

The feasibility and effects of mindfulness-based relapse prevention on reducing craving and addictive behaviour in local adults with substance abuse disorders

Final Research report submitted to Beat Drugs Fund Association

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Acknowledgements

This project is funded by Beat Drugs Fund, Narcotics Division, Security Bureau. We would like to thank Security Bureau for the valuable support. We also thank all the participants who were involved in this study. We would like to express our sincere gratitude to the following NGOs and Specialist Out-patient Clinics (in alphabetical order) for facilitating us in recruiting participants: Prof. Johnson Zixin WANG and his team member, Rainbow Lutheran Centre, Hong Kong Lutheran Social Service, LC-HKS, Southern and Islands Office and Eastern and Wan Chai Office from Tung Wah Group Hospitals' CROSS Centre, Substance Abuse Clinics (SACs) from Northern district Hospital (NDH) and Alice Ho Miu Ling Nethersole Hospital (AHNH), the Society of Rehabilitation and Crime Prevention (SRACP). We sincerely thank all the participants in this study for their generous contributions.

報告摘要

背景：在治療藥物濫用障礙的患者中，復吸問題影響超過 60% 的人群。儘管認知行為治療 (CBT) 等心理治療方法在預防復吸方面有所幫助，但復吸率依然居高不下。近來，靜觀 (Mindfulness) 作為一種干預措施在臨床醫療和精神健康領域中變得備受關注。初步研究表明，專門為藥物使用障礙患者設計的靜觀預防復吸程序 (MBRP) 可能有效，但其在非西方人群中的效果尚未被研究。

目標與目的：本項研究旨在評估 MBRP 在香港藥物濫用者中的實施可行性及其有效性。

研究設計與方法：本研究為一項隨機對照試驗，旨在評估 MBRP 在香港成年藥物濫用者中的可行性與有效性。本研究在 2019 年 10 月至 2023 年 5 月間成功招募了 81 名參加者。研究分為兩個組別：實施靜觀練習的 MBRP 組和等候名單對照組 (WCG)。兩組的結果數據均在相同時間點收集，包括在介入開始前、結束後，以及結束後的 3 個月和 6 個月。本研究的主要結果指標是通過 7 天內藥物使用的自我報告來衡量戒斷情況。次要結果指標包括 PCS、GAD-7、PHQ-9、ASI、DASES、AAQ-II、FFMQ 和 EQ5D 等。此外，參與者在完成 MBRP 課程後，會被邀請填寫課程評估表並參與小組討論或個別訪談，以收集對 MBRP 的反饋。

研究結果：與以往研究相比，本研究顯示課程出席率和隨訪評估參與率都很高。66% 的參與者至少出席了一半的課程。在評估隨訪方面，介入後立即、介入後 3 個月和 6 個月的參與率分別為 82.7%、76.5% 和 66.7%。在 MBRP 組，介入後立即、介入後 3 個月和 6 個月隨訪的參與率分別為 80.5%、70.7% 和 63.4%。而等候名單對照組在同一時間點的參與率略高，分別為 85%、82.5% 和 70%。MBRP 從參與者那裡獲得了非常正面的評價，他們認為課程重要且有效，這從課後評價中對課程的重要性 ($M = 8.31, SD = 1.35$)、幫助性 ($M = 8.19, SD = 1.87$)、滿意度 ($M = 8.31, SD = 1.66$) 和持續實施靜觀練習的意願 ($M = 7.31, SD = 2.44$) 的高分數中得到證明。從小組討論和個別訪談中收集的數據表明，MBRP 所帶來的實際好處包括了情緒調節的改善、覺察的提升和向積極思維的轉變。雖然在主要結果指標上兩組之間的藥物戒斷情況沒有顯著差異，但 MBRP 組在介入後 3 個月時的組內分析顯示了顯著的改善。在次要結果指標方面，MBRP 組與等候名單對照組相比，在介入後立即的避免吸毒自我勝任感量表 (DASES) 得分和介入後 6 個月的成癮嚴重程度指數 (ASI) 綜合得分上顯示出顯著的差異。組內分析顯示 MBRP 組在所有時間點的 DASES 得分及 6 個月後的 ASI 得分也顯示出顯著改善，而在等候名單對照組中並未觀察到這一結果。在其他次要結果指標中，兩組之間並未看到顯著差異。

結論：總體上，參與者對 MBRP 課程評價很高，並認為它極具價值和效果。MBRP 與提高預防復吸的能力、增強抗拒毒品的自我效能感、減輕成癮嚴重性和對毒品的心癮有關。未來的研究應包括更多的中國藥物濫用者樣本，並與一個活性對照組 (active control) 進行比較，以便提供更確定的 MBRP 效果證據。

Executive summary

Background: Among people who have undergone treatment for substance abuse disorders, relapse continues to be a significant problem, affecting more than 60% of people with the disorder. Although there is empirical evidence to support the use of psychological treatment such as CBT to prevent relapse, the relapse rate continues to be high. Recently, mindfulness as an intervention measure has gained significant attention in the fields of clinical medicine and mental health. Although preliminary studies show that mindfulness-based relapse prevention (MBRP) specifically designed for people with substance use disorders may be a promising intervention to prevent relapse in substance use, no studies have been conducted in a non-Caucasian population.

Aim and Objectives: The aim was to evaluate the feasibility and effectiveness of MBRP among individuals with substance abuse in Hong Kong

Study Design and Methods: This study is a single-blinded, randomized controlled trial to test the feasibility and effectiveness of the MBRP programme among adults with substance abuse in Hong Kong. 81 participants were successfully recruited from Oct 2019 to May 2023. There were two study arms: the MBRP group and the waitlist control group (WCG). Outcome measures were collected at same time points in both the MBRP and WCG groups (baseline, immediately post-intervention, at 3 months post-intervention and 6 months post-intervention). The primary outcome was the abstinence status measured by a 7-day drug taking self-report. Secondary outcome measures included PCS, GAD-7, PHQ-9, ASI, DASES, AAQ-II, FFMQ, and EQ5D. Evaluation forms, focus group discussions or individual interviews were also conducted to obtain feedback on the MBRP programme from participants after the MBRP course.

Results: The current study demonstrated a strong retention rate for course attendance and follow-up assessments compared to previous studies. 66% of participants attended at least half of the sessions. Regarding assessment follow-up, the retention rates were 82.7%, 76.5%, and 66.7% immediately after intervention, at 3 and 6 months post-intervention follow-ups, respectively. For the MBRP group, retention rates were 80.5% immediately after intervention, 70.7% at 3 months, and 63.4% at 6 months post-intervention follow-ups. The waitlist control group saw slightly higher retention rates of 85%, 82.5%, and 70% at the same respective time points. The MBRP programme received highly positive evaluations from participants, who found it to be important and beneficial, as evidenced by high ratings in terms of importance ($M = 8.31$, $SD = 1.35$), helpfulness ($M = 8.19$, $SD = 1.87$), satisfaction ($M = 8.31$, $SD = 1.66$), and the intention to continue mindfulness practice ($M = 7.31$, $SD = 2.44$). Taking account of the qualitative component, those practical benefits included improved emotional regulation, heightened awareness, and shifts towards more positive thinking. For the primary outcome, no significant differences between groups were found in abstinence status across measured time points. However, within the MBRP group, a significant improvement was observed at the 3-month follow-up. Secondary outcomes showed significant differences between the MBRP and waitlist control groups, particularly in Drug Avoidance Self-Efficacy Scale (DASES) scores immediately after intervention and Addiction Severity Index (ASI) composite scores at the 6-month post-intervention follow-up. Furthermore, within-group analysis showed that the MBRP group significantly improved in DASES across all the time points and in ASI at 6 months post-intervention follow-up. Similar results were not seen in the waitlist control group. Significant differences between two groups were not seen in other secondary outcomes.

Conclusions: Overall, the program was highly regarded by participants, who reported it as valuable and beneficial. MBRP was associated with improvements in relapse prevention, self-efficacy in drug avoidance, the severity of addiction, and the intensity of drug cravings. Further studies involving a larger sample size of Chinese drug abusers and a comparison with an active control group could provide more definitive evidence of MBRP's effects.

Main Body

Introduction

Among people who have undergone treatment for substance abuse disorders, relapse continues to be a significant problem affecting more than 60% of people with the disorder.¹ Although there is empirical evidence to support the use of psychological treatment such as cognitive behavioral treatment (CBT) to prevent relapse, relapse rate continues to be high.² The socioeconomic costs report of drug abuse in Hong Kong suggests that the total cost attributable to drug abuse was nearly 10.33 billion (about HK\$460,000 per person per year).³ Hong Kong has long-adopted a multi-modality approach to drug treatment and rehabilitation to cater for the divergent needs of drug dependent persons from varying backgrounds, including compulsory placement scheme, voluntary outpatient methadone treatment programme, voluntary residential drug treatment and rehabilitation programs, counselling centres for psychotropic substance abusers, centres for drug counselling and substance abuse clinics. However, there are still service gaps due to shortage of mental health professionals e.g. psychiatric nurses and social workers to provide timely services to drug abusers. Furthermore, many barriers are perceived by drug abusers in seeking professional help due to stigma and self-stigma, poor accessibility and lack of continuity of service. The Three-year Plan on Drug Treatment and Rehabilitation Services in Hong Kong (2018-2020) states 1) a great need to explore and evaluate innovative interventions for preventing relapse with an evidence-based approach for formulating new programmes, and also to provide professional trainings to healthcare professionals with the use of new interventional services; 2) more evidence-based anti-drug services at the community level especially for those out-patients to stabilize their conditions; and 3) arrangement of more flexible service time in non-working hours to reach more drug abusers in need. Very often they may need services out of the normal working hours, e.g. weekends or nights, as about one quarter of reported drug abusers in the Central Registry of Drug Abuse (CRDA) from the Narcotics Division, Security Bureau of the government of Hong Kong, are full-time workers. They also prefer those services adoptable without influencing their work and family responsibilities, i.e. services that can be easily integrated into their daily life. To accommodate the needs of drug abusers outside typical working hours, it is noted that the operation times of some non-governmental organisations (NGOs) have been extended. For instance, the Tung Wah Group of Hospitals' CROSS Centre can now schedule interviews and programs from 6:00 p.m. to 10:00 p.m. on weekdays, and from 10:00 a.m. to 1:00 p.m. on Saturdays. Similarly, Rainbow Lutheran offers individual and group counselling services from Tuesday to Friday evenings and Saturday mornings. The latest two updates of the

Three-year Plan (2021- 2024 and 2024-2026) continued to encourage the exploration of new or alternative treatment services.

Innovative interventions that can integrate the efficacious treatment components can further reduce the relapse rate among people with substance abuse disorders. Mindfulness-based interventions can be very promising as an intervention for people with substance abuse problems. Mindfulness is defined as “the awareness from paying attention in a particular way: on purpose, in the present moment, and non-judgmentally”.⁴ Over the past three decades, therapeutic interventions such as mindfulness based stress reduction (MBSR) programme and mindfulness based cognitive therapy (MBCT) that have used mindfulness skills and practices as a therapeutic modality in treating physical and psychological disorders such as chronic pain, anxiety disorders and recurrent depression have been shown to be beneficial with accumulating evidence.⁵⁻¹² When enrolled in these programmes, participants learn various mindfulness skills including sitting and walking meditation, yoga, a somatically focused technique called the body scan⁴ and are instructed to maintain attention on their immediate experience with an attitude of openness, acceptance, and compassion.⁴ Recently, research on the use of mindfulness in the treatment of substance use disorders has received more and more attention in the literature¹²⁻¹⁵ and a novel mindfulness based approach, called the mindfulness based relapse prevention (MBRP) which integrates traditional cognitive behavioural relapse prevention with mindfulness techniques and practices adapted from MBSR has been developed. Recently, several randomized controlled trials that evaluated the feasibility and efficacy of MBRP in adults with substance abuse disorders have been conducted which showed promising results in the reduction of substance use in those who have received MBRP as compared to people in the usual care control.¹⁵⁻¹⁷ Moreover, adults who had been randomized to the MBRP had demonstrated¹⁸ larger reduction of craving, and increases in acceptance and acting with awareness measured by validated psychological scales as compared to adults in the control group. The theoretical foundations for the integration are that mindfulness may enhance a participant’s ability to cope with relapse triggers by interrupting the cycle of automatic substance use behaviour. For a potential relapse of addictive behaviour, awareness and acceptance cultivated by mindfulness practice can help the individual to recognize his or her negative thinking and/or negative emotions associated with the relapse and learn to assume a detached and decentred relationship to these thoughts and feelings which then can prevent the escalation of thought patterns and emotions that lead to a full relapse of addictive behaviour.¹⁵⁻¹⁷ In a way, these individuals, through mindfulness training, enhance their ability to cope with triggers of relapse, with negligible side effects reported.

Mindfulness-based interventions are promising interventions as an adjunctive therapy to be integrated into current existing anti-drug services. The advantages of MBRP can include: 1) having very low stigma as mindfulness courses are already widely accepted and used among different populations including healthy populations. The running of mindfulness courses can be more acceptable by the community; 2) it could be more accessible and cost-effective as it can be provided in group and in community settings; 3) it is a skill that can be learned and be used after the 8 week course, e.g. when the drug abuser is triggered in unforeseen circumstances, they may apply the learnt mindfulness skills to help themselves overcome the difficulties when timely professional help is not available; 4) CRDA statistics showed that the most common reasons for recurrent drug use were to avoid discomfort of its absence (44%) and relief of depression/stress/boredom (48%). Mindfulness-based interventions can potentially reduce drug use by increasing the acceptance of uncomfortable and craving feelings due to drug absence by observing and letting go the feelings through various mindfulness practices such as body scan, mindful breathing and sitting,^{15-17,19-21} and also by reducing depression and anxiety.²²⁻²⁵

Although preliminary studies show that mindfulness based relapse prevention (MBRP) specifically designed for people with substance use disorders may be a promising intervention to prevent relapse in substance use, no studies have been conducted in a non-Caucasian population,^{15-17,19-21} except a small study was conducted among 24 participants in Taiwan with pre and post assessments,²¹ thus the generalizability of these interventions in different cultures and healthcare system is not known. Furthermore, since previous studies have rarely followed the participants past pre and post intervention, the long-term impact of MBRP in Chinese is still unknown.

Recently, mindfulness as an intervention has garnered significant interest. It is noted that some NGOs have been implementing this approach to support and treat drug abusers. For example, the Rainbow Lutheran Centre has incorporated the Mindfulness-Based Relapse Prevention (MBRP) programme into their services to develop peer support for hidden drug users.

Objectives

1. To evaluate the feasibility of using mindfulness-based relapse prevention (MBRP) programme among adults with substance abuse in Hong Kong;
2. To examine the changes of craving, substance use, mood symptoms, self-efficacy, acceptance, level of mindfulness and quality of life between those who have enrolled in the MBRP as compared to those in the usual care control group;

3. To evaluate the correlations between changes in substance use and craving and changes in mood symptoms, self-efficacy, acceptance, level of mindfulness, and quality of life; and
4. To study participants' characteristics related to adherence and benefits associated with MBRP.

Methods

This study is a single-blinded, randomized controlled trial to test the feasibility and effectiveness of the mindfulness-based relapse prevention (MBRP) programme among adults with substance abuse in Hong Kong. There were two study arms: the MBRP group and the waitlist control group (WCG). Outcome measures were collected at same time points in both the MBRP and WCG groups (baseline, immediately post-intervention, at 3 months post-intervention and 6 months post-intervention). Focus group discussions or individual interviews were also conducted to obtain feedback on the MBRP programme from participants after the MBRP course.

Study population

The eligibility of participants was based on the following inclusion and exclusion criteria. The inclusion criteria will be: (a) aged between 18 and 70; (b) fluent in Cantonese; (c) has ever fulfilled the Structured Clinical Interview for DSM-IV/DSM-5 (SCID) drug module criteria for substance use disorder diagnoses; and (d) has completed outpatient or inpatient treatment for substance abuse in the previous 6 months or currently in community-based rehabilitation services. The exclusion criteria will be: (a) inability to provide valid consent; (b) current or lifetime psychotic disorder assessed by the Structured Clinical interview for DSM-IV/DSM-5; (c) imminent suicidal risk; or (d) dementia.

Recruitment

This pioneering study in Hong Kong aimed to assess the viability, acceptance, and impact of Mindfulness-Based Relapse Prevention (MBRP) for those with drug addiction. We engaged with various parties that offer community and residential detox services to assist with recruiting participants. Our research assistant (RA) screened willing referrals from these centres to ensure they met the study's criteria before they were invited to join and provided informed consent.

We recruited participants with drug use disorders from diverse backgrounds on a voluntary basis from a range of centers and clinics. These included Rainbow Lutheran Centre, Hong Kong

Lutheran Social Service, LC-HKS, offices of Tung Wah Group Hospitals' CROSS Centre, Substance Abuse Clinics (SACs) at Northern District Hospital (NDH) and Alice Ho Miu Ling Nethersole Hospital (AHNH), the Society of Rehabilitation and Crime Prevention (SRACP), as well as a team from the JC School of Public Health and Primary Care at CUHK conducting a men's health study.

The recruitment process faced significant hurdles due to the 2019 social movement and the COVID-19 pandemic, with frequent service suspensions at NGOs impacting our ability to find participants. Initial briefings with NGOs were repeatedly delayed by social unrest and the pandemic, such as the one for Rainbow Lutheran Centre, which was moved from November 2019 to February and then to June 2020. The pandemic's fourth and fifth waves further complicated recruitment, with service suspensions at collaborating NGOs and restrictions on outside visitors.

For example, Caritas Wong Yiu Nam Centre, which previously agreed to support our project, had to restrict external access. Social workers also reported challenges in sourcing new participants after extended periods of service cessation. Issues of confidentiality prevented the merging of participants from different NGOs, and it often took 6-8 months for each NGO to gather enough participants for a new group.

Despite these difficulties, our research team strived to find solutions and maintain strong connections with social workers from collaborating NGOs. We expanded our recruitment efforts, such as conducting on-site recruitment at SACs at HA during the periods between COVID-19 waves, and we collaborated with another research team conducting a men's health study, which provided additional referrals. Even with recruitment activities halted during the peak of the fifth wave, we managed to enrol a number of eligible participants when the situation improved.

Randomization allocation, concealment and blinding

In this open-label trial, it was not feasible to blind therapists or participants. Once the research assistant screened individuals, randomization faced significant constraints due to confidentiality requirements and the policies of the collaborating entities. Combining eligible participants from different sources into a single group was not permissible. Challenges in recruiting participants also made it impractical to adhere to the initial method of randomizing participants into intervention and control groups. Consequently, we adapted our approach by creating a random sequence for group

allocation within each participating party. The social workers involved in recruitment were kept unaware of the group assignment sequence.

Intervention and Control

Mindfulness-based Relapses Prevention (MBRP)

The development of MBRP was based on a cognitive behavioral approach called Relapse Prevention (RP).²⁶ Individuals with substance abuse disorders would learn to identify high risk situations (e.g. feeling stressed, being alone) and apply effective coping skills to prevent relapse of their addictive behaviours. They would also learn to identify and modify beliefs that might contribute to their relapses e.g. biased expectation towards the positive effect of substance use during craving. In MBRP, it enriched RP with mindfulness practices with a core intention of cultivating a non-judgemental awareness to the present moment with a sense of openness and acceptance.²⁷ This particular way of paying attention helped individuals with substance abuse disorders to be more aware of the internal and external factors that contributed to their relapses and responded in a more compassionate way. Instead of reacting in their habitual substance use, individual with substance abuse disorders would learn to take a pause, notice their here-and-now experiences, and respond according to their underlying needs. MBRP was different from traditional RP that, instead of changing the content of the thoughts, it changed the relationship with their thoughts. In other words, it cultivated a de-centred approach towards their internal experiences, including their thoughts.

MBRP is a manualized program with 8 weekly 2-hour sessions.²⁸ There are variations in the number of sessions and the duration of each session. In this study, we adopted the standard 8-week program plus an 1-hour orientation session before the 8-week program began in order to explain the logistic of the study and the group arrangement. MBRP is originally designed for relapse prevention of individuals who completed treatment for their substance use problems. They would not be excluded even they had lapse or relapse in their substance use unless they came to the class intoxicated. Throughout the 8 sessions, participants would practice various mindfulness exercises. For example, in session 1, they would practice a 30-minute body scan, which they learnt to pay attention to different part of their body with curiosity and openness. There were mindful practices that tailored-made for individuals with Substance abuse disorders. For example, participants would learn SOBER breathing space in session 3. In SOBER breathing space, participants would learn to take a pause, attend to the here-and-now internal experiences, anchor the awareness to the breathing, and finally expand the awareness to the body and the surrounding in order to prepare for finding appropriate responses to

their needs. MBRP maintained some of the very helpful cognitive behavioural exercises, such as identifying high risk situations of relapse. The details of each session could be referred to the **Appendix 1**.

MBRP highly valued participants' direct practice experiences. Home practice was strongly recommended and audio recording of each mindful exercise was given to participants to facilitate their home practice. In each session, participants would have chances to share their home practice or in-session practice experiences. MBRP facilitator would respond in an inquiry-based style i.e. to deepen participants' experience through questions and reflections instead of giving answers directly. The ideal group size of MBRP was about 8 to 12. Since this study was carried out during the time of COVID-19, some of the MBRP groups were delivered in a tele-health format via video conferencing.

In this study, all MBRP groups were delivered by an experienced MBRP facilitator with rich experiences in teaching mindfulness-based interventions and with expertise in addiction treatment service. All participants' handouts were first translated by a research assistant, who was fluent in both Chinese and English, and reviewed by the MBRP facilitator. The handout of each session could also be referred to **Appendix 2**. All of the home practice audio recordings were made by the MBRP facilitator according to the script from the manual.²⁸ All scripts were translated into Chinese in a similar way as mentioned before. Cultural adaptation was made with some of the mindful practices. For example, SOBER breathing space was replaced by the 3-step breathing space used in Mindfulness-based Cognitive Therapy²⁹ since most participants did not understand the meaning of "SOBER". It was easier to remember 3-step in the 3-step breathing space instead of 5-step in SOBER breathing space. For the discussion on high-risk situation, participants would bring up examples that related to Hong Kong context. For example, participants reported that they could order "delivery service" for the substance in a way similar to food delivery during the COVID-19 period.

Fidelity Check of MBRP

A clinical psychologist verified the fidelity of the intervention. An external statistician, not affiliated with the research team, randomly chose 25% of the MBRP sessions to undergo fidelity assessment. For this purpose, we developed a tailored checklist, adapted from one used in prior research, which evaluated elements of adherence to the protocol and the competence of the delivery.³⁰

Waitlist Control Group (WCG)

Participants in the WCG condition remained in their standard outpatient aftercare provided by the treatment agency with an aim to maintain their abstinence with the help from social workers or other healthcare professionals through different activities, such as topics on life training skills, rational thinking skills, grief and loss, assertiveness, self-esteem, goal setting, effects of drugs on interpersonal relationships and experience. Following the completion of the follow up assessments, we would offer the same MBRP course to the participants from the waitlist control group for 8 weeks. Participants in WCG could decide to join or not on a voluntary basis.

Course Attendance, Participant Feedback and Qualitative Components

Course attendances were recorded. A questionnaire assessed course satisfaction at the end of the 8-week course using a 10-point Likert scale ranging from “Not at all” to “Very”. Questions included: “How important is this program to you?”, “How likely are you going to continue engaging in mindfulness practice after this course?” and “Would you recommend this course to your friends or people affected with addiction problems?”. Furthermore, Qualitative focus group discussions and individual interviews were conducted after the course and moderated by an experienced research assistant in running focus group discussions. The discussions will be audio-recorded to ensure data accuracy. A topic guide was used, which covered open-ended questions categorized by the following topics: overall viewpoints, practice of mindfulness, perceived facilitators and barriers when applying mindfulness skills, perceived changes after the course and suggestions for improvement.

Quantitative Outcome Measures

All the quantitative assessments used in this study are widely used validated tools among drug abusers or used in our previous studies. An overview of the data collection for each subject is given in **Figure 1**. Data was gathered from structured interviews administered by a trained research assistant. The assessment components included the following items: Basic demographic data (age, sex, education, employment, marital status, personal monthly income) at baseline. The following quantitative primary and secondary outcome measures were collected at baseline, immediately after intervention, at 3 months post-intervention and at 6 months post-intervention follow-ups.

Primary outcome measures:

Substance Use (self-report and urine test)

The Substance Use Calendar was administered at each data collection time-point to assess substance use in the past seven days . Patient self-report of drug use was verified by the collection of urine for toxicology screens for drug use at each data collection time point (i.e. baseline, post-intervention, 3 months and 6 months post-interventions). Self-reports of no substance use and a negative urine test were used at baseline and each assessment to confirm abstinence status.

Secondary outcome measures:

Drug Craving

The Penn Alcohol Craving Scale (PCS),³¹ which has been adapted to include items on drug craving, was used. The Penn Alcohol Craving Scale is a 5-item self-report measure that assesses the frequency, intensity and duration of craving. It has been shown to have excellent internal consistency and predictive validity for substance abuse relapse.

Depression and Anxiety

Depression was measured by the 9-item Patient Health Questionnaire (PHQ-9).³² Anxiety was measured by the 7-item Generalised Anxiety Disorder (GAD-7).³³ Both scales have high reliability and validity and are widely used among different populations. These two scales have four-point scales with scores ranging from 0 (rarely) to 3 (most of the time). The scores of 5 to 9, 10 to 14, 15 to 19, and 20 to 27 in PHQ-9 indicate mild, moderate, and severe depressive symptoms, respectively. The scores of 5 to 9, 10 to 14, and 15 to 21 in GAD-7 indicate mild, moderate, and severe anxiety symptoms, respectively. A score ≥ 10 for the PHQ-9 and GAD-7 indicates the presence of positive depression and anxiety symptoms, with higher scores indicating more severe symptoms.

Addiction Severity Index

The Addiction Severity Index (ASI) – Lite Version³⁴ is a multi-dimensional interview that was used to measure subjects' substance use, health and social problems.³⁵ In our study, we modified the ASI of only including the component of drug abuse. In our study, we focused solely on the aspect of drug abuse, which necessitated a modification to the index calculation. We computed the composite score

by taking the count of days a specific drug was used in the past 30 days, dividing it by 30—the total possible days—and further dividing by 11, representing the total number of drug categories assessed. The formula is as follows: $(\text{Heroin} / 330 + \text{Methadone} / 330 + \text{Other opiates/analgesics} / 330 + \text{Barbiturates} / 330 + \text{Other sed./hyp./tranq} / 330 + \text{Cocaine} / 330 + \text{Amphetamines} / 330 + \text{Cannabis} / 330 + \text{Hallucinogens} / 330 + \# \text{ days used more than one drug} / 330)$.³⁶

A higher composite score indicates a higher level of addiction severity.

Drug Avoidance Self-Efficacy

Drug Avoidance Self-Efficacy Scale (DASES) measured self-efficacy of drug avoidance in 16 situations that may trigger someone's intention to take drugs.³⁷ The scale's Cronbach's alpha was 0.914. Responses are rated on a 7-point scale ranging from "certainly yes" to "certainly no" which corresponds to a measure of "strength" of self-efficacy. Some items are reversely coded. The total score is obtained by summing across the 16 items. Higher scores indicate higher level of self-efficacy.

Level of Acceptance

The Acceptance and Action Questionnaire – second edition (AAQ-II)³⁸ was used to assess acceptance versus avoidance and control of negative private experiences. Items of this scale are rated on a 7-point Likert-type scale, with higher scores indicating higher acceptance. Higher total scores mean less flexibility, while lower total scores mean more flexibility.

Level of Mindfulness

Mindfulness was measured by the Five Facet Mindfulness Questionnaire to evaluate whether the increase or changes in mindfulness are related to changes in the outcomes of menopausal symptoms. This scale has been translated into Chinese by our team and has shown to have acceptable reliability and validity.³⁹

Health related Quality of Life

Health-related quality of life was measured by the 5-item EuroQol EQ-5D-5L (EQ5D).⁴⁰ It is validated and widely used. It has an index score. The Hong Kong version has the predicted EQ-5D-

5L values ranged from -0.864 to 1. It also has a visual analogue scale ranging from 0 to 100 with higher scores indicate better quality of life.

Data analyses

The baseline characteristics of the two groups were compared using the independent samples t-test for continuous variables and the chi-square test for categorical variables. The baseline factors included age, sex, education, employment, marital status, and personal monthly income. Our primary outcome was the change in abstinence status based on the 7-day drug-taking self-report. Additional analyse using different durations of abstinence (within 3 and 5 days) were performed to examine any significant changes over time with shorter reported timeframes. Secondary outcomes included scores of PCS, PHQ-9, GAD-7, modified ASI-Lite Version, DASES, AAQ-II, FFMQ-SF, and EQ-5D-5L. For primary analyses, abstinence status was assessed using a Generalized Estimating Equation (GEE) for longitudinal data. Abstinence status (1= non-abstinence and 0= abstinence) was the dependent variable. For secondary analysis, outcome variables that included PCS, PHQ-9, GAD-7, modified ASI-Lite Version, DASES, AAQ-II, FFMQ-SF, and EQ-5D-5L were entered as dependent variables into the linear mixed models (LMM). GEE and LMM utilized all available data, including individuals who only provided baseline data. Excluding those 2 participants absent from all the intervention courses and assessments, the remaining 79 participants were included in the analysis of GEE and LMM.

For qualitative results, the audio recordings were transcribed verbatim. A quality check was completed independently by another research assistant. Framework analysis was used by first reading through the transcripts and field notes by two researchers to become familiar with the data, then conceptualizing the themes and subthemes and piloting coding with the themes. Based on similarities and differences between initial themes, the themes and subthemes were finalized, which would include comments on the course (dislike or useless parts, preferred or useful parts, difficult parts and easy parts), home practice (frequency, length and future practice), changes after the course, barriers and facilitators for course participation and compliance and suggestions for course improvement.

Sample size

As far as we know, this is the first study that compares the change in drug use over six-month follow-up time between patients assigned to MBRP and those assigned to WCG in Hong Kong. Previous literature suggests that, as a rule of thumb, a number of 12 participants in each group were

needed in pilot studies.⁴¹ Furthermore, Guest and McKenna found three focus groups were also enough to identify the most prevalent themes within a data set.⁴² As the attrition rate among people with substance use disorder was higher than other populations, as well as due to diverse backgrounds and needs of different drug abusers such as younger adults, ethnic minorities, men who have sex with men, mothers or pregnant women in Hong Kong, it was enlarged to a sample size of 40 in each group (a total of 80 participants) to ensure the final sample would have more than 24 completed cases in total. Therefore, the final sample of 49 completed cases, who completed all the assessments, was larger than the originally proposed number of 24 participants in total for the pilot study.

Ethical

The conduction of this study followed the Code of Ethics of the Declaration of Helsinki. Ethics approval was obtained from the Joint Chinese University of Hong Kong – New Territories East Cluster Clinical Research Ethics Committee (CREC) before the trial.

Trial Registration

This trial was registered in ClinicalTrials.gov (Trial Registration Number: NCT04034732) and the Chinese Clinical Trial Register (ChiCTR). (Trial Registration Number: ChiCTR1900026247).

Result

Participants were recruited from Oct 2019 to May 2023. Out of the 102 screened participants, 81 were eligible for the study and were successfully recruited, which met the expected sample size. All 81 participants were included in the analysis, except for the analysis of Generalized Estimating Equation (GEE) and linear mixed models (LMM), which excluded 2 participants who were absent from all the intervention courses and follow-up assessments. **Figure 1** shows the flow diagram of this study. Basic information on the study participants can be seen in **Table 1**. Most participants in this study were male, singled, with an education level at or above secondary school. The characteristics of the two groups (n=79) were imbalanced at baseline. There were significant differences on the age and income level between the two groups.

Course Attendance, Participant Feedback and Qualitative Components

Course Attendance

The Mindfulness-Based Relapse Prevention (MBRP) course had an 85.4% retention rate, with participants attending an average of 4.59 sessions (SD=2.63). 66% of the participants attended at least half of the sessions (4 out of 8). There was a 14.6% dropout rate, with 6 participants dropping out either at the beginning or during the middle of the course. The reasons for dropout included relocation from the residential detoxification centre (2 participants), disinterest in MBRP (3 participants), and personal issues (1 participant).

Regarding assessment follow-up, the retention rates were 82.7%, 76.5%, and 66.7% immediately after intervention, at 3 and 6 months post-intervention follow-ups, respectively. For the MBRP group specifically, retention rates were 80.5% immediately after intervention, 70.7% at 3 months, and 63.4% at 6 months post-intervention follow-ups. The waitlist control group saw slightly higher retention rates of 85%, 82.5%, and 70% at the same respective time points. The primary reason for loss to follow-up in both groups was the inability to contact participants. Notably, in the waitlist control group, most participants were unable to continue due to hospitalization for drug relapse.

Participants Feedback

After completing the MBRP program, 16 participants provided feedback by submitting an evaluation form. **Table 2** compiles the participants' evaluations of the program. They rated 5 different items using a 10-point scale where "1" signified "Not at all" and "10" indicated "Very." All feedback from participants was favourable. Specifically, the participants found the courses to be both beneficial and valuable, with mean scores of 8.19 (SD = 1.87) and 8.31 (SD = 1.35) for helpfulness and importance, respectively.

Qualitative Components

Altogether, 22 individuals from the MBRP group took part in either focus groups or individual interviews. Participants' ages ranged from 25 to 57, averaging at 38.36 years, and the majority, numbering 20, were male.

During the focus group discussions, participants contributed their perspectives on a range of topics, including perceived barriers and facilitators for course participation and compliance, the practice of mindfulness, perceived changes after the course, and suggestions for course improvement.

Perceived barriers and facilitators for course participation and compliance

For the driving factors behind enrolling in the course, the majority of participants indicated that their curiosity to acquire new knowledge was the primary reason for their interest in the program.

"I'm curious about mindfulness, want to see what it is, and see if it can help me."

P004/Male/ Age 50

"There are many methods for drug rehabilitation, and there are many ways to prevent relapse. I have never known about intervening in the problem of drug addiction through mindfulness. The first thing is curiosity. I want to try and see how it works."

P020/Male/Age 49

"At that time, I felt that the term 'mindfulness' was something I had not encountered before, and I wanted to understand more about it."

P010/Female/Age 25

"I naturally like to learn more and try new things, so when I come across a method..."

P008/Male/Age 26

Some participants noted their desire to participate in the course stemmed from a specific interest in exploring whether mindfulness practices could aid in managing their particular issues, including emotional challenges or preventing relapse.

"Because I'm very tense personally, whether it's doing things, walking, just everything makes me tense. I want to use mindfulness to slow myself down and relax. Sometimes, when my temper flares, I wonder if, through mindfulness, is it possible to help me calm down and prevent me from getting angry?"

P022/Male/Age 40

"Because I feel very impatient in doing things, I want to learn or find a way to calm myself down."

P015/Male/Age 35

"I am very interested in some sort of training for the mental, or perhaps some kind of... further education."

P002/Male/Age 34

"I had previously come into contact with religion, Buddhism, and those kinds of things, and then I felt that meditation and introspection are good methods. After hearing about mindfulness, I wondered if I could also adopt this method to solve or alleviate my CF (Chem Fun) condition."

P012/Male/ Age 47

"The reason I participated initially was because I thought mindfulness might help with my psychological cravings for drugs. It seems that sometimes when those cravings come, they are hard to control. Mindfulness could perhaps provide an opportunity for me to observe these cravings and learn how to deal with them."

P006/Male/ Age 32

"Regarding the impulse for drugs, when another impulse comes, can I restrain myself, can I control myself? I want to learn more within this group about how to control just the thoughts of taking drugs."

P020/Male/ Age 49

Regarding compliance, most participants expressed that they continued their participation because they perceived the course material to be beneficial and relevant to their needs.

"Why keep participating? Well, it's because I feel that I hadn't learned or touched upon this before. Having learned it, I found that it's useful, so... I don't want to have a superficial understanding, so I try to attend all the classes to understand fully."

P008/Male/Age 26

"And the reason for compliance is I think each class has new content that I can use, so there are different content I may choose to use?"

P014/Male/Age 32

"After attending the class, I realized it was quite a different experience because I had never had a teacher before telling me how to feel the things around me, the events, the sensations. This curiosity and a whole new experience make me want to continue attending classes to discover how they can help me."

P011/Male/Age 32

"I do learn things that are useful to myself, so I will persist. I don't want to be in a situation where I attend one class and then miss the next one. I am afraid I will be confused and not understand, So I keep persisting... it's something I've always wanted ..., it has its allure. Especially if it's useful to myself, and there's no downside, I will still go."

P022/Male/Age 40

Additionally, some participants cited the sense of camaraderie and support from fellow course members as a reason for their sustained involvement in the program.

" there's a sense of mutual encouragement, or the involvement of other people can make it easier for you to accept it, or maybe you'll be more interested, and it won't be so easy to give up. So this is one of the reasons for persistence."

P017/Male/Age 31

"After joining ... because I had depression before, so in this course, that is by talking with everyone about... that is, the things I'm thinking about at that moment... some sharing... it has helped me a lot. That's why I will keep coming as long as I am able to."

P010/Female/Age 25

Regarding perceived barriers, while most participants reported no adverse effects from attending classes or participating, a minority did mention instances where confronting their emotions during practice proved challenging.

"The course keeps progressing, and it also uncovers more of the unhappiness in my heart. Maybe when I got to that point, I couldn't bear it, and then I didn't have the time to deal with it or whatever... attending the class and doing those exercises increased my chances of relapsing."

P002/Male/Age 34

"One of the things it teaches me is to imagine a bad situation, that is, some bad events, and then to confront those emotions. However, I feel that this is not so easy."

P001/Female/Age 33

"When I go back home, sometimes I practice mindfulness alone. At times, my thoughts aren't just about drug use but more about emotions, and it becomes... it's not that I don't want to practice. I'm afraid that sometimes it might bring up very upsetting things. Practising alone, I wonder if that's a good thing."

P010/Female/Age 25

Furthermore, some participants disclosed that they experienced moments where they questioned the efficacy of mindfulness practices.

"At the beginning, it was like a phase of exploration. The first two or three classes were about relaxing myself or not yet having a clear idea of how to use mindfulness to connect with the relationship to the drug, to help myself."

P021/Male/ Age 49

"And I think it's not that simple because initially, when I joined this class, in the first and second classes, it was something I had never been exposed to, and it seemed like it wasn't something I understood. Could this new thing help me change? ... I had my doubts about this matter. I even complained about it."

P007/Male/Age 47

Practice of mindfulness

During participant discussions or interviews, it was noted that those individuals who practised mindfulness regularly and formally at home often engaged in activities like body scans and breathing exercises. They could detail the precise steps of these practices and report positive outcomes, such as a sense of calm and comfort.

"I've been practising all along, and during the process, there's comfort... mostly it's breathing exercises."

P020/Male/Age 49

"So just sit down slowly, calm yourself, yes, do these exercises; there is a breathing exercise."

P021/Male/Age 42

"Pay attention to different parts of my body, then make myself more focused, relax as much as possible to go to sleep. Pay attention to... that is, observe calmly, like my ankles, heels, knees, thighs, think about each part individually, and after thinking and focusing."

P004/Male/Age 50

Pay attention to my breathing while sitting on a chair, with my feet planted on the ground as if sitting in a mountain pose. It brings me back to the present moment, becoming aware that my heartbeat is fast, my breathing is rapid, and my body is warm, almost as if there's a slight trembling..... I've stepped out and am observing myself as a third person."

P016/Male/Age 42

Besides thoughts, it's a matter of relaxation; I follow my breathing to relax my whole body and myself, to calm down so that I'm not as impatient or restless.

P017/Male/Age 31

Perceived Changes after the course

Participants reported experiencing beneficial changes following their mindfulness practice. These changes could be grouped into improvements in emotional regulation, enhanced awareness, and altered thought patterns.

Regarding emotional control, some participants noted that through practising and implementing mindfulness techniques, they enhanced their ability to regulate emotions, which manifested as increased calmness and a decrease in impatience.

"Knowing how to handle those emotions is better than before. I feel like a lot of the time in the past, it was about enduring or getting angry.....Now, I think it's easier to see, recognize, and deal with them instead of suppressing them... or avoiding them. Because usually, if I avoid them, I might turn to medication."

P014/Male/Age 32

"I feel that after using drugs, my personality, or even the way I do things, becomes very impatient, and I may even exhibit some quite impulsive behaviour. I believe that the mindfulness course helped me calm down in those moments, or at least try to use a different method, the mindfulness approach, to handle my impulses. Because in the past, they might not have been so effective if I had used my own methods. But after learning and trying mindfulness, I feel that I am able to control my impulsive behaviours more."

"Sometimes in life, I work, or my usual personality is very impatient; I want to get things done quickly. But sometimes I become so busy that I'm gasping for breath... in those moments when I'm sweating profusely or in a rush to do something, I've tried to hide in the bathroom, then tried to breathe and remember what my instructor taught me about paying attention to my breath, or adjusting it, or methods to calm myself down, and I feel it works."

P015/Male/Age 35

"I feel that I can relax quite well on my own, if indeed... with mindfulness... that is, perhaps saying when sitting and feeling my body, these moments are quite good."

P001/Female/Age 33

"So through mindfulness, I can try to relax myself, It's like the stress seems to have been relieved."

P020/Male/Age 49

The majority of participants indicated that mindfulness practice contributed to enhanced awareness. This enhanced awareness encompasses mindful attentiveness, which involves actively

observing one's thoughts, feelings, and physical sensations as they occur in the present, as well as self-reflection.

"When I'm angry, the first thing I need to do is to be aware of my feelings, which means the physical sensations in my body at that time... whether it's the body's expressive reactions or the internal emotional responses. Then, this can eventually lead you to make a better choice instead of immediately hitting someone or causing destruction when you're angry."

P002/Male/Age 34

"Teaching me to pay attention to my body. When I focus on my body, I won't easily fall back into hurting my body or return to drugs. Then I realize the importance of the body, which can help me learn how to focus, help myself not to be controlled by my emotions, and try my best to calm myself down."

P003/Male/Age 50

"So there was once when I started to hallucinate after taking drugs. I remembered two things I had learned in class and applied them. This helped me to resolve the issue of my hallucinations and brought me back. Before, when I had hallucinations, I didn't know what to do, but over the past few weeks, when I experienced hallucinations again, I brought my thoughts back to the present moment and looked clearly at what was happening. That moment, I felt, helped me a lot."

P016/Male/Age 42

"I've become more attentive to my body. Sometimes, I suddenly realize that my breathing has become shallow, or after becoming shallow, it also becomes faster. So, I pay more attention to whether I am feeling tense. It's like being aware of your current emotions. This gives me more opportunities to observe my physical state – whether it's a craving coming on or perhaps the environment affecting my emotions. I might become more aware of my body, my emotions, and the things in my surroundings."

P014/Male/Age 32

"Why does this thought emerge, what can I do when it appears, and how can I solve it? Is it necessary for me to follow what I want to do, or do I have other options to consider?"

P013/Male/Age 29

"In mindfulness, there is more space to think about my feelings or needs. There's more time to consider why I want to do certain things, like why I want to use drugs. It's about understanding where the problem lies. For example, if the reason I use drugs is because I'm very afraid of boredom, then in this practice, I would think about why boredom leads me to drug use. Maybe this boredom is just a thought of mine. Within mindfulness, I can look at my issue with drug use, my issue with boredom from a third-person perspective."

P020/Male/ Age 49

Several participants were able to articulate how mindfulness assisted in altering their ways of thinking. From their accounts, it appeared that mindfulness had a favourable influence on their perspectives and responses to various circumstances.

"Having learned mindfulness, that is, maybe positively, will affect my way of thinking to be more positive. Often, I won't immediately explode with emotions and revert to my old ways."

P005/Male/Age 57

"It's like looking at a half-filled glass of water. You can see it as either half empty or half full. So, I try to take things that are naturally 'sinking' and see if I can change the perspective to make them seem 'rising'. that is, in these aspects, I will now pay more attention to how I view things."

P008/Female/Age 25

"Many persistent loops can be approached with mindfulness, leading to a different perspective and thus providing different solutions."

"When facing these difficulties or temptations, it's natural to be drawn towards certain actions or fixed habits. I think that through mindfulness practice, I can develop a different way of thinking. ... there can be many other perspectives or different activities to engage in. When facing these challenges or temptations, there are various angles from which to handle them."

P011/Male/Age 32

"Sometimes, when things happen, I start to think, why must I react this way? Do I have other options? Or when I feel these emotions, and I get these urges at these moments, or when different emotions arise, could there be different methods that might be better? In the past, I might have just done what I wanted, but now I pay more attention and consider things more carefully."

P013/Male/Age 29

"Sometimes I use mindfulness to, you know, even if there are times when I've mentioned passing through certain scenes or places near where my friends are, places that used to evoke very strong feelings and sometimes scare me into avoiding them, but now it's not like that. Now, I feel that, to some extent, mindfulness has given me the confidence that I can revisit the places."

P002/Male/Age 34

Suggestion for improvements

As a consequence of the COVID-19 pandemic, several sessions were conducted online. Participants who joined these sessions through ZOOM indicated a preference for in-person classes, noting that the online format could detract from the quality of their

learning experience and potentially diminish the effectiveness of mindfulness training compared to traditional face-to-face instruction.

"If it's learning face to face, actually the efficiency and the results will be much better..... "

I would still recommend to you, and I suppose it should be put as a strong suggestion, that the participants or students should seriously consider if they can attend classes offline.... The effectiveness is vastly different. It could significantly impact the results of your research or the data, whether online or offline."

P017/Male/Age 31

"Such an arrangement is indeed very convenient, but I also feel that if you're not physically practising mindfulness in the same environment together, it's easier to get distracted, I should say. Just looking at the screen, watching the instructor speak, phone can be distracting. Yes, or many other things can cause distractions, making it harder to engage fully."

P015/Male/Age 35

"Maybe because it changed to Zoom, the difficulty increased because the instructor ultimately can't see our immediate reactions in person. It's tough for them to make real-time responses. The most memorable instance was when we were preparing to feel the craving. That is, we had to recall them. I think this was a big challenge. Because the craving would stir those desires up, right? And maybe because we were on Zoom, the instructor couldn't go too deep into it."

P014/Male/Age 32

Quantitative Outcome Measures

Primary Outcome

Table 3 and **Figure 2** present the Primary Outcome of the study. There was a significant difference at baseline between two groups. No significant differences were observed between the Mindfulness-Based Relapse Prevention (MBRP) group and the waitlist control group at any measured time points. However, when analysing each group individually using generalized estimating equations, a significant effect within the MBRP group was seen at the 3-month follow-up after the intervention. This effect was not present in the waitlist control group. As a significant difference between two groups in substance use was found at baseline, baseline values were included in the model for adjustment. No significant between-group difference was observed at all follow up assessments, even adjusting for the baseline values.

Additional analyses using different durations of abstinence (within 3 and 5 days) were also presented in the **Table 3**. Similar to the results based on the 7-day drug-taking self-report, no significant differences between groups were found for shorter reported timeframes of 3 and 5 days. However, a significant effect within the MBRP group at the 3-month follow-up was still observed.

The frequency of types of drugs is presented in the Table 4. Most participants reported taking ‘Ice’ at baseline (n=9), with four from the intervention group and five from the control group. The frequency of other major drugs was less than five, such as Cannabis (n=4), Cough Medicine (n=4), Ketamine (n=3), and Tranquillizers (n=3). Therefore, subgroup analysis could only be performed for the ‘Ice’ subgroup. Table 5 presents the subgroup analysis for ‘Ice’ abusers. The control group exhibited a lower non-abstinence rate for ‘Ice’ at the 6-month follow-up (p=0.047 by Fisher’s exact test). However, in the MBRP group, only four subjects reported taking ‘Ice’ at the 6-month follow-up, so the significant difference might not be reliable.

Secondary Outcomes

Secondary outcomes of the study are presented in **Table 6** and **Figure 3**. Significant differences between the two groups were seen immediately after intervention and at 6 months post-intervention follow-up in the Drug Avoidance Self-Efficacy Scale (DASES) scores and the Addiction Severity Index (ASI) respectively. Specifically, the mean DASES score improvement from baseline to post-intervention was 9.85 for the MBRP group compared to 0.54 for the waitlist control group. In terms of ASI, the decrease of mean composite score from baseline to the 6-month post-intervention follow-up was 0.03 for the MBRP group and 0.005 for the waitlist control group. These results suggest greater gains in drug avoidance self-efficacy and reduced addiction severity in the MBRP group.

Referring to **Table 6** and **Figure 3** again, within-group analysis utilizing linear mixed models showed that several significant improvements were only found in the MBRP group for the secondary outcomes at specific time points. These improvements were seen in the PCS at 3 months post-intervention follow-up, PHQ-9 at 6 months post-intervention follow-up, GAD-7 immediately after intervention and at 6 months post-intervention follow-up, DASES at 3 months and 6 months post-intervention follow-ups, AAQ-II immediately after intervention and at 6 months post-intervention follow-up, FFMQ at 3 months post-intervention follow-up, and EQ5D-5L_Health Score at 3 months and 6 months post-intervention follow-ups. Similar results were not found in the waitlist control

group. However, the waitlist control group showed a significant increase in EQ5D-5L index at 6 months post-intervention follow-up, an outcome not observed in the MBRP group.

Significant differences in age and income level were taken into account in the analysis. By including age and income as variables, the analysis was adjusted to account for these factors. After this adjustment, similar results were found in primary and secondary outcomes, expecting that several significant within-group effects were found in both groups. Nevertheless, the general trends of the estimates were unchanged (refer to **Table 6**, where "[^]" indicates $p < 0.05$ after adjustment for age and income level). In addition, a significant increase in EQ5D-5L index at 6-month post-intervention follow-up, which was not seen before adjustment, was also found in the MBRP group.

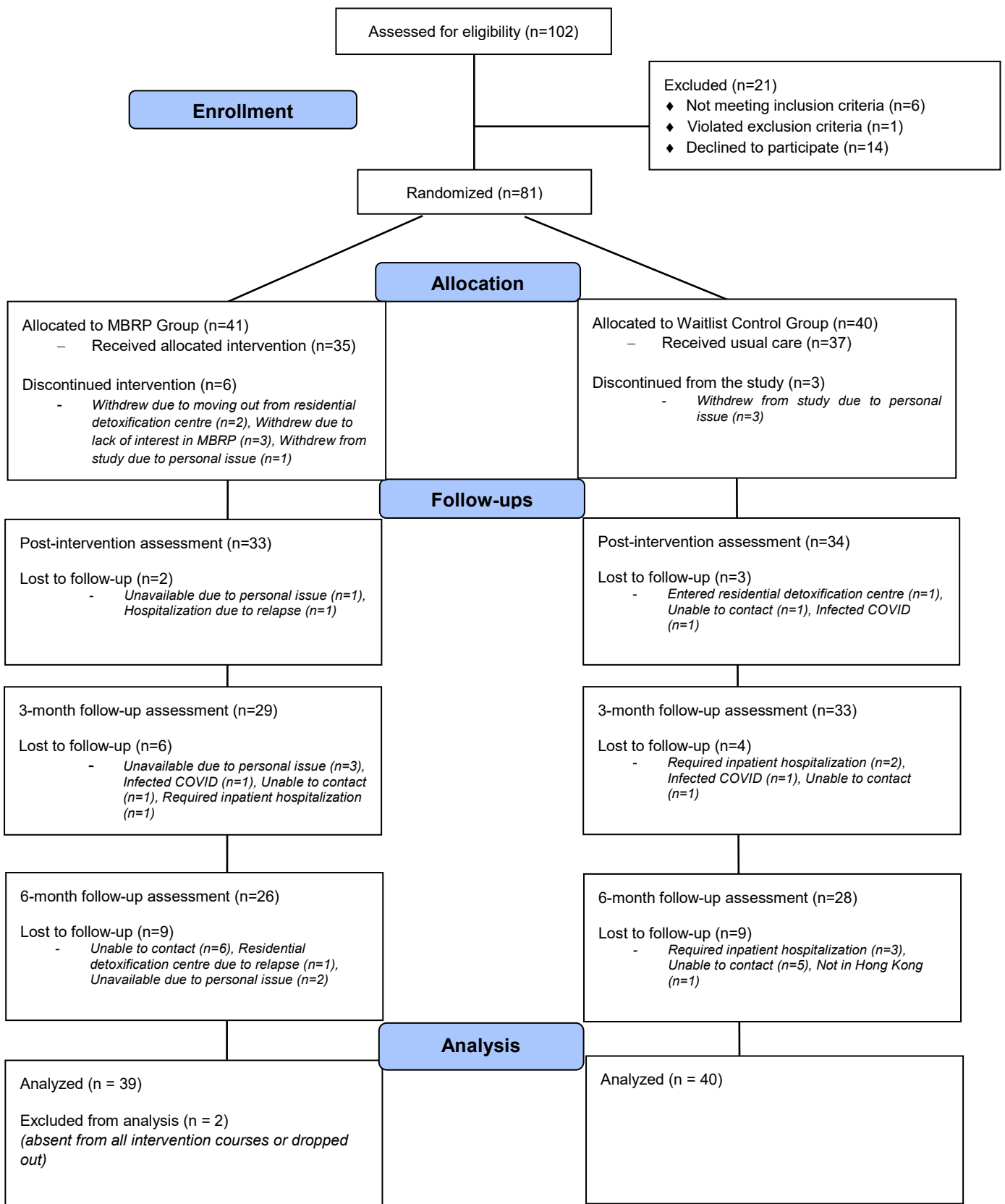


Figure 1 The CONSORT (Consolidated Standards of Reporting Trials) flow diagram of the study

Table 1: Baseline information of participants

Items	MBRP (n=39)	Control (n=40)	<i>P</i> value
Age at enrolment, mean(sd)	40.3 (10.6)	34.1 (7.1)	.003
Male, n(%)	84.6	90	.472
Education, n(%)			.826
No formal education	0	0	
Primary School	2.6	5	
Secondary School	69.2	65	
Preparatory School or above	28.2	30	
Employment			.369
Full-time	33.3	47.5	
Part-time	23.1	17.5	
Unemployed	35.9	32.5	
Housewife	0	2.5	
Retired	2.6	0	
Unanswered	5.1	0	
Marriage			.361
Single	61.5	75	
Married	17.9	7.5	
Divorced	12.8	15	
Cohabitation	5.1	0	
Widow	0	0	
Unanswered	2.6	2.5	
Income			.047
No income	5.1	7.5	
<\$5,000	10.3	0	
\$5000-\$9999	5.1	5	
\$10,000-19,999	15.4	10	
\$20,000-29,999	10.3	12.5	
\$30,000-\$39,999	2.6	10	
Above \$40,000	17.9	17.5	
Welfare Support	23.1	5	
Don't know/Unanswered	10.3	32.5	

Table 2: Participants' Ratings of the MBRP programme

Items	<i>Mean</i>	<i>SD</i>
How important is this program to you?	8.31	1.35
How likely are you going to continue engaging in mindfulness practice after this course?	7.31	2.44
Would you recommend this course to your friends or people affected with addiction problems?	7.75	1.81
Overall, how helpful do you think this course is for you	8.19	1.87
Overall, how satisfied are you with this course?	8.31	1.66

Table 3: Primary outcomes using Generalized Estimating Equations

	7 days					5 days					3 days				
	Percentage in count (non-abstinence)		B-coefficient		B-coefficient (interaction term)	Percentage in count (non-abstinence)		B-coefficient		B-coefficient (interaction term)	Percentage in count (non-abstinence)		B-coefficient		B-coefficient (interaction term)
	MBRP	Control	MBRP	Control		MBRP	Control	MBRP	Control		MBRP	Control	MBRP	Control	
Non-abstinence Status															
Baseline	59.0%	30.0%				59.0%	25.0%				56.4%	22.5%			
Post-intervention	54.5%	26.5%	-0.148	-0.219	0.066	54.5%	23.5%	-0.123	-0.138	-0.037	51.5%	23.5%	-0.230	-0.099	-0.164
3 months	39.3%	21.2%	-0.451*	-0.576	0.048	34.5%	15.2%	-0.685*	-0.755	0.010	31.0%	15.2%	-0.791*	-0.727	-0.102
6 months	42.3%	14.8%	-0.592	-0.934	0.360	42.3%	14.3%	-0.633	-0.693	-0.042	42.3%	10.7%	-0.702	-0.994	0.226

Note: Baseline as referent; Control group as reference group; * $p < 0.05$; MBRP = Mindfulness-based Relapse Prevention

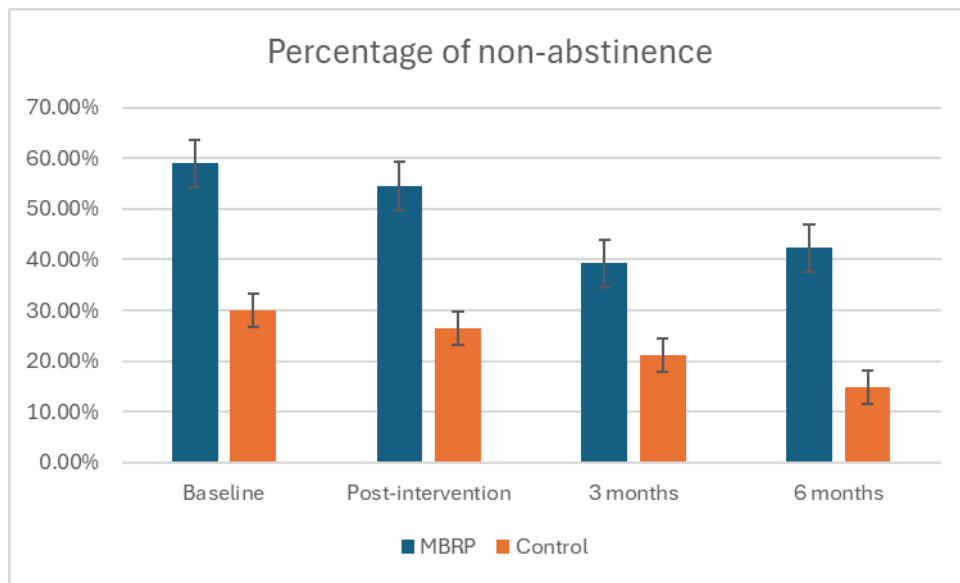


Figure 2 percentage of non-abstinence from baseline in MBRP and waitlist control groups

Table 4. Frequency of drug types taken by participants at baseline

	MBRP	Control	Total
Ice	4	5	9
Cannabis	2	2	4
Cough Medicine	2	2	4
Ketamine	3	0	3
Tranquillizers	2	1	3
Cocaine	2	2	2
Heroin	1	0	1
Ecstasy	1	0	1
Others (e.g. Paint thinner, Benzodiazepine, Phencyclidine)	10	5	15

Note: Some participants reported taking more than one kind of drug, with the frequency shown in the table

Table 5: Subgroup results for the ‘Ice’ abusers

Non-abstinence Status (Amphetamines, Methamphetamine, Ice)	MBRP	Control	p-value
Baseline	10.3%	12.5%	1.000
Post-intervention	12.1%	14.7%	1.000
3 months	6.9%	3.0%	0.595
6 months	15.4%	0%	0.047*

Note: *p < 0.05 by Fisher’s exact test

Table 6: Secondary outcomes using linear mixed models

		Mean (Standard Deviation, SD)		Estimate (within-group)		Estimate (interaction term)
		MBRP	Control	MBRP	Control	
PCS						
	Baseline	9.67 (9.36)	6.55 (7.07)			
	Post-intervention	9.36 (9.78)	6.50 (7.56)	-0.565	-0.085	-0.656
	3 months	6.28 (7.06)	4.79 (5.53)	-2.788*	-1.922	-0.895
	6 months	7.73 (8.03)	5.18 (6.15)	-1.739	-1.161	-0.541
PHQ-9						
	Baseline	9.97 (7.89)	7.21 (5.69)			
	Post-intervention	8 (6.38)	5.50 (5.24)	-2.406*	-1.680*	-0.728
	3-months	5.45 (4.71)	5.27 (4.52)	-4.297*	-2.106*	-2.151
	6 months	5.81 (5.50)	5.50 (4.68)	-3.687*	-1.814	-2.154
GAD-7						
	Baseline	7.26 (6.76)	5.75 (6.00)			
	Post-intervention	5.06 (4.95)	4.24 (3.79)	-2.538*	-1.524 [^]	-0.940
	3 months	4.07 (3.63)	3.82 (4.13)	-3.060*	-2.055*	-0.961
	6 months	4.46 (4.62)	5.04 (4.43)	-2.443*	-0.868	-1.686
ASI						
	Baseline	0.046 (0.066)	0.016 (0.032)			
	Post-intervention	0.031 (0.040)	0.009 (0.019)	-0.014	-0.007	-0.007
	3 months	0.014 (0.027)	0.007 (0.013)	-0.027*	-0.009*	-0.019
	6 months	0.016 (0.032)	0.011 (0.027)	-0.033*	-0.001	-0.024*
DASES						
	Baseline	72.82 (22.55)	79.58 (15.43)			
	Post-intervention	82.67 (24.52)	80.12 (18.23)	9.632*	0.467	9.265*
	3 months	83.79 (23.24)	83.09 (20.58)	9.294*	3.444	5.573
	6 months	83.77 (21.49)	83.61 (17.11)	11.256*	2.902	9.130
AAQ-II						
	Baseline	24.08 (11.70)	22.73 (10.44)			
	Post-intervention	21.94 (10.06)	20.94 (9.56)	-2.564*	-2.063	-0.402
	3 months	18.10 (9.11)	20.09 (10.29)	-6.438*	-2.953*	-2.743
	6 months	18.54 (7.92)	21.32 (9.55)	-5.466*	-2.198	-3.328
FFMQ						
	Baseline	60.62 (9.80)	59.33 (9.81)			
	Post-intervention	64.00 (9.02)	61.47 (8.90)	3.637*	2.630*	1.141
	3 months	64.83 (10.48)	60.91 (9.48)	4.532*	2.014	2.231
	6 months	61.61 (11.04)	59.75 (8.67)	2.007	1.321	0.342
EQ5D-5L						
	Baseline	0.79 (0.23)	0.87 (0.13)			
	Post-intervention	0.81 (0.25)	0.91 (0.09)	0.021	0.039	-0.018
	3 months	0.86 (0.19)	0.91 (0.09)	0.066 [^]	0.045 [^]	0.021
	6 months	0.86 (0.13)	0.92 (0.09)	0.071 [^]	0.055*	0.016
EQ5D-5L_Health Score						

Baseline	67.71 (19.14)	72.10 (18.00)			
Post-intervention	74.33 (13.47)	75.82 (13.12)	6.615	3.724	2.892
3 months	78.59 (12.33)	77.55 (13.41)	10.868*	5.445 [^]	5.423
6 months	79.02 (12.22)	78.04 (12.52)	11.301*	5.936 [^]	5.366

Note: Baseline as referent; Control group as reference group; * $p < 0.05$; [^] $p < 0.05$ after adjustment of age and income level; *MBRP* = Mindfulness-based Relapse Prevention; *Penn Alcohol Craving Scale (PCS)*; *9-item Patient Health Questionnaire (PHQ-9)*; the *7-item Generalised Anxiety Disorder (GAD-7)*; *Addiction Severity Index-Lite Version (ASI)*; *Drug Avoidance Self-Efficacy Scale (DASES)*; *Acceptance and Action Questionnaire – second edition (AAQ-II)*; *Five Facet Mindfulness Questionnaire (FFMQ)*; *EuroQol EQ-5D-5L (EQ5D)*;

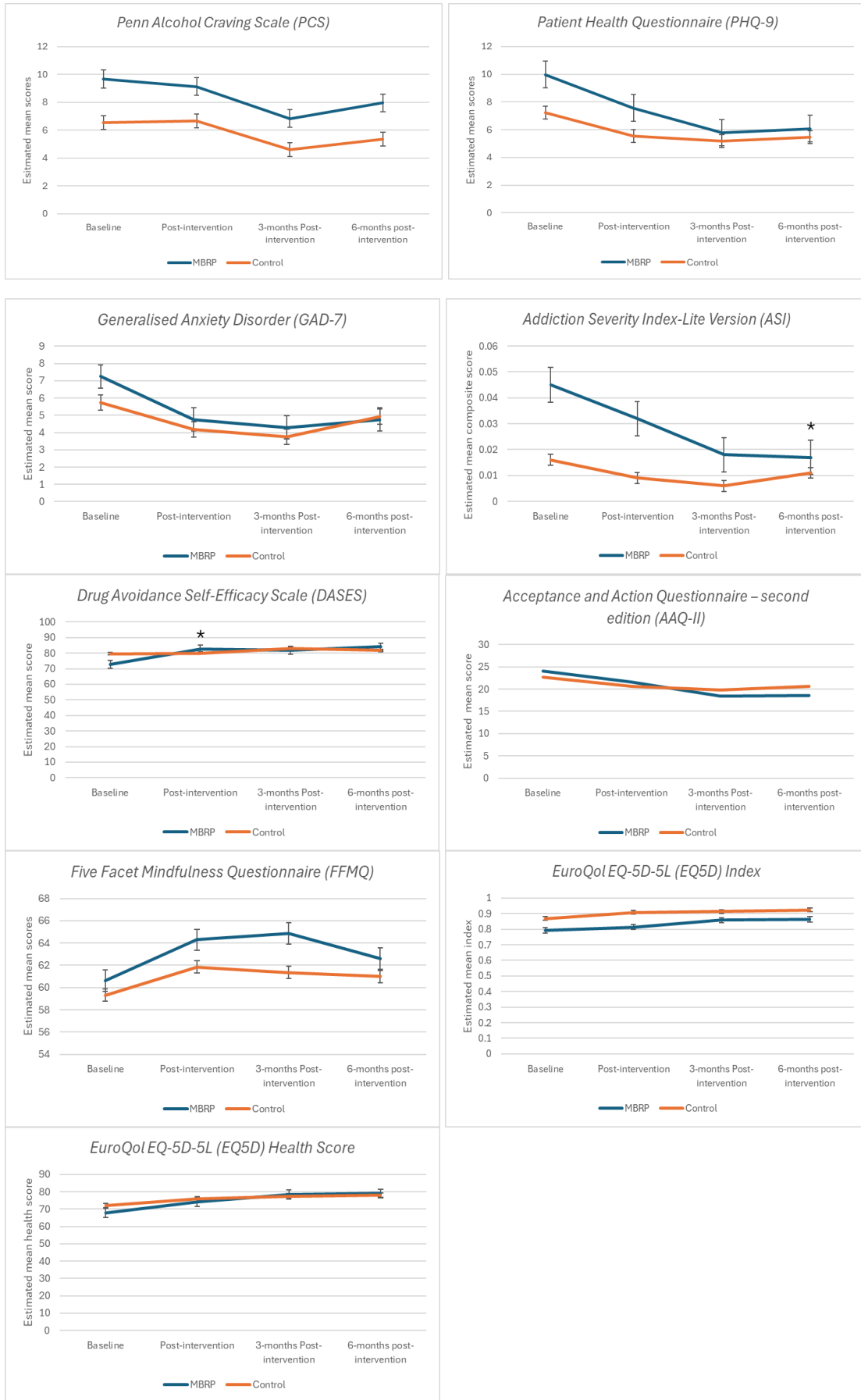


Figure 3: Mean Change of scores and index from baseline in both MBRP and waitlist control

Discussion

Main findings

The current study demonstrated a strong retention rate, with 85.4% of participants completing the course and an average attendance of 4.59 sessions out of 8 (SD = 2.63). 66% of participants attended at least half of the sessions. Drop-out reasons included relocation, disinterest, and personal issues.

Follow-up assessments showed retention rates decreasing over time, with 82.7%, 76.5%, and 66.7% immediately after intervention, at 3 months and 6 months post-intervention follow-ups, respectively. The MBRP group had slightly lower retention rates at each time point compared to the waitlist control group. Loss to follow-up was primarily due to an inability to contact participants and, in the case of the waitlist control group, inpatient hospitalization following relapse. Compared to previous studies, our study exhibited notably higher participation and follow-up rates, where earlier studies indicated that only about 35.8% of participants attended between 5 to 9 sessions, with a substantial 44.3% not attending any sessions at all,⁴³ our study's attendance was significantly better. Additionally, while previous research with a similar design showed a 65.3% attendance at the 3-month follow-up,⁴⁴ our study achieved higher rates at this interval.

Participant feedback on the MBRP program was overwhelmingly positive. Based on a 10-point scale, participants rated the program as highly important (M = 8.31, SD = 1.35) and helpful (M = 8.19, SD = 1.87). Additionally, participants expressed a high likelihood of continuing mindfulness practice after the course (M = 7.31, SD = 2.44) and a willingness to recommend the course to others (M = 7.75, SD = 1.81). Satisfaction with the course was also rated highly (M = 8.31, SD = 1.66). Through the focus group discussion and individual interviews, participants shared that curiosity and the pursuit of new knowledge primarily drove them to join the program, while the benefits and relevance of the course content, along with peer group support, encouraged their continued participation. Challenges such as confronting emotions and questioning mindfulness's effectiveness were perceived barriers. Regular home mindfulness practice like body scans and breathing exercises was associated with increased sense of calm and comfort. After practising mindfulness, participants reported improved emotional regulation, enhanced awareness, and positive shifts in thought patterns. They suggested improvements for the course, particularly favouring in-person sessions over online ones, suggesting that the online format could detract from the quality of their learning experience and potentially diminish the effectiveness of mindfulness training compared to traditional face-to-face instruction. The Mindfulness-Based Relapse Prevention (MBRP) program received highly positive

evaluations from participants, who found it to be important and beneficial, as evidenced by high ratings in terms of helpfulness, satisfaction, and the intention to continue mindfulness practice. Taking account of the qualitative component, those practical benefits included improved emotional regulation, heightened awareness, and shifts towards more positive thinking.

Regarding the effectiveness of MBRP, comparing the Mindfulness-Based Relapse Prevention (MBRP) group to a waitlist control group, no significant differences were found in abstinence status across measured time points. However, within the MBRP group, a significant improvement was observed at the 3-month follow-up, which was not present in the control group. Secondary outcomes showed significant differences between the MBRP and waitlist control groups, particularly in Drug Avoidance Self-Efficacy Scale (DASES) scores immediately after intervention and Addiction Severity Index (ASI) composite scores at the 6-month post-intervention follow-up. Furthermore, within-group analysis showed that the MBRP group significantly improved in DASES across all the time points and in ASI at 6 months post-intervention follow-up. Similar results were not seen in the waitlist control group, indicating that MBRP showed significant improvements in drug avoidance self-efficacy and addiction severity. MBRP group also showed Significant improvement in the Penn Alcohol Craving Scale (PCS) at 3 months post-intervention follow-up. These significant improvements were not observed in the waitlist control group. Overall, these outcomes align with findings from previous research, which indicate that individuals in the MBRP group are likely to experience a lower risk of relapse,^{17,44} reduced drug severity,⁴³ enhanced self-efficacy,⁴⁵ and diminished cravings.⁴⁶ Additionally, scales like the DASES and ASI demonstrated significant improvements at the 3-month and 6-month post-intervention follow-ups, suggesting that the benefits of MBRP may have a sustained impact over time.

Interestingly, there was a significant difference in baseline between two groups, noting that MBRP group had a higher non-abstinence status than the waitlist control group. It appears that the timing of the recruitment for a number of participants in the MBRP group coincided with the period of relaxed COVID-19 measures (for instance, between July and August 2021), which occurred between waves of the pandemic, as well as after the pandemic (February 2023). This timing may have heightened the potential for social gatherings and the associated risk of encountering drug-related situations.

Strength

The current study is a pioneering randomized controlled trial that explores the feasibility and effectiveness of the Mindfulness-Based Relapse Prevention (MBRP) program on individuals with drug addiction in China with a relatively long follow-up.

Limitations

The study is subject to several limitations. A primary limitation is the absence of an active control group. Consequently, there is no equivalent intervention for comparison to accurately gauge the impact of MBRP. The lack of such a group complicates the process of determining whether the positive outcomes observed are attributable to MBRP specifically or to general factors such as participants' belief in the intervention's effectiveness, the attention provided by the researchers, or simply the effect of time. This limitation poses a challenge in firmly establishing the effectiveness of the MBRP program. Thus, addressing this limitation is essential for future research to clarify the specific impact of MBRP.

Secondly, the study may have been subjected to recall bias concerning the self-reported drug use over the past 7 days and the number of drug-using days within the past 30 days, as reported on the ASI scales, despite their validation as measurement tools. While urine toxicology screens were employed to verify self-reports of drug use, the COVID-19 pandemic presented challenges that sometimes precluded the collection of urine samples, such as social distancing requirements and the suspension of certain social services. Furthermore, interpreting positive results from the toxicology screens was complicated by the fact that many participants were on prescribed sedatives or antidepressants, making it difficult to determine if these prescriptions contributed to the positive drug test results.

Thirdly, the ages, income levels and baseline of abstinence status between the two groups were significantly different.

Fourthly, the sample size is relatively small. The relatively small sample size in the study may account for the absence of significant differences in primary and several secondary outcomes when comparing two groups but still allow for finding significant within-group effects in the MBRP group. Further research might be needed to explore these possibilities, potentially with a different study design or larger sample size, to clarify the efficacy of the MBRP.

Conclusion

This is the first study in Hong Kong to investigate the feasibility, acceptability and efficacy of MBRP in the population with drug addiction. Overall, the program was highly regarded by participants, who reported it as valuable and beneficial. MBRP was associated with improvements in relapse prevention, self-efficacy in drug avoidance, the severity of addiction, and the intensity of drug cravings. To further validate these findings, further research involving a larger sample size of Chinese drug abusers and a comparison with an active control group could provide more definitive evidence of MBRP's effects.

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Appendix

Appendix 1. Session Summary of the Mindfulness Meditation Relapse Prevention 8-week Course

Session	Brief Summary
1. “Automatic pilot” and its relation to craving	Introduction to basic concepts and techniques of meditation; how to be “present in the moment”; acceptance and nonjudgmental; awareness of the tendency to make assumptions and judgments of experience; how automatic thoughts can distract from being “present” and lead to craving
2. Barriers to a mindful, skillful response to situational cues	Sitting meditation, brief “urge surfing” meditation, “noticing triggers and craving” especially in face of relapse triggers, craving, and urges
3. Mindfulness in everyday life	Mini-meditation and walking meditation; exercises advancing skills in being “present” and in skillful response to situational cues; ways of integrating meditation into daily life—use of brief meditative techniques to cope with stressors and discomfort (eg, during craving)
4. Staying “present,” especially in high-risk situations	Yoga meditation; discussion of high-risk situations for relapse and how meditation can help cope; exercises using yoga and mini-meditation to cope in high-risk situations; use of brief meditation techniques in daily life, including their integration into one’s usual response to everyday challenges
5. Balancing acceptance and change	Sitting meditation, mini-meditation, and walking meditation; focus on acceptance, especially of difficult experiences (eg, the discomfort of craving, uncomfortable sensations and emotions, and other people’s behavior); ways of coping with problematic relationships and other common causes of relapse
6. Relationship between one’s thought patterns and relapse	Sitting meditation, emphasis on thoughts via “thought-labeling” exercise; discussion of lapse and relapse; learning one’s own thought patterns; recognition that thoughts often are triggered “automatically” and are not necessarily an accurate reflection of oneself or reality; how certain thought patterns may lead to relapse
7. How can I best take care of myself...?	Mini-meditation and sitting meditation; discussion of one’s own warning signs of relapse; use of meditation to recognize and cope with warning signs in high-risk situations to reduce relapse risk; creating subject-specific “action plans,” including identifying “support network”; practicing mini-meditation in a context of these individual plans
8. Balanced living and what has been learned	Body scan, mini-meditation, and sitting meditations; reflection on what has been learned from the course;

ways how subjects can incorporate meditation into daily life; achieving and maintaining “life balance” to better take care of oneself; use of meditation to help maintain life balance and to reduce relapse risk

Adapted with permission from Bowen S, Chawla N, Marlatt G, et al. Mindfulness-based relapse prevention treatment guide. University of Washington, addictive behaviors Research Centre, Seattle, WA, 2007 (unpublished).

Appendix 2: MBRP Sessions 1-8 handouts

靜觀預防吸毒復發小組【MBRP】

第一課 自動導航 與 靜觀覺察

「靜觀」是

有意識地

不加批判地

留心當下此刻

籍此培養對身心的認識

滋潤智慧和慈悲

Jon Kabat-Zinn, 2014

課程概覽

第一課：「自動導航」與靜觀覺察

- 介紹什麼是「自動導航」：即習慣性地或無意識地行動，而不知道自己在做什麼。
- 認識「自動導航」與成癮行為的關係：即自動地跟着心癮和衝動盲目反應而不自知。
- 從身體掃描學習有意識地將注意力帶到身體不同部份及留心當下的感覺。

第二課：與不適感建立新關係

- 學習如何面對誘因和心癮而不盲目反應。
- 覺察伴隨誘因和心癮的身體感覺、念頭和情緒。
- 帶着靜觀去留心這個自動化的過程，學習經驗心癮和衝動而不盲目反應，從而更有能力去作出選擇，去如何回應當下。

第三課：從反應到回應

- 透過呼吸空間將靜觀由家中練習擴展到日常生活。
- 學習與不舒適的身體感覺及情緒同在而不盲目反應，尤其是那些和誘因和心癮有關的不良反應。此外，我們亦會探索這些心癮和衝動背後是什麼推動著。
- 學習靜坐練習。

第四課：靜觀迎向挑戰

- 透過靜觀，學習即使遇上那些和吸毒或衝動行為有關的人或情景，都能夠回到當下，經驗着壓力或吸毒的衝動時，不需盲目地去吸毒或者衝動反應。
- 找出每個人復發的高危情境，並學習如何應對高危情境所帶來的強烈情緒。

- 學習靜觀步行練習。

第五節：接納和善巧回應

- 學習接納不喜歡的想法、情緒和身體感覺。雖然可能會感到不習慣，但這可能是邁向改變的第一步。
- 接納當下所有經驗是重要的基礎，去幫助我們如實看清如何才能真正照顧自己，作最恰當的行動選擇。
- 覺知復發預兆，然後在日常生活和高危情境停一停，作出善巧回應。
- 繼續練習呼吸空間，特別是那些具挑戰性的情景。

第六節：視念頭只是念頭

- 探索念頭，和與念頭的關係。
- 覺知念頭只是念頭，並不一定等同事實。
- 認識念頭和吸毒復發循環的關係，並學懂如何善巧回應一些具挑戰的念頭。
- 學習靜觀念頭。

第七節：善待自己

- 認識個人復發預兆，並學習如何善巧回應，包括在生活層面如何平衡、對自己和他人慈愛、參與滋養活動。從而令生活更加豐盛和健康。
- 學習慈心練習。

第八節：社交支持及擴展所學

- 回顧所學。
- 帶出建立一個社交支援網絡的重要性。
- 探索如何繼續將靜觀融入生活。

第一課主題

- 「自動導航」形容我們盲目反應的習性。
- 當我們遇到心癮、吸毒及其他衝動時，我們常常跌入「自動導航」的狀況，即是不知不覺地被心癮或衝動驅使去行動，完全忘卻了後果。
- 靜觀幫助我們踏出「自動導航」，讓我們有意識地選擇如何回應當下，而不必慣性地盲目反應，重蹈傷害自己的覆轍。

課外修習

1. 身體掃描

可以的話，在第二課前，練習身體掃描。不需期望任何特別的效果，亦不需加以控制及刻意改變，只讓自己體會當中感受，例如分心、沉悶、不耐煩、有睡意等。下星期我們會在課堂上分享修習的經驗。

2. 靜觀日常活動

選擇一項日常的活動(如刷牙、沐浴、進食、洗碗等)。做這項活動時，就像你細嚐食物一樣，只是全神貫注覺察當下，留心物件的各種特質，以及活動時每一刻的身體感覺、念頭或情緒。

3. 填寫修習記錄表

每次修習後，在記錄表上如實寫下修習的經歷，以助下次課堂上的分享。你怎樣記錄，或記錄多少，都不會被批評。

每天修習記錄

姓名：_____

記錄每天在靜觀練習時的經歷、發現或困難

日期	跟隨錄音練習 練習時間	靜觀日常活動	觀察/感想
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	

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靜觀預防吸毒復發小組【MBRP】

第二課 與不適感建立新關係

修習中(和日常生活中)常見的挑戰

在靜觀練習中，常常會遇到不同的挑戰，例如厭惡、渴求、坐立不安、昏沉、或懷疑...。在修習時遇到這些經驗，並不代表你做得不好，或是做錯了，亦不代表你不適合靜觀。它們只是練習的一部份。其實在幾千年前已有人紀錄這些挑戰。

很多人不知道如何回應這些挑戰，因為當它們出現時，會很容易令我們分心，亦令一些人感到洩氣、挫敗。其實當這些挑戰來臨時，我們只需要覺知它們的出現，知道它們只是練習的一部分，很多人都會遇上，這可能已經十分有幫助。記得你並不孤單！

所有練習靜觀的人都會遇到這些挑戰，包括你在內。當我們能夠覺察到它們，這已經可以減少它們對我們的障礙，它們也沒有變得那麼大問題。我們學習帶着一份好奇心，不批判地觀察它們。

厭惡

厭惡是指我們「不想要」「不喜歡」某一些經驗。每一次當我們不喜歡，或想逃離某些經驗，這便是厭惡的反應。這包括恐懼、憤怒、不耐煩、嫌棄、不滿...

貪愛 或 渴求

貪愛或渴求是形容我們渴望擁有某些經驗。這可以是十分隱晦的，例如想要放鬆、想要平安...有時候可以是十分強烈的，例如想吸毒的衝動...

坐立不安 或 躁動

這就好像痕癢時不舒服的感覺，可以是在身體上呈現的，例如在靜觀練習時，有強烈衝動去移動身體；也可以在心理方面呈現成躁動不安，例如感到坐立不安、或內心不舒坦...

昏沉 或 睡意

昏沉可以在身體上呈現，例如感到疲倦、眼瞓；或者精神上感到遲緩、沉悶；或兩者皆有

懷疑

你可能是對自己懷疑，例如：「我不能夠完成這個靜觀練習」；又或者對靜觀練習、甚至整個課程抱有懷疑，例如：「這太沒道理！只是坐著和留心呼吸會有什麼幫助。」

懷疑是不容易應對的，因為有時候可能我們覺得有充分的理由去懷疑練習的用處。這時候，我們可能可以這樣提醒自己，靜觀練習已經有幾千年的歷史，成千上萬的人的生命因為練習靜觀而轉化。雖然練習有時富有挑戰性，但只要我們願意去修習，任何人都可以從中獲益。重要的是當我們遇到挑戰時，繼續保持覺察便可以了。

不只在修習時出現，也會在生活中遇到。當我們從練習中開始學習如何回應這些挑戰，可能也會幫助我們在生活中，覺知這些挑戰的出現，而不用盲目反應。

覺知誘因工作紙

日期	情景/ 觸發點	有什麼身體感覺？	有什麼情緒？	有什麼念頭？	做了什麼？
星期五 3/26	例子：和朋友爭吵	心口繃緊、發冷、手心冒汗、心跳急促	焦慮、渴求	我真的需要一些東西幫我渡過	散步，和朋友吐苦水
星期					
星期					
星期					
星期					
星期					

星期					
----	--	--	--	--	--

這星期請留意在什麼時候觸發你盲目反應。以下的一些問題可以幫助我們更仔細去覺察盲目反應的狀況。

第二課主題

- 當遇到想吸毒的衝動或心癮時，我們常常被它們牽引或奮力抵抗。這一節我們學習以一個不同的方式回應，即是覺察著身心的當下的經驗而不盲目反應。
- 首先，找出引發吸毒衝動或心癮的誘因，並覺察伴隨而來的身體感覺、念頭、情緒。透過靜觀，容讓我們更留心整個過程，由盲目反應，轉變成用心回應，更自由地作一個對自己長遠來說更有益的選擇。

課外修習

1. 身體掃描

可以的話，在第三課前，練習身體掃描。下星期我們會在課堂上分享修習的經驗。

2. 每天填寫覺知誘因工作紙

每天填寫覺知誘因工作紙，記錄想吸毒的衝動或心癮來臨時所經驗的念頭、情緒(例如憤怒、傷心、焦慮、開心...)、和身體感覺(例如心口壓著、繃緊...)。如果那一天沒有想吸毒衝動或心癮，只需記錄沒有。你亦可以記錄其他你想改變的行為和其誘因，例如憤怒、羞愧...

3. 靜觀日常活動

繼續靜觀日常活動。你可以選擇繼續同一項，或者選擇不同的活動。刻意留心做這項活動時每一刻的感覺。全神貫注覺察當下所留心到的身體感覺、影像、聲音、當時升起的念頭或情緒。

4. 填寫修習記錄表

每次修習後，在記錄表上如實寫下修習的經歷，以助下次課堂上的分享。你怎樣記錄，或記錄多少，都不會被批評。

每天修習記錄

姓名：_____

記錄每天在靜觀練習時的經歷、發現或困難

日期	靜觀練習 練習時間	靜觀日常活動	經歷：包括任何發現、挑戰(厭惡、貪愛、昏沉、 坐立不安、懷疑)...
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	
星期 日期：	_____分鐘	哪一項日常活動？	

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靜觀預防吸毒復發小組【MBRP】

第三課 從盲目反應到回應

這星期我們練習安住覺察於呼吸上。我們的心不停忙著完成過去未完成的事務和達到將來的目標，常常處於自動導航的狀態，因此時常渙散迷亂。我們需要找到一個可靠的方法，有意地回到此時此地，尤其是當我們感到大壓力或在高危情況。

呼吸無時無刻都在，只要我們留心呼吸，就可以再次靜心安住，安頓心神。由遇到心癮或衝動時的盲目反應，到回到當下，靜心回應。

專注於呼吸：

- 帶你回到當下——此時此地
- 無論你在那裡，呼吸與你時刻相伴，是你的錨，是你的安全港
- 能助你回到更廣闊的空間，以更寬宏的視野細觀萬物，轉化經歷

三步呼吸空間: 基礎指示

你可以隨時隨地做這個簡短而簡單的練習，特別是當你感到很大壓力、傷心、或者面對心癮的時候。這個練習可以幫助你跳出慣常的自動導航模式，停止對誘因作不自覺的反應，從而更有意識及覺察地去作適當的回應。

呼吸空間包括以下三步：

第一步：停下來、覺察當下

無論你在坐或企的姿勢，讓自己停下來，回到當下。這已是踏出自動導航的第一步。帶著開放和好奇的心，留心外在周圍和此刻身心的狀況：

「此刻覺察到什麼身體感覺？」

「此刻的情緒是什麼？」

「腦海有什麼念頭飄過？」盡可能覺察到念頭只是心的活動。

第二步：專注呼吸

將覺察帶到呼吸，全神貫注呼吸時身體感覺的變化。留意全程的吸入、全程的呼出，讓呼吸如錨般助你安住當下。

第三步：擴展覺察及善巧回應

現在把覺察從呼吸擴展到整個身體，包括身體姿勢、面部表情…就好像整個身體同時呼吸一樣，同時亦覺察你現在身處的環境。即使有衝動或心癮出現，請記得即使你什麼也不作，它們也會過去的。容讓這些經驗自然而來、自然而去。盡可能保持這份擴展了的覺察，善巧和有意識地選擇如何回應眼前的經歷。記得你是有選擇的，你不一定要重複舊有的習慣，了解自己真正的需要，真正照顧自己。

參考 Mindfulness-Based Cognitive Therapy for Depression – Second Edition

Zindel Segal, Mark Williams, & John Teasdale (2018)

第三課主題

- 靜觀修習能夠提升覺察力，從而令我們在每天的生活裡，作出更善巧的選擇。
- 呼吸經常發生於此時此刻。當我們停一停，並留心呼吸，便已經可以與當下連繫，返回身體。
- 當我們愈能夠與當下連繫，覺察當下；我們便愈能減少盲目反應，從一個更清晰及有力的位置去做決定。
- 「靜觀呼吸」可以幫助我們將靜觀，從正規練習伸延到日常生活中，特別是遇到挑戰或困難時。

課外修習

- 隨著錄音，練習「靜觀呼吸」，並將修習經驗寫在記錄表上。
- 開始將「呼吸空間」融入生活之中。無論是在日常生活中，或遇到挑戰時，都是非常好的練習機會。請把修習經驗寫在記錄表上。

每天修習記錄

姓名：_____

記錄每天在靜觀練習時的經歷、發現或困難

日期	正規練習 練習時間	呼吸空間	經歷、發現或困難
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	

星期		3 3 3	
日期：	_____分鐘	在什麼情境下？	

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靜觀預防吸毒復發小組【MBRP】

第四課 靜觀於高危情景中

第四課主題

- 靜觀修習能夠幫助我們培養一份更廣闊的空間和新的角度去面對富挑戰性的情境。
- 本課的重點在於如何從以往引發吸毒、或其他盲目反應的情景中安住當下。
- 我們會學習以不同的方式和壓力或吸毒的衝動相處，並練習用心回應，而非“自動導航”或出於習慣而做出反應。

課外修習

1. 隨著錄音，每天進行「靜坐練習」或「身體掃描」，並將修習經驗寫在記錄表上。
2. 定時練習「呼吸空間」。在每一次遇到具挑戰性的情緒、身體感覺、衝動或覺察到自己在自動導航時，都是絕佳的練習機會。請把修習經驗寫在記錄表上。
3. 這星期至少練習「靜觀步行」一次。「靜觀步行」能夠幫助我們從動態中覺察身體，讓我們更能在日常生活和身體連繫。你可以在私人空間中正式地進行練習，沿著一條短路徑來回走動。你亦可以在日常生活中練習，例如行走至巴士站或遛狗的時候。如果在日常生活中練習，你可以體驗將注意力由步行的感覺，轉移至視覺、聽覺或呼吸之上。在一段時間內保持對上述其中一項經驗的覺察，然後轉移至另一項。

每天修習記錄

姓名：_____

記錄每天在靜觀練習時的經歷、發現或困難

日期	正規練習 練習時間	呼吸空間	靜觀步行	經歷、發現或困難
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	_____次	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	_____次	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	_____次	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	_____次	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	_____次	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	_____次	

星期		3 3 3		
日期：	_____分鐘	在什麼情境下？	_____次	

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靜觀預防吸毒復發小組【MBRP】

第五課 接納和善巧回應

靜觀伸展 讓我們：

- 建基於身體掃描的練習上，學習如何將覺察力帶到並安住於身體經歷和感覺上
- 看到心的習慣模式（尤其是執著強求的模式）
- 跟身體的限制和強烈感覺相處及學習接納我們的局限
- 學習新的方法照顧自己

這些動作直接地讓我們連繫覺察身體。很多時，情緒不自覺地在身體裡面表達出來。因此，提高對身體的覺察，我們就多了一個立足點去觀察我們的思緒。

*參考 Mindfulness-Based Cognitive Therapy for Depression – Second Edition
Zindel Segal, Mark Williams, & John Teasdale (2018)*

你是否不願意做運動，因為覺得太辛苦，或覺得要有器材或有人作伴，或覺得要到運動場所去做太麻煩？若然，這些伸展運動可能十分適合你。

這些柔軟的伸展運動十分容易，持之以恆，就有顯著裨益，不但促進肌肉骨骼的彈性和功能，加強平衡能力，而且幫助你精神充沛，輕鬆自在；很多人更會感到心境平和，氣息暢通，體格結實，健康有力。

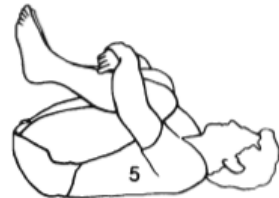
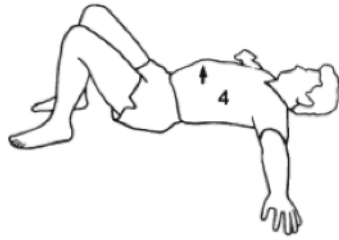
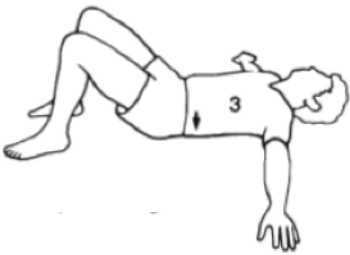
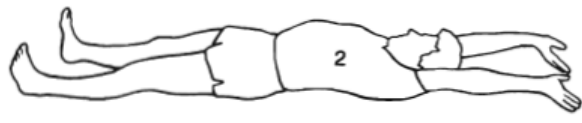
做伸展運動時，需要保持靜觀的心態，每一刻留心自己的動作，不急於達到任何境況，量力而為，不批評或強迫自己。用心的慢慢地移動，探索自己的局限，不勉強去超越它，只是徘徊於這個局限上，繼續呼吸... 你需要尊重自己的身體和它給你的訊息，它會告訴你：何時因應自己的需要而避免做某些動作，何時休止。

這些伸展運動無需任何器材，幾乎在任何地方都可以做。你從靜觀課程的光碟學會了這些動作後，可以進而設計你自己的動作或者從其他課程和書本吸取靈感。伴著慢音樂做這些動作，可以很好玩哩！用心去試驗吧。

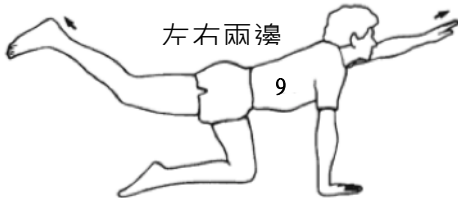
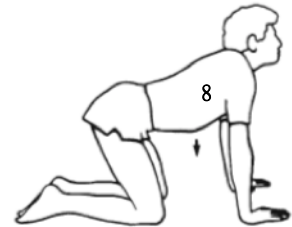
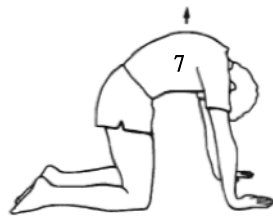
The Stress Reduction and Relaxation Program Workbook,

University of Massachusetts, U.S.A.

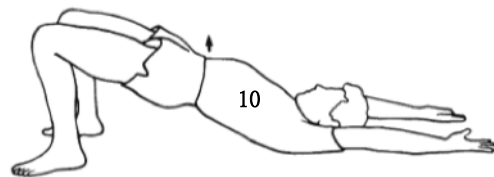
靜觀伸展



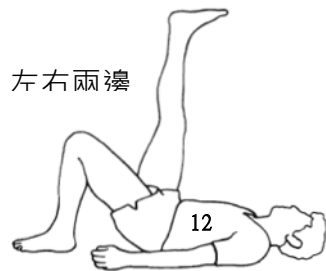
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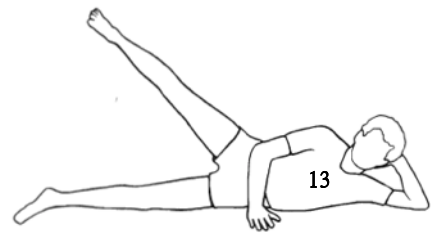
左右兩邊



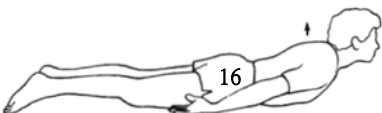
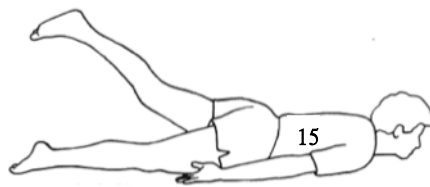
左右兩邊



左右兩邊



左右兩邊



Kabat-Zinn:
Full Catastrophe Living

高危情景中修習「呼吸空間」工作紙

說明：在第一欄中，列出本週令你感到困難、觸發你的情緒、或高危的情景（人，地點，關係，情緒，事件）。在第二欄中，寫下你注意到的即時反應，特別是身體感覺，念頭，情緒，這些都是邀請你進行「呼吸空間」。在第三欄中，請記下是否做到「呼吸空間」。並在最後一欄中，寫下您對此情況的回應。

高危情景或觸發點 (人，地點，情緒，事件)	即時反應 (身體感覺，念頭，情緒) → 這可能是進行「呼吸空間」的提示	呼吸空間 (有 / 沒有)	如何回應?
		有 / 沒有	
		有 / 沒有	
		有 / 沒有	
		有 / 沒有	
		有 / 沒有	
		有 / 沒有	

請注意，你在第二欄中列出的即時反應可以成為提示讓你停下來並做「呼吸空間」。看看你是否能認知到這些即時反應，並開始以它們作為提醒，讓自己走出平時的自動導航式和盲目反應，並觀察你當下的體驗。

第五課主題

- 有時候，學會如何去接受某些情況下發生的事情是十分艱難，但重要的。這是我們在日常生活中採取健康或積極行動的第一步。
- 例如，我們可能無法控制發生在我們身上的事情，情緒的升起，我們目前的工作或家庭情況，或人們對我們的行為和反應。當我們抗拒這些事情時，無奈我們往往感到沮喪，憤怒或挫敗，這可能會觸發吸毒的衝動或其他盲目反應的行為。
- 當我們接受現實的情況，不代表我們是被動的；我們接受已發生的事情是指我們不需掙扎或抵抗。這通常是邁向改變必要的第一步。接受自我也是同樣道理；在真正的改變發生之前，往往需要我們完全接受自己。

課外修習

1. 隨著錄音，進行「靜坐練習」、「身體掃描」或「靜觀伸展」，並將修習經驗寫在記錄表上。
2. 定時練習「呼吸空間」。在每一次遇到具挑戰性的情緒、身體感覺、衝動或覺察到自己在自動導航時，都是絕佳的練習機會。請把修習經驗寫在記錄表上。
3. 填寫於高危情景中修習「呼吸空間」工作紙

每天修習記錄

姓名：_____

記錄每天在靜觀練習時的經歷、發現或困難

日期	正規練習 練習時間	呼吸空間	經歷、發現或困難
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	

星期		3 3 3	
日期：	_____分鐘	在什麼情境下？	

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靜觀預防吸毒復發小組【MBRP】

第六課 覺知念頭只是念頭

第六課主題

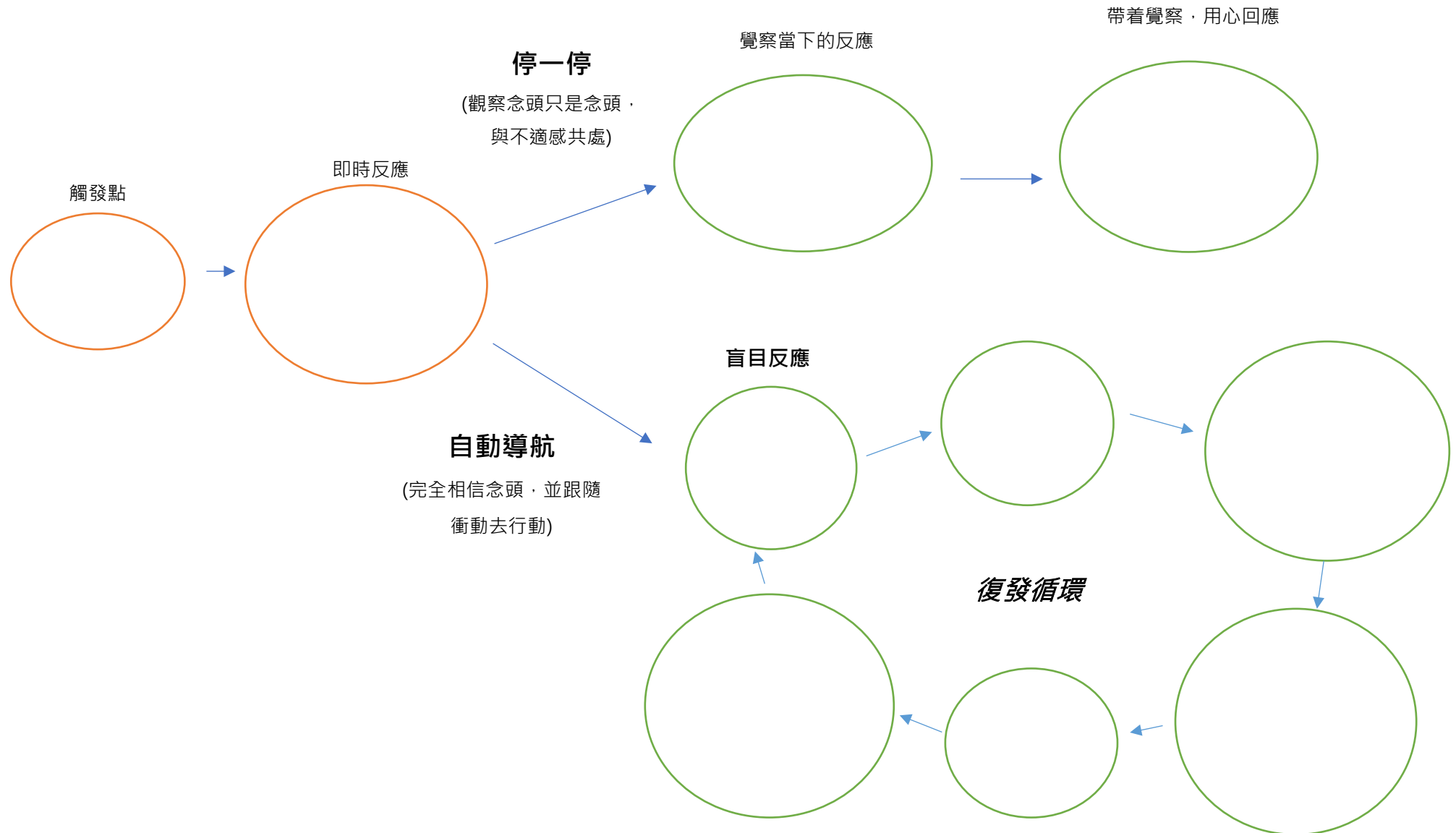
- 在不同靜觀練習中，我們常常留意到心不自覺地遊走。我們已經練習了溫柔地將注意力集中在呼吸或身體感覺上。
- 現在我們會有意識地將注意力轉向念頭，並開始將念頭體驗為只是腦海中的文字或圖像。而我們可以選擇相信或不相信。
- 在本課中，我們將討論念頭在復發過程中的角色；更具體地說，當我們相信這些念頭時，會發生什麼事情。

課外修習

1. 從我們迄今為止學到的一系列靜觀練習中選擇你自己的練習。並將修習經驗寫在記錄表上。
2. 定時練習「呼吸空間」。在每一次遇到具挑戰性的情緒、身體感覺、衝動或覺察到自己在自動導航時，都是絕佳的練習機會。請把修習經驗寫在記錄表上。
3. 完成復發循環工作紙

復發循環工作紙

請細心回想一個過去曾經導致吸毒復發的情景，或者一個你認為可能會高危的情況。將觸發點及隨後的即時反應寫下來，以及下面圓圈中每一個可能出現的情況。與自動導航相比，如果帶着覺察的話，你的回應又會怎樣不同呢？



每天修習記錄

姓名：_____

記錄每天在靜觀練習時的經歷、發現或困難

日期	正規練習 練習時間	呼吸空間	經歷、發現或困難
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	

星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
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靜觀預防吸毒復發小組【MBRP】

第七課 善待自己

檢視日常生活工作紙

1. 請列出什麼的活動、人或情景會讓你聯繫到**困擾**、**具挑戰性的情緒**或增加**自我懷疑**。請描述當你投入這些活動時通常會出現的情緒。

活動、人、地方或情景	通常會出現的情緒
i.	
ii.	
iii.	
iv.	
v.	

2. 除了吸毒，請列出什麼的活動、人或情景會讓你聯繫到**快樂**、或增加**自信心**。請描述當你投入這些活動時通常會出現的情緒。

活動、人、地方或情景	通常會出現的情緒
i.	
ii.	
iii.	
iv.	
v.	

提示卡

<p>保持復元的原因</p> <ul style="list-style-type: none">●●●●	<p>呼吸空間</p> <p>第一步：停下來、覺察當下</p> <p>第二步：專注呼吸</p> <p>第三步：擴展覺察及善巧回應</p>
<p>替代的活動/計劃</p> <ul style="list-style-type: none">●●●●	<p>有用的資源</p> <ul style="list-style-type: none">●●●●

第七課主題

- 過去幾星期，我們仔細觀察什麼情景、念頭、或情緒讓我們有機會復發吸毒。
- 在復元旅程中，照顧自己及投入滋養自己的活動同樣重要。
- 在本課中，我們將檢視日常生活，並找出什麼的活動能夠幫助我們建立一個更健康及更有生命力的生活。同樣我們亦留心什麼活動會讓我們處於高危情景。
- 生活平衡和對自己有慈悲心是健康幸福生活的重要一環。

課外修習

1. 從我們迄今為止學到的一系列靜觀練習中選擇你自己的練習並建立一個習慣，例如一星期做三次「身體掃描」和三次「靜觀呼吸」、或一星期做六次「靜觀呼吸」。讓自己投入當中。
2. 一天至少三次練習「呼吸空間」- 定時或每一次遇到具挑戰性的念頭、情緒、或心癮出現時。
3. 參考檢視日常生活工作紙，這星期至少做三項滋養自己的活動。
4. 若在堂上未完成「提示咭」，請在家中完成。

下一課，請帶：

- 一件可以代表你修習靜觀的歷程的物件，可以是實物，也可以是抽象的，如歌、相片等。
- 一個信封，上面寫有你的地址和貼上足夠本地平郵的郵票。

每天修習記錄

姓名：_____

記錄每天在靜觀練習時的經歷、發現或困難

日期	正規練習 練習時間	呼吸空間	經歷、發現或困難
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
星期 日期：	_____分鐘	3 3 3 在什麼情境下？	
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靜觀預防吸毒復發小組【MBRP】

第八課 社交支持及繼續修習

第八課主題

- 使用在過去八週中學到的靜觀技巧，可以幫助我們以不同的方式面對我們的經驗；我們可以接受這種體驗而不是與之鬥爭，並從那裡做出更明智、更開放的選擇。這趟靜觀及復元之旅，有時就像逆水行舟，並不輕鬆，但我們是可以做到的。到目前為止，我們已經了解那些使我們處於危險之中的因素，並學習了一些駕馭高危情景的技巧，以及維持生活平衡的重要。
- 這小組也希望能提供一種社交支持。擁有支援網絡對於復元及繼續修習靜觀至關重要。同路人可以幫助我們識別復發的預兆，並在我們感受到有復發危機時時提供支持及鼓勵。共同修習靜觀可以幫助我們持續修習靜觀，並選擇和生活連繫。
- 許多事情是我們無法控制的，我們往往未能如願以償。但是，我們可以選擇如何回應，及如何經驗我們的生活。持之以恆地練習靜觀可以幫助我們減少進入自動導航和盲目反應，提高我們對自身選擇的覺知，從而使自己獲得更多自由。照顧好自己以及參與滋養活動，是維持生活平衡和預防復發的重要部分。維持練習並不容易。眼前會出現困難和阻礙。請對自己溫柔一點。請記得任何練習都是好的練習；你可以隨時重新開始。

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生活每一天 - 十三種保持心境平和的方法

以下十三種方法只是一些路標，希望你沿途尋幽探勝，踏出適合自己的路，達到身心健康平和的境界。

1. 早上醒來，起床前，留心五下呼吸。起床時，留心身體移動的感覺。
2. 洗面刷牙時，用一刻感受一下牙刷觸及牙齒，毛巾觸及面龐的感覺。
3. 等候升降機或公共汽車時，靜靜留心站立姿勢，留心腳踏實地的感覺，留心呼吸。有感覺不耐煩嗎？
4. 在街上，感受一下今天的天氣，是滿地陽光？是陰霾密佈？是涼風送爽？是細雨微寒？感受一下內心的天氣如何？
5. 走路時，腳踏實地，步步在心。留心自己是否不由自主的在疾步急行，這時的感覺是怎樣的？
6. 坐車時，當車停站時或在交通燈前停下，讓思緒停一下，留心呼吸。
7. 到達目的地，不論是菜市場，寫字樓，茶樓或家門... 用一刻讓自己心裡準備進入新的環境。
8. 做事時，不論是掃地，洗碗，寫字或看報... 觀察身體的感覺。如果留意到身體有任何地方緊張，吸氣時，把空氣送到緊張的部分，呼氣時，放開，可以溫柔地跟自己默默說：「我和你在一起。」假如還有緊張的感覺在頸項、肩膀、腹部、下顎或腰背，可靜心慢慢地伸展轉動一下。
9. 拿起電話前、開門前或會客前，給自己片刻的安靜，留心一下呼吸。如果可以，在心中先送給對方一點祝福。
10. 談話時，細心覺察。聆聽時，你可否不急於去贊同或反對，喜歡或不悅，或計畫待會說什麼？說話時，你可否恰如其份，不卑不亢？你可否留意身心的感覺？
11. 進食前，細心欣賞食物的色、香、味，默想：「這些食物含有陽光、雨水、土壤和很多人的勞力，我心懷感激，願這些食物滋養我的身體，幫助我過健康快樂的生活。」
12. 不一定時常要收音機或電視機的聲音作伴。把它們關上，嘗試靜靜跟自己相處。在你的家或工作的地方，或在你的心中，關一個地方、一個角落，你可以去竭一竭、靜一靜。
13. 晚上臨睡前，懷欣賞感恩的心，細味今天快樂的時刻。寫下明天要做的事，放下。靜靜留心呼吸...

參考 *Mindfulness-Based Cognitive Therapy for Depression – Second Edition*
Zindel Segal, Mark Williams, & John Teasdale (2018)

自傳五章

第一章

我去在路上。

道上有個深洞。

我跌進去。我不知身在何處。我覺得無助。

這不是我的錯。

我用了好半天才找到出路。

第二章

我走在同一路上。

道上有個深洞。

我裝作看不見。

我又掉進去。

我難以相信我又掉進同一地方，可是這不是我的錯。

今次仍用了好半天才爬出來。

第三章

我走在同一路上。

道上有個深洞。

我見到它。

我依然跌進去。這是個習慣。我眼睛是睜開的。我知自己在哪裡。

這是我負責任的。

我立刻出來。

第四章

我走在同一路上。

道上有個深洞。

我繞著它走過。

第五章

我走另一條路。

*Portia Nelson:
Autobiography in
Five Short Chapters*

今天是以後生命的開始

寧可短、不可斷

「新的生活不是垂手可得的，須要有堅定的意願，鍥而不捨，不斷修練。」

專為靜觀課程畢業生而設的共修聚會

香港靜觀課程畢業生通訊

by Mindfulness HK

透過定期分享靜觀共修及課程消息，持續支持大家的修習。

<https://tinyletter.com/MindfulnessHK>

參考資料

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