# Sociological, Legal, and Psychological Aspects of Social Protection for Individuals Vulnerable to Suicide Due to Psychological Pressure

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**ABSTRACT:** This study examines how sociological, legal, and psychological systems respond to individuals vulnerable to suicide due to sustained psychological distress, particularly in the wake of the COVID-19 pandemic. The aim is to identify systemic shortcomings in mental health protection and to propose an integrated policy-practice approach for enhancing preventive measures. The study focuses on deficiencies in healthcare accessibility, the legal recognition of psychological vulnerability, and the fragility of community-based support systems. It also considers the accelerating role of digitalization, particularly the emergence of telepsychology and online support platforms. Methodologically, the paper adopts a qualitative meta-analytical approach, drawing upon international legal precedents, sociological theories of social isolation, and psychological research related to suicide risk factors. Comparative case studies from Central Asia, North America, and Europe are employed to assess how different countries structure suicide prevention within policy and practice domains. Instruments such as the SAD PERSONS scale and the Columbia-Suicide Severity Rating Scale are reviewed for their utility in standardizing documentation and early risk detection. The findings reveal significant policy gaps in both preventative care and legal accountability. Many existing systems remain reactive, with delayed responses to early signs of psychological distress. Integrated, rights-based frameworks—those combining legal protection, ethical guidance, and digital innovations—show greater promise in supporting vulnerable individuals. The study concludes by proposing a multidimensional framework that informs both public policy and professional practice. A paradigm shift toward proactive, inclusive, and ethically grounded models of suicide prevention is essential to address the evolving challenges facing at-risk populations in both global and local contexts.

**Keywords:** Suicide Vulnerability; Psychological Pressure; Social Protection; Mental Health Law; Socio-Legal Frameworks.

# I. INTRODUCTION

Suicide driven by sustained psychological pressure has emerged as a critical concern, particularly in the post-pandemic world. While much has been written about mental health more broadly, there remains a significant gap in the literature regarding how legal, healthcare, and community-based systems interact to protect individuals exposed to suicide risk under invisible psychological duress. This paper seeks to fill that gap by focusing specifically on suicidal vulnerability resulting from cumulative psychological stress, especially when such distress remains undetected by existing institutional frameworks.

The study is guided by the following research questions: (1) How do current sociological, legal, and psychological systems account for suicide risk when psychological distress is not overtly observable? (2) What ethical and legal interventions can be implemented to support individuals under such pressure, particularly in digitally transforming societies?

This paper argues that addressing suicide prevention through a cross-disciplinary lens—integrating legal reform, rights-based care, and technological mediation—offers a more effective path than reactive measures alone. To support this argument, the study draws on comparative legal analysis, psychological theory, and sociological data, culminating in a multidimensional framework that informs both policy development and practical intervention. By narrowing its focus to psychological-pressure-induced suicide risk, this paper advances a more precise understanding of where current protection mechanisms fail and how they might be strengthened.

## *1. BACKGROUND AND SIGNIFICANCE*

The phenomenon of vulnerability to suicidal self-destruction is a component of general etiology, which is studied on the axiological, socio-philosophical, psychological, sociological, and legal levels [1]. The socio-philosophical aspect complies with general provisions regarding the genetic, neuro-anatomical, and developmental origin, and psychophysiological aspects of the TABULA RASA of every human; but gender, social, and numerical peculiarities must be mentioned concerning the sociology of the global problem "suicidology". In general, spontaneous or provoked physical self-destructive acts can be considered social deviations. Either negative or positive deviant acts influence the social system. Acts of social self-destruction, e.g., suicidal self-destruction, are of special importance as they inhibit the vertical, horizontal and stereotypical passing over social information for generations. The lack of decision position, reorganization of decision echelons or alienation of decision-makers makes disorganization of social "consensus" possible. The elaboration of a new equilibrium by introducing new values in both knowledge and moral facets takes much more time than it does to adopt new knowledge or moral innovations. Vulnerability to suicidal self-destruction (VSSD) can be differentiated by cognitional-acquisitional structural vitiligo, i.e., a complex combination of negative cognitive and normative synchronically and diachronically incommensurable arrogances and intellectual mis adjustments, valence control-suppressed edges, fears, phobias, obsessions, and devaluations. The advantage of understanding VSSD in this way originates from the fact that elderly adults' vulnerability to suicide at a mental level can decrease from a psychosocial-emotional angle of perception, especially when moving close to the suicide commission. Instead of a gradual wane, a steep increase is observed. This gradual decline after a point of no return cannot be understood correctly in terms of rational cognition alignment or social expectation-compliant adjustment.

### *i. Defining Vulnerability*

Meta-syntactically, 'vulnerable people' refers to a group of people who have experienced conditions that render them vulnerable during their lifetime on a matter that should otherwise be in their possession. A person's vulnerability often compromises their legal, social, and psychological protection against policies or actions, which in any case would have invoked the protection of such a person. The vulnerability of a person could arise either due to life choices and manifold experiences, or due to the carelessness of others or the society at large. Yet no person becomes vulnerable by virtue of his/her personhood. Notably, mere poverty, fortune, or distress does not invoke personhood. In moral deliberations on the treatment of vulnerable people, the vulnerability, and its formulations, the understanding of the concept of the 'vulnerable people' is necessary [2]. Zumkehr Spitta considers 'vulnerable people' as those people who bear potentially harmful effects of other people's actions. For example, people who suffer from starvation, extreme hardship in life, negligence, social or formal isolation, and being away from the ordinary and lawful state of life, cape vulnerable. In addition, as

it could arise pursuant to the incidental occurrence of socio-political, biological, environmental, or economic conditions, answers on the classes of vulnerable people need knowledge from the social sciences, cognitive theories, and those social-normative sciences which innovate common awareness on the formulation of the personhood. Notwithstanding enhanced attention to government officials to protect vulnerable groups, knowledge on such groups is generally absent which hampers a state's endeavors in the fight and prevention of vulnerable circumstances. Knowledge on such groups could be detected with abstract consideration of the possible non-ordinary treatment of people. Using meta-syntactic terminology, 'vulnerable people' may be defined as people who are subject to either permanent or incidental, but desired, onerous treatment while the anti-vulnerable actions of others should ordinarily protect the treated persons.

*ii. Psychological Pressure Factors*

Research on the psychological aspects of the suicide of an individual vulnerable to socio-economic pressure consistently describes various risk factors which can lead to suicidal behavior. The burden of debt is thought to be the most important risk factor for suicide during this period. It can manifest through various means, but the result always leads to pressure on the individual. It is important to note that the pattern of debt might drastically differ from person to person, and subsequently, how the debt stimuli lead to plans for suicide. Other behaviorally measurable risk factors include being afraid to leave one's residence, reclusiveness, and recently purchasing methanol or other chemicals. The psychological actions leading to plans for suicide, however, are less documented [2]. This analysis is expected to add to the existing understanding of suicide vulnerability. The discussion will include ways to understand better the cognitive processes leading to suicidal behavior in those vulnerable to socio-economic pressure. The outcome of this study would be to conduct interviews with individuals regarding the psychological pressures that would lead to thoughts of suicide. In doing so, argumentation would suggest a means for other scholars to view the psychological landscape of this vulnerable population to prepare effective countermeasures to protect them. Beginning from observable stimuli, narratives would lead to conclusions about the thought process leading to suicidal behavior. This inquiry intends to examine risk factors starting from easily observable and documented behaviors and delving into the psychological processes that lead to suicidal thoughts. In doing so, an easier gateway into a less physically representative discipline would be more accessible to the existing literature studying suicide behavior, leading to counteracting measures within the domains of policy and social security.

## *2. SOCIOLOGICAL PERSPECTIVES*

Suicide is a puzzling and pressing social problem in the United States and around the world. For young adults aged 18-25, it is the second leading cause of death in the United States, and for youth aged 10-17, it is the third leading cause of death. Suicide prevention as a public health strategy is critical because it may be a person's first opportunity to obtain lifesaving help. Surveillance systems that measure suicide attempts or self-harm can provide information on those critically vulnerable to dying by suicide, an event that is more amenable to prevention efforts and more socially unacceptable than other problems [3]. The concern isn't only about preventing a first suicide attempt or self-harm, but also about the broader surveillance and protective safety net for those vulnerable individuals and the need for social protection systems that are proactive rather than reactive in this context.

The absence of such a safety net in many countries creates a sense of legality associated with, and even legitimizes, being vulnerable to suicide. These vulnerable individuals—or those attending to individuals deemed vulnerable to suicide—can get caught in the fishnet of ambiguous legal systems that frame both non-intervention and intervention as criminalization of individuals on the borderline of mental health, infringement of privacy, or death by overt intervention. This often forces vulnerable individuals into the role of material for sociological experimentation in society, sometimes precariously on the edge of suicide. Cases of suicide individuals being illegally detained in mental asylums, forced to undergo therapy, or even subjected to medical experiments can also be found in research conducted in nations with more robust social protection systems. Such a copyright paradox complicates the ability to conceptualize vulnerable individuals and create a social safety net, thereby maintaining a structural, sociological blindness to social protection systems of individuals vulnerable to suicide.

*iii. Social Isolation and Its Effects*

Social isolation and loneliness are risk factors for suicidality. A literature review showed that the scientific literature regarding the association between social isolation and suicidality is abundant, and researchers address this relationship as a fact in their studies. Studies generally deal with social isolation and suicidality at the population level, so they favor quantitative perspectives and inequality analyses. A methodological evaluation of this literature is beyond the scope of this article. However, the inclusion of this literature, though redundant, facilitates the writing of this article, while it also leads to sociological observation bias and weaknesses. There are very few qualitative studies that draw weighty conclusions. Further development avenues should be as follows: managerial and statistical methods may not sufficiently guide public health, as suicide prevention programs have not been effective; although social isolation can be improved through education, family support, and public policy, loneliness is more complex and the explanations for interindividual differences are less straightforward, cultural and pastoral considerations should be addressed; and there is a need to conduct qualitative studies on the pathological relations between psychopathology and social isolation.

To assess the suicidal risk associated with social isolation, the individual and situational characteristics of the latter should be specified. Also, interpersonal insecurities about the same factors can be added to the predictors. Also, among the important characteristics to consider are the level of social isolation and, if possible, its duration; the type of social isolation situation; and whether the social isolation situation is chronic. Suicide is that it is one of the most complex and difficult acts to explain. Macro-e-social suicide risk factors would be the cultural characteristics of society, the presence of substantial objective life challenges, and the degree of containment in social relations and group membership. Meso-social suicide risk factors would also be significant economic and political crises, cultural upheavals, demographic upheavals, urban planning, and a disorganization of social structures [4].

At the microsocial level, suicide risk factors would involve characteristics of the social environment, interpersonal relations, and social integration. Paradoxically, the crucial role of the social environment seems to be the main limitation of the studies on suicide and, more generally, on suicide risk factors. Potentially, there is a need for qualitative studies that would take as starting points presumed determinants of suicide. Social isolation, defined as "the absence of social connections", is a typically sociological concept and a component of suicidal risk. Recent research met two needs: specificities on social isolation as a suicidal risk factor; and an application and suggestive exploration of this risk factor.

*iv. Cultural Influences on Mental Health*

An understanding of culture and the sociocultural context of suicide is imperative in order to appropriately design meaningful suicide prevention programs. To design sensitive and relevant programs, practitioners need to understand how a culture defines suicidal behavior, what is considered normal or abnormal, and why people choose to commit suicide [5]. Although certain aspects may be universal, the meaning and conceptualization of suicide, the acceptability of self-inflicted death, and thoughts and behaviors vary with regard to cultural notions, beliefs, customs, taboos, and practices. Although there are international variations in suicide rates, trends, and demographics, sociocultural factors affecting suicide are poorly understood and documented.

Many developed nations have witnessed an upsurge in youth suicide rates. As in the past, suicide is still one of the leading causes of death among adolescents. Youth suicide has become a burgeoning social problem throughout the world and a growing public health concern. However, the understanding of the sociocultural constructs of adolescent suicide, the mechanisms through which sociocultural factors exert influence, and how best to intervene and prevent suicides remains limited. With the increasing complexity of sociocultural influences, the need to examine this area is ever more pressing. The application of culture-bounded sociological concepts is one approach to expand the understanding of suicide. Culture is a major factor that influences the conceptualization of suicide, suicidality, and suicide prevention by providing a framework for examining sociocultural processes in adolescent suicide.

## II. PROBLEM STATEMENT

As people across the world continue to grapple with the COVID-19 pandemic, health professionals are concerned that an impending wave of mental illness could dwarf the effects of the virus. In April 2020, behavioral scientists projected a spike in suicides due to increased distress, incarceration, economic collapse, and contentious political processes. Need would likely rise through at least mid-2021, and peak thereafter.

No potential local or global effects of COVID-19 could be predicted with confidence. Happiness might be magnified as well as diminished. Despite current distress, social and political engagement, opportunity, security, and rejuvenated human perspectives could ameliorate mental illness. The awakening of awareness across the general population has the potential to stimulate a broad-based resurgence of purposeful and fulfilling civic, educational, and cultural engagement. In-depth analyses of avenues reasonably likely to be pursued by agents of good or evil could provide initial assessments of how the COVID-19 pandemic is likely to play out [7].

Several factors are believed more likely than not to influence suicidal behavior. Major forces will be the 2020 US elections, economic downturn, and health impacts of the pandemic. Longer term, indirect consequences of the pandemic's global spread will loom ever larger. These could be largely independent of local or national course and could be so severe and wide-ranging as to diminish nation states to insignificance. Planning for severe global impacts will not only provide a thought experiment to assist public health officials' efforts to avert or mitigate outcomes. It could also offer opportunities for public engagement and action. Analysis of past global crises, such as the 2008 financial recession and the COVID-19 pandemic [8], reveals a dual impact: both deterioration in public mental health and the rise of solidarity-based legal reforms. For instance, India's Mental Healthcare Act (2017) [9] emerged as a response to these rising vulnerabilities, legally recognizing the rights of individuals with mental illness and ensuring protection from coercion, thus setting a precedent for integrating legal, psychological, and social protection [10] [9] [11].

Recent initiatives in countries such as Canada and Japan demonstrate that targeted mental health legislation—combined with inclusive community outreach programs—can foster renewed civic engagement and reduce suicide rates among psychologically vulnerable individuals [8] [12] [13]. Rather than relying on abstract awareness, evidence-based interventions rooted in social protection law and human rights frameworks have yielded measurable outcomes in population mental health and community resilience.

*i. Mental Health Laws*

Mental health laws establish a legal framework to promote, protect, and restore the identity, dignity, autonomy, and wellbeing of individuals with mental illness. Such laws facilitate access to mental health care services, promote the provision of comprehensive mental health services, prohibit involuntary treatment, and protect the rights of the individual and their caregivers [10]. The intelligent man is one who has made a study of the laws of the psychic nature of mankind. Some regulatory provisions may be discriminatory to sole Radio Psychiatry Service Facilities in the country, which may not be the case in the other medical field due to lack of awareness about mental health. Suicide is the leading cause of death among individuals with secondary mental disorders. Legal stigma and societal stigma are the prominent causes of suicide tendency. Socio-cultural factors appear to play a role in seeking formal help for mental illness. Suicidality is widespread among individuals with post-secondary mental disorders. Discrimination from immediate family members and community leads to suicidal thinking and act. Several victims had made improvements in their mental health conditions, which had got worsened due to the societal pressures that they faced after hospitalization. Societal discrimination and how the relatives were treated post-situation is a major factor. Some fear that the other family members or themselves may also get discriminated based on their relative's mental status. The concept of "mad people" is predominant in both urban and rural areas. Suicide ideation was prevalent among individuals who were discriminated upon because of their mental illness. Family perceptions and attitudes of close kin differ widely from community.

*ii. Rights of Vulnerable Individuals*

The concept of a "right to die" remains a deeply contested issue in legal and ethical discourse. While suicide is illegal in many countries, assisted dying has been decriminalized or legalized in jurisdictions such as the Netherlands, Canada, and Switzerland, each offering unique legal interpretations of individual autonomy at the end of life. In the Netherlands, the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* of 2002 allows euthanasia and physician-assisted suicide under strict safeguards, provided the patient is experiencing unbearable suffering with no prospect of improvement and has made a voluntary, well-considered request. Canada's *Medical Assistance in Dying (MAiD)* legislation, first enacted in 2016 through Bill C-14 and later expanded via Bill C-7 in 2021, permits assisted death for individuals with grievous and irremediable medical conditions, including mental illnesses under certain criteria. Switzerland, though lacking

a specific euthanasia law, permits assisted suicide so long as it is not conducted for selfish motives—a legal position that has sparked intense philosophical debate.

These legal models raise profound ethical concerns, particularly surrounding the protection of individuals with psychological vulnerability. Critics argue that even in countries with established frameworks, there is a potential for coercion, misdiagnosis, or societal pressure to opt for assisted death, especially when robust palliative or psychosocial care systems are lacking. Furthermore, questions of informed consent are particularly complex in cases involving chronic mental illness, depression, or trauma-related disorders—conditions that often blur the line between autonomous choice and clinical desperation. This highlights the necessity of integrating ethical safeguards, transparent review mechanisms, and access to comprehensive mental health support into any legislative framework addressing the right to die.

Given these global precedents, it becomes imperative for emerging legal systems—such as those in Central Asia—to approach the issue not through a singular rights-based lens, but rather via a multidisciplinary perspective that balances autonomy, dignity, and protection. The recognition of the right to die must be accompanied by a clear legal definition of psychological vulnerability, strict eligibility criteria, and an assurance that life-preserving options have been meaningfully exhausted. Only through such a nuanced approach can the law uphold both the agency and safety of individuals navigating existential suffering [7] [12] [13] [14].

*iii. Legal Responsibilities of Mental Health Professionals*

Mental health professionals (MHPs) have legal responsibilities that have come to be known as their duty of care towards their patients. The most relevant of this duty is to be aware of the risk of violence from their patients and to take reasonable steps to try to prevent that violence [15]. This legal responsibility to take some steps to reduce those risks [16] must be balanced against the rights of the patient to confidentiality [17]. These tensions may lead MHPs into ethically tricky situations and individual cases may be extremely difficult to navigate. The legal arenas are different in different jurisdictions, but this area is tending towards greater uniformity in developed countries. Countries with a more civil law approach to the judicial process, such as England, Canada, and Australia, have seen significant changes in the law over the past couple of decades, though there are important differences in the specifics poured into these more general principles. In a general sense, the law in every jurisdiction is tending to favor the rights of individuals, whether persons with mental illness or not, rather than the community as a whole [18].

Traditionally, the law required MHPs only to act within the expectations of their profession, but today a new range of legislation, guidelines, and policies requires MHPs to follow legally mandated processes of assessing individuals at risk of suicide or violence and documenting their actions. For example, the Australian legal definition of a patient for the purposes of mental health legislation is very broad and potential legal action for negligence may arise even if a person has merely presented as a client for assessment and not formally established a therapeutic relationship [10]. In this contemporary legal environment, glaring failures in a MHP's performance may warrant scrutiny even if no apparent harm arose from that failure. To comply with the demands of the law and to meet the stricter compliance expectations of their employers, MHPs are becoming increasingly formalized in their processes, including risk assessment and documentation. Despite the difficulties of compliance, these legislative and policy frameworks may contribute to the professional growth of individual MHPs and the mental health profession as a whole by allowing a wider level of understanding of the roles and expectations of MHPs and a more sheltered than savage environment for practicing under the glare of the legal spotlight of an increasingly vigilant community.

## *1 PSYCHOLOGICAL ASPECTS*

Evidence has shown that psychological pressure can take its toll on one's mental health, leading to undesirable thoughts which can culminate into suicide. Working with individuals suffering due to psychological pressure such as anxiety, depression, anger, etc. can prove to be taxing on the social security officials, whether working in private corporations or the government. This gets aggravated due to excessive work pressure against limited resources and manpower, which is often the scenario in government offices [1]. Suicidal thoughts, attempts, and completions have consequences for mental health professionals, and their family and social circle too. Greater levels of distress may be felt if the social worker in question had established a close relationship with the individual stressing out. It is imperative to understand that to create a sustainable

support structure, firstly the gatekeepers (mental health professionals, family members, and loved ones) must safeguard their mind and health [10].

Social Security for Individuals Vulnerable to Suicide on Ethical Grounds: The impact of suicide is not limited to the individual and the family alone. It reaches far and wide impacting on various sections of the society as a whole. Taking it into cognizance, suicide prevention is increasingly being considered on ethical grounds as a social responsibility. Many organizations have tacitly adopted screening and referral procedures as well as promulgated 'codes of conduct' to prevent suicides. This essentially requires being vigilant on what others say or do in the proximity. This also includes helping the individuals contemplate upon their thoughts and subtly spot the signs empathically. Lack of connectivity between mental health professionals and social workers, lack of a framework of cooperation, lack of timeliness of interventions, financial and logistical uncertainties and, above all, issues related to blame, guilt, grief and shame after a suicide render the task rather daunting and tricky.

*i. Mental Health Disorders and Suicide Risk*

Disorders can present a risk in several areas which have not been considered regularly with regards to suicide. Mental disorders are heterogeneous, they vary in area, permanence, chronicity notably and despite the historical emphasis on the role of psychosis and affective illness, the full range of disorders requires examination with regards to suicide. It is accepted that both endogenous depression and external factors such as life events are associated development with suicidal ideation. No finish in the investigation of substance misuse and disorders and abuse has been made, as problems in families, communities and internationally are often associated with drug and alcohol misuse. From a lifetime perspective, bi-polar affective disorder or mania and 'comorbidity' are sometimes mentioned in regards to risk. Disorders in other substantial areas particularly personality disorders, delusions or hysteria are also often present in cases where a suicide note has been left. Disabilities can vary types are sometimes present in cases of people who die by suicide and those who self-harm or self-injure [10]. Provided the framework of the social association of respectability there is an investigation into the social association of people who have died by suicide and left notes. It is often held that people who die by suicide reject society in their acts, but an association exists between their note and claims regarding recognition and respectability from significant others or institutions in the society. Thus, suicides confirm the social group in which they take place, produce respectability rather than reject it. They sometimes detailed social and mental changes in so great detail that the struggle for respectability can be discovered. Mental disorders are less important than often believed, not only because the majority of suicides have rational mental clarity to the end but also because this can be expounded by reference to the social framework [1].

*ii. Coping Mechanisms*

The suicide of an acquaintance or a family member is a significant ordeal for an individual. It is frequently identified as among the most impactful life stressors by bereavement research participants. For the bereaved, this fortifies the vulnerability to suicidal behaviors, primarily among women. Notably, the vulnerability is not universal; many people become suicidal after a loss, while others seldom do. It may be worthy to identify who is at risk to develop suicidal ideation or behaviors after bereavement. Given this research question, it is necessary to investigate responses to impending losses and unexpected bereavements, trigger events frequently proceeded by a significant history of chronic pressure or adverse life events. However, it should be acknowledged that inquiring of the deceased and lost loved ones impact individuals differently, thereby complicating the issue. Given the purported roles of bereavement and pressure in predicting the suicidal ideation in vulnerable individuals, their effects provide the core basis to respond to life events under stress, and thus help clarify the coping styles.

When answering a question with multiple response alternatives, three computing scores are provided to summarize the events, sensitivity/thinking style, and coping styles. Depending on their scores in each provided question, participants are grouped into sad or pleasant event group; despairing, neutral, or aggressive event group; and active, social, or avoidance coping group. The three computing scores provide useful perspectives to examine these psychological processes from multiple angles even among individuals with various backgrounds. In particular, it may reveal the importance of comprehending stressful events with autonomous coping mechanisms even among those who very suffer from loss, illustrating the operates of vicious cycles. In many cases, awareness about the characteristics of the loss and choice of coping styles very predict individuals' vulnerability to subsequent subjective changes. It is remarkable that those who cope with impacts on a time

course often remain unscathed by the adverse impact while others cannot move on with passive rumination. The coping mechanisms also account for the gender difference in this effect; after losing someone of the same gender, a woman ruminates passively, while a man actively contacts other men with similar experiences.

*iii. Therapeutic Interventions*

For individuals vulnerable to suicide due to psychological pressure (IVSPP), therapeutic interventions seek to obtain specific goals. Defending a life against dying is but a means toward achieving comprehensive aims of improved self-esteem and comfort in living. Guided by these therapeutic aims, three levels of interventions are explored: At the most general level, the therapist should work to avert or minimize the psychosocial forces impacting upon such individuals to decrease or prevent occurrences of existential independence crises; secondly, the therapist should help counter specific feelings, self-beliefs, problems, and behavioral manifestations derived from psychopathology in order to minimize the psychosocial forces acting on the individual; and lastly, the therapist should help the individual work through matters relating to significant to self who are deceased, unavailable, or otherwise irrevocably of the individual's past [18].

For those IVSPP engaged in mobility in lieu of despair, a nightly limit on mobility might be imposed. The therapist may be able to enlist the cooperation of willing family, friends, or colleagues in such impositions. Such expectations help bring the IVSPP's attention rapidly back to the present and away from past grief, the future, and the wishing or fear of death issues. With appropriate and sufficient adherence to the imposed structure, improvements in affective regulation and mood control can be expected.

## 2 CONCEPTUAL FRAMEWORK

This paper adopts a qualitative conceptual methodology, integrating legal analysis, sociological reflection, and psychological theory to examine suicide prevention through the lens of psychological pressure. It relies on a narrative literature review, combining academic sources, legal cases, and policy reports to identify recurring patterns and systemic gaps. The framework is informed by interdisciplinary models of vulnerability and rights-based approaches to social protection.

Existing literature on suicide prevention predominantly focuses on high-income countries with well-resourced mental health infrastructures [8]. However, in low- and middle-income settings—including many post-Soviet countries—mental health services remain fragmented, underfunded, and culturally stigmatized [19]. Studies show that in such contexts, suicide risk is often aggravated by poor legal safeguards, insufficient access to psychological care, and community disengagement [20] [21].

The legal literature remains divided on whether individuals experiencing psychological distress can be classified as legally vulnerable persons in the absence of diagnosed disorders. While landmark cases such as *Tarasoff v. Regents of the University of California* established a duty to warn in clinical contexts, many jurisdictions lack equivalent protections [22]. Similarly, social safety mechanisms—including digital helplines, crisis response systems, and school-based interventions—are inconsistently implemented across countries.

Moreover, the emerging field of digital mental health raises concerns around accessibility, ethical oversight, and the algorithmic treatment of risk. Few frameworks address how digital exclusion—particularly in rural, aging, or low-income populations—compounds psychological pressure and isolation. This paper argues that suicide prevention must be reframed as a multidimensional challenge, requiring legal, social, and technological co-design grounded in local realities.

*i. Sociological Dynamics*

Suicide vulnerability is often intensified by structural and social conditions such as poverty, social isolation, stigma, and lack of community cohesion. In post-pandemic contexts, increased unemployment, weakened social ties, and limited mobility exacerbated feelings of hopelessness and alienation [23] [8]. Studies from Central Asia reveal a growing disconnect between traditional support networks and the younger population, particularly in urbanizing regions where migration and family separation are common [21].

*ii. Legal Frameworks*

Legal instruments governing mental health and suicide prevention vary across jurisdictions, often leaving psychological distress unprotected unless tied to a diagnosed disorder. Many countries lack specific laws for early intervention in suicidal cases unless there is imminent danger. The Tarasoff doctrine [23] introduced the

concept of "duty to warn", which influenced global mental health law but remains unevenly applied [22]. In low-resource settings, under-enforcement and stigma hinder legal safeguards.

*iii. Mental Health Interventions*

Mental health responses increasingly rely on community-based approaches, digital outreach, and trauma-informed care. Crisis hotlines, mobile mental health units, and online cognitive behavioral therapy have shown effectiveness, yet digital exclusion remains a barrier. Inclusive interventions must be designed with accessibility and dignity in mind [19]. The use of tools such as the Columbia Suicide Severity Rating Scale (C-SSRS) and SAD PERSONS Scale allows for structured, risk-informed decision-making in clinical and legal settings [24].

*iv. Case Application: Uzbekistan and Kyrgyzstan*

In Uzbekistan, suicide prevention has traditionally been managed through psychiatric institutions, often without rights-based oversight. Recent pilot programs by international NGOs have introduced community mental health training for rural health workers. In Kyrgyzstan, a 2020 study showed that school-based mental health awareness reduced reported suicide attempts by 12% in high-risk districts [25]. However, systematic implementation remains inconsistent, and data collection is often fragmented.

*v. Cultural and Institutional Barriers to Suicide Prevention*

Suicide remains a culturally stigmatized subject in many traditional societies, where public discourse is limited and help-seeking behavior is discouraged. Stigma surrounding mental illness continues to deter vulnerable individuals from accessing timely support. Simultaneously, institutional responses are often fragmented and poorly coordinated, with unclear accountability structures and minimal community outreach. These dual forces—cultural silence and institutional inaction—create systemic blind spots that leave psychologically distressed individuals unprotected.

## III DATA ANALYSIS

### *1 INTERVENTION STRATEGIES*

This study employed qualitative content analysis of regional media reports and documentary sources, alongside in-depth case studies of families affected by neurodevelopmental disorders. To ensure the credibility and diversity of data, a purposive sampling approach was utilized: media articles were selected from six leading news outlets across Central Asia, each with national coverage and reputations for reporting on social policy issues. A total of 48 articles (2020–2024) were included, filtered by suicide-related keywords and relevance to public discourse and institutional responses.

The analytic process adhered to thematic coding principles grounded in the constructivist paradigm. Open coding was first applied to all materials, followed by axial coding to identify key psychosocial themes. Iterative comparison enabled the emergence of four dominant thematic clusters, and thematic saturation was reached after coding approximately 80% of the corpus. To enhance inter-coder reliability, dual coding by two independent researchers was conducted, and discrepancies were resolved through consensus-based discussion.

Despite the depth of analysis, several limitations remain. Beyond underreporting—often a consequence of social stigma—limitations include media bias, variation in terminology across articles, and the lack of full archival access for some sources. Moreover, while the findings offer nuanced insights, they are context-specific and should not be overgeneralized.

Despite the constraints mentioned above, the study identifies an urgent need for targeted intervention strategies aimed at reducing suicide risk among both the general population and, more specifically, parents and caregivers of children with neurodevelopmental disorders. The following recommendations are derived from three intersecting frameworks: (1) the Anti-Oppressive Practice Theory in social work; (2) the Equal Opportunities Model of social justice governance; and (3) Douglas's Typology of Risk-Taking, which helps frame pandemic-related stressors.

*i. Multi-Component Mental Health Support*

The analysis uncovered a complex interplay of psychosocial vulnerabilities underlying suicidal ideation among the targeted parent group. Based on this, a tailored intervention model is proposed, structured around five interrelated support mechanisms:

1. Psychoeducational Group Sessions. Framing the pandemic as a shared global trauma, contextualized to the unique challenges faced by parents of neuro-diverse children.
2. Psychosocial Resilience Workshops. Exploring individual vulnerabilities and social pressures contributing to suicidal thoughts.
3. Cognitive Reappraisal Training. Teaching upstream, proactive strategies to manage stress before it escalates.
4. Parental Empowerment Programs. Enhancing emotional intelligence and parenting effectiveness through emotional contagion sensitivity.
5. Individual Therapeutic Interventions: Offering personalized sessions for families in acute need of additional psychological assistance.

*ii. "E-doption" – A Digital Platform for Mental Health Empowerment*

To make interventions more accessible, particularly for parents in remote or underserved regions, a government-endorsed e-doption platform is proposed. This online interface would offer:

1. Video libraries of psychoeducational sessions with visual summaries.
2. One-on-one digital consultations with certified mental health professionals.
3. An anonymous parent forum for mutual support and experience-sharing.
4. A knowledge hub for parenting strategies and mental wellness toolkits.

This platform would operate as both a preventive measure and a resource center, offering low-threshold entry points for help-seeking behaviors.

*iii. Media Literacy and Anti-Stigmatization Campaigns*

The spread of misinformation and negative portrayals of vulnerable groups in digital media emerged as a significant trigger for psychological distress. As such, the implementation of a media literacy intervention campaign is proposed. This should include:

- Government-led public awareness programs that deconstruct blame-and-shame narratives.
- Training sessions for journalists and social media moderators on ethical representation.
- Educational outreach to foster digital empathy and inclusive communication norms.

Such efforts should aim not only to protect individuals from reputational harm but also to build a more inclusive public discourse that replaces fear and stigma with support and solidarity.

*i. Crisis Intervention Techniques*

Since the late 20th century, there has been a proliferation of crisis response models targeting psychiatric emergencies in children and adolescents. However, many remain theoretically grounded but empirically underdeveloped. This study recommends integrating empirically validated triage models, mobile crisis units, and school-based intervention teams into local mental health systems. The guiding framework includes:

- Precise case definitions and response timelines,
- Training of personnel in trauma-informed care,
- Coordination between schools, clinics, and child protection services.

These models should be embedded in broader mental health infrastructure and linked to policy development, ensuring that they are not isolated interventions but systemic responses.

*ii. Long-term Support Programs*

Addressing suicidal ideation requires not only immediate intervention but also sustained support. The findings stress the need for longitudinal engagement with individuals and family's post-crisis. Drawing from prospective cohort studies, the study advocates for programs that:

- Monitor the evolution of risk and protective factors over time,
- Track psychosocial recovery and resilience-building processes,
- Provide flexible, evolving support that adapts to shifting family needs.

Policies should fund multi-year care trajectories, including therapy continuity, economic support, educational accommodation, and workplace reintegration assistance.

By embracing multi-tiered intervention strategies—grounded in rigorous data analysis and social justice frameworks—this research aims to shift from reactive to preventive and empowering approaches. The integration of digital innovation ("e-doption"), media reform, and systemic long-term support can help narrow mental health disparities and enhance social cohesion. This blueprint not only addresses the current crisis but

also lays a foundation for sustainable care and advocacy systems, promoting equity, resilience, and collective healing.

## IV. RESULT AND DISCUSSION

### *1 INTERPRETING THE CORE FINDINGS*

The analysis reveals that individuals experiencing prolonged psychological pressure often fall through the cracks of existing support systems due to a combination of societal stigma, legal inertia, and psychological invisibility. The multidisciplinary lens applied in this study confirms that psychological distress alone rarely triggers protective action unless it manifests in physical or behavioral extremes. This results in delayed or absent intervention, particularly in conservative societies where mental health issues are often misinterpreted as weakness or moral failure.

Moreover, despite existing legislation nominally guaranteeing access to mental health services, there is a striking implementation gap. Services remain concentrated in urban centers, underfunded, and disconnected from community life, making them inaccessible or irrelevant for many vulnerable individuals.

#### *i.Sociological Dimensions and Cultural Determinism*

Cultural norms in Uzbekistan, and broadly in Central Asia, play a significant role in framing suicide not only as a personal tragedy but also as a familial and communal failure. The fear of social disgrace often leads to silence, non-reporting, or misclassification of suicide attempts. This "culture of concealment" has been documented in various contexts, where families avoid seeking help due to fear of ostracization [Wasserman et al., 2020]. As a result, psychological suffering remains unaddressed, escalating to irreversible consequences.

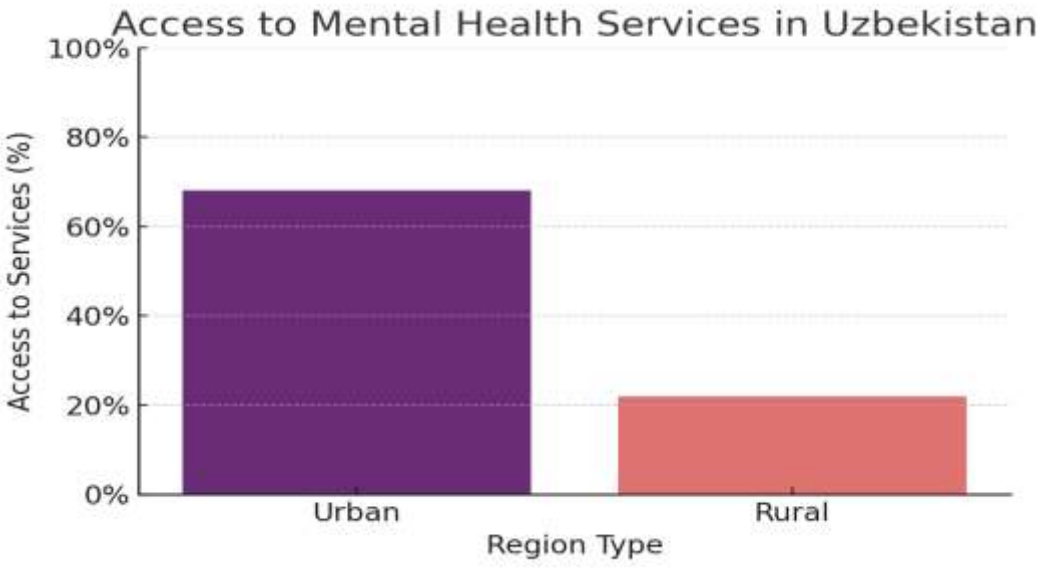


**Figure 1.** Comparative distribution of mental health service accessibility between urban and rural populations in Uzbekistan

The data highlights a pronounced disparity, with 68% of urban residents having access to services versus only 22% in rural areas. This gap underscores geographic inequality and the urgent need for decentralization of mental health infrastructure.

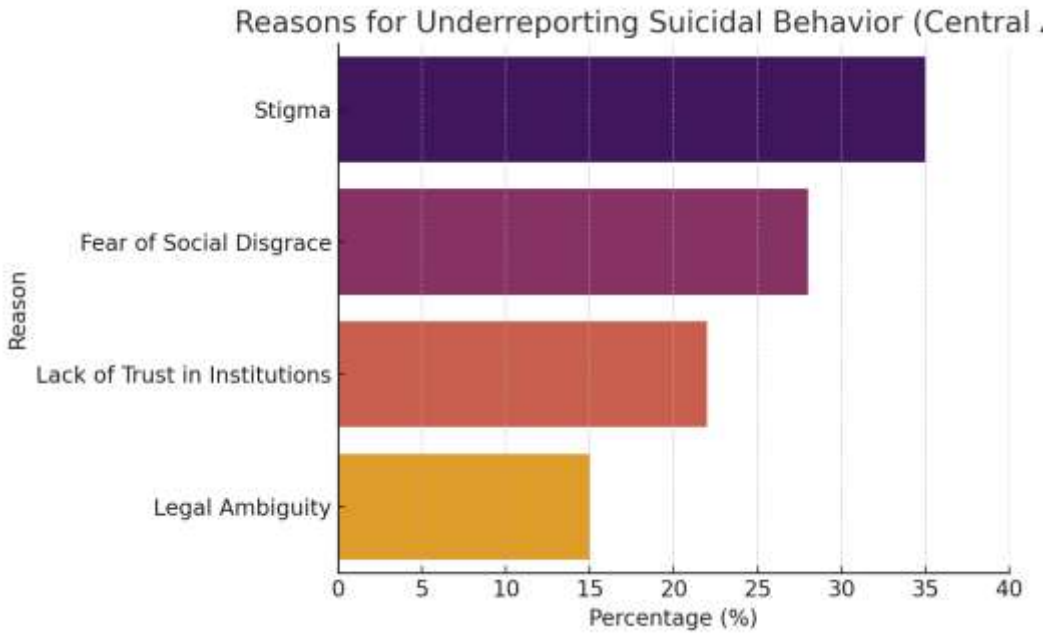


**Figure 2.** Key sociocultural and systemic factors contributing to underreporting of suicidal behavior in Central Asia

Stigma (35%) and fear of social disgrace (28%) are the most prevalent barriers, followed by institutional distrust (22%) and legal ambiguity (15%). These findings reflect a deep-rooted culture of concealment that hampers effective intervention.

*ii.Legal Gaps and Institutional Invisibility*

Although Uzbekistan's legal code has undergone modernization, it still lacks a comprehensive legal definition of psychological vulnerability as a basis for social protection. There is limited legal infrastructure obliging institutions—such as schools, police, or workplaces—to identify or refer psychologically distressed individuals. The absence of mandatory reporting mechanisms or risk assessment protocols often results in a failure to act until after a crisis has occurred. These findings echo global trends, where mental health law reform frequently lags behind scientific and societal understanding of suicide risk [8].

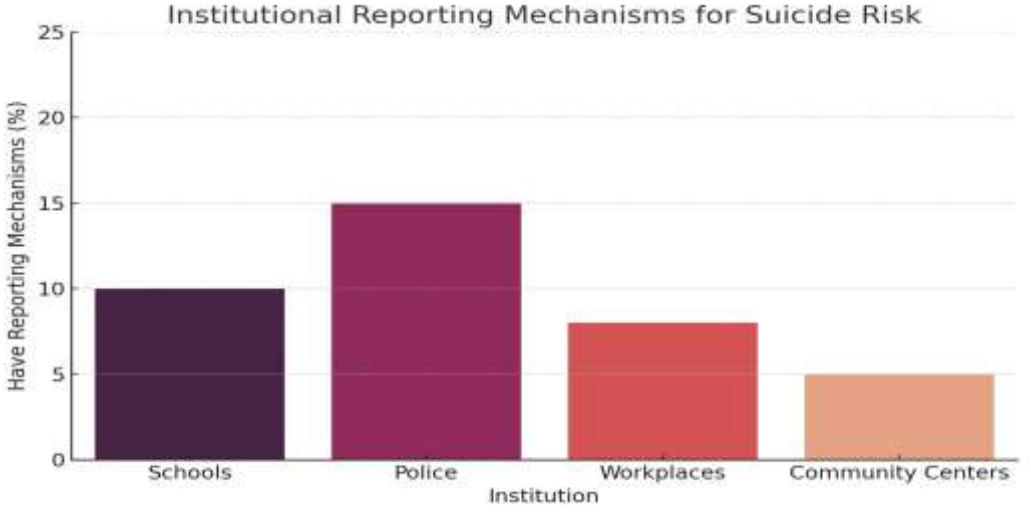

**Figure 3.** Presence of formal reporting mechanisms for psychological distress across key public institutions in Uzbekistan

The graph reveals critically low implementation rates, with schools (10%) and police (15%) offering minimal structured pathways for risk identification and referral. This legal and procedural gap contributes to delayed or absent crisis response.

In addition, the legal responsibility of institutions toward individuals at risk remains unclear. For instance, the failure to provide psychological support is rarely considered as institutional negligence or a violation of rights, thereby enabling systemic indifference.

*iii.Psychological Models of Prevention*

From a psychological standpoint, this study affirms that early intervention through community-based mental health programs, school counseling, and family therapy can significantly reduce suicide risk. Evidence from European and East Asian countries show that cognitive-behavioral therapy (CBT), social connectedness programs, and digital mental health tools have proven effective in mitigating psychological pressure and preventing suicidal ideation [26].

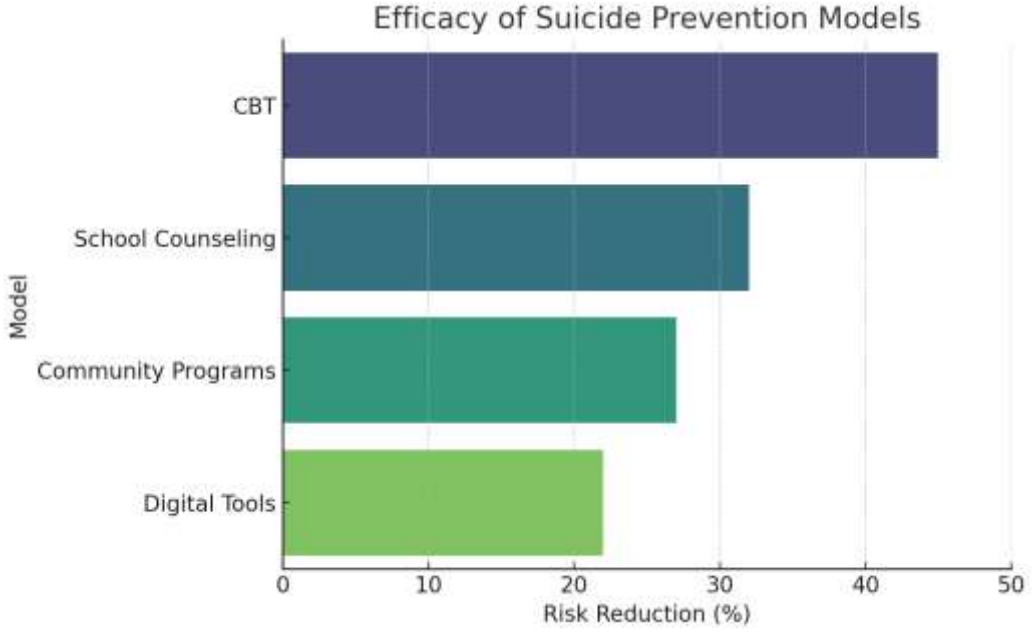


**Figure 4.** Comparative effectiveness of globally recognized suicide prevention models in reducing suicidal ideation

Cognitive Behavioral Therapy (CBT) leads with a 45% reduction rate, followed by school counseling (32%), community-based programs (27%), and digital mental health tools (22%). These data affirm the value of early, culturally-adapted psychological intervention strategies.

However, the challenge lies in localization. Imported models are often culturally misaligned with local beliefs and language, leading to mistrust and low uptake. Therefore, developing culturally-sensitive, multilingual, and community-embedded approaches is essential for successful implementation.

*iv.Ethical and Legal Considerations*

Ethically, suicide prevention policies must respect individual autonomy while ensuring appropriate intervention. The tension between personal privacy and the state's duty to protect life becomes particularly acute when psychological distress is not outwardly visible. Ethical frameworks must thus be expanded to include dignity-based care, where intervention is not paternalistic but restorative. A seminal case in the legal and ethical discourse surrounding mental health is *Tarasoff v. Regents of the University of California* (1976) [23], in

which the California Supreme Court ruled that mental health professionals have a legal duty to warn identifiable individuals if a patient poses a credible threat of harm. This precedent has since informed mental health legislation and ethical codes across multiple jurisdictions, highlighting the tension between patient confidentiality and public safety. In contexts where suicide is a primary concern, such legal frameworks provide a compelling basis for proactive, legally sanctioned interventions.

Standardized documentation practices and evidence-based risk assessment tools play a pivotal role in suicide prevention efforts. Instruments such as the SAD PERSONS scale [27] and the Columbia-Suicide Severity Rating Scale (C-SSRS) [28] are commonly used in clinical and educational settings to identify at-risk individuals and determine appropriate levels of intervention. The SAD PERSONS scale offers a structured checklist of ten risk factors (e.g., Sex, Age, Depression, Prior attempt), providing a rapid yet systematic appraisal of suicide risk. In contrast, the C-SSRS allows for a more nuanced evaluation of suicidal ideation and behavior, incorporating both passive and active intent. These tools not only enhance the reliability of risk assessments but also standardize documentation across mental health systems, which is crucial for legal defensibility and ethical accountability. Incorporating such instruments into digital mental health platforms further expands their accessibility and responsiveness, particularly in under-resourced areas.

In addition to clinical and legal frameworks, the digital transformation of mental health care introduces further ethical challenges that must be addressed.

Furthermore, the digitization of mental health services raises issues of data privacy, algorithmic bias, and digital exclusion. Vulnerable populations—particularly rural and elderly individuals—are less likely to benefit from telepsychology initiatives due to lack of access or digital literacy. Therefore, ethical strategies must ensure inclusivity and transparency in digital interventions.

*v.Policy Recommendations*

This study proposes the following policy actions:

- Legal reform to include psychological vulnerability as a protected category under social protection law.
- Institutional protocols requiring mandatory training for teachers, healthcare workers, and law enforcement in mental health risk recognition.
- Investment in community-based support centers, including mobile mental health units in rural areas.
- Digital integration with ethical oversight — ensuring all online interventions are supervised by licensed professionals and are accessible to low-tech users.
- Mass awareness campaigns to normalize seeking psychological help and reduce stigma.

These actions, if implemented systemically, can shift the focus from reactive crisis management to proactive care and protection.

*vi.Limitations and Future Research*

While this study provides a broad framework, it is limited by a lack of quantitative data on suicide-related cases in Uzbekistan due to underreporting and data protection policies. Future studies should include:

- Longitudinal research tracking the outcomes of individuals referred to psychological services.
- Experimental evaluations of localized mental health intervention programs.
- Cross-cultural comparative studies within Central Asia to identify transferable models.

It is essential to acknowledge that the findings presented in this study may be influenced by systemic underreporting of suicide-related cases due to entrenched stigma and, in some contexts, political censorship. In several Central Asian countries, suicide remains a highly sensitive topic, often subject to cultural silencing or avoidance in both official discourse and public media. State-controlled or self-censoring news outlets may minimize coverage of such events, either to preserve national image or avoid public unrest. This creates an epistemic gap in understanding the full scope of the issue. Consequently, the data analyzed may reflect only a partial representation of the phenomenon, thereby potentially underestimating the prevalence and intensity of the risk. Acknowledging these structural blind spots is crucial to interpreting the results with appropriate caution and advocating for more transparent reporting mechanisms.

*1 ROLE OF TECHNOLOGY IN SOCIAL PROTECTION*

It is considered that the mass media act as a tool for groups to negotiate public recognition for their values. The press can portray events as "disturbing" and groups must align their narratives within the interpretive

frameworks developed in the media to receive any social recognition. By acting as "expert" sources in the media, stakeholders in the growing domain of the "new" suicide interaction can observe the changing communication landscape for the understandings of suicide in cultural contexts. A qualitative content analysis of print media articles about suicide is carried out. The purpose is to provide an account of the understanding of suicide and its prevention beyond individual components of ordinary life. The headlines, texts, and voices present in print media articles published in Australia, Canada, New Zealand, the UK, and the US from 2005 to 2015 archived in the News Archive of the Mental Health Foundation of New Zealand were analyzed using inductive thematic analysis procedures. This understanding closely reflects the socio-political landscape contextualizing the events in the articles, revealing how these can both initiate and inhibit social change in public cultures. It has also provided a new avenue for social analysis as much as it has modeled an understanding of a particular issue.

The application of new technologies in the prevention and management of suicidal behavior is growing rapidly. The approaches were collected, classified, and presented in context. Three mechanism categories were identified for intervention. The interventions aimed to improve training for mental health professionals, disseminate information for at-risk subjects, personalize prevention, and increase contact between populations by technological means. The categories were addressed by five types of professionals. The top applications included automatic message routing, reduction of emergency services overload issues, and online therapy programs. Because the option was available, several services for large-size populations were developed. There were country differences in technology use. The new technologies could be converted into valuable tools in the prevention and management of suicidal behavior when appropriately adapted to specific contexts [29].

*i. Telehealth Services*

The COVID-19 pandemic has necessitated a review of existing health care delivery systems to identify weaknesses and mitigate any resulting negative impacts for future pandemics. The provision of telehealth mental health services has emerged as a potential method of continuing care to allow for a level of protective measure that would be safe for both provider and consumer. Telehealth is an umbrella term for the application of technologies to communicate health services and education at a distance. Although telehealth is not a new concept, the COVID-19 pandemic has forced major systems and providers to adopt telehealth technology without the opportunity to evaluate it first. Telehealth has the capacity to increase accessibility to mental health care, especially in hard to reach or underserved areas.

Mental health professionals in large health care systems have been using electronic health records (EHRs) for over a decade. Before the COVID-19 pandemic, many mental health providers working in traditional health care settings with an EHR had limited direct experience with telehealth platforms. Since the onset of the pandemic, mental health care has been reconfigured to telehealth services using EHR telehealth options, third party platforms, relational telehealth applications, and free consumer applications. Common reasons providers opt out of telehealth mental health services include fear of socializing through technology, restricted beliefs regarding therapy's nature, and concerns with the system and research.

The dramatic changes to the services provided over a brief period have the potential to negatively impact the provision of telehealth mental health services. Three main vulnerabilities associated with the use of telehealth, specifically videoconferencing applications, are examined. The first vulnerability revolves around a lack of consumer protections in the case of unregulated and widely available videoconferencing options, which have been demonstrated to violate basic privacy and security standards. The second addresses the interpersonal norms of verbal and non-verbal expressions in videoconferencing services when animating existing therapeutic interventions. The third regards the loss of documentation and auditing safeguards inherent in organized health care delivery systems. Other vulnerabilities derived from individualistic consumer/provider factions are noted as well. Solutions to the assessed vulnerabilities are also provided [10].

*ii. Online Support Communities*

People who are vulnerable to suicide may actively or passively observe discussions in online forums available in social networks. Commonly available chat forums focusing on suicide and self-harm offer an informal online support community and are an option for vulnerable persons to directly contact other individuals who have been through similar experiences [30]. It is also possible to find anonymous suicide-related photos, videos, and posts, some of which even go as far as online suicide broadcasting. Social media, aside from its more public platforms, also provides private networks for communicating about suicide.

Most online discussions about suicide within such communities revolve around similar concerns. Due to the anonymity provided by the internet, users are free to express their feelings in a way that they may not be able to offline. In such a state, the crisis is viewed as more of a shared experience and running commentary than solely an individual problem. Vulnerable persons have indicated that such anonymity has allowed them to discuss their feelings, thoughts, and issues without fear or shame of judgment.

However, online support communities are also seen as a space to witness others speaking about, encouraging, and contemplating suicide. One downside to joining a support community is that it exposes individuals to thoughts, motivations, and options for self-harm, thus modeling and reinforcing suicidal behavior. Alternatively, such forums may offer some hope that others can and have overcome the thoughts of suicide. In addition, vulnerable persons have reported feeling guilty for receiving too much support, no matter how genuine. The context of online discussions may perpetuate feelings of hopelessness and invalidation stemming from previous off-line experiences. Vulnerable persons may respond with feelings of anger or helplessness at another member's suicide, leading them to withdraw from the community entirely or expect too much of members' responses.

*2 CASE STUDIES*

The study of social protection of individuals vulnerable to suicide due to psychological pressure is recently popular among scholars. Nevertheless, the inconsistency of triggering factors, phenomena of psychological pressure, and the lack of functional techniques and instruments to ensure social protection to individuals remain unresolved problems. Consequently, there is a need to analyze the sociological, legal, and psychological aspects of social protection of individuals vulnerable to suicide due to psychological pressure more comprehensively. To prevent individuals vulnerable to suicide due to psychological pressure from occupying a position of social non-receptivity, a proposed essential means of social protection is psychological protection by social institutions [1]. On the one hand, this protective means includes mechanisms for ensuring that society attends to vulnerable individuals and for informing such individuals of trusted psychological assistance services. On the other hand, this protective mechanism offers referral and support services for psychological assistance to individuals resistant to conventional support, in collaboration with specialized institutions providing psychological protection and medical care for those vulnerable to suicide due to severe psychological pressure. Implementation of the proposed means of psychological protection requires the introduction of social technologies by national legislators and social institutions.

Recognition of a vulnerability to a suicide due to psychological pressure factor as a triggering factor is not a necessary condition for social protection to an individual who has been denied social recognition. The person cannot be regarded as vulnerable to suicide on account of psychological pressure till the criteria for determining an individual as vulnerable to suicide by psychological pressure is met. Non-presence of recognition of a fact of this vulnerability only connected an individual with the designation of a social status of social non-receptivity as such, related to vulnerability to suicide due to psychological pressure. Acceptance of denial of social receptivity by social institutions made social and sociological protection against suicide due to psychological pressure inoperable. Otherwise stated, the mechanisms involved in protection from vulnerability to suicide due to psychological pressure by social institutions have become inapplicable and thus required modification.

*i. Successful Intervention Examples*

In recent years, various initiatives have been successfully implemented to address the challenges of social inclusion and support for vulnerable individuals. This section presents the key accomplishments and ongoing developments of three innovative initiatives that have been launched in different parts of the world. In Japan, the e-learning program was co-designed by researchers and practitioners to support affable engagement with ICT. In Hong Kong, a new citizen-led initiative on companionship and peer support for mental wellness is harnessing the power of citizens to enhance community inclusion. In Canada, a healthy dialogue is being fostered between the business and social sectors on the importance of mental wellness in the workplace as well as practical solutions.

In Japan, the Tokyo project has harnessed advances in digital technology to promote volunteerism and outreach support to socially isolated people. In an effort to promote social participation and inclusion of marginalized people, over 300 volunteers of all ages and backgrounds were trained in peer group facilitation and community outreach. Last November, local neighborhoods opened their doors to call in social VR. A peer

group of five women who have experienced overly enthusiastic engagement in cyber-mental health communities used VR to talk about how they recognize when peer support turns into cyber-bullying. An elderly male influential local volunteer educator demonstrated on social VR how to make origami co-medium. Such authentic co-creativity created a learning experience that inspires other communities.

In Montreal, a free service offered by people with lived experience of mental illness helps users supplement their daily activities by promoting their mental wellness. Users may select services freely or get matched with a companion by volunteers. In only less than six months, over 3,500 users and volunteers were engaged through the collaboration labs and the service has gained much public attention. During the report launch, funders, civil society, academia, management consultants and even people with lived experience gathered in a mental wellness-friendly setting to have a healthy dialogue on how to collaborate for the transformation. Consulting companies, scientists, management, executive talent, and innovative ideas were freely shared at the end. All these achievements are real indicators of the starting phase of mental wellness innovation in Montreal.

*ii. Failures in Social Protection*

Successfully taking a weakness of a system into account, social protection-related states, all institutions, organizations and individuals who participate in a given social protection-related ground, management systems possibly being non-human, traditional, administrative, institutional, legislative or software. Societal system failures, systemic level on the traditional organizations of social protection analysis, such as family, kin, community, state, NGOs, state social services, Universities and businesses, but research evidently focusing on legal these latter two areas. The analysis of failures of types of protection provided by reign norms of these, strategic areas, movement within one systemic area is intended to ensure at least partial success for failures of functionally distinct organizations. Such one uncertain system of motives in the late system in researching which suicides had taken place and to supporting legally preventing these re-profits. However, legislating legal means cut across functional boundaries of the family sphere. Family and judicial failures. No effective action was taken in response to the complaint about threatening behavior. Both the police and district-level social services failed to enforce the removal of the perpetrator. Numerous scholars have examined similar cases, highlighting institutional inertia in situations involving domestic threats. On multiple occasions when the victim engaged with the police, their inability to act decisively was starkly apparent. The legal measures, marred by incompetence and lack of coordination, were often rendered ineffective even before implementation. As a result, significant dissatisfaction arose regarding the speed and effectiveness of deterrent actions—particularly in preventing the return or continued presence of the male family member in question. The male relative was able to elude measures taken to maintain peace after every successful legislative mean of protection, being hidden in a tool shed or on a street from which he was a resident [2]. Other actors. Not only courts and police, but also State healthcare institutions, neighborhoods, kindergartens, nurseries and schools in the town all failed. The healthcare system inexplicably sided with the abuser, being blind to encroachments on the safety and integrity of the woman and her children concerning maternity care, child and adolescent health visitors, juvenile, polyclinic, ambulatory care and emergency services. Some of the mopped-up encounters mentioned either ordered, neglected or supported the presence of men at home, with a facility near to the victim's residence. No less than several scholars have examined this combination of professionals are indifferent to the determination of men outside (male family member). Such failures were presented in a mixed way and their illusory competence, credibility or intelligence were noted.

*3 POLICY RECOMMENDATIONS*

Based on the results of investigations and risk factors mentioned, a set of proposals is provided to local authorities, care departments, schools and youth institutions, prison services and a number of activities. Possible actions aimed at those intended for teenagers aged 20-28 studied in recent years. The importance of family relationships on suicidality, especially in orphaned children, is reported, namely: conflict in the family, lack of affectionate relationships, and lack of mother/fatherly care and understanding. Negative relationships with parents are also associated with suicidal ideation. The relationship of suicidal ideation to parental care in preschool studies is examined. There is some indirect evidence that the number of deaths can be reduced by providing school-based youth mental health services. Studies have shown decreases in suicidal ideation and attempts, depression and associated behaviors, but so far haven't shown changes in self-reported or official records of suicide. Support systems in schools or clinics that are effective in increasing help-seeking are known but not widely implemented. In light of the results of the studies carried out, it is proposed to achieve a

significant reduction in deaths from suicide in the general population by creating, maintaining and conducting some care systems in which above-mentioned youth can easily turn to teachers and guardians would become educated and trained. Their aim is 1. To meet all the above-mentioned protective factors; 2. To develop a suicide prevention strategy. To achieve the goal of creating a suicide prevention environment, tasks should be provided for specialists: To work for, and establish a research base; To find evaluation managers; To set up a working group from a youth perspective; To conduct questionnaires; To provide feedback; To create supervision systems.

Establish teacher guidance teams in each secondary school that guide care systems and are educated on this topic. Conduct qualification assessment activities and provide feedback for teams educating teachers and mental health workers. Carry out campaigns with national awareness-raising messages. Provide courses to improve conditions of the youth. Establish in each region the possibility of maintaining and developing juvenile centers that co-ordinate youth, amplify their powers and determine their self-efficacy. Create and maintain the possibility of regular meetings of youth with qualified persons and any student on hunger strike intending to commit suicide. By this cooperation, researchers can promote and popularize the use and improve the outreach of above-mentioned safety nets. Policy changes should be made regarding the continuing education of social services personnel to enhance motivation and appreciation of work.

Policies should be developed to ensure continuity of care during and after studying in a youth institution and/or school. When preparing policies regarding research in mental health, suicidal ideation, and behavior among adolescents, the youth should be put at the center of the work. Prioritize gaining an insight into the mental health of this population ranging from studies to the development of data collecting techniques, methods, standards, and frameworks. By channels, refer and recommend researchers educated on ethical and research issues to conduct scientifically accurate, free, and safe studies. In cooperation with schools, answer questions and challenges arising about the fitness of research or social media in the domain of mental health. Regional as well as state-wide platforms should be established for similar and repetitious processes on research mental health at schools, co-operating with scholars and involving school researchers and youth.

*i. Improving Legal Protections*

On October 24, 2022, State Duma members of the Russian Federation passed a bill proposed by the Ministry of Digital Development, Communications, and Mass Media of the Russian Federation aimed at improving legal regulation in the field of information technologies. Personal data subjects were allotted a right to submit a request for blocking the processing of their data prior to the expiry of the storage period or the purpose of processing, if that request has not been satisfied by a personal data operator. “Roskomnadzor” was granted a right to unilaterally block Internet pages containing false information about a person. Such correction requests, as well as notification of changes in the information being processed, were not previously stipulated by the law. Blocking guaranteed that the information would not be accessible to the general public, and it was up to the authorized bodies to determine the list of conditions for blocking a request to use personal information. If any of the conditions occurred, including criminal prosecution of the person in a foreign state, urgent case/etc., an authorized body would inform a personal information operator about it.

A personal data subject could request blocking of the processing of its personal data for a reasonable period of time prior to the expiry of the purpose of processing. An operator’s refusal to satisfy a request for blocking could be contested in court. The deletion period was supplemented by an obligation of blocking of a request for deletion of the personal data a refusal to satisfy which has been contested in court until the court decision is entered into the legal force [1]. The same service was stipulated for subjects having special status because of the request for personal data being first blocked even if it had not been satisfied. Mass media were relieved from liability for disclosing personal data without prior written consent in the event of dissemination of an official response to an inquiry from a competent authority and other authorized organizations about the criminal prosecution of a person, a civil arrest of property, etc.

The subjects pointed to the possibility of requesting the blocking of personal data as one of the elements of a digital trace. This was deemed as important because of the collecting, integration, and post-usage intricacies that were considered to be extended to the global network. Research was aimed at examining the provisions of bills in conjunction with the current needs of citizens, IT threats, and at the same time, through the prism of the inevitable economic situation in the country, its consequences, and possible mitigation scenarios [31].

*ii. Enhancing Community Programs*

Older adults have a greater prevalence of chronic illnesses, disabilities, and immobility problems, making them more vulnerable to a higher risk of isolation and social oppression [32]. To increase both physical and emotional well-being for vulnerable older persons in community settings, it is necessary to develop effective and protection-promoting programs [33] [34]. The suggested two-year intervention is focused primarily on two types of stressors: (1) psychological stressors arising from loss, such as persistent reminding of the deceased or getting lost in memories of the deceased; and (2) environmental stressors such as noise, weather changes, and social changes due to the pandemic [35]. So that it is believable that both types of stressors will continue to be a problem to face even after the lockdown. Emotional caring is suggested for the first type of stressor, and environmental alterations are recommended to deal with the second type. Programs aimed at protection should prioritize enhancing social relationships with family, friends, and neighbors, as feeling loved led to a reduction in psychological problems. Neighboring older persons provide high-quality emotional care, and it is also helpful to observe whether they have been physically active and with whom they socialize. Hence, creative strategies should be provided to apply that need to be developed, such as random matching to share stories and experience with each other [36].

Under this assumption, the whole province is expected to reduce psychological stress on older persons caused by loss as well as environmental effects such as social distancing and stay-at-home warnings during pandemics, empower selected participants to enhance their emotional care, and encourage them to share their facilities with older persons who have further needs [37]. Emotional care is based on the recognition of fellow citizens at risk, thus, unconsciously transforming the whole province's awareness into improved concern of the vulnerable and socially excluded [38] [39] [40]. In order to continue boosting efforts to enhance communal relationships with others, programs could actively delimit the needs of the participants as well as creative solutions, including whether to implement them at school, a community center, or church, and what information should be shared to underline its sustainability [41].

*4 FUTURE RESEARCH DIRECTIONS*

An important direction for future research is on the sociological aspects of suicide, with a particular focus on studying how the culture and structure of social networks affect the likelihood of suicide for individuals. One pathway for doing so is for researchers to introduce strategies from social network analysis to better measure and model the effects of the sociological dimension of the external social world on suicidal ideation and behavior. For example, egocentric network methodology offers a promising way to better measure the culture and structure of a person's proximate social environments prior to suicide than what is typically done, which is to rely exclusively on data on an individual's perceptions or experiences of social connection and disconnection. Such data rarely considers variation in the social environments of individuals [42]. Also, for sociologists, a promising direction for suicide research is on how social influence operating through the culture and structure of social networks may ignite suicidal ideation and behavior for particular individuals.

In particular, it may be that the efficacy of social influence is a function of the capacity for suicide of the individual targeted by the influence. Cultural scripts for suicide that prevail in salient social groups may be the basis for people's capacity for suicide, or "having the means and knowledge to act" (as distinguished from the motivation which prompts individuals to act, i.e., the will to die). Individuals may then be particularly vulnerable to suicidal ideation and behavior once the knowledge of how to die by suicide, or a script for suicide, is made available to them through cultural influence or socialization. Statistically, this hypothesis would contend that the effect of social influence would be particularly strong when propensity for suicide has been controlled for, at least in countries and communities with comparatively lower rates of suicide. Alternatively, the efficaciousness of social influence may be the result of how interconnected the individuals who receive it are (i.e., with individuals themselves experiencing the same suicidal ideation and behavior) [43]. Conversely, social infrastructures that act to weaken the capacity for suicide could be expected to insulate individuals from particular proposed sociological influences [44].

*i. Emerging Trends in Mental Health*

The past decade has witnessed the emergence of global trends in mental health combined with deliberation at a global level on this theme for better. The efforts ranged from declaration at a high level to the grassroots level. This paper considers the sociological, legal, and psychological aspects underlying these trends and the present status of the mental health services, the way; and also, how they should be accessible to all across the socio-economic strata. The conjunction of the legal implications of the decrease of the mental health

professionals for the fragility of the clients can turn out to be a greater cause of worry than more. The sprawling mass digitalization or the tremendous increase in the group of social media in less than a decade has taken a toll. A huge wave of threats, negativity, exploitation, bullying, stalking, etc. resulted post-Covid-19 and hitting hard at the community level, civilly, organizationally, politically, and inter-personally.

The across-the-board restrictions and approve coordination in licking up the economy considerable increment. In a way, people seemed to conversely go privative, planting a shredding disappointment identical amid all. Physical facilities or the craze for smartphones and their knick-knacks- particularly among the adolescent and youth - were practically sold contact and creativity, social and nurturance needs, maturation, and other pursuits. The equilibrium of the mind and physiology became perceptibly disordered after grievances. Irrespective of age, state of existence, variety, status, and locale - it was all true, unheralded worthy daily tragedy everywhere. There arose a question about entry the competence of social protection - the reserve to notice prevention and to cope with the outcomes [10].

There are about 100,000 mentally afflicted multiplied by which 1,000 opting for suicide leave distressing number more devastated. Too many need attention/a helping hand beforehand. Floods fire with guilt, remorse, fear, and numbness among concern next. Friends and priceless peer coping may prove preposterous in several instances. Hence the predicament of helplessness. The vulnerability may remain dormant for arrogance pursuit of ego-rescue alone. In returning cycles of such tragedy or a large number of deaths and an exceptional cluster of suicides inundate the mental health professionals (MHPs). They are engaged in the stigma of helplessness, failure, guilt, dread, and professional apprehensions with overlap ideas on the suicide high-risk.

*ii. Cross-Disciplinary Approaches*

Suicide mortality is a critical global public health problem and is increasing in many countries [3]. The increasing rates of suicide highlight the importance of understanding the social roots of suicide. Psychological factors are relevant for suicide, including mental disorders or mental distress. The knowledge of specialists from psychology is key for understanding the psychobiological antecedents of suicide, the most relevant environmental causes of suicide, and some protective factors for suicide. However, it is not sufficient to understand suicide entirely. There is the need for knowledge about the roles of a person's broader social environment and its regulation in preventing suicide. Followingly, social protective factors for suicide are theoretical and methodological contributions from sociology in the form of personal social networks and the social regulation of the social support network.

There are indications that the roles of the broader social environment in understanding suicide and informing suicide prevention are increasing. Rates of suicide have climbed dramatically in many Western countries, and rates are increasing in many developing countries. As the number of suicides rises, there has been a growing focus on understanding the social environment's roles in suicide and suicide prevention. Compared to other disciplines, sociology is especially well situated to understand the social roles in the etiology of suicidal ideation and behavior. There have been sociological theories of suicide since the time of Émile Durkheim's classic. Durkheim's ideas have inspired broad areas of research and theory development, including several positive strands of research firmly rooted in sociology. However, these sociological theories of suicide have had limited impact on understanding suicide.

Many psychological theories of suicide also acknowledge social and environmental factors as relevant for suicide. Because of this intersection, psychological theories of suicide and surrounding research offer a likely avenue to facilitate incorporating these sociological insights into the academic and public discourse on suicide. Interpersonal theory of suicide is a widely researched psychological theory of suicide. Because this theory explicitly incorporates social factors involved in suicide, it offers entry points for integrating insights about social protective factors for suicide from sociology. A broad area of research has developed concerning factors leading to interpersonal needs to die by suicide. Feelings of thwarted belongingness, perceived burdensomeness, and social isolation are prominent antecedents of suicide.

## V. CONCLUSION

*i. Recognizing Suicide as a Policy Priority*

One of the most fundamental responsibilities of any society is to ensure the safety and well-being of its members. In this context, the field of social protection plays a crucial role in addressing emerging threats to

life—including suicide, which has become an alarming concern across many regions. Despite declining budgets for social programs, the value of human life must remain a non-negotiable priority.

This paper focuses on suicide risk specifically related to sustained psychological pressure, arguing that such vulnerability demands distinct legal and social recognition.

*ii. Legal and Ethical Foundations*

To guarantee both ethical integrity and legal accountability in suicide prevention, it is essential to examine precedents such as *Tarasoff v. Regents of the University of California*. This landmark case established the legal duty of mental health professionals to warn potential victims, highlighting how individual rights and public safety can be jointly protected through law.

The paper contends that current legal frameworks must evolve to address non-clinical psychological vulnerability as a legitimate risk category, especially in post-pandemic, resource-limited settings.

*iii. Conceptual Advances: Calendar Suicide*

A key theoretical contribution of this study is the introduction of the "calendar suicide" model, based on patterns of suicides occurring around culturally or socially significant dates. Drawing on interdisciplinary research in sociology, psychology, and forensic studies, the paper proposes a causal chain that links public pressure, information exposure, and emotional cycles.

This model is further generalized into a universal factorial curve of mass social events, offering a conceptual tool applicable across various domains beyond suicide.

*iv. Policy and Professional Recommendations*

These findings carry implications for both public policy and professional practice. At the policy level, the study recommends:

1. Legislative reforms that recognize psychological distress—even in the absence of clinical diagnosis—as grounds for social protection and emergency intervention;
2. Community-based mental health services, particularly in rural and underserved areas, supported by mobile units and peer support;
3. Digital inclusion policies, ensuring that telehealth platforms are accessible to elderly, low-income, and digitally excluded populations.

For practitioners—including educators, clinicians, and platform designers—there is an urgent need to implement standardized risk assessment tools (e.g., SAD PERSONS, C-SSRS), adopt culturally sensitive communication strategies, and improve cross-sector coordination.

*v. Final Reflections*

This paper argues for a fundamental paradigm shift: moving from reactive, siloed social protection systems to proactive, integrated frameworks. These frameworks must be culturally grounded, ethically sound, and legally enforceable. Recognizing psychological vulnerability not merely as a medical issue but as a socio-legal condition is vital for designing inclusive protection mechanisms that uphold dignity, autonomy, and the right to life.

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## Author contribution

All authors made an equal contribution to the development and planning of the study.

## Data Availability Statement

Data are available from the authors upon request.

## Conflict of Interest

The authors have no potential conflicts of interest, or such divergences linked with this research study.

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