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Presentation on micro-interventions

Choice and Partnership national forum – June 2025

The following are the slides and notes from Terry's presentation at the Choice and Partnership national forum in June 2025

Slide 1:

Micro interventions

Small, timely steps while waiting

Terry Fleming
Te Kua Tātai Hauora- The School of Health
Te Herenga Waka - VUW

Photo: Takitahi in fresh green (before it has dried). This is the most 'basic pattern'. What does it mean? One over one –people woven into one another

Dr Kirsten Smiler *Te Whānau a Kai, Te Aitanga-a-Māhaki, Rongowhakaata, Whakatōhea*

Slide 2:

Micro-interventions:

- **Bite-sized timely chunks that**
- **Offer immediate value &**
- **Not a treatment replacement – add up**
- *With human warmth*

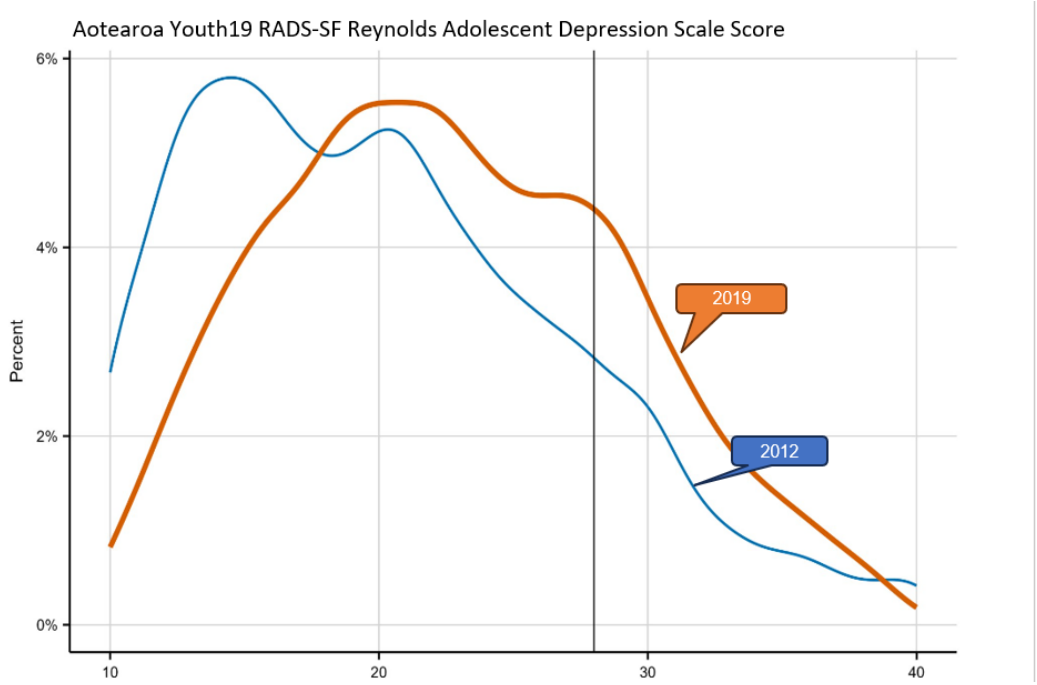
Notes:

Another approach to addressing limited engagement (in face-to-face as well as in digital approaches) is single session interventions (SSIs), or structured programs that intentionally involve only one visit or encounter.[46] Online SSI mental health interventions have produced effect sizes only slightly smaller than those gained in multiple sessions.[44,47] Prof Weisz and team are currently trialling a digital SSI for US young people on MHS waitlists and are interested in collaborating to explore interest in this or similar approaches as part of this project. In our design processes, we will explore participants' interest in micro-interventions and or SSIs and proceed accordingly (for a possible model, see Fig 1).

- Small fast often low effort
- Not a full treatment
- Add up

Receiving an answer to a question posted in a Facebook community about parenting could be viewed as a micro intervention. Playing an uplifting song may assist individuals with emotion regulation and could also be viewed as a micro intervention…. These digital micro interventions could substantially increase access to effective behavioural and mental health care by lowering the amount of effort required to reach beneficial gains.

Slide 3:



Notes:

5% GBD Puts it in top 10 causes of disease

https://link.springer.com/referenceworkentry/10.1007/978-3-319-33228-4_140

One tenth of the global population is younger than 25 years and currently experiencing a mental disorder (World Health Organization [WHO] 2013). Without intervention, robust evidence shows that two-thirds of adolescents who experience one episode of a mental disorder, lasting longer than 6 months, will experience repeat episodes as a young adult (Patton et al. 2014), and three-quarters of those who experience episodes before age 24 will go on to develop mental disorders in adulthood (Kessler et al. 2005). Episodes of depression and anxiety are prominent (Patton et al. 2014), with co-occurring mental disorders present in up to 90% of youth suicides.

For several years, suicide has been ranked as the second most common cause of death in adolescents and young people the world over (Lozano et al. 2012).

Worldwide, up to 85% of young people in low- and middle-income countries and 50% in high-income countries do not access standard services and supports to improve their mental disorders (WHO 2013). Up to 60% of 12–25-year-olds with current, past year, or lifetime suicidal ideation, plans, or attempts do not access or engage with standard interventions that are known to prevent suicide (Hom et al. 2015).

Slide 4:

Uncertain & extended delays:

- Sense of being 'cruelly ignored'
- Declining trust in the system, worsening symptoms
- Uncertainty about what to do & which information to trust.

- Adolescents - distress and suicidality in the face of even short waits, - frustration that they are not getting help, despite taking challenging steps to ask
- Family - increased stress and impacts on employment and activities
- Providers – stress, moral compromise
- System – multiple follow up, duplicate referrals, escalation of concerns, compromised or out of scope service

Notes:

Untreated mental health issues are more likely to recur and contribute to suicide risk.[14,15]

Focusing on th/e needs of young people on waitlists is important. While MHS waitlists are just one area of unmet need, they were identified as a key priority in a project involving close to 400 Māori and tauiwi young people;[10] they are a top target identified by youth consumer advisors (see support letter); and they have been identified as a major problem by the Government Inquiry into Mental Health and Addiction and the New Zealand Mental Health and Wellbeing Commission

Gibson K. What young people want from mental health services: a youth informed approach for the digital age: Routledge; 2021.

New Zealand Mental Health and Wellbeing Commission (2022). Te Huringa: Change and Transformation. Mental Health Service and Addiction Service Monitoring Report 2022. Wellington.

New Zealand Government. He Ara Oranga: Report of the government inquiry into mental health and addiction. Wellington, New Zealand; 2018.

Gagliardi AR, Yip CYY, Irish J, Wright FC, Rubin B, Ross H, et al. The psychological burden of waiting for procedures and patient-centred strategies that could support the mental health of wait-listed patients and caregivers during the COVID-19 pandemic: A scoping review. Health Expectations. 2021;24(3):978-90.

Slide 5:

Tertiary students experiences of waiting for adolescent mental heatlh services

Esta Wilson-Burke

"I remember like a month afterwards just my Mum brought it up, like 'you had this going' 'oh right' (laughs) 'have they contacted you?' 'no, not at all', 'ah shit'. But then it's like, did I need to contact them first or?

"I'm not getting any concrete dates. I'm not getting concrete information... I remember feeling very frustrated and very upset... especially after I'd make a phone call and I would be given nothing"

"When you call the phone number and you need help, you're on hold for an hour... And then you're given very basic regurgitated responses... Not treated with any sort of unique element or any sort of personal advice"

"It's really exhausting to always have to like advocate for yourself... and it's like... I'm trying to survive over here, you know?"

Notes:

Theme one – navigating the unknown

Uncertain time; participants described being unsure where to begin, what to expect, what was happening, what might happen, how they might cope. This uncertainty contributed to a sense of anxiety and stress

Often radio silence, not sure when to reach out to services or if they had been forgotten about

Exhausting trying to find out what is happening on top of managing your mental health

Some participants actively tried to find out everything they could which was difficult and distressing, others became more disillusioned that they would ever receive help and instead disengaged – both responses have negative impacts on young people

Slide 6:

Micro interventions - informed by

Youth Voice & concepts of:

- Manakitanga
- Active components of therapy & SSI
- Mental Health Helpseeking Journeys
  - Addressing Help negation, Effort overwhelm
- Behavior change
  - Nudges, Timely, Chunking down, Perceivable rewards
- Digital Health
  - **Live, Coming TO me, Via someone I trust**

Slide 7, 8, 9:

Imagining getting mental health help

- When people are doing OK, most can identify people, services or things that they could do that might help if they were feeling down
- It doesn't necessarily feel so hard…
- However, increased emotional distress associated with increased

2. Help negation & stigma

- Triad of negative beliefs
- Disengage or withdraw from helping opportunities
- Perseveration on negative thoughts; difficult processing accurate info about help, recalling helpful events…
- Internal & social stigma
- Concerns about making it worse

Effort negation & overwhelm

- Even though goals are rational & people want to achieve them, they are overtaken by competing cognitive, emotional & environmental processes.
- Those waiting for MH help face multiple competing demands

Notes to slides 7,8,9:

Help-negation" first appeared in the suicide literature almost 50 years ago. Based on an audit of the records of 30 acutely suicidal patients, help-negation was defined as "a specific form of help rejection wherein the patient persistently withdraws from, terminates, or denies any helpful relationships with staff or significant others" (Fawcett et al. 1969, p. 132). This groundbreaking study found that help-negation was "*the only observable interpersonal behavior that differentiated all patients with high suicide risk from those with low risk*." Much later, help-negation was described as an important empirical risk factor for suicide (Clark and Fawcett 1992).

across studies, results suggest that adolescents with the highest levels of suicide risk and associated mental disorders are often those who do not access or continue to engage with standard interventions for their condition.

Neuroscience research suggests that help-negation among suicidal adolescents is determined more by impaired neurological capability associated w dep and suicidality than by demographic and psychological characteristics.

The overlay of psycho and neuroscience research suggests that help-negation for suicidal ideation among adolescents is likely to be explained by complex network of changes that manifest as:

1. Difficulty redirecting one's current thinking away from suicide and toward seeking help for suicidal thoughts
2. Difficulties in processing accurate information about the availability of support from different a range of different help sources
3. Difficulties in accurately identifying and recalling positive helping events from the past that can be used to support current help-seeking behaviors
4. Difficulties in identifying and describing current suicidal thoughts and needs

https://link.springer.com/referenceworkentry/10.1007/978-3-319-33228-4_140

Radez, J., Reardon, T., Creswell, C. *et al.* Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. *Eur Child Adolesc Psychiatry* **30**, 183–211 (2021).

Almost all studies (96%) reported barriers related to young people's individual factors, such as limited mental health knowledge and broader perceptions of help-seeking.

The second most commonly (92%) reported theme related to social factors, for example, perceived social stigma and embarrassment.

The third theme captured young people's perceptions of the therapeutic relationship with professionals (68%) including perceived confidentiality and the ability to trust an unknown person.

The fourth theme related to systemic and structural barriers and facilitators (58%), such as financial costs associated with mental health services, logistical barriers, and the availability of professional help.

….In addition to making effective support more available, targeted evidence-based interventions are required to reduce perceived public stigma and improve young people's knowledge of mental health problems and available support, including what to expect from professionals and services.

Slide 10:

Slide 11:

Help Negation & Effort-optimized approaches

Focus on gains the in face of help negation & competing demands:

- Small, graded steps
- *Some* choice - Avoid option paralysis
- Timely
- Salient
- As effortless as possible to make a small gain
- Turning necessary efforts into sustainable assets.

Notes:

Baumel A, Muench FJ. Effort-Optimized Intervention Model: Framework for Building and Analyzing Digital Interventions That Require Minimal Effort for Health-Related Gains. J Med Internet Res. 2021 Mar 12;23(3):e24905. doi: 10.2196/24905. PMID: 33709943; PMCID: PMC7998331.

A recent report [11] on the use of MindSpot, an Australian digital mental health service may shed light on this phenomenon—the researchers reported an increase in the proportion of users looking for confidential assessment and a substantial decrease in the proportion of users looking for a traditional course-based internet intervention [11]. This suggests that many users are expecting far shorter therapeutic encounters such as microinterventions [12] compared with what would have been traditionally expected from users engaging digital health interventions.

We propose that a primary challenge with user engagement in digital interventions is that individuals who are struggling to change must work hard to achieve even a minor change because of the automatic forces propelling them back to their habitual behaviors [13-15]. Substantial literature has emphasized the continuum of automatic processes driving psychological distress and effortful processing fostering psychological health [16,17].

Oinas-Kukkonen and Harjumaa [30] developed a set of principles to build sustainable interventions that include concepts such as tunneling and choice reduction to foster engagement. Michie and colleagues [31] have developed a set of core behavior change principles, in which effort-reduction is implied, to guide intervention development heavily focused on learning theory and shaping behavior.

One of the reasons text-messaging interventions are acceptable may not be because they are just-in-time interventions, but rather, because individuals do not have to do anything except passively receive a text message once they sign-up. Text-messaging interventions have higher engagement over time than app-based interventions for perhaps no other reason than their effortlessness.

selection of interventions that meet individuals where they are in terms of motivation, ability, and barriers

what is the lowest burden method to trigger behavior change?" For example, if one is trying to reduce arousal before bedtime, interventions may require a range of engagement levels

Exploring the continuum of required effort enables the selection of interventions that meet individuals where they are in terms of motivation, ability, and barriers [28].

A person with almost no self-efficacy in changing a behavior may easily change the display options on their mobile phone to reduce blue light after 8 PM but may be unlikely to engage in guided paced breathing. At the same time, there may be no barriers to creating additive models of effortful engagement for those who are motivated and engaged.

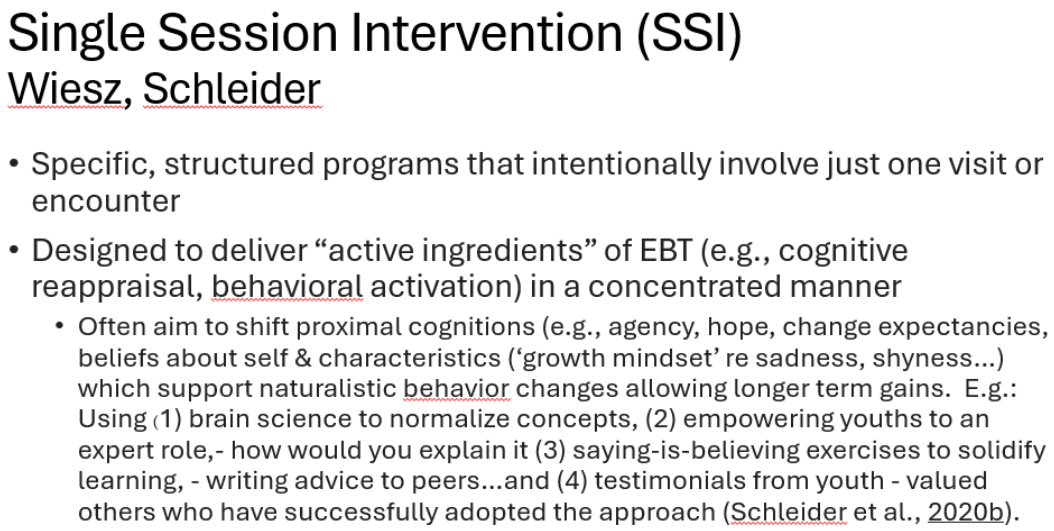
Unfortunately, the majority of effort targets for behavioral and mental health have fallen on the higher end of the spectrum. As a result, we are required to optimize effortful behaviors in times when we cannot make them fully effortless or passive.

Documenting and reflecting on past effort-related activities in a meaningful way Turning effort into assets by documenting and reflecting on aspects users care about during the therapeutic process; once assets are made, users are inclined to keep investing so that their assets will not go to waste Presenting effortful activities the user conducted (eg, user reports on socializing with a friend) and how these activities are helpful (eg increase life satisfaction other time)

Turning effort into a meaningful narrative Helping people acknowledge the link between the effort they just exerted and their commitment to the therapeutic process Upon reporting a positive interaction with their child, parents are asked to celebrate investing effort in becoming better parents

Reframing effort as positive Embedding a narrative in which the reward is the respect for asserting effort beyond skills acquisition

Slide 12:



Single-session interventions (SSIs) for youth mental health problems have shown promise in reducing and preventing youth psychopathology, including anxiety and depression [1,2,3]. Given that a majority of youths in the United States with significant mental health problems go without services each year [4, 5], empirically supported SSIs may serve as helpful alternatives or adjuncts to traditional, multi-session psychotherapy, which is often inaccessible to families due to logistical and financial constraints. However, like most evidence-based prevention and treatment programs, even SSIs with strong empirical support may not benefit all youths with mental health needs—and among youths who do benefit, some may experience greater symptom reductions than others. Thus, there is a need to differentiate youths for whom a brief, light-touch intervention could be sufficient to reduce symptomatology, from youths likely to require more intensive services, as in stepped care models of intervention [6].

B.E.S.T. elements of SSIs, grounded in social psychological research (Aronson, 1999) and participatory action research (Baum, 2006), are (1) using **b**rain science to normalize concepts, (2) **e**mpowering youths to an expert role, (3) **s**aying-is-believing exercises to solidify learning, and (4) **t**estimonials from valued others (Schleider et al., 2020b). In a personality mindset SSI, this may look like (1) explaining neuroplasticity in age-appropriate terms, (2) asking youths to help scientists explain these concepts to same-age peers, (3) using learned concepts to write advice to same-age peers, and (4) reading stories from other youths who have successfully adopted a growth mindset.

growth mindset (the belief that personality is malleable - through effort and support, we can all change the types of people we are and can become—) (JW)

Slide 13:

OMI

- Online 5-15 min interactions for immediate or short term gain (eg Bunge Walker Hunt et al, 2023)
  - small but significant *immediate* impact
  - Increase chance of return
- Targeting thoughts, activities, sleep, assertiveness & esp BA associated with improvements at one week follow-up (Bunge et al., 2016; Bunge et al., 2017).

Bunge, E.L., Walker, H., Hunt, G. *et al.* The Impact of a Behavioral Activation Online Micro Intervention on Mood and Activity Level. *J. technol. behav. sci.* **8**, 196–204 (2023). https://doi.org/10.1007/s41347-023-00314-5

OMIs - brief interactions lasting between five to fifteen minutes that aim to produce immediate or short-term improvements

Small immediate benefits – increase chance of return

Fuller-Tyszkiewicz,Richardson, Lewis et al., 2019

A randomized trial exploring mindfulness and gratitude exercises as eHealth-based micro-interventions for improving body satisfaction,

Computers in Human Behavior, 95, 58-65,

https://doi.org/10.1016/j.chb.2019.01.028.

brief video activities (e.g., gratitude tasks, breathing, and relaxation) based on previously demonstrated in experimental studies to improve body satisfaction. Findings showed greater improvements in body satisfaction at post-intervention for the intervention group than the waitlist controls (Cohen's *d* = .42). Use of the intervention content was associated with immediate increases in state-like body satisfaction ratings, and the magnitude of these in-the-moment improvements was predictive of greater post-intervention symptom improvement and retention (*p*s < .05

Slides 14,15:

Warm friendly welcome

During CAPA? + Video, Booklet Letter, or Call or Text?

- a warm friendly welcome; from the clinic
- an apology re delays?
- positive expectations
- when and how to get extra help
- Orientate for micro interventions - there are small steps that can help in the meantime;

Small steps over time

Phone call? Text? Video, Booklet, or socials page

- Relaxation Breathing
- Expecting change
- Talking about it some
- Getting on with the good
- Steps that help (sleep, PS..)
- What to expect when you ARE seen
- Digital tools & getting started

Slides 16,17:

TALKING TO SOMEONE

Why might it be good to talk to someone?

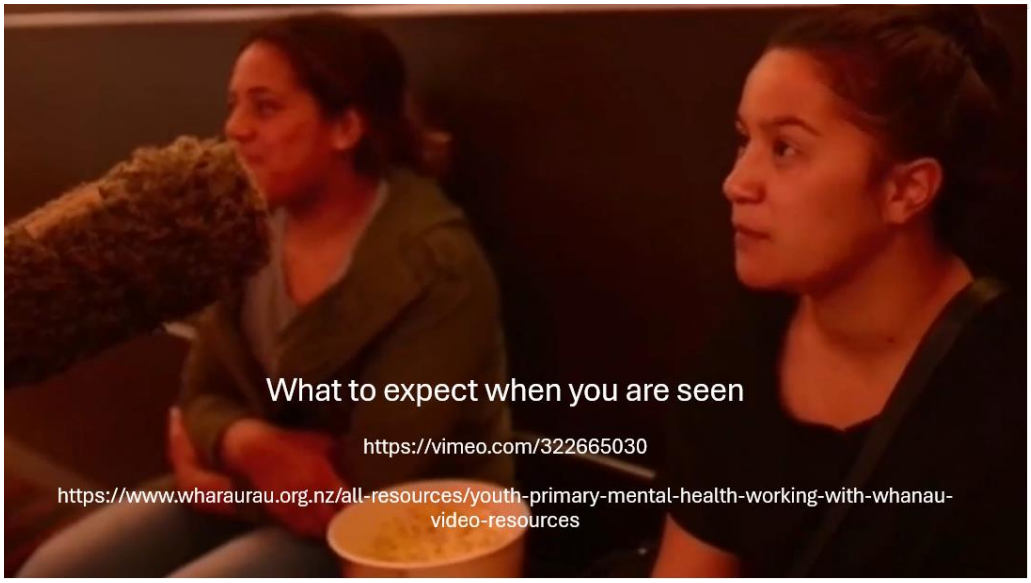
What if it's hard?

What if I don't know what to say?

Sometimes it is hard to know what to say. Try something like:

- *"I don't know what to say. I am having a really bad time"*
- *"I want some help because I'm worried about what's going on"*
- *"I don't know what to do"*
- *"I need someone to listen to me"*

Slides 18:



Slide 19:

Digital:
I want it live, coming to me, via someone I trust

From

- Long list of sites
  - Some might be outdated
  - Hard to load on phone
  - Wrong vibe
- No follow up

To

- Personalised
  - Look with them, Select 1; check they can start
- Ask to try it for 10 min & feedback to you
- Follow Up

References

- Baumel A, Fleming T, Schueller SM. Digital Micro Interventions for Behavioral and Mental Health Gains: Core Components and Conceptualization of Digital Micro Intervention Care. J Med Internet Res. 2020 Oct 29;22(10):e20631. doi: 10.2196/20631
- Bunge, E.L., Walker, H., Hunt, G. *et al*. The Impact of a Behavioral Activation Online Micro Intervention on Mood and Activity Level. *J. technol. behav. sci.* **8**, 196–204 (2023). https://doi.org/10.1007/s41347-023-00314-5
- Schleider JL, Mullarkey MC, Chacko A. Harnessing Wise Interventions to Advance the Potency and Reach of Youth Mental Health Services. Clin Child Fam Psychol Rev. 2020 Mar;23(1):70-101. doi: 10.1007/s10567-019-00301-4. PMID: 31440858.