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Bridging the Gaps: A DOTMLPF-P Assessment of Suicide Intervention and Prevention Efforts Across the Military

June 2026

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Prepared for the Naval Postgraduate School, Monterey, CA 93943

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ABSTRACT

Suicide within the Department of Defense (DoD) is a persistent and complex problem despite the numerous prevention programs, policy reforms, and increased behavioral health resources. This study hypothesizes that current suicide prevention efforts are limited by inconsistent implementation and insufficient integration of programs across the DoD. Using the DOTMLPF-P framework, this study conducts a comparative analysis of suicide prevention efforts across the Army, Navy, Air Force, and Marine Corps. Information was gathered from DoD suicide reports, Government Accountability Office findings, RAND research, Service level doctrine, and existing program evaluations. The analysis found that suicide prevention efforts across the Services operate as parallel systems rather than a unified prevention program. Prevention efforts are strongest after suicide risk becomes observable. Significant gaps were identified in leadership education, organizational coordination, personnel distribution, training design, and coordination between clinical and non-clinical prevention systems. The findings suggest that suicide prevention in the DoD functions as a reactive system rather than a preventative one. Recommendations include strengthening early intervention capabilities, standardizing prevention implementation across the Services, and integrating more efficient prevention methods that increase integration across DOTMLPF-P domains for a more proactive suicide prevention system.

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ENS Emily Rose Kosanovich is a Student Naval Aviator. She began her service in 2018 when she enlisted as an Intelligence Specialist. She then went to the United States Naval Academy and commissioned with a bachelor's in science in Applied Mathematics in 2025. After graduating from the Naval Postgraduate School, she will be reporting to NAS Pensacola to begin Flight School Training where she hopes to fly helicopters. In her free time, she enjoys running, reading, and hanging out with her cat, Miso.

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We would also like to acknowledge the Service members who have died by suicide. This work is shaped by the memory of their lives and the impact it continues to have across the Department of Defense. This thesis is dedicated to Michael, the brother of one of the authors, whose memory is the reason this research was done.

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LIST OF ACRONYMS AND ABBREVIATIONS

DSPO	Defense Suicide Prevention Office
USU	Uniformed Services University
DoD	Department of Defense
GAO	Government Accountability Office
SPRIRC	Suicide Prevention and Response Independent Review Committee
DOTMLPF-P	Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel, Facilities, and Policy
CJCS	Chairman of the Joint Chiefs of Staff
HBC	Health Behavioral Change
SAIL	Sailor Assistance and Intercept for Life
MCSPS	Marine Corps Suicide Prevention System
ASPP	Army Suicide Prevention Program
DAFSPP	Department of the Air Force Suicide Prevention Program
CY	calendar year
PHRC	Psychological Health Resource Center
MHS	Military Health System
ASPP	Army Suicide Prevention Program
ACE-SI	Ask, Care, Escort-Suicide Intervention
NCCOSC	Naval Center for Combat and Operational Stress Control
SAIL	Sailor Assistance and Intercept for Life
DON	Department of the Navy
DAFSPP	Department of the Air Force Suicide Prevention Program
PCS	permanent change of station
SOP	standard operating procedure
DoDI	DoD instruction
DSPP	Defense Suicide Prevention Program
SPGOSC	Suicide Prevention and Risk Reduction Committee
DoDSER	Department of Defense Suicide Event Report
MICT	Management Internal Control Toolkit
PME	Professional Military Education

OUSDPR	Office of the Under Secretary of Defense for Personnel and Readiness
DHA	Defense Health Agency
UCMJ	Uniform Code of Military Justice
ERPO	extreme risk protection order

DISCLOSURES

Our thesis team received permission through email from Professor Mortlock to use AI in a limited way, that being for grammatical and structural uses. We used ChatGPT 5.3 to formulate outlines for structuring our paper and to help with grammar. The content and synthesis of the paper is our own. We asked ChatGPT to help structure an outline for our paper to make sure the logical flow of the paper was easy to read, and to ensure that the paper itself had the structure of an academic essay. We reviewed the structural outlines that ChatGPT recommended and adjusted wherever we felt was necessary to make sure that the structure of the paper was indicative of the arguments we were making. When using it as a grammar tool, we reviewed the suggestions and only accepted changes that did not change our voices or the content of our writing.

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I. INTRODUCTION

Suicide remains one of the most prevalent, complicated, and emotionally charged problems facing the United States military today (Defense Suicide Prevention Office [DSPO], 2024). Despite decades of prevention efforts, ranging from increased mental health resources to mandatory annual training, Service members continue to face mental stressors, operational pressures, and personal hardships that directly contribute to elevated suicide risk (Uniformed Services University [USU], n.d.). The continued presence of these challenges suggests that suicide in the military cannot be explained by a single cause or solved by a single solution. Instead, it points to a complicated relationship between personal mental health, larger military culture, and the institutional resources that are available to Service members.

Over the past several years, the Department of Defense (DoD) has invested considerable time, funding, and attention into suicide prevention initiatives (DSPO, 2024). These initiatives include resiliency programs, leader education, stigma reduction efforts, better counseling access, and policy reforms, specifically for Service members seeking help (DSPO, 2024). However, despite these efforts, suicide rates within the force continue to gradually increase. This reality has prompted renewed concern among military leaders, policymakers, and researchers, which has led to important questions about how these prevention programs are designed and overall implemented across the DoD (DSPO, 2024; Government Accountability Office [GAO], 2021). Independent evaluations by organizations such as the DoD Suicide Prevention Office (DSPO), the Government Accountability Office (GAO), and the RAND Corporation repeatedly point to the same issues.

In addition, these organizations consistently highlight issues like uneven implementation across the different Service branches, weak inter-service coordination, no standardization, difficulty in the process of assessing program deliverables, and challenges with integrating data effectively (GAO, 2021; Suicide Prevention and Response Independent Review Committee [SPRIRC], 2022; Acosta et al., 2014). These findings suggest that suicide prevention efforts may be hindered not only by difficulties

in identifying and supporting at-risk individuals, but also by broader organizational and policy-level shortcomings. This observation means that even well-intentioned programs may fail if they are not supported by strong doctrine, leadership emphasis, strong organizational structures, and good resources.

Since suicide in the military is influenced by a wide range of structural, organizational, and cultural factors, a broader framework is necessary to understand where gaps exist and how they can be addressed. The DOTMLPF-P framework, as the acronym suggests covers the areas Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel, Facilities, and Policy which serves as the DoD's tool for identifying and understanding capability gaps. While the DOTMLPF-P framework is traditionally used to assess military capabilities and operational requirements (Chairman of the Joint Chiefs of Staff [CJCS], 2015), it can also be applied analytically to institutional challenges such as suicide prevention among Service members. In this context, using DOTMLPF-P to examine suicide prevention efforts enables a more holistic analysis, one that goes beyond clinical care within the individual branches to consider how systemic factors influence daily prevention efforts.

The DOTMLPF-P framework has already been used within the DoD to assess capability gaps and inform solutions beyond traditional operational requirements. For example, DoD researchers applied DOTMLPF-P assessments to a Health Behavioral Change (HBC) framework designed to guide how health behavior interventions are structured and evaluated across the military health system, showing that this approach can be applied to more complex related problems (Schulz et al., 2023). Although this study did not specifically assess programs to address suicide prevention, it suggests that the DOTMLP-F framework can be applied to broad health and behavioral challenges within the DoD, showing its relevance for looking at suicide prevention efforts as well. Additionally, the DoD has implemented policy updates in 2023 in response to Government Accountability Office reports aimed at improving suicide prevention effectiveness (GAO, 2021).

However, despite these updates, there is still more that a DOTMLPF-P analysis can reveal to better support active-duty Service members. To identify these gaps, this

study uses the DOTMLPF-P framework to assess suicide prevention across the services. By using the DOTMLPF-P lens to evaluate the different branches of the U.S. military, this study aims to identify where current suicide prevention efforts may be misaligned, under-resourced, or insufficiently integrated across the DoD. This approach also highlights opportunities to strengthen existing programs, improve organizational coordination, and support policy reforms focused on reducing suicidality and promoting Service member health and readiness. Ultimately, understanding suicide prevention through the DOTMLPF-P framework can help the Department of Defense develop better integrated, effective, and sustainable strategies to save the lives of our troops.

A. PROBLEM STATEMENT

Despite the many programs the DoD has put in place, suicide is still a serious and consistent problem in the military. This is evident in the rising number of suicide deaths. In 2023, there were 523 suicides across the total DoD, which was an increase from the 493 suicides in 2022 (DSPO, 2023). Among active-duty Service members, suicide numbers rose from 331 in 2022 to 363 in 2023 (Watson, n.d.). These increases show that, even though the military has been trying for years to lower the number of suicides and improve prevention programs, the results still are not where they need to be. Suicide rates are still high, and the programs attempting to rectify the situation have not led to long-term decrease in deaths. Although the programs have helped raise awareness, encouraged people to seek help, and reduced suicidal thoughts in the short term, these improvements do not always lead to fewer actual suicides. Overall, incidence of suicide remains high despite intentional efforts from policy creators and researchers, and a reduction in these numbers appears fleeting.

One major challenge in attempting to address the incidence of suicide is that the different branches of the military are not using the same approach to suicide prevention. Each Service has its own programs, training, and resources. This lack of standardization creates a gap in suicide prevention by leading to inconsistent implementation, limited coordination, and uneven evaluation of suicide prevention efforts across the Services, which makes it difficult to identify and implement effective practices throughout the DoD (SPRIRC, 2022). When looking at the Services that are currently available, there is some

overlap in the different branches. All Services utilize the Military Crisis Hotline (988), Military OneSource, The Brandon Act, and annual suicide prevention trainings. However, no standardization across the Services appears to exist. For instance, the Navy uses the Sailor Assistance and Intercept for Life (SAIL) program, while the United States Marine Corps uses the Marine Corps Suicide Prevention System (MCSPS), despite being within the Department of the Navy. The Army uses the Army Suicide Prevention Program (ASPP) and the Air Force has its own program called The Department of the Air Force Suicide Prevention Program (DAFSPP). Each of these programs has the same underlying goal of suicide prevention, yet because there is no standardization among the branches, these efforts lead to uneven implementation across the different branches and weak inter-Service coordination. These points of disconnection mean there is no unified plan for suicide prevention across the DoD, which makes it difficult to ensure everyone, throughout all the Services, is getting the same level of support. While many of the current prevention efforts focus on clinical care or crisis response, these efforts do not cover everything that the Service members must face in their daily operations (GAO, 2022).

The DOTMLPF-P assessment works to identify where these individual programs can be better implemented so that they positively affect the Service member's life, including unit organization, leadership communication, improved training, better resource distribution, and stronger inter-Service coordination. For example, some commands may not have enough trained personnel to support the prevention programs, while others may not have clear leadership responsibility guidance or policies. Another prevalent issue is that in some locations, behavioral health resources might be stretched thin or are inaccessible. These challenges weaken even the best-intentioned programs. When the systems supporting the program are weak or disorganized, the program itself struggles to make a lasting impact.

Without a full DOTMLPF-P assessment, it is easy for gaps of this nature to go unnoticed or unaddressed. Looking at the system as a whole can help the DoD see where prevention programs are misaligned, under-resourced, or not able to be fully integrated into daily operations. Research shows that the DoD uses capability-based assessments tied to DOTMLPF-P to identify gaps and guide solutions across areas like health

behavior change, which shows the framework can be applied beyond traditional combat planning (Schulz et al., 2023). Using DOTMLPF-P to look at suicide prevention can help the DoD move past individual remedies and build a better and more coordinated approach on suicide prevention across all branches. Ultimately, a system-wide strategy is needed to reduce suicides and better protect the well-being of Service members

B. PURPOSE OF THE STUDY

The purpose of this study is to conduct a comprehensive DOTMLPF-P assessment of current military suicide prevention and intervention efforts. This analysis will evaluate how well existing programs are supported within each DOTMLPF-P domain, identifies capability gaps that affect program effectiveness, and develops recommendations for improving suicide prevention strategy, policy, and implementation across the military. The ultimate goal is to strengthen force resilience, improve prevention effectiveness, and save Service members' lives. This shift in programs, based on the analysis presented here, shifts the focus onto caring for the Service member when they are suicidal, rather than simply responding to the aftermath of a suicide. In short, this research emphasizes prevention over reaction and prioritizes the Service member's life and overall well-being.

C. RESEARCH QUESTIONS

This study answers the following research questions.

1. Primary Research Question

What differences exist across the DOTMLPF-P domain in the Army, Air Force, Navy, and Marine Corps, and how can these differences inform improvements in suicide prevention across the U.S. military?

2. Secondary Research Questions

1. How are suicide prevention efforts currently implemented across DOTMLPF-P domains within each service?
2. What gaps or misalignments across DOTMLPF-P domains limit the effectiveness of these efforts, and how can they be addressed?

D. RESEARCH OBJECTIVES

This research accomplishes the following:

- Analyzes how suicide prevention programs in individual branches of the military contribute to or hinder overall force readiness and resilience.
- Assesses the degree to which current programs are supported across each DOTMLPF-P domain.
- Identifies systemic, organizational, and policy-level gaps that limit prevention effectiveness.
- Provides recommendations for improving suicide prevention efforts within specific DOTMLPF-P areas.

E. METHODOLOGY OVERVIEW

This study uses a qualitative, document-based methodology using the DOTMLPF-P assessment as the primary research tool. Data sources include

- GAO reports
- RAND Corporation studies
- DoD Suicide Prevention Annual Reports
- Peer-reviewed scholarly literature
- Current DoD and Service-specific suicide prevention policies.

The methodology consists of three major steps:

1. Document Review: Identify and summarize recurring gaps in current suicide prevention programs and policies.
2. DOTMLPF-P Mapping: Categorize existing efforts and gaps within each DOTMLPF-P domain.
3. Gap Analysis and Recommendations: Assess shortcomings and propose improvements supported by findings.

This approach allows for a comprehensive assessment of the factors influencing military suicide prevention.

F. SCOPE AND LIMITATIONS

The scope of this study is limited to

- Publicly available, unclassified information
- Existing DoD and Service-level suicide prevention programs and policies within the Army, Air Force, Navy, and Marine Corps
- Analysis through the DOTMLPF-P framework

Limitations include

- Lack of access to classified or internal program evaluations
- Constraints related to the availability and completeness of public datasets
- Potential variations in the quality and consistency of reporting across Services
- The complexity of suicide as a phenomenon that cannot be fully explained by policy or organizational factors alone

Due to these limitations, this study focuses on systemic and structural gaps rather than individual-level clinical analysis.

G. ORGANIZATION OF THE THESIS

This thesis is organized into five chapters:

1. **Chapter I: Introduction**
   Provides the background, problem statement, research questions, methodology, scope, and significance of the study.
2. **Chapter II: Background**
   Examines the history of military suicide prevention efforts, DoD policies, and the institutional context of suicide in the armed forces.
3. **Chapter III: Literature Review**
   Reviews academic research, GAO findings, RAND analyses, and DoD documentation related to suicide, prevention theory, and organizational factors.
4. **Chapter IV: Analysis**
   Presents the DOTMLPF-P assessment, including methodology, data synthesis, and domain-specific findings.
5. **Chapter V: Summary, Conclusions, and Recommendations**
   Answers the research questions and provides actionable recommendations for improving suicide prevention across the DOTMLPF-P domains.

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II. BACKGROUND

Suicide remains a critical issue within the U.S. military, affecting Service members across all branches and ranks. Despite numerous prevention programs and initiatives, suicide rates continue to gradually increase, highlighting the need for a more comprehensive assessment of these efforts. The DOTMLPF-P framework, covering Doctrine, Organization, Training, Materiel, Leadership, Education, Personnel, Facilities, and Policy, provides a structured way to evaluate how well these programs are integrated and supported across the force. By analyzing suicide prevention through this lens, the study aims to identify systemic gaps across DOTMLPF-P domains that may be undermining the effectiveness of existing suicide prevention efforts and offer recommendations to save lives and as a result, improve force readiness.

A. CURRENT TRENDS AND SCOPE OF THE PROBLEM

Suicide remains a persistent and complex issue within the U.S. military that affects Service members across all branches of Service. The DoD systematically tracks suicide deaths through annual and quarterly reports that are produced by the Defense Suicide Prevention Office (DSPO). The most recent full report covers calendar year (CY) 2023, while there is preliminary data for 2025 through DoD's quarterly reports (DSPO, 2024; DSPO, 2025).

In CY 2023, the DoD Annual Reports on Suicide in the Military documented a total of 523 Service member suicides, which has increased from 493 in 2022 (DSPO, 2024). Among active-duty personnel, the suicide rate was approximately 28.2 deaths per 100,000, showing a 12% increase from the previous year (DSPO, 2024). DoD analysts emphasize long-term trends rather than single year fluctuations; thus, after adjusting for age and sex, active-duty suicide rates from 2011 through 2023 have remained generally comparable to trends in the U.S. civilian population (DSPO, 2024).

Official DoD reports also look at branch-specific differences in 2023 as shown in Table 1. The Marine Corps had one of the highest rates at 35.9 per 100,000, followed by the Army at 34.8 per 100,000 (DSPO, 2024). The Air Force and Navy had reported rates of 22.5 and 21.0 per 100,000 (DSPO, 2024). This reflects longstanding patterns that

indicates that the Army and Marine Corps report higher suicide rates compared to the other Services (DSPO, 2024).

Table 1. Suicide Rates in the Active Component, CY 2018–2023 (per 100,000 personnel)

Service	2018	2019	2020	2021	2022	2023
Total Active	24.9	26.3	28.6	24.3	25.1	28.2
USA	29.9	30.5	36.2	36.1	28.9	34.8
USMC	30.8	25.3	34.5	23.9	36.0	35.9
USN	20.7	22.1	19.0	17.0	20.6	21.0
USAF	18.5	25.1	24.3	15.3	19.0	22.5

Source: DoD Annual Report on Suicide in the Military, CY 2023 (DoD SPRO, 2024)

The data from the Department of Defense Suicide Prevention Office (2024) show that suicide rates among active-duty Service members between 2018 and 2023 have fluctuated rather than steadily increased or decreased. While the overall active component rate in 2023 (28.2 per 100,000) is higher than it was in 2018 (24.9 per 100,000), the numbers rise and fall throughout the period. For example, rates peaked in 2020, dropped in 2021, and then increased in both 2022 and 2023. This pattern is also visible within individual Service branches, particularly the Army and Marine Corps, which show a noticeable year-to-year fluctuation.

Rather than showing a consistent upward trend, the data suggests a lack of sustained improvement. The lack of evidence of a long-term decline in the suicide rate suggests that current suicide prevention efforts may not be providing lasting effects across the military. These ups and downs suggest suicide in the military is a complicated problem and there are multiple factors affecting suicide rates, including how prevention efforts are implemented across the different Service branches (DSPO, 2024).

While the official DoD annual suicide report for CY 2024 has not yet been published, DSPO's quarterly suicide surveillance reports provide more recent counts of the suicide deaths in 2025. According to the Q1 2025 Quarterly Suicide Report, suicide counts through March 31, 2025, show 71 suicide deaths within the active-duty

component DSPO, 2025). Although these active-duty deaths decreased in the first quarter of 2025 compared to the first quarter of 2024 (71 versus 91 deaths), these counts do not account for differences in population size and do not represent official suicide rates (DSPO, 2025). Because quarterly counts do not reflect annualized rates or population adjusted measures, they should be interpreted as early indicators of trends rather than definitive evidence of change. These quarterly fluctuations can occur due to short-term events or random variation, so these fluctuations may show changes in suicide risks that are not accurate. To understand the scope and direction of the suicide prevention progress, these numbers must be considered in parallel with annualized rates and population data, which provide a more accurate picture of suicide trends within the military (DSPO, 2025).

The data from CY 2023 and the preliminary 2025 data point to a few critical observations:

1. Suicide rates in the military have not declined significantly over the past decade despite prevention efforts.
2. Rates vary by branch, with the Army and Marine Corps reporting higher active-duty suicide rates compared to the Navy and Air Force.
3. Quarterly data provides context but does not provide a substitute for annual rates.
4. The delayed publication of the 2024 annual reports indicates that there is a problem in obtaining timely data and transparency, which can affect research and policy decisions (Baker, 2026).

Altogether, this data shows the challenges that suicide poses for active-duty readiness and personnel well-being while highlighting the need for timely and standardized prevention efforts (DSPO, 2024; DSPO, 2025).

B. OVERVIEW OF EXISTING PREVENTION PROGRAMS

The Department of Defense has implemented a wide range of suicide prevention programs aimed at supporting active-duty Service members across all branches. Currently, the DoD offers a variety of suicide prevention programs, several of which are available to all Service members regardless of their specific branch (Ferrara, 2025). These DoD-wide programs are designed to provide access to mental health care, crisis response services, and non-clinical support resources. In addition to these initiatives, each

military branch maintains its own suicide prevention programs tailored to the Service-specific cultures and operational stressors.

To better understand the scope and purpose of existing suicide prevention efforts, DoD-wide programs can be grouped according to their primary function: access and referral, crisis response, and non-clinical support.

1. DoD-Wide Suicide Prevention Programs

One of the primary access-focused initiatives is the Brandon Act, which was enacted following the death of Sailor Brandon Caserta in 2018 (Department of Defense [DoD], 2023). Advocated by Caserta's family, the Brandon Act was signed into law in 2021 and fully implemented across the fleet in 2023 (DoD, 2023). The Act allows Service members to initiate confidential self-referrals for mental health evaluations without the requirement of command involvement. The intent of this policy is to reduce barriers required to seek care, particularly those associated with stigma and concerns about overall career impact, by empowering Service members to seek help proactively (DoD, 2023).

In addition to the Brandon Act, the DoD has expanded its embedded and virtual behavior health services, which integrate mental health professionals within operational units or provide care through some telehealth platforms. These services are intended to increase accessibility to behavioral health support by reducing wait times and minimizing disruptions to daily operations (Ferrara, 2025). Embedded and virtual care models primarily serve active-duty personnel and are designed to facilitate early engagement with mental health services rather than relying solely on traditional in-person military treatment facilities.

When looking at crisis response programs, the Suicide Crisis Hotline, commonly known as 988, serves as a nationwide crisis response system available to Service members and civilians alike. The 988 system provides callers with immediate access to mental health and crisis support through the existing National Suicide Prevention Lifeline infrastructure (H.R. 7116, 2022). The implementation of the three-digit dialing code was

intended to reduce barriers to accessing crisis support by eliminating the need to memorize a longer phone number during times of distress (988, n.d.).

Another DoD-wide crisis resource is the Psychological Health Resource Center (PHRC), a 24/7 service that offers consultation, referrals and information related to psychological health care (Military Health System [MHS], n.d.). The PHRC assists Service members, families, and leadership by connecting individuals to the appropriate local or military-specific mental health resources while also answering questions related to those available services (MHS, n.d.). Unlike treatment programs, the PHRC is primarily a resource navigation and support tool within the broader mental health system.

As for the non-clinical support systems, Military OneSource represents a comprehensive non-clinical support system available to active-duty Service members and their families (Military OneSource, n.d.). This program provides confidential assistance for concerns ranging from everyday stressors to deployment-related challenges. Military OneSource offers both in-person counseling referrals and online support options. Military OneSource addresses issues like financial stress, relationship issues, and family concerns, which could indirectly contribute to overall psychological stress. While Military OneSource does not provide long-term treatment, it enables early access support that can connect Service members and their families to the appropriate services when needed (Military OneSource, n.d.)

Collectively, these DoD-wide programs are available at no cost and operate continuously, providing Service members with multiple support access points. While some resources focus on treatment or referral, others emphasize crisis response or non-clinical support. These initiatives are intended to serve the entire DoD, while recognizing that additional programs may be needed to address branch specific operational and cultural stressors.

2. Service-Specific Suicide Prevention Programs

In addition to the DoD-wide programs, each branch of the Service has developed its own suicide prevention programs tailored to its specific mission and organizational requirements. The U.S. Army maintains the Army Suicide Prevention Program (ASPP or

SP2) through their service regulation, AR 600-92, which emphasized strengthening protective factors and reducing suicide risk among Soldiers (U.S. Army, n.d.). SP2 focuses on developing and implementing training and education for leaders, Soldiers, and prevention professionals to promote awareness and enable suicide risk reduction (Army Suicide Prevention Program, n.d.). The Army also uses the Ask, Care, Escort-Suicide Intervention (ACE-SI) initiative (Walker, 2011) The ACE-SI program is the Army's mandatory annual suicide prevention and awareness training that is intended to empower individuals to Ask, Care, and Escort Soldiers who are at risk to the proper professional help (Walker, 2011).

The U.S. Navy and U.S. Marine Corps utilize the Naval Center for Combat and Operational Stress Control (NCCOSC), which provides standardization guidance for suicide prevention training and mental health practices across the Naval Service (Naval Center for Combat and Operational Stress Control [NCCOSC], 2015). NCCOSC emphasized operational stress control and resilience as part of a broader approach to psychological health. The Navy also uses the Sailor Assistance and Intercept for Life (SAIL) program. This program is available to active-duty Sailors who are at risk of suicide or have exhibited suicide-related behavior (Department of the Navy [DON], 2021). The Marine Corps has implemented the Marine Corps Suicide Prevention System (MCSPS), which is an initiative that educates Marines and their families to identify at-risk Marines and assist in prevention, intervention, and postvention efforts to reduce deaths related to suicide in the Marine Corps (DON 2021).

Similarly, the U.S. Air Force has the Department of the Air Force Suicide Prevention Program (DAFSPP), which is an integrated framework that helps to identify at risk Airmen and Guardians while promoting help-seeking behaviors and reduce Service suicide (U.S. Air Force, 2025). Additionally, the Air Force has the Wingman-Connect, a peer-based suicide awareness initiative that teaches Service members the ACE model for recognizing and responding to individuals in crisis, emphasizing peer-level intervention and personal responsibility within units (SafeSide Prevention, n.d.).

Together, these branch-specific programs are used to complement the DoD side resources by addressing specific Service-level stressors and reinforcing suicide

prevention through proactive leadership, training, and peer involvement. These initiatives, working together, reflect the complexity of suicide prevention within the military and show the importance of coordinated, military-wide approaches.

3. Effectiveness and Ineffectiveness Related to These Initiatives

Collectively, existing suicide prevention initiatives within the U.S. military demonstrate strengths in expanding access to support, increasing awareness of suicide risk, and improving short-term intervention capabilities. Policy reforms embedded and virtual behavioral health Services, crisis response systems, and peer-based training have increased the visibility and availability of mental health resources while reducing some traditional barriers related to stigma, geography, and operational demands (DoD, 2023; Barron et al., n.d.; Madsen et al., 2023). In summary, these efforts represent meaningful progress in improving access and early engagement across the military.

However, despite these initiatives, overall suicide rates among active-duty Service members have not declined, suggesting that current approaches have limited effectiveness in reducing long-term suicide outcomes (Stephens, 2024). Much of the available evidence points to improvements in intermediate outcomes, like help-seeking behaviors, increased knowledge, confidence in interventions and short-term reductions in suicidal ideation, rather than consistent reductions in suicide attempts or deaths (Bowersox et al., 2021; Osteen et al., 2016; Wyman et al., 2020). This distinction is important because while training and peer-based interventions may reduce thoughts of suicide or increase willingness to seek help, these gains do not always mean that there will be fewer attempts or deaths (Bowersox et al., 2021; Osteen et al., 2016; Wyman et al., 2020). Moreover, improvements observed in these programs often decrease over time (Osteen et al., 2016; Wyman et al., 2020), showing the need for system-level strategies that address the larger factors contributing to suicide risk across the military.

Additionally, many of these initiatives operate as parallel efforts rather than as components of a fully integrated prevention system. Variability in implementation, utilization, and continuity of care across military units may limit the overall impact of otherwise effective programs (Barron et al., n.d.; Bayliss et al., 2025). Access-focused policies and crisis response resources frequently rely on individual self-identification or

peer intervention. These strategies may be limited in environments characterized by a higher operational tempo, prolonged stress exposure, and remaining cultural barriers to help-seeking behaviors (GAO, 2021; DSPO, 2023).

Altogether, the current suicide prevention landscape can be seen as resource rich, but its outcomes are limited. While existing initiatives are effective in addressing immediate needs such as crisis intervention, counseling access, and short-term mental health services, they appear less successful in mitigating the broader and cumulative factors to suicide risk across the force. This gap emphasizes the need for a comprehensive, system-level evaluation of suicide prevention efforts that go beyond individual program effectiveness to look at how policy, training, leadership, personnel practices, and organizational structures interact to influence suicide risk within the military (Stephens, 2024).

C. NEED FOR SYSTEMIC EVALUATION

Even with the expansion of suicide prevention efforts across the DoD, suicide rates among active-duty Service members have yet to show a meaningful decline. While the existing programs have helped to improve awareness, provide access to behavioral health services, and enabled short term help, these results have not consistently reduced suicide attempts or deaths (Bowersox et al., 2021; DSPO, 2024). Part of the limitation of these efforts is that the programs themselves remain program focused, rather than assessing how these programs can work collectively within the military organization as a whole.

Program-level assessments rely on intermediate or process-based outcomes, like training completion, use of the crisis response system, and peer intervention success rather than on long-term measures of effectiveness (Osteen et al., 2016; Wyman et al., 2020). While these measures are beneficial for tracking implementation and engagement within the respective Service branches, they do not offer insight on whether prevention efforts are addressing the systemic factors that lead to increased suicide risk. Thus, individual programs may appear effective when looking at them under a microscope, yet the broader organizational conditions still show Service members at an elevated risk.

Suicide within the military is influenced by a mix of operational demands, organizational structures, leadership, personnel, and cultural norms related to the stigma surrounding mental health help (Barron et al., n.d.; Bayliss et al., 2025). These factors can diminish the effectiveness of prevention programs, especially when access to care is inconsistent or support is not continuous. Program-focused evaluations fail to show how these factors interact across units and branches, which limits the ability to identify certain systemic issues that remain despite the investment in suicide prevention resources.

Complicating evaluation efforts further is the inconsistent nature of suicide prevention across the military organization as a whole. Prevention, intervention, and postvention responsibilities are distributed across different offices, which leads to variability in oversight and accountability (DSPO, 2023; Stephens, 2024). Moreover, differences across Service culture, leadership involvement, staffing, and resource availability can lead to mismatched use of these programs. Additionally, delays in the publication of annual suicide data decreases transparency and limits timely policy assessments and the ability of leaders to respond to the new data trends (DSPO, 2025).

Operational and cultural barriers reinforce the need for a system-level evaluation. Many of the current suicide prevention programs rely on self-referral or peer intervention, which are approaches that can be less effective where stigma, career impact, and leadership discourage help-seeking behaviors (Bowersox et al., 2021). Leadership plays a critical role in shaping these environments, yet leadership behaviors, command climate, and policy enforcement are not typically evaluated as key components of suicide prevention success. Without looking at these key factors, suicide prevention efforts risk remaining reactive rather than preventive and long-lasting.

Taken together, these factors point to the need for a more comprehensive and structured approach to evaluate suicide prevention as a military-wide readiness issue rather than a finite collection of programs. By using a systemic evaluation framework, this analysis examines gaps and unintended consequences across the military Services that may be harming prevention efforts despite good intentions and resource investment. Accordingly, this study uses the DOTMLPF-P framework to assess suicide prevention efforts across doctrine, organization, training, materiel, leadership, education, personnel,

facilities, and policy, providing a holistic foundation for identifying weaknesses and informing long-lasting recommendations. The next section introduces the DOTMLPF-P framework and explains why it is relevant as the analytic tool for evaluating suicide prevention within the U.S. military.

D. THE DOTMLPF-P FRAMEWORK

The DOTMLPF-P framework is a tool used by the Department of Defense to evaluate how the military organizes, trains, equips, and sustains the force. DOTMLPF-P stands for Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel, Facilities, and Policy and is commonly used to identify capability gaps and ensure solutions address the entire system and not just isolated areas (CJCS, 2015). This framework reflects principles of systems thinking, which shows that complex problems require coordinated solutions across these interrelated domains (Sterman, 2000).

Suicide in the military is a complex issue that is influenced by factors like operational stress, organizational culture, leadership climate, and access to behavioral health services (Madsen et al., 2023). Therefore, the DOTMLPF-P framework allows for identifying gaps that may not be identified in program evaluations.

Each domain of the DOTMLPF-P framework allows for a distinct perspective in this study. Doctrine includes official guidance and strategies, such as defining responsibilities for suicide prevention, which supports consistency in program implementation (CJCS, 2012) Organization looks at how responsibilities are distributed across different units since broken oversight can hinder continuity of care (Bayliss et al., 2025) Training enhances knowledge and confidence in identifying and responding to risk, though evidence for long-term reductions in suicide deaths is limited (Osteen et al., 2016; Wyman et al., 2020). Materials include tools and systems like telehealth platforms and behavioral health data systems, which can expand across to care for Service members in operationally limited environments (Madsen et al., 2023). Leadership and Education focus on command climate and leader engagement. Supportive leadership has been shown to reduce stigma and increase the use of mental health resources (McGuffin et al., 2021). Personnel addresses staffing levels and deployment cycles, because high operational turnover and stress exposure are recognized risk factors for suicide (Madsen

et al., 2023). Facilities are the physical buildings that support care, where lack of privacy or access to these locations can limit Service member use (Hoge et al., 2004). Policy includes statutory requirements and departmental directives like self-referrals, which can reduce stigma if reinforced by leadership (SPRIRC, 2022).

Applying the DOTMLPF-P to suicide prevention frames the issue as a force readiness issue, not just a clinical issue. Many suicide prevention programs can improve intermediate outcomes like awareness or short-term reductions in suicidal ideations, but they do not necessarily lead to a reduction in suicide deaths (Wyman et al., 2020; SPRIRC, 2022). This lack of a reduction in suicide deaths shows why it is necessary to look at the bigger picture by reviewing the current literature on military suicide and prevention programs.

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III. LITERATURE REVIEW

This chapter reviews three key components that are all necessary to paint the full picture of just how pressing the issue of suicide is in the armed forces. In order to apply the DOTMLPF-P framework to the suicide programs that are currently employed by the DoD, it is first necessary to analyze the nature of suicide in the military from both organizational and cultural perspectives.

A. THE NATURE OF SUICIDE IN THE MILITARY

As stated previously, suicide is one of the most prevalent risks that plague soldiers and sailors alike, with copious amounts of effort and capital being put into it to prevent it. With this reality at play, studies on this topic still suggest that despite efforts to mitigate this issue, suicide rates within the armed forces continue to rise and are greater compared to the suicide rates in civilian populations (Clark-Sestak et al., 2016). The disparity between the suicide rates of the military and general population points to factors that are more than just a difference in case-by-case examples, but rather the disparity touches on the differences of cultural and organizational factors that might lead to the increased suicide rates.

1. Cultural Factors

The culture of the military is markedly unique compared to other organizations, and even within the military itself, there are differences in culture across the different branches. According to Soeters et al. (2006):

> Military organizations are "greedy institutions" because they require a lot from their personnel: during active-duty personnel are on a permanent, 24-hour call with rather idiosyncratic working shifts; their leave is subject to cancellation; and they can be ordered to far-off places on short notice. The jobs in the military may be dangerous and potentially life threatening. (Soeters et al., 2006, p. 237)

With the military culture being operational at all times, Service members are often bombarded with stressful tasks, training, and events that often lead to pent-up stress and anxiety. This "always on the go" culture, mixed with a "Warrior Ethos" mindset creates

an environment for warfighters that is not conducive for them to properly address these inherent daily stressors. According to the article *Warrior Ethos versus Well-Being: Correcting a Cultural Dichotomy:*

> The Army's warrior mindset, while crucial for being successful in battle, can also lead to chronic suppression of emotions, and hamper help-seeking behavior. Messages to prioritize well-being are often presented in a confusing juxtaposition to the warrior mindset. In spite of the Army's emphasis on a 'People First Strategy,' accompanied by calls to reduce the stigma associated with help-seeking behaviors, the culture of toughness created by the Warrior Ethos continues to be an imposing obstacle for those in need of help. (Konheim-Kalkstein et al., 2022, p. 29)

One can observe this cultural tug-of-war, where soldiers and sailors are expected to be brave, stoic, and mission-oriented, while there is a simultaneous push for mental health and emotional transparency. This seeming contradiction is not necessarily a design flaw in the culture of the military; however, this highlights the unique cultural circumstances that military members experience. Although the DoD is putting more emphasis on suicide prevention, the very culture of the military is a factor in the suicide rates seen in the military.

2. Organizational Factors

While significant cultural factors play a role in the suicide epidemic within the military, these cultural factors do not just exist in a vacuum; rather, they are compounded when they are operating under the organizational structure within the military. With this important caveat in mind, it is imperative to also understand the organizational factors that are also involved in the suicide epidemic. According to the results of an Air Force study by Pflanz and Sonnek (2002):

> Military personnel were significantly more likely to report suffering from job stress than civilian workers ($p < 0.001$). One-quarter (26%) reported suffering from significant work stress, 15% reported that work stress was causing them significant emotional distress, and 8% reported experiencing work stress that was severe enough to be damaging their emotional health. (Pflanz & Sonnek, 2002, p. 877).

While it is not necessarily a surprising finding that a career in national defense is more stressful than its civilian counterparts, the important takeaway of these findings is

that systemic and organizational factors make these job stressors more prevalent in the military.

In addition to a noticeable increase in stress levels in the military compared to civilian counterparts, researchers have also identified specific work factors that increase this elevated level of stress. Campbell and Nobel (2009) propose a framework that categorizes military stressors into several domains, including work-related demands, social and interpersonal pressures, family-related strain, challenges to self-identity, the broader psychological environment, and physical environmental conditions. With this framework, it is possible to distinguish where stressors emerge from in an organizational point of view, enabling a more precise analysis of the suicide risk among personnel in the military.

One of the most prominent organizational stressors that is extremely prevalent within the military is work-related stress. In the context of the military, soldiers and sailors are often subject to work that is high in operational tempo, littered with copious amounts of training requirements, and requires long deployment cycles that limit the time needed for mental and physical recovery. Research on the effects of operational tempo and deployment cycles highlight that "Soldiers who deployed longer were more likely to score high on a psychological symptom test than soldiers deployed for shorter periods of time. The highest rates occurred among those personnel deployed for more than five months" (Castro & Adler, 1999, p. 90). This is a problematic statistic given that most deployments range from 6 to 12 months long (Johnson, 2022). With studies showcasing that deployment cycles being 5 months or longer are detrimental to a soldier's psychological health, and typical deployment cycles being 6 to 12 months, this is a clear organizational factor within the military that plays a role in the suicide risk of military personnel.

Social and interpersonal pressure is another organizational stressor that can strongly influence the psychological state of military members, largely in the form of unit cohesion. Unit cohesion is specifically a military-style form of social support that is seen to be beneficial in addressing mental distress in military members (Buhler et al., 2023). Research has shown that "social support helps people to confront their painful emotional

and cognitive reactions to trauma. … Perceived unit cohesion also was found to reduce avoidant coping and thereby indirectly facilitating mental health" (Buhler et al., 2023, p. 2).

Although the importance of unit cohesion is highlighted in research, there are drawbacks that can create unintended consequences that affect mental health in the military. Given that the military is a dynamic organization with multiple moving parts, like permanent change of station (PCS) movement, personnel changes, and deployment rotations, unit cohesion is also subject to these dynamic changes. With these changes, the social bonds and safety nets that are created through unit cohesion also change and can cause disruption. DoD data shows that military members typically relocate every two to four years, which is a pattern that showcases fragmentation in social cohesion within units (Armed Services YMCA, 2022). This loss of social bonds and unit cohesion can lead to individuals being socially isolated and reduces access to peer support, which exacerbates psychological strain and can increase vulnerability to suicide risk.

In addition to work-related demands and social and interpersonal pressures, Campbell and Nobel (2009) identify other organizational stressors including self-identity issues, the broader psychological climate, and physical environment conditions. These other factors also influence how Service members navigate the maze of mental health and suicide prevention, highlighting that the issue of suicide in the military is not just a personal matter, but an organizational matter. While not all of these stress domains are inherently linked to suicide risk, they do illustrate that the nature of stress is a multifaceted issue.

3. Interaction and Accumulation of Organizational Stressors

The cultural and organizational stressors that are discussed above do not operate in a vacuum, but rather, they often interact with each other, which creates a compounding effect on psychological stress over time. Constant disruptions to unit cohesion may weaken social support systems that counteract stress, while high operational tempo and endless deployment cycles may cause emotional distress and bleed into the time necessary to recover physically and psychologically. At the same time, perceived stigmas and leadership climate surrounding seeking mental health help could cause a resistance to

allow for early intervention, which compounds distress within high performance environments. Outside factors like family strain, constant relocations, or just "off days" also compound distress levels on top of what is already happening.

When framed in a way that considers these factors as a collective, it suggests that suicide in the military is not attributed to one stress factor or another, but rather it results from the cumulative effects of a greedy organization (Soeters et al., 2006). With the culture of the military emphasizing "Warrior Ethos" and mission-first behavior, and its organizational structure not being conducive for proper mental and physical recovery, long-lasting social cohesion, and help-seeking behavior, over time, the intersection of the cultural and organizational stress factors of the military leads to increased psychological vulnerability and greater risk of suicide.

On a macro scale, framing these stress factors in an accumulation model highlights that suicide risk in the military is deeply embedded within institutional systems rather than purely individual psyche. The literature showcases that work-related stress, social cohesion, leadership climate, and family strain are all factors that are deeply intertwined with military service (Campbell & Nobel, 2009). It is imperative that effective prevention efforts not only account for individual resilience but also analyze how organizational structures themselves influence the persistence of suicide vulnerability among Service members.

B. CURRENT SUICIDE PREVENTION EFFORTS WITHIN THE DOD

The analysis above suggests that suicide vulnerability within the military is influenced by complex interactions between cultural and organizational factors. It is imperative for suicide prevention efforts within the Department of Defense to address said factors in a way that truly tackles the accumulative nature of these issues. Understanding the architecture of existing programs provides an essential foundation for analyzing whether institutional responses align with the identified systemic drivers found in the literature. In this section of the paper, current suicide prevention initiatives across the Department of Defense, including institutional oversight mechanisms, prevention and resilience programs, clinical and crisis response resources, and leadership responsibilities and command involvement, are reviewed.

1. Institutional Oversight and Surveillance

In the Department of Defense, suicide prevention is coordinated through centralized oversight mechanisms. These mechanisms enable the Department of Defense to monitor suicide trends, create coordinated prevention policy, and aid in the coordinated implementation of suicide prevention initiatives across all military services. The primary organization to enable these mechanisms is the DSPO, which serves as the overseeing organization for suicide prevention efforts within the Department of Defense (DSPO, n.d.a). DSPO collects and analyzes suicide-related data across all branches of the armed forces, which it then uses to publish the *Annual Report on Suicide in the Military.* This publication provides insightful data on suicide deaths, demographic trends, and risk factors among Service members. These reports are then used by policymakers and military leadership to advocate for change and evaluate the effectiveness of current prevention strategies (DSPO*,* 2024).

In addition to the internal monitoring of suicidality, there is also external oversight, namely in the form of the GAO and the Suicide Prevention and Response Independent Review Committee (SPRIRC), that influence policy review of suicide prevention efforts. These independent organizations conduct their own assessments of the current policy, and they can identify numerous systemic issues. From an outside view, the GAO and SPRIRC can identify that there is fragmented oversight, inconsistent program implementation across Service branches, and limitations in data integration between prevention initiatives (DSPO, 2024; SPRIRC*, 2022).*

The findings gained from these oversight bodies have influenced several policy corrections within the Department of Defense that highlight the importance of effective coordination, transparency, and accountability within overall suicide prevention efforts. These institutional oversight mechanisms provide valuable and pertinent data for suicide surveillance and prevention that influences prevention policy within the Department of Defense.

2. Prevention and Resilience-Based Initiatives

In conjunction with the institutional oversight and surveillance mechanisms of suicide risk, the Department of Defense has also implemented numerous prevention and

resilience-based initiatives that are aimed at decreasing suicide risk among Service members. These initiatives are primarily focused on increasing awareness of suicide risk factors, creating a sense of resiliency within Service members, and advocating early intervention through peer support. These programs are used to address the issue of suicide risk on the individual and unit levels, emphasizing the importance of early warning signs and the proper response to potential suicide risk before it occurs.

One of the most pertinent approaches used across the military services is gatekeeper training, which emphasizes useful skills for Service members to identify and respond to other members who may be experiencing suicidal ideation (Teo et al., 2024). An example of gatekeeper training is the U.S. Army program Ask, Care, Escort - Suicide Intervention (ACE-SI), which trains Service members to recognize the early indications of suicide and provides immediate support and access to appropriate mental health resources (Walker, 2011). A similar peer-driven program is also employed in the U.S. Air Force called Wingman-Connect. Wingman-Connect highlights peer accountability and enables Service members to help one another in identifying mental health concerns and seeking help when necessary (SafeSide Prevention, n.d.). Through gatekeeper programs, Service members are able to improve knowledge of suicide risk factors among other Service members, create a culture of intervening peers, and enabling a more cohesive unit environment (Wyman et al., 2020).

Overall, prevention and resilience-based initiatives showcase an effort by the Department of Defense to curate a culture in which Service members are more equipped to identify mental health challenges and intervene early on. By highlighting the importance of peer involvement, education, and resilience training, these programs are set forth to strengthen protective factors within military units and encourage help-seeking behavior among Service members.

3. Clinical and Crisis Response Resources

In addition to prevention and resilience-based initiatives, the Department of Defense has also increased clinical and crisis response resources to provide Service members with direct access to mental health support. The expansion of these resources aims to address suicide risk by increasing accessibility to health services, reducing

barriers to care, and ensuring that Service members experiencing mental health problems are able to receive intervention early on. Recently, the DoD has increased its emphasis on the expansion of in-person and remote health services to better support Service members in a variety of operational environments.

An important crisis response resource for Service members is the 988 Suicide and Crisis Lifeline, which is a nationwide hotline that connects members to trained mental health counselors (988, n.d.). This hotline was intended to create easier access to crisis support and provide immediate assistance if a Service member was feeling psychologically distressed (H.R. 7116, 2022). Additionally, the DoD has other programs like Military OneSource, which is used for confidential counseling referrals and other clinical services for Service members and their families (DoD, 2018). Military OneSource helps Service members in a spectrum of stressors, such as financial, relationship, and deployment-related stress, with the goal of decreasing overall psychological stress (114th Fighter Wing, n.d.).

Additionally, the DoD has also increased the integration of professional mental health providers and telehealth services within units to improve mental health accessibility across the force. Doing this allows Service members to receive aid within their commands without disrupting the daily work schedule and high operational tempo (Martinez et al., 2023). Expanding access to telehealth services has also enabled Service members to engage with mental health professionals remotely, addressing the issue of the disparity between different locations and the access to mental health facilities (Tenso et al., 2024). Policy reforms, such as the Brandon Act, have also enabled Service members to seek mental health evaluations in a confidential process that does not involve direct command notification, aiming to reduce the mental health stigma within the armed forces and increase early engagement with mental health services (U.S. Department of War, 2023).

The expansion of clinical and crisis response resources highlights the DoD's efforts in improving accessibility and engagement of mental health throughout the military. By reducing barriers to care, expanding crisis response infrastructure, and increasing behavioral health accessibility, the DoD's initiatives aim to ensure that Service members can seek appropriate support when facing psychological distress.

4. Leadership Responsibilities and Command Involvement

In addition to institutional oversight, prevention training, and clinical resources, suicide prevention is also deemed a key responsibility within the military chain of command. Commanders of units influence the organizational climate and culture of their respective units and are responsible for ensuring that suicide prevention policies and initiatives are implemented within their units.

Leadership influence is of utmost importance in combating suicide within the military because it can strongly affect whether a Service member in their unit is comfortable seeking mental health support. Research suggests that leadership environments that are supportive can decrease the stigma behind mental health care, which increases the chances that Service members will use available health resources (McGuffin et al., 2021). On the other end of the spectrum, a negative leadership environment may unintentionally have the opposite effect and create more barriers to mental health care (McGuffin et al., 2021). By influencing command climate, encouraging help-seeking behavior, and reinforcing prevention initiatives within units, military leaders play a marked role in enacting suicide prevention policy into reality across the forces.

C. LIMITATIONS OF CURRENT SUICIDE PREVENTION EFFORTS

Despite the Department of Defense's efforts to implement many suicide prevention initiatives across institutional oversight, prevention training, clinical resources, and leadership engagement, suicide rates within the military are not declining as anticipated initially. Although there have been many suicide prevention policies enacted, data from the Department of Defense Suicide Prevention Office showcases that over the past decade, suicide rates within the military have fluctuated rather than decreasing linearly over time (DSPO, 2024). As a result, oversight bodies and research have identified challenges that might limit the effectiveness of current prevention strategies, which include fragmented program oversight, uneven implementation across Service branches, and persistent cultural barriers (DSPO, 2024; SPRIRC, 2022).

One of the most critical factors that have been identified that limits current DoD suicide prevention policies is the fragmentation of program oversight and overall coordination across the military services. Third-party evaluations from the GAO have highlighted that the DoD has numerous suicide prevention policies and programs; however, they have struggled to consistently evaluate the effectiveness of these initiatives and create coordinated efforts across the different Services (GAO, 2021). In addition to this, the Suicide Prevention and Response Independent Review Committee has also emphasized that there are improvements to be made in how suicide prevention responsibilities are distributed across various commands and offices within the DoD. Overlapping of responsibilities can create additional complications and overall inconsistencies in program implementation, which makes creating a unified approach to suicide prevention across the force more difficult (SPRIRC, 2022). Given these findings, suicide prevention initiatives are implemented in a variety of ways across differing units and Services, which can limit the overall effectiveness of these programs on a DoD-wide scale.

Another limiting factor that is identified in existing research is the effectiveness of suicide prevention training programs. Several DoD prevention initiatives highlight the importance of gatekeeper training and awareness of warning signs of suicide to help Service members potentially intervene when peers are experiencing psychological distress. Although research suggests that these programs may improve the overall awareness of suicide risk factors and increase the likelihood of suicide intervention among peers, studies examining the long-term impact of these initiatives point to the fact that increased awareness of suicide risk factors and more confidence in peer-to-peer suicide intervention do not necessarily translate into reductions in suicide attempts or deaths among Service members (Wyman et al., 2020; Bowersox et al., 2021). Although these programs are important in spreading awareness of suicide risk factors and encouraging peer-to-peer suicide intervention, the training alone does not sufficiently address the larger organizational and cultural factors that influence suicide risk within the military.

These findings suggest that current Department of Defense suicide prevention efforts cannot be evaluated based on individual programs or policies, but rather they

should be evaluated as a broader system. Although the DoD has implemented programs that increase awareness of suicide risk factors, expand mental health infrastructures, and encourage early intervention, the existing research consistently showcases that there are systemic issues that limit the effectiveness of these programs. Fragmented oversight, inconsistent implementation, and cultural barriers highlight that suicide prevention within the military is influenced by many complex factors, namely organizational, cultural, and institutional factors. Evaluating suicide prevention efforts requires a framework that examines how all these factors interact with each other across the military. The DOTMLPF-P framework provides this type of approach by assessing how doctrine, organization, training, material, leadership and education, personnel, facilities, and policy interact and collectively influence the effectiveness of suicide prevention programs and initiatives. The following chapter uses this framework to evaluate previously discussed prevention efforts, to then identify capability gaps that can influence prevention outcomes across the Department of Defense.

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IV. COMPARATIVE ANALYSIS

Suicide rates within the Department of Defense continue to fluctuate despite increased funding and broader situational awareness. This points to what Rittel and Webber (1973) called a "wicked problem." In contrast, "tame problems" are well defined, have clear stopping points, and can be solved through linear and technical applications, while wicked problems are "mischievous" and "ill-defined" (Rittel & Webber, 1973). Wicked problems do not follow fixed formulas in the way tame problems do. Once one aspect of the problem is addressed, another symptom presents itself elsewhere within the system (Rittel & Webber, 1973).

A. METHODOLOGY

The methodology for this analysis uses the DOTMLPF-P framework (Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel, Facilities, and Policy). This framework is traditionally used in military acquisition and force development, but here it has been used here to provide a holistic view of the DoD's suicide prevention initiatives.

The DOTMLPF-P framework is used to categorize and evaluate existing DoD data across eight domains to identify capability gaps and misalignments in suicide prevention efforts. The analysis begins with Doctrine, which examines the principles and the standard operating procedures (SOPs) that shape how the specific branches respond to suicide prevention matters. The Organization domain shows how the DoD structures its suicide prevention offices. The Training and Materiel domains analyze the delivery of prevention skills and the effectiveness of long-term success of these trainings. These domains also focus on the physical materials surrounding personnel safety, such as lethal means safety, both physical equipment and effective training. This is followed by the Leadership and Education domain, which assesses how the branches and individual command climates can influence help seeking behavior. The next domains are Personnel and Facilities. Analyzing these domains allows for the identification of personnel and manning levels of military mental health professionals and their support staff, and evaluating the care facilities, including accessibility and availability. The Policy domain

reviews current policy implementations and assesses if these policies are aligned in a way that are effective in the operational environment.

B. DATA AND ANALYSIS

This analysis draws from existing DoD suicide reports, service specific data, GAO findings, RAND reports and existing program evaluations. Using the DOTMLPF-P framework allows for the organization of the data in a way that highlights gaps, program overlaps, and inconsistencies in military suicide prevention efforts. The following sections show the key findings within these domains and show their implications for addressing suicide in the DoD.

1. Doctrine

The DoD has its own doctrine, DoD Instruction (DoDI) 6490.16, that outlines the Defense Suicide Prevention Program. This instruction was put into effect on November 6, 2017, and last updated in February 2023 (Office of the Under Secretary of Defense for Personnel and Readiness [OUSDPR], 2023). Under the DoDI, each branch has its own governing doctrine for suicide prevention; these include Army Regulation 600-92, OPNAV Instruction 1720.4B, Marine Corps Order 1720.2A, and DAFI90-5001. With DoD Instruction 6490.16 as the parent instruction, the different branches implemented their own instructions for service specific suicide prevention programs. It's design to balance centralized oversight with service level execution, but that balance breaks down in practice. DoDI 6490.16 sets a baseline, but service level doctrine introduces variability that affects consistency in suicide prevention across the DoD.

DoDI 6490.16 establishes the responsibilities and procedures for the Defense Suicide Prevention Program (DSPP) through a public health framework that emphasizes prevention, intervention and postvention (OUSDPR, 2023). The framework prioritizes governance, data standardization, and postvention (OUSDPR, 2023). To achieve a unified approach amongst the branches, the instruction lays out formal governance through the Suicide Prevention General Officer Steering Committee (SPGOSC) and the Suicide Prevention and Risk Reduction Committee (SPARRC), which provides oversight as well as policy recommendations (OUSDPR, 2023). Together, these requirements point

to a more data driven public health model of suicide prevention. However, the effectiveness of this model depends on whether implementation is consistent across the services. It also depends on how prevention efforts are evaluated. The instruction also mandates standardized definitions for suicide related behaviors and requires consistent data collection by using the Department of Defense Suicide Event Report (DoDSER) to ensure adequate comparability across the services (OUSDPR, 2023). The instruction also highlights postvention practices which show the importance of unit memorial ceremonies that are intended to provide closure and allow for grieving while avoiding the glorification of suicide (OUSDPR, 2023). Furthermore, DoDI 6490.16 requires for all non-clinical prevention actions to be evaluated against a defined theory of change to verify that the implemented programs are effectively reducing suicide related risk factors (OUSDPR, 2023).

Despite the standardization outlined in the DoDI, there are significant differences that arise at the service level when looking at how suicide prevention is conceptualized and subsequently implemented. Each branch adapts the DoDI instruction to fit its organizational culture, leadership philosophy, and mission requirements. That leads to notable differences in the doctrine that is implemented within the different services and how they handle reporting and administrative requirements, and the specific tools or programs they use. In practice, this means suicide prevention in the DoD functions less as a unified system and more as a parallel system operating under a universal framework. These variations show that service-level doctrine differs not only in implementation, but also in how suicide prevention is conceptually understood.

One area where these differences can be seen is in how each branch approaches the idea of resilience and overall fitness. In the Air Force, DAFI 90- 5001 connects suicide prevention to Comprehensive Airman Fitness and Total Force Readiness, which focuses on mental, physical, social and spiritual fitness (DeFilippi, 2025). The Army conceptualizes resilience through a different approach in AR 600-92 by using a framework called the Five Dimensions of Strength, which encompasses physical, emotional, social, spiritual and family factors (Department of the Army, 2023). Army doctrine also uses a four-tiered approach which includes sustain, protect, engage, and act to organize prevention efforts (Department of the Army, 2023). The Marine Corps links

suicide prevention to Combat and Operational Stress Control, which focuses on leadership and managing stress in the operational environment (Commandant of the Marine Corps, 2021). In the Navy, "deck plate leadership" places the Navy's approach of prevention responsibility at the lowest level through direct and frequent interactions with service members (Office of the Chief of Naval Operations, 2018). Therefore, while all branches follow the same guidance outlined in DoDI 6490.16, they each frame resilience in a way that is reflective of their different missions and cultures. These differences reflect different assumptions about what drives suicide risk, whether that is individual wellness, unit cohesion, leadership engagement, and operational stress. Consequently, prevention efforts may be looking for similar outcomes through different models, which complicates evaluation of effectiveness across the services.

Apart from conceptual differences, the branches have differences in doctrinal implementation methods for administrative reporting and suicide surveillance standardization. While the DoDI 6490.16 requires the use of the DoDSER, each branch uses its own additional methods that operationalize DoDI requirements within the function of their organizational structures (OUSDPR, 2023). The Army requires DA Form 7747 and AR 15-6 investigations as inputs to support postvention analysis that is aligned with DoDI reporting requirements (Department of the Army, 2023). The Marine Corps requires a MF 30-day death or suspected death by suicide report in addition to the standard OPREP-3 SIR reports which support timely command level awareness but also feed into the larger DoD-level data systems (Commandant of the Marine Corps, 2021). The Air Force implemented a self-assessment process and using the Management Internal Control Toolkit (MICT) to track annual program compliance and reinforce consistent doctrinal implementation (DeFilippi, 2025). These differences point to distinct approaches to oversight, accountability, and reporting. These reporting approaches range from formal reporting systems to internal monitoring, and the result is uneven accountability across the different services. While flexibility allows each service to fit its reporting process with its organizational structure, it may also introduce inconsistencies in data quality and comparability across the different branches and potentially limit the effectiveness of centralized governance and oversight. Each branch has developed specific policies to deal with suicide risk with its own operational environment. While

these different policies further highlight how each of the services implements the broader DoD Instruction, these policies will be covered in more detail under the Policy domain of the DOTMLPF-P framework.

This variation of doctrines also introduces a shift in language that is used within the services. Specifically, the Marine Corps discourages the phrases "committed suicide" or "successful suicide," and instead uses phrases such as "death by suicide" to reduce stigma (Commandant of the Marine Corps, 2021). Not only does this shift in vernacular change the way suicide is discussed, but it also makes it easier for service members to seek help and aligns with the American Foundation for Suicide Prevention in how to talk about suicide safely (American Foundation for Suicide Prevention, n.d.). This shift in language reframes suicide as a public health issue instead of an individual failure. Ultimately, the unified DoDI 6490.16 is looked at through service specific lenses, resulting in different approaches to the same problem. These variations show that each service is solving the same problem with slightly different assumptions about where risk comes from.

2. Organization

Structural misalignments within the DoD's organizational domain limit the effectiveness of current suicide prevention efforts. Existing responsibility is divided between the DSPO, which oversees policy and evaluations, and the DHA, which manages clinical care (OUSDPR, 2023; DSPO, n.d.a). This division creates a structural separation between prevention oversight and clinical treatment pathways, limiting the extent to which information, data, and decision making are shared across DoD systems. As service members move between levels of care, this lack of integration which breaks continuity of care and limits opportunities for early intervention.

The problem is compounded by the DoD's limited evaluation of its non-clinical prevention efforts. GAO (2021) notes that the DoD has not fully assessed the effectiveness of non-clinical prevention efforts or the connection to clinical outcomes (GAO, 2021). Without that connection, prevention programs continue without clear evidence of impact, so the DoD can't tell which of these efforts actually work. In practice, this separation prevents the DoD from refining its approach or prioritizing

resources that are based on measured results. At the unit level, responsibility is further diluted. In the Navy, the suicide prevention coordinator (SPC) is a collateral duty under OPNAVINST 1720.4B (Department of the Navy, 2018). While this does satisfy the requirements outlined in DoDI 6490.16, it shows that suicide prevention is not a core responsibility. RAND research shows that the DoD's organizational approach is a "fragmented" collection of programs that often lack centralized coordination (Ramchand et al., 2011). Specifically, this study highlights that when the services rely on "gatekeepers," they are often not provided with the sustained training that is necessary to shift from basic awareness to intervention (Ramchand et al., 2011). This study suggests that when suicide prevention is treated as a secondary duty, units lack a method to identify behavioral health risks early, narrowing the window for effective intervention.

Another issue lies in the placement of the suicide prevention program. For example, in the Army, suicide prevention sits within G-1 (Personnel). This placement frames prevention as an administrative task rather than an operational one. In contrast, functions tied to readiness fall under G-3 (Operations), where they receive greater priority and integration (Ritchie et al., 2011). Given the continued elevation in suicide rates from 2011 to 2024, the current structure for suicide prevention programs has not met its intended effect (DSPO, 2024). Overall, the DoD's organizational structure for suicide prevention is split across clinical, non-clinical, and unit-level responsibilities. This limits coordination, weakens continuity of care, and reduces suicide prevention to an administrative task rather than an operational priority. The DoD's organizational structure does not function as an integrated suicide prevention system, but as a set of disconnected efforts across clinical care and unit level execution.

3. Training

Training for suicide prevention within the DoD is centered around an expectation that personnel can identify warning signs and then make proper referrals through the proper suicide prevention response pathways. DoDI 6490.16 formalizes this approach through a public health framework that emphasizes early identification, intervention, and reporting resources across the different branches (DoDI, 2023). Suicide prevention training across the DoD focuses on responding once risk indicators appear, with less

emphasis on the earlier conditions that build up before those same suicidal indicators become known.

Service level implementation reflects this in different forms, though underlying logic remains consistent. The Army's Ask, Care, Escort (ACE) model organizes intervention as a sequential process after indicators are identified (Department of the Army, 2023). Navy training distributes prevention responsibility across leadership and peers, reinforcing escalation of care through proper chains of command (DON, 2018). Air Force programs integrate suicide prevention into Comprehensive Airman Fitness and Master Resilience Trainer instruction, linking prevention to readiness (My Air Force Benefits, 2025). The Marine Corps embeds suicide prevention within Combat and Operational Stress Control, tying intervention to operational stress exposure and leadership engagement in operational environments (DON, 2021). Despite differences across the services in framing and organizational culture, suicide prevention training consistently prioritizes recognition of suicide risk that is then followed by appropriate response once indicators are present. As a result, differences in the training structure may shape how well personnel are able to interpret and act on unclear or early warning signs, which leads to an uneven ability to identify suicide risk before it is clearly visible.

The DSPO competency framework reinforces this structure by outlining the knowledge and skills expected of personnel, particularly in recognizing warning signs, understanding suicide risk factors, and starting intervention (DSPO, 2016). These competencies establish a common baseline across the DoD, but they remain largely oriented toward observable indicators and defined crisis response actions. Training is designed to ensure that personnel know what to do when suicide risks become identifiable, rather than how to understand situations where indicators are not entirely clear or even still developing. SPRIRC survey findings indicate that only approximately half of service members reported receiving suicide prevention training within the past year, highlighting variability in training exposure across the DoD (SPRIRC, 2023). The bigger limitation isn't whether service members are taught what the suicide indicators are, but how training teaches them to wait until suicide risk indicators become obvious before intervening.

SPRIRC highlights that suicide prevention training across the DoD is delivered in a standardized, compliance driven manner that prioritizes completion over engagement or skill development. Training is primarily delivered through annual mandatory requirements rather than continuous cycles. It is often delivered in short training events that limits opportunities for skill reinforcement (SPRIRC, 2023). Additionally, SPRIRC found a significant portion of service members did not report increased confidence in identifying or responding to suicide risks following these trainings, suggesting a gap between training completion and perceived effectiveness (SPRIRC, 2023). Even when the training content is sound, the training environment may still limit how service members internalize and apply intervention skills into challenging or unclear situations.

Broader oversight findings reinforce this concern. While suicide prevention training requirements exist across the DoD, there is variability in training delivery and retention of information at the instructional level (GAO, 2022). The GAO notes that the DoD has established suicide prevention training requirements but has not fully ensured standard implementation across the services, especially in areas tied to response and post event responsibilities (GAO, 2022). Although this observation extends into organizational execution, it also showcases a training issue, with there being a reliance on standardized methods rather than adaptive pathways, which ultimately limits how well training prepares individuals for uncertain situations in the real world.

These findings suggest that suicide prevention training in the DoD is less a developmental learning process and more about structured compliance that is designed to ensure a baseline level of recognition and response capability. The system effectively trains personnel to act once risk is identifiable, but it does not consistently develop the mental flexibility needed to understand developing behavioral stressors before they become visible warning signs. Training is not absent or insufficient, but that its design logic is bounded by a reactive framework. The DoD may be producing a force that is procedurally prepared to respond to suicide risk, but less consistently prepared to recognize how that risk develops in its less visible stages, which is critical to prevention efforts. Training is the main way DoD suicide prevention capability is translated into individual action, but current instructional design emphasizes compliance over the development of actionable skills.

4. Material

While training focuses on the human element of suicide prevention, the materiel domain focuses on the physical and technological tools that are used to disrupt the path to suicide and suicide-related behaviors. A central component of the materiel domain is the concept of lethal means safety, which involves actions like the distribution of cable firearm locks and providing lockboxes for medications (Forefront Suicide Prevention, n.d.). By creating time and distance between a service member in crisis and lethal means, by increasing time and friction between impulse and action, these interventions reduce the likelihood of suicidal behavior. (Forefront Suicide Prevention, n.d.). Lethal means safety is reinforced in DoDI 6490.16 as part of creating safe and healthy environments (2023). In addition to physical means like firearm locks and medication lockboxes, the materiel domain also includes broader infrastructure that supports the public health approach to suicide prevention, including systems for crisis response, early identification, and environmental safeguards that reduce access to lethal means in the operational environment, consistent with DoDI 6490.16 (2023).

Beyond the physical means, the materiel domain includes digital infrastructure that is necessary for a public health approach. This is centered on the DoDSER, a technological tool that allows for the identification of standardized DoD surveillance points across the services as it pertains to suicide prevention (OUSDPR, 2023). The value of the DoDSER is its ability to turn suicide incident data into information that allows leadership to see where lethal means interventions are needed most (OUSDPR, 2023). According to the most recent Annual Report on Suicide in the Military, suicide rates for CY 2024 decreased from 23.8 per 100,000 in 2023 to 23.2 per 100,000 in 2024 (DSPO 2024). Despite this decrease, the Army and Marine Corps remain the leaders in suicide deaths at rates of 29.8 and 27.3 respectively, with the primary method of suicide deaths being the use of firearms (DSPO, 2024).

Lethal means safety is critical in decreasing suicide deaths, with research highlighting that restricting access to lethal means is associated with up to a 91% reduction in suicide in certain context (Pirkis et al., 2015). For the Army and Marine Corps specifically, the challenge is not about a lack of good ideas or missing framework,

it reflects gaps in the consistent implementation of these prevention methods. This suggests a gap between the potential effectiveness of lethal means safety interventions and their observed impact at a broader level. Materiel interventions exist, but uneven unit level adoption reduces their ability to consistently interrupt access to lethal means during periods of acute risk. Ultimately, success of the materiel domain is not about how many locks are on a base but on whether the military can overcome the cultural barriers that keep service members from using the materiel elements that have been put in place. While the materiel domain provides the tools necessary to reduce suicide risk, their effectiveness depends heavily on how they are implemented and used at the unit level. This shifts the focus to leadership and education, which shape the command climate and influences whether service members engage with these suicide prevention efforts. Materiel interventions exist, but their effectiveness is constrained by inconsistent unit level implementation and reinforcement.

Figure 1. Firearm Safety Tips. Source (Defense Suicide Prevention Office, n.d.-b)

5. Leadership and Education

The DoD currently relies on DoDI 6490.16 and the 2023 Suicide Prevention Memorandum to define leadership responsibilities regarding command climate.

Leadership and education in DoD suicide prevention programs center on the expectation that commanders and supervisors shape command climate to reduce suicide risk behaviors and encourage early help seeking behaviors, as outlined in DoDI 6490.16 (2023), a framing that is consistent with broader suicide prevention literature, which highlights leadership engagement as an important component of prevention efforts

(Acosta et al., 2014). The issue is not unclear expectations. Leaders are given complex, long-term responsibility without being shown how to understand or manage suicide prevention efforts. Command climate is treated as something leaders control rather than something they continuously analyze, assess, and improve. Command climate is central to suicide prevention, but current guidance treats it as a leadership responsibility without clearly defining how it should be evaluated. While leaders are expected to shape climate, there is limited clarity on how leaders can evaluate whether their actions are actually reducing suicide risk or improving trust within the unit.

The 2023 DoD suicide prevention memorandum reinforces this by doubling down on leadership engagement as the solution. It emphasizes reducing stigma and improving how leaders respond to suicide risks (DoD, 2023), but it still treats leadership behavior as a kind of adjustable lever for influencing outcomes rather than addressing how behavior is learned or internalized. It assumes more leader involvement will improve outcomes, but it does not explain how leaders develop the judgment to recognize when morale is decreasing. This creates a gap between expectation and capability. Professional Military Education (PME) is designed to develop leaders for that responsibility, but suicide prevention within PME still reflects a narrow focus. Across DoD guidance and PME materials, the emphasis is placed on recognizing warning signs, encouraging help seeking behaviors, and responding appropriately when risk is identified (OUSDPR, 2023; DoD, 2023; My Air Force Benefits, 2025). That emphasis may shape how leaders interpret command climate in broader terms. If leadership and education focus on individual risk indicators, it does not allow leaders to recognize broader patterns within their units, such as changes in morale, cohesion, or service members' willingness to seek help. A focus on immediate intervention is reasonable, but it does not fully align with how risk develops over time. Command climate is not shaped in moments of crisis, but through daily leadership behavior, consistency, and trust over time. When education focuses primarily on recognition and response, it does not fully develop how leaders connect their leadership practices to long term suicide risk outcomes within their units. This means there's a need for leadership education to move beyond procedural responses and instead focus on developing judgment and continuous assessment of command climate.

Leaders describe suicide prevention education as procedural and difficult to apply in real situations where warning signs are unclear (Briggs, 2025). That suggests the issue is not a lack of exposure to the topic, but a lack of depth. Leaders are given steps, but not the ability to interpret unclear situations. In reality, risk develops gradually, and requires the judgment to recognize it, not just instructional compliance. Leadership responses may be technically correct but may still create a disconnect between leadership actions and what service members are experiencing (Ramchand et al., 2011). This disconnect is not just about individual leaders, but rather how organizational climate is experienced. If leaders rely on procedure rather than understanding, the environment can feel reactive and impersonal, even when leaders are trying to do the right thing. That limits early intervention because individuals are less likely to seek help until their situation becomes more severe.

These sources point to the same issues from different angles. Leadership is treated as the first line of defense in suicide prevention, but the education system does not fully support leaders for that function. DoDI 6490.16 and the 2023 memorandum set the expectation, PME reinforces recognition and response, and Briggs' dissertation shows leaders struggling to apply suicide prevention efforts. The gap in leadership and education is not awareness, but how leaders are developed to understand and adapt command climate over time. Without a structured way for leaders to interpret command climate, leadership responses remain largely reactive rather than preventative.

6. Personnel

The effectiveness of the DoD suicide prevention system depends on whether appropriately trained personnel are available at a service member's point of need. Although DoDI 6490.16 assigns suicide prevention responsibilities across health providers, chaplains, and other personnel (DoD, 2023), implementation is limited by workforce capacity and timely access to care. Capacity limitations are consistently identified in DoD assessments. The GAO reports ongoing shortages within military behavioral health systems, including provider vacancies in some military treatment facilities exceeding 40%, and delays in accessing care across both military treatment facilities and civilian provider networks, with some service members experiencing wait

times of over two weeks for urgent behavioral health referrals (GAO, 2022). In practice, this means availability determines access more than design. Distribution of providers further shapes how these limitations are experienced across the force. RAND highlights that behavioral health personnel are unevenly distributed across installations and care environments, resulting in variation in access to care based on location and duty station (Sousa et al., 2024). Access to care varies across the DoD depending on location, staffing, and system capacity.

Beyond availability and distribution, the way personnel roles are organized affects continuity of care. SPRIRC identifies persistent staffing shortages and fragmentation across prevention, intervention, and postvention functions (SPRIRC, 2023). Personnel responsible for different stages of suicide prevention do not function as a coordinated system, limiting continuity once a service member enters care. The DoD has acknowledged these limitations and taken targeted steps to expand behavioral health staffing and improve access to care (DoD, 2023). However, GAO evaluations indicate these efforts have not yet closed existing workforce gaps, and capacity constraints continue to limit implementation (GAO, 2022). Chaplains and other non-clinical personnel expand access points within the system by providing additional avenues for support. These roles can reduce barriers to initial engagement, particularly in cases where stigma or preference for non-clinical support affects help seeking behavior (DoD, 2023). However, their function is limited to access facilitation and does not substitute for clinical behavioral health capacity.

Workforce constraints in the DoD suicide prevention system reflect limited capacity, uneven distribution, and incomplete integration of roles. These conditions produce variability in access to care across the DoD, where care depends on location, staffing conditions, and system capacity at a service members' point of need. In practice, workforce limitations set the boundaries of what the system can reliably deliver.

7. Facilities

Facilities are often treated as supporting readiness, but in suicide prevention, they act as a structural risk factor. Both GAO-23-105797 and the DoD Suicide Prevention Campaign Plan point to the same idea that the physical environment, especially the

barracks, can increase stress and isolation and contribute to suicide risk and suicidal behaviors (GAO, 2023; Secretary of Defense, 2023). The GAO report highlights ongoing issues with barracks across the services, including overcrowding, maintenance issues, and even discrepancies in the quality of living conditions. While these problems are usually addressed under readiness or quality of life, they also directly impact mental health. Living in crowded or poorly maintained barracks can increase stress and contribute to feelings of social detachment. GAO also notes that the DoD does not have a way of connecting facility condition data with behavioral health data, so facilities are not analyzed as a potential suicide risk factor, thus preventing facility level prevention targeting (GAO, 2023).

The 2023 DoD Suicide Prevention Campaign Plan introduces a more direct facilities link through lethal means safety. The plan highlights the requirement to prohibit storage of privately owned weapons in barracks, which directly ties suicide prevention to the management and security of service members' living spaces (DoD, 2023). There is also an emphasis on creating supportive environments on installations, through communal areas, privacy in living spaces, and access to care, which are all contingent on the physical layout of the facilities and supporting infrastructure, which determines whether help seeking behavior is physically and socially achievable (DoD, 2023). The reporting on suicide clusters with personnel at Tinker Air Force Base shows how physical and social separation is shaped by spatial configuration. Even though personnel are on the same base, they may still be separated from broader installation life depending on how workspaces and barracks are configured (Bailey, 2026). This suggests that installation layout may structurally contribute to isolation.

Facilities and suicide prevention are still managed in separate systems, engineering and logistics focusing on installation condition and maintenance, and behavioral health focusing on individual risk and intervention. Because of that separation, housing conditions are treated like maintenance issues rather than potential suicide risk factors. This gap is particularly important for enlisted personnel who rely heavily on barracks facilities for their living environment, where installation conditions are not adequately captured as part of suicide risk assessment (GAO, 2023; DoD, 2023). This separation prevents installation level conditions from being integrated into behavioral

health risk modeling, leaving environmental contributors to suicide unaccounted for in prevention planning.

8. Policy

Suicide prevention policy in the DoD is standardized in structure but fragmented in application. DoDI 6490.16 establishes a framework for prevention, intervention, and postvention, yet each service implements that framework into distinct policies that shape how suicide prevention is carried out in practice (DoDI, 2023). Policy guides more than implementation. It determines when intervention occurs, who is responsible, and whether prevention is treated as an operational requirement or as an administrative task. DoDI 6490.16 establishes a DoD wide baseline for suicide prevention through standardized reporting, structured oversight, and a public health framework (DoDI, 2023). It requires uniform reporting through systems like DoDSER, allowing for cross-service comparison and trend analysis. While this creates a shared policy foundation, it does not guarantee consistent implementation across the different branches. The instruction functions as a broad framework that each service interprets and adapts according to its own organizational priorities and culture.

The gap becomes apparent at the service level, where each branch operationalizes suicide prevention differently based on its mission. The Army's ACE model focuses on Ask, Care, and Escort. It trains personnel to identify warning signs and intervene once risk becomes observable (Walker, 2011). This structure makes prevention dependent on visible behavior, meaning that intervention occurs only after distress has already been escalated into critical indicators. The Navy takes a different approach with SAIL, which provides structured follow up after suicide related behavior or elevated risk has been identified (DON, 2021). This strengthens continuity of care after an event, but it still activates late in the process. It supports recovery and monitoring, not early disruption of risk. The Airforce expands prevention efforts through readiness policy and peer responsibility. DAFI 90–5001 ties suicide prevention to Comprehensive Airman Fitness and overall readiness (My Air Force Benefits, 2025). The Wingman concept builds on this by assigning every Airman responsibility for watching out for peers and stepping in when someone starts to seem off (SafeSide Prevention, n.d.). It pushes prevention into

everyday interaction instead of keeping it at the leadership or clinical level. That widens the number of people who might notice risk. But this policy still depends on something being noticed in the first place. The Marine Corps ties suicide prevention to operational stress control and command responsibility. Placing leadership at the center of suicide prevention through influence on unit climate and stress management (DON, 2021). This makes prevention heavily dependent on how leaders interpret and respond to changes in their units. It strengthens the role of leadership, but it still relies on early recognition after risks start to show.

Across all services, the structure looks different, but the timing is the same. Prevention can only be triggered once risk becomes visible, whether that is through peers, leaders, or follow up systems after an incident. Even when responsibility is spread more broadly, like the Wingman model, the system still depends on observable warning signs before an action happens. These warning signs are difficult to identify in operationally demanding environments. This shows that suicide prevention across the DoD is unified in design, but inconsistent in how it functions. The services are not working towards different goals. They are operating at different points in the same cycle. Most policy tools activate after suicide risk has already surfaced, not in the early stages where it is still forming. This matters because it defines what prevention actually means in practice. If prevention only starts once suicide risk is observable, then the system is not preventing escalation. It is responding to it. Even with standardized doctrine, shared reporting systems, and expanded peer and leadership involvement, the structure still leans toward recognition rather than early disruption. Suicide prevention cannot be effective if it is more focused on labeling signs than it is helping service members before they get to the point of crisis.

The result is a policy environment that looks integrated, but functions unevenly. DoDI 6490.16 provides a shared foundation, but it does not standardize when prevention begins. Each service fills in that gap differently, in their own way based on their organization and culture, which leads to variation in timing across the DoD. That difference in timing, more than any other factors, limits how effective suicide prevention policy can actually be.

9. Cross-Branch Relevance

Across the DOTMLPF-P framework, suicide prevention takes shape as a set of aligned but disconnected systems. The Army, Navy, Air Force, and Marine Corps all work under the same DoD suicide prevention instruction, but each branch turns that framework into something slightly different. Those differences come from mission demands, culture, and how each branch organizes responsibility. On paper, the system looks unified. In practice, it operates more like parallel efforts that rarely fully connect across domains.

Doctrine and policy show this clearly. Every branch adheres to DoDI 6490.16, but each one defines prevention in a different way. Across the different branches, prevention models vary in structure but rely on identifiable warning signs for action. Each approach is built on different assumptions about when prevention actually starts. Some begin at recognition, others after escalation, and others try to push responsibility to peers.

Training follows the same pattern. Training across the services highlights recognition and response, but it does not consistently develop the ability to intervene earlier. Most of these programs prepare service members to act once suicide risk is already identifiable. The structure across branches is different, but the logic behind it is all the same. Organization and personnel domains reinforce this fragmentation. Suicide prevention responsibility is spread across DSPO, DHA, service level programs, and collateral duty roles. Suicide prevention responsibility being widely distributed broadens accountability but limits coordination on prevention efforts

Materiel and facilities show another layer of limitations. All services acknowledge environmental risk factors like access to lethal means, housing conditions, and installation layout. The difference is not whether these tools exist, but how consistently they are applied. Environmental and materiel factors influence suicide risk across all services. As a result, physical suicide risk conditions and clinical systems operate in parallel rather than operating together. Leadership and education highlight a similar issue. Every branch positions leadership as critical to suicide prevention, but none provide a consistent way to measure command climate in relation to suicide risk. While there are programs that do increase engagement, they don’t fully close the gap between

leadership intent and measurable prevention outcomes. Leaders are expected to shape climate, but they are not always given the tools to track whether those efforts actually reduce risk over time.

Across all domains, the most consistent finding is not lack of effort or lack of policy. It is inconsistency in timing and integration. Each service has suicide prevention systems in place, but those systems are triggered at different points. They are operating in the same space, but not at the same level of prevention. The DoD is not missing a suicide prevention program. It has multiple systems that are structurally aligned but operationally inconsistent. Prevention is mismatched across the branches because each service intervenes at different points in the suicide risk timeline. The result is a DoD wide system that responds to suicide risk in pieces rather than as a coordinated whole.

10. Comparative Analysis Summary

The comparative analysis shows a system that looks aligned at the strategic level but operates separately in practice. The DoD has built a solid framework for suicide prevention through standardized doctrine, shared policy guidance, and a public health model. This creates the conditions for a unified approach. However, alignment in design does not directly translate into consistency in practice. As shown in Table 2, each service follows the same foundational instruction yet interprets and applies it through its own organizational structure and culture. These differences shape how suicide prevention is defined, when the system is initiated, and who is responsible for carrying out suicide prevention efforts. These differences influence how suicide prevention is defined, when it is initiated, and who is responsible for the process, resulting in a suicide prevention system with a shared framework but no unified approach.

Table 2. Suicide Prevention DOTMLPF-P Branch Comparison

Domain	Army	Navy	Air Force	Marine Corps	Approach	Limitations
Doctrine	AR 600-92	OPNAVINST 1720.4B	DAFI 90–5001	MCO 1720.2A	Standardized under DoDI 6490.16	Different definitions of resilience and prevention across branches

Organization	Under G-1	SPC collateral duty	Readiness integration	Leadership centered	Split between DSPO, DHA, and services	Split between policy and clinical systems
Training	ACE model	SAIL model	Resilience training integration	Operational stress-based training	Teaches recognition and referral pathways	Built around identifying visible warning signs & no confidence in early intervention methods
Materiel	Lethal means safety tools	Lethal means safety tools	Lethal means safety tools and tracking tools	Lethal means safety tools	Emphasizes reducing access to lethal means	Assumes consistent use at unit level
Leadership & Education	Command climate responsibility	Command climate responsibility	Command climate responsibility	Command climate responsibility	Leaders expected to reduce stigma and encourage help seeking	No clear method to measure effectiveness & lack of formal suicide prevention training for leaders
Personnel	Defined roles across providers	Defined roles across providers	Defined roles across providers	Defined roles across providers	Multi-layered support (clinical & nonclinical)	Assumes sufficient staffing and access
Facilities	Safe living quarters	Safe living quarters	Safe living quarters	Safe living quarters	Facilities support well-being and safety	Not directly tied to suicide risk models
Policy	ACE	SAIL	Wingman	Leadership/ Peer Driven	Public health framework	Most policies are reactive

That gap appears more clearly in how suicide prevention is actually observed across the DoD. Table 2 highlights how execution across the domains is uneven and often disconnected. Efforts tend to begin only after suicide risks are already visible. Training focuses on recognizing warning signs instead of understanding how risks become critical. Leaders are expected to shape command climate, but they do not have any way of measuring whether their efforts are working. These patterns show that suicide prevention across the DoD is still largely reactive. The system is designed to respond once suicide risk is identifiable, but it does not consistently operate early enough to interrupt that risk as it develops.

Table 3. Suicide Prevention Program Observations

Domain	Observation	Observed Gap
Doctrine	Services interpret guidance differently based on culture	System functions as parallel approaches instead of as a unified model
Organization	Responsibilities fragmented across DSPO, DHA, units	Weak continuity of care
Training	Annual compliance driven training with uneven participation and retention	Personnel wait for clear warning signs before intervening
Materiel	Lethal means tools exist but are inconsistently used	Cultural resistance and uneven enforcement limit effectiveness
Leadership & Education	Leaders rely on checklists and procedures	Limited ability to assess command climate as it relates to suicide risk, hard to detect early risk, lack of formal suicide prevention training for leaders
Personnel	Provider shortages, uneven distribution, delays in care	Access depends on location, not need
Facilities	Barracks issue, increase stress and isolation	Environmental risks not integrated into prevention planning
Policy	Programs trigger after risk becomes visible (ACE, SAIL, etc.)	System is reactive instead of preventative

This pattern reflects what Rittel and Webber (1973) describe as a wicked problem. Suicide prevention in the DoD does not behave like a technical issue with a clear solution. Instead, it shifts as different parts of the system are altered. Efforts to improve across the DOTMLPF-P framework do not resolve the problems in suicide prevention programs in a linear way. They often change where and how risk appears within the system rather than eliminating it. Suicide prevention is not a problem that can be solved through a single policy, program, or intervention. It is a persistent and evolving challenge where each attempt to address the problem reshapes the conditions that produce it. Despite the problem changing, meaningful impact is still within reach. Lasting progress is possible when efforts are aligned across the DOTMLPF-P framework.

V. SUMMARY OF THE RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

Suicide prevention in the DoD is built on a universal framework, but it does not function as a holistic program. Each service applies the same overarching instruction in ways that are representative of its own organization and culture, which leads to different priorities across the branches. Across the DOTMLPF-P domains, the results highlight a consistent system level issues rather than individual gaps. Prevention activity is focused around responding to identifiable risk behaviors while earlier stages of risk development do not receive the same level of attention. Roles and responsibilities in suicide prevention programs are widely distributed, but that level of reach does not always correlate into coordination or accountability. The system produces multiple parallel approaches to the same problem rather than a cohesive prevention model. The comparative analysis shows that the difference across the services is in how prevention is implemented and operationalized across the DOTMLPF-P domains. This affects when intervention occurs, how responsibility is distributed, and whether suicide prevention functions proactively or reactively within each branch. Understanding these differences provides insight into how the DoD can improve suicide prevention through earlier intervention and a stronger alignment between the Service-level programs and the DoD objectives.

The current system does have its strengths. It provides a standardized policy foundation, established reporting pathways, and extensive prevention avenues across clinical, leadership, and peer levels. These elements allow for heightened visibility into suicide related behaviors and ensure that intervention pathways are available once suicide risk is identified. The limitations that remain are timing and integration. Across the branches efforts are most consistent after suicide risk is observable, while earlier disruption of risk identification is less developed across the DoD. Greater impact would come from shifting prevention efforts earlier in the risk timeline and strengthening how the services connect their efforts across domains, so they function as a single integrated system rather than operating on separate parallel tracks of care.

A. CONCLUSIONS

The findings from this study show that suicide prevention in the DoD is not limited by a lack of policy, programs, or resources. The challenge is how those pieces work together once they are implemented. The DoD has built a broad framework that includes doctrine, training, leadership expectations, organizational systems, clinical and non-clinical support, and reporting pathways. These elements create a holistic approach, yet they do not function as a connected system. Across the services, these efforts are implemented differently depending on the branches culture and leadership structure. While each branch maintains suicide prevention programs, implementation varies in execution. The implication is that the system is strongest at responding to identified suicide risk, not identifying or stopping the conditions that lead to it. These misalignments reduce continuity of care and limits the DoD's ability to intervene earlier in the suicide risk process. That timing matters. The system is active, but it is active later in the process where prevention would have the most lifesaving effects.

This study also shows that suicide prevention in the DoD does not behave like a straightforward problem. Improvements in one domain to not necessarily strengthen the others. Changes shift how and where suicide risk appears across the system. This reflects a problem that is shaped by structure, culture, and timing rather than a clear failure point. Suicide prevention issues are not stable in the way linear problems are, and they are not resolved through single isolated corrections. The results point to areas where meaningful improvement is possible. Greater progress depends on earlier engagement in the risk process, stronger integration across DOTMLPF-P domains, and clearer ways to evaluate whether prevention efforts are actually reducing risk rather than just documenting it. The most significant improvement would come from moving from a parallel service specific approach toward are more connected system that is consistent across the entire DoD.

The DoD has a suicide prevention program that is extensive but not fully integrated in practice. The system is designed to respond after crisis, not to prevent before a crisis occurs. Closing that gap requires shifting attention from isolated program strength to how the system functions as a whole across the DoD. The findings suggest that improving suicide prevention across the military depends less on creating additional

standalone programs and more on integrating existing efforts across the DOTMLPF-P domains into a coordinated and consistently applied prevention system.

B. RECOMMENDATIONS

Improving suicide prevention across the DoD requires shifting from isolated intervention methods to earlier and more structured actions across the system. One practical step in that direction is adopting a red flag law within the Uniform Code of Military Justice (UCMJ). This would allow for the temporary separation from firearm access when suicide risk is identified, combined with mandatory evaluation and follow up mental health care (Watford, 2025). Evidence from Extreme Risk Protection Order (ERPO) research shows that this approach is effective. Studies show meaningful reductions in firearm suicide in locations where these laws have been implemented, highlighting 13 to 16 percent declines in firearm related suicides (Johns Hopkins Bloomberg School of Public Health, n.d.). The main point of this approach is that it is not punitive. This approach's benefit is that it creates a structured pause during periods of elevated suicide risk.

Training is another area that would benefit from bolstering resources for mid-level leadership. Obligating ASIST training for E5s and further on ASIST training for higher paygrades would strengthen intervention capability earlier in the process. ASIST focuses on practical skills like identifying warning signs, the ability to have direct conversations, and being able to connect individuals to care in real time (LivingWorks, 2026). This is essential training for E5s because this is the first time a Service member is in a direct leadership role and can notice behavioral changes early.

Leadership education also needs to be improved. Integrating structured material such as the book *Rethinking Suicide* into professional military education would support that shift. Bryan describes suicide as a process that develops over time through interacting stressors rather than a single moment of crisis (Bryan, 2021). This understanding encourages leaders to think in terms of progression rather than waiting for traditional warning signs before taking action.

Access to care also needs to be expanded beyond traditional military treatment systems. Strengthening partnerships between TRICARE and online mental health services like Talkspace and Better Help would increase flexibility and reduce service members barrier to entry, particularly for service members in remote locations, on deployment, or reluctant to seek in person help (Talkspace, n.d.). Digital care options do not replace the need for clinical care but help to reduce the burden on providers while offering a low friction entry point when time and accessibility to care matter most. With that, stigma continues to limit the effectiveness of existing programs. Even when resources are available, service members may delay help seeking because of concerns about being judged or career impact. Addressing stigma requires clear messaging from leadership that normalizes and encourages help seeking as part of readiness instead of a last resort option.

These recommendations focus on earlier intervention, stronger leadership capability, improved cultural support, and extended access avenues. Each addresses a different friction point in the system, but they all point toward the same need which is caring for service members when they are suicidal, before those moments result in a suicide death.

C. FUTURE RESEARCH

Future research should focus on how suicide risk develops earlier in the life cycle of service members experience, especially as it pertains to command climate, training environments, and operational stress. This analysis shows that risk is often already happening before it becomes visible, so identifying and understanding the earlier conditions matter. There is also a need to evaluate which prevention efforts actually make a measurable difference across the different branches. Quantitatively comparing effectiveness across the branches would help clarify what is working versus what is just standard procedure. Future work should focus on how leaders interpret suicide prevention guidance in real operational environments. The gap is not just what is written in policy, but in how it is understood and applied under operational stress. Understanding this would help address one of the most consistent limitations identified in this study.

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