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Santa Clara County Foster Care Surge, 2024–2026

A Public Health and Epidemiological Analysis of Foreseeable Excess Morbidity and Mortality Resulting from Increased Parental Separation and Non-Kin Out-of-Home Placement

Prepared for	Santa Clara County Board of Supervisors
Prepared by	Kevin Campbell and Elizabeth Wendel · Pale Blue.
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> *"Without the right to health, the other rights don't matter much."*
>
> *— Judge Michael Nash (Ret.)*

KEY FIGURES

399	4–12	55%	↑ 15×
additional children removed	foreseeable excess deaths	lifetime poor-health rate, non-kin placement	cost increase, kinship to STRTP placement

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EXECUTIVE SUMMARY

After several high-profile child fatalities, child-welfare removals in Santa Clara County rose sharply: from **149 children in SFY 2023** to **276 in SFY 2024** and **421 in SFY 2025**, a 229 percent peak increase. Under panic-induced system overload, each additional child entering care in Santa Clara is more likely to be placed with strangers rather than relatives. The drift is not supply-constrained: in the same surge window, Ventura County reached **74.7 percent kinship-first placements in Q1 2026**, up from below 50 percent six quarters earlier, and Los Angeles County under the Nash–Edwards kin-first protocol places more than 75 percent of removed children with relatives, with second-look protocols reaching approximately 90 percent. The Santa Clara mechanism is reactive fear after high-profile deaths, rising caseloads, reduced vetting, and volume-driven removals without the time for thoughtful deliberation with parents, kin, and community that kinship-first placement requires. Both placement with strangers and the placement instability that follows are documented independent risk multipliers in the placement-outcome literature.

Applying three decades of replicated international cohort evidence, the only randomized trial in the field, and California Medi-Cal–linked vital records to the additional Santa Clara cohort of roughly 400 children yields the following placement-attributable projections by early mid-life. *Placement-attributable* means disease and death that would not be expected to occur but for the forcible separation from parents and kin followed by non-kin placement: these are outcomes produced by the system's intervention, not a description of the family conditions that preceded it. Projections: about 42 excess cases of long-term limiting illness or disability, about 48 excess cases of poor self-rated health, a substantially elevated mental-illness burden, and 4 to 12 excess premature deaths concentrated in unnatural causes. A separate evidentiary track (Section IV) documents reproductive-health harms specific to non-kin placement: a 24 percent rate of sexual abuse in placement among girls in best-practice non-kin homes; a 2-fold to 7-fold elevation in preterm birth among care-experienced mothers; and a six-fold elevation in next-generation child removal among foster youth who exit without Extended Foster Care support. These harms fall disproportionately on Black, Native American, and Latinx children, who are already overrepresented in California's child-welfare system.

A 50-state, 14-year analysis published in *JAMA Network Open* (Edwards, Fong & Apel, 2025) finds no association between higher foster-care entry rates and lower child-maltreatment fatality rates. The surge therefore produces measurable downstream harm in children, youth, and parents without a documented population-level safety benefit.

No placement type on the gradient, and no society in any era, has produced a child cohort with zero excess morbidity or mortality. The framing the Board faces (Section V) is not how to reach zero. It is which available response, given that all responses produce some harm, minimizes total preventable harm in the populations the policy decision affects. The placement-preference framework in federal and California law (Section II) points to the same answer the science does: prevention with the family of origin first, then kin, then family-based non-kin, with congregate care reserved for narrow clinical need. Section VII names seven concrete steps the County can take to align practice with this evidence base. California pays the most per child for the placements that produce the worst outcomes and the least for those that produce the best, a 15-fold spread from kinship to STRTP (Section VII.6).

I. BACKGROUND: THE 2024–2026 ENTRY SURGE

After media coverage of several child fatalities, including the April 2026 death of Jaxon Juarez (the third child fatality under county supervision in this window), Santa Clara County's child-welfare system shifted toward higher-volume removal. State data show the following entry trajectory:

State Fiscal Year	Children Entering Care	Change vs. Baseline
SFY 2023 (baseline)	≈ 149	—
SFY 2024	276	+85%
SFY 2025	421	+183%
Cumulative excess (2024–2025)	≈ 399 additional children	+229% peak-year increase

System-strain indicators accompanying the surge include the closure of the county's primary parent-defense provider, multiple staff placements on leave, and extension of state oversight and the corrective action plan beyond June 2026. Under panic-induced system overload, each additional child entering care in Santa Clara is more likely to be placed with non-kin caregivers rather than with relatives. The drift toward non-kin is not a supply problem. In the same window, Ventura County reached **74.7 percent kinship-first placements in Q1 2026**, up from below 50 percent six quarters earlier, and Los Angeles County under the Nash–Edwards kin-first protocol places more than 75 percent of removed children with relatives (sometimes the same day of removal), with second-look protocols reaching approximately 90 percent (Edwards, 2026, “The Los Angeles Miracle,” *Juvenile Courts & Ethics* column, *Bench*, Spring 2026). The drift is a decision-making outcome under conditions of rising caseloads and rising fear: reduced vetting, less time for thoughtful deliberation with parents, kin, and community, and volume-driven removals in lieu of kinship-first practice. Both placement with strangers and the placement instability that follows independently increase the risks modeled in Section III.

Disproportionality in the surge cohort.

California's child-welfare system removes Black, Native American, and Latinx children at rates substantially above white children, a pattern documented in the California Child Welfare Indicators Project (CCWIP) administrative data and in the California birth-record-linked CPS work of Putnam-Hornstein and colleagues. The disparity persists after adjustment for poverty and family-level adversity. A surge response that increases removals proportionally amplifies existing disproportionality. The placement-attributable harms projected in Sections III and IV therefore fall disproportionately on the same populations that already bear the underlying disparity in entry rates. Any County response to the surge that does not separately track disproportionality will deepen it.

Demographic audit of the 399 cohort. CCWIP infrastructure permits a Santa Clara County-specific breakdown of the surge cohort. The Board can request from County Social Services and the CCWIP team a

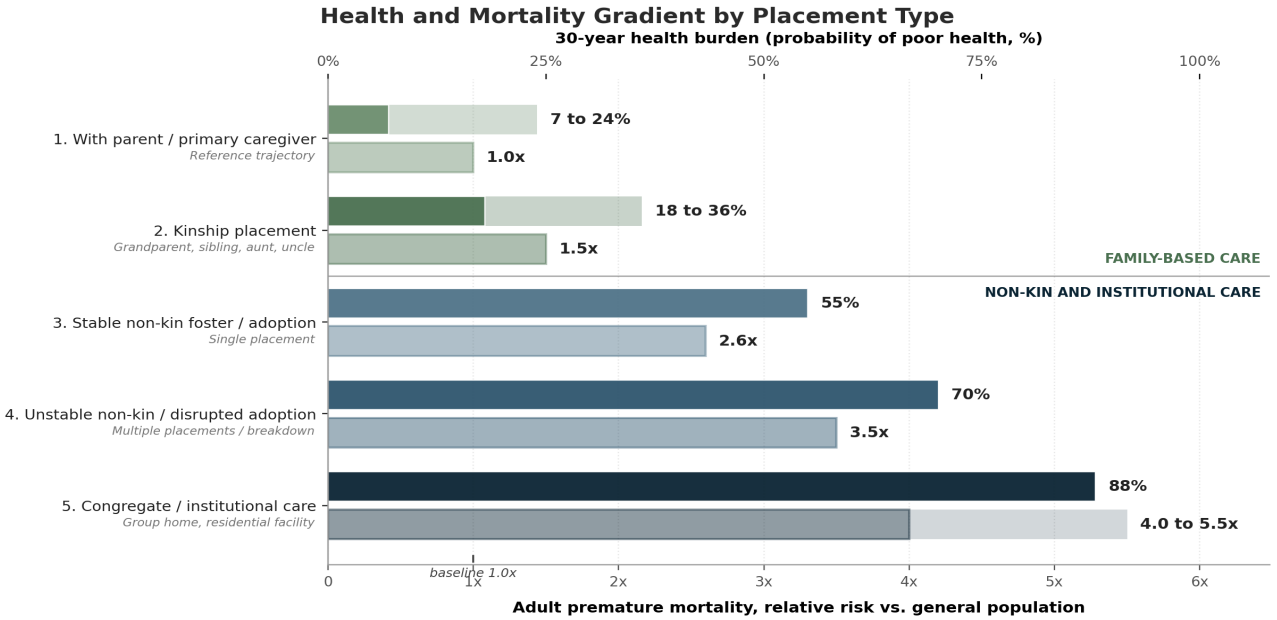
30-day audit of the 399 children by race and ethnicity, age at entry, primary entry allegation, and placement type at first removal (kinship, non-kin RFA, FFA-administered non-kin, STRTP). Without that audit, the disparate-impact analysis above remains a statewide pattern applied locally. With it, the disparate-impact prong of the legal framework in Section VI moves from inferred to documented for this specific cohort, and the fiscal projections in Section VII.6 become concrete instead of parametric.

What is predictable is preventable. The health and mortality evidence assembled in Sections II through IV supports cohort-level prediction: the 399 children carry elevated risk for the specific disease burden and premature-mortality patterns the placement gradient names. The principle Pale Blue applies is that what is predictable is preventable, and that no health future projected from a placement decision is a destiny. The demographic audit above should therefore extend beyond placement composition to include health and mortality risk factors for each of the 399 children, and each audit record should attach a mitigation plan for the child and the family: Bright Futures comprehensive trauma-informed assessment within 30 days of placement, the AAP Foster Care Health Supervision Supplement schedule of follow-up care, Family Finding due diligence under WIC § 309 and 42 U.S.C. § 671(a)(29), and active-efforts movement up the placement gradient toward the highest achievable level (Section IV author note; ICWA active-efforts standard, 25 U.S.C. § 1912). The projections in Section III are foreseeable. They are therefore actionable. Healing is always possible.

II. THE EPIDEMIOLOGICAL FRAMEWORK: A REPLICATED PLACEMENT GRADIENT

Long-term cohort studies across multiple countries find a consistent ordinal relationship between placement type and downstream health and mortality. The ranking holds in the Office for National Statistics Longitudinal Study (England and Wales, N = 157,896, 30-year follow-up; Murray et al., 2020), the U.S. National Survey of Child and Adolescent Well-Being (NSCAW), the Looked-After Children Grown Up cohort (Sacker et al., 2021–2022), the six-country meta-analysis of 13 prospective cohort studies covering 3.2 million individuals (Batty et al., 2022, *Lancet Public Health*), the Swedish and Danish national-register sibling-design studies (Brännström et al., 2017, 2020; Sørensen et al., 2023; Gao et al., 2017), the Bucharest Early Intervention Project RCT (Humphreys et al., 2022, 2023), and California Medi-Cal vital records (McNellan, Prindle, Eastman & Putnam-Hornstein, 2026, *American Journal of Epidemiology*).

Figure 1 presents this evidence as a **foreseeability tool**. Each placement type occupies one row with two stacked horizontal tracks: the upper bar shows the 30-year health burden (read against the top axis, in percent), and the lower bar shows the adult premature-mortality risk (read against the bottom axis, as relative risk versus the general population). Both worsen as placement moves from family-based care into non-kin and congregate settings. Because the gradient is replicated across independent cohorts, the harms associated with each placement decision are foreseeable when the decision is made.



Sources: Murray et al. 2020 (ONS-LS, N=157,896, 30-yr follow-up); Batty et al. 2022 (Lancet Public Health 6-country meta-analysis, N=3,223,580); Sacker et al. 2021 (LACgro); Brannstrom et al. 2020 (sibling design, Child Maltreatment); Sorensen et al. 2023 (Danish register); Gao et al. 2017. Kinship mortality (about 1.5x) inferred from Batty early-entry subgroup.

Figure 1. Health and Mortality Gradient by placement type. A foreseeability tool: both tracks worsen together as placement moves down the gradient. Each placement is shown as two stacked bars. The upper bar shows the 30-year health burden, read against the top axis (probability of poor health, percent). The lower bar shows adult premature mortality, read against the bottom axis (relative risk versus the general population). Color deepens as placement moves down the gradient. The horizontal divider separates family-based placements (rows 1 and 2) from non-kin and institutional placements (rows 3 to 5).

The same data are summarized in Table 1 below for reference.

Placement Type	30-Yr Poor Health	Adult All-Cause Mortality (RR vs. population)
1. With parent / primary caregiver (with support)	7–24%	1.0× (reference)
2. Kinship placement	18–36%	≈ 1.5× (inferred)
3. Stable non-kin foster care or adoption	≈ 55%	≈ 2.6×
4. Unstable non-kin foster care / disrupted adoption	≈ 70%	≈ 3.5×
5. Congregate / institutional care	≈ 88%	4.0–5.5×

Sources: Murray et al. 2020 (ONS-LS); Batty et al. 2022 (Lancet Public Health 6-country meta-analysis); Sacker et al. 2021 (LACgro); Brännström et al. 2020 (sibling design, Child Maltreatment); Sørensen et al. 2023 (Danish register); Gao et al. 2017 (Stockholm cohort).

Two methodological points deserve emphasis. The sibling-cohort design (Brännström et al. 2020; Gao et al. 2017; Sørensen et al. 2023) compares brothers and sisters from the same household where some were removed and some remained, controlling for shared genetic endowment and shared family-level adversity. The placement-attributable risk persists after that control. Doyle (2007, *American Economic Review*) used the random assignment of families to investigators with different removal tendencies as a natural experiment. Among children whose cases were close enough to the removal threshold that one investigator would have removed them and another would not, those who remained at home did better than comparably situated children who were placed, on teen pregnancy, juvenile arrest, and young-adult employment. The same investigator-assignment design extended in Doyle (2008, *Journal of Political Economy*) found that children removed under that quasi-random assignment had substantially elevated rates of adult criminal involvement. The argument that removed children would have done worse regardless is not supported by these causal designs.

The placement hierarchy the science describes also tracks the placement and permanency preferences embedded in federal and California law for more than four decades. The Indian Child Welfare Act of 1978 (25 U.S.C. § 1901 et seq.), the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272), the Adoption and Safe Families Act of 1997 (P.L. 105-89), the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351), and the Family First Prevention Services Act of 2018 (P.L. 115-123) each establish, in different language, the same ordering: prevention with the family of origin first, then kin, then a family-based non-kin placement, with congregate care reserved for narrowly defined clinical need. California law operationalizes that ordering in Welfare and Institutions Code § 309 (immediate diligent search for relatives), § 361.3 (relative placement preference), § 16002 (sibling placement and contact), § 224 et seq. (California Indian Child Welfare Act), and through the Continuum of Care Reform (AB 403, 2015), Extended Foster Care to age 21 (AB 12, 2010), and the Family Urgent Response System (SB 80 / SB 89, 2019). The hierarchy of harm the science describes is the hierarchy of preference the law has long required.

The hierarchy also matches what the public asks for. The Bipartisan Policy Center's national survey of American attitudes toward the child welfare system finds majority support for keeping families together with supportive services, prioritizing kin when removal is unavoidable, and limiting the use of group and institutional settings. Empirical outcomes, statutory preference, and public opinion converge on the same ordering.

III. PROJECTED EXCESS HEALTH AND MORTALITY BURDEN: SANTA CLARA COHORT

What ‘excess’ means in this analysis.

The projections that follow describe disease and death that would not be expected to occur but for the forcible separation from parents and kin followed by non-kin placement. They are not a description of the underlying adversity these children carried into the system. They are the increment over that adversity: the morbidity and mortality the placement decision itself produces. The sibling-design literature (Brännström et al. 2020; Gao et al. 2017; Sørensen et al. 2023) and Doyle’s (2007) instrumental-variable design isolate this increment from pre-placement confounders by holding the family of origin and the child’s pre-removal conditions constant. The harms named below are iatrogenic in the precise sense: caused by the system’s intervention, not by the family conditions that preceded it. The outcomes are produced by the system, not by the family.

The mechanism is established in the developmental neuroscience. The primary caregiver functions as the external regulator of multiple physiological subsystems in the developing child, and separation produces dysregulation rather than only distress (Hofer, 1984). Repeated dysregulation becomes a durable trait through use-dependent neural development: chronic stress states become structural traits in the regulatory system, in Perry’s formulation, “states become traits” (Perry et al., 1995). This is why keeping the child with a parent, rapid reunification, and kinship placement carry the lowest long-term morbidity and mortality on the gradient: they sustain or return the external regulator the developing nervous system uses to complete its regulatory cycle. The placement gradient is a biological hierarchy, not a hierarchy of social preference.

Applying 30-year follow-up rates from Sacker et al. (2021) and mortality estimates from Murray et al. (2020) and Batty et al. (2022) to the additional Santa Clara cohort of roughly 400 children, most of whom enter non-kin pathways under surge conditions, yields the following placement-attributable excess events by early mid-life (ages 40 to 50):

Outcome	Absolute Excess Risk (non-kin vs. parental)	Projected Excess Cases
Limiting long-term illness / disability	+10.6 percentage points	≈ 42 cases
Poor self-rated health (chronic-disease proxy)	+12.0 percentage points	≈ 48 cases
Mental-illness burden (clinical diagnoses)	Substantially elevated; drives external-cause mortality	Substantial; not separately quantified
Premature death (all-cause)	HR 1.62 (Murray); pooled HR 2.21 (Batty)	≈ 4–12 excess deaths

These projections are conservative. They use the stable-non-kin gradient rather than the more severe unstable-placement or congregate gradient, even though caseload pressure during entry surges is documented to increase placement instability. Each placement change independently predicts behavioral deterioration (Rubin et al. 2007), and the dose-response relationship between placement count and adverse mental-health outcomes is confirmed in two contemporary meta-analyses (Sparks et al. 2026, *JCPP Advances*; Varnish et al. 2026, *British Journal of Psychiatry*). The projections do not include children whose existing kin or biological-parent placements are destabilized by reduced reunification capacity. The California-specific McNellan et al. (2026) Medi-Cal analysis indicates the lower end of the premature-death range may materialize earlier than mid-life, in the late-teen to early-thirties window, consistent with the external-cause mortality concentration in young adulthood.

Mechanistic note. Separation from a primary attachment figure dysregulates the hypothalamic-pituitary-adrenal (HPA) axis (Hofer, 1984). Foster children show this dysregulation directly in their diurnal cortisol patterns (Dozier et al., 2006). Chronic HPA dysregulation produces measurable elevations in inflammatory biomarkers (C-reactive protein, IL-6, TNF-α; Danese et al. 2007; Baumeister et al. 2016; Elwenspoek et al. 2021), and chronic systemic inflammation is the documented common pathway to the leading causes of adult death (Shonkoff & Garner, 2012, AAP Technical Report; Suglia et al. 2018, AHA Scientific Statement). The projected outcomes follow a documented etiological pathway, not a statistical artifact.

> **The outcomes are produced by the system, not by the family.**

IV. REPRODUCTIVE HEALTH HARMS IN NON-KIN PLACEMENT

The placement-attributable harms documented in Section III include a specific category that warrants dedicated attention: harms to reproductive health, pregnancy, and the next generation. The ADA Amendments Act of 2008 expressly enumerates *reproductive function* as a major bodily function (42 U.S.C. § 12102(2)(B)). Two evidentiary tracks apply.

In-placement sexual and physical harm to girls. The Northwest Foster Care Alumni Study (Casey Family Programs, 2005, p. 30) found that 24 percent of girls placed in Casey's own best-practice non-kin homes reported actual or attempted sexual abuse in placement, asked only about the placement in which they had lived the longest. Across all alumni in the same study, 32.8 percent experienced maltreatment by a foster parent or other adult in a foster home as documented in the case-file record. Case files are maintained by the agencies that placed the children, and the study authors describe the 32.8 percent figure as a floor.

Pregnancy, maternal, and intergenerational outcomes. The HPA-axis dysregulation, chronic inflammation, and accelerated biological aging documented in Section III continue into pregnancy. Mothers with four or more ACEs are at least twice as likely to deliver preterm; mothers with documented childhood

neglect carry an approximately seven-fold elevation in preterm-birth risk (Christiaens et al., 2015; Glover, 2011, Annual Research Review). Care-experienced women show elevated rates of preeclampsia, gestational diabetes, and postpartum depression, each linked to chronic adversity-associated inflammation. The prenatal cortisol pathway transmits maternal HPA dysregulation to the fetus through suppression of the placental enzyme 11-beta-HSD2, programming the next generation's stress response system before birth. Adolescent pregnancy occurs at rates roughly two to three times the general adolescent population among female foster youth (Courtney CalYOUTH; Midwest Evaluation). The Washington State Institute for Public Policy (2020) documents an intergenerational placement signal in the state's own linked administrative records: youth who exited foster care without participating in Extended Foster Care had a 6 percent rate of having their own children removed by ages 18 to 23, against 1 percent for those who participated. Putnam-Hornstein et al. (2013, *Pediatrics*) established the same pattern at scale using California birth records linked to CPS data.

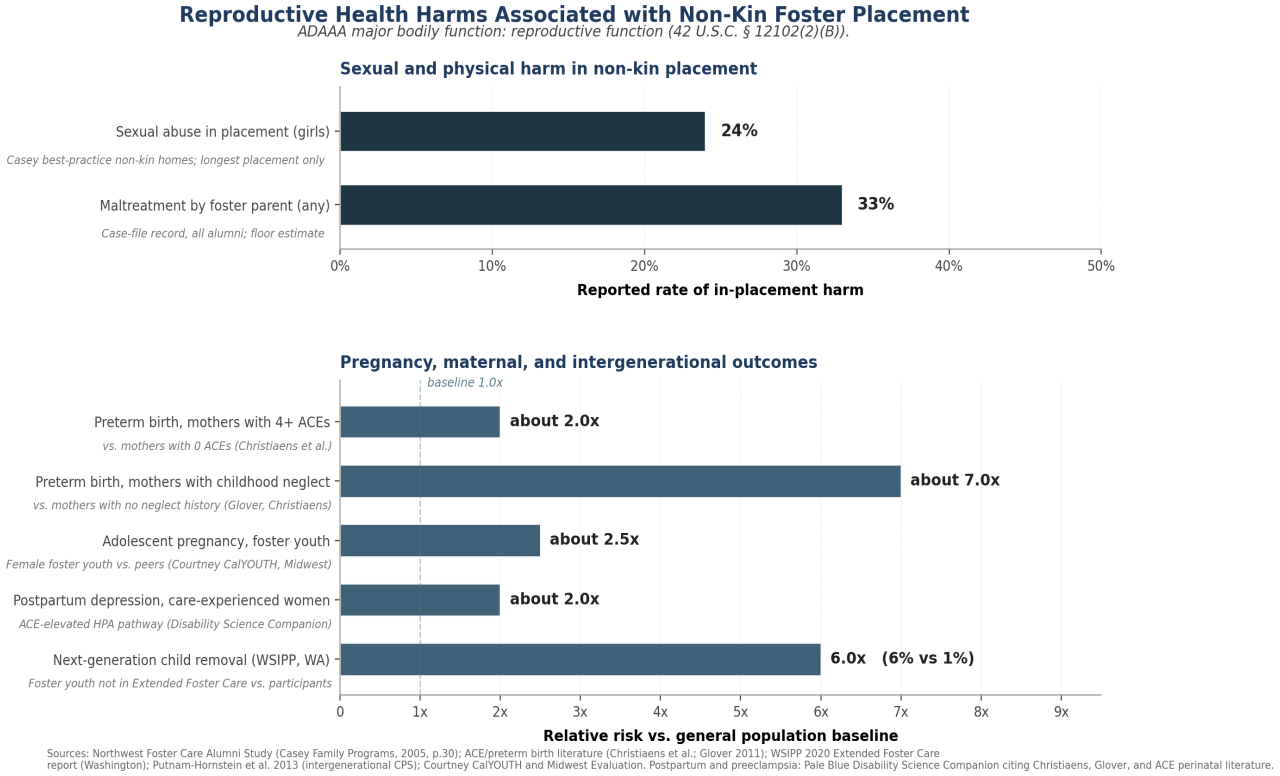


Figure 2. Reproductive health harms associated with non-kin foster placement. Top panel: rates of in-placement sexual and physical harm. Bottom panel: pregnancy, maternal, and intergenerational outcomes expressed as relative risk versus the general population baseline.

ADA / Section 504 application. Reproductive function is a major bodily function under 42 U.S.C. § 12102(2)(B). The HHS Section 504 Final Rule (89 Fed. Reg. 40066, effective July 8, 2024) expressly names biological and adoptive parents as protected persons and creates pass-down obligations through Medicaid managed-care contracts. Together these provisions cover the reproductive-health and pregnancy outcomes documented above. Placement decisions made by the County today produce identifiable reproductive-function impairment in the affected cohort over the next two decades, reachable under both the present-impairment prong and the regarded-as prong of the ADA framework when those decisions occur in the absence of the kin-first and family-preservation alternatives the evidence and statutes both require.

A note from the authors.

The science presented in Figures 1 and 2 describes a population. Each row of those charts also describes, the projected outcome for a specific child currently separated from family in Santa Clara County as a result

of the surge. We hope each member of the Board will reflect deeply on what these data imply for those children individually, and will act on two practical commitments. First, ensure that every child currently in placement receives the AAP Bright Futures developmental assessment standards and the pediatric care the Bright Futures Foster Care Health Supervision Supplement specifies: a comprehensive, trauma-informed health assessment within 30 days of placement, a follow-up within 60 to 90 days, and developmental screening at every subsequent encounter using validated instruments. Second, undertake active efforts, in the sense the Indian Child Welfare Act establishes (25 U.S.C. § 1912; *Brackeen v. Haaland*, 599 U.S. 255 (2023)) and federal law recognizes as the highest prevention standard, to move each child up the placement gradient toward the highest achievable level: from congregate to family-based, from unstable to stable, from non-kin to kin, and where safely possible, from kin to reunification with the family of origin.

V. THE POPULATION-LEVEL SAFETY QUESTION

> **Public child welfare operates on a trade-off curve, not a zero floor.**

Zero Child Mortality as a Policy Floor.

No placement type on the gradient in Figure 1 produces a cohort with zero excess morbidity or zero excess mortality. Even children who remain with a supported primary caregiver, the best available trajectory, experience a 7 to 24 percent rate of poor health at 30-year follow-up and the population baseline rate of premature mortality. No society has produced a child cohort with zero adult morbidity or zero premature mortality. A policy oriented toward a zero-mortality floor is therefore oriented toward a benchmark that has no real-world instance. Public child welfare operates on a trade-off curve, not a zero floor. The policy question the County faces is not how to reach zero. It is which response, given the placement-attributable harms documented in Sections III and IV and the population-level evidence below, minimizes total preventable harm to children. A response that focuses only on the harms the system has notice of and fails to prevent, while treating the harms the system itself produces in placement as outside the count, will appear protective in the news cycle and produce greater aggregate harm in the cohort over time.

Material Consequences in Children, Youth, and Parents.

The differences between gradient positions are not benchmark scores or preference rankings. They are quantities of disease and quantities of death in identifiable populations. Position 1 produces 7 to 24 percent poor health at 30-year follow-up and population-baseline mortality. Position 5 produces 88 percent poor health and 4 to 5.5 times population mortality. Each step down the gradient adds measurable, biologically specific harm: more cardiovascular disease, more inflammatory burden, more reproductive-function impairment, more deaths in the late teens and twenties, more next-generation removals. Every position on the gradient produces measurable disease and measurable death in the children placed there.

The materiality moves across three populations the policy reaches. Children removed today carry the immediate gradient burden in their developing nervous, endocrine, immune, and cardiovascular systems. The same children become youth carrying the cumulative biological load five and ten and fifteen years later, where the McNellan California Medi-Cal mortality data, the Midwest Evaluation, and the CalYOUTH outcomes already trace its trajectory. Parents are also material participants. They lose children. They experience attachment rupture as a clinical event of their own. In a substantial proportion of cases, they were themselves the children of the previous removal cohort, now processed through the system as evidence of parental unfitness for the same biological damage the system produced in them. The materiality does not stop at the child in current placement. It propagates through subsequent decades and into the next generation.

These consequences are material, not political. A popular policy that produces 4 to 12 additional premature deaths in a cohort of 400 children is still a policy that produces 4 to 12 additional premature deaths. Public sentiment is an input the County has to manage; child, youth, and parent outcomes are the material constraint. The decision to remove 399 additional children and the harm those placements will produce are inseparable elements of the same decision.

Does removal reduce child-maltreatment deaths?

Does increasing the rate of removal reduce child-maltreatment deaths? Edwards, Fong & Apel (2025), *JAMA Network Open*, drew on 3.4 million foster-care records and more than 24,000 maltreatment fatalities across all 50 states from 2010 to 2023. They found no evidence of a negative association between foster-care entry rates and child-maltreatment fatality rates. At the population level, higher removal does not produce fewer maltreatment deaths.

The individual fatalities that prompted the surge remain serious. The available population-level data, however, do not show that the surge response reduces deaths of the kind it was intended to prevent, while the placement-attributable harms projected in Sections III and IV are well documented.

VI. LEGAL AND ETHICAL FRAMEWORK

The epidemiological evidence intersects with several legal frameworks that inform Board decision-making.

Foreseeability.

Because the relationship between placement type and downstream health and mortality outcomes is replicated across multiple independent cohorts, the harms that follow are foreseeable consequences of placement decisions made today. The state-created danger doctrine (*DeShaney v. Winnebago County*, 489 U.S. 189 (1989)) recognizes affirmative state actions that substantially increase risk as a basis for constitutional cause of action.

ADA Title II and Olmstead.

Olmstead v. L.C., 527 U.S. 581 (1999), requires states to administer services in the most integrated setting appropriate to the needs of persons with disabilities. The ADA Amendments Act of 2008 (42 U.S.C. § 12102(2)(B)) expressly designates neurological, brain, endocrine, cardiovascular, immune, and **reproductive** function as major bodily functions. Each is implicated by the toxic-stress and HPA-axis pathways documented in Sections III and IV. Where placement in non-kin or congregate care is driven by capacity rather than clinical necessity (as the ACF 2015 national review and Wulczyn et al. 2017 demonstrate), the integration mandate is engaged.

Family-integrity and placement-preference statutes.

Stanley v. Illinois, 405 U.S. 645 (1972), recognizes a constitutional liberty interest in the parent-child relationship. Federal statutes operationalizing that interest include the Indian Child Welfare Act of 1978 (25 U.S.C. § 1901 et seq.), the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272, requiring reasonable efforts to prevent removal), the Adoption and Safe Families Act of 1997 (P.L. 105-89), Fostering Connections (2008, P.L. 110-351; 42 U.S.C. § 671(a)(29) requiring 30-day diligent search for relatives), and the Family First Prevention Services Act of 2018 (P.L. 115-123). California implements these preferences through Welfare and Institutions Code §§ 309, 361.3, 16002, and 224 et seq. (California ICWA), and through the Continuum of Care Reform (AB 403, 2015), Extended Foster Care (AB 12, 2010), and the Family Urgent Response System (SB 80 / SB 89).

Section 504 and the Final Rule (effective July 8, 2024).

The HHS Section 504 Final Rule (89 Fed. Reg. 40066) explicitly names biological and adoptive parents as protected persons and creates pass-down obligations through Medicaid managed-care contracts. The

Rule's coverage of pregnancy-related and reproductive-health conditions in the protected class includes the population whose outcomes Section IV documents. These protections constrain the lawful range of policy responses available to the County under conditions of documented disability-affecting harm.

VII. POLICY OPTIONS ALIGNED WITH THE EVIDENCE

Given the floor problem and the material consequences framed in Section V, the options below are the available trade-offs that minimize total preventable harm in the populations the placement decision affects. They follow from the evidence in Sections II to IV and from existing federal and California statutory preferences.

VII.1. Use the placement gradient as an explicit decision instrument. Record each removal and placement against the expected long-term morbidity and mortality risk for the placement type selected.

VII.2. Apply rigorous Family Finding due diligence in every case, consistent with 42 U.S.C. § 671(a)(29) and California Welfare and Institutions Code § 309. Records-based methods routinely identify 200 to 400 relatives within hours. Each kin placement substituted for a non-kin placement moves the child up the gradient by an epidemiologically meaningful amount: lower lifetime morbidity, lower premature-mortality risk, and a placement structurally closer to the family of origin.

VII.3. Scale intensive family-preservation services as a primary alternative to removal. Doyle (2007) compared children whose cases were close enough to the removal threshold that one investigator would have removed them and another would not. Among those borderline cases, the children who remained at home with conventional service support consistently outperformed comparably situated children who were removed, on adult outcomes including teen pregnancy, juvenile arrest, and young-adult employment.

VII.4. Track placement stability as a primary safety metric. Each placement change is an independent risk multiplier. Reducing placement moves is among the most cost-effective interventions available to a county system.

VII.5. Establish a long-term cohort-tracking instrument for the surge population. Through Medi-Cal linkage and vital-records integration (the McNellan et al. 2026 California methodology), the County can validate or revise the projections in this briefing against local data and create an evidentiary record sufficient for future policy correction. Track race and ethnicity separately so the disproportionality trajectory is visible to future Boards.

VII.6. Align the fiscal gradient with the harm gradient. California Resource Family Approval payment rate structures establish the cost gradient by placement tier: approximately **$1,059 per child per month** for kinship caregivers; approximately **$1,301 per child per month** for the home-based caregiver rate under the equalized RFA structure; an additional **$1,316 per child per month** for the Foster Family Agency administrative layer when a non-kin placement is FFA-certified (Pale Blue, *A Chain of Strangers*, March 2026, citing California Department of Social Services rate schedules); and approximately **$16,328 per child per month** for Short-Term Residential Therapeutic Programs (STRTPs). The payment ladder moves from roughly $12,700 per year for kinship to roughly $196,000 per year for STRTPs, a 15-fold spread.

Read against Figure 1, the payment ladder is inverted. The placements with the highest long-term morbidity and mortality also have the highest per-child price tag, and the placements with the best long-term outcomes have the lowest. Table 3 sets the two columns side by side.

Placement Tier ↓	Per Child / Month ↑	Per Child / Year ↑	Adult Mortality (RR) ↑	30-Yr Poor Health ↑
Kinship (RFA)	$1,059	≈ $12,700	≈ 1.5×	18–36%
Non-kin RFA home (county-supervised)	$1,301	≈ $15,600	≈ 2.6×	≈ 55%
Non-kin home via Foster Family Agency	$1,301 + $1,316 ≈ $2,617	≈ $31,400	≈ 2.6× (3.5× if unstable)	55–70%
STRTP / congregate care	$16,328	≈ $196,000	4.0–5.5×	≈ 88%

Table 3. Cost-harm inversion in California's placement payment ladder. As Placement Tier moves from kinship to STRTP (↓), every other column increases (↑). As cost increases, projected long-term morbidity and mortality also increase. The placements the evidence base ranks lowest in lifetime harm are at the bottom of the payment ladder; the placements the evidence base ranks highest in lifetime harm are at the top.

Every child moved one step up the gradient (toward kin or home of origin) reduces both projected long-term harm and current-year placement spend. The arithmetic is verifiable from the California payment rates above. Moving one child from FFA-administered non-kin placement to kinship saves the County approximately **$18,696 per child per year** (the difference between $31,404 and $12,708). Moving one child from STRTP to FFA-administered non-kin saves approximately **$164,532 per child per year**. Applying Ventura's Q1 2026 kinship-shift magnitude (about 25 percentage points over six quarters) to the 399 Santa Clara surge cohort means roughly 100 children moved from non-kin to kinship, with corresponding placement-spend savings of approximately **$1.87 million per year**, before accounting for the downstream cost of the avoided morbidity and mortality the gradient predicts. The Board can request CDSS and the Auditor-Controller produce surge-specific per-child cost projections at the actual current Santa Clara placement composition, and model the offset that becomes available for prevention services and Family Finding capacity at each magnitude of kinship shift.

The inverse payment structure also penalizes the caregivers who are already most economically vulnerable. Families involved with Santa Clara County child welfare overwhelmingly face the cascading material hardship the Stanford RAPID Survey Project has named the “chain reaction of hardship”: material hardship raises parental emotional distress, which in turn raises measurable developmental disruption in young children (RAPID Survey Project, Stanford Center on Early Childhood). The relatives who step in as kinship caregivers when a removal occurs are documented in the literature as older, more often single, less formally educated, lower-income, and in poorer health than non-kin foster parents (Geen, ed., *Kinship Care: Making the Most of a Valuable Resource*, Urban Institute Press, 2003). They are also providing the placement type with the best long-term health and mortality outcomes for the child.

The County therefore pays its kin caregivers, who are older, sicker, poorer, and providing the best-outcome placement, less than half what it pays an FFA to administer a non-kin home in one of the most extreme wealth-concentration jurisdictions on the planet. The inverse payment structure is industry common sense, not an equity, child safety, or public health imperative.

VII.7. Establish Board-level outcome benchmarks tied to high-performing California counties. The practice recommendations in VII.1 through VII.4 name what the County should do; they do not specify what the County should achieve. The Board can establish measurable benchmarks across four metrics: (a) kinship placement rate at first removal, anchored to Ventura County's Q1 2026 documented 74.7 percent; (b) kinship placement rate after second-look review, anchored to the Los Angeles County Nash–Edwards protocol's approximately 90 percent (Edwards, 2026); (c) reunification rate at 12 and 24 months; and (d) prevention-services dollars per child-welfare-involved family. Anchoring to peer California counties makes the benchmarks concrete and forecloses the standard objection that they are aspirational: Ventura is at 74.7 percent at first removal, Los Angeles is at 75 to 90 percent under the Nash–Edwards protocol, and Santa

Clara has no factual basis to claim it cannot reach the same. Public reporting against benchmark at each Board meeting creates the accountability the practice framework alone lacks.

> **California pays the most for the placements that produce the most disease and death, and the least for the placements that produce the least. The placement payment ladder is inverted relative to safety, health, and life span.**

VIII. LIMITATIONS AND UNCERTAINTY

The projections in Section III are population-level estimates derived from 30-year follow-up data and a six-country mortality meta-analysis. Three categories of uncertainty should be made explicit. The kinship mortality estimate (about 1.5 times the population baseline) is inferred from the Batty early-entry subgroup rather than directly observed in a kinship-specific cohort. The Bucharest RCT, the only randomized evidence in the literature, involved extreme deprivation in Romanian orphanages, so applicability to contemporary U.S. placements is partially attenuated. The 4 to 12 excess-death range reflects the interval between the Murray (HR 1.62) and Batty (HR 2.21) estimates and the assumption that the surge cohort experiences the stable-non-kin trajectory rather than the more severe unstable or congregate trajectories. These limitations bound the precision of the estimates; they do not reverse the direction.

Closing.

The 2024–2026 surge has placed approximately 399 additional children in Santa Clara County into a trajectory the published evidence describes with unusual precision. The science, the federal and California statutory framework, the public, and the placement payment structure all point to the same hierarchy: prevention with the family of origin first, then kin, then family-based non-kin, with congregate care reserved for narrow clinical need. No response to the surge can deliver zero child mortality, because no available response and no society in any era ever has. The response the Board ratifies, sustains, or alters will determine which trajectory those 399 children occupy across the next four decades. The consequences are biological. They appear in the children themselves, in the youth they become, and in the parents they will be.

The Board has direct authority over County Social Services, Behavioral Health Services, the County Health System, County Counsel, and the Auditor-Controller. Bright Futures pediatric care for each of the 399 children, comprehensive trauma-informed assessment within 30 days of placement followed by the AAP Foster Care Health Supervision Supplement schedule, is already required by federal law and already funded through Medi-Cal. What the Board needs to ensure is that the Medi-Cal managed care entity coordinates with its provider network and with County Social Services to make Bright Futures real for each child, consistent with the law and the rights those children hold under law. The HHS Section 504 Final Rule creates the pass-down obligation through Medi-Cal managed care contracts (Section VI). The same coordination authority covers Family Finding due diligence under WIC § 309 and 42 U.S.C. § 671(a)(29), and active-efforts movement up the placement gradient under the ICWA standard (25 U.S.C. § 1912). This is reparative work the Board can begin now for the children the surge has already placed. Children are still being removed as a result of continued fears of professionals within the system, and mitigation efforts will need to include them also.

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