A Virtual Interprofessional Collaborative to Improve Fetal Alcohol Spectrum Disorders:

Recognition & Management in Child Welfare Populations

1

VIOLENCE
INTERVENTION
PROGRAM

Roxanne Chang, MD

TIES for Families, South Bay - Los Angeles County Department of Mental Health

Dept of Pediatrics, Harbor-UCLA Medical Center - Los Angeles County Department of Health Services

Michele Walker-Bauer, PhD

VIP FASD Clinic

We have no financial relationships to disclose.

2

Special Acknowledgment

THANK YOU
Ana Cardenas LCSW (VIP FASD Clinic)
for helping with
questionnaire technology / QR codes!

3

Background

- Repeat encounters of misdiagnosis/ under-support in children w FASDs.
- Struggled to find FASD-informed providers and obtain proper support for children and families.
- The literature told us:
  - Fetal Alcohol Spectrum Disorders (FASDs) are common in child welfare populations (conservatively 18.8%).
  - FADSs are often un- or misdiagnosed (86.5% +).
  - Without identification and supports, individuals with FASD are likely to experience a variety of adverse life outcomes.
  - Children with FASDs are best served utilizing integrated models of care delivery.
  - Barriers to identification and proper support include *provider knowledge gaps, stigma, and fragmented healthcare*.

4

Objective

To test the feasibility of a *grassroots* inter-professional, inter-agency virtual collaborative within Los Angeles County to address these gaps:

- Provider knowledge
- Fragmented health care

Improve the self-efficacy of clinicians to:

- *identify and manage FASDs*
- *by providing education and networking opportunities*

5

Conceptual Model

COM-B framework for behavior change:

- **Capability:** provider education, access to tools.
- **Opportunity:** forum for networking.
- **Motivation:** relational shared space for support through difficult cases and situations.

(Michie 2011)

6

Methods

Collaborative leads:

- **Pediatrician**, specialist in foster-adoptive care.
- **Psychologist**, FASD Program Manager at community mental health center

Format: 1.5 hour monthly teleconference (Zoom format)

Agenda:

- Participant introductions, advocacy updates, and resource sharing.
- Short didactic
- Complex case examples: opportunities for brainstorming and discussion related to diagnostic challenges, clinical and treatment information, and referrals between agencies.

Evaluation of program effectiveness:

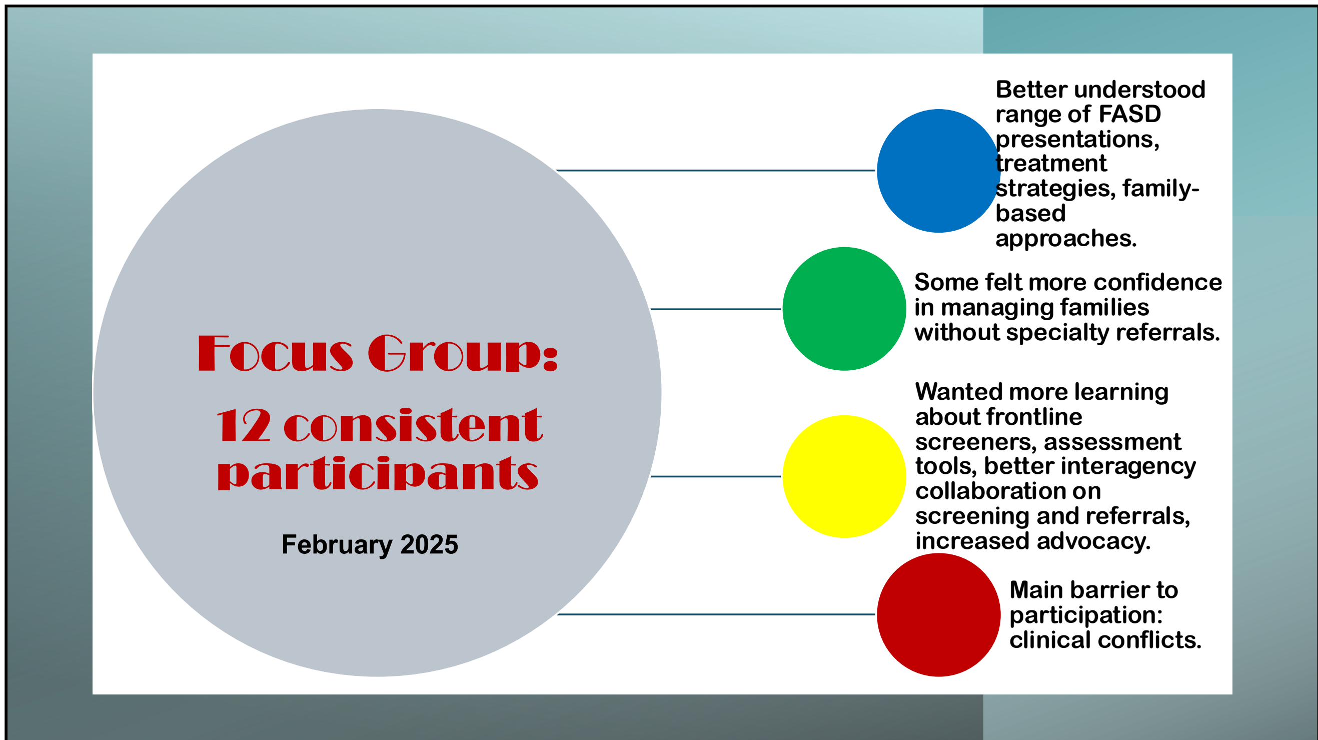
- Focus group.
- 6-question survey (emailed).
- Adjust to ongoing feedback from participants.

7

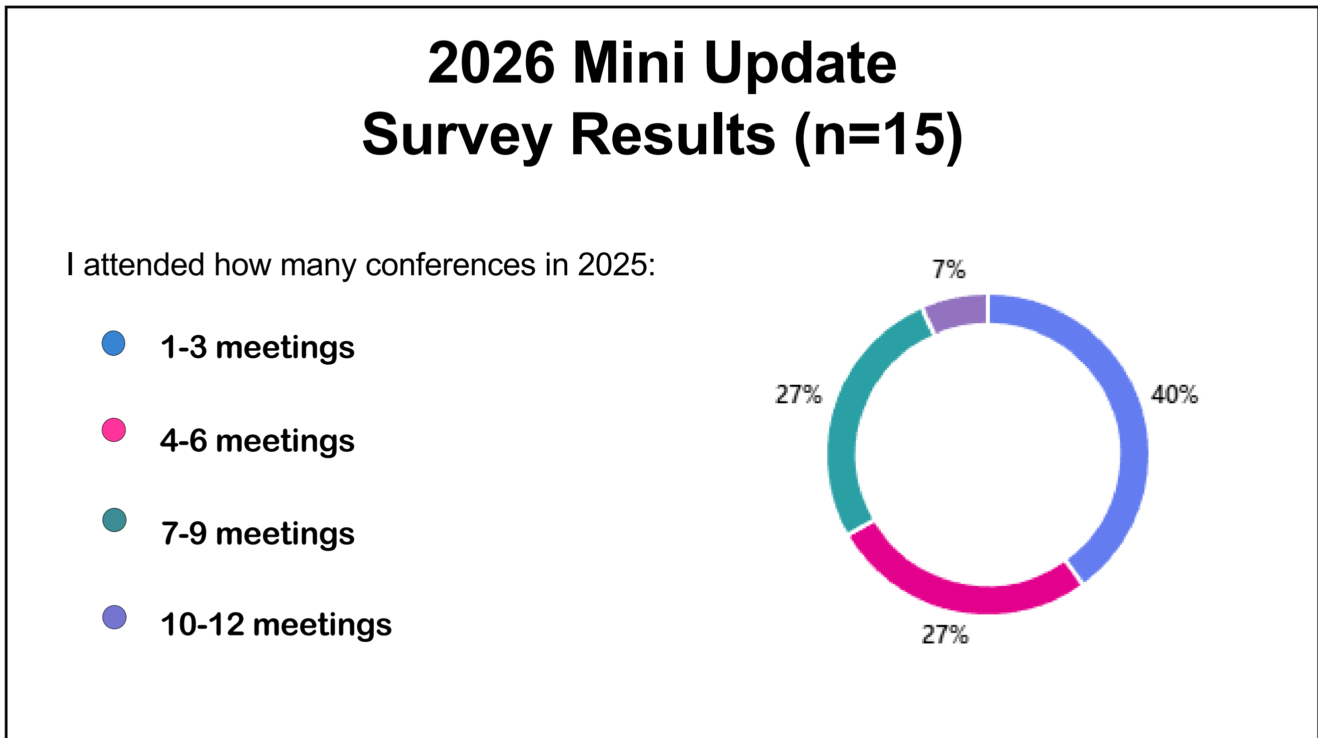
Descriptive Results

- 32 conferences - August 2022 to March 2026.
- Voluntary participants:
  - grew from 4 to average of 15-25 (3.75 to 6.25-fold growth)
  - 45 on the listserv at time of reporting.
- Participants: physicians, psychologists, social workers, occupational therapists, educational consultants, school counselors, behavioral therapists, parent partners, a family disability liaison, and a national FASD program manager.
- 4 participants have *living experiences with FASD*.
- Agencies represented: county departments of health, mental health, child welfare, disability services, schools, and the national AAP FASD program.
- Participants found value in discussions and requested meeting time to extend from 1 hr to 1.5 hrs (June 2023).

8



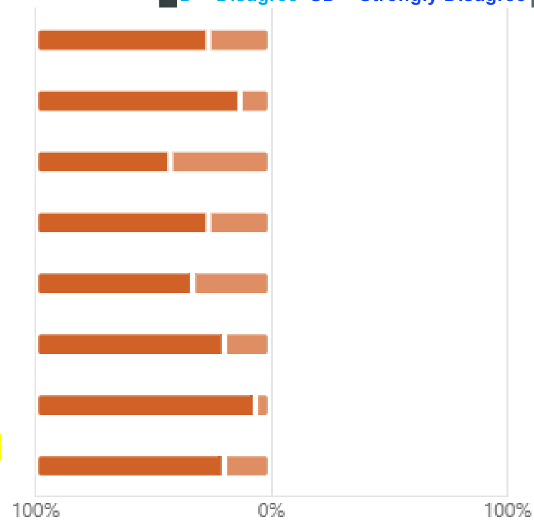
9



10

March 2026 Survey Results

- Increased my understanding of FASD stigma.
- Increased my professional network of other FASD-aware providers.
- Helped me learn FASD assessment and/or treatment perspectives.
- Helped me learn about interventions and services that can support children and families with FASD.
- Helped me learn about ways to advocate for children with FASD in school, Regional Center, DCFS, etc.
- Helped me feel more supported when working with children with FASD.
- The case discussions increased my understanding of how FASD can vary in presentation and needs.
- The case discussions have helped increase my confidence in providing resources and recommendations for FASD.



11

Discussion

- The virtual interagency space likely enhanced care coordination and improved patient outcomes.
  - Of 24 child-welfare involved cases discussed and followed, multiple interagency referrals and several IEP amendments for FASD eligibility were made.
  - Two adoption dissolutions were averted, and a third child was placed with a disability-trained caregiver after a disrupted prospective adoption.
- Growth in participation reflected organic, word-of-mouth community building.
- Practical, case-based learning and resource sharing sustained engagement.
- A loosely structured agenda with participant-driven discussion was effective and generalizable to other communities seeking to raise FASD awareness.
- Limitations & challenges:
  - Totally dependent on volunteer commitment
  - Bandwidth and capacity issues
  - Limited meeting times potential barrier to participation

12

For further thought: Next Steps

❑**Capability:**

- •Plan additional drop in "office hours" (quarterly? Every other month?) to discuss case-related questions.
- •Share practical tools e.g. dot phrases for EHRs, local workflows, etc.
- •Share billing strategies.

❑**Opportunity:**

- •Stagger meeting times to include alternative days and times to increase access.
- •Invite additional living experience perspectives from local FASD United affiliate leadership (e.g. FASDNow! FASD So Cal)

❑**Motivation:**

- •Offer CME/ CEUs: may increase opportunity & motivation for participation.
- •Develop more specific metrics to survey program effectiveness.

13

Last thoughts: From Grassroots to Real Change

This started small – because it had to.

- •Few people
- •Shared frustration
- •Commitment to do better

What made it work:

- •Bottom up – build from relationships, trust, shared purpose
- •Imperfect – iterative, responsive, participant-driven

What we learned:

- •You don't need permission to start
- •You don't need a large grant to make impact
- •You need people who care – and a space to connect

Impact grows organically:

- •One case → one connection → community change → culture change → systems change

14

"Never doubt that a small group of thoughtful, committed people can change the world; indeed, it's the only thing that ever has."
— Margaret Mead

If you see a gap – build something!

If you feel the fragmentation – connect people!

If you know better – you are already ready.

15

References

1. Bolton R, Logan C, Hoffer Gittell J. Revisiting Relational Coordination: A systematic Review. J Applied Beh Sci 2021;57 (3) 290-322.
2. Chasnoff IJ, Wells AM , King L. Misdiagnosis and Missed Diagnoses in Foster and Adopted Children with Prenatal Alcohol Exposure. Pediatrics 2015; 135(2):264-270.
3. Engesether B, Hoffner M et al. Prevalence of fetal alcohol spectrum disorder in foster care: A scoping review. Alcoholism: Clinical and Exp Res 2024;48(6):1443-1450.
4. Flannigan K, Edwards D et al. Integrated service delivery for individuals with fetal alcohol spectrum disorder. J Appl Res Intellect Disabil 2024;37:e13277.
5. Michie S, van Stralen MM, West R. The Behaviour Change Wheel: a new method for characterizing and designing behaviour change interventions. Implementation Science. 2011;14:42. doi: 10.1186/1748-5908-6-42.

16