PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Best practice when working with suicidal behaviour and self-harm in primary care: a qualitative exploration of young people's perspectives
AUTHORS	Bellairs-Walsh, India; Perry, Yael; Krysinska, Karolina; Byrne, Sadhbh; Boland, Alexandra; Michail, Maria; Lamblin, Michelle; Gibson, Kerry; Lin, Ashleigh; Li, Tina Yutong; Hetrick, Sarah; Robinson, Jo

VERSION 1 – REVIEW

REVIEWER	Su-Gwan Tham University of Manchester, England
REVIEW RETURNED	01-May-2020

GENERAL COMMENTS	For this study, the authors conducted focus groups with young people to explore their perspectives on best practices by GPs with regards to self-harm and suicidal behaviour. This work contributes to the literature with the authors also providing recommendations as to how to incorporate participants' preferences to improve the practice of GPs. It also highlights the important contribution of young people in health services research. Below are some comments which I hope the authors will find helpful. Page 2, line 7-8. Does this refer to the nature/frequency of disclosure to the GP? Or the decision about whether to disclose to the GP? Page 5, line 51 – it is noted in supplementary file 1 and Materials that the interview schedule was piloted on young people. It might be helpful to mention this in the patient and public involvement section to emphasise that young people's views were also sought for the design of the study material. Page 6, Materials – reference in the manuscript is to GP practices but in the interview schedule, the questions mainly refer to 'professionals'. Please clarify this inconsistency. Q5 refers to GP and other professionals. Who did (other) professionals refer to? Page 7 – Data analysis. Was negative cases analysis undertaken? Page 8, line 33 – does this refer to participants' perception of their own lack of mental health literacy, or their view of the GP's possible lack of mental health literacy? Page 16, line 17 – it seems like you erroneously included 'with' - 'GPs' transparency about with the consequences.'

	Discussion – could be more concise as some results were repeated in this section. It might also be helpful to refer to the below paper in your discussion to reflect how your findings compliments/contrasts with GP's perspectives. Fiona Fox, Paul Stallard, Geraldine Cooney, GPs role identifying young people who self-harm: a mixed methods study, Family Practice, Volume 32, Issue 4, August 2015, Pages 415–419 Limitation – perhaps expand on your point about convenience sampling. Young people who took part in this study were self-selecting and so may have been more willing to talk about mental health, suicide and self-harm than those who did not volunteer. They might also have expressed different views from those who chose not take part in the study. Overall, I found the paper informative with the selected quotes illustrative of the identified themes.

REVIEWER	Ying Yeh Chen Taipei City Psychiatric Center, Taiwan
REVIEW RETURNED	20-Jun-2020

GENERAL COMMENTS	Review for manuscript entitled "Best practice when working with suicidal behavior and self-harm in primary care: a qualitative exploration of young people's perspectives" Adopting a qualitative design, the paper aims to explore young people's views specific to the care of suicidal behavior and self-harm. Although the authors aimed to focus on young people, however, their explorations did not specifically focus on young people. The conclusions were very general. For example, I cannot see a focus on 'young people' regarding the five inter-related themes identified --- these five themes were --- 1) wanting a collaborative diaglogue, 2) Fearing a loss of privacy when disclosing risk, 3) labels and assessments as problematic and reductionist 4) The importance of GPs' attitudes 5) the provision of practical support. All these five themes and the discussions into these themes can be applied to all age groups, I did not see any age-specific explorations/discussions. Other comments: 1. sample selection – the authors recruited individuals aged 16-24 but did not specifically included those who experienced self-harm/suicidal behaviors, this is a big limitation (only 5 individuals ever had previous history of self-harm/suicidal behaviors, data saturation can be a problem!). For those who had no previous history of self-harm, it is hard for them to talk about their opinions about 'best practice of GPs for suicidal behaviors." 2. Focus group: it seems that the focus group was not very focused. In general, we'd like to recruit homogenous people in the same focus group to have in-depth explorations of common issues for the participating members. You only had 10 participants and 2 focus groups , it is more reasonable to separate these two groups based on their history of self-harm. So the focus group can be more focused (e.g. the self-harm group could discuss their GP experiences of treating their self-harm behavior and the non-selfharm group could discuss their expectations). Currently, the participants were randomly assigned to each focus group, this way the focus group may become not so focused. The authors should explain why they used this strategy rather than organizing a homogenous focus group.

	3. Clinical applications of the current findings were not very clear. Please explain.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1:

1. Page 2, line 7-8. Does this refer to the nature/frequency of disclosure to the GP? Or the decision about whether to disclose to the GP?

Author response: Thank you, we have changed the wording here to make this clearer, whilst trying to keep within the 300-word limit for the abstract. The revised text now reads:

"However, little is known about young people's opinions and experiences related to GPs' practices for such presentations, and their decisions to disclose suicidal behaviour/self-harm to GPs." [P2, Line 4].

2. Page 5, line 51 – it is noted in supplementary file 1 and Materials that the interview schedule was piloted on young people. It might be helpful to mention this in the patient and public involvement section to emphasise that young people's views were also sought for the design of the study material.

Author response: Thank you for this suggestion. Please see the revised text:

"The study was conceptualised and designed in collaboration with a youth advisor (TYL), who also assisted in the development of the interview schedule and question testing with young people. During a consultation process at Orygen, young people's views were sought on the design of the study material, in which they provided feedback on the interview questions to ensure that these were accurately capturing rich information on the areas of interest." [P5, Line 26].

3. Page 6, Materials – reference in the manuscript is to GP practices but in the interview schedule, the questions mainly refer to 'professionals'. Please clarify this inconsistency. Q5 refers to GP and other professionals. Who did (other) professionals refer to?

Author response: Thank you for picking up this discrepancy, we have now clarified this further in the Materials section as required. Indeed, the language of the interview schedule was positioned as being slightly broader, however, during the conduct of the interviews, the actual questions that were asked to participants were narrowed to specifically focus on and refer to GPs, and we asked directly about their experiences with GPs. When we did refer to 'professionals' as worded throughout the schedule, this was in the context of primary care professionals. The revised text now reads:

"Because depression is a known risk factor for both suicidal behaviour and self-harm, this was also included in the interview schedule[12,53], and although the language throughout the schedule refers more broadly to 'professionals', the focus was narrowed to refer to GPs specifically during the interviews themselves." [P6, Line 32].

4. Page 7 – Data analysis. Was negative cases analysis undertaken?

Author response: Yes, during the data analysis and coding process we actively considered negative or discrepant cases that were contradictory to the themes, and cases that didn't align with the other data. We didn't identify any major or prominent contradictions to the reported themes, in fact the similarity of young people's views was notable. In earlier drafting processes, we had included some minor examples of what may be considered 'discrepant' instances; however, these were removed for

conciseness as we felt that they didn't add significantly to the interpretation of the data, nor were they divergent to the major themes. However, we have re-integrated these minor examples, which (although still reflect the dominant themes) provide slightly more context. We have also updated the Data Analysis section to explain this more clearly. The revised text now reads:

"To enhance validity and rigor, disconfirming case analysis was conducted throughout the coding and analysis process to consider data that did not fit with the themes and patterns identified[59]. Notably, young people's views were well-aligned both across and within the focus groups, and we identified only very minor instances of differing perspectives which are reported in the relevant themes below. Transcripts were also second-coded…" [P7, Line 28].

We also added the following reference to the section above to describe disconfirming case analysis:
59. Creswell JW, Miller DL. Determining validity in qualitative inquiry. Theory Pract 2000;39(3):124-30.

The revised sections in the Results can be found in Theme 1: Wanting a collaborative dialogue [P8, Line 23] and in Theme 3: Labels and assessments as problematic and reductionist [P11, Line 3].

Additionally, although not considered a 'discrepant case' as such, we have added in a further point in Theme 3: Labels and assessments as problematic and reductionist, that relates to suggestions from young people about alternative terms for 'risk assessments'. This was removed from earlier drafts for conciseness, but based on reviewer feedback, we have decided to include it. Please see P10, Line 26.

5. Page 8, line 33 – does this refer to participants' perception of their own lack of mental health literacy, or their view of the GP's possible lack of mental health literacy?

Author response: This refers to their own perception that they themselves, and young people in general, can have a lack of mental health literacy, and that this can prevent them from disclosing issues to their GP. We have updated the text as below:

"Participants described a range of barriers that prevented young people from raising concerns about mental health issues, suicidal behaviour, and self-harm with their GP. These included young people often having a lack of mental health literacy, as well as experiencing the consequences of mental health symptoms themselves…" [P9, Line 1].

6. Page 16, line 17 – it seems like you erroneously included 'with' - 'GPs' transparency about with the consequences.'

Author response: Thank you for picking this up, we have edited this section.

7. Discussion – could be more concise as some results were repeated in this section. It might also be helpful to refer to the below paper in your discussion to reflect how your findings compliments/contrasts with GP's perspectives. Fiona Fox, Paul Stallard, Geraldine Cooney, GPs role identifying young people who self-harm: a mixed methods study, Family Practice, Volume 32, Issue 4, August 2015, Pages 415–419

Author response: Thank you for this feedback, we have edited our Discussion section to avoid repetition of the results as much as possible, whilst still trying to summarise the findings and highlight the key points. We have also incorporated the Fox et al. 2015 study where applicable. The revised text(s) now reads:

"However, previous research has identified that often GPs feel they lack the confidence and skills to

enquire about and discuss suicidality and self-harm with young people, or that there may be negative outcomes associated with asking about these issues[45, 63]. Clearly, this is an obstacle to providing the type of care that young people want, and GPs have outlined that they would welcome training in this area[45, 63].” [P16, Line 26].

“Whilst GPs have indicated previously that they try to prioritise listening and sensitive discussion, time constraints are a significant barrier[45, 63].” [Page 18, Line 27].

“Previous research has shown that while GPs often signpost resources and services, they are concerned that young people may lack the confidence or maturity to access these effectively[63].” [Page 19, Line 14].

We have also added the Fox et al. 2015 reference to other points in the Discussion where relevant.

8. Limitations – perhaps expand on your point about convenience sampling. Young people who took part in this study were self-selecting and so may have been more willing to talk about mental health, suicide and self-harm than those who did not volunteer. They might also have expressed different views from those who chose not take part in the study.

Author response: Many thanks for this helpful suggestion. Indeed, there may be a sample selection bias as participants self-selected to take part, and thus were likely to have more interest and experience in the topic than other young people who did not volunteer. We have updated the relevant Strengths and Limitations section to better reflect this:

“As participants self-selected to take part, there is also a strong likelihood of selection bias in the sample. Thus, the findings may not be fully generalisable to all young people.” [Page 21, Line 6].

Reviewer 2:

1. Although the authors aimed to focus on young people, however, their explorations did not specifically focus on young people. The conclusions were very general. For example, I cannot see a focus on ‘young people’ regarding the five inter-related themes identified --- these five themes were --- 1) wanting a collaborative dialogue, 2) Fearing a loss of privacy when disclosing risk, 3) labels and assessments as problematic and reductionist 4) The importance of GPs’ attitudes 5) the provision of practical support. All these five themes and the discussions into these themes can be applied to all age groups, I did not see any age-specific explorations/discussions.

Author response: Thank you for your feedback. We have integrated some explanations into the Discussion section to better explain why our findings might be particularly relevant to young people, considering their developmental stage and needs. We agree, many of the findings share similarities with good clinical and patient-centred care, which are applicable to all age groups, however, this does not mean that they are not even more relevant to young people. Similar concerns have been consistently raised by young people across multiple studies and healthcare settings, and all the themes in our study were identified as important by our sample of young people themselves. Thus, our findings reiterate that these are key components of youth-friendly and developmentally appropriate care, which should recognise young people’s self-expressed needs and preferences. However, we have amended the text in a number of areas throughout to incorporate this suggestion. Please see below:

“Stigma is by no means unique to young people, however, this population may be especially vulnerable to labels that could increase stigma, as they are experiencing a developmental period where identity formation and consolidation are paramount[65-67]. Bearing a label may mean

relinquishing control and a sense of social acceptance – things young people value highly[68, 69]." [Page 17, Line 10].

"These preferences reflect young people's emerging developmental capacity for decision-making and their growing needs for autonomy, agency, and control[44, 65, 66, 73]. They are also consistent with young people's priorities in other types of health services[68, 74]…" [Page 18, Line 13].

"Young people may be particularly sensitive to power disparities and condescension[79], and as such, a genuine connection between the young person and GP, and GPs having a friendly, non-judgemental attitude are critical" [Page 18, Line 19].

"Additionally, young people may have had little previous experience of how the healthcare system is structured[85], and therefore may also require more 'scaffolding' than adults[86]." [Page 19, Line 16].

We have also added a number of references to help support and contextualise these findings:
65. Christie D, Viner R. Adolescent development. BMJ 2005;330(7486):301-04.
66. Arnett JJ. Emerging adulthood: a theory of development from the late teens through the twenties. Am Psychol 2000;55(5):469.
67. Moses T. Self-labeling and its effects among adolescents diagnosed with mental disorders. Soc Sci Med 2009;68(3):570-78.
69. Wills C, Gibson K, Cartwright C, et al. Young women's selfhood on antidepressants:"not fully myself". Qual Health Res 2020;30(2):268-78.
73. Lerner RM, Steinberg L. Handbook of adolescent psychology. 1: Individual bases of adolescent development. Hoboken, NJ: John Wiley & Sons 2009.
74. Gibson K, Cartwright C. Young people's experiences of mobile phone text counselling: balancing connection and control. Child Youth Serv Rev 2014;43:96-104.
79. Hanna FJ, Hunt WP. Techniques for psychotherapy with defiant, aggressive adolescents. Psychother Theor Res Pract Train 1999;36(1):56.
85. James AM. Principles of youth participation in mental health services. Med J Aust 2007;187(7):S57.
86. Roisman GI, Masten AS, Coatsworth JD, et al. Salient and emerging developmental tasks in the transition to adulthood. Child Dev 2004;75(1):123-33.

2. Sample selection – the authors recruited individuals aged 16-24 but did not specifically included those who experienced self-harm/suicidal behaviors, this is a big limitation (only 5 individuals ever had previous history of self-harm/suicidal behaviors, data saturation can be a problem!). For those who had no previous history of self-harm, it is hard for them to talk about their opinions about 'best practice of GPs for suicidal behaviors."

Author response: Thank you for highlighting this, however, we think there may be a misunderstanding. In the Participants and Recruitment section, we reported that five participants indicated 'previous experience of directly undergoing a 'risk assessment' with a GP' in the demographic questionnaire. This was referring to whether participants had undergone the process of a 'risk assessment', not whether they had had previous experience of suicidality/self-harm. For those participants who responded 'no', this does not mean that they didn't have direct experience of suicidality and/or self-harming behaviours.

The recruitment strategy was more targeted than it initially sounded, and we have updated the Participants and Recruitment section and included the Recruitment Advertisement as a Supplementary File to better reflect this. It was made clear in the advertising materials that we sought to recruit young people who had knowledge and/or experience in discussing or presenting with suicidality/self-harm to their GP. From the interviews, it was evident that this was indeed the case,

and as such, it is likely that even those participants who indicated they had not undertaken a 'risk assessment' process still had lived experiences of presenting to a GP with suicidality and self-harm. Furthermore, had we only included those participants with experience of a 'risk assessment', we may have missed some key perspectives. As discussed in the paper, there are many barriers as to why risk may not be identified (and thus assessed) in young people, and as such, this population is relevant here. The revised text now reads:

"Convenience sampling methods were employed, with targeted advertisements posted on the Facebook, Twitter, and webpages of youth mental health organisations across Perth, including headspace centres, the Telethon Kids Institute, The Commissioner for Children and Young People, and the Youth Affairs Council of Western Australia. To take part, young people had to be aged between 16 and 25, and advertisements specified that we sought to recruit those with experience of presenting to a GP practice for suicidal behaviour and/or self-harm (see Supplementary File 2). As a risk assessment for suicide/self-harm is a very specific process, and we aimed to explore young people's broader opinions on, and experiences of, the identification, assessment, and care practices conducted by GPs, participants were not required to have had direct experience of undergoing a risk assessment. Rather, we wanted to include young people who had not undergone this process (n = 3), as they could offer valuable insights into the barriers that may prevent risk identification and assessments from occurring – hence providing additional perspectives and depth of understanding[52]." [Page 6, Line 7].

We also added the following reference to justify this sample heterogeneity:
52. Roller MR, Lavrakas PJ. Applied qualitative research design: a total quality framework approach. 1 ed. New York, NY: Guilford Press 2015. 398.

3. Focus group: it seems that the focus group was not very focused. In general, we'd like to recruit homogenous people in the same focus group to have in-depth explorations of common issues for the participating members. You only had 10 participants and 2 focus groups, it is more reasonable to separate these two groups based on their history of self-harm. So the focus group can be more focused (e.g. the self-harm group could discuss their GP experiences of treating their self-harm behavior and the non-selfharm group could discuss their expectations). Currently, the participants were randomly assigned to each focus group, this way the focus group may become not so focused. The authors should explain why they used this strategy rather than organizing a homogenous focus group.

Author response: Many thanks for pointing out this potential methodological issue. We have sought to clarify this in our response to the reviewer's previous comment about sample selection (Comment 2). There were not in fact two distinct groups with differing histories of suicidality/self-harm, but rather, just three participants who indicated that they had not undergone a 'risk assessment' with a GP before. The 'groups' were otherwise homogenous in many ways on the basis of their shared characteristics – e.g., young people who had experience of GPs' practices for the identification, assessment, and care of suicidal behaviour and/or self-harm. The issue of whether some had undergone a 'risk assessment' or not was less important than whether they had had these experiences in general – as this was the phenomenon of interest. The sample thus contains a continuum of people who had different types of engagements with GPs around these issues, rather than two separate, distinctive groups. Upon reflection, the wording of this demographic variable regarding 'risk assessment' potentially introduces a false dichotomy that isn't necessarily relevant.

We believe that this diversity was actually a positive thing, as heterogeneity of group participants can stimulate different points of view (Roller & Lavrakas, 2015, pp. 107-109) – those who hadn't undergone a risk assessment before could discuss their insights on the barriers that may have prevented this from occurring. The themes identified were also not always specific to the process of

the ‘risk assessment’ as well; young people who hadn’t undertaken this process were still able to offer valuable insights into GPs’ practices for suicidality/self-harm more broadly.

Feasibility and practicality constraints (which are common) also dictated the heterogeneity of the sample for this ‘risk assessment’ variable. The focus groups were conducted across two districts in the Perth region, that were still quite geographically far apart with limited transport options. In order to make the study more accessible, young people opted to attend the session that was most convenient for them. Because of the topic of the study and the potential for this to be a vulnerable group, we didn’t want to place any further undue burdens on taking part. The literature on ethical participatory research outlines that it is important to give people autonomy in how they decide to take part, to make it as convenient and accessible for them as possible, and to decrease any burdens that study participation may pose (Gemmill et al, 2012; Thomas & O’Kane, 1998). Thus, we prioritised accessibility of participation above trying to make the focus groups exactly homogenous. We felt this was a reasonable and ethical compromise, and that it was preferable to do this rather than prioritising separating the groups based on whether they had undertaken a risk assessment with a GP or not.
To address this suggestion, we have updated the relevant text(s) as follows:

- Participants and Recruitment (please see the revised text above for Comment 2 – Page 6, Line 7).

- Procedures: “Participants selected to take part in the focus group session that was most convenient and accessible to them, in order to provide autonomy and decrease any potential burdens[54, 55].” [Page 7, Line 6].

- Strengths and Limitations: “However, this is not uncommon for this type of exploratory study, and we are satisfied that the sample offers new insights and understandings[57]. It was also beneficial to include a selection of young people who had a variety of assessment experiences with GPs for suicidal behaviour and/or self-harm.” [Page 21, Line 8].

We also added the following references to explain participant accessibility:
54. Gemmill R, Williams AC, Cooke L, et al. Challenges and strategies for recruitment and retention of vulnerable research participants: promoting the benefits of participation. Appl Nurs Res 2012;25(2):101-07.
55. Thomas N, O’Kane C. The ethics of participatory research with children. Child Soc 1998;12(5):336-48.

4. Clinical applications of the current findings were not very clear. Please explain.

Author response: Thank you for your feedback. We have tried to make this clearer by emphasising a number of suggestions for GPs to improve their clinical practice with young people, in the ‘Identification’, ‘Assessment’, and ‘Care’ sections of the Discussion. We have also tried to somewhat address this issue with our response to the reviewer’s first comment (please see Comment 1). However, we have also added the following in the Implications for Practice section of the Discussion for clarity:

“Primary care services and GPs should deliver care for suicidality and self-harm in a way that is sensitive to young people’s identified needs and preferences, and tailored to their developmental stage[44, 92-95]. Indeed, it has been argued that not doing so could adversely impact young people’s future engagement with healthcare, satisfaction, and their eventual health and well-being related outcomes[92, 95].” [Page 20, Line 1].

We also added the following references to the section above to help contextualise this point:
92. Farre A, Wood V, Rapley T, et al. Developmentally appropriate healthcare for young people: a

scoping study. Arch Dis Child 2015;100(2):144-51.
93. D'Agostino NM, Penney A, Zebrack B. Providing developmentally appropriate psychosocial care to adolescent and young adult cancer survivors. Cancer 2011;117(S10):2329-34.
94. Dovey-Pearce G, Rapley T, McDonagh JE. Delivering developmentally appropriate health care: roles for psychologists as members of the multi-disciplinary health care team. Clin Child Psychol Psychiatry 2020:1359104520907147.
95. Dovey-Pearce G, Hurrell R, May C, et al. Young adults' (16–25 years) suggestions for providing developmentally appropriate diabetes services: a qualitative study. Health Soc Care Community 2005;13(5):409-19.

Thank you again for the time taken in considering this submission for BMJ Open. We greatly appreciate the time and effort that yourself and each of the reviewers dedicated to providing us with constructive feedback and are grateful for the insightful comments on and valuable improvements to our manuscript. We hope we have adequately addressed the reviewers' comments.

VERSION 2 – REVIEW

REVIEWER	Su-Gwan Tham University of Manchester, England
REVIEW RETURNED	12-Aug-2020

GENERAL COMMENTS	Thank you for addressing the comments. I have nothing further to add.

REVIEWER	Ying-Yeh Chen Taiwan
REVIEW RETURNED	02-Sep-2020

GENERAL COMMENTS	As stated in my previous review, the authors did not specifically recruit young suicide cases as their interviewees, however, the aim of the study was to explore "Best practice when working with suicidal behaviour and self-harm in primary care". I think this is the reason why the themes you identified from your qualitative interviews were very general, because most of these participants had no history of attempted suicide (based on your advisement, they received suicide risk assessment from GP, but they themselves did not need to have histories of self-harm/suicide attempt). The research topic is important but the sample recruiting process would not lead you to the research goal you identified.

VERSION 2 – AUTHOR RESPONSE

lease see below for our response to the remaining comment from Reviewer 2.

"As stated in my previous review, the authors did not specifically recruit young suicide cases as their interviewees, however, the aim of the study was to explore "Best practice when working with suicidal behaviour and self-harm in primary care". I think this is the reason why the themes you identified from your qualitative interviews were very general, because most of these participants had no history of attempted suicide (based on your advisement, they received suicide risk assessment from GP, but

they themselves did not need to have histories of self-harm/suicide attempt). The research topic is important but the sample recruiting process would not lead you to the research goal you identified."

Thank you for the feedback and for clarifying this. Perhaps we misunderstood your previous comment, i.e., that your concern is about the heterogeneity of the sample in terms of whether participants all had lived experience of suicidality/self-harm, as opposed to experiences of a 'risk assessment'. Indeed, we sought to recruit young people with experience of discussing suicidality/self-harm with their GP, and this was reflected in the study sample. Whilst it is likely that participants did have lived experience of suicidality/self-harm (as was evident from the interviews, and implied throughout the recruitment process), we cannot be certain this is the case. Those that had discussed suicidality/self-harm or undergone a 'risk assessment' process with a GP may not have been experiencing suicidality/self-harm at the time of the presentation (however, this is also important), nor necessarily had a history of suicidality/self-harm. Despite this limitation, we believe these are important perspectives to include, as even being asked about suicidality/self-harm or undergoing a risk assessment (whether risk is present or not) can provide insight into young people's preferences for these processes.

We have updated the Participants and Recruitment section to better reflect this [Page 6, Line 10 of the updated, clean manuscript version]:

"To take part, young people had to be aged between 16 and 25, and advertisements specified that we sought to recruit those with experience of discussing suicidal behaviour and/or self-harm with a GP (see Supplementary File 2). However, as a risk assessment for suicide/self-harm is a very specific process, having direct experience of undergoing a risk assessment, or having a history or presence of suicidal behaviour/self-harm was not necessary for inclusion in the sample. Rather, we wanted to include young people who had not undergone a risk assessment (n = 3), as well as those where risk might not have been present, yet was still asked about by their GP. This could offer valuable insights into the barriers that may prevent risk identification and assessments from occurring in the presence of risk, as well as preferences for these processes even in the absence of risk – hence providing additional perspectives and depth of understanding[52]."

We have also included the following text in the Limitations section to better address these concerns and highlight that future studies may wish to use stricter inclusion criteria [Page 21, Line 10]:

"It is also noted that whilst we sought to recruit young people with experience of discussing suicidality/self-harm with their GP, and it was evident from the interviews that participants had histories of suicidal behaviour/self-harm, there was no specific inclusion criteria for this. Similarly, the study included a small number of young people who had not undergone a risk assessment with a GP. Whilst a limitation, it is important to note that qualitative paradigms are not necessarily concerned with achieving 'representativeness' of variables[103], and thus sample heterogeneity in terms of differing histories of suicidality/self-harm or risk assessments were not of particular significance. Instead, the focus was on exploring the phenomena of interest – young people's broader opinions on, and experiences of, the identification, assessment, and care practices conducted by GPs. Even being asked about suicidality/self-harm or undergoing a risk assessment in the absence of risk can provide insight into young people's preferences for these processes, and similarly, not receiving a risk assessment can highlight the barriers to this occurring. Thus, we consider that it was important to include this diversity, although future studies could utilise stricter inclusion criteria."

We have included the addition of the following reference to support this:

103. Charmaz K. Constructing grounded theory: a practical guide through qualitative analysis. London, UK: Sage Publications 2006.

We have also added the following to the Strengths and Limitations section at the beginning of the manuscript [Page 3, Line 12]:

• Convenience sampling based on interest in participating and geographical region, as well as the relatively small and heterogenous sample, may limit the robustness and generalisability of the findings.

We very much hope that this satisfies the concerns of the reviewer. However, should you have any additional queries please do not hesitate to contact us.