# Asylum and Autism: A Case Report

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## CASE INTRODUCTION :

An **asylee** is a person "in the United States or at a port of entry who is unable or unwilling to return to his or her country of nationality, or to seek the protection of that country because of persecution or a well-founded fear of persecution. Persecution or the fear thereof must be based on religion, nationality, membership in a particular social group or political opinion." (3)

Children of immigrants experience a **significantly higher risk of neurodevelopmental disorders, particularly autism spectrum disorder** (ASD). (1) Despite this, enormous structural barriers prevent early detection, diagnosis, and access to critical interventions for children with ASD from immigrant families.

Access to disability and special education services are critical for the long-term developmental prognosis of children with ASD. (2) However, for the newly arrived family without permanent legal status in the U.S., this is anything but a simple prescription.

**This case report examines the unique challenges faced, from both a systems and clinical perspective, in treating a 10-year-old bilingual (Portuguese & English speaking) Brazilian male with low-functioning ASD and comorbid ADHD who arrived in the U.S. at age 7 by crossing the Mexican-U.S. border with his mother and her boyfriend, seeking asylum from violent gang threats and his allegedly abusive biological father.** Further motivating their decision to immigrate was the lack of access to early healthcare and educational interventions in rural Brazil.

**The objective of this case report is to:**

- Describe the clinical complexity of treating a child asylee with severe ASD in the context of developmental trauma, diagnostic delay, lack of early intervention, and acculturation stress.
- Understand the systemic challenges and urgency to obtaining access to legal protections, medical, and educational services for asylee families who have a child with ASD.
- Recommend strategies child psychiatrists can use to mobilize the system to promote more timely, comprehensive, and culturally sensitive interventions.

## CLINICAL COURSE:

Birth-5 y/o: **Experienced early life adversity** including financial hardship, exposure to community violence, and **disrupted attachment** from his bio father who was minimally involved and allegedly abusive.

5-6 y/o: **Not yet speaking by age 5**. Evaluated by Neurologist who diagnosed ASD and prescribed **risperidone and methylphenidate.** Limited access to ASD-specialized services. Missed one year of school due to transportation strikes.

6-7 y/o: Family received threats from organized crime. In Fall 2019 they left Brazil for the U.S. On arrival, mom's boyfriend was detained and deported – yet **another early loss.**

7-8 y/o: In January 2020, child psychiatrist formalized ASD diagnosis using CARS-2. **Provider believed insurance would not cover specialized services.** Cont'd prior medications. Enrolled in school. In Spring 2020, the COVID-19 pandemic hit, further **disrupting access to educational services**.

8-9 y/o: In Fall 2020, case management was engaged and **confirmed eligibility for state disability services** (DDS). Application was submitted but not followed-up on and ABA referral was not made. Struggled with online learning. Concern about weight gain on risperidone but had not completed labs. Stimulant was switched but family did not present again for care until 6 months later.

9-10 y/o: **Transferred to new provider**. Reported palpitations and chest pain on exertion with prior stimulant trials. Exploration of family cardiac history led to referral for pediatric cardiology. **Discontinued stimulant and risperidone** and **started guanfacine.** In January 2022, pt. **started individual therapy** and **started at a new school**.

Over the first 6 months of individual therapy, we successfully:

1. Coordinated care with the school to participate in **IEP review**, which led to an **increase in services offered** including extended-school year.
2. **Re-engaged case management**, discovering the DDS application was incomplete and ABA referral never made. Case management was able to aid in completion of DDS application and pt. was **referred for Portuguese language ABA therapy.**
3. Provided a **letter of support for inclusion in the application for Special Juvenile Immigrant status**, helping secure his path to citizenship.
4. Consolidated therapy with med management to **decrease variability of appointments and providers.** Therapy took on a trauma-informed approach and included aspects of social skills training, play-therapy, and parent management training with Portuguese translation..

**Current:** Making steady progress in home, school, and community settings with bi-weekly therapy and alpha-2 agonist monotherapy.

## PRACTICE RECOMMENDATIONS:

BARRIERS → INTERVENTIONS

| BARRIERS | | INTERVENTIONS |
|---|---|---|
| Lengthy applications for services. + Multi-stressed family, language barriers, low health/systems literacy. | → | **CASE MANAGEMENT**<br>• Support application completion<br>• Follow-up on outcomes<br>• Place referrals for language-specific services |
| Lack of familiarity with IDEA laws entitling to Sp.Ed. services. + Public school systems protective of limited resources. | → | **EDUCATIONAL ADVOCACY**<br>• Assist caregiver in submitting request for Sp.Ed. testing.<br>• Attend IEP meetings, review, and recommend inclusion of social and communication goals. |
| Limited social support during long, arduous immigration process. + Applications may require and/or are strengthened by support letters. | → | **LEGAL ADVOCACY**<br>• Offer letters of support for immigration applications ( e.g. Special Juvenile Immigrant).<br>• Obtain consent to coordinate care with legal counsel, as needed. |
| Traumatic experiences prior to and during immigration. + Acculturation stress, social skills deficits, stigma, low social support. | → | **INDIVIDUAL THERAPY AND PARENT SUPPORT**<br>• Culturally-informed and trauma-informed formulation and approach to therapeutic intervention with caregivers and child. |
| Med trials from country of origin may be carried over. + Polypharmacy risk with unindicated/ unnecessary meds. | → | **THOUGHTFUL DE-PRESCRIBING**<br>• Carefully reassess indications for meds with high side effect profiles.<br>• Complete new, thorough work-up.<br>• Offer culturally-sensitive psycho-education and informed consent. |

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