Foundations
What Works Centre for Children & Families

Last reviewed: January 2021

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

GUIDEBOOK INTERVENTION INFORMATION SHEET

Blues Programme

Please note that in the 'Intervention summary' table below, 'child age', 'level of need', and 'race and ethnicities' information is **as evaluated in studies**. Information in other fields describes the intervention as **offered/supported by the intervention provider**.

Intervention summary	
Description	The Blues Programme is a school-based cognitive behavioural therapy intervention for young people aged between 13 and 19 years who are experiencing depressive symptoms. It is delivered by youth support workers/practitioners to groups of young people for six weeks.
Evidence rating	4+
Cost rating	1
Child outcomes	• Supporting children's mental health and wellbeing - Reduced depression - Improved social behaviour. • Preventing substance abuse - Reduced substance misuse.
Child age (population characteristic)	13 to 19 years
Level of need (population characteristic)	Targeted Indicated

Intervention summary	
Race and ethnicities (population characteristic)	• African • African American • Asian • Asian American • Caribbean • Hispanic • Indian • Latin American • Native American • South-East Asian • White.
Type (model characteristic)	Group
Setting (model characteristic)	Secondary school
Workforce (model characteristic)	Youth support workers and young person's practitioners
UK available?	Yes
UK tested?	No

Model description

The Blues Programme is a school-based group intervention designed to support young people aged 13 to 19 years who are experiencing early signs of depression. Delivered in secondary schools, this six-week intervention uses cognitive behavioural techniques to help adolescents:

- Identify and challenge negative thinking patterns
- Increase participation in enjoyable activities
- Build coping skills and flexibility.

Each weekly session lasts one hour and is co-facilitated by trained Young Persons Practitioners and Support Workers. The sessions include guided group discussions, real-life reflections, and take-home activities to reinforce learning.

Students are invited to participate based on a screening questionnaire (CES-D), which helps identify those who might benefit from the intervention. The intervention is aimed at young people

facing challenges such as academic pressure, family issues, low self-esteem, or identity exploration. It is not intended for those with clinical depression.

The Blues Programme can be described as evidence-based: it has evidence from at least one rigorously conducted RCT demonstrating a statistically significant positive impact on a child outcome, and also has evidence of a long-term effect.

Target population

Age of child	13 to 19 years
Target population	Adolescents who experience depressive symptoms

Please note that the information in this section on target population is as **offered/supported by the intervention provider**.

Theory of change

Why		Who	How	What		
Science-based assumption	**Science-based assumption**	**Science-based assumption**	**Intervention**	**Short-term outcomes**	**Medium-term outcomes**	**Long-term outcomes**
Negative thoughts and feelings can create a vicious cycle and may increase the risk of depression.	Thoughts, feelings, physical sensations, and actions are interconnected; engaging in positive activities can positively affect thoughts and feelings.	Adolescents aged 13 to 19 who experience depressive symptoms.	The intervention 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.	Participants learn how to identify negative thoughts, and work towards cognitive restructuring.	Participants increase their involvement in pleasant social or physical activity.	Participants have reduced risk of depression.

Implementation requirements

Who is eligible?	Young people who experience depressive symptoms but do not meet the diagnostic criteria for Major Depressive Disorder.
How is it delivered?	The Blues Programme is delivered in six sessions of one hours' duration each by two trained support workers, to groups of 8 to 10 young people.
What happens during the intervention?	The sessions focus on building group rapport and increasing participant involvement in enjoyable activities across sessions 1 to 6, while introducing cognitive restructuring techniques in sessions 2 to 4, and developing response plans for managing future life stressors in sessions 5 to 6. In-session exercises allow youth to apply these skills directly, with homework reinforcing the skills learned and supporting their use in everyday life. Motivational enhancement activities are also included to encourage participants' willingness to adopt the new skills. To further internalise key principles, strategic self-presentation is used alongside behavioural techniques, which reinforce skill use. Group activities create a sense of social support and cohesion among participants.
Who can deliver it?	The intervention is co-facilitated by a Young Persons Practitioner with and a Young Persons Support Worker.
What are the training requirements?	The practitioners have two days of intervention 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.
How are practitioners supervised?	It is recommended that practitioners are supervised by one case management supervisor, with one hour of intervention training. Additionally, it is recommended that practitioners are also supervised by one fidelity and quality supervisor with two days of intervention training and completion of 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). Each year, three recorded two-hour sessions are reviewed by the developer to check the fidelity scoring of the quality performance coordinator.

Implementation requirements (Cont.)

What are the systems for maintaining fidelity?	Intervention fidelity is maintained through the following processes: • Training manual • Other printed material • Face-to-face training • Fidelity monitoring • Peer managers network within host organisation.
Is there a licensing requirement?	No
***Contact details**	Contact person: Robyn Brady Organisation: Action for Children Email address: Blues@actionforchildren.org.uk Website: https://www.actionforchildren.org.uk/our-work-and-impact/children-and-families/good-mental-health/blues-programme/ *Please note that this information may not be up to date. In this case, please visit the listed intervention website for up to date contact details.

Evidence summary

Blues Programme's most rigorous evidence comes from three RCTs which were conducted in Canada and the United States. The intervention can be described as evidence-based: it has evidence from at least one rigorously conducted RCT demonstrating a statistically significant positive impact on a child outcome, and also has evidence of a long-term effect.

This study identified statistically significant reductions in Major Depressive Disorder, depressive symptoms, risk of developing major depressive disorder, and Major Depressive Disorder onset. It also found improvements in social adjustment, and reduced substance use frequency.

Child outcomes			
Outcome	**Improvement index**	**Interpretation**	**Study**
Reduced risk of developing major depressive disorder	+36	12-percentage point reduction in proportion of participants at risk of developing a major depressive disorder (measured using the Structured Clinical	1

		Interview for DSM-IV Disorders) – 6 months later	
Reduced risk of developing major depressive disorder	+27	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) – 2 years later	2
Reduced risk of developing major depressive disorder	+21	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) – 6 months later	3a
Reduced risk of developing major depressive disorder	N/A	Reduction in risk of developing major depressive disorder (measured using the Schedule for Affective Disorders and Schizophrenia) – a year later	3b
Reduced depressive symptoms	+12	0.10-point improvement on the Schedule for Affective Disorders and Schizophrenia for School-Age Children – post-test	2
Reduced depressive symptoms	+18	0.17-point improvement on the Schedule for Affective Disorders and Schizophrenia – post-test	3a
Reduced depressive symptoms	+16	0.16-point improvement on the Schedule for Affective Disorders and Schizophrenia – 6 months later	3a
Reduced depressive symptoms	+15	0.06-point improvement on the Schedule for Affective Disorders and Schizophrenia – a year later	3b
Reduced depression symptom severity	+19	4.51-point improvement on the Beck Depression Inventory – post-test	3a

Reduced depression symptom severity	+15	3.87-point improvement on the Beck Depression Inventory – 6 months later	3a
Decreased substance use	+11	0.08-point improvement on a self-report measure on frequency of substance use – post-test	3a
Decreased substance use	+18	0.17-point improvement on a self-report measure on frequency of substance use – 6 months later	3a

Search and review

	Number of studies
Identified in search	8
Studies reviewed	0
Meeting the L2 threshold	0
Meeting the L3 threshold	3
Contributing to the L4 threshold	0
Ineligible	0

Individual study summary: Study 1

Study 1	
Study design	RCT
Country	Canada

Study 1	
Sample characteristics	74 secondary school students aged between 14 and 18 years with elevated depressive symptoms in the disadvantaged areas of Montreal, Canada
Race, ethnicities, and nationalities	• 69% Canadian • 11% Latin American • 10% Caribbean • 8% Middle Eastern • 7% African • 7% Western European • 6% Maghreb • 6% Indian subcontinent • 3% South-East Asian • 3% Eastern European • 4% Other.
Population risk factors	Participants were located in disadvantaged areas of Montreal, Canada and had elevated depressive symptoms but did not meet criteria for Major Depressive Disorder
Timing	• Baseline • Post-intervention • 6-month post-intervention.
Child outcomes	• Reduced major depressive disorder (Clinician report) • Reduced depressive symptoms (Child report).
Other outcomes	Increased interactions with parents
Study Rating	3
Citation	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, 728–740.

Brief summary

Population characteristics

The study involved 74 secondary school students (66% female) aged between 14 and 18 years (mean age = 15.50). Participants were located in disadvantaged areas of Montreal, Canada and had elevated depressive symptoms but did not meet criteria for Major Depressive Disorder.

Study design

The study adopted a two-armed randomised controlled trial design. Participants were randomly allocated to the following conditions using block randomisation with stratification by sex and school:

- The intervention group (37 participants) received a cognitive-behavioral group intervention (Blues Programme) aimed at preventing depression through cognitive restructuring and behavioral activation.
- The control group (37 participants) received an educational brochure about depression from a mental health organisation.

Measurement

Measurement took place at baseline, post-intervention, and 6-month post-intervention.

- **Child report** measures included the French variant of the Center for Epidemiologic Studies-Depression (CES-D) screener, the Social self-evaluation in young adults scale (Évaluation sociale de soi chez les jeunes adultes), social phobia and generalised anxiety subscales of the Spence Children Anxiety Scale (SCAS), Measure of the Social and Personal Adjustment of Quebec Adolescents (Mesures de l'Adaptation Sociale et Personnelle des Adolescents Quebecois), the Automatic Thoughts Questionnaire (ATQ), and a subset of items from the pleasant events schedule (PES).
- **Clinician report** measures included the French variant of the Structured Clinical Interview for DSM-IV Disorders (SCID-IV).

Study retention

36 intervention group and 36 control group families participated at post-intervention (90% and 90% retention rate, respectively).

At 6-month follow-up, 36 intervention group and 34 control group families completed the study measures (90% and 92% retention rate, respectively).

Findings

Data-analytic strategy

The study used logistic regression and linear regression models to estimate the interventions effect on the intended outcomes.

Findings

Logistic regression indicated that control participants were six times more likely than the intervention group participants to develop Major depressive disorder by six months. Youth in the intervention group showed statistically significant reductions in depressive symptoms at post-intervention according to both youth and clinician report measures.

In addition, at post-intervention, intervention youths were found to engage in more pleasant activities. They were also found to have more interactions with parents. Closer examination

suggested that the intervention had a significant effect on decreasing negative interactions (conflict) with parents (d = -.64) rather than increasing positive ones (d = .05).

Study 1: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child outcomes					
Major depressive disorder	French variant of the Structured Clinical Interview for DSM-IV Disorders (SCID-IV) (Clinician report)	Odds ratio: 6.0*	Yes	70	6 months post-intervention
Depressive symptoms	French variant of the Structured Clinical Interview for DSM-IV Disorders (SCID-IV) (Clinician report)	d=−.51	Yes	74	Post-intervention
Depressive symptoms	French variant of the Structured Clinical Interview for DSM-IV Disorders (SCID-IV) (Clinician report)	d=−.06	No	70	Post-intervention
Depressive symptoms	French variant of the Center for Epidemiologic Studies-Depression (CES-D) screener (Child report)	d=−.40	Yes	74	Post-intervention

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Depressive symptoms	French variant of the Center for Epidemiologic Studies-Depression (CES-D) screener (Child report)	d=-.29	No	70	6 months post-intervention
Social adjustment	Subscale of the Social self-evaluation in young adults scale (Child report)	d=.08	No	74	Post-intervention
Social adjustment	Subscale of the Social self-evaluation in young adults scale (Child report)	d=-.18	No	70	6 months post-intervention
Anxious symptoms	Social phobia and generalized anxiety subscales of the Spence Children Anxiety Scale (SCAS) (Child report)	d=-.10	No	74	Post-intervention
Anxious symptoms	Social phobia and generalized anxiety subscales of the Spence Children Anxiety Scale (SCAS) (Child report)	d=-.26	No	70	6 months post-intervention

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Interactions with parents**	Measure of the Social and Personal Adjustment of Quebec Adolescents (Child report)	d=.34	Yes	74	Post intervention
Interactions with parents	Measure of the Social and Personal Adjustment of Quebec Adolescents (Child report)	d=-.04	No	70	6 months post-intervention
Negative thoughts	Automatic thoughts questionnaire (ATQ) (Child report)	d=-.34	No	74	Post intervention
Negative thoughts	Automatic thoughts questionnaire (ATQ) (Child report)	d=-.35	No	70	6 months post-intervention
Pleasant activities	Subset of items from the pleasant events schedule (PES) (Child report)	d=.49	Yes	74	Post intervention
Pleasant activities	Subset of items from the pleasant events schedule (PES) (Child report)	d=.04	No	70	6 months post-intervention

*Logistic regression indicated that control participants were six times more likely than the intervention group participants to develop Major depressive disorder by six months.

**Closer examination suggested that the intervention had a significant effect on decreasing negative interactions (conflict) with parents (d = -.64) rather than increasing positive ones (d = .05).

Individual study summary: Study 2

Study 2	
Study design	RCT
Country	United States
Sample characteristics	378 students with elevated depressive symptoms aged between 13 and 19 years
Race, ethnicities, and nationalities	• 72% Caucasian • 18% Other or mixed heritage • 6% African American • 6% Hispanic • 2% Asian American • 1% Native American.
Population risk factors	Participants had elevated depressive symptoms
Timing	• Baseline • Post-intervention • 6 months post-intervention • 12 months post-intervention • 18 months post-intervention • 24 months post-intervention.
Child outcomes	• Reduced major depressive disorder onset (diagnostic interview) • Reduced depressive symptoms (diagnostic interview).
Other outcomes	None
Study Rating	3
Citation	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), 736–747.

Brief summary

Population characteristics

The study involved 378 students (68% female) aged between 13 and 19 years (mean age = 15.5) across five selected schools in the United States. Participants were screened and chosen based on experiencing elevated depressive symptoms or feelings of sadness, but they did not meet the criteria for Major Depressive Disorder or exhibit acute suicidal ideation.

Study design

The study adopted a three-armed randomised controlled trial design. Participants were randomly allocated within blocks created by gender and school, using computer-generated random numbers to three conditions:

- Intervention Group (n=126) received a cognitive-behavioral group intervention (Blues Programme) aimed at preventing depression through cognitive restructuring and behavioural activation
- Bibliotherapy Control (n=128) received a self-help book which provides cognitive behavioural techniques for preventing and reducing negative moods
- Brochure Control (n=124) received an educational brochure about depression and local treatment options.

Measurement

Measurement occurred at baseline, post-intervention, 6-month, 12-month, 18-month, and 24-month follow-up.

- **Youth report** measures included the Social Adjustment Scale-Self Report for Youth, and 10 items from Stice, Barrera, and Chassin (1998).
- **Diagnostic interview** included the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS).

Study retention

121 intervention group families, 128 bibliotherapy control group families, and 124 brochure control families participated at post-intervention.

116 intervention group families, 128 bibliotherapy control group families, and 124 brochure control families participated at 6-month post-intervention.

116 intervention group families, 112 bibliotherapy control group families, and 106 brochure control families participated at 12-month post-intervention.

112 intervention group families, 117 bibliotherapy control group families, and 115 brochure control families participated at 18-month follow-up.

108 intervention group families, 119 bibliotherapy control group families, and 112 brochure control families participated at 24-month post-intervention.

Overall, there was high retention with 88% of participants remaining in the study at 2-year follow-up.

Findings

Data-analytic strategy

The study used Cox proportional hazard regression to examine Major depressive disorder incidence. It evaluated changes in depressive symptoms, social adjustment, and substance use using random effects growth models in a hierarchical modeling framework and fit with SAS PROC MIXED specifying an unstructured covariance structure. Multiple imputations were used for missing data.

Findings

Youth in the intervention group showed statistically significant reductions in depressive symptoms at 2-year follow-up compared to the brochure control group. Cox proportional hazard regression also indicated that the hazard ratio (HR) for Major Depressive Disorder onset over follow-up was significantly greater for participants in the bibliotherapy control group compared to the intervention group.

Study 2: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child outcomes					
Major depressive disorder onset	Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) (diagnostic interview)	Not reported	Yes only for intervention group vs bibliotherapy control group	227*	2-year follow-up
Depressive symptoms	Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) (diagnostic interview).	d=.26	Yes only for intervention group vs brochure control group	220**	2-year follow-up

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Social adjustment	17 items from the Social Adjustment Scale-Self Report for Youth.	Not reported	No	339	2-year follow-up
Substance use	10 item scale.	Not reported	No	339	2-year follow-up

*Sample size for intervention group and bibliotherapy control group only.

**Sample size for intervention group vs brochure control group only.

Individual study summary: Study 3

Study 3	
Study design	RCT
Country	United States
Sample characteristics	The study involved 341 students with depressive symptoms aged between 14 and 19 years (mean age = 15.6)
Race, ethnicities, and nationalities	• 46% Caucasian • 33% Hispanic • 10% Other or mixed heritage. • 9% African American • 2% Asian.
Population risk factors	• Participants have elevated depressive symptoms • Recruitment occurred systematically at schools with high proportions of minority students to maximise the ethnic diversity of the sample.
Timing	• Baseline • Post-intervention • 6-month follow-up • 1-year follow-up • 2-year follow-up.
Child outcomes	• Reduced depressive symptoms (diagnostic interview and youth report)

Study 3	
	• Decreased risk of developing major depressive disorder (diagnostic interview) • Improved social adjustment (youth report) • Reduced substance use frequency (youth report).
Other outcomes	None
Study Rating	3
Citations	**Study 3a:** Stice, E., Rohde, P., Seeley, J. & Gau, J. M. (2008) Brief cognitive-behavioral depression prevention program for high-risk adolescents outperforms two alternative interventions: A randomized efficacy trial. *Journal of Consulting and Clinical Psychology*. 76 (4), 595–606. **Study 3b:** 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.

Brief summary

Population characteristics

The study involved 341 students in six schools who reported depressive symptoms aged between 14 to 19 years (mean age = 15.6). 56% of participants were female. Recruitment occurred systematically at schools with high proportions of minority students to maximise the ethnic diversity of the sample.

28% of the sample had received treatment services for emotional/behavioral problems during the 12-month period preceding the study. Of those who received treatment, 41% received individual therapy, 9% group or family therapy, 8% took medication, and 42% a combination of treatment types.

Study design

The study adopted a four-armed randomised controlled trial design. Participants were randomly allocated within blocks created by gender and school, using computer-generated random numbers to four conditions:

- Intervention group (n=89) received a cognitive-behavioral group intervention (Blues Programme) aimed at preventing depression through cognitive restructuring and behavioral activation

- Supportive Expressive Control Group (n=88) which provided non-directive supportive intervention
- Bibliotherapy Control Group (n=80) where participants were provided with a self-help book
- Educational Brochure Control Group (n=84).

Measurement

Measurement took place at baseline, post-intervention, 6-month follow-up, 1-year follow up, and 2-year follow up.

- **Youth report** measures included Beck Depression Inventory, Social Adjustment Scale-Self Report for Youth, and a 10 item scale measuring substance use.
- **Researcher administered** measures included the adapted Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) (diagnostic interview) and the Eating Disorder Diagnostic Interview.

Study retention

88 intervention group families, 85 supportive-expressive group families, 76 Bibliotherapy control group families, and 83 educational brochure control families participated at post-intervention.

81 intervention group families, 82 supportive-expressive group families, 76 Bibliotherapy control group families, and 77 educational brochure control families participated at 6-month post-intervention.

75 intervention group families, 80 supportive-expressive group families, 61 Bibliotherapy control group families, and 73 educational brochure control families participated at 1-year follow-up.

70 intervention group families, 65 supportive-expressive group families, 58 Bibliotherapy control group families, and 72 educational brochure control families participated at 2-year follow-up.

Overall, 77.7% participants were retained at 2-year follow-up.

Results

Data-analytic strategy

The study used repeated measures ANCOVA analysis of covariance models and Cox proportional hazard models were used to evaluate change in depressive symptoms, social adjustment, and substance use. Intent-to-treat analysis was used with maximum-likelihood estimates to impute missing data.

Findings

Youth in the intervention group showed statistically significant reductions in depressive symptoms (from post-intervention through to 2-year follow-up) and substance use frequency (at post-intervention and 6-month follow-up). They also showed improvements in social adjustment at 6-month follow-up. The study also found that intervention group youths showed significantly lower risk for onset of depressive episodes at 6-month and 2-year follow-up.

Study 3: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child outcomes					
Depressive symptoms	Adapted Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) (diagnostic interview)	N/A	Yes (compared to all three control conditions)	332	Post-intervention
Depressive symptoms	Adapted Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) (diagnostic interview)	d=.42	Yes (only compared to educational brochure control condition)	316	6-month follow-up
Depressive symptoms	Adapted Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) (diagnostic interview)	N/A	Yes (compared to bibliotherapy and educational brochure control conditions)	289	1-year follow-up
Depressive symptoms	Adapted Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) (diagnostic interview)	d=0.45	Yes (only compared to bibliotherapy control condition)	265	2-year follow-up

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Risk for onset of depressive episodes	Adapted Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) (diagnostic interview)	β = .92, OR = 2.5	Yes	316	6-month follow=up
Risk for onset of depressive episodes	Adapted Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) (diagnostic interview)	β = 0.80, OR = 2.23	Yes	265	2-year follow-up
Depressive symptoms	Beck Depression Inventory (Youth report)	N/A	Yes (compared to all three control conditions)	332	Post-intervention
Depressive symptoms	Beck Depression Inventory (Youth report)	N/A	Yes (compared to bibliotherapy and educational brochure control conditions)	316	6-month follow-up
Depressive symptoms	Beck Depression Inventory (Youth report)	N/A	No	289	1-year follow-up

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Depressive symptoms	Beck Depression Inventory (Youth report)	d=0.34	Yes (only compared to bibliotherapy control condition)	265	2-year follow-up
Social adjustment	Social Adjustment Scale-Self Report for Youth (Youth report)	N/A	Yes (compared to all three control conditions)	316	6-month follow-up
Substance use frequency	10 items from Stice, Barrera and Chassin (1998) (Youth report)	N/A	Yes (compared to bibliotherapy and educational brochure control conditions)	332	Post-intervention
Substance use frequency	10 items from Stice, Barrera and Chassin (1998) (Youth report)	N/A	Yes (compared to all three control conditions)	316	6-month follow-up

Other studies

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

Action for Children. (2020) *The Blues Programme. Reach and impact of the Blues Programme Delivered by Action for Children 2017-20*.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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Note on provider involvement: This provider has agreed to Foundations' terms of reference (or the Early Intervention Foundation's terms of reference), and the assessment has been conducted and published with the full cooperation of the intervention provider.