

CLINICAL TRAINING RESOURCE

# Smoking Cessation Motivational Interviewing Packet

*A Comprehensive Clinical Training Resource*

**Published by Oklahoma Child Wellbeing**

---

**Prepared by: Oklahoma Child Wellbeing**

Resource Type: Educational and practicum training resource

Organization: Oklahoma Child Wellbeing

Website: [www.okchildwellbeing.org](http://www.okchildwellbeing.org)

Publication Label: Oklahoma Child Wellbeing

*All client names and case details in this packet are fictional and used solely for educational and training purposes. This resource does not replace individualized medical, mental-health, clinical-supervision, or emergency guidance.*

---

## CONTENTS

### Table of Contents

**Section 1** — Introduction to Motivational Interviewing for Smoking Cessation

---

**Section 2** — Full MI Counseling Session Script (Annotated Transcript)

---

**Section 3** — One-Page MI Cheat Sheet for Smoking Cessation

---

**Section 4** — Case Note Template (MI Session)

---

**Section 5** — Role-Play Practice Script & Debrief Guide

---

**Section 6** — SBIRT + MI Flowchart (Tobacco Screening Protocol)

---

**Section 7** — Handling Objections and Common Client Statements

---

**Closing Page** — Professional Note & Acknowledgments

---

## SECTION 1

# Introduction to Motivational Interviewing for Smoking Cessation

## What Is Motivational Interviewing (MI)?

---

Motivational Interviewing is a **collaborative, person-centered guiding style of communication** designed to elicit and strengthen a person's own motivation and commitment to change. Originally developed by William R. Miller and Stephen Rollnick in the 1980s as a treatment for alcohol use disorder, MI has since been extensively adapted and applied across a broad spectrum of health behavior change contexts — including tobacco cessation, medication adherence, physical activity, and chronic disease management.

Rather than telling clients what they should do, the MI practitioner engages in a *partnership* that honors the client's autonomy, draws out their inherent values and goals, and explores the ambivalence that so often underlies addictive behaviors. MI is not a technique to manipulate clients into change; it is a clinical style grounded in genuine respect, curiosity, and empathy.

In the context of smoking cessation, MI is particularly well-suited because the majority of people who smoke are *ambivalent* — they simultaneously recognize reasons to quit and reasons to continue. This ambivalence is normal and expected. The MI counselor's role is not to resolve that ambivalence *for* the client, but to create conditions in which the client can resolve it *themselves*.

## The Spirit of MI: PACE

The effectiveness of MI rests not merely on technique, but on the underlying spirit from which the counselor operates. This spirit is captured in four interconnected elements, commonly referenced as **PACE**:

Element	Description
<b>Partnership</b>	MI is conducted <i>for</i> and <i>with</i> the client, not <i>on</i> the client. The counselor and client are collaborators working together toward the client's goals, not an expert prescribing a course of action to a passive recipient.
<b>Acceptance</b>	The counselor accepts the client as a whole person with absolute worth, regardless of their behavior or readiness to change. Acceptance encompasses acknowledging the client's autonomy, affirming their strengths, seeking accurate empathy, and supporting their right to self-determination.
<b>Compassion</b>	The counselor actively promotes the client's wellbeing and prioritizes their needs. Compassion means the counselor's motivation is genuinely the client's welfare — not adherence to a protocol, not statistics, and not the counselor's own agenda for the client.
<b>Evocation</b>	Clients already possess within them the values, strengths, and motivations needed to change. The counselor's task is to <i>draw these out</i> — to evoke rather than install motivation. This stands in direct contrast to the "educational" model of simply providing information and advice.

## Core MI Skills: OARS

The foundational behavioral skills of MI are encapsulated in the acronym **OARS**. These skills are not simply techniques; they are the means through which the spirit of MI is expressed moment to moment in session.

- **Open-Ended Questions:** Questions that invite elaboration and exploration rather than simple yes/no responses. They signal curiosity and allow the client to direct the narrative. *Example: "What concerns you most about your smoking right now?"*

- **Affirmations:** Genuine statements that recognize and acknowledge the client's strengths, efforts, values, and past successes. Affirmations build self-efficacy and reinforce the therapeutic alliance. *Example: "It says a great deal about your commitment to your health that you're willing to talk about this today."*
- **Reflective Listening:** The cornerstone skill of MI. The counselor makes a statement (not a question) that reflects back what the client has said — either the content, the emotion, or a deeper meaning. Reflections may be simple (repeating or rephrasing) or complex (inferring meaning, highlighting discrepancy, double-sided). *Example: "So part of you is worried about your health, and at the same time, smoking has been a real source of comfort for you."*
- **Summaries:** Periodic consolidations of what the client has shared during the session. Summaries demonstrate attentive listening, help the client hear their own words organized and reflected back, and can be used strategically to amplify change talk or transition between MI processes.

## The Four Processes of MI

---

Miller and Rollnick (3rd ed., 2013) describe MI as organized around four sequential — though fluid and overlapping — processes:

1. **Engaging:** Establishing a working relationship characterized by trust, safety, and mutual respect. Without strong engagement, subsequent processes will be ineffective. The counselor listens, reflects, and demonstrates that the client is truly heard.
2. **Focusing:** Collaboratively establishing a direction or agenda for the conversation. In tobacco cessation contexts, this may mean explicitly discussing that the visit will address smoking, while also following the client's lead on what aspect of their tobacco use they most want to explore.
3. **Evoking:** The process most unique to MI. The counselor strategically elicits the client's own reasons, desires, and commitments to change — the client's *change talk* — while minimizing sustained discussion of reasons not to change (sustain talk). Techniques include ruler questions, exploring the pros and cons, asking for elaboration on change talk, and asking key questions.
4. **Planning:** When the client has built sufficient momentum toward change, the counselor collaboratively helps them develop a concrete, individualized plan. Planning respects client autonomy — it is developed *with* the client, not handed to them.

## Why MI Is Effective for Smoking Cessation

---

Tobacco use is one of the leading preventable causes of death worldwide. Most people who smoke report wanting to quit, yet successful unaided quit attempts are rare. The gap between wanting to quit and actually quitting is bridged — in part — by ambivalence and low self-efficacy. This is precisely where MI excels.

Meta-analytic evidence supports the efficacy of MI for tobacco cessation. A comprehensive review and meta-analysis published in *Tobacco Control* (Heckman et al., 2010), analyzing 31 randomized trials with 9,485 participants, found an overall odds ratio of **1.45 (95% CI: 1.14–1.83)** favoring MI over control conditions for smoking abstinence. MI has been shown to be effective across diverse populations including adolescents, adults with co-occurring health conditions, pregnant women, and individuals in justice-involved settings.

MI is particularly valuable because:

- It **meets clients where they are** — it does not require readiness to quit as a prerequisite.
- It **avoids evoking reactance** — by affirming autonomy, it sidesteps the "righting reflex" that so often triggers client defensiveness.
- It is **flexible in intensity** — effective in brief (5–15 min) encounters as well as extended counseling sessions.
- It **integrates naturally with other interventions** — including pharmacotherapy referral, SBIRT protocols, and cognitive-behavioral strategies.

## Key Concepts in MI for Tobacco Cessation

---

### Change Talk vs. Sustain Talk

**Change talk** is any client speech that favors movement toward behavior change. It is categorized using the **DARN-CAT** framework: *Desire* (I want to quit), *Ability* (I think I could do it), *Reasons* (My kids need me to be healthy), *Need* (I have to do something about this), *Commitment* (I will quit by January), *Activation* (I'm ready to start looking into patches), and *Taking Steps* (I actually threw out a pack last week). The counselor's task is to elicit, reinforce, and reflect change talk.

**Sustain talk** is client speech that favors the status quo or continued smoking. *Example: "But smoking is the only way I can deal with stress."* The counselor acknowledges sustain talk without amplifying it — reflecting it empathically and pivoting back toward exploration of the client's own ambivalence.

### Rolling with Resistance / Responding to Discord

In the third edition of *Motivational Interviewing*, Miller and Rollnick reframed "resistance" as **discord** — a signal that the counselor-client relationship needs attention. When a client pushes back, argues, or disengages, the MI-consistent response is to soften one's approach: reflect the client's perspective without arguing, affirm their autonomy, and avoid the **righting reflex** (the natural impulse to correct, inform, or persuade).

### Developing Discrepancy

MI counselors help clients become aware of the gap between their *current behavior* (smoking) and their *core values or goals* (being healthy for their children, performing well at work, saving money). This discrepancy, when gently highlighted, can be a powerful motivator. The key is that the discrepancy must be drawn out from the client's own articulated values — not imposed by the counselor.

### Supporting Self-Efficacy

Self-efficacy — a client's belief in their own ability to quit — is a strong predictor of quit success. MI counselors actively reinforce self-efficacy through affirmations, highlighting past successes (even partial attempts), and eliciting "ability" change talk.

## SBIRT Integration

---

**SBIRT** (Screening, Brief Intervention, Referral to Treatment) is a public health framework for identifying individuals with substance use concerns, providing brief evidence-based intervention, and connecting those with more complex needs to appropriate treatment. MI is the clinical engine of the Brief Intervention component. When embedded within SBIRT, MI-based tobacco screening and intervention can be effectively delivered in primary care, behavioral health, school-based, and community settings. See Section 6 for the full SBIRT + MI Flowchart.

### SECTION 2

# Full MI Counseling Session Script

**Client Profile:** Alex, 34-year-old male. Smokes approximately one pack per day (20 cigarettes). Has smoked since age 18. Reports stress and social situations as primary triggers. Has attempted to quit once before, approximately 3 years ago, lasted 6 weeks. Referred by primary care physician following a routine check-up. Presents as ambivalent — somewhat interested in quitting but uncertain about his ability and readiness.

**Counselor:** Tracie (Clinician-in-Training)

**Session Format:** Individual, approximately 45–60 minutes.

*Annotations appear throughout the script in italics and brackets to identify MI-consistent techniques and key moments.*

*This is for training purposes only.*

## Part 1: Opening and Rapport Building (Engaging Process)

**C:** Hi Alex, it's really good to meet you. I'm glad you came in today. I want you to know that this is a space where we can talk about whatever feels most important to you — there's no agenda I'm pushing, and nothing you say here will be judged. How are you doing today?

*[Engaging — establishing safety and warmth; signaling non-judgment and client-centeredness]*

**Alex:** I'm okay, I guess. A little nervous, honestly. My doctor sent me here. I wasn't sure what to expect.

**C:** That makes a lot of sense — walking into something new can feel uncertain. I'm glad you came despite that. Your doctor mentioned you've been thinking about your smoking, but I'd love to hear from you directly — what brought you in today, in your own words?

*[Open-ended question — inviting client's own narrative; Affirmation — acknowledging the courage in showing up]*

**Alex:** Well, my doctor said my blood pressure is up and my lungs aren't sounding great. He kind of pushed me to come. I smoke — about a pack a day — and I know it's probably connected. But honestly I'm not sure I'm ready to quit. I've tried before.

**C:** So your doctor has some concerns, and part of you hears that and wonders if your smoking might be playing a role. And at the same time, you've been down the road of trying to quit before, and that history is making you cautious about getting your hopes up.

*[Reflection — double-sided; reflects both the health concern and the hesitation stemming from past attempt]*

**Alex:** Yeah, exactly. I did try to quit about three years ago. Made it almost six weeks. But then things got really stressful at work and I just... fell back into it.

**C:** Six weeks is genuinely significant. That's not nothing — that's six weeks of doing something incredibly hard. It tells me you have the ability to go without smoking when you put your mind to it. What was that time like for you?

*[Affirmation — genuine, specific; Open-ended question — exploring past experience to elicit ability change talk]*

**Alex:** Honestly? Parts of it felt really good. I could breathe better, I had more energy in the mornings. But the cravings were brutal, especially around stress.

**C:** So you noticed some real benefits — your breathing, your energy. And the hardest part was managing those cravings when the pressure at work picked up.

*[Reflection — simple; acknowledging both change talk (benefits noticed) and barrier (stress trigger)]*

## Part 2: Agenda Setting and Exploring Tobacco Use

---

**C:** I appreciate you sharing all of that. Before we go further, I want to check in about what you'd most like to get out of today's conversation. We can talk about your smoking history, explore how you're feeling about it, or just see where things go — it's really up to you. What sounds most useful?

*[Agenda setting — reinforcing client autonomy; collaborative focus-setting]*

**Alex:** I guess I'm curious what options are out there. And maybe just... figuring out where I actually stand on this. Because I go back and forth a lot.

**C:** Going back and forth — that's actually a really honest and normal place to be with something like this. Let's explore that together. Can you tell me a bit more about your smoking? Like when it started, how it fits into a typical day for you?

*[Normalization of ambivalence; Open-ended question — exploring tobacco use history and patterns]*

**Alex:** I started at 18 — college. It was social at first. Now it's just... automatic. Morning coffee, that's a big one. After meals. My whole break at work. And when I'm stressed or anxious, I'll chain-smoke without even thinking about it.

**C:** So it's woven all through your day — coffee, meals, work breaks, stress. It sounds like cigarettes have taken on a lot of roles for you: social, habitual, and as a way to manage stress and anxiety.

*[Reflection — complex; summarizing smoking's functional roles; validates client's experience]*

**Alex:** Yeah. When you put it that way... it's a lot.

### Part 3: Decisional Balance — Exploring Pros and Cons

---

**C:** What are some of the things you like about smoking — the reasons it's been a part of your life this long?

*[Open-ended question — exploring the "pros" of smoking; avoids prescriptive tone; shows genuine interest in the client's perspective]*

**Alex:** Stress relief — honestly, it's the big one. Gives me a break from everything. And socially, a lot of my friends smoke. It's almost like... a bonding thing. And it just feels good in the moment, I'm not going to pretend otherwise.

**C:** So it genuinely offers you something — relief, connection, pleasure in the moment. Those are real. And what about the other side — the not-so-great parts of smoking, if there are any?

*[Affirmation of client's honesty; pivot to exploring concerns — eliciting change talk without forcing it]*

**Alex:** The cost, for one — I spend a lot of money. My lungs, obviously, like my doctor said. I cough a lot in the mornings. And honestly... my girlfriend hates it. She's mentioned kids someday, and I think about what kind of example I'm setting, you know?

*[Change talk: Reasons — health, finances, relationships; Change talk: Need — future role as a parent]*

**C:** I hear something really meaningful there — thinking about the kind of father you want to be someday. That landed differently than the other things you mentioned. Can you tell me more about that?

*[Reflection — amplifying change talk; Open-ended question — deepening exploration of a personally meaningful value]*

**Alex:** Yeah... I just don't want my kids to grow up watching me smoke. My dad smoked. He died of a heart attack at 57. I think about that sometimes.

*[Change talk: Reasons — strong, emotionally loaded; Developing discrepancy emerging naturally from client's values]*

**C:** That's a powerful thing to carry. Watching your father, knowing what smoking did to him, and now thinking about what you want your own life to look like. There's a real tension there between what smoking gives you day to day and what you want for your future.

*[Reflection — developing discrepancy; empathic; not confrontational]*

## Part 4: Ruler Questions — Importance and Confidence

---

**C:** I want to try something if that's okay. On a scale from 0 to 10, where 0 is "not at all important" and 10 is "the most important thing in my life right now," how important would you say it is for you to quit smoking?

*[Ruler question — Importance; standard MI tool to assess motivation and elicit change talk]*

**Alex:** Honestly... maybe a 6? Like, I know it matters. But it's not like front and center every day.

**C:** A 6. What makes it a 6 and not something lower, like a 2 or a 3?

*[Ruler follow-up — asking "why not lower" to elicit the client's own change talk; this is a key MI technique]*

**Alex:** Because of my health, and because of my dad. And I guess my girlfriend. Those things do matter to me.

*[Change talk: Reasons, Need — client articulating their own motivations]*

**C:** Those are real and important reasons — your health, honoring what you watched your father go through, and the relationship you care about. Now, same scale — how confident are you, right now, that you *could* quit if you decided to?

*[Ruler question — Confidence; assessing self-efficacy]*

**Alex:** Maybe a 4 or 5. I know I can do it short-term because I've done it before. But long term... I'm not sure.

**C:** What would it take to move that confidence up even one point — from a 4 to a 5?

*[Ruler follow-up — asking "what would move it up" to explore barriers and potential supports; evokes planning talk]*

**Alex:** I think if I had a real plan for when things get stressful. That's what got me last time. If I knew what to do instead of reaching for a cigarette, I think I could do better.

*[Change talk: Ability — client identifying what they need; Beginning of planning orientation]*

## Part 5: Evoking — Key Question and Strengthening Change Talk

---

**C:** I've been listening to you talk about this, and I hear someone who knows quite well why this matters — your health, your dad, your future family. What I'm curious about is: given all of that, what do you think you want to do?

*[Key question — the central evocative question in MI; places agency firmly with the client]*

**Alex:** I think... I think I want to try. Really try. Not just say I'm going to. I'm tired of going back and forth in my head about it.

*[Change talk: Commitment — strong; Activation — expressing readiness to move forward]*

**C:** That's a really significant thing to say. You're ready to stop going back and forth and actually move toward something. I want to reflect something back to you: you came in today not sure you were ready. You've shared some really honest things — about your dad, about what you want your life to look like. And now you're telling me you want to really try. That took courage.

*[Affirmation — genuine, draws on session content; Summary — bridges Evoking to Planning process]*

## Part 6: Rolling with Discord

---

**C:** I know we've been talking about quitting. I want to ask — is there anything about this process that feels frustrating or like you're being pushed in a direction you don't want to go?

*[Proactive discord check — inviting honest expression of any discomfort or resistance]*

**Alex:** A little bit, yeah. Like, I get that smoking is bad for me. I don't need to be lectured. It starts to feel like everyone's just ganging up on me — my doctor, my girlfriend, now this.

**C:** You don't want to be told what to do — and that's completely fair. This is your life and your choice. I'm not here to lecture you or tell you what's right. Honestly, it's not my job to convince you of anything. What happens with your smoking is entirely up to you. I'm just here to think through it with you, if that's useful.

*[Rolling with discord — affirming autonomy, stepping back from any prescriptive stance; avoids argumentation]*

**Alex:** (pauses) Yeah... okay. That actually helps. I just didn't want to feel like I was being cornered.

**C:** You're in charge here. Whatever you decide is the right decision for you, we'll work with it.

*[Autonomy support — reinforcing that the client directs the process]*

## Part 7: Transition to Planning

**C:** Earlier you said you want to really try. I'd like to honor that. Would it be okay if we spent a few minutes thinking about what that could actually look like — a plan that fits your life?

*[Transition to Planning process — asking permission before shifting focus; maintains collaborative tone]*

**Alex:** Sure, yeah. Let's do that.

**C:** Okay, great. One of the first things that's often helpful is setting a quit date — a specific day that becomes your target. Not because it's a deadline, but because it gives you something concrete to prepare for. What would feel realistic for you?

*[Planning — quit date setting; framed as preparation, not pressure]*

**Alex:** I have a lighter week in about two weeks. That might be a good time.

**C:** Two weeks from now — that gives you time to prepare, which is actually ideal. Between now and then, we can think about a few things. You mentioned last time the stress was the biggest barrier. What are some things that helped, even a little, during those six weeks?

*[Open-ended question — eliciting existing coping strengths; reinforces self-efficacy from past experience]*

**Alex:** I chewed a lot of gum. And I tried to go for a walk when I got the urge. That helped sometimes.

*[Taking Steps — client recalling prior adaptive behaviors; strengths to build on]*

**C:** Those are solid strategies — and they're yours, not something I invented. We could look at also adding some support. There are nicotine replacement options — patches, gum, lozenges — that can reduce the physical pull, which might make those stressful moments a little easier to get through. Would it be useful to talk about those, or maybe get a referral to your doctor about prescription options?

*[Open-ended offer — providing information with permission framing; informing about NRT options without prescribing]*

**Alex:** Yeah, I'd be open to that. I tried the patch briefly last time but I think I didn't use it right.

**C:** That makes a lot of sense — the patch works best when it's used consistently and often people discontinue too early. We can definitely connect you with your doctor on that, and there are also some free resources — like a state quit line at 1-800-QUIT-NOW — that offer free coaching and even free NRT in some states. What about social support — is there anyone in your life who could be a real ally in this?

*[Psychoeducation with permission; referral information; Open-ended question — exploring social support]*

**Alex:** My girlfriend would be thrilled. She'd be really supportive, I think. And maybe my brother — he quit a few years ago.

**C:** You've got people in your corner. That matters a lot. So let's pull this together: you've identified a target quit date about two weeks out, you'll keep walking and using gum as coping strategies, we'll get you connected with your doctor about NRT, and you've got your girlfriend and your brother as support people. How does that feel as a starting place?

*[Summary — collecting change talk, plan elements, and strengths; collaborative plan-building]*

**Alex:** It actually feels more doable than I thought it would when I walked in here.

*[Self-efficacy increase — natural outcome of MI-consistent session]*

## Part 8: Closing and Affirmation

**C:** I want to say something before we wrap up. You came in today saying you weren't sure you were ready. You talked honestly about a really painful history with your dad. You identified what matters most to you. And you made a plan — one that came from you, not from me. That's what this work looks like when it's real. I'm genuinely impressed with how you engaged today.

*[Affirmation — detailed, session-specific; honors the client's process and agency]*

**Alex:** Thanks. I wasn't expecting to actually commit to anything today. But... here we are.

**C:** Here you are. I'd like to schedule a follow-up in about two weeks — right around your quit date — so we can check in on how things are going, celebrate what's working, and problem-solve anything that's come up. Would that work for you?

*[Next steps — follow-up scheduling; reinforces continuity and support]*

**Alex:** Yeah, absolutely. That sounds good.

**C:** Perfect. Take care of yourself, Alex. I'm really glad you came in.

**Session-End Supervisor Note:** *This session illustrates successful navigation of all four MI processes: Engaging (rapport, safety), Focusing (agenda-setting), Evoking (rulers, key question, decisional balance), and Planning (quit date, coping strategies, NRT referral, social support). The counselor maintained the spirit of MI throughout — particularly during the discord moment in Part 6. Change talk was elicited across multiple DARN-CAT categories without the counselor explicitly directing the client toward any predetermined outcome.*

**SECTION 3**

# MI Cheat Sheet: Smoking Cessation Quick Reference

Print this page as a standalone reference. Designed for use during supervision, role-play practice, or session preparation.

## OARS — Quick Definitions with Smoking Cessation Examples

<b>O — Open-Ended Questions</b>	Questions inviting elaboration; cannot be answered with yes/no	"What's been the hardest part about thinking about quitting?"
<b>A — Affirmations</b>	Genuine statements recognizing strengths, values, efforts	"The fact that you tried to quit before — even though it was hard — shows real determination."
<b>R — Reflections</b>	Statements (not questions) that reflect content, emotion, or deeper meaning	"So part of you is ready to quit, and another part really relies on cigarettes to get through the day."
<b>S — Summaries</b>	Periodic collection of what the client has shared; used to transition, amplify, or consolidate	"You've shared that you're concerned about your lungs, you've tried before and have skills from that, and the biggest challenge is stress. Let me see if I've got that right..."

## Change Talk — DARN-CAT Cue Words to Listen For

Category	What it sounds like	Example Client Statement
<b>D — Desire</b>	want, wish, like, hope	"I really want to be smoke-free before the baby comes."
<b>A — Ability</b>	can, could, able, might be able to	"I think I could do it if I had the right support."
<b>R — Reasons</b>	because, since, in order to	"I want to quit because I can't keep up with my kids anymore."

Category	What it sounds like	Example Client Statement
<b>N</b> — Need	need, have to, must, really should	"I have to do something — my doctor said my lungs are getting worse."
<b>C</b> — Commitment	will, am going to, I promise, plan to	"I'm going to quit by my birthday. That's my deadline."
<b>A</b> — Activation	ready, prepared, about to, starting to	"I'm ready to look into the patch this week."
<b>T</b> — Taking Steps	already, have been, I started, did	"I already cut back from 20 to 12 cigarettes a day."

## Sample Open-Ended Questions for Smoking Cessation

5. "What's brought you to think about your smoking at this point in your life?"
6. "What do you like about smoking — what does it do for you?"
7. "What concerns, if any, do you have about your tobacco use?"
8. "Tell me about a time when you tried to cut back or quit — what happened?"
9. "What would your life look like if you weren't smoking anymore?"
10. "If you were to quit, what do you think would be the hardest part?"
11. "What would have to be different for quitting to feel more possible?"
12. "Who in your life knows you've been thinking about this?"

## Ruler Question Scripts

**Importance Ruler:** "On a scale from 0 to 10, where 0 is 'not at all important' and 10 is 'the most important thing in my life right now,' how important is it to you to quit smoking?"

Follow up: "Why a [X] and not a [lower number]?" → Elicits change talk.

**Confidence Ruler:** "On the same scale, how confident are you that you *could* quit if you decided to?"

Follow up: "What would it take to move that up even one point?" → Explores barriers and supports.

## Responses to Common Sustain Talk

Client Says...	MI-Consistent Response
"Smoking helps me deal with stress."	"It's been a real go-to for managing pressure. And I'm also hearing you wonder if there's another way..."
"I'll quit when I'm ready."	"That makes sense — this really has to be your decision. What would 'ready' look like for you?"
"I've tried before and it didn't work."	"You've been down this road before. What did you learn about yourself from that experience?"
"I enjoy it — it's my choice."	"Absolutely — it's your life and your choice. I'm just curious what mixed feelings, if any, you have about it."

## Key Affirmations to Use

- "Coming in today took real effort, and I don't take that lightly."
- "You clearly care deeply about your health and your family."
- "The fact that you've tried before tells me you have the capacity to do this."
- "You're being really honest with yourself right now, and that takes courage."
- "Even cutting back by a few cigarettes shows you can exercise control over this."

## MI Spirit Reminder (PACE) and Key Tips

Do	Avoid
Reflect more than you ask (2:1 ratio)	Arguing or debating with the client
Affirm autonomy: "It's your choice"	The righting reflex — urge to correct, lecture, or advise
Follow client's change talk with curiosity	Amplifying or dwelling on sustain talk

Do	Avoid
Ask open-ended questions	Yes/no questions that close down exploration
Maintain PACE: Partnership, Acceptance, Compassion, Evocation	Premature problem-solving before client is ready

**SECTION 4**

## Case Note Template — MI Tobacco Cessation Session

Complete this form following each MI-based tobacco cessation session. Maintain in the client record per your site's documentation standards. All fields are confidential.

<b>Client Identifier / Case #:</b>	<b>Date of Session:</b>
<b>Session #:</b>	<b>Session Length:</b>
<b>Clinician Name / Credentials:</b>	<b>Supervisor Name:</b>

### 1. Presenting Concern / Reason for Visit

### 2. Tobacco Use Status

Check all that apply:

- Current daily smoker  
  Current occasional smoker  
  Recently quit (within 6 months)  
  Non-smoker  
 Smokeless tobacco  
  E-cigarette / vape user

**Cigarettes per day / frequency:**

**Years of use:    Primary triggers identified:**

### 3. Readiness Assessment — Ruler Scores

Ruler	Score (0-10)	Client Quote (verbatim if possible)
<b>Importance Ruler</b> "How important is it to quit?"		" "
<b>Confidence Ruler</b> "How confident are you that you could quit?"		" "

#### 4. Stage of Change

Circle or check the most applicable stage:

- Precontemplation** (Not considering change)  
  **Contemplation** (Ambivalent; considering change)  
  **Preparation** (Planning to change; taking small steps)  
  **Action** (Actively making change)  
  **Maintenance** (Sustaining change; relapse prevention)

#### 5. MI Techniques Used — Checklist

Technique	Used in Session?	Notes
Open-ended questions	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Affirmations	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reflective listening (simple)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reflective listening (complex / double-sided)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Summaries	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ruler questions (Importance and/or Confidence)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Decisional balance exploration	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Change talk elicited (DARN-CAT)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rolling with discord / autonomy affirmation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Agenda setting	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Key question asked	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Planning / quit date discussion	<input type="checkbox"/> Yes <input type="checkbox"/> No	

#### 6. Summary of Change Talk Themes

Note DARN-CAT categories observed (e.g., "Client expressed Desire to be healthier; articulated Reason related to children"):

## 7. Summary of Sustain Talk / Discord Noted

## 8. Client Strengths and Values Identified

## 9. Plan / Next Steps Discussed

Target Quit Date (if set):

## 10. Referrals Made

State Quit Line (1-800-QUIT-NOW)    NRT — Patch    NRT — Gum / Lozenge    NRT — Inhaler / Nasal Spray    Prescription Medication (specify):    Behavioral Counseling Program    Smokefree.gov    Other:

## 11. Follow-Up Appointment

Next Scheduled Session:    Modality:

---

Clinician Signature:

Credentials / Title:

Supervisor Signature (if applicable):

Date Signed:

### SECTION 5

# Role-Play Practice Script and Debrief Guide

## Instructions for Trainer / Supervisor

---

This role-play exercise is designed for dyadic practice in which one participant plays the Counselor Trainee and one plays the Client Actor (using the character profile below). The exercise is divided into three scenes corresponding to the MI processes of Engaging, Evoking, and Planning. After each scene, pause for brief reflective check-ins. A full debrief follows Scene 3.

### Setup guidelines:

- Allow the trainee counselor to read the client profile in advance; the client actor should also review the profile and feel free to improvise within the character's established context.
- The trainer/supervisor observes and uses the MI Adherence Checklist below during the session.
- A third participant may serve as an observer and provide peer feedback during the debrief.
- Sessions may be video-recorded with consent for later review using the MITI (Motivational Interviewing Treatment Integrity) coding system if available.
- Recommended total time: 20–30 minutes for the role-play, 15–20 minutes for debrief.

## Client Character Profile: Jordan

---

**Name:** Jordan • **Age:** 28 • **Gender:** Female

**Smoking History:** Has smoked since age 16 (approximately 12 years). Currently smokes about 15 cigarettes/day (approximately  $\frac{3}{4}$  pack). Tried to quit twice: once at age 22 (used willpower alone, lasted 3 weeks) and once at age 25 (used nicotine gum, lasted 2 months before a breakup led to relapse).

**Current Living Situation:** Lives with a long-term partner who also smokes. Many of her social interactions involve smoking with her partner.

**Primary Concerns:** Concerned about weight gain if she quits. Notices she's short of breath more than before. Has a primary care appointment next month and her doctor is likely to bring up smoking again.

**Core Ambivalence Statement:** "I know I should quit but it's really my stress relief — I don't know what I'd do without it."

**Counselor should know:** Jordan is not in crisis. She is ambivalent but not resistant. She responds well to empathy and genuine curiosity. She shuts down if she feels judged or lectured. She has expressed in passing that she wants to be healthier "someday."

## Scene 1: Engaging and Exploring (5–10 Minutes)

---

**Counselor Goal:** Build rapport, establish safety, explore Jordan's tobacco history and daily patterns using OARS.

Do not push toward change yet. Listen and reflect.

**Sample Counselor Opening:** "Hi Jordan, thanks for coming in today. I'd love to just start by hearing a little about you — what brings you in, in your own words?"

**Sample Client Responses for Client Actor:**

- "I guess my doctor mentioned I should come. I smoke, and I know it's not great, but I'm not sure I'm ready to do anything about it yet."
- "I've smoked since I was 16. It just kind of became part of my life. My whole family smokes — my partner smokes. It's everywhere."
- "When I'm stressed, I'll step outside and light up and honestly it's the only thing that calms me down. I know that sounds bad."
- "I tried to quit a couple of times. Didn't stick. I'm scared to try again and fail."
- "The weight thing is a big deal for me. I've heard you gain weight when you quit and that's honestly not something I'm willing to deal with."

**Counselor reminders during Scene 1:** Use at least 2 open-ended questions, 1 affirmation, and 2 reflections before offering any information or advice. Follow the client's lead. Explore, don't prescribe.

## Scene 2: Evoking (5–10 Minutes)

---

**Counselor Goal:** Elicit change talk using ruler questions and evocative open questions. Reflect change talk.

Respond to sustain talk without amplifying it.

**Sample Ruler Exchange:**

Counselor: "On a scale from 0 to 10, how important is it to you to quit smoking?"

**Client Actor:** "Maybe a 5. I know it's affecting my health. But I also really like smoking."

Counselor: "What makes it a 5 and not a 2?"

**Client Actor:** "Because I don't want to end up with lung cancer or something. And I'm kind of embarrassed about it — like, I know better. I'm a grown adult."

**Sample Change Talk Statements (for client actor to work in naturally):**

- *[Desire]* "I do kind of want to quit. I just don't know if I can."
- *[Reasons]* "I'm already getting winded going up stairs. That bothers me."
- *[Ability]* "I quit for two months once, so I know I can do it — at least for a while."
- *[Need]* "My partner quit once and I felt left out. I think I need to figure this out too."

**Sample Sustain Talk Statements (for client actor to work in):**

- "But my partner smokes — I'd be the only one not smoking at home. That'd be really hard."
- "I really don't want to gain weight. That's not a trade-off I'm willing to make."
- "I've failed before. What's different this time?"

**Counselor reminders during Scene 2:** Use the ruler follow-up questions ("why not lower?" and "what would move it up?"). Reflect change talk with energy and curiosity. Respond to sustain talk with a simple reflection or autonomy statement — do not argue.

---

## Scene 3: Planning (5 Minutes — Only if Client Appears Ready)

---

**Counselor Goal:** If Jordan has expressed sufficient change talk and readiness cues, transition collaboratively to planning. Ask permission before shifting. Build a plan that comes from Jordan, not from the counselor.

**Sample transition:** "You've talked about wanting to be healthier, and you've mentioned you know you can do this because you've done it before. Would it be okay if we spent a few minutes thinking about what a realistic first step might look like for you?"

**Sample Client Responses:**

- "I guess I could try cutting back first — maybe go from 15 to 10 and see how that goes."
- "I'd want to talk to my partner about it. We'd need to figure out something together."
- "The weight thing is still really on my mind. Is there anything that helps with that?"
- "What are the options for quitting aids? I didn't really use much last time."

**Counselor reminders during Scene 3:** Provide information only when asked or with explicit permission. Affirm every step Jordan identifies as her own idea. If Jordan is not ready to plan, honor that and close with an affirmation and an open door.

## Debrief Questions for Supervisor / Peer Feedback

13. How did the counselor open the session? Did it feel welcoming and non-judgmental?
14. Where did you notice change talk? Did the counselor reflect it with energy and curiosity?
15. Was there any moment that felt like the righting reflex? What happened?
16. Did the counselor follow the client's lead, or did the session feel directed by the counselor?
17. How did the counselor handle the sustain talk about weight and the partner who smokes?
18. Did the counselor affirm Jordan's autonomy throughout? Give an example.
19. If planning was reached: Did the plan come from Jordan, or was it largely the counselor's idea?
20. What would you do differently in your next practice attempt?

## MI Adherence Checklist (Supervisor Observation)

Observed Behavior	Yes	No
Used open-ended questions (at least 3 observed)	<input type="checkbox"/>	<input type="checkbox"/>
Reflected more than asked (approx. 2:1 ratio)	<input type="checkbox"/>	<input type="checkbox"/>
Used at least 1 genuine affirmation	<input type="checkbox"/>	<input type="checkbox"/>
Used at least 1 summary	<input type="checkbox"/>	<input type="checkbox"/>
Used ruler question(s) with appropriate follow-up	<input type="checkbox"/>	<input type="checkbox"/>
Elicited and reflected change talk	<input type="checkbox"/>	<input type="checkbox"/>
Responded to sustain talk without argumentation or counterpoint	<input type="checkbox"/>	<input type="checkbox"/>
Avoided the righting reflex	<input type="checkbox"/>	<input type="checkbox"/>
Affirmed client autonomy at least once	<input type="checkbox"/>	<input type="checkbox"/>
Asked permission before providing information or advice	<input type="checkbox"/>	<input type="checkbox"/>
Maintained non-judgmental, empathic tone throughout	<input type="checkbox"/>	<input type="checkbox"/>
If planning: Plan was collaboratively developed (not imposed)	<input type="checkbox"/>	<input type="checkbox"/>

**Supervisor Notes / Overall Impressions:**

**SECTION 6**

## SBIRT + MI Flowchart: Tobacco Screening Protocol

The following clinical decision pathway integrates **SBIRT** (Screening, Brief Intervention, Referral to Treatment) with MI-based tobacco cessation practice. This protocol is appropriate for use in primary care, behavioral health, community health, school-based health centers, and substance use treatment settings. Each step is sequenced and includes decision points, clinical guidance, and recommended actions.

**STEP 1 — SCREEN: Ask About Tobacco Use**

**Ask:** "Do you currently use any tobacco products, including cigarettes, cigars, chewing tobacco, or e-cigarettes?"

**Validated tools:** Single-item tobacco screener; AUDIT-C (for co-occurring alcohol use); PHQ-2 (for co-occurring depression if indicated).

If Response is NO

If Response is YES

✓

Provide brief affirmation: "That's great — staying tobacco-free is one of the best things you can do for your health."

✓

Document in chart.

✓

Exit screening pathway.

✓

Document tobacco type, frequency, amount.

✓

Proceed to

Step 2: Assess



## **STEP 2 — ASSESS: Readiness to Change**

**Ask:** "On a scale from 0 to 10, where 0 means 'I have no intention of quitting' and 10 means 'I am ready to quit right now,' where would you put yourself?"

Score 1–3 (Not Ready)

Score 4–6 (Ambivalent)

Score 7–10 (Ready)

**Brief Intervention:**

Provide brief information with permission. Affirm autonomy. Plant a seed. Schedule follow-up. Do not push for commitment.

**MI-Based Brief Intervention:**

15–30 min session. Explore ambivalence using OARS. Use decisional balance. Elicit change talk. Reflect double-sided ambivalence.

**Move to Planning:**

Elicit and reinforce change talk. Collaboratively develop quit plan. Refer to treatment as indicated (Step 4).



## **STEP 3 — BRIEF INTERVENTION: MI-Based Counseling**

**Key actions:**

- Use OARS throughout — open questions, affirmations, reflections, summaries.
- Elicit change talk using DARN-CAT framework.

- Use Importance and Confidence Rulers with follow-up questions.
- Explore decisional balance (pros/cons of smoking and quitting).
- Ask permission before providing any information or advice.
- Offer feedback with permission: "Would it be okay if I shared some information about what we know about smoking and [their specific concern]?"
- Address identified barriers (stress management, social environment, weight concerns, etc.).
- Roll with any discord — affirm autonomy, avoid argumentation.
- Close with affirmation of the client's efforts and an open door for follow-up.



#### **STEP 4 — REFERRAL TO TREATMENT: Connect with Resources**

**Refer when:** Client expresses readiness or commitment, requests medication support, or requires more intensive behavioral intervention than brief counseling allows.

Resource Type

Details

State Quit Line

1-800-QUIT-NOW (1-800-784-8669) — Free telephone coaching, NRT in many states, available in multiple languages.

Nicotine Replacement Therapy (NRT)

Patch (21mg/14mg/7mg taper), Nicotine gum (2mg/4mg), Lozenge (2mg/4mg), Nicotine inhaler (prescription in U.S.), Nasal spray (prescription). Recommend physician consultation for appropriate selection and dosing.

Prescription Medications

Varenicline (Chantix) — partial nicotinic agonist; most effective pharmacotherapy. Bupropion SR (Wellbutrin/Zyban) — antidepressant with cessation efficacy. Requires physician prescription and monitoring.

Behavioral Counseling Programs

Intensive outpatient groups; individual behavioral therapy; hospital-based cessation programs; employer wellness programs.

Digital / Self-Help Resources

Smokefree.gov (web + app); SmokefreeTXT (text message support); QuitGuide app; quitSTART app.



**STEP 5 — FOLLOW-UP: Monitor and Support Ongoing Change**

- Schedule follow-up appointment within 1-2 weeks (ideally around client's quit date).
- At follow-up: assess current tobacco use status, review coping strategies used, affirm successes (even partial), troubleshoot barriers, and reinforce commitment.
- If relapsed: normalize relapse as part of the change process; explore what was learned; re-engage in MI-based planning.
- Document all contacts, assessments, interventions, and referrals in the client record per site protocol.
- Assess outcome at 30 days, 3 months, and 6 months where feasible.

**SBIRT Integration Across Settings**

Setting	SBIRT + MI Integration Notes
<b>Primary Care</b>	Screening at every visit via vital signs or nursing intake. Brief MI intervention from PCP or care coordinator. Warm handoff to behavioral health or quit line. NRT prescribed on-site.
<b>Behavioral Health / Substance Use Treatment</b>	Tobacco often addressed concurrently with other substance use. Co-occurring mental health (anxiety, depression) requires integrated treatment. MI is especially effective with this population due to high smoking prevalence and ambivalence.
<b>School-Based Health Centers</b>	Adolescent-specific screeners; confidential setting important; peer influence and e-cigarette use are common complicating factors; involve parents/guardians per age and consent laws.

Setting	SBIRT + MI Integration Notes
<b>Community / Public Health</b>	Community health workers trained in brief MI; population-level SBIRT integrated into health fairs, mobile clinics; culturally adapted materials essential; quit line referral highly feasible.
<b>Hospital / Inpatient</b>	Mandatory smoke-free environment creates natural "teachable moment." Bedside SBIRT during hospitalization; discharge planning includes NRT and follow-up appointment. Highly cost-effective setting for brief intervention.

## SECTION 7

# Handling Objections and Common Client Statements

The following table provides MI-consistent counselor responses to common client objections, expressions of sustain talk, and statements of ambivalence. These responses are not scripts to be memorized verbatim but are offered as models of MI-consistent language. The underlying principle in each response is: **reflect, affirm, explore** — **do not argue, lecture, or prescribe.**

Client Statement / Objection	MI-Consistent Counselor Response
"I've tried before and failed."	"You've been down this road before — and each attempt teaches you something. What did you learn about yourself when you tried to quit? What worked, even a little?" [ <i>Affirmation of past effort; Open question to elicit ability change talk and learning from experience</i> ]
"Smoking is the only thing that helps my stress."	"Smoking has really served as your go-to stress reliever — it's become woven into how you cope. I'm also hearing that you wonder whether that's the best option long-term. What would it mean to have another way to manage stress?" [ <i>Complex reflection; Double-sided; Evocative open question</i> ]
"I'm not ready to quit yet."	"That's completely okay — this is your decision and your timeline. I'm just curious: what would 'ready' look like for you? What would need to be different?" [ <i>Autonomy affirmation; Open question exploring the path to readiness</i> ]
"I don't want to gain weight."	"That's a really common and understandable concern — and it makes sense that you don't want to trade one problem for another. There are actually some strategies that can help manage weight during quitting. Would it be okay if I shared a bit about what we know about that?" [ <i>Validation; Permission-based information offer; avoids dismissing a legitimate concern</i> ]
"My family all smokes — it'll be impossible."	"Living in an environment where everyone around you smokes is genuinely one of the hardest challenges in quitting — you're not making that up. What do you imagine it would take to navigate that? Have any of the people in your life ever talked about quitting too?" [ <i>Empathic reflection; Normalizing the barrier; Open question exploring social context</i> ]

Client Statement / Objection	MI-Consistent Counselor Response
"I only smoke a few a day — it's not that bad."	"You don't see yourself as a heavy smoker, and that makes sense given what you're comparing it to. I'm curious — what, if anything, has made you think about it at all?" <i>[Reflection without argument; Open question designed to elicit the client's own concerns]</i>
"I'll quit on my own when I'm ready."	"Absolutely — and many people do. You clearly have confidence in your own ability to make changes when you decide to. What's kept you from making that decision so far?" <i>[Affirmation of self-efficacy; Open question exploring ambivalence]</i>
"The patch doesn't work for me."	"It sounds like you've already tried NRT and it wasn't the right fit. That's really useful to know. There are actually several different options — some people do much better with a lozenge or an inhaler, or even a prescription medication. Would you be open to hearing about some alternatives?" <i>[Reflection; Provides information with permission; reframes past attempt as information, not failure]</i>
"I enjoy smoking — it's my choice."	"Absolutely — and it is your choice. I'm not here to take that away from you or tell you what to do. I'm just curious: are there any parts of smoking you enjoy less, or any mixed feelings you have about it?" <i>[Autonomy affirmation; Curiosity without pressure; Invites exploration of ambivalence]</i>
"I can't quit because of my anxiety."	"Anxiety and smoking can feel really connected — like the cigarette is actually treating the anxiety. Interestingly, research suggests that quitting can actually reduce anxiety over time, even though the first few weeks can be harder. I'd never want to dismiss what you're experiencing though — how do you feel about that?" <i>[Empathy first; Information with permission framing; Checks in rather than prescribing]</i>
"I've smoked for 30 years — what's the point now?"	"It can feel like the ship has sailed after that long. And I want to share something: the body starts recovering from smoking within hours of quitting — regardless of how long someone has smoked. But more than the biology, I'm curious what you'd want your next 30 years to look like." <i>[Validation; Brief motivating fact; Evocative open question focused on the future]</i>
"I'll quit when I get less stressed at work."	"It makes sense to want conditions to be right before making a big change. I'm wondering — do you imagine that day will come? And in the meantime, is there any part of you that wonders if quitting might actually affect how you handle that stress?" <i>[Gentle reflection; Evocative questioning about the waiting strategy; invites new perspective without confrontation]</i>
"I'm pregnant but I can't seem to stop."	"I can hear how hard you're trying, and how much you want to do the best thing for your baby — and yourself. The fact that you're talking about this takes real courage. Quitting during pregnancy is one of the most important things for your baby's health, and also one of the hardest. What kind of support do you feel like you need most right now?" <i>[Compassion first; Affirmation of values; Open question to elicit what kind of support would help]</i>
"My doctor never mentioned it before."	"It can feel a little surprising to suddenly have this on the table. You might be wondering why now — or why it matters. What do you make of the fact that it's come up?" <i>[Reflection; Normalizing surprise; Open question inviting client to process the experience]</i>
"I don't	"You're skeptical about what you've heard — that makes sense, there's a lot of information

Client Statement / Objection	MI-Consistent Counselor Response
believe the statistics about smoking."	out there and not all of it is trustworthy. I'm not going to try to convince you of anything. What I'm more curious about is what you've noticed in your own body or your own life when it comes to your smoking." <i>[Rolls with resistance; Avoids argumentation; Redirects to personal experience, which is more persuasive than abstract statistics]</i>

**Supervisor Note:** *When reviewing these responses with trainees, emphasize that the goal is not to "win" the interaction or maneuver the client toward quitting. The goal is genuine curiosity and empathic engagement with the client's perspective. A client who feels truly heard — even in their ambivalence — is far more likely to move toward change than one who feels argued with or lectured. In MI, the counselor's restraint is often more therapeutic than their words.*

## Oklahoma Child Wellbeing - Educational Resource Closing Note

### About This Packet

This packet was developed as a comprehensive clinical training resource for counseling students and practitioners in behavioral health, substance use treatment, and primary care integration settings. It is intended for use in practicum preparation, supervision review, classroom instruction, and individual professional development.

The MI principles, techniques, and frameworks presented in this document are grounded in the foundational work of **William R. Miller and Stephen Rollnick** (*Motivational Interviewing: Helping People Change*, 3rd ed., 2013) and are consistent with established clinical training standards in the field.

**Supervisors and instructors are encouraged to adapt, expand, or modify any section of this packet** to reflect the specific clinical population, setting, or training objective of their program. No section should be taken as a rigid protocol; MI is a clinical style requiring ongoing practice, supervision, and reflective development.

**All client names, characters, and case details in this packet — including Alex and Jordan — are entirely fictional** and are used solely for educational illustration. Any resemblance to actual persons is coincidental.

For questions about SBIRT implementation, NRT resources, or quit line integration in your state, contact your state's tobacco cessation program or visit **Smokefree.gov** or call **1-800-QUIT-NOW**.

## Recommended References and Resources

- Miller, W. R., & Rollnick, S. (2013). *Motivational Interviewing: Helping People Change* (3rd ed.). Guilford Press.
- Heckman, C. J., Egleston, B. L., & Hofmann, M. T. (2010). Efficacy of motivational interviewing for smoking cessation: A systematic review and meta-analysis. *Tobacco Control*, 19(5), 410–416.
- Lindson, N., Thompson, T. P., Ferrey, A., Lambert, J. D., & Aveyard, P. (2019). Motivational interviewing for smoking cessation. *Cochrane Database of Systematic Reviews*, Issue 7.
- Substance Abuse and Mental Health Services Administration (SAMHSA). SBIRT: Screening, Brief Intervention, and Referral to Treatment. Retrieved from [www.samhsa.gov](http://www.samhsa.gov)
- U.S. Department of Health and Human Services. (2020). *Smoking Cessation: A Report of the Surgeon General*. HHS, Centers for Disease Control and Prevention.
- Motivational Interviewing Network of Trainers (MINT): [www.motivationalinterviewing.org](http://www.motivationalinterviewing.org)
- National Cancer Institute / Smokefree.gov: [www.smokefree.gov](http://www.smokefree.gov)

**Student Signature:**

**Date:**

**Supervisor / Instructor Signature:**

**Date Reviewed:**

Smoking Cessation Motivational Interviewing Packet • A Comprehensive Clinical Training Resource • All client profiles fictional • For educational use only.