No More Waiting Lists

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It all began with an unexpected finding in Oregon. We had randomly assigned people with alcohol use disorders to either 10 weeks of immediate outpatient behavioral counseling or what we regarded to be a minimal treatment control condition—a single session and instructions to keep a diary of alcohol use (Miller, Gribskov, & Mortell, 1981). Both groups also received a self-help book with suggestions based on the same behavioral approach (Miller & Muñoz, 1976). To our surprise, both groups showed marked and equal reduction in drinking at 3-month follow-up. We replicated the study twice in New Mexico with the same finding: no difference between a single session of counseling plus self-help materials and 10 (Miller & Taylor, 1980) or 12 weeks (Miller, Taylor, & West, 1980) of individual or group counseling. The large reductions in alcohol use were maintained in both groups across two years of follow-up (Miller & Baca, 1983).

It turned out that we were not alone in this finding. In England, Edwards and colleagues (1977) found no difference in outcomes between clients randomly assigned to state-of-the-art alcoholism treatment or a single session of “brief advice.” It is now well documented in dozens of trials that brief counseling yields significantly more change in substance use than no treatment at all (e.g., Bernstein et al., 2009; Bernstein et al., 2005; Bien, Miller, & Tonigan, 1993; Miller & Wilbourne, 2002), often equivalent to the impact of more extensive treatment (Project MATCH Research Group, 1998; UKATT Research Team, 2005). Similarly “bibliotherapy” (providing behavioral self-help materials) rather consistently is more beneficial than no treatment, at least in addressing alcohol problems (Apodaca & Miller, 2003). I had not fully considered the implications of these findings until we conducted studies in which clients randomly assigned to a “waiting list” showed no change at all over the same period of time. For example, in Figure 1 both the therapist-directed (dashed line, outpatient counseling) and the self-directed group (dotted line, single session, and self-help material) showed reductions following intake whereas two waiting list groups (solid line) showed no change at all over the same 10 week-period (Harris & Miller, 1990).

Why was there no change at all in the waiting list groups? It occurred to me that these clients did exactly what we had told them to do: they waited! Then once we could treat them, their drinking decreased. On the other hand, if we gave them a single session of encouragement and empowerment with some self-change guidelines, they showed at least as much improvement as those who were treated immediately.

Waiting lists are pernicious, and immediate treatment on demand would be ideal, albeit beyond the resources currently available in many settings. It appears, however, that we can at least give clients something valuable in the very first session that is far more beneficial than a fact-gathering “intake” whether or not they eventually return. Instead of implying that no change is expected until we can get to them, why not tell clients to take steps, to get started and then check back with them to see how they are doing? It can’t be worse than telling them to wait, and there is solid evidence that even a brief, empathic, encouraging, and empowering conversation can trigger change. If there is a disadvantage to this approach, it could be that by the time we are ready to offer treatment some people will no longer need us. Even from a commercial perspective this is likely to be offset by a decrease in the inevitable attrition rate of those who are put on a waiting list. Just one humane counseling session gives people a reason to return once further care is available.

There is also good evidence available regarding the kind of brief counseling and self-help materials that are most likely to be effective. Presumably brevity is not the active ingredient in brief intervention. Some common elements of effective brief counseling have been summarized by the acronym FRAMES: Feedback of personal status, emphasis on Responsibility for change, gentle Advice to change, a Menu of options, an Empathic counselor style, and support for Self-efficacy (Bien et al., 1993; Miller, 1999). The clinical style of motivational interviewing (Miller & Rollnick, 2013) has strong support for efficacy as a brief intervention. There are also self-help materials with evidence of effectiveness as “bibliotherapy” that can be provided in concert with a brief counseling session.
FIGURE 1. Drinking outcomes for treatment, brief intervention, and waiting list groups.

(for reviews see Apodaca & Miller, 2003; Miller, 2014). Why not give clients something that is likely to help them in the very first contact?

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William R. Miller, Ph.D., is Emeritus Distinguished Professor of Psychology and Psychiatry at the University of New Mexico. He received his PhD in clinical psychology from the University of Oregon in 1976 and has published over 50 books and monographs and 400 articles and chapters, focused primarily on the treatment of substance use disorders and the psychology of change. He is a recipient of the Jellinek Memorial Award for excellence in alcoholism research.

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