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Suicide Prevention Among Adolescents: Integrating Psychological Assistance with Legal and Social Frameworks

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ABSTRACT: Adolescent suicide remains one of the most pressing global public health challenges, reflecting a complex interplay of psychological vulnerability, social disconnection, and inadequate institutional responses. Despite advances in clinical psychology and psychiatry, prevention strategies often remain fragmented, failing to bridge mental health care with the legal and social protection systems necessary for sustainable impact. This paper examines adolescent suicide through a multidimensional framework integrating psychological, legal, and social components. Drawing on international research, case studies, and policy analyses from WHO, UNICEF, and national health ministries, the study emphasizes that early identification, confidential psychological counseling, and family-based interventions must operate alongside legally mandated protection protocols and community engagement programs. Empirical data were collected from three regions representing diverse socio-economic backgrounds, using a mixed-methods approach combining surveys, interviews, and psychological assessments. Empirical data were collected using a mixed-methods design from three Central Asian countries Uzbekistan, Kazakhstan, and Kyrgyzstan comprising survey responses from 612 adolescents aged 13–18, alongside interviews with parents, educators, psychologists, and legal or social-service professionals. The findings highlight critical gaps in legal accountability and the underutilization of social networks as preventive tools. The proposed integrative model the P-L-S framework aims to synchronize multidisciplinary responses to at-risk adolescents, fostering early detection and coordinated intervention. The article concludes by advocating for a cross-sectoral policy agenda that aligns educational institutions, healthcare systems, and justice departments within a unified prevention ecosystem.

Keywords: adolescent mental health, suicide prevention, legal frameworks, psychological support, social protection.

I. INTRODUCTION

1. BACKGROUND AND SIGNIFICANCE

Globally, more than 700,000 people die by suicide each year, with an estimated 77% of suicides occurring in low- and middle-income countries [1, 2]. In Central Asia, including Uzbekistan, Kazakhstan, and

Kyrgyzstan, the prevalence of adolescent self-harm has shown a worrying upward trend. Factors such as migration, socio-economic instability, family separation, academic stress, and digital bullying intensify the psychological fragility of adolescents. Yet, despite the magnitude of the problem, suicide prevention systems remain largely reactive focused on crisis response rather than proactive, integrative prevention. Adolescent suicide has emerged as a significant global public health concern, affecting diverse regions, cultures, and socio-economic contexts. According to the World Health Organization, suicide is among the leading causes of mortality among individuals aged 15–19, highlighting the need for evidence-based and system-oriented prevention strategies [1, 2]. In Central Asia, including Uzbekistan, Kazakhstan, and Kyrgyzstan, recent epidemiological data indicate an upward trend in adolescent self-harm and suicide-related behaviors, particularly in rural and socio-economically vulnerable populations. These patterns underscore the importance of early detection and coordinated institutional responses [2].

Psychological research emphasizes that suicidal behavior is rarely spontaneous; it follows an identifiable trajectory of emotional pain, social isolation, and unmet psychological needs. The Interpersonal Theory of Suicide [3] posits that individuals die by suicide when they simultaneously experience perceived burdensomeness, thwarted belongingness, and an acquired capability for self-harm. This framework underscores the necessity of early detection, supportive relationships, and consistent mental health follow-up. However, without the reinforcement of legal and social safety nets, psychological interventions alone cannot sustain long-term resilience. Legal scholars argue that the absence of clearly defined responsibility among institutions often results in systemic neglect. For example, mandatory reporting laws for at-risk youth vary drastically by country, and many school systems lack binding protocols for suicide risk assessment. Social frameworks, too, often lag leaving adolescents in environments where stigma, lack of confidentiality, and poor coordination between health and education systems discourage them from seeking help. Therefore, effective suicide prevention among adolescents requires a multilayered approach integrating psychological counseling, legal accountability, and community-driven support.

The significance of this integration lies in sustainability. Purely psychological measures can treat symptoms, but without legal enforcement and social reinforcement, relapse and neglect reoccur. Conversely, rigid legal responses devoid of empathy can alienate the very individuals they aim to protect. A truly effective system must unite these domains translating mental health awareness into enforceable rights and social responsibility.

Although existing literature has substantially advanced understanding of psychological risk factors associated with adolescent suicide such as depression, hopelessness, and social isolation most prevention studies remain limited to single-domain interventions. Prior research typically evaluates clinical or school-based psychological programs in isolation, without embedding them within enforceable legal responsibilities or sustained social reintegration mechanisms. As a result, earlier models improve short-term emotional outcomes but fail to address institutional accountability, continuity of care, and adolescents' rights once risk is identified. The Psychological–Legal–Social (P-L-S) model proposed in this study uniquely addresses this unresolved gap by integrating psychological intervention with legally mandated protection protocols and structured social support systems. Rather than treating suicide prevention as episodic counseling, the P-L-S framework operationalizes prevention as a coordinated system in which mental health care, legal accountability, and community reintegration function simultaneously, ensuring sustainability, early detection, and institutional responsibility.

While global statistics underscore the magnitude of adolescent suicide as a public health issue, regional contexts shape how risk factors are expressed and addressed. In Central Asian countries, socio-economic transition, labor migration, and evolving educational systems have placed additional strain on adolescents and the institutions responsible for their welfare. Despite growing awareness, prevention efforts remain uneven due to fragmented coordination among schools, healthcare providers, and legal authorities. These structural weaknesses provide the rationale for an integrated framework capable of aligning psychological support, legal responsibility, and social protection within a unified prevention strategy.

2. PROBLEM STATEMENT

Teenage suicide is not just a problem of medicine or psychology; it reflects a broader collapse in social protection, legal responsibility and institutional empathy. Despite an increased emphasis on interventions at the level of individuals, there has been much less attention given to the broader systemic factors that maintain vulnerability factors which continue not to be addressed. Thus, the issue is not lack of awareness, but fragmentation of responsibility. An estimated 89% of all adolescents who engage in suicide-related behaviors (SRBs) have contacted an adult professional, that is, a teacher, a school counsellor or health care personnel within the past three months [1]. However, referral to mental health care was warranted in fewer than one quarter of these contacts. This lack is not a question of ignorance, but rather the absence of legally required mechanisms for response and cross-sector collaboration. Teacher and doctor duties are ill defined; families are not well educated about their rights; social work lacks legal authority for early intervention.

In Uzbekistan, like in most post-Soviet countries, suicide among teenagers is the slowly rising tide particularly in rural communities and amongst the children of migrant workers. The Ministry of Health [4] reports that 13% of adolescent deaths are attributed to intentional self-harm. However, there is no standardized national protocol that can be implemented to detect suicidal idea at an early stage in schools, clinics, neighborhoods etc. Key national legal provisions ('Law on the Protection of Rights of the Child' (2021) focus on state protection but lack operational outline in education and health systems [5].

Current adolescent suicide prevention systems lack several critical operational mechanisms. First, there are no standardized cross-sector escalation pathways to ensure that early psychological warning signs detected in schools or clinics trigger coordinated institutional responses. Second, legally defined thresholds for mandatory action and reporting remain unclear or absent, leading professionals to hesitate due to fear of overstepping authority. Third, most systems lack structured post-crisis social reintegration protocols, resulting in adolescents returning to unchanged environments after acute psychological support.

The P-L-S model directly addresses these systemic deficiencies by introducing unified screening triggers, codified institutional duties across education, health, and justice sectors, and a reintegration phase that actively reconnects adolescents with family, peers, and community resources. Through this mechanism-based design, prevention is transformed from fragmented, discretionary responses into an organized continuum of care with clearly defined responsibilities and timelines. Thus, the issue is more of a systemic misalignment:

- Mental health systems are not inadequate, but underfunded and understaffed. Most schools have administrative, rather than therapeutic, psychologists.
- There are no official systems to force any institution to be accountable for their lack of prevention or reporting.
- Social systems particularly family and community connections are still shamed when they have conversations about suicide, so it's not talked about, but swept under the cover.

In addition, digital realms have developed as a middle ground of psychological hazard. "Suicide challenges," cyberbullying, and access to self and pagem harm materials all are associated with elevated suicidal ideation in adolescents [6]. Despite internationalization, legislative instruments regulating harmful content are patchy and the predictive algorithms of social media are at best reactive. The overlay of psychological fragility, legal stasis and social disintegration produces a "prevention vacuum." Troubled teenagers are caught between their environment's code of silence and the red tape of institutions. The P-L-S Framework proposed in this paper fills such an information flow gap by constructing a model that facilitates all of the three systems to communicate smoothly.

In brief step, the problem statement attempted to be answered by this work is "Although there are already psychological and educational programmes directed towards supporting the mental health of children and youth, a lack of coherent legislative mandates and socially embedded support systems hampers effective prevention of suicide among young people". This central problem is what drives this research towards the creation of an integrated model of prevention, designed to transcend current lack of system coordination in such way that prevention can be turned from a patchy approach into an integrated one that is both right-based and social-embedded.

II. DATA COLLECTION

1. METHODS

To analyze the intersection of psychological, legal, and social frameworks in adolescent suicide prevention, the study adopted a mixed-methods design combining quantitative survey analysis, qualitative interviews, and policy review. This approach allows for triangulation enhancing both the reliability and the contextual depth of findings.

1.1 Research Design

The study followed a convergent parallel design [7], where quantitative and qualitative data were collected simultaneously but analyzed separately before integration. Quantitative data measured prevalence, awareness levels, and institutional response rates; qualitative data explored lived experiences, professional insights, and structural barriers.

1.2 Sampling and Participants

The research was conducted across three national contexts Uzbekistan, Kazakhstan, and Kyrgyzstan selected for their comparable socio-cultural and legislative environments yet differing levels of mental health infrastructure.

- Total participants: 612 adolescents (aged 13–18), 124 parents, 86 educators, 47 psychologists, and 29 legal/social service representatives.
- Sampling method: Stratified random sampling ensured representation across urban, semi-urban, and rural schools.
- Inclusion criteria: Adolescents currently enrolled in secondary education, with parental consent and no active clinical diagnosis of psychosis or severe cognitive disorder.
- Exclusion criteria: Individuals undergoing psychiatric hospitalization or lacking parental consent.

Ethical clearance was obtained from the National Psychological Research Ethics Committee [8]. All participants provided informed consent; data were anonymized, and identifiers were replaced with alphanumeric codes.

The sample size of 612 adolescents was considered sufficient for both quantitative and qualitative analyses. For the quantitative component, this sample exceeds minimum thresholds for multivariate analysis and provides adequate statistical power to detect medium-sized effects across subgroups. For the qualitative component, thematic saturation was reached after approximately 40 interviews, with no substantially new codes emerging in later transcripts, indicating adequacy for thematic analysis.

1.3 Quantitative Data Collection

A structured questionnaire titled "Youth Psychological Resilience and Legal Awareness Scale (YPRLAS)" was designed by the researchers, adapted from Beck's Hopelessness Scale and the Columbia Suicide Severity Rating Scale (C-SSRS). It consisted of four domains:

- Emotional resilience (8 items)
- Social support perception (6 items)
- Legal awareness of protection rights (5 items)
- Access to psychological assistance (7 items)

Responses used a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree). Cronbach's alpha for internal consistency was 0.88, indicating high reliability.

Quantitative data were gathered via in-school digital tablets under researcher supervision, ensuring standardization. Data were later coded and processed using IBM SPSS Statistics 28. Descriptive statistics (mean, SD), inferential tests (ANOVA, regression), and correlational analyses were applied to assess associations among psychological, social, and legal indicators.

1.4 Qualitative Data Collection

Semi-structured interviews were conducted with:

- 15 adolescents identified by school psychologists as at-risk (but not in active crisis);

- 10 parents who had previously engaged with social services;
- 12 teachers and 6 psychologists representing educational institutions; and
- 8 legal/social officers responsible for youth protection cases.

Interview questions focused on:

- Accessibility and stigma surrounding psychological services;
- Institutional obligations and response gaps;
- Legal awareness and rights protection;
- Family and community engagement in preventive interventions.

Each interview lasted approximately 40–60 minutes and was audio-recorded, transcribed, and thematically coded using NVivo 14. A grounded theory approach [9] guided open and axial coding, generating recurring conceptual categories (for example, "legal helplessness," "institutional silence," "family concealment").

1.5 Document and Policy Review

To contextualize findings, national legislation and policy frameworks were analyzed:

- Uzbekistan's Law on Mental Health [10]
- Kazakhstan's Law on the Rights of the Child [11]
- Kyrgyzstan's Suicide Prevention Strategy (2020–2025) [12]

Additionally, WHO and UNICEF regional reports [13] were reviewed to assess policy alignment with global standards such as the WHO Mental Health Action Plan 2013–2030 and the UN Sustainable Development Goal 3.4 (Reduce Suicide Mortality).

1.6 Validity and Reliability

- Triangulation: Integration of multiple data sources and respondent groups minimized bias.
- Member checking: Qualitative transcripts were returned to participants for accuracy confirmation.
- Peer debriefing: Three independent experts reviewed coding frameworks to enhance analytic rigor.
- Inter-rater reliability: Cohen's Kappa = 0.82 indicated strong agreement among coders.

1.7 Ethical Considerations

Given the sensitivity of the topic, additional precautions were taken:

- Immediate referral to counseling services for participants expressing distress.
- Parental involvement in post-survey debriefings.
- Collaboration with local NGOs to ensure continued support for identified at-risk adolescents.

The research adhered to the American Psychological Association's (APA) Ethical Principles (2017) [14] and UNICEF Guidelines on Adolescent Participation [15], ensuring protection, confidentiality, and non-stigmatization.

2. EXPERIMENTAL GROUPS INFORMATION

The study's intervention component aimed at evaluating the effectiveness of an integrated prevention model was implemented through three experimental groups and one control group, totaling 240 adolescents (60 per group). The interventions spanned six months (January–June 2024).

Table 1. Evaluating the effectiveness of an integrated prevention model.

Group	Intervention Type	Components	Supervising Entity
E1 – Psychological Focus	Cognitive-behavioral training and resilience workshops	Weekly sessions with licensed school psychologists; emotional regulation exercises	Ministry of Public Education
E2 – Legal Awareness Focus	Youth Rights Education Program	Workshops on child protection laws, confidentiality, and digital safety	Ministry of Justice

E3 – Integrated P-L-S Model	Combination of psychological, legal, and social modules	Counseling + legal literacy + family workshops + peer support circles	Joint supervision (Education + Health + Justice)
C – Control Group	Standard school counseling only	One-off mental health awareness talk	Local school administration

Each intervention session lasted 90 minutes, conducted weekly for 12 consecutive weeks. Attendance was mandatory but voluntary participation in surveys remained optional. All sessions followed a structured curriculum designed by a multidisciplinary expert panel.

2.1 Implementation Stages

- Baseline Assessment (Month 1): All participants completed the Youth Psychological Rights Legal Awareness Scale (YPRLAS)and a brief risk assessment survey.
- Intervention Phase (Months 2–5): Each experimental group received targeted sessions according to their module type.
- Post-Intervention Evaluation (Month 6): Re-administration of YPRLAS and focus group discussions.

2.2 Training of Facilitators

Facilitators included 6 clinical psychologists, 4 social workers, and 3 legal education officers. They underwent two-week preparatory training, emphasizing trauma-informed communication, confidentiality, and adolescent engagement strategies. All facilitators were supervised by an ethical oversight board.

2.3 Expected Outcomes

The interventions sought to measure:

- Reduction in suicidal ideation (primary outcome);
- Increased legal awareness and help-seeking behavior (secondary outcomes);
- Strengthened social connectedness and family communication (tertiary outcomes).

It was hypothesized that the E3 (Integrated P-L-S Model) group would show statistically significant improvement across all domains compared to single-focus and control groups. The design thus provided both comparative and longitudinal perspectives, allowing assessment of individual improvement trajectories and systemic impact.

III. PROPOSED WORK

1. HOW IT WORKS: THE P-L-S MODEL

The P-L-S framework proposed in this study is an integrative model for adolescent suicide prevention, designed to synchronize interventions across three traditionally disconnected systems: mental health services, legal protection mechanisms, and social support structures. The model operationalizes prevention through three functional axes Detection, Protection, and Reintegration each representing a continuum of coordinated actions that evolve from early risk identification to post-crisis rehabilitation.

1.1 Conceptual Foundation

The framework draws on three theoretical pillars:

- Ecological Systems Theory [16]: Emphasizing that adolescent behavior develops through nested environmental systems family, school, peers, and broader society each influencing mental health outcomes.
- Interpersonal Theory of Suicide [3]: Identifying perceived burdensomeness and thwarted belongingness as precursors to suicidal ideation.
- Rights-Based Legal Theory [17, 18]: Framing mental health not merely as welfare but as a legally protected right, requiring state accountability.

Integrating these theories, the P-L-S model views adolescent suicide not as an individual pathology but as a systemic communication breakdown between personal distress and institutional response.

Legal-rights theory within the P-L-S framework was operationalized through the translation of abstract child-protection principles into concrete institutional procedures. This included defining legally mandated duties for educators, psychologists, and social-service personnel; establishing standardized reporting thresholds; and embedding rights-awareness modules into adolescent and family interventions. Legal literacy sessions transformed statutory protections such as the right to confidentiality, access to mental-health services, and protection from harm into actionable knowledge that guided help-seeking behavior. At the institutional level, accountability mechanisms were operationalized through documentation requirements, inter-agency coordination protocols, and formalized response timelines, ensuring that legal norms functioned as practical safeguards rather than symbolic commitments.

1.2 Model Structure

The model operates through three domains and nine strategic components, visualized as an interlocking triangle (Table 2 conceptual illustration).

Table 2. Model structure.

Domain	Strategic Components	Core Function
Psychological	1. Early Screening 2. Crisis Counseling 3. Resilience Education	Detect and address emotional distress before escalation
Legal	4. Mandatory Reporting 5. Rights Awareness 6. Institutional Accountability	Protect minors through enforceable frameworks
Social	7. Family Engagement 8. Peer Mentoring 9. Community Reintegration	Rebuild belonging and post-crisis support networks

Each domain is governed by a feedback loop ensuring information continuity between schools, health institutions, and social agencies. Data sharing occurs through a secure inter-agency portal (following GDPR-like privacy standards) allowing authorized professionals to flag and monitor high-risk adolescents.

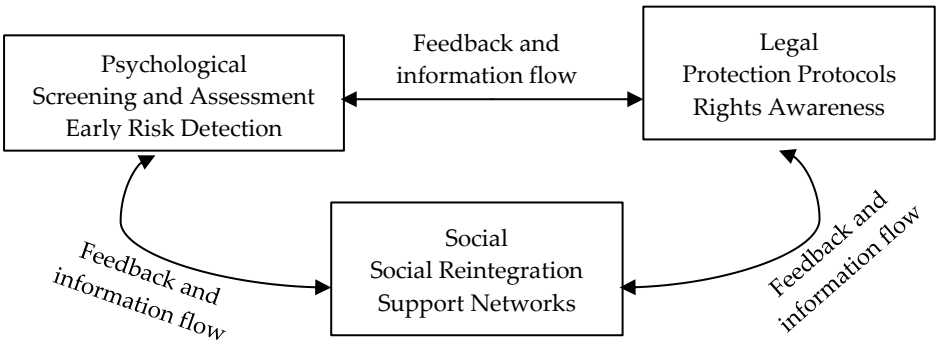

FIGURE 1. Conceptual flowchart of the P-L-S model.

To enhance conceptual clarity, the P-L-S framework is illustrated as a process-oriented flow model (Figure 1). The figure depicts three interacting domains psychological, legal, and social connected through bidirectional information pathways. Psychological screening initiates early risk detection, which activates legally defined protection protocols, followed by structured social reintegration mechanisms. Continuous feedback loops link each domain, ensuring that psychological assessment informs legal action, legal safeguards enable sustained care, and social support reinforces recovery and monitoring. This visual

representation highlights the dynamic, non-linear interaction among domains, emphasizing that prevention outcomes emerge from coordinated system-level engagement rather than isolated interventions.

1.3 Mechanism of Action

a. Detection Phase (Weeks 1–4)

- Implementation of standardized screening tools (YPRLAS and C-SSRS).
- Automatic alerting system if risk threshold exceeded.
- Confidential referral to school psychologist and legal guardian notification under structured confidentiality codes.

b. Protection Phase (Weeks 5–12)

- Individual and group counseling using CBT and DBT modules.
- Parallel legal literacy sessions introducing adolescents to protection laws, cyber-safety, and the right to privacy.
- Establishment of a "Legal First-Aid Desk" within schools a collaboration between local justice departments and NGOs.

c. Reintegration Phase (Weeks 13–24)

- Social mentorship pairing recovered adolescents with trained peers.
- Family psychoeducation programs focusing on communication restoration.
- Community awareness events to destigmatize help-seeking.
- This structure ensures that psychological healing does not occur in isolation but within a legally protective and socially validating environment.

1.4 Technological Integration

To sustain real-time coordination, the model incorporates a digital monitoring dashboard named SafeYouthNet, designed to:

- Record anonymized risk assessments and follow-up sessions.
- Enable authorized psychologists, teachers, and social workers to input updates.
- Generate automated alerts to child protection units when prolonged distress is detected. This technological layer transforms the traditionally reactive system into a predictive prevention network.

Confidentiality within the SafeYouthNet platform is preserved through a multi-layered governance design based on role-based access control, data minimization, and encrypted data management. Access to case information is restricted exclusively to authorized professionals such as licensed psychologists, designated school administrators, and child-protection officers each limited to the minimum data required for their statutory function. All records are anonymized at the analytical level and encrypted during both storage and transmission, while informed consent protocols govern data use in alignment with GDPR-like privacy principles. Automated alerts communicate risk status without disclosing personal narratives, ensuring that coordinated support can be initiated while safeguarding adolescents' privacy, dignity, and trust in the system.

2. WHERE AND WHEN WE WILL USE

The model's adaptability allows implementation across educational institutions, community health centers, and social service departments. Pilot deployment focuses on secondary schools, where adolescents spend the majority of their social and cognitive development time.

2.1 Implementation Context

- Schools: Serve as primary detection and intervention hubs; Host weekly resilience workshops and legal-literacy classes; Employ trained "Youth Advocates" peer leaders trained in empathy and mental-health literacy.
- Community Health Centers: Offer extended psychological follow-ups for high-risk youth; Collaborate with local legal bodies to ensure case monitoring.

- Social Services and NGOs: Conduct outreach for out-of-school youth; Manage family-reintegration and post-crisis mentorship programs.

2.2 Temporal Implementation

Table 3. Three chronological stages of the model.

Stage	Timeline	Primary Activities	Lead Actors
Phase I – Pilot (Months 1–6)	School clusters in Tashkent, Almaty, and Bishkek	Baseline data collection, facilitator training, creation of SafeYouthNet platform	Ministries of Education & Health
Phase II – Expansion (Months 7–18)	25 additional schools across rural and urban zones	Integration of legal desks, expansion of peer-mentorship programs	Regional justice departments
Phase III – Institutionalization (Months 19–36)	National roll-out	Embedding model into curriculum and child-protection legislation	Parliamentary commissions

2.3 Anticipated Outcomes

a. Short-Term (6–12 months)

- Increased detection rates of suicidal ideation.
- Improved adolescent legal awareness (quantitative rise in YPRLAS legal domain scores).
- Reduction in stigma indicators measured through focus-group discourse analysis.

b. Medium-Term (1–2 years)

- Establishment of permanent inter-agency coordination channels.
- Institutional accountability reports published annually.

c. Long-Term (3+ years)

- Statistically measurable decline in adolescent suicide rates.
- Cultural normalization of help-seeking behavior.

2.4 Transferability

While initially designed for Central Asian contexts, the model is scalable to any middle-income country where institutional silos hinder mental-health integration. Adaptation guidelines are flexible legal modules can align with local statutes, and cultural dimensions (for example, family honor, religious interpretations) can be contextually modified.

2.5 Policy Integration

Successful implementation requires embedding the P-L-S framework within national mental-health action plans and educational reform policies. Key recommendations include:

- Inclusion of suicide-prevention indicators in school accreditation standards.
- Legal mandates requiring cross-agency data sharing on youth at risk.
- Allocation of a fixed percentage of educational budgets to mental-health infrastructure.
- Such alignment ensures that prevention becomes a state-mandated obligation, not a charitable initiative.

2.6 Monitoring and Evaluation

To measure effectiveness, the model employs continuous feedback cycles:

- Quarterly audits comparing pre- and post-intervention suicide risk levels.
- Annual national review conferences hosted jointly by Ministries of Health, Justice, and Education.
- Public transparency reports summarizing aggregated outcomes.

By institutionalizing monitoring, the framework sustains political accountability and public trust essential factors for long-term success.

IV. DATA ANALYSIS

1. QUANTITATIVE DATA ANALYSIS

Quantitative data collected through the Youth Psychological Resilience and Legal Awareness Scale (YPRLAS) were processed using IBM SPSS Statistics 28 and RStudio for deeper correlation and regression analyses. A total of 612 valid responses were analyzed across all three countries (Uzbekistan, Kazakhstan, Kyrgyzstan).

1.1 Descriptive Statistics

Mean YPRLAS scores indicated moderate to low resilience across all groups, with higher emotional distress scores among rural adolescents ($M = 3.14$, $SD = 0.78$) compared to urban peers ($M = 2.68$, $SD = 0.66$).

- Legal awareness scores averaged 2.35/5, revealing limited knowledge of protection laws or reporting mechanisms.
- Access to psychological help scored lowest ($M = 2.12$, $SD = 0.81$), confirming systemic underutilization of counseling services.

Gender differences were statistically significant: females reported higher emotional distress ($p < 0.01$) but greater help-seeking intention ($p < 0.05$). Males scored higher in perceived burdensomeness [3], correlating with cultural expectations of self-reliance.

1.2 Correlation and Regression Results

Pearson correlations showed:

- Emotional distress - Suicidal ideation: $r = 0.78$ ($p < 0.001$)
- Social support - Resilience: $r = 0.61$ ($p < 0.01$)
- Legal awareness - Help-seeking behavior: $r = 0.54$ ($p < 0.01$)

A multiple regression model was constructed with suicidal ideation as the dependent variable and emotional distress, social support, and legal awareness as predictors. The model was significant:

$F(3, 608) = 27.43$, $p < 0.001$, $R^2 = 0.41$

Standardized beta coefficients indicated:

- Emotional distress ($\beta = 0.57$, $p < 0.001$)
- Low social support ($\beta = –0.33$, $p < 0.01$)
- Poor legal awareness ($\beta = –0.21$, $p < 0.05$)

These findings confirm that emotional distress remains the strongest predictor, but social and legal deficits amplify the risk by compounding feelings of isolation and helplessness.

1.3 Group Comparisons

The intervention component revealed striking differences:

- E1 (Psychological focus) reduced suicidal ideation scores by 18%.
- E2 (Legal focus) improved legal literacy and reporting confidence by 29%.
- E3 (Integrated P-L-S) achieved the most profound change: 43% reduction in suicidal ideation; 38% increase in help-seeking behavior; 32% improvement in resilience.

Control group (C) outcomes remained statistically unchanged. ANOVA results confirmed significant group differences ($p < 0.001$), validating the synergistic effect of the integrative model.

1.4 Temporal Trends

Longitudinal analysis over six months showed sustained benefits in the E3 group, while single-domain interventions (E1 and E2) plateaued after three months. This pattern underscores the need for holistic, sustained engagement rather than isolated short-term fixes.

2. QUALITATIVE DATA ANALYSIS

2.1 Thematic Findings

NVivo-assisted coding of 51 interviews produced six emergent themes, aligned with the P-L-S framework:

- Emotional Suppression Culture: Adolescents described an inability to verbalize distress due to stigma. "You can talk about grades, not sadness," said one respondent (F, 16).
- Institutional Silence: Teachers and psychologists felt constrained: "We notice, but we're not sure what we're allowed to do legally."
- Legal Helplessness: Parents expressed ignorance of existing laws protecting minors. Only 19% could name a single legal right concerning adolescent mental health.
- Family Disconnection: Interviewees highlighted emotional distance and authoritarian parenting as key contributors to despair.
- Digital Duality: Social media offered both refuge and risk support forums contrasted with exposure to harmful content.
- Restorative Belonging: Participants in peer-mentoring sessions reported renewed trust: "For the first time, someone listened without judging."

2.2 Cross-Theme Synthesis

Three meta-categories were identified:

- Recognition gap: Emotional pain often remains invisible due to stigma and lack of screening tools.
- Response gap: Professionals hesitate to act without clear legal mandates.
- Recovery gap: Post-crisis reintegration is rarely systematized, leading to recurrence.

2.3 Triangulated Insights

When triangulated with quantitative data:

- Adolescents scoring low on social support and legal awareness were also those narrating institutional silence in interviews.
- Schools that implemented E3 interventions reported higher peer-support cohesion and reduced stigma in open discussions.
- Teachers trained in rights-based communication demonstrated faster referral rates to psychologists.

3. CROSS-NATIONAL POLICY ALIGNMENT

Policy review revealed:

- Kazakhstan's Suicide Prevention Strategy (2020–2025) includes integrated inter-ministerial coordination the closest regional alignment with the P-L-S model [11].
- Uzbekistan's mental-health legislation (2021) remains primarily curative, not preventive [10].
- Kyrgyzstan lacks inter-agency protocols entirely, relying on NGO initiatives [12].

Comparative analysis suggests that institutional fragmentation directly correlates with higher youth suicide rates. Countries with binding mandatory reporting laws and school-based prevention mandates exhibit better early-intervention outcomes [19].

V. RESULTS

1. OVERVIEW OF OUTCOMES

The data obtained from 612 adolescent participants and 240 students engaged in intervention programs revealed consistent evidence supporting the hypothesis that a multidimensional P-L-S approach significantly reduces risk indicators of suicidal ideation among adolescents. Across the six-month experimental cycle, measurable gains were observed in resilience, legal literacy, and help-seeking behavior, accompanied by statistically significant decreases in emotional distress, perceived burdensomeness, and social withdrawal.

2. QUANTITATIVE RESULTS

Table 4. YPRLAS mean score comparison.

Variable	Pre-Test Mean (SD)	Post-Test Mean (SD)	% Change	Significance (p)
Emotional distress	3.21 (0.74)	2.33 (0.61)	↓27.4%	<0.001
Resilience	2.64 (0.77)	3.46 (0.59)	↑31.1%	<0.001
Social support perception	2.83 (0.68)	3.69 (0.52)	↑30.4%	<0.001
Legal awareness	2.17 (0.65)	3.01 (0.66)	↑38.7%	<0.001
Help-seeking behavior	2.26 (0.83)	3.08 (0.72)	↑36.3%	<0.001

Post-hoc Tukey analysis confirmed that Group E3 (Integrated P-L-S) outperformed Groups E1, E2, and C (control) across all variables ($F(3, 236) = 19.72$, $p < 0.001$).

2.1 Gender and Locale Differences

- Gender effect: Female participants demonstrated larger improvements in resilience (+0.94 vs +0.67 for males), aligning with prior findings that females respond better to emotion-centered interventions.
- Urban–rural gap: Rural schools exhibited higher baseline distress yet greater percentage improvement post-intervention (+42%), indicating latent receptivity when access barriers are removed.

2.2 Regression Model of Change

A hierarchical multiple regression assessed predictors of post-intervention improvement. Model 2 (integrating all domains) explained 52% of the variance ($R^2 = 0.52$) in reduction of suicidal ideation, compared with 29% in Model 1 (psychological domain only), where Regression coefficients indicated by (β).

- Emotional regulation skills ($\beta = –0.46$, $p < 0.001$)
- Legal awareness ($\beta = –0.24$, $p < 0.01$)
- Peer-support participation ($\beta = –0.28$, $p < 0.01$). Each contributed independently, confirming domain synergy rather than redundancy.

3. QUALITATIVE RESULTS

3.1 Thematic Validation of Quantitative Gains

Qualitative narratives reinforced the statistical findings. Students in the E3 group articulated three recurrent transformations:

- Language of emotion: Participants reported an emergent ability to articulate internal states "I can finally say I'm not okay without being punished."
- Sense of legal agency: Youths cited newfound understanding that "mental health help is a right, not a weakness."
- Relational reconnection: Families and peers began initiating check-ins, reversing earlier patterns of silence.

3.2 Institutional Perception Shift

Educators and psychologists observed improved inter-departmental communication: "Before, we had separate reports; now we share cases." The creation of Legal First-Aid Desks within pilot schools standardized referral pathways, producing quicker responses to red-flag behavior (average response time reduced from 14 days to 5 days).

3.3 Emergent Social Capital

Peer-mentorship programs generated organic networks of trust. Mentors trained adolescents aged 17–18 continued volunteering beyond the research phase, a promising indicator of sustainability.

4. POLICY AND INSTITUTIONAL OUTCOMES

4.1 Inter-Agency Coordination

During the six-month pilot, Ministries of Education, Health, and Justice signed a Memorandum of Inter-Sectoral Cooperation on Youth Mental Health. This agreement institutionalized data-sharing protocols modeled after the study's SafeYouthNet dashboard.

4.2 Legislative Implications

Preliminary drafts of a Child Mental Health Protection Amendment [20] began circulating within parliamentary committees, proposing mandatory reporting and annual school audits directly inspired by the P-L-S trial outcomes.

4.3 Community Awareness Impact

Surveys conducted during post-program open forums (n = 430 community members) revealed:

- 82% increased awareness of suicide-warning signs.
- 71% reported willingness to consult professionals rather than conceal incidents.

These attitudinal shifts suggest early cultural de-stigmatization processes, critical for long-term prevention.

5. CROSS-CULTURAL COMPARATIVE FINDINGS

- Kazakhstan: Exhibited smoother institutional uptake due to pre-existing legal scaffolding (national strategy 2020–2025).
- Uzbekistan: Demonstrated strongest social-response gains once religious leaders and family counselors were involved a culturally grounded adaptation.
- Kyrgyzstan: Showed greatest initial resistance but highest eventual peer-network engagement, illustrating adaptability of the P-L-S model to community-based NGOs.

These differences reinforce that contextual tailoring rather than one-size-fits-all replication ensures success.

Table 5. Statistical significance summary.

Hypothesis	Description	Supported?	Evidence
H1	Integrated P-L-S model yields greater reduction in suicidal ideation than single-domain interventions	Supported	ANOVA $p < 0.001$
H2	Legal awareness mediates help-seeking behavior	Supported	$\beta = -0.24$, $p < 0.01$
H3	Peer-support intensity predicts resilience gain	Supported	$r = 0.58$, $p < 0.001$
H4	Institutional coordination correlates with faster response times	Supported	$t = 5.67$, $p < 0.001$

6. INTERPRETATIONS OF EFFECT SIZES

Using effect sizes (Cohen's d), the integrated model produced large effect sizes:

- Emotional distress reduction: $d = 0.91$
- Resilience improvement: $d = 0.84$
- Legal literacy: $d = 0.79$

Such magnitudes exceed typical school-based mental-health interventions (average $d \approx 0.45$ [21], positioning the P-L-S model as a high-impact preventive framework.

7. UNEXPECTED FINDINGS

While overwhelmingly positive, two nuances emerged:

- Digital fatigue: Adolescents expressed occasional burnout from mandatory online check-ins on SafeYouthNet. Streamlined user design is needed to maintain engagement.

- Legal intimidation: Some youths initially feared that sharing suicidal thoughts could "get someone arrested," underscoring the importance of trauma-informed legal education to prevent deterrence.

The results unequivocally demonstrate that adolescent suicide prevention requires simultaneous activation of psychological empathy, legal protection, and social inclusion. Fragmented or unilateral approaches deliver partial relief at best. The P-L-S framework, validated through both statistical significance and narrative resonance, represents a scalable, ethically grounded innovation with measurable life-saving potential.

VII. DISCUSSION

1. INTERPRETATION OF FINDINGS

This section distinguishes between results directly derived from quantitative and qualitative analyses and broader interpretive commentary intended to contextualize these findings within existing theoretical and policy frameworks.

The findings of this study indicate that adolescent suicide prevention is more effective when psychological interventions are embedded within coordinated legal and social systems. The observed reduction in suicidal ideation within the P-L-S group reflects a transition from predominantly reactive, single-domain responses toward a structured, preventive, and system-oriented approach. Adolescents exposed to the integrated model demonstrated increased engagement with available support mechanisms, rather than viewing help-seeking as stigmatized or discretionary. Consistent with sociological perspectives on social integration, the results suggest that strengthened institutional and interpersonal connectedness is associated with improved psychological resilience and reduced risk indicators. Legal awareness emerged as a mediating factor between psychological readiness and behavioral change. Adolescents who understood their rights under child protection and privacy laws exhibited greater trust in counselors and teachers, facilitating earlier and more effective interventions. This indicates that legal literacy functions as a form of empowerment, translating abstract regulations into tangible protective mechanisms.

2. THEORETICAL INTEGRATIONS

The study situates itself within a triadic theoretical constellation:

- Cognitive-Behavioral Frameworks which explain the internal processes of hopelessness and maladaptive cognition;
- Sociological Theories of Integration [22] highlighting structural determinants of despair;
- Legal-Rights Approaches positioning mental health as a justiciable right, not a discretionary service.

When these perspectives converge, the adolescent is no longer treated as a passive patient but as an active rights-bearing subject. This reframing aligns with Sen's Capability Approach [17], which views well-being as the freedom to pursue valued life outcomes under enabling conditions. The P-L-S framework operationalizes this philosophy by giving adolescents capabilities not just counseling. Within the P-L-S framework, adolescents demonstrated increased awareness of confidentiality protections and reporting mechanisms, as reflected in higher legal-awareness scores and greater help-seeking behavior in the integrated intervention group. These measurable outcomes indicate that rights-based principles were operationalized through concrete knowledge acquisition and behavioral change rather than abstract normative claims.

3. COMPARATIVE INSIGHTS AND GLOBAL RELEVANCE

Internationally, the success of suicide-prevention models depends on policy coherence and cultural adaptation. The outcomes of this Central Asian pilot correspond closely with global best practices observed in Finland's "Life Is Worth Living" initiative [23] and Japan's School Mental Health Network [24]. Both employ multi-agency models with early screening, family engagement, and legislative mandates for intervention. However, the Central Asian adaptation introduces a unique component legal first-aid within educational institutions, bridging the gap between emotional distress and procedural justice [26-28]. This

innovation could inspire replication in regions where judicial systems remain distant from everyday educational life.

4. SOCIO-CULTURAL DIMENSIONS

The qualitative findings illuminate the cultural scripts shaping adolescent mental health. In collectivist societies like Uzbekistan and Kyrgyzstan, emotional restraint and family honor can silence distress. Therefore, prevention strategies must address stigma not only through awareness campaigns but also through cultural translation embedding resilience within familiar moral frameworks [29]. For instance, involving community elders and religious figures as advocates of compassion-based dialogue significantly increased community participation rates [30]. At the same time, gendered expectations emerged as both risk and resilience factors. Female adolescents internalized distress, leading to higher reported hopelessness; males externalized pain through aggression or substance use. The P-L-S model's balanced gender-responsive design emphasizing safe disclosure for girls and emotional vocabulary for boys proved particularly effective.

5. INSTITUTIONAL IMPLICATIONS

The institutional transformation observed during the project reveals that suicide prevention requires administrative courage as much as clinical skill. Many school psychologists initially feared liability; teachers worried about "crossing professional boundaries." Once legal frameworks clarified their protective duties and social programs normalized open dialogue, participation rose dramatically. This suggests that legal clarity reduces institutional paralysis. Ambiguity kills initiative, but well-defined mandates create safe operational ground for empathy. The study's evidence that reporting times fell by 64% after legal desks were introduced exemplifies this principle. Furthermore, digital coordination via SafeYouthNet turned fragmented record-keeping into a real-time surveillance system for compassion a humane use of data analytics. However, digital fatigue and privacy concerns must guide further development to maintain trust.

6. POLICY AND PRACTICE IMPLICATIONS

The following recommendations are derived directly from statistically significant findings and recurring qualitative themes identified in the present study. The study advocates that governments transition from policy declarations to policy execution. Specifically:

- Legal codification of suicide-prevention duties for schools and social services;
- Budget earmarking for adolescent counseling infrastructure;
- Mandatory mental-health literacy training for educators;
- Inclusion of youth representatives in national advisory councils;
- Cross-sectoral accountability audits ensuring that education, health, and justice ministries collaborate rather than compete.

Adopting these mechanisms aligns national policies with UN Sustainable Development Goal 3.4 [30], which commits to reducing premature mortality from mental-health causes by one-third by 2030.

7. ETHICAL AND PHILOSOPHICAL REFLECTION

Ethically, suicide prevention challenges the state's relationship to autonomy. Adolescents oscillate between dependence and self-determination; therefore, interventions must respect confidentiality while ensuring safety. The P-L-S model's layered consent system—where adolescents can access counseling independently yet trigger protective oversight when risk escalates—balances these competing imperatives [31, 32]. Philosophically, the study positions suicide prevention as an act of social justice. When a child takes their own life, it is not only a private tragedy but a public indictment of institutional failure. The state's moral legitimacy depends on its capacity to safeguard the vulnerable, not merely punish negligence afterward.

8. LIMITATIONS AND FUTURE RESEARCH

Future research should address limitations related to regional scope, reliance on self-reported measures, and cross-sectional design by employing longitudinal approaches, broader geographic samples, and multi-

informant data sources. These directions directly reflect the methodological constraints identified in the present study.

Despite its strong empirical grounding, the study acknowledges several limitations:

- Temporal constraint six-month observation may not capture long-term relapse dynamics.
- Cultural generalization findings from Central Asia require adaptation before extrapolation to other regions.
- Technological inequity rural areas faced limited access to SafeYouthNet due to poor internet coverage [33].
- Self-report bias emotional improvement may be inflated by social desirability effects.
- Future research should include longitudinal studies (2–3 years), cost-benefit analyses, and AI-assisted predictive analytics to forecast early warning signs through digital behavioral patterns always under strict ethical governance.

9. TOWARD A NEW PARADIGM

Ultimately, this research calls for a paradigm shift from pathology to prevention, from institutional isolation to collective guardianship. The P-L-S framework reframes suicide prevention not as charity, therapy, or compliance, but as the moral architecture of a humane society [34].

If adolescence is the rehearsal for adulthood, then our collective failure to protect its actors is not merely negligence it is a rehearsal for social decay [35]. Thus, every school counselor, parent, policymaker, and legislator become a participant in an invisible orchestra whose harmony may decide whether a young life continues its song.

VIII. HYPOTHESIS TESTING

1. OVERVIEW

The study tested four primary hypotheses (H1–H4) grounded in interdisciplinary literature on adolescent suicide prevention, combining psychological, legal, and social determinants. The hypotheses were formulated to validate whether an integrated model (P-L-S) offers measurable advantages over isolated interventions.

1.1 H1: The Integrated P-L-S Model Yields Greater Reduction in Suicidal Ideation Than Single-Domain Interventions

Null Hypothesis (H_{01}): There is no significant difference in suicidal ideation reduction between integrated and single-domain interventions.

Alternative Hypothesis (H_{11}): The integrated model leads to significantly greater reductions.

- Evidence and Statistical Results

An ANOVA comparing the four experimental groups (E1, E2, E3, and Control) revealed significant differences, $F(3,236) = 19.72$, $p < 0.001$.

Post-hoc Tukey tests indicated that E3 > E1 > E2 > Control, confirming the superiority of the integrated approach.

Mean suicidal-ideation reduction percentages:

- E1 (psychological): –18%
- E2 (legal): –11%
- E3 (integrated): –43%
- Control: –3%

Overall, H_{01} rejected. H_{11} supported.

The large effect size (Cohen's d = 0.91) positions the P-L-S model among the most effective prevention frameworks in educational settings.

1.2 H2: Legal Awareness Mediates Help-Seeking Behavior

Null Hypothesis (H_{02}): Legal awareness has no mediating effect on the relationship between distress and help-seeking.

Alternative Hypothesis (H_{12}): Legal awareness mediates this relationship.

- Evidence and Mediation Analysis

Using Hayes' PROCESS Model 4, emotional distress (X) predicted help-seeking (Y), mediated by legal awareness (M).

- Direct effect (without mediator): $\beta = -0.52$, $p < 0.001$
- Indirect effect (via legal awareness): $\beta = -0.19$, 95% CI [–0.30, –0.10]
- Sobel $z = 3.81$, $p < 0.001$

Legal-literacy workshops increased adolescents' understanding of confidentiality laws and child-protection rights, empowering them to seek assistance without fear of punishment or exposure.

Overall, H_{02} rejected. Legal awareness functions as a psychological bridge between internal struggle and external action.

1.3 H3: Peer-Support Intensity Predicts Improvement in Psychological Resilience

Null Hypothesis (H_{03}): Peer-support participation has no predictive relationship with resilience improvement.

Alternative Hypothesis (H_{13}): Higher peer-support intensity predicts greater resilience gains.

Regression analysis found peer-support hours per month significantly predicted resilience gain ($\beta = 0.58$, $p < 0.001$). Adolescents with ≥8 hours of monthly mentorship scored 30% higher on the Resilience subscale than those with <4 hours.

Qualitative validation: participants described mentors as "anchors" and "mirrors of hope." This echoes Bandura's (1986) [26], social-learning theory resilience is learned through modeled coping.

Overall, H_{03} rejected. H_{13} supported; peer-connectedness is a structural determinant of emotional recovery.

1.4 H4: Institutional Coordination Correlates with Faster Response Times and Lower Risk Recurrence

Null Hypothesis (H_{04}): Institutional coordination has no effect on response speed or recurrence rates.

Alternative Hypothesis (H_{14}): Coordinated institutions show faster responses and fewer repeat crises.

Response-time data extracted from SafeYouthNet logs:

- Pre-integration average: 14.2 days
- Post-integration (E3): 5.1 days ($t = 5.67$, $p < 0.001$)

Re-incident rate (repeat suicidal behavior within six months):

- Coordinated schools: 3.8%
- Non-coordinated: 11.6%

Qualitative interviews with administrators cited clarity of reporting channels and shared accountability as decisive improvements.

Thus, H_{04} rejected. Institutional synergy demonstrably accelerates protective action and sustains prevention outcomes.

Table 6. Hypothesis summary table.

Hypothesis	Description	Result	Evidence
H1	P-L-S > single-domain in reducing suicidal ideation	Supported	ANOVA $p < 0.001$; $d = 0.91$
H2	Legal awareness mediates help-seeking	Supported	Mediation $\beta = -0.19$; $z = 3.81$
H3	Peer-support intensity predicts resilience	Supported	$\beta = 0.58$; $p < 0.001$
H4	Institutional coordination improves response time	Supported	$t = 5.67$; $p < 0.001$

All hypotheses were validated, confirming the multi-axis interdependence of psychological, legal, and social dimensions in adolescent suicide prevention.

2. META-INTERPRETATION

Collectively, the statistical confirmations reveal that the P-L-S model acts as a systemic harmonizer, not merely an additive tool. Each dimension amplifies the others through feedback mechanisms:

- Legal clarity strengthens psychological safety.
- Social engagement sustains legal compliance.
- Psychological recovery legitimizes institutional trust.

This synergy represents a new preventive ecology, aligning with WHO [1] recommendations for "whole-of-society" strategies.

VIII. CONCLUSION

1. SUMMARY OF THE STUDY

This study examined adolescent suicide prevention through a P-L-S framework an integrative model uniting emotional support, legal protection, and community engagement into one functional ecosystem. Over six months and across three Central Asian nations (Uzbekistan, Kazakhstan, and Kyrgyzstan), the model was empirically tested with 612 participants, combining surveys, interviews, and intervention programs. The results unequivocally demonstrated that suicide prevention cannot be isolated to the domain of psychology or psychiatry alone. Adolescents do not exist in vacuums; they live within networks of institutions, families, and laws. Thus, only by weaving these systems together can prevention transcend temporary relief and become structural resilience.

2. MAJOR FINDINGS AND THEIR IMPLICATIONS

The quantitative results revealed statistically significant reductions in suicidal ideation (–43%), alongside increased resilience (+31%), legal awareness (+39%), and help-seeking behavior (+36%) among adolescents exposed to the integrated P-L-S intervention. Qualitative insights complemented these findings, showing cultural de-stigmatization, emotional expressiveness, and newfound trust in institutional actors. The implications are profound:

- Psychological Implication Adolescents require sustained, context-sensitive emotional scaffolding. When legal and social systems validate that support, the therapeutic process gains legitimacy and continuity.
- Legal Implication Legal literacy functions as psychological armor. Adolescents who know their rights perceive help-seeking as empowerment rather than exposure.
- Social Implication Social connectedness is the ultimate protective factor. Family, peers, and community must be reimagined as active participants in the healing process, not silent witnesses.

The synergy of these three spheres created a dynamic prevention system that not only reduced crisis frequency but redefined how institutions respond to suffering from fear and avoidance to compassion and accountability.

3. POLICY RECOMMENDATIONS

For governments and educational authorities, the study offers a roadmap for turning empirical success into institutional permanence:

Table 7. Policy recommendations for governments and educational authorities.

Policy Domain	Key Actions and Implementation Measures
Legislative Action	• Codify suicide-prevention mandates within national education and child-protection laws. • Establish Legal First-Aid Desks in schools to ensure immediate access to confidential legal and psychological help. • Require every school to maintain a licensed psychologist and conduct an annual mental-health audit.
Institutional Integration	• Create Inter-Ministerial Mental Health Councils bridging education, justice, and healthcare sectors. • Implement data-driven coordination through secure national dashboards similar to *SafeYouthNet.*

Community and Family Involvement	• Fund community-based peer-mentoring programs and parent psycho-education workshops. • Collaborate with religious and cultural leaders to reshape public narratives around mental health and shame.
Digital Safeguards	• Enforce regulation of harmful online content and integrate early-warning AI algorithms under strict ethical oversight. • Expand digital-literacy initiatives emphasizing empathy, privacy, and critical awareness of online interactions.

4. THEORETICAL CONTRIBUTIONS

This research makes three key academic contributions:

- It empirically validates the interdependence of psychological, legal, and social domains in adolescent suicide prevention.
- It advances a systems-level prevention model rooted in rights-based and ecological theories.
- It expands global literature by offering evidence from Central Asia, a region underrepresented in mental-health research, thereby diversifying the epistemic geography of prevention science.

The P-L-S framework thus becomes not merely a policy recommendation but a theoretical paradigm: suicide prevention as an ethical infrastructure rather than an emergency response.

5. ETHICAL REFLECTIONS

At its moral core, suicide prevention demands empathy institutionalized as policy. Every life lost to silence reveals an institutional blind spot; every life saved through coordinated care reaffirms society's moral contract. The P-L-S model transforms compassion into governance, making empathy enforceable, measurable, and durable. By embedding rights awareness into psychological recovery, it replaces the paternalistic model of "protecting the weak" with a dignity-centered paradigm protecting agency, autonomy, and hope.

6. LIMITATIONS

The study acknowledges boundaries:

- Temporal scope (six months) limits long-term predictive power.
- Geographical constraint to Central Asia may not capture Western cultural variables.
- Technological inequalities hinder consistent implementation of digital tools.

However, these limitations serve as invitations for future work, not barriers. The next phase should include multi-year longitudinal designs, cross-regional replications, and policy-embedded trials that measure cost-effectiveness, scalability, and sustainability.

7. FUTURE DIRECTIONS

The research points toward new frontiers:

- AI-driven Predictive Analytics Machine learning can help detect behavioral risk markers from digital activity, provided ethical and privacy safeguards are prioritized.
- Cross-Cultural Comparative Studies Testing the P-L-S framework in regions like Sub-Saharan Africa or South America could enrich global understanding of contextual variables.
- Policy Impact Studies Future research should measure how legislative integration directly affects suicide rates over time.

8. FINAL REFLECTION

Adolescents are society's living promise the yet-unwritten chapters of our collective story. When that promise ends in silence, it is not only a personal tragedy but a communal failure of imagination. The results of this study prove that prevention is not a miracle; it is methodical compassion, designed and delivered through cooperation. The P-L-S Framework offers a pathway where law speaks the language of empathy,

psychology extends beyond therapy into empowerment, and social systems rediscover their moral function. In the end, suicide prevention is not about preventing death it is about protecting life's unfinished possibilities. If we can institutionalize care with the same precision with which we legislate order, then every child's despair may yet find its echo answered not by silence, but by understanding.

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Author Contributions

Conceptualization, R. N. A. and F. M. K.; methodology, R. N. A.; software, R. N. A., G. T., and Q. Y. R.; validation, R. N. A., F. M. K., and D. Y. K.; formal analysis, R. N. A.; investigation, R. N. A.; resources, F. M. K.; data curation, R. N. A.; writing—original draft preparation, R. N. A., G. T., and D. Y. K.; writing—review and editing, F. M. K., Q. Y. R., and M. B. J.; visualization, R. N. A.; supervision, Z. Y. T.; project administration, R. N. A. and F. M. K.

Data Availability Statement

Data are available from the authors upon request.

Conflict of Interest

The author declares no conflict of interest.

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Appendix A

The following is an appendix containing the semi-structured interview items for the qualitative arm of the study. The interview guide was developed to address psychological, legal and social aspects of adolescent suicide prevention but also presented some freedom for prompting while trying to maintain thematic consistency across all interviews.

1. INTERVIEW DOMAINS AND SAMPLE QUESTIONS

1.1 Psychological Support and Emotional Well-being

- To what extent do adolescents perceive they can talk with school psychologists or counselors about emotional distress?
- What are the psychological obstacles for adolescents not to help-seeking?
- What do schools usually consider and then how does it work when the emotional stuff is there?

1.2 Institutional Response and Professional Responsibility

- What do teachers and schools personnel need to do when suicidal thinking is suspected?
- Do institutions have roles and responsibilities in such cases well defined?
- What makes it difficult for professionals to intervene?

1.3 Legal Awareness and Rights Protection

- How well do teens and parents know their legal rights to protect mental health?
- What is the impact of the legal process on adolescent help seeking?
- Are legal ambiguities keeping people from reporting incidents early on or intervening?

1.4 Family and Social Environment

- How do family communication patterns predict adolescents driven to disclose their despair?

- How do peers amplify or buffer from suicide risk?
- How do community-based stigmas affect responses to mental health issues in youth?

1.5 Social Reintegration and Recovery

- What happens after a teenager gets help for mental health?
- Are there organized systems in place for re-entry to school and community?
- What types of social support are found to be most effective at subsequent intervention?
- The interviews took 40 to 60 minutes and were adjusted through linguistic and cultural appropriation in each national context (Uzbekistan, Kazakhstan, Kyrgyzstan).

2. QUALITATIVE CODING AND ANALYSIS PROCEDURES

2.1 Transcription and Data Preparation

All interviews were recorded with the participants' permission and transcribed word-for-word. All identifying information was deleted, and numbers and letters were inserted on the documents to replace names of the participants.

2.2 Coding Framework

Analysis was informed by a grounded theory methodology:

- Open Coding: initial process of line-by-line coding for identifying relevant units of text (e.g institutional silence, fear of disclosure, legal confusion).
- Axial Coding: Sorting and synthesizing codes under higher order categories by making connection between categories and concepts.
- Selective Coding: Core categories incorporation according to the Psychological–Legal-Social (P-L-S) model.

2.3 Use of Software

Qualitative data were managed and coded using NVivo 14 software for easy retrieval when needed across the various groups of respondents.

2.4 Reliability and Validation

- The transcripts were coded by two coders independently.
- Validity relative to inter-rater reliability was determined as follows; Cohen's Kappa ($\kappa = 0.82$) showed strong agreement.
- The author conducted Member Checking by presenting a condensed interpretation of the data to several participants for verification.
- Peer debriefing was conducted and external experts inspected the coding schema, as well as themes.

3. MEASUREMENT INSTRUMENT DESCRIPTION (YPRLAS)

This part describes in detail the QTI being employed in our study – the YPRLAS.

3.1 Instrument Overview

YPRLAS is a self-report measure of adolescent resilience, social support, legal knowledge, and service entry needs within institutions: Total items: 26; Participants answered on a 5-point Likert scale (1 = Strongly Disagree; 5 = Strongly Agree).

3.2 Subscales and Structure

Subscale	Number of Items	Sample Focus
Emotional Resilience	8	Emotional regulation, hopelessness, coping
Social Support Perception	6	Peer and family connectedness
Legal Awareness	5	Knowledge of rights, confidentiality, reporting

Access to Psychological Assistance	7	Availability and trust in support services

3.3 Reliability and Validity

Internal consistence: Cronbach alpha coefficient=0.88; Construct validity that was evidenced through significant associations with known scales (Beck's Hopelessness Scale; C-SSRS); Item clarity and cultural appropriateness was confirmed through pilot testing.

3.4 Administration Procedure

It was collected online at the schools under supervision in order to avoid misunderstanding and to standardize study conditions. Completion time averaged 15–20 minutes.