 74 pupils with depressive symptoms between 14 and 18 with a mean age of 15.5

Timing: Post-test

Child outcomes:

-
- Decreased risk of developing major depressive disorder

Other outcomes:

- None measured

Study rating: 3

Brière, F. N., Reigner, A., Yale-Soulière, G., & Turgeon, L. (2019). Effectiveness trial of brief indicated cognitive-behavioral group depression prevention in French-Canadian Secondary Schools. *School Mental Health*, *11*(4), 728-740.

Available athttps://link.springer.com/article/10.1007/s12310-019-09316-2

Study design and sample

The first study is a rigorously conducted RCT.
This study involved random assignment of children to one of several Blues Programme groups or a brochure control group.
This study was conducted in Canada, with a sample of 74 children between the ages of 14 and 18 (mean age 15.5). 66% of the sample were female.

Measures

Major depressive disorder was measured using the French variant of the Center for Epidemiologic Studies-Depression (CES-D) (child self-report).
Depressive symptoms were measured using the French variant of the Center for Epidemiologic Studies-Depression (CES-D) (child self-report).

Findings

This study identified statistically significant positive impact on a number of child outcomes. This includes reduced risk of developing major depressive disorder and reduced depressive symptoms (post-intervention).

Study 2

Citation: Rohde, Stice, Shaw, & Gau, 2015

Design: RCT

Country: United States

Sample: 378 pupils with depressive symptoms between 13 and 19 with a mean age of 15.5

Timing: Post-test; 2-year follow-up

Child outcomes:

- Decreased depressive symptoms
- Decreased risk of developing major depressive disorder

Other outcomes:

- None measured

Study rating: 3

Rohde, P., Stice, E., Shaw, H., & Gau, J. M. (2015). Effectiveness trial of an indicated cognitive–behavioral group adolescent depression prevention program versus bibliotherapy and brochure control at 1-and 2-year follow-up. *Journal of consulting and clinical psychology*, *83*(4), 736.

Available athttps://psycnet.apa.org/record/2015-17271-001

Study design and sample

The second study is a rigorously conducted RCT.
This study involved random assignment of children to one of several Blues Programme groups, to a bibliotherapy group or to a brochure control group.
This study was conducted in the USA, with a sample of 378 children between the ages of 13 and 19 (mean age 15.5). 68% of the sample were female. The sample included 72% Caucasians, 6% African Americans, 6% Hispanics, 2% Asians, and 18% who specified other or mixed heritage.

Measures

Major depressive disorder was measured using 16 items from the Schedule for Affective Disorders and Schizophrenia (diagnostic interview).
Depressive symptoms were measured using 16 items from the Schedule for Affective Disorders and Schizophrenia (diagnostic interview).

Findings

This study identified statistically significant positive impact on a number of child outcomes. This includes reduced risk of developing major depressive disorder (post-intervention, 2-year follow-up) and reduced depressive symptoms (post-intervention).

Study 3a

Citation: Stice, Rohde, Gau, & Wade, 2008

Design:	RCT
Country:	United States
Sample:	341 pupils with depressive symptoms between 14 and 19 with a mean age of 15.6
Timing:	Post-test; 6-months follow-up

Child outcomes:

- Decreased depressive symptoms
- Reduced depression symptom severity
- Decreased risk of developing major depressive disorder
- Decreased substance use

Other outcomes:

- None measured

Study rating: 3

Rohde, P., Stice, E., Shaw, H., & Brière, F. N. (2014). Indicated cognitive behavioral group depression prevention compared to bibliotherapy and brochure control: Acute effects of an effectiveness trial with adolescents. *Journal of Consulting and Clinical Psychology*, *82*(1), 65-74.
Available athttps://psycnet.apa.org/record/2013-35106-001

Study design and sample

The third study is a rigorously conducted RCT.
This study involved random assignment of children to one of several Blues Programme groups, to a bibliotherapy group, to a supportive-expressive group or to a brochure control group.
This study was conducted in the USA, with a sample of 341 children between the ages of 14 and 19 (mean age 15.6). 56% of the sample were female. The sample involved 46% Caucasians, 9% African Americans, 33% Hispanics, 2% Asians, and 10% who specified other or mixed heritage.

Measures

Major depressive disorder was measured using 16 items from the Schedule for Affective Disorders and Schizophrenia (diagnostic interview) and the 21-item Beck Depression Inventory (self-report).
Depressive symptoms were measured using 16 items from the Schedule for Affective Disorders and Schizophrenia (diagnostic interview) and using the 21-item Beck Depression Inventory (self-report).
Substance use was measured with 10 items from Stice, Barrera, and Chassin (1998) (self-report of the frequency of consuming certain types of alcohol or illicit drugs as well as of being drunk).

Findings

This study identified statistically significant positive impact on a number of child outcomes. This includes reduced risk of developing major depressive disorder (six months follow-up), reduced depressive symptoms at post-intervention and 6-months follow-up (on both depression measures) as well as reduced substance use (post-intervention and six months follow-up).

Study 3b

Citation: Stice, Rohde, Gau, & Wade, 2010

Design: RCT

Country: United States

Sample: 341 pupils with depressive symptoms between 14 and 19 with a mean age of 15.6

Timing: 1-year follow-up; 2-year follow-up

Child outcomes:

- Decreased depressive symptoms
- Decreased risk of developing major depressive disorder

Other outcomes:

- None measured

Study rating: 3

Stice, E., Rohde, P., Gau, J. M., & Wade, E. (2010). Efficacy trial of a brief cognitive–behavioral depression prevention program for high-risk adolescents: Effects at 1-and 2-year follow-up. *Journal of consulting and clinical psychology*, *78*(6), 856.

Available athttps://content.apa.org/record/2010-19649-001

This paper describes additional outcomes from study 3a described above. In this case, the paper presents follow-up results.

This includes reduced risk of developing major depressive disorder (one-year follow-up) and reduced depressive symptoms (one-year follow-up).

Other studies

The following studies were identified for this programme but did not count towards the programme's overall evidence rating. A programme receives the same rating as its most robust study or studies.

Brière, F. N., Rohde, P., Shaw, H., & Stice, E. (2014). Moderators of two indicated cognitive-behavioral depression prevention approaches for adolescents in a school-based effectiveness trial. Behaviour research and therapy, 53, 55-62 - **This reference refers to a randomised control trial, conducted in the USA**.
Rohde, P., Stice, E., Shaw, H., & Brière, F. N. (2014). Indicated cognitive behavioral group depression prevention compared to bibliotherapy and brochure control: Acute effects of an effectiveness trial with adolescents. Journal of Consulting and Clinical Psychology, 82(1), 65 - **This reference refers to a randomised control trial, conducted in the USA**.
Stice, E., Rohde, P., Seeley, J. R., & Gau, J. M. (2010). Testing mediators of intervention effects in randomized controlled trials: An evaluation of three depression prevention programs. Journal of Consulting and Clinical Psychology, 78(2), 273 - **This reference refers to a randomised control trial, conducted in the USA**.
Stice, E., Rohde, P., Gau, J., & Ochner, C. (2011). Relation of depression to perceived social support: Results from a randomized adolescent depression prevention trial. Behaviour research and therapy, 49(5), 361-366 - **This reference refers to a randomised control trial, conducted in the USA**.
Rohde, P., Stice, E., & Gau, J. M. (2012). Effects of three depression prevention interventions on risk for depressive disorder onset in the context of depression risk factors. Prevention science, 13(6), 584-593 - **This reference refers to a randomised control trial, conducted in the USA**.
Rohde, P., Stice, E., Gau, J. M., & Marti, C. N. (2012). Reduced substance use as a secondary benefit of an indicated cognitive–behavioral adolescent depression prevention program. Psychology of Addictive Behaviors, 26(3), 599 - **This reference refers to a randomised control trial, conducted in the USA**.
Gau, J. M., Stice, E., Rohde, P., & Seeley, J. R. (2012). Negative life events and substance use moderate cognitive behavioral adolescent depression prevention intervention. Cognitive behaviour therapy, 41(3), 241-250 - **This reference refers to a randomised control trial, conducted in the USA**.
Action for Children (2020) The Blues Programme. Reach and Impact of the Blues Programme Delivered by Action for Children 2017-20.
Rohde, P., Stice, E., Shaw, H., & Gau, J. M. (2014). Cognitive-behavioral group depression prevention compared to bibliotherapy and brochure control: Nonsignificant effects in pilot effectiveness trial with college students. Behaviour research and therapy, 55, 48-53 - **This reference refers to a randomised control trial, conducted in the USA**.
Burton, E., Stice, E., Bearman, S. K., & Rohde, P. (2007). Experimental test of the affect?regulation theory of bulimic symptoms and substance use: A randomized trial. International Journal of Eating Disorders, 40(1), 27-36 - **This reference refers to a randomised control trial, conducted in the USA**.
Stice, E., Burton, E., Bearman, S. K., & Rohde, P. (2007). Randomized trial of a brief depression prevention program: An elusive search for a psychosocial placebo control condition. Behaviour research and therapy, 45(5), 863-876 - **This reference refers to a randomised control trial, conducted in the USA**.
Stice, E., Shaw, H., Bohon, C., Marti, C. N., & Rohde, P. (2009). A meta-analytic review of depression prevention programs for children and adolescents: factors that predict magnitude of intervention effects. Journal of consulting and clinical psychology, 77(3), 486 - **This reference refers to a meta-analysis.**

Guidebook

The EIF Guidebook provides information about early intervention programmes that have at least preliminary evidence of achieving positive outcomes for children. It provides information based on EIF's assessment of the strength of evidence for a programme's effectiveness, and on detail about programmes shared with us by those who design, run and deliver them.

The Guidebook serves an important starting point for commissioners to find out more about effective early interventions, and for programme providers to find out more about what good evidence of impact looks like and how it can be captured. As just one of our key resources for commissioners and practitioners, the Guidebook is an essential part of EIF's work to support the development of and investment in effective early intervention programmes.

Our assessment of the evidence for a programme's effectiveness can inform and support certain parts of a commissioning decision, but it is not a substitute for professional judgment. Evidence about what has worked in the past offers no guarantee that an approach will work in all circumstances. Crucially, the Guidebook is not a market comparison website: ratings and other information should not be interpreted as a specific recommendation, kite mark or endorsement for any programme.

How to read the Guidebook

EIF evidence standards

About the EIF Guidebook

EIF

The Early Intervention Foundation (EIF) is an independent charity and a member of the What Works network. We support the use of effective early intervention for children, young people and their families: identifying signals of risk, and responding with effective interventions to improve outcomes, reduce hardship and save the public money in the long term.

We work by generating evidence and knowledge of what works in our field, putting this information in the hands of commissioners, practitioners and policymakers, and supporting the adoption of the evidence in local areas and relevant sectors.

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