Case Study: Suicide Risk

Mia Carter is a 19-year-old first-year student living in Harbor Hall who has a documented autism spectrum disorder (ASD) and receives academic accommodations through disability services. Since moving in, Mia has struggled with social problems and misreading peer cues, resulting in repeated conflicts with her roommate Sophie Nguyen and floor peers. Several students report Mia's attempts to connect can feel "intense" (frequent messages, showing up uninvited in common spaces), while Mia describes feeling excluded and "targeted," reporting she is being mocked or talked about. Her RA, Jordan Ellis, has documented multiple incidents where Mia became overwhelmed by noise and routine disruptions, escalating into tearfulness, shutdowns, and angry outbursts. Mia's sleep has deteriorated over several weeks, and she has missed morning classes and meals, describing the dorm as "too loud to rest."

Two weeks before midterms, Mia experienced an acute crisis in the residence hall following a confrontation with peers about "creepy texting" and being asked to stop contacting them. That night, Jordan Ellis found Mia in her room after she sent messages to Sophie stating, "I can't do this anymore" and "you won't have to deal with me soon." Mia had superficial cuts on her forearm and reported she had been thinking about suicide and "just wanted it to stop." Campus police and the on-call clinician were contacted, and Mia was transported to the hospital for evaluation, resulting in a brief psychiatric hospitalization and discharge with a follow-up care plan. In post-crisis conversations, Mia acknowledges feeling ashamed and overwhelmed, and she reports her warning signs are "not sleeping, not eating, and feeling like everyone hates me," with intensifying rumination and agitation.

After the hospitalization, the university considered a structured return to housing with supports. However, several residents and multiple parents contacted Residence Life expressing concern about Mia's return, citing fear of another crisis and frustration with ongoing peer conflict. Sophie requested a room change and reported feeling harassed by frequent messages. Mia's parents, Karen and Louis Carter, are supportive but worried about finances and treatment continuity, and have asked for clarity on what safety measures will be in place. The BIT/CARE team is now assessing how to manage suicide risk and residence hall stability while addressing Mia's disability-related social communication challenges, ensuring clear behavioral expectations, structured supports, and a plan to reduce triggers (noise, peer conflict, unstructured late-night interactions) that have contributed to crisis escalation.

Questions to Consider

1. **What do we know about Mia's suicide risk and stability since discharge?**
   Based on the case description, Mia had recent suicidal communications ("I can't do this anymore") and self-injury in the residence hall that led to hospitalization**,** which elevates baseline risk in the near term. The BIT/CARE team should treat her as having higher vulnerability during transition back until stability is demonstrated. The team should try to determine whether she has current ideation/intent**,** whether there is a safety plan, and whether she is connected to follow-up care. The description implies a discharge plan exists but does not confirm adherence, so the team's working conclusion should be that an acute event resolved, but ongoing risk requires monitoring, means-safety planning, and structured follow-up. Consider asking about any ongoing suicidal thoughts, intent, access to means, recent self-injury, adherence to discharge recommendations, follow-up appointments scheduled/attended, and her personal warning signs (sleep loss, appetite changes, feeling rejected).

2. **What specific triggers and patterns led up to the residence hall crisis?**
   The narrative suggests an escalating pattern of peer conflict, perceived rejection, sensory overload, and disrupted routines, compounded by sleep and eating deterioration. The proximal trigger appears to be a confrontation about "creepy texting" and being told to stop contacting peers, followed by late-night distress and suicidal messaging. So, it is likely the crisis emerged from cumulative stressors (social rejection, overstimulation, isolation) with an acute precipitant (boundary-setting confrontation), and warning signs were present beforehand (worsening sleep, missed meals/classes, escalating conflict). Explore the timeline of peer conflict, noise/sensory overload, changes in routine, disciplinary interactions, social rejection moments, late-night escalation, and whether there were missed opportunities for earlier intervention.

3. **How do ASD-related social communication challenges show up behaviorally, and where do they cross into boundary violations?**
   In the description, Mia's ASD-related difficulties show up as intense, persistent bids for connection (frequent messages, appearing in common spaces) and misreading cues (continuing contact after peers want distance). The boundary-crossing point is when contact becomes unwanted or repetitive after a clear "stop," or when she shows up uninvited in ways others find intrusive. So, the answer is: her behavior likely reflects misinterpretation of social cues and perseveration rather than malice, but the impact on peers still requires clear limits and replacement skills. Determine what the frequency/content of messages, uninvited visits, perseveration, difficulty reading "stop" cues, and what clear, concrete replacement behaviors and scripts Mia can use to seek connection appropriately.

4. **What supports and accommodations would make a return to housing safer and more sustainable?**
   Given the crisis pattern, the strongest answer is a structured return plan that reduces triggers and increases predictable support: quiet housing or single room, consistent routine, scheduled check-ins (RA and case manager), sensory supports (noise reduction, designated quiet space), explicit social boundaries plan (communication rules and scripts), and coordinated clinical follow-up (with consent). The immediate recommendation is: return only with a documented safety plan, clear behavioral expectations, and environmental modifications to reduce overload.

5. **What is the safety and communication plan for the community (roommate, floor, and parents) without violating privacy?**
   The answer here is to separate privacy-protected details from community safety procedures. Residence Life can communicate that concerns were assessed, staff have a monitoring plan, and there are clear reporting channels, without sharing Mia's diagnosis or hospitalization details. For the roommate/floor, the plan should emphasize: do not confront; report concerns to staff; use escorts if needed; and rely on staff-led boundary enforcement. Discuss how to address concerns, what staff will do if distress escalates, how to prevent rumor-driven escalation, what expectations apply to peers (reporting vs. confronting), and how to balance inclusion with boundaries and safety. For parents, provide reassurance about processes (supervision, crisis response, conduct expectations) while protecting student confidentiality.

Pathways Scoring

Pathways factor	Score	Rationale (brief)
Suicide	3	Recent suicidal communications, hall crisis/hospitalization
Depression	2	Low mood/withdrawal, shame, "can't do this anymore" theme; impairment signals.
Self-Injury	2	Superficial cutting reported in crisis event.
Alcohol/THC	0	Not mentioned.
Serious Drug Use	0	Not mentioned.
Being Teased	2	Reports feeling mocked and excluded (perceived teasing).
Social Problems	2	Peer/roommate floormate concerns/conflict, difficulty w/cues
Academic Trouble	1	Missed morning classes; no major academic trouble
Financial Insecurity	1	Family worries about treatment/travel costs
Adjusting to Change	3	Transition to dorm and routine disruption strongly destabilizing; repeated overwhelm.
Loss or Bereavement	0	Not described
Being Stalked (victim)	0	Not indicated.
Anxiety	2	Heightened worry/rumination and distress around peer perception and dorm environment.
Intense Thoughts/Action	2	Crisis escalation and impulsive self-harm amid overwhelm.
Hallucinations/Delusions	0	Not indicated.
Group Pressure	0	Not indicated.
Vandalism	0	Not indicated.
Being Controlled (victim)	0	Not indicated.
Harassing Behaviors	2	Repeated unwanted messaging/uninvited; peers want space.
Stalking Others	0	No clear monitoring/following behaviors described
Partner Violence	0	Not indicated.
Sexual Violence	0	Not indicated.
Incel Behavior	0	Not indicated.
Eating/Sleeping	3	Sustained deterioration in sleep and meals
Affective Violence	1	Low-to-moderate angry outbursts/overwhelm
Trolling Actions	0	Not indicated.
Transient Threats	0	No threats to others described.
Substantive Threats	0	No threats to others described.
White Supremacy	0	Not indicated.
Weapons Interest/Access	0	Not indicated.

Suicide Wayfinder Scoring

Factor	Score	Case-based rationale
Statement	2	Indirect suicidal statements ("I can't do this anymore," "you won't have to deal with me soon") suggest ideation but no plan described.
Self-injury	2	Superficial cutting occurred in the residence hall; intent unclear
Loss/bereavement	0	No death/relationship loss/bereavement described in this case narrative.
Treatment	3	Recent hospitalization for safety/psychiatric evaluation implies high acuity and need for close follow-up.
Self-concept	2	Shame and "everyone hates me / I'm a burden" themes are implied by rejection sensitivity and crisis messaging; not described as pervasive worthlessness.
Adjusting to change	3	Transition to dorm/life changes are central destabilizers tied to escalating distress and suicidality.
Hopelessness	2	"Can't do this anymore" reflects trapped/limited coping during crisis, but no sustained "no way out / only solution" described.
Impulsivity	2	Crisis escalated to cutting and emergency intervention; suggests acting quickly under distress (no lethal attempt described).
Bullied/teased	2	Mia reports feeling mocked/targeted/excluded; impacts self-worth and stability, though not described as chronic severe bullying.
Depression	2	Functional decline (withdrawal, sleep/appetite disruption) and persistent sadness suggested, but not "severe, unable to care for self" baseline.
Substance use/abuse	0	No substance use indicators provided.
Lethality access	2	Access to sharp objects is implicit given cutting; no firearm/stockpiling or refusal to restrict means described.
Isolation	2	Difficulty forming/maintaining peer connections and escalating outsider feelings; not "complete isolation/no supports" in narrative.
Eating/sleeping	3	Sustained sleep deterioration and missed meals are prominent, impairing functioning and worsening risk.
Previous attempts	0	No prior suicide attempts described; current event is ideation + self-injury with hospitalization (attempt not established).

Intervention and Mitigation Planning

Immediate intervention should focus on stabilizing suicide risk and reducing the residence-hall conditions that amplified Mia's crisis. Upon discharge, the BIT/CARE team should confirm a current suicide risk check (active ideation/intent, access to means, recent self-injury) and ensure there is a concrete, written safety plan Mia can follow, including coping steps for sensory overload, who to contact 24/7, and clear thresholds for seeking urgent help.

Housing should be modified to lower triggers and prevent recurrence, ideally a single room or quieter placement, predictable routine supports, and scheduled check-ins with a designated case manager and Residence Life (e.g., brief daily check-ins initially, then taper as stability is demonstrated). In parallel, the plan should address boundary and social-conflict drivers by giving Mia explicit, behaviorally specific expectations (limits on messaging/visiting peers, guidance for "stop" cues, and replacement scripts for seeking connection), while providing coaching/supports appropriate to ASD (structured social skills support, sensory accommodations, and clear written schedules).

To mitigate community concerns without violating privacy, Residence Life should communicate that there is an active monitoring and response plan and instruct peers/parents to report concerns through official channels rather than confronting Mia. The plan should define escalation triggers (sleep collapse, renewed self-harm talk, repeated boundary violations, refusal of check-ins) and corresponding steps (same-day clinical evaluation, temporary increased supervision, higher level of care, or interim housing change), with return-to-normal privileges contingent on sustained stability, treatment follow-through, and demonstrated adherence to behavioral expectations.