PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Implementing referral to an electronic alcohol brief advice website in primary health care: results from the ODHIN implementation trial
AUTHORS	Bendtsen, Preben; Mussener, Ulrika; Karlsson, Nadine; Lopez-Pelayo, Hugo; Palacio-Vieria, Jorge; Colom, Joan; Gual, Antoni; Reynolds, Jillian; Wallace, Paul; Segura, Lidia; Anderson, Peter

VERSION 1 - REVIEW

REVIEWER	Sion Kim Harris Boston Children's Hospital, Harvard Medical School, USA
REVIEW RETURNED	14-Nov-2015

GENERAL COMMENTS	This large multi-national study evaluating implementation in real-world practice settings of hazardous alcohol use screening and clinician brief advice in the presence or absence of an option to refer patients to an online alcohol brief intervention tool is an important addition to the field, as there are few such studies to date. This manuscript has some areas for improvement, however, which are offered below: Some general comments: 1) There were some aspects of the Study Method that were not well elucidated. Specifically, the following information would be helpful to include: a. What were the eligibility criteria for patients and visits for this study? That is, what was the denominator for "percent screened among those eligible for screening?" Were only patients coming in for an annual physical included or were these ALL patients seen (including those seen for urgent or sick visits) during the time period? Please clarify. This distinction is important. Clinicians may feel more reluctant to conduct an alcohol screen when a patient has come in seeking care for influenza or back pain. b. How were the participating providers trained or oriented to this study? Were they given any information about the evidence base for the effectiveness of screening and brief intervention for alcohol use? Were they given specific language for introducing the e-BI to their patients? When were providers asked to familiarize

themselves with the e-BI material? Were the providers assigned to the e-BI conditions shown any of the e-BI during an orientation meeting? This information about how the providers were set up for the study is an important aspect of the study protocol.

c. Were any demographic data collected on patient and provider participants? There is no demographic description of either the provider or patient sample in the manuscript. As the authors indicate in the Discussion, the age of provider or patient may be an important predictor of acceptability and use of the e-BI intervention, and if such data were available, it would be important to include in the manuscript. If these data were not collected, please indicate this in the Methods.s

d. A bit more detail about what constituted "brief advice" would be helpful, if available. The authors state that providers "were asked to deliver brief alcohol advice to screen positives, with the length and format of the advice based on country-specific guidelines or existing routines." Since the mean time for delivering face-to-face advice was 7.0 minutes, this indicates to me that the "advice" involved more than simply recommending that a patient stop or cut down their use (which would have taken much less time). Were providers doing brief negotiated interviews, utilizing some motivational enhancement techniques? There is some variation in the field in how "brief advice" and "brief intervention" are used and defined. Therefore, it would be helpful for the authors to be more specific about what "brief advice" in this study entailed. Also, on page 5, line 81, the authors refer to "electronic brief advice websites (eBI)" and, again, I think it is confusing to interchange "brief advice" and "brief intervention" since each has specific connotations. My recommendation is to, in this instance, say "brief intervention" rather than "brief advice."

2) The Results seem incomplete. Specifically, the study design involved randomizing providers to e-BI arms vs. no e-BI arms. In addition, a baseline pre-implementation period was compared to the implementation period. It appears that the authors choose to present results at times comparing the baseline to the implementation period WITHIN the e-BI group, while at other times they present the results comparing the e-BI vs. no e-BI groups (e.g., Table 2). It is not clear to me why the authors choose to present both of these different types of comparisons at some times and not at others. For example, the Results regarding change in screening and brief advice rate in the presence of the e-BI option vs. no-e-BI could be examined both by comparing the e-BI vs. no-e-BI arms and by comparing the no-e-BI baseline period and the e-BI implementation period within the e-BI arms. Both sets of results are shown in Table 2, but only the baseline/implementation period comparison is described in the Results text. It seems to me that the authors

could choose to focus solely on the within-provider baseline/implementation comparison in their paper, in which case they should drop the "Without e-BI option" data from Table 2 (since they do not describe these results in the text), or they describe the results comparing the "without e-BI option" and "with e-BI options" in the text.

Specific comments:

Abstract:

1) Line 29: Add the word "which" before "60".
2) Primary outcome: Clarify that the "baseline" is actually a "baseline 4-week pre-implementation period."
3) Line 47: I recommend dropping the words "perhaps mistrust" since this is not a finding that they could derive from their study (which is what should be reported in a Results section) – it is conjecture about why providers did not refer more people to the e-BI.
4) Line 50: I recommend including the range of the mean proportion of log-ons (i.e., 0.58% to 36.95%) across the different countries, not just the overall proportion of 18%.

Participant and Methods:

1) Line 193-4: The last part of the sentence "and the proportion of screen positive patients referred to e-BI" seems redundant with the previous part of the sentence of line 191 ("the proportion of screen positive patients who were offered brief advice in any of the following formats:… referral to e-BI").
2) Line 235: This sentence is awkward. Were the authors trying to say that the models were analyzed with patient as a random effect variable?
3) Lines 236-240: The authors describe testing for interaction effects between the training and support (TS), financial reimbursement (FR), TS+FR. and e-BI. However, I was unable to find any information in the Results section describing the results of these analyses.
4) Also, it is mentioned that staff were asked to complete a questionnaire about their attitudes towards dealing with heavy drinkers. However, the authors do not mention any results from this questionnaire. Perhaps there may be differences in attitudes across providers that could help to explain the variability in screening and BI rates across countries?
5) Line 221: "spend" should be "spent"

Results:

1) Lines 279-281: The statistics described in the text are redundant of those shown in Table 1, and could be dropped from the text.
2) Table 2: It seems to me that Poland experienced a significant increase in proportion screened from baseline to implementation in the "Without e-BI" group since the 95% confidence intervals do not overlap (0.5-6.2 vs. 14.3-34.4). However, this different is not marked with an asterisk to indicate a significant difference.
3) Line 335: I think the word "majority" should be "minority."
4) In the Methods, the authors state that "Providers were advised that referral should consist of taking a few minutes to encourage

	screen-positive patients to log on to the designated eBI package." It seems to me that providers could interpret spending these few minutes encouraging patients to log-on to the e-BI site as part of the face-to-face advice which is why we would tend to find the rates of face-to-face advice always HIGHER than rates of referral to e-BI, and the proportions receiving ONLY a referral to BI to generally be quite low (as is the case in all countries except Poland). This point could be made in the Discussion. 5) Could oral advice ENHANCE motivation to use the e-BI? Did the authors examine the rates of accessing e-BI among patients that received face-to-face advice vs. did not? Discussion: Line 446: "in average" should be "on average" and "spend" should be "spent" Line 463: "grater" should be "greater"

REVIEWER	Nick Heather Emeritus Professor of Alcohol & Other Drug Studies, Northumbria University, UK. None declared. I know several of the authors well in a professional capacity but I do not believe that this represents a conflict of interest.
REVIEW RETURNED	01-Apr-2016

GENERAL COMMENTS	This paper analyses and reports data from the OHDIN project to answer the question whether offering the possibility of facilitated access to an electronic brief alcohol intervention (eBI), as an alternative to brief face-to-face intervention (BI), would increase the proportion of patients screened and given brief advice in general medical practice. For the reasons given by the authors in their Introduction, eBI provides an important potential solution to many of the problems encountered in implementing BI routinely in general practice and is, almost certainly, the way forward for widespread BI implementation. The findings of this study were mainly disappointing to those to those who recognise this potential but this is precisely what makes this paper a useful addition to the literature on eBI, i.e., in describing from an international perspective the difficulties that stand in the way of widespread use of facilitated eBI and suggesting ways in which such difficulties might be better understood and addressed in future research. Necessary revisions to the manuscript are relatively minor: 1) There are several grammatical errors and typos which should be corrected, e.g., p.3, lines 29-31; p.13, line 276; p.25, line 483. 2) Background: Readers may be interested to know the investigators' reason for offering providers the option of using facilitated eBI or face-to-face- BI rather than obtaining their agreement to refer all patients in the eBI conditions to eBI. The latter might be argued to be a stronger, more informative design. What was the thinking behind this decision?

	3) p.10, lines 189-104: "The tally sheet .....: oral advice, handing out an informative leaflet about sensible drinking, referral for oral advice by other staff, or referral to eBI, and the proportion of screen positive patients referred to eBI." What is the difference between the last two categories? Unclear. 4) p.21, lines 390-394: "this proportion increased to 40% among those who referred at least one patient (51% of the 392 providers), indicating that those who were familiar with the eBI package were more likely to recommend its use." Or it could be the other way round, i.e., those who recommended eBI were more likely to make themselves familiar with it. No causal relationship should be implied here. 'Suggesting' would be better than 'indicating'. 5) p.23, lines 428-429: We did not specify an obligatory revisit to the provider, which might have increased the adherence rate somewhat." It is not clear what 'obligatory' means in this context. 6) p.26, lines 519-521: Simulation studies on the effects of introducing an eBI on alcohol on a larger scale to a whole nation such as the Netherlands shows substantial cost effectiveness for the health care system." This points to the importance of organisational (top-down) factors as well as professional behaviour (bottom-up) factors in achieving implementation of eBI. The wider literature on BI makes clear that little will be achieved by relying solely on trying to persuade professionals to incorporate this work in their practice without the addition of organisational and structural changes that support or even mandate the use of BI. The same no doubt applies to eBI and this might feature more prominently in the discussion of findings. 7) Discussion: There is no speculation as to why the brief advice rate among those screening positive was higher in England. 8) Conclusions: This is too long; a Conclusions sections needs to be more succinct. Much of the text here could be transferred to the Discussion. 9) The paper as a whole is perhaps a bit too long and could beneit from being pruned.

VERSION 1 – AUTHOR RESPONSE

Response to reviewer 1

1) What were the eligibility criteria for patients and visits for this study? That is, what was the denominator for “percent screened among those eligible for screening?” Were only patients coming in for an annual physical included or were these ALL patients seen (including those seen for urgent or sick visits) during the time period? Please clarify. This distinction is important. Clinicians may feel more reluctant to conduct an alcohol screen when a patient has come in seeking care for influenza or back pain.

Response: The eligibility criteria were ALL patients 18 years of age or older that attended the PHCU for any reason and thus only annual physicals. This has been clarified on line 161

2) How were the participating providers trained or oriented to this study? Were they given any

information about the evidence base for the effectiveness of screening and brief intervention for alcohol use? Were they given specific language for introducing the e-BI to their patients? When were providers asked to familiarize themselves with the e-BI material? Were the providers assigned to the e-BI conditions shown any of the e-BI during an orientation meeting? This information about how the providers were set up for the study is an important aspect of the study protocol.

Response: Participants in all arms were given a 30-45 minutes introduction to brief alcohol intervention including the evidence base for the effectiveness of screening and brief advice. This has been clarified on line 151-152.

The participants in the eBI arm were trained in offering the eBi to the patient using a designated script in addition to handing over written information to the patient with a unique log in code for the individual patients. This has been clarified in line 177.

Response: The participants were asked to familiarize themselves with the eBI before starting to refer patients to the eBI. This has been clarified in line 178.

3) Were any demographic data collected on patient and provider participants? There is no demographic description of either the provider or patient sample in the manuscript. As the authors indicate in the Discussion, the age of provider or patient may be an important predictor of acceptability and use of the e-BI intervention, and if such data were available, it would be important to include in the manuscript. If these data were not collected, please indicate this in the Methods

Response: No demographic data was collected concerning the patients.This is clarified on line 183 in the methods section.

Demographic description of the providers has been added in line 162-166:
Providers in PHCUs allocated to referral to eBI (alone or in combination) had a mean age of 47.1 years (SD=9.4; range 24-67 years) and 76% were women. The mean age of the providers was lowest for the Netherlands (44,1 years) and highest for Poland (48.9 years). sThe proportion of women varied from 68% in The Netherlands to 90 % in Sweden.

4) A bit more detail about what constituted “brief advice” would be helpful, if available. The authors state that providers “were asked to deliver brief alcohol advice to screen positives, with the length and format of the advice based on country-specific guidelines or existing routines.” Since the mean time for delivering face-to-face advice was 7.0 minutes, this indicates to me that the “advice” involved more than simply recommending that a patient stop or cut down their use (which would have taken much less time). Were providers doing brief negotiated interviews, utilizing some motivational enhancement techniques? There is some variation in the field in how “brief advice” and “brief intervention” are used and defined. Therefore, it would be helpful for the authors to be more specific about what “brief advice” in this study entailed. Also, on page 5, line 81, the authors refer to “electronic brief advice websites (eBI)” and, again, I think it is confusing to interchange “brief advice” and “brief intervention” since each has specific connotations. My recommendation is to, in this instance, say “brief intervention” rather than “brief advice.”

Response: Thank you for this comment. The research group (about 25 researchers) consist of very experienced and leading alcohol intervention researchers in Europe. So naturally the group has discussed extensively if brief advice or brief intervention should be used. Since we did not expect the talk about alcohol would be very long and therefore probably not be including any particular motivating or negotiating elements we decided to use the term brief advice throughout this paper and other papers published from the ODHIN study.The reasons for expecting fairly short talks about alcohol was that we requested the staff to ask all patients about drinking habits as part of a visit for

other reasons. So, we prefer to stick to the term brief advice.

5) The Results seem incomplete. Specifically, the study design involved randomizing providers to e-BI arms vs. no e-BI arms. In addition, a baseline pre-implementation period was compared to the implementation period. It appears that the authors choose to present results at times comparing the baseline to the implementation period WITHIN the e-BI group, while at other times they present the results comparing the e-BI vs. no e-BI groups (e.g., Table 2). It is not clear to me why the authors choose to present both of these different types of comparisons at some times and not at others. For example, the Results regarding change in screening and brief advice rate in the presence of the e-BI option vs. no-e-BI could be examined both by comparing the e-BI vs. no-e-BI arms and by comparing the no-e-BI baseline period and the e-BI implementation period within the e-BI arms. Both sets of results are shown in Table 2, but only the baseline/implementation period comparison is described in the Results text. It seems to me that the authors could choose to focus solely on the within-provider baseline/implementation comparison in their paper, in which case they should drop the "Without e-BI option" data from Table 2 (since they do not describe these results in the text), or they describe the results comparing the "without e-BI option" and "with e-BI options" in the text.

Response: Thank you for this comment. However, we prefer to leave the table as it is, because the design and statistical tests are testing for differences in the implementation proportions screened and advised between those with, as opposed to those without the factor (eBI), controlling for the baseline rates. Thus the test takes into account the situation where the proportion for the without eBI option may go down between baseline and implementation and the proportion for the with eBI option may go up between baseline and implementation. And, thus when presenting the results, we only report the impact of eBI.

6) Line 29: Add the word "which" before "60".
Response: We have changed the phrasing (in line 30) to: Sixty primary care units….

7) Clarify that the "baseline" is actually a "baseline 4-week pre-implementation period."

Response: This has been added in line 39-40

8) Line 47: I recommend dropping the words "perhaps mistrust" since this is not a finding that they could derive from their study (which is what should be reported in a Results section) – it is conjecture about why providers did not refer more people to the e-BI.

Response: We agree that this is speculative and has deleted the words as suggested in line 46.

9) Line 50: I recommend including the range of the mean proportion of log-ons (i.e., 0.58% to 36.95%) across the different countries, not just the overall proportion of 18%.

Response: This has been added as suggested in line 49-50

10) Participant and Methods: Line 193-4: The last part of the sentence "and the proportion of screen positive patients referred to e-BI" seems redundant with the previous part of the sentence of line 191 ("the proportion of screen positive patients who were offered brief advice in any of the following formats:… referral to e-BI").

Response: Thank you for pointing out this. The sentence "and the proportion of screen positive patients referred to e-BI" has been deleted since this was already explained in the previous sentence.

11) Line 235: This sentence is awkward: “Because of the hierarchical structure of the data (provider within PHCU within jurisdiction), models were analysed with random variable subject (jurisdiction×PHCU)”. Were the authors trying to say that the models were analysed with patient as a random effect variable?

Response: We have revised the text in line 264-266 to: Because of the hierarchical structure of the data (provider within PHCU within jurisdiction), models were analysed with PHCU nested within country as random effect variables.

12) Lines 236-240: The authors describe testing for interaction effects between the training and support (TS), financial reimbursement (FR), TS+FR. and e-BI; “Evidence for interactions between TS, FR and e-BI was investigated. There was an interaction between FR and eBI for screening rates and the interaction term FR×eBI was entered in the models. There was an interaction between TS, FR and eBI for brief advice rates and the interaction term TS×FR×eBI was entered in the models”. However, I was unable to find any information in the Results section describing the results of these analyses.

Response: Because of the factorial design, we need to test for interactions and include them in the model, so as to adjust the final impact of the factor (in this case eBI). As we are only examining and reporting on the factor eBI, it is our opinion that it is not necessary to report on the interactions, only to state that they were tested and included in the model.

13) Also, it is mentioned that staff were asked to complete a questionnaire about their attitudes towards dealing with heavy drinkers. However, the authors do not mention any results from this questionnaire. Perhaps there may be differences in attitudes across providers that could help to explain the variability in screening and BI rates across countries?

Response: This is a valid point but we do not think that we have the power to do the suggested analysis in this paper. Also, we have previously published a paper from the ODHIN baseline survey analysing the correlation between attitudes and screening and brief advice rates. This study showed a weak relationship between role security/therapeutic commitment and screening and brief advice rates.
Ref:
Professional's Attitudes Do Not Influence Screening and Brief Interventions Rates for Hazardous and Harmful Drinkers: Results from ODHIN Study. Bendtsen P, Anderson P, Wojnar M, Newbury-Birch D, Müssener U, Colom J, Karlsson N, Brzózka K, Spak F, Deluca P, Drummond C, Kaner E, Kłoda K, Mierzecki A, Okulicz-Kozaryn K, Parkinson K, Reynolds J, Ronda G, Segura L, Palacio J, Baena B, Slodownik L, van Steenkiste B, Wolstenholme A, Wallace P, Keurhorst MN, Laurant MG, Gual A. Alcohol Alcohol. 2015 Jul;50(4):430-7

14) Line 221: “spend” should be “spent”
Response: This has been changed accordingly in line 248

15) Results, Lines 279-281: The statistics described in the text are redundant of those shown in Table 1, and could be dropped from the text.
Response: The statistics has been deleted in the text as suggested.

16) Table 2: It seems to me that Poland experienced a significant increase in proportion screened from baseline to implementation in the “Without e-BI” group since the 95% confidence intervals do not overlap (0.5-6.2 vs. 14.3-34.4). However, this different is not marked with an asterisk to indicate a significant difference.
The design and statistical tests are testing for differences in the implementation proportions screened

and advised between those with, as opposed to those without the factor (eBI), controlling for the baseline rates. Thus the test takes into account the situation where the proportion for the without eBI option may go down between baseline and implementation and the proportion for the with eBI option may go up between baseline and implementation. And, thus when presenting the results, we only report the impact of eBI

17) Line 335: I think the word “majority” should be “minority.”
Response: Thank you for pointing this out. Has been changed to minority in line 391

18) In the Methods, the authors state that “Providers were advised that referral should consist of taking a few minutes to encourage screen-positive patients to log on to the designated eBI package.” It seems to me that providers could interpret spending these few minutes encouraging patients to log-on to the e-BI site as part of the face-to-face advice which is why we would tend to find the rates of face-to-face advice always HIGHER than rates of referral to e-BI, and the proportions receiving ONLY a referral to BI to generally be quite low (as is the case in all countries except Poland). This point could be made in the Discussion.

Response: We agree and have added the following in line 502-505 in the discussion.
”However, we asked staff to take a few minutes to encourage and motivate patients to log-on to the eBI so the latter is highly probable. This is also supported by a somewhat higher log on rate to the eBI among those who received both oral advice and eBI (log on rate on 22% versus 17%).”

19) Could oral advice ENHANCE motivation to use the e-BI? Did the authors examine the rates of accessing e-BI among patients that received face-to-face advice vs. did not?

Response: This is a valid suggestion and we have added the following analysis in line 383:

“The log on rate was somewhat higher among these patients (22.0%; CI 18.5%, 25.5%) compared with those only being referred to the eBI (16.9%; CI 13.2%, 20.6%)”.

20) Discussion:Line 446: “in average” should be “on average” and “spend” should be “spent”

Response: Thank you for pointing this out. Has been changed – and the manuscript has been rechecked by a native speaking professional copyeditor

21) Line 463: “grater” should be “greater”
Response: Thank you for pointing this out. Has been changed in line 531– and the manuscript has been rechecked by a native English-speaking copyeditor

Response to reviewer 2

1) There are several grammatical errors and typos which should be corrected, e.g., p.3, lines 29-31; p.13, line 276; p.25, line 483.

Response: Thank you for pointing out these errors which has been corrected accordingly. Also the whole manuscript has been edited by a native English-speaking copyeditor

2) Background: Readers may be interested to know the investigators' reason for offering providers the option of using facilitated eBI or face-to-face- BI rather than obtaining their agreement to refer all

patients in the eBI conditions to eBI. The latter might be argued to be a stronger, more informative design. What was the thinking behind this decision?

Response: Thank you for this very relevant questions. This was discussed intensively by the whole study group (consisting of about 25 researchers) during the preparation phase of the study. In the end a consensus was reached that meant that we agreed that it was deemed more feasible to use eBay as an add on instead of as the only option in the eBi study arm. Still, I agree that the design suggested would have been more informative.

3) p.10, lines 189-104: "The tally sheet .....: oral advice, handing out an informative leaflet about sensible drinking, referral for oral advice by other staff, or referral to eBI, and the proportion of screen positive patients referred to eBI." What is the difference between the last two categories? Unclear.

Response: The sentence “and the proportion of screen positive patients referred to e-BI”
has been deleted

4) p.21, lines 390-394: "this proportion increased to 40% among those who referred at least one patient (51% of the 392 providers), indicating that those who were familiar with the eBI package were more likely to recommend its use." Or it could be the other way round, i.e., those who recommended eBI were more likely to make themselves familiar with it. No causal relationship should be implied here. 'Suggesting' would be better than 'indicating'.

Response:We agree with this comment and has changed accordingly.

5) p.23, lines 428-429: We did not specify an obligatory revisit to the provider, which might have increased the adherence rate somewhat." It is not clear what 'obligatory' means in this context.

Response: We meant that the project did not make it mandatory as part of the project to schedule a follow-up visit. Obligatory has been changed to mandatory in line 482.

6) p.26, lines 519-521: Simulation studies on the effects of introducing an eBI on alcohol on a larger scale to a whole nation such as the Netherlands shows substantial cost effectiveness for the health care system." This points to the importance of organisational (top-down) factors as well as professional behaviour (bottom-up) factors in achieving implementation of eBI. The wider literature on BI makes clear that little will be achieved by relying solely on trying to persuade professionals to incorporate this work in their practice without the addition of organisational and structural changes that support or even mandate the use of BI. The same no doubt applies to eBI and this might feature more prominently in the discussion of findings.

Response: We fully agree on this and has added the following on line 502-505:

”However adding a new tool such as referrals to eBI will probably not be enough to incorporate more alcohol preventive measures in primary health care without additional organisational and structural changes to support the use of eBI”.

7) Discussion: There is no speculation as to why the brief advice rate among those screening positive was higher in England.

With the exception of Poland (where the baseline rate was very high to begin with), the BA rate increased in all countries - it just so happens that this reached statistical significance in England -

8) Conclusions: This is too long; a Conclusions sections needs to be more succinct. Much of the text here could be transferred to the Discussion.

Response: We agree on this and have deledet the second and third paragraph in the conclusion and moved the last paragraph to the discussion section. and will do the changes later

9) The paper as a whole is perhaps a bit too long and could benefit from being pruned
Response: We have shortened the conclusion as indicated above making the article a bit shorter.

This ends the response to reviewers comments.

VERSION 2 – REVIEW

REVIEWER	Sion Kim Harris Boston Children's Hospital Harvard Medical School Boston, Massachusetts, USA
REVIEW RETURNED	24-May-2016

GENERAL COMMENTS	Reviewers' comments have been adequately addressed, although this was difficult to determine since the line numbers that the authors refer to in their response letter did not match up with where the edits actually were in the manuscript. It took some time to find the accurate places in the text. The one minor edit that I still recommend is on line 77 on page 5 of the revised manuscript. The sentence reads "As access to the Internet has increased, electronic brief advice websites (eBI)..." My comment that this should really read "...electronic brief intervention websites (eBI)..." was not addressed in the authors' response. I agree with the authors about the distinction between brief advice and brief intervention and what the clinicians in their study were providing was brief advice. It seems to me this is all the more reason to be distinguish eBI as a brief intervention, not brief advice.

REVIEWER	Nick Heather Northumbria University,UK
REVIEW RETURNED	18-May-2016

GENERAL COMMENTS	The authors have responded satisfactorily to my criticisms of the previous version of this paper.