A survey of the problem of lead poisoning in children with emphasis on the defects in institutions which make this problem possible, and what can be done.

COMMUNITY ASPECTS OF CHILDHOOD LEAD POISONING

Jean E. Moore, M.S.S.

THE fact that lead poisoning exists at all in the United States is but another of the numerous manifestations of society's lack of interest and concern for its impoverished members. For the community, it represents just one more of the many burdens it must bear, react to, and fight against in order to survive in the hell of impoverishment. Recent estimates indicate that "as many as 250,000 youngsters in the United States may have had lead poisoning last year . . ."[1]—mostly from eating lead-based paint that peels off sills and walls.

In a recent issue of *Today's Health*, reference is made to a new screening technique that purportedly can accomplish, through one person, 1,000 analyses per week by use of a simplified urinary test.* But, urgent and medically important as *all* diagnostic tools may be, they are not at the core of concern for people in most communities. The majority of the people living in the kind of conditions that spawn lead poisoning want *out* from the slum. They want to know *why* measures are not taken when there is a way to prevent needless death. The tragedy of it all is that we care so little and do even less in addressing the basic issues involved in this problem. At the recent national conference on lead poisoning, Dr. Rene Dubos is quoted as stating that "the problem is so well defined, so neatly packaged with both causes and cures known, that if we don't eliminate this social crime, our society deserves all the disasters that have been forecast for it."†

When we address ourselves to the community aspects of this problem, we can approach it from several angles. When we speak of community we can consider the agencies and institutions—particularly health, housing, education, social services, and welfare; we can consider business and industry—particularly real estate owners and the housing industry; and we can zero in on the residents—the citizens who live in the community.

The Institutional Community

Institutions have a remarkable way of identifying that which *they* see as the problem—more often that which is a problem to them, *their* problem. They tend to operate unilaterally, in isolation one from the other—with as much concern for "turf" as the gangs that are so highly criticized for their more obvious murders and rampaging qualities. There are health agencies in some cities that carry responsibility for housing inspections, and there are other cities

* Medical Briefs. Today's Health (Sept.), 1969.

† Lead Poisoning: A Preventable Childhood Disease of the Slums. *Science* (Sept. 5), 1969, p. 991.

which have separate departmental responsibilities. Still others have different alignments—sometimes not at all related to problem areas in a currently relevant way—which continue to function in earlier patterns geared to former needs and/or different populations and housing. In what resembles a constant ping-pong game, the child with lead poisoning may be batted between agencies and legalities—for example, between a health department and a housing department, with neither deciding to play the game to a conclusion. Thus the community's child is inevitably the loser.

Housing codes often provide for labeling a house unfit, based on a point system involving cumulative violations. The peeling of paint, in and of itself, would not be reason for the designation of "unfit," or for involving the relocation services that some communities (too few) make available in a planned and meaningful way. In Philadelphia,* however, according to the assistant housing director, the presence of lead paint on walls is now cause for unfit designation and relocation assistance. Although enforcement against a landlord may be effective in cities where specific legislation prevents use of lead paint on interior surface or on toys, it is apt to be as ineffective as other types of code enforcement. Code violation cases usually go through the machinations of the lower judiciary, in hearings resulting in relatively low fines; too frequently these are ridiculous charades of the enforcement process.

It has been my experience (in the housing end of things) that a number of variables can come into play on a local level when it has been determined that a child is suffering from lead poisoning—values having a bearing on whether he lives or dies, and *apart* from his medical treatment. In one specific case that came to the attention of the relocation agency, a family with a child having lead poisoning was relocated from an unfit house, that was *also* a lead-infested building, to a standard dwelling—all pretty and painted. Later, through the child's increased illness, it was discovered that this house was a monster in disguise, the monster being paint with *lead* underneath. This relocation action took place twice more, finally terminating in a new public housing unit. The other units, although superficially standard, were located in that area of the city most often restricted to the poverty population, largely made up of black and other nonwhite people, i.e., the ghetto. In the half-bulldozed shells found in similar sections of cities across the country, lead represents the artifact of the ages, an invisible inscription of the past emblazoned throughout layers of colorful paint.

It took the intricate planning of a number of people working across several agency lines to effectuate one relocation action of the family described above. To avoid such red tape, the utilization of the relocation services in a community should be an integral part of activities involving cases of lead poisoning, and all other types of housing/health violations that may require movement as well as other remedial actions to a property. But rarely, with the exception of crash experimental programs in a few cities, are paint chips routinely taken from peeling paint in inspections to determine *if* a house is lead-free. I understand that a method, similar to detection with a geiger counter, has been or is being developed to detect lead without defacing the paint. When this is available, what will our hang-up then be for not securing this kind of data? Probably another cost-benefit analysis proving the "inefficiency" of such routines—a device behind which

*21st Annual Community Orientation Institute, Philadelphia, October 30, 1969. Panel on Housing.

there invariably lies a maze of bureaucratic unconcern for the community.

Poverty, Housing, and Discrimination

Make no mistake about it, when we talk of housing containing lead, we are addressing the community problems of poverty and of the crowded urban ghetto inhabited by the black and other minorities. These citizens, referred to in the report of the National Advisory Commission on Civil Disorders, are "condemned by segregation and poverty to live in decaying slums of our city . . ."* "Today," the report states, "after more than three decades of fragmented and grossly underfunded federal housing programs, decent housing remains a chronic problem for the disadvantaged urban household. Fifty-six per cent of the country's nonwhite families live in neighborhoods marked by substandard housing and general urban blight."†

We are really talking about a lack of commitment to enable families to break out of the poisoned ghetto. We are talking about locking people in *to the death*—through decidely racist policies. For, regardless of the legislation on the books for fair housing, for low-income housing, for the prevention of real estate discrimination, for the prosecution of violations, and so on, agencies do not effectively carry out the mandates. Furthermore, mandates are ofttimes issued tongue-in-cheek—with little intent toward change. Realtors lock people in, poverty holds them tight, and racism provides the glue.

Program Approaches

Methods do exist to bring agencies together to concertedly attack lead poisoning or other problems—if agencies wish to use them. These involve the formation of agency-resource committees and use of the multiservice conference for the planning and development of solutions to identified problems such as lead poisoning. Furthermore, the use of a centralized relocation service can be a valuable answer to the need to remove a family from the environment—*providing* the ability exists to secure pretesting of the new housing unit *before* completion of the move.

The comprehensive planning concept, cutting across many problem areas, is perhaps best exemplified in the Model Cities legislation in which the concept of joint planning and implementation to effectuate change within a community involves numerous groups. In Model Cities, agencies and residents are currently working together—identifying areas of concern and priorities in the fields of manpower, economic development, health, education, recreation, welfare, crime, housing, transportation, and social services—for the avowed purpose of bringing together all forces in the community to attack the total problems of the community. Each area of concern is so vitally interrelated with the others that the total approach of all groups—federal, state, local, private and public, and *citizen participation*—will hopefully eliminate the basic causes of the existent conditions. To realize this assumes a great deal on the part of all participants, and no one can envisage smooth and easy going in this most difficult of processes.

Very few of the first-round model cities in this region contained specific reference to lead poisoning, in their initial applications. Furthermore, I do not recall that any of the first-year plans emanating from those cities contained specific projects aimed at the elimination of lead poisoning.

In most communities there is a basic

* Report of the National Commission on Civil Disorders, March, 1968, Chapter 17, Section IV "Housing."

† Ibid.

problem in fighting lead poisoning. To the people who live in blight, however, isolating "lead" as a crusading issue is somewhat difficult because of the many other related but more obvious community concerns.

Citizens are suspicious of causes. They are tired of being "used" for studies. Nevertheless, the community *can* be aroused and involved. Social agencies have formed teams to help families scrape walls. Case conferences tighten up the fragmented proliferated delivery of services. Skilled psychiatric delineation of causal factors presents data on oral needs of certain children, on the overindulgent mother, or on the perpetuation of dependency needs (that may also come from a hungry stomach). But at what point do we stop addressing the palliative to grapple with the basic policy issues that cause perpetuation of the roadblocks to solution?

Resident Involvement

Residents are tired of waiting for the many things promised but never delivered, and of the stop-gap measures that occasionally but rarely involve them. Too few communities have invited resident participation in evolving a plan of attack that could result in wholesale rehabilitation of houses or of the scraping and sampling of paint. More importantly, too few agencies develop community input to work-training ladders into the health professions, using urgent problems as a rallying point. Fewer still have added trained community organization staff as liaison with the community, let alone, as community advocates.

Therefore residents develop their own power. Perhaps the residents' greatest weapon, when aroused, is group pressure. The *Village Voice,* (Sept. 18, 1969) tells of citizen concern and of the organization known as Citizen Committee to End Lead Poisoning.* The article describes their feelings of pain and frustration in fighting the bureaucratic webs that enfold them in their struggle for change.

Rent strikes, community pressures such as boycotts, picketing of realtors, use of legal services—all of these and more—continue to develop in the community over major housing issues, and in areas of specific concern such as lead poisoning. Perhaps citizen reaction to needless deaths may reach high pitch in some few communities. Nevertheless, many residents see these crusades as another evidence of the grand design that produces lots of motion with no real movement, either intended or accomplished. They begin to realize that *their* so-called inertia, or their "paranoid" reactions, are reactions of hate, caused by years of being opted out of the human race.

Today, no community agencies can plan among themselves, without the community's residents. Community groups *will* be included in, or you can forget the grand schemata. One of the great early hopes of the Model Cities program has been that the *inclusion* of residents in the planning and decision-making processes will enable the evolution of valid methods of change. This does not mean that what residents have said about agencies has been found palatable by agencies, or that agencies—health agencies—have agreed with residents. Quite the reverse! It is a hard and difficult process.

In most Model City plans, residents spoke of many over-all *and* specific problems; of *decay of housing* in the context of poverty, undereducation and underemployment. They expressed fear and grave doubts over the ability of the establishment to deliver in either gross terms or in specifics. They wanted *in*

* The Village Voice (New York City), XIV, 49 (Sept. 18), 1969.

on the decisions of how and what happened in their communities and over priorities of what to attack first.

Health centers got "hung-up" *not* on whether there would be a multiphasic screening mechanism, or a specific test for lead levels, or referrals between health and welfare agencies. They got caught in the question of *who* was ultimately going to have some say in the decisions of how and *what* that health center *did*. Residents were willing to forfeit thousands of dollars in grants when such monies had strings tacked onto them relating to specific agencies that residents felt had been completely unresponsive to community concerns. One community literally told a state health department that it could keep its $100,000 if it was going to go through the old channels. The department's methods were "suspect" because people had been treated condescendingly, with a lack of concern for the whole person and his dignity as a human being.

When we talk about the community aspects of lead poisoning, we must, of course, address ourselves to methods of cure, to immediate measures of a stopgap nature, and to mobilizing community pressures and cooperation; but we *cannot* avoid the larger community factors that are operating. These include the matter of racism that permeates our entire society—both in attitude and, more important, in behavior toward specific groups of people who are thereby *committed* to closed, poisoned housing.

Summary

Agencies must work together *with* community residents in developing specific methods of identifying poor housing and lead-infested units; methods of removal can and must be developed through legal channels and through community pressures; landlords must be made to uphold codes adequately designed and enforced to include removal of paint layers. The use of relocation services as a resource is a basic tool—but only when coupled with adequate methods of securing and screening the new unit. Unfair housing is no longer just unfair—it is illegal! Most important, the behavior manifested in our governmental and other structures that *perpetuates* these conditions *must change.*

The institutions that fail to respond to the obvious must be rattled; they must recognize that their time is limited. Agencies that *refuse* to involve themselves in the destinies of these communities, officials who ignore their constituents, who bureaucratically block ways of dealing with specific problems such as lead poisoning, and who choose to be guided by insidious, sometimes unconscious, but all too often, frightfully conscious racist motivations, must be forced to change.

We diagnose and treat patients and clients. It would appear that, more often than not, we are focusing on the wrong target.

Mrs. Moore is Associate Professor and Director, New Career Ladders in Social Welfare, Temple University School of Social Administration (1824 North Park Mall), Philadelphia, Pa. 19122

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