PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Exploring general practitioners' views and experiences on suicide risk assessment and management of young people in primary care: a qualitative study in the UK
AUTHORS	Michail, Maria; Tait, Lynda

VERSION 1 - REVIEW

REVIEWER	Annette Sofie Davidsen The Research Unit for General Practice and Section of General Practice Institute of Public Health University of Copenhagen Denmark
REVIEW RETURNED	30-Aug-2015

GENERAL COMMENTS	Thank you for inviting me to review this paper which explores GPs' views on suicide risk assessment in young people. This is a relevant topic which needs investigation because it is known that GPs are not sufficiently skilled in detecting suicide ideation and suicide risk in their patients, including young people. The authors have explored GPs' views on this topic and the GPs' proposals for improving the situation through further education and training. The authors have done that by carrying out focus group interviews with 28 GPs and they have analysed the data material using Framework Analysis. They have then reported the findings in an article where they describe six themes and add quotes related to these themes in six tables. I think that the form and structure of the article could be improved considerably. The article is much too long (about 5.650 words plus six long tables with quotes), exceeding the proposed limit of the journal. However, the length combined with the structure also makes the article appear much as a listing and descriptive reporting rather than as an in-depth analysis and a narrative which tells about interesting findings. It appears more as a report than as a journal article. The result section starts with listing the themes and then these themes are reported on through eight pages without illustrating quotes inserted into the text and with much overlap between themes and much repetition. I think that the article must be re-written. The language must be slimmed down and made more interesting and meaningful. The quotes must be incorporated in the text to illustrate the individual arguments. Moreover, the background section should include reflections and literature on the link between self-harm and suicide and that different diagnoses that can lead to suicide, which is not only depression. There could also be a differentiation between suicidal thoughts and suicidal. Screening is mentioned but not reflected on in relation to the primary care setting, either in the background or in the discussion. In the last part of the background section it is said that

	‘education …could enhance GP knowledge’. We do not know that yet, and the authors must be more cautions. There is research showing that traditional education of GPs in mental disorders does not have effect on their treatment of patients. The aim of the article is two-fold, which does not appear from the title. The method could have been explained more thoroughly. It is not made clear how the focus groups were arranged. Did they consist of GPs who were in the same practice, and who knew each other? Was this the reason why the GP from the single-handed practice was interviewed individually? Were these GPs especially interested in mental disorders? The focus groups were rather short (45 minutes) not leaving time for a more thorough discussion. It is not described how the group discussions were initiated, and how many GPs there were in each group. In addition, some of the method is described in the beginning of the result section but should be incorporated in the method section. As mentioned the result section could be described in a less listing manner and without having a list of the themes in the beginning. The themes could be mentioned shortly at the end of the method section and the result section could start with a short overall description of the findings before going more deeply into the themes which should not be mentioned as such, but appear from the headings. The result section should have a more narrative form, and it could be shortened considerably by removing redundant material – and inserting illustrating quotes. This would make the results appear much clearer and more meaningful. Less would be more. The discussion also contains much redundant and superfluous material but it also lacks some important points. If the result section was made clearer the repetition of findings could be made much shorter. There is also redundant material in the strengths and limitations paragraph. It is mentioned that the in-depth interview verified the data from the focus groups. I only think the authors can say that this interview revealed the same themes. It should also be discussed how the focus groups were formed (from the same practice?) and it this possibly influenced the results. There is much praise of own study which in my opinion is too much and could be toned down. What I lack in the discussion is a reflection of what these GPs describe as their attitudes and needs in relation to the problem they have to address and a further discussion in relation to relevant literature. The discussion could have been lifted to a higher level. When GPs say that the young people are difficult to communicate with this is seen as a fault in the young people. But there is no mention of that it is the GP who is the professional and who has the responsibility for making the communication professional. These young people are seen as attention seeking, but this is rooted in a psychic pain which it is the GP’s duty to reveal. Possibly the organization of general practice does not support a deeper exploration of mental problems, and it could have been discussed which changes in primary care organization are needed to reach a solution (change of structure and reimbursement system, do we have the right quality indicators, collaborative care?). It seems that the proposal for an educational approach is seen very much as training micro-skills for separate problems more than training an overall therapeutic attitude and the GPs’ ability to understand patients’ thoughts, feelings, and needs and so on, and maintaining the focus on possibilities for improving the doctor-patient relationship. The conclusion section is kept in very general terms and should inform more about the specific conclusion of this study.

	In addition, I have some minor comments. In the abstract the GPs' average years of professional experience is said to be 'XX', and the information is not found in the method section. The result section in the abstract could be more descriptive. As it is now it is simply a listing of the themes. The Article Summary is not very informative. The language is ambiguous in many places with doubt about what a pronoun is referring to. In several places there are adjectives in the comparative form without the comparison being mentioned. The description of the Framework Analysis (p. 4) shifts between the third and the first person. These bullet points could also be shortened. It is said that GPs' negative attitudes towards young suicidal people are confirmed by previous findings (p. 13) but without mentioning any references. In conclusion I think that this article must undergo a major revision and be re-written to become publishable.

REVIEWER	Coralie Wilson University of Wollongong, Australia
REVIEW RETURNED	14-Sep-2015

GENERAL COMMENTS	The study examined GP views of working with suicidal young people in primary care. The script is clear and well written – thank you. Article summary P2 Last point: it would be helpful if the authors could comment on any cultural influence that might have resulted from convenience sampling Background P3 Ln14: add "often" after "GPs are…". The sentence currently reads as an absolute and this is not the case P3 Ln 44-47: Clarify the aims as primary and secondary Methods Study design P3 Ln 56: "convenience sampling" is stated but the process is not provided. The reader is not able to determine the extent to which bias might be present or the extent to which the study lends itself to generalizability beyond Nottingham City. P4 Ln 3: the study used COREQ guidelines but a completed checklist is not provided P4 Ln26-30: need to provide a copy of the topic guide. Need to provide a copy of the additional probes and prompts that were used. Focus groups took 45 minutes in a time-limited space and covered a lot of material – to what extent did "pressure to perform" rush input and impair the quality or depth of opinions given by the participating GPs? Results P11 Ln16: Is there a word missing from the first sentence of the paragraph? Conclusions P12 Ln25: The authors state that findings will inform the development of an educational intervention. Please follow this with a qualification of where the training will take place – Nottingham only?

	Because the level of bias in the sample is not clear, it is unclear whether such training will be relevant for locations other than Nottingham. P13 Ln57: The authors state that they have carried out “extensive” co-production. It is unclear where this has occurred – either cite the appropriate study or limit the language to reflect the small number of focus groups/interview that were conducted for this study.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1:
I think that the form and structure of the article could be improved considerably. The article is much too long (about 5.650 words plus six long tables with quotes), exceeding the proposed limit of the journal. However, the length combined with the structure also makes the article appear much as a listing and descriptive reporting rather than as an in-depth analysis and a narrative which tells about interesting findings. It appears more as a report than as a journal article. The result section starts with listing the themes and then these themes are reported on through eight pages without illustrating quotes inserted into the text and with much overlap between themes and much repetition. I think that the article must be re-written. The language must be slimmed down and made more interesting and meaningful. The quotes must be incorporated in the text to illustrate the individual arguments.

Thank you for the constructive feedback about improving the structure of the manuscript. The results section has been re-written in a more narrative fashion with themes emerging from the data supported by illustrative quotes taken from the transcripts. Quotes now appear in the text as opposed to tables.

Moreover, the background section should include reflections and literature on the link between self-harm and suicide and that different diagnoses that can lead to suicide, which is not only depression. There could also be a differentiation between suicidal thoughts and suicidal. Screening is mentioned but not reflected on in relation to the primary care setting, either in the background or in the discussion. In the last part of the background section it is said that ‘education …could enhance GP knowledge’. We do not know that yet, and the authors must be more cautions. There is research showing that traditional education of GPs in mental disorders does not have effect on their treatment of patients.

The background section has now been amended to include further information on the link between suicide and self-harm along with very recent evidence (Fox et al, 2015) on the role of GPs in identifying young people who self-harm (page 3).
The sentence (page 3) “education…could enhance GP knowledge” has been amended to “education could have the potential to enhance GP knowledge”, following the reviewer’s comment about showing caution.

The aim of the article is two-fold, which does not appear from the title.

The aim of the article has been amended – page 3.

The method could have been explained more thoroughly. It is not made clear how the focus groups were arranged. Did they consist of GPs who were in the same practice, and who knew each other? Was this the reason why the GP from the single-handed practice was interviewed individually? Were these GPs especially interested in mental disorders? The focus groups were rather short (45 minutes) not leaving time for a more thorough discussion. It is not described how the group discussions were initiated, and how many GPs there were in each group. In addition, some of the method is described in the beginning of the result section but should be incorporated in the method section.

The methods section has been amended to clarify how the focus groups were arranged and how they were conducted. It is now clarified how group discussions were initiated. We acknowledge that focus groups were short in duration (45 minutes) which might have influenced the depth of discussion and interaction among participants. We reflect on this in the discussion section (page 11).

As mentioned the result section could be described in a less listing manner and without having a list of the themes in the beginning. The themes could be mentioned shortly at the end of the method section and the result section could start with a short overall description of the findings before going more deeply into the themes which should not be mentioned as such, but appear from the headings. The result section should have a more narrative form, and it could be shortened considerably by removing redundant material – and inserting illustrating quotes. This would make the results appear much clearer and more meaningful. Less would be more.

The results section has been significantly amended following the reviewer's comments. We present each of the six themes supported by illustrative quotations, which are incorporated in the text.

The discussion also contains much redundant and superfluous material but it also lacks some important points. If the result section was made clearer the repetition of findings could be made much shorter. There is also redundant material in the strengths and limitations paragraph. It is mentioned that the in-depth interview verified the data from the focus groups. I only think the authors can say that this interview revealed the same themes. It should also be discussed how the focus groups were formed (from the same practice?) and it this possibly influenced the results. There is much praise of own study which in my opinion is too much and could be toned down.

We have re-written the discussion section which now provides a more critical reflection of the findings (e.g. how GPs understand and operationalise risk and the impact of this on the assessment of and attitudes towards young suicidal people) followed by implications for practice and the strengths and limitations of the study. We reflect on the arrangement and duration of the focus groups and how these might have influenced the findings.
The sentence "The in-depth interview verified the data from the focus group" has been amended to "The data obtained from the in-depth interview revealed the same themes as the data obtained from the focus groups".

What I lack in the discussion is a reflection of what these GPs describe as their attitudes and needs in relation to the problem they have to address and a further discussion in relation to relevant literature. The discussion could have been lifted to a higher level. When GPs say that the young people are difficult to communicate with this is seen as a fault in the young people. But there is no mention of that it is the GP who is the professional and who has the responsibility for making the communication professional. These young people are seen as attention seeking, but this is rooted in a psychic pain which it is the GP's duty to reveal. Possibly the organization of general practice does not support a deeper exploration of mental problems, and it could have been discussed which changes in primary care organization are needed to reach a solution (change of structure and reimbursement system, do we have the right quality indicators, collaborative care?). It seems that the proposal for an educational approach is seen very much as training micro-skills for separate problems more than training an overall therapeutic attitude and the GPs' ability to understand patients' thoughts, feelings, and needs and so on, and maintaining the focus on possibilities for improving the doctor-patient relationship.

We would like to thank the reviewer for her insightful comments about improving the discussion section. We have reflected on the findings in relation to the attitudes and beliefs of GPs towards young people and have considered how facilitating a shift in GPs' conceptualisation and assessment of risk along with changes in the organisation of primary care could improve communication between GPs and young people and help bridge some of the barriers identified by the present study in relation

to how GPs view suicide and young suicidal people.
We have also argued for the use of a psychosocial needs based assessment for young people in primary care and have provided examples of good practice (page 10).

The conclusion section is kept in very general terms and should inform more about the specific conclusion of this study.
The conclusion section now offers insights specific to this study.

In addition, I have some minor comments. In the abstract the GPs' average years of professional experience is said to be 'XX', and the information is not found in the method section. The result section in the abstract could be more descriptive. As it is now it is simply a listing of the themes. The Article Summary is not very informative.

We apologise for this minor error. The median number of years of GPs' professional experience is now presented in the abstract and the methods section. We have now presented the results section of the abstract in a more narrative form. The Article Summary has been amended to provide clearer information about the strengths and limitations of the study.

The language is ambiguous in many places with doubt about what a pronoun is referring to. In several places there are adjectives in the comparative form without the comparison being mentioned.

We have proof-read and edited the manuscript accordingly.

The description of the Framework Analysis (p. 4) shifts between the third and the first person. These bullet points could also be shortened.
The section on Framework Analysis has been shortened and it is now presented more succinctly.

It is said that GPs' negative attitudes towards young suicidal people are confirmed by previous findings (p. 13) but without mentioning any references.
References to support this are now presented (page 10).

In conclusion I think that this article must undergo a major revision and be re-written to become publishable.
We have undertaken significant revisions to the manuscript following the reviewers' comments and we trust that the paper is now publishable.

Reviewer: 2
Article summary P2
Last point: it would be helpful if the authors could comment on any cultural influence that might have resulted from convenience sampling.

We do not believe that the issue of probabilistic generalisations to a population is relevant to qualitative research as it is to quantitative research. We refer to Popay et al. (1998) on the subject of generalizability, who emphasized that, '…the aim is to make logical generalizations to theoretical understanding of a similar class of phenomena rather than probabilistic generalizations to a population''. Horsburgh (2003) also highlights that demographic representativeness of the sample is not relevant to qualitative research.
We have clarified however how convenience sampling based on accessibility; interest in the study and willingness to participate could have influenced our findings. We have reflected on this in the Discussion section under "Strengths and limitations" (page 11).

Background

P3 Ln14: add “often” after “GPs are…”. The sentence currently reads as an absolute and this is not the case.
We have corrected this sentence to “GPs are often the first point of contact for people in distress….”.

P3 Ln 44-47: Clarify the aims as primary and secondary
The aim of the study has now been clarified: “The aim of this study was to explore GPs’ views and experiences of assessing, communicating with, and managing suicidal young people aged 14-25 which would inform the development of an educational intervention for GPs on youth suicide prevention tailored to their perceived needs and feasible to be delivered in primary care.”

Methods
Study design
P3 Ln 56: “convenience sampling” is stated but the process is not provided. The reader is not able to determine the extent to which bias might be present or the extent to which the study lends itself to generalizability beyond Nottingham City.
We have clarified that convenience sampling for the recruitment of GPs was based on accessibility; interest in the study and willingness to participate. We have reflected on this in the Discussion section under “Strengths and limitations” (page 11).

P4 Ln 3: the study used COREQ guidelines but a completed checklist is not provided.
We have now provided a complete COREQ checklist (supplementary file A).

P4 Ln26-30: need to provide a copy of the topic guide. Need to provide a copy of the additional probes and prompts that were used. Focus groups took 45 minutes in a time-limited space and covered a lot of material – to what extent did “pressure to perform” rush input and impair the quality or depth of opinions given by the participating GPs?
We have now provided a copy of the topic guide including additional probes and prompts (Supplementary file B). We acknowledge that focus groups were short in duration (45 minutes), which might have affected the depth of discussion and interaction among participants. We reflect on this in the discussion section (page 11).

Results
P11 Ln16: Is there a word missing from the first sentence of the paragraph?
We apologise for this minor error. We have corrected this sentence: “For the successful delivery and implementation of the educational intervention, GPs emphasized the role of a professional who would have a thorough understanding of the role of GPs and with experience in conducting risk assessments.”

Conclusions
P12 Ln25: The authors state that findings will inform the development of an educational intervention. Please follow this with a qualification of where the training will take place – Nottingham only? Because the level of bias in the sample is not clear, it is unclear whether such training will be relevant for locations other than Nottingham.
We refer to our previous response to the issue of generalisability in qualitative research.

P13 Ln57: The authors state that they have carried out “extensive” co-production. It is unclear where this has occurred – either cite the appropriate study or limit the language to reflect the small number of focus groups/interview that were conducted for this study.
In addition to the GP focus groups, we have conducted qualitative interviews with young people with a history of attempted suicide to explore their views on GP service provision and ways we could improve this through the provision of specialist education and training to GPs. Data analysis is underway for this work.

References
Popay, J., Rogers, A., & Williams, G. (1998). "Rationale and standards for the systematic review of qualitative literature in health services research." Qualitative Health Research. 8(3), 341-351.
Horsburgh, D. Evaluation of qualitative research, Journal of Clinical Nursing 2003; 12: 307–312

VERSION 2 – REVIEW

REVIEWER	Annette Sofie Davidsen Research Unit for General Practice and Section of General Practice University of Copenhagen Denmark
REVIEW RETURNED	01-Nov-2015

GENERAL COMMENTS	I think that the authors have improved the article much by structuring it otherwise and inserting the quotes in relevant places in the result section. However, I think that the article still suffers from certain deficiencies, especially as regards the analysis which is somewhat superficial leading to the result section being rather descriptive and in addition with the different sub-sections reporting material which does not necessarily belong to the sub-heading. In the background section it is a prevailing thought that the problem is that the GPs lack specific education and training in managing suicidal behaviour in young people. This mirrors a view on education and training of GPs as a fragmented endeavour which should add specific skills in different fragmented areas and not an overall training of a more basic approach to understanding patients' emotional problems. It is known that GPs also have problems with revealing suicidal thoughts in adults and that they have problems with emotional talk altogether. It is now mentioned that the focus groups had on average seven members. This does not tell if some had few and others had several. The dynamic of focus groups differs depending on the number of participants. The result section contains six sections based on six themes. I still think that this result section is somewhat unstructured and that this has to do with the analysis being somewhat superficial. The result section could be strengthened by being shortened and more structured. As it is now there is much repetition and much overlap between the themes and content of the different sub-headings. The result section would gain from a being tightened through a reconsideration of the material leading to fewer themes. The first section 'Risk assessment – process and good practice' is actually about challenges: time constraints, organization, 'is this normal?', and communication problems. The next section is also about barriers (challenges): patient related, organizational, communication with crisis teams. In this section it is also mentioned that some GPs propose training and education, although this belongs to a special sub-heading later in the result section. Caregiver involvement could be both a barrier and a facilitator. The attitudes of GPs, which are rather negative and not expressing much emotional understanding, could have been described at the beginning of the result section. In the section with the last subheading 'Ways of addressing challenges..' there is much repetition and demand for specific training of specific skills to overcome the challenges of talking with young people and offering them brief psychological interventions.

	Perhaps this is rather a need for more general competencies in psychological interventions, not limited to a specific age group. The 'Educational approach' could have been described under a sub-heading in the previous section and could have been shortened. Altogether, and to avoid the repetition, I would prefer that the result section was shortened and more focused and that the headings were ordered otherwise like 1) attitudes, 2) barriers (challenges), 3) ways of addressing. The remaining themes could then be mentioned as sub-headings in these sub-sections. I still think that the discussion should be lifted to a higher level. It seems that GPs have communication problems in relation to these young patients and negative attitudes towards them. There is not much discussion of GPs' attitudes, which are known to influence the treatment of mental illness in adults. The discussion of risk is somewhat diffuse. It is correctly mentioned in implications for practice that the problem is changing GPs' attitudes. This is, however, not done by educational approaches, whereas the proposal of involving young people seems relevant and appropriate. The organizational barriers could also have been discussed in greater detail. Neither the organization of general practice with 10-minutes consultations nor the cooperation with crisis teams is a law of nature and these barriers are not overcome by education.

VERSION 2 – AUTHOR RESPONSE

Reviewer: I think that the authors have improved the article much by structuring it otherwise and inserting the quotes in relevant places in the result section. However, I think that the article still suffers from certain deficiencies, especially as regards the analysis which is somewhat superficial leading to the result section being rather descriptive and in addition with the different sub-sections reporting material which does not necessarily belong to the sub-heading. In the background section it is a prevailing thought that the problem is that the GPs lack specific education and training in managing suicidal behaviour in young people. This mirrors a view on education and training of GPs as a fragmented endeavour which should add specific skills in different fragmented areas and not an overall training of a more basic approach to understanding patients' emotional problems. It is known that GPs also have problems with revealing suicidal thoughts in adults and that they have problems with emotional talk altogether.

Response: The aim of this particular study was to explore GPs' views and experiences of assessing and managing suicide risk in young people aged 14-25. Research on GPs' skills to manage general emotional distress in young people already exists (Haller et al, 2009; Roberts et al, 2013) and confirms, in line with the reviewer, that managing emotional distress in young people is a professional challenge to GPs. This was also a finding of our study. We have therefore argued in the Discussion that any training to support GPs in the assessment and management of youth suicide risk should extend beyond the provision of micro-skills to enhancing GPs' competencies and capabilities in conducting a holistic, psychosocial needs based assessment in line with NICE recommendations (2012) to facilitate therapeutic engagement and communication with young people. This argument is based on the study findings and therefore presented in the Discussion rather than the Background.

Reviewer: It is now mentioned that the focus groups had on average seven members. This does not tell if some had few and others had several. The dynamic of focus groups differs depending on the number of participants.

Response: We have now clarified the exact number of GPs in each focus group (FG1=7; FG2=7;

FG3=7; FG4=6).

Reviewer: The result section contains six sections based on six themes. I still think that this result section is somewhat unstructured and that this has to do with the analysis being somewhat superficial. The result section could be strengthened by being shortened and more structured. As it is now there is much repetition and much overlap between the themes and content of the different sub-headings. The result section would gain from a being tightened through a reconsideration of the material leading to fewer themes. The first section 'Risk assessment – process and good practice' is actually about challenges: time constraints, organization, 'is this normal?', and communication problems. The next section is also about barriers (challenges): patient related, organizational, communication with crisis teams. In this section it is also mentioned that some GPs propose training and education, although this belongs to a special sub-heading later in the result section. Caregiver involvement could be both a barrier and a facilitator. The attitudes of GPs, which are rather negative and not expressing much emotional understanding, could have been described at the beginning of the result section. In the section with the last subheading 'Ways of addressing challenges..' there is much repetition and demand for specific training of specific skills to overcome the challenges of talking with young people and offering them brief psychological interventions. Perhaps this is rather a need for more general competencies in psychological interventions, not limited to a specific age group. The 'Educational approach' could have been described under a sub-heading in the previous section and could have been shortened. Altogether, and to avoid the repetition, I would prefer that the result section was shortened and more focused and that the headings were ordered otherwise like 1) attitudes, 2) barriers (challenges), 3) ways of addressing. The remaining themes could then be mentioned as sub-headings in these sub-sections.

Response: We agree with the reviewer that the results section would benefit from further re-structuring and editing yet we do not believe that this is a reflection of the analysis being superficial. In line with the reviewer's recommendations, we now have 3 main themes: 1) Challenges in the assessment and management of suicide risk in young people; 2) Attitudes and beliefs of GPs; 3) Ways of addressing challenges in the assessment and management of youth suicide risk in primary care. Each theme includes sub-themes supported by illustrative quotations from the transcripts.

Reviewer: I still think that the discussion should be lifted to a higher level. It seems that GPs have communication problems in relation to these young patients and negative attitudes towards them. There is not much discussion of GPs' attitudes, which are known to influence the treatment of mental illness in adults. The discussion of risk is somewhat diffuse. It is correctly mentioned in implications for practice that the problem is changing GPs' attitudes. This is, however, not done by educational approaches, whereas the proposal of involving young people seems relevant and appropriate. The organizational barriers could also have been discussed in greater detail. Neither the organization of general practice with 10-minutes consultations nor the cooperation with crisis teams is a law of nature and these barriers are not overcome by education.

Response: We thank the reviewer for these comments. Given space constraints stipulated by the journal, the Discussion was centred on those findings which offer an original contribution to the extant literature. We consider our findings in relation to GPs' understanding and operationalisation of risk and how this could have direct implications on the assessment and management of suicide risk and on GPs' attitudes towards at-risk young people to be of great importance; especially so as our study findings indicate that some GPs conceptualise and treat psychological problems in the same way as they would treat physical problems. What we are highlighting is the need to understand the processes that underlie GPs' negative attitudes and the extent to which such attitudes result from how GPs conceptualise risk. We argue that a narrowly focused identification of risk, which some GPs in our study supported, would not adequately capture the emotional, psychological and social mechanisms that underlie self-harm and other risk factors leading thus to misinterpretation of such behaviours as

attention seeking which could subsequently be treated with negativity and lack of compassion.
We do not agree with the reviewer's comment that changing GPs' attitudes is not done by educational approaches. Educational interventions in primary care, including one conducted by the authors (Tait et al, 2009; Lester et al, 2009), as well as in other settings (e.g. Chisholm et al, 2012) have invariably targeted attitudes either through the provision of knowledge and/or direct or extended/indirect contact, based on Allport's contact hypothesis.
We agree with the reviewer that some organisational barriers reported by GPs in this study such as time limited consultations cannot be addressed through an educational intervention. This was also pointed out by the reviewer in their original feedback "…and it could have been discussed which changes in primary care organization are needed to reach a solution (change of structure and reimbursement system, do we have the right quality indicators, collaborative care?)". In response to this, we have argued in the Discussion, that if any educational intervention is to be implemented effectively certain organisational changes need to take place e.g. reviewing existing quality indicators; promoting a collaborative model of care where young people are at the centre of the decisions made about their care.

VERSION 3 - REVIEW

REVIEWER	Annette Sofie Davidsen Research Unit for General Practice and Section of General Practice, University of Copenhagen Denmark
REVIEW RETURNED	07-Dec-2015

GENERAL COMMENTS	I think the article has improved considerably through the restructuring of the result section according to my suggestions. I just have a few remaining comments and proposals for minor changes: On page 5, lines 39-40: "GPs highlighted the importance of open communication and direct questioning about suicide as a way of facilitating disclosure and combating suicide-related stigma." This sentence is somewhat out of context as it is placed. I think the sentence should be moved and placed in the beginning of the paragraph starting with line 55, where the first part of the sentence could be deleted and then start with: 'However, some GPs faced…'. The paragraph starting with line 13 on page 10 should be reformulated in some places. It still contains rhetorical questions, which I think should be omitted and replaced with the authors' answers or reflections. I also think that the quotation "not knowing what to do with them" does not cover all the barriers/problems, which are mentioned, viz. organisational barriers, heavy workload and limited management options. And if the authors think that these barriers could result from how GPs conceptualise risk this must be explained in greater detail. As I read the article, the GPs' problems primarily have to do with difficulties with creating an alliance with and understanding these young patients. In addition, there are some organisational barriers.

VERSION 3 – AUTHOR RESPONSE

Reviewer: I think the article has improved considerably through the restructuring of the result section according to my suggestions. I just have a few remaining comments and proposals for minor changes. On page 5, lines 39-40: "GPs highlighted the importance of open communication and direct questioning about suicide as a way of facilitating disclosure and combating suicide-related stigma."

This sentence is somewhat out of context as it is placed. I think the sentence should be moved and placed in the beginning of the paragraph starting with line 55, where the first part of the sentence could be deleted and then start with: 'However, some GPs faced…'.
Response: We do not agree with the reviewer's suggestion to move the sentence "GPs highlighted…..suicide-related stigma" to the next paragraph. This is an opening sentence to say that GPs agree it is important to talk openly with young people about suicide yet they do not know how to do this effectively. We have now clarified the wording to reflect this.
Reviewer: The paragraph starting with line 13 on page 10 should be reformulated in some places. It still contains rhetorical questions, which I think should be omitted and replaced with the authors' answers or reflections. I also think that the quotation "not knowing what to do with them" does not cover all the barriers/problems, which are mentioned, viz. organisational barriers, heavy workload and limited management options. And if the authors think that these barriers could result from how GPs conceptualise risk this must be explained in greater detail. As I read the article, the GPs' problems primarily have to do with difficulties with creating an alliance with and understanding these young patients. In addition, there are some organisational barriers.
Response: The question "However, to what extent could these views also result from how GPs conceptualise risk?" has been re-phrased accordingly "However, it is also important to consider the extent to which these views could also result from how GPs conceptualise and understand risk".
The quote "now knowing what to do with them" is used in relation to the limited management options (not organisational barriers or heavy workload) GPs feel they have within primary care when it comes to suicidal young people. We have re-worded this to clarify.
We agree with the reviewer that undeniably there are organisational barriers and communication problems between GPs and young people supported by the findings of this study. In terms of understanding the processes underlying GPs' negative attitudes towards young people we argue for the importance of looking into how GPs' conceptualise and understand risk and the potential impact of this on therapeutic engagement and management.