Effectiveness of smoking cessation in a dentistry setting in Sweden
– a randomized trial

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Running title: Effectiveness of smoking cessation

Keywords: RCT, tobacco, treatment intensity, point value, follow-up

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Abstract

Background: The aim of the present study was to assess the relative effectiveness of a high intensity intervention compared with a low intensity intervention for smoking cessation support in a dental clinic setting.

Method: 300 smokers attending dental or general health care were randomly assigned to two arms and referred to the local dental clinic for smoking cessation support. One arm received support with low treatment intensity (LTI), whereas the other group was assigned to high treatment intensity (HTI) support. The main outcome measures included self-reported point prevalence and continuous abstinence (≥183 days) at the 12-month follow-up.

Results: Follow-up questionnaires were returned from 86% of the participants. People in the HTI-arm were twice as likely to report continuous abstinence compared with the LTI-arm (18% vs. 9%, p=0.02). There was a small (not significant) difference between the arms in point prevalence abstinence in favour of the HTI-protocol (24% vs. 16%). However, point prevalence cessation rates in the LTI-arm reporting additional support were relatively high (23%) compared with available data assessing abstinence in smokers trying to quit without professional support.

Conclusion: Screening for willingness to quit smoking within the health care system and offering smoking cessation support within dentistry may be an effective model for smoking cessation support in Sweden. The LTI approach is more cost-effective as a first treatment option, but should be integrated with other forms of available support in the community. The more extensive and expensive HTI-protocol should be offered to those unable to quit with the LTI approach.

Trial registration number: NCT00670514
Introduction

In Sweden, in spite of being one of the leaders among high income countries in reducing the proportion of smokers in the population, tobacco is still the number one life style risk factor for ill health and premature death [1]. Globally, tobacco-attributable deaths are projected to rise from 5.4 million in 2005 to 6.4 million in 2015 [2].

In many countries, dentistry may be a potential setting for several aspects of clinical public health interventions throughout their regular recall system of patients, and thereby possibilities of assisting people to life style changes. There is a growing interest in several countries to develop tobacco cessation support in dentistry setting [3-5]. Tobacco use is one of the major contributors to oral problems in Sweden [6]. That is probably why many Swedish dentists and dental hygienists regard smoking cessation support as a natural part of their work and have ambitions to develop tobacco cessation support at their clinics [5, 7]. However, factors such as effectiveness and cost effectiveness are of central importance for the implementation of different kinds of smoking cessation interventions [8].

The aim of the present study was to assess the relative effectiveness of a high intensity intervention compared with a low intensity intervention, using the local dentistry as a setting for cessation support.

Material and method

The county of Västmanland, Sweden with 250 000 inhabitants, is a mixture of urban and rural areas. Västerås, the largest city, has approximately 134 000 inhabitants. During a period of 18 months (August 2003 through February 2005) dental and health care personnel, as well as industrial health service, in Västerås with surroundings were encouraged to screen for daily smokers, over 20 years of age, and refer them to the local dental service or to a study administrator, for possible inclusion in a study on smoking cessation. Smokers accepting the
offer were randomly assigned to two arms. One arm received support of relatively low treatment intensity (LTI), whereas the other group was assigned to high treatment intensity (HTI) support. People with reading difficulties and those not fluent in the Swedish language were excluded from the study. Power calculation estimated that 150 smokers would have to be recruited to each arm to statistically confirm a 5% difference between the groups. The randomization was performed by an independent person using an envelope technique in blocks of four [9]. All counselling was carried out by three experienced dental hygienists who had been trained in smoking cessation support methods.

*Treatment protocols*

The *High Treatment Intensity* group (HTI) received support at the local dental clinic over a period of 4 months. The HTI-program was a traditional smoking cessation program based on a mixture of behavior therapy, coaching, and pharmacological advises. The program comprised eight 40-minute sessions at the clinic. All counselling was carried out by a dental hygienist with special training in smoking cessation and the counsellor “tailored” the advice to each individual [10].

The *Low Treatment Intensity* program (LTI) consisted of one 30-minute counselling session focusing on explaining the content of a traditional self-help program (“Fimpa dig fri”). The leaflet contained an 8-week program with instructions and tasks to perform each week. The self-help program was not “tailored” to each individual but included several tests and behaviour registration exercises suggesting different action plans for different outcomes. In general, the self-help program and the clinic-based program were based on similar treatment protocols.

At the first meeting, a smoking cessation date was fixed for all participants in both groups. The participants were informed that they would be followed-up through a questionnaire, after
12 months counting from their fixed smoking cessation date. Both programs were free of charge.

**Outcome measures**

After written consent had been obtained, a baseline questionnaire and a covering letter were mailed to the participants. They were requested to fill in the questionnaire at home and bring it to the first appointment. A follow-up questionnaire was sent by mail 12 months after the planned smoking cessation date along with a pre-stamped return envelope. HTI-participants completing the program as well as all LTI-participants, received a more comprehensive questionnaire including the three abstinence and intent to quit questions, as well as questions about depressive mood, use of smokeless tobacco, other support and additional factors relevant for the study.

Abstinence was assessed with the question: Have you smoked during the past seven days? The answer alternatives were: No I have not smoked at all; Yes but not daily; Yes daily. The first answer alternative had an attendant question: How many days have you been smoke-free?

*Point prevalence abstinence* was defined as self reported; “not one puff of smoke during the past seven days.” *Continuous abstinence* was defined as self reported; “not one puff of smoke during the past six months (183 days)”. The continuous abstinence is based on the cut-off for the maintenance stage according to the transtheoretical model of stages of change [11].

To assess the intention to quit we used the question: If you are still smoking, what are your intentions concerning trying to quit? The answer alternatives, based on the stages of change model [11], were: I am trying to quit just now; I intend to try to quit within one month; I intend to try to quit within the next six months; I do not intend to quit.
The question assessing depressive mood was: Have you been in a, for you, abnormally depressive mood during some period, since your first contact with the smoking cessation program? The answer alternatives were Yes and No.

The question about other support was: Is there anyone else besides The National Dental Health Service in Västmanland who have supported you in your attempt to quit? The answers were categorized into Yes or No in the present analysis.

A subgroup of participants in the HTI-group did not complete the program, most of them left the program within the first three weeks. This group received a short questionnaire with three questions, assessing point prevalence and continuous abstinence at the time of follow-up, and a question on future plans to quit.

Due to the design of the LTI-program it was impossible to get information about participants not completing that program.

The questions used in the study were developed and tested for face validity by means of in-depth interviews and focus groups at the Centre for Tobacco Prevention in Stockholm and had previously been used to assess the treatment effectiveness of the Swedish National Tobacco Quitline (“Sluta-röka-linjen”) [12].

The study was approved by the ethical committee at Uppsala University (Dnr:Ups 02-457).

We analyzed the data in two steps. First using the “intention to treat” approach, where all participants answering the baseline questionnaire were included in the analysis and non-responders to the follow-up questionnaire were treated as smokers at follow-up. Secondly we analyzed data from those answering the follow-up questions, excluding non-responders.

For statistical analyses, parametric as well as non-parametric tests were used according to the type of data. Logistic regression analysis was performed to calculate odds ratios (ORs) with 95% confidence interval for the outcome measures. First we made a univariate analysis of
separate independent variables and then a multiple analysis including the same variables plus sex and age to get adjusted ORs.
Results

Of the 363 invited to participate in the study, 300 (83%) accepted and were randomly assigned to the two arms. Of these, six did not reply to the baseline questionnaire, leaving 294 in the study population, 146 in the “High Treatment Intensity” (HTI) arm and 148 in the “Low Treatment Intensity” (LTI) arm (Figure 1).

Answers on point prevalence and continuous abstinence were received from 252/294 (86%) of the participants at the 12-month follow-up, 131/146 (90%) responded to these questions in the HTI-group and 121/148 (82%) in the LTI-group (Figure 1).

At baseline there were no significant differences between the arms regarding assessed background variables. Approximately eight out of ten were women and the majority of the participants had 10 years or more of education (Table 1). The participants in both groups had, on average, been daily smokers for 29 years, smoking a mean of 15 cigarettes per day in the week prior to the first interview (not in table).

People in the HTI-group were twice as likely to report continuous abstinence compared with the LTI-group when analyzing the data using the “intention to treat” method and treating all non-responders as smokers. The results were almost identical when only those who had answered the follow-up questions were included in the analysis (Table 2). There was a small (not significant) difference between the arms in point prevalence abstinence in favour of the HTI-protocol (Table 2).
People with a higher level of education appeared to gain more from the HTI-protocol. A 20% difference in continuous abstinence, 10% vs. 30%, was noted between the arms for those with ten years or more of education. Conversely, only 7% difference, 15% vs. 22% in continuous abstinence was noted between the treatment protocols for those reporting less than ten years of education (Table 3).

The LTI-program did not appear to have any long term effect on its own. None of the people in the LTI-group reported continuous abstinence in the absence of additional support, compared with 14% of those who had access to other support. Additional support had little (if any) additional effect on continuous abstinence in the HTI-group (Table 3).

With the exception of point prevalence abstinence in the LTI-arm, people reporting periods of depressive mood during the previous 12 months, were less likely to be abstinent at follow-up than people not reporting depressive mood (Table 3). However, these differences were not significant in the present material.

142 of the 193 (74%) participants, responding to the questionnaires, who were still smoking at follow-up, intended to make a new quit attempt within the following 6 months, with no significant differences between the groups (not in table).

<Insert Table 3 about here>

Half of the participants had used Nicotine Replacement Therapy (NRT) and there was no difference in NRT use between the LTI- and the HTI-group (not in table). Twelve participants (6%) had used oral tobacco (snus) as a substitute for smoking after cessation, five in the LTI-group and seven in the HTI-group (not in table).

According to the multiple logistic regression analysis (Table 4), type of program and number of smoked cigarettes at baseline (0-9/day compared to ≥20/day) were the only variables with
significant effect on the point prevalence and continuous abstinence, after adjusting for sex, age, education level, other support and depressive mood. For point prevalence abstinence, the adjusted OR for being smoke-free with the HTI-program compared to the LTI-program was 2.1 and for smoking 0-9 cigarettes/day compared to ≥20/day the adjusted OR was 4.5. For continuous abstinence, the adjusted OR for HTI compared to LTI was 3.0, while for smoking 0-9 cigarettes/day compared to ≥20/day the adjusted OR was 3.2. Sex and age appeared to have no effect on any of the outcome measures after adjustment (not in table).

<Insert Table 4 about here>

In a drop-out analysis we compared the baseline characteristics of participants answering the complete follow-up questionnaire with the participants who either did not respond to the follow-up questionnaire at all or the non-completers in the HTI-group who responded to the short follow-up questionnaire. The drop-out group had higher cigarette consumption at baseline and fewer earlier week-long quit attempts (p<0.05), however no differences were seen between the groups regarding sex, age, intention to quit, second-hand smoke, snus or NRT (not in table).
Discussion

The HTI-protocol was significantly more effective than the LTI-protocol in terms of proportion of smokers reporting continuous abstinence at the 12-month follow-up (Table 2). After adjusting for sex, age, number of smoked cigarettes at baseline, education level, other support, and depressive mood the HTI-protocol was still significantly more effective than the LTI-protocol for both point prevalence and continuous abstinence, with ORs of 2.1 and 3.0, respectively (Table 4). Besides program, only number of smoked cigarettes at baseline had a significant influence on the probability of abstinence, adjusted for the other variables.

There was no evidence that the LTI-protocol had any long-term effect on its own, with only 8% of those having no access to other support reporting point prevalence abstinence and none of those reporting continuous abstinence (Table 3). However, of the people in the LTI-group reporting to have had access to other support, 23% reported point prevalence abstinence at the 12-month follow-up (Table 3), which is relatively high compared with spontaneous quit rates of motivated smokers trying to quit on their own [13]. Corresponding point prevalence proportions in the HTI-group were 27% for those reporting no other support and 37% for those reporting to have had access to additional support (Table 3).

Most studies show point prevalence quit rates at 12-month follow-up between 7-10% for motivated smokers trying to quit without assistance [13]. Overall, the LTI-group responding to the questionnaire was approximately twice as likely (20%) to report point prevalence abstinence (Table 2). Thus, the LTI approach may be preferable as first treatment option from cost effectiveness point of view in situations where additional support is available, e.g., in form of a telephone quitline.

One part of the LTI-program was the self-help manual. The value of such manuals for smoking cessation is under scrutiny [14]. The design of the present study does not allow us to isolate the possible effect of the self-help material, since the LTI-program was a combination
of five factors comprising; screening for tobacco use, offering support, one 30-minute
treatment session, the 12-month follow-up, and the self-help material.
Although the LTI-protocol in the present study did not appear to have any long term effect
(continuous abstinence) on its own, 14 % of people in the LTI-group reporting additional
support reported continuous abstinence at the 12-month follow-up (Table 3). Unfortunately,
there are methodological problems in separating the effect of the LTI-program from the effect
of the additional support. However, the relatively high success rate of those LTI clients
reporting additional support suggests the possibility of improving the effectiveness of the LTI
intervention, e.g., by combining it with systematic referrals to professionally run quitlines.
Quitlines are presently widely available and have proven to be highly potent treatment options
for smoking cessation in their own right [15, 16]. The Swedish quitline has reported 12–
months point prevalence abstinence (using the same method of assessment and definition as
the present study) ranging from 28% abstinence for a reactive treatment protocol to 33% for a
proactive treatment [12].
The high proportion (83%) of daily smokers accepting the offer of participation in the study
and the proportion of unsuccessful quitters planning to make another quit attempt within the
next six months (74%), indicates a widespread desire amongst daily smokers in Sweden to
quit smoking.
The overwhelming majority of women in the present study reflect previous findings that
Swedish women are more willing to seek support for smoking cessation [12]. Also, where
Swedish women tend to seek professional help and use medication to treat their nicotine
dependency, Swedish men have tended to substitute smoking with other forms of tobacco,
mainly the Swedish oral tobacco (snus). Consequently, approximately 32% of adult Swedish
men are still daily tobacco users compared with approximately 18% of Swedish women [17].
In the present study one problem is the lack of detailed information from those 43 people in the HTI-arm who did not complete the program. Although this does not affect the main outcome measure since all participants received the three central questions regarding abstinence, it creates problems in the comparison between the arms on other variables included in the more extensive questionnaire, some of which are presented in Table 3. The decision to retrieve only the most relevant information from those “dropping out” of the HTI-arm was based on the belief that the response rate from these people would be low if they received the longer version of the questionnaire. Obviously, the relative differences in abstinence rates between the arms is larger in Table 3, since all unsuccessful quitters in the HTI-arm who did not complete the program, are excluded from the analysis. However, the fact that the results in Table 2 were similar, independently of which analysis was applied, indicates that drop outs probably did not seriously effect the main results in the analysis presented in Table 3.

In accordance with previously reported data from the Swedish quitline, people reporting depressive mood after the quit date were less likely to report abstinence at the follow-up [12], with the exception of point prevalence abstinence in the LTI-arm (Table 3). The lack of statistical significance in the present analysis is probably due to statistical power. However, there was no difference whatsoever between the “depressed” and “not depressed” on the point prevalence abstinence outcome measure in the LTI-group (Table 3). It should be noted that depressive mood does not refer to clinical depression. We can not explain why people with higher levels of education appeared to gain more from the HTI-protocol (Table 3).

**Conclusions**

The results of the present study indicate that screening for willingness to quit smoking within the health care system and offering smoking cessation support within dentistry may be an effective model for smoking cessation support in Sweden. The LTI approach is probably more
cost-effective as a “first treatment option”, but should be integrated with other kinds of available support such as a proactive quitline. The more extensive and expensive HTI-protocol should probably only be offered to those who are unable to quit with LTI-support in combination with other support.

Acknowledgments

This study was supported by grants from the Västmanland County Council.

We wish to thank the dental hygienists Ann-Cathrine Engström-Stangfors, Lena Storholm and Agneta Wedelstam for the practical work with the smoking cessation support and Associate Professor Stefan Sörensen for statistical advice.

Declaration of competing interests

The authors declare that they have no competing interests.

Authors contributions

EN: data collection and analysis, manuscript preparation, (project co-ordinator)
ÅT: study design, manuscript preparation, (project leader)
PT: study design, construction and validation of outcome measures, manuscript preparation
PJ: construction of outcome measures
AR: statistical analysis, consultation
ARH: study design, construction and validation of outcome measures, data analysis, manuscript preparation
All authors read and approved the final manuscript.
References


Tables:

**Table 1.** Population characteristics

**Table 2.** Abstinence and ORs at the 12-month follow-up, by treatment intensity

**Table 3.** Abstinence and ORs for different variables, by treatment intensity

**Table 4:** Multivariate ORs and 95% CI for abstinence

Figures:

**Fig 1.** Flowchart of the study.

Detailed legend: Flowchart of the study. Also presenting the proportion of people reported to be smoke-free (point prevalence) at the 12-month follow-up.
### Table 1. Population characteristics

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
<th>High treatment intensity</th>
<th>Low treatment intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><em>Recruited</em> (N)</em>*</td>
<td>294</td>
<td>146</td>
<td>148</td>
</tr>
<tr>
<td>% (n)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 – 34</td>
<td>8 (5)</td>
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<td>35 – 49</td>
<td>36 (23)</td>
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</tr>
<tr>
<td>50 – 64</td>
<td>45 (29)</td>
<td>50 (15)</td>
<td>41 (14)</td>
</tr>
<tr>
<td>65 – 84</td>
<td>11 (7)</td>
<td>10 (3)</td>
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<tr>
<td>Education in years:</td>
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<tr>
<td>0 – 9</td>
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<td>33 (10)</td>
<td>29 (10)</td>
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<tr>
<td>≥ 10</td>
<td>69 (44)</td>
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<td>70 (24)</td>
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<tr>
<td>Smoker at first interview:</td>
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<td>Yes</td>
<td>98 (63)</td>
<td>97 (29)</td>
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<tr>
<td>No</td>
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<td>3 (1)</td>
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</tr>
<tr>
<td>N of smoked cigarettes:</td>
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<td>≥ 20/day</td>
<td>48 (31)</td>
<td>50 (15)</td>
<td>47 (16)</td>
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<td>10-19/day</td>
<td>34 (22)</td>
<td>30 (9)</td>
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<td>17 (11)</td>
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<td>79 (116)</td>
<td>77 (114)</td>
</tr>
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<td>99 (228)</td>
<td>99 (115)</td>
<td>99 (113)</td>
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<tr>
<td>N of smoked cigarettes:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>≥ 20/day</td>
<td>30 (68)</td>
<td>26 (30)</td>
<td>33 (38)</td>
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<tr>
<td>10-19/day</td>
<td>56 (129)</td>
<td>58 (67)</td>
<td>54 (62)</td>
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<tr>
<td>0-9/day</td>
<td>14 (33)</td>
<td>16 (19)</td>
<td>12 (14)</td>
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* Recruited = all those who came to the first interview
Table 2. Point prevalence and continuous abstinence at the 12-month follow-up, by treatment intensity. First analyzed as “intention to treat” then comparing those answering the follow-up questions on abstinence.

<table>
<thead>
<tr>
<th></th>
<th>Point prevalence abstinence*</th>
<th>Continuous abstinence *</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>% (n/N)</td>
<td>p-value</td>
</tr>
<tr>
<td>LTI (ref.)</td>
<td>16 (24/148)</td>
<td>1.0</td>
</tr>
<tr>
<td>HTI</td>
<td>24 (35/146)</td>
<td>1.5</td>
</tr>
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</table>

Comparing people who answered the follow-up questions on abstinence:

<table>
<thead>
<tr>
<th></th>
<th>Point prevalence abstinence*</th>
<th>Continuous abstinence *</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>% (n/N)</td>
<td>p-value</td>
</tr>
<tr>
<td>LTI (ref.)</td>
<td>20 (24/121)</td>
<td>1.0</td>
</tr>
<tr>
<td>HTI</td>
<td>27 (35/131)</td>
<td>1.5</td>
</tr>
</tbody>
</table>

* Point prevalence abstinence = not smoked at all in the seven days prior to follow-up. Continuous abstinence = not smoked at all in the 6 months (≥183 days) prior to follow-up.
Table 3. Abstinence (point prevalence and continuous) by education level, number of smoked cigarettes at baseline, additional support and depressive mood as well as odds ratios for the two abstinence standards. Only including the 121 from the LTI-group and the 97 from the HTI-group who answered the complete follow-up questionnaire.

<table>
<thead>
<tr>
<th></th>
<th><strong>Point prevalence abstinence</strong></th>
<th><strong>Continuous abstinence</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n/N)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td></td>
<td>% (n/N)</td>
<td>OR (95% CI)</td>
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<tr>
<td><strong>Education: 0-9 years</strong></td>
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<tr>
<td>LTI (ref.)</td>
<td>19 (5/26)</td>
<td>1.0</td>
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<tr>
<td>HTI</td>
<td>30 (7/23)</td>
<td>1.8 (0.5-6.9)</td>
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<tr>
<td><strong>Education: ≥10 years</strong></td>
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<tr>
<td>LTI (ref.)</td>
<td>20 (19/95)</td>
<td>1.0</td>
</tr>
<tr>
<td>HTI</td>
<td>38 (28/74) *</td>
<td>2.4 (1.2-4.8) *</td>
</tr>
<tr>
<td><strong>N of cigarettes: ≥ 20/day</strong></td>
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<td></td>
</tr>
<tr>
<td>LTI (ref.)</td>
<td>10 (4/40)</td>
<td>1.0</td>
</tr>
<tr>
<td>HTI</td>
<td>24 (6/25)</td>
<td>2.8 (0.7-11.3)</td>
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<tr>
<td><strong>N of cigarettes: 10-19/day</strong></td>
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<tr>
<td>LTI (ref.)</td>
<td>22 (14/63)</td>
<td>1.0</td>
</tr>
<tr>
<td>HTI</td>
<td>35 (18/51)</td>
<td>1.9 (0.8-4.4)</td>
</tr>
<tr>
<td><strong>N of cigarettes: 0-9/day</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTI (ref.)</td>
<td>33 (6/18)</td>
<td>1.0</td>
</tr>
<tr>
<td>HTI</td>
<td>52 (11/21)</td>
<td>2.2 (0.6-8.1)</td>
</tr>
<tr>
<td><strong>Other support: No</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTI (ref.)</td>
<td>8 (2/25)</td>
<td>1.0</td>
</tr>
<tr>
<td>HTI</td>
<td>27 (3/11)</td>
<td>4.3 (0.6-30.7)</td>
</tr>
<tr>
<td><strong>Other support: Yes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTI (ref.)</td>
<td>23 (22/96)</td>
<td>1.0</td>
</tr>
<tr>
<td>HTI</td>
<td>37 (32/86) *</td>
<td>2.0 (1.04-3.8) *</td>
</tr>
<tr>
<td><strong>Depressive mood: Yes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTI (ref.)</td>
<td>19 (12/62)</td>
<td>1.0</td>
</tr>
<tr>
<td>HTI</td>
<td>33 (18/55)</td>
<td>2.0 (0.9-4.7)</td>
</tr>
<tr>
<td><strong>Depressive mood: No</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTI (ref.)</td>
<td>20 (12/59)</td>
<td>1.0</td>
</tr>
<tr>
<td>HTI</td>
<td>41 (17/42) *</td>
<td>2.7 (1.1-6.4) *</td>
</tr>
</tbody>
</table>

* Statistically significant difference between the programs at the 5% level
** Statistically significant difference between the programs at the 1% level
† Impossible to compute because of too few individuals in the cell
‡ Point prevalence abstinence = not smoked at all in the seven days prior to follow-up. Continuous abstinence = not smoked at all in the 6 months (≥183 days) prior to follow-up.
Table 4. Multivariate ORs and 95% CI for abstinence (point prevalence and continuous) adjusted for sex, age, and other variables in the table. Only including the 121 from the LTI-group and the 97 from the HTI-group who answered the complete follow-up questionnaire.

<table>
<thead>
<tr>
<th></th>
<th>Point prevalence abstinence†</th>
<th>Continuous abstinence†</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n/N) OR (95% CI)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td><strong>Program</strong></td>
<td></td>
<td></td>
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<tr>
<td>LTI (ref.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HTI</td>
<td>56 (121/218) 1.0</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>44 (97/218) 2.1 (1.1-3.9) *</td>
<td>3.0 (1.4-6.3) **</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-9 years (ref.)</td>
<td>22 (49/218) 1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>≥10 years</td>
<td>78 (169/218) 1.5 (0.7-3.2)</td>
<td>1.2 (0.5-3.0)</td>
</tr>
<tr>
<td><strong>N of cigarettes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 20/day (ref.)</td>
<td>30 (65/218) 1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>10-19/day</td>
<td>52 (114/218) 2.1 (0.9-4.8)</td>
<td>1.9 (0.7-5.0)</td>
</tr>
<tr>
<td>0-9/day</td>
<td>18 (39/218) 4.5 (1.7-12.0) **</td>
<td>3.2 (1.05-9.6) *</td>
</tr>
<tr>
<td><strong>Other support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No (ref.)</td>
<td>17 (36/218) 1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Yes</td>
<td>83 (182/218) 2.5 (0.9-7.3)</td>
<td>2.5 (0.7-9.2)</td>
</tr>
<tr>
<td><strong>Depressive mood</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (ref.)</td>
<td>54 (117/218) 1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>No</td>
<td>46 (101/218) 1.3 (0.7-2.5)</td>
<td>1.8 (0.8-3.7)</td>
</tr>
</tbody>
</table>

* Statistically significant difference at the 5% level
** Statistically significant difference at the 1% level
† Point prevalence abstinence = not smoked at all in the seven days prior to follow-up. Continuous abstinence = not smoked at all in the 6 months (≥183 days) prior to follow-up.
Asked to participate 363

- Declined 63

Included/ randomized 300

- Drop out 6

Study population 294

HTI 146 (50 %)
- Completed the program 103 (71 %)
- Completed follow-up 97 (94 %)
  smoke-free 36 % (35/97)
- Non-responders 6 (6 %)

LTI 148 (50 %)
- Did not complete the program 43 (29 %)
- Completed a 3-questions’ drop out questionnaire 34 (79 %)
  smoke-free 0 %
- Completed follow-up 121 (82%)
  smoke-free 20 % (24/121)
- Non-responders 27 (18 %)

Non-responders 27 (18 %)
(ALLTSÅ:

<table>
<thead>
<tr>
<th></th>
<th>HTI</th>
<th>LTI</th>
<th>S:a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fullst uppf</td>
<td>97</td>
<td>121</td>
<td>218</td>
</tr>
<tr>
<td>3-frågors uppf</td>
<td>34</td>
<td>0</td>
<td>34</td>
</tr>
<tr>
<td>Totalt uppf av rökvanor och SOC</td>
<td>131</td>
<td>121</td>
<td>252</td>
</tr>
</tbody>
</table>