Report on the Planning Meeting of the Community Action on Lead Project of the Boston Public Health Commission, December 18, 2019[1]

The Community Action on Lead (CAL) Project applies a Health in All Policies[2] lens to look at existing policies, programs, and resources for lead poisoning prevention in Boston (and to some extent state-wide) to accelerate progress in preventing further poisoning. It consists of public conversations about how this may be accomplished, identifying gaps in communication between organizations working to prevent lead poisoning, unmet needs for resources for dealing with lead, improvements that can be implemented in program practice and policy, and regulatory or legislative changes that address the underlying social determinants of health that create lead risks, particularly those that place different demographic or geographic groups at disproportionate risk for lead exposure. Community Action on Lead, a project of the Boston Public Health Commission (BPHC), is funded by the National Association of City and County Health Officials.

This is a report on the first meeting of the CAL Project, which consisted of individuals who have worked on lead issues or represent organizations that have been involved in lead poisoning prevention. Below is a summary of general comments provided, including from some who were not in physical attendance at the time, followed by suggestions made by these experts, to aid the BPHC in its efforts. These comments will guide the discussions to take place over the course of the three formal meetings in this project.

General Comments by Attendees

Blood levels are no longer going down at the national level. We are actually seeing levels increase. However, in Massachusetts and Suffolk County, rates are declining.[3] Production of lead is also

[1] The first meeting was held at Boston University and was hosted by Paul Shoemaker and Stephanie Sellers of the BPHC and facilitated by Rick Reibstein of BU's Department of Earth and Environment, who prepared this report. He thanks students Josh Taylor and Isabelle Guelin for their invaluable help taking notes.

[2] "Health in All Policies" (HiAP) is a collaborative approach to incorporating health considerations into decision-making across sectors and policy areas, that addresses the social determinants of health (social, physical and economic environments) that drive health outcomes and inequities. The Helsinki Statement on HiAP, issued at the World Health Organization's 8th Global Conference on Health Promotion in 2013, called upon governments "to ensure that health considerations are transparently taken into account in policy-making, and to open up opportunities for co-benefits across sectors and society at large." https://www.who.int/healthpromotion/conferences/8gchp/8gchp_helsinki_statement.pdf?ua=1

[3] The National Surveillance Data Table shows a reduction from 2012 to 2015, from 63,901 (2.4% of children tested) with confirmed blood lead levels above 5 micrograms per deciliter, to 43, 270 (2%); but then an increase to 46,270 in 2016 before dropping to 40,122. However, during the five-year period measured the number of children tested dropped from 2,612,859 to 2,014,208, and the percentage of children tested found with levels above 5 increased from 2.4% to 3%. The percentage with blood lead levels above 10 increased from 0.6% to 1%. (https://www.cdc.gov/nceh/lead/data/national.htm). (The national average percentage of children tested ranged from 16 to 18.7%).

rising. There is no current political movement on lead, though it cuts across so many issues. Only 10% of pre-1978 housing in Massachusetts has undergone deleading. Twenty-three percent of children are not screened for lead.[4] Public awareness is low. People are not sufficiently aware of when they are at risk. It is politically difficult to do even moderate legislation at this time. Funding for lead-related programs is down, including the state's loan program to help property owners. It is necessary to take action to generate the political will to act.

Although Flint exploded public attention, response has not been adequate, and lead in water is not the primary problem in Massachusetts. When Massachusetts recently provided money to voluntarily test water in schools for copper and lead, only a fraction of schools actually followed through and tested their water. Schools sent information to parents and it brought awareness to the subject but what about the schools that didn't want to test? They may have felt that if they found it they would have to fix it, and avoided the cost of fixing by not testing.

As temperatures rise, lead is increasingly released and available for uptake.[5]

The economic benefits of preventing lead poisoning are very substantial, far outweighing the costs of taking action. This has been shown by many investigators, notably Jessica Reyes of Amherst.[6]

Boston Children's Hospital sees about three hundred children with elevated lead blood levels each year, twelve requiring hospitalization. A preventive approach - looking for lead in the child's environment before looking in the child, would be far more intelligent, efficient and humane.

Current law permits too many opportunities to delay action. An attorney with the Medical-Legal Partnership shared a case in which a child with lead at more than ten times the recommended action level waited nearly a year for the court to force a response.

In Massachusetts, blood lead levels above 5 during that same period dropped from 2.5% of those tested to 1.5%. Massachusetts screening rates are in the seventies, far higher than the national average. The Bureau of Environmental Health measures prevalence of elevated blood levels - cases per 1,000. By that measure, Suffolk County's prevalence is higher than the state average, but has declined from 32.3 cases per 1,000 in 2012 to 18 in 2017. https://matracking.ehs.state.ma.us/Health-Data/Childhood_Blood_Lead_Levels.html#MyPopup. (The CDC's data covers children up till 72 months of age, while the Massachusetts data covers children up till 48 months).

[4] 2017, statewide average. Rates, highly variable across communities and years, can be viewed in an interactive table at https://matracking.ehs.state.ma.us/Health-Data/Childhood_Blood_Lead_Levels.html#MyPopup

[5] See: "Lead seasonality in humans, animals, and the natural environment", R. Levin et al, *Environmental Research* 180 (2020) 108797.

[6] See, for example, https://www.bostonfed.org/publications/communities-and-banking/2012/winter/lead-exposure-and-academic-performance.aspx, an example of the financial community recognizing impacts.

Suggestions for Action or Investigation from the Attendees

Inspect apartments for lead safety when they are vacated. Automatic inspections have been implemented in other parts of the country. Change the current practice of responding after a child has been poisoned.

Title Five, which requires ensuring a septic system is adequately functioning when property is transferred, is an example of an analogous requirement. Until the inspection is performed verifying functional adequacy, banks will not issue mortgages on the property. The onus can be on the bank as well as the realtor.

Require occupancy permits for rental housing, as Philadelphia is doing. Require a license to be a rental unit, and lead safety as a condition for receiving the license.

Increase funding for the lead programs. The Department of Public Health has experienced cuts in funding for the lead program. More staff resources are needed.

Ensure that sanitation and housing inspectors are trained by the Department of Health to do lead determinations. Provide the inspectors with sodium sulfide (and the knowledge of how to use it to detect lead), and the parental permission form when they inspect for other conditions.

Revisit compliant buildings. When a building has been inspected and marked as compliant with the lead law, follow-up is lacking, but certificates of lead safety are valid only so long as buildings remain in compliance, and buildings fall out of compliance. Formally "sunset" these letters so that they expire within a reasonable time frame and require re-certification.

Ensure consistency of enforcement across the state. Towns have varying levels of compliance (and screening) with the lead law.

Sue those who put lead in products, the original cause of the problem. Paint companies knowingly sold a hazardous product. Liability risks must be increased so that manufacturers think twice before using lead in their products. This litigation should be pursued by both public authorities (such as the Attorney General) and by those harmed by lead. A California suit[7] resulted in a several hundred million dollar award to be used to prevent lead poisoning, providing a pathway to litigation. However, this suit did not include compensation for harm to victims. Obstacles to such litigation should be removed (such as, requiring specific causation by specific lead paint manufacturers). The payment of tort lawyers should be managed better than the tobacco suit (too much went to the attorneys). Instead, use the money to ensure funding of lead poisoning prevention programs. While tort litigation may not be the best way to make policy, it is necessary when regulations are inadequate.

[7] *People v. ConAgra Grocery Prods. Co*., 227 Cal. Rptr. 3d 499, 541 (Ct. App. 2017)

Increase funding for remediation. The "Get the Lead Out" program for assisting property owners in reducing lead risks is critically low on funding. The cap for receiving assistance should be raised. Loans, subsidies and other assistance should be available to middle-income as well as low-income housing, to nonrental housing, and to housing that is not now in noncompliance.

Bring down the cost of deleading. Investigate why the cost has not gone down. Expand the use of the moderate risk deleading license to increase capacity and competition in the private sector. Provide subsidies for certified deleaders to offer their services in high-lead neighborhoods.

Increase testing for lead in children, until all children are tested. Too few entities in the state have the resources to do screening. Provide resources and education to community health centers. Determine if doctors are skipping it or children are not going to the doctor. Conduct screening in daycare, preschool, and kindergarten facilities, and seek out immigrant and foster care children who may be falling through the cracks.

Increase attention to risks in daycare facilities.

Require certificates of lead compliance by daycare facilities and schools.

Increase funding for related programs, such as early education, and use them to increase lead screening and education. Take action to increase funding for and utilization of early education programs. Only 15-20% of children eligible for Head Start received funding.

Impose a fee on those who produced lead products that led to harm, to fund deleading.

Impose a small tax surcharge on high-income property transactions to fund deleading.

Include lead water service lines as a component of lead-safe compliance. Train inspectors in identifying leaded pipes and components in water delivery.

Institute systematic inspection and replacement of water service lines made of lead. Train sanitary and other relevant inspectors in identifying lead service lines.

Address the unintended effect of discrimination against families with children. Data shows that landlords avoid having to delead by avoiding renting to families with children under six. Notify landlords and realtors when they advertise in violation of anti-discrimination law. Step up enforcement of anti-discrimination law. The MA Fair Housing Center has filed suit in federal court claiming the state's lead law violates federal fair housing law, as a result of serving hundreds of families with children who cannot find housing[8]. Instead of using the presence of children to trigger deleading, use another method.

[8] *MA Fair Housing Center v Bharel*, https://dockets.justia.com/docket/massachusetts/madce/3:2019cv30152/216289

Improve access to health care. Fund pop-up clinics in hard-hit areas to make evaluation and education more accessible to those who may not have the time or resources to bring their children and themselves to health facilities as often as they should.

Require relocation of the family (at property owner's expense) when lead hazard is first identified. Current law requires that relocation occur while deleading work is being done, but requiring it when it is found will prevent continued exposure as delays in deleading increase risk.

Provide a case manager/advocate for each family with a lead-poisoned child to help them navigate the process and understand their rights and options. Improve access to resources that can lower the stress on parents dealing with lead-poisoned children. Develop a "legal tool-kit" that can enhance know-your-rights trainings given by tenants' associations and others, and given to families that have been harmed. Develop referral information about legal and social work expertise that can be tapped, building on the example of the Medical-Legal Partnership. Do parents know their rights concerning housing? Investigate what barriers may exist to utilizing existing services, such as fears of eviction, or lack of awareness of the issue.

Increase outreach efforts. More education is needed for medical professionals, particularly ob/gyns, and more outreach to pregnant and soon-to-be pregnant women, to vulnerable immigrant populations, to nonprofits concerning the recommended actions in this document, and to the public concerning the continuing importance of this issue and the benefits of prevention. Make clear that significant costs fall on all of us, not just the victims. Work with churches and social organizations. Translate existing information and proactively provide to English-limited populations.

Increase outreach to the real estate and construction communities. Raise awareness of the benefits to them of acting to prevent lead poisoning. Dampen fears that they are targets. Provide more significant help to property owners. Reduce barriers they face to reducing lead risks. Change the building code so that action to address lead does not trigger consequences, such as condemnation, that would create an incentive not to investigate. The example of how heating is addressed was cited, in which inspectors only review heating, so that no other building code reviews are triggered. Use energy efficiency programs to change out windows that are the primary source of lead dusts. Provide tax credits for voluntary deleading. Incentivize banks to ensure that properties are deleaded. Use consumer protection law to create the right mix of incentives and disincentives. Include the regulated communities in evaluation of options for eliminating barriers to action.

Create a registry of lead-safe housing for homes that were voluntarily deleaded. Make it publicly searchable to make safe housing easier to find. Make it desirable for property owners to get on the list by marketing it to families searching for safer homes.[9] Include lead water service lines.

[9] A registry currently exists, but it is for homes that were in violation and have been corrected.

Create insurance incentives for deleading, such as discounts for lead-safe housing and renter's insurance. Modify the lead exclusion clause so that it provides an incentive to delead.

Increase attention to adult lead poisoning. Since July 1st of this year eleven incidents have been reported concerning poisoning of 40 micrograms per deciliter,[10] and it is expected that many incidents are not reported. The poisoning involved firearms instructors, construction workers, furniture restorers, and people working in stained glass. We lack sufficient assurance that people working in lead abatement are protected, and there are indications that some of the training in low income contexts may not be accurate. Address "take-home" exposure, when adults bring home lead on their clothes, and hobbies that involve lead.

Do more research. Find out why people do not seek out help, why property owners do not take action, why children are not screened, whether people know about legal and other resources they can use, whether people feel authorities can be trusted. Get people who are trusted, such as physicians, to ask these questions, to improve the accuracy of the response. What did parents know before their child was identified as having elevated blood lead levels? What have they learned since? What would they tell other parents? What do they wish they had known? What are their fears concerning the process? Can we eliminate the fear of losing one's home, or having to spend money one doesn't have, or experiencing stigma?

Avoid priority wars. Respect differing perspectives on priorities, adjust to context. Don't waste time with arguments that don't move anyone's priority forward. For example, though lead in water or lead in soil are on average less of a danger to families than lead in paint, lead accumulates in the body, so all sources must be addressed. Make progress where you can.

Next Steps

BPHC is planning the following series of meetings (locations to be announced).

February 18, 4-6 PM: How can we better prevent lead exposure and lead poisoning?

April 14, 6-8 PM: What resources do parents and property owners need to protect children from lead exposure and lead poisoning?

June 16, 4-6 PM: How can we better address lead in products?

Interested parties should contact Paul Shoemaker or Stephanie Sellers at PShoemaker@bphc.org and/or SSellers@bphc.org to be added to the mailing list and for questions about the Community Action on Lead Project. Please put CALP in the subject line of the message. Please contact Rick Reibstein at rreibste@bu.edu for questions about this report.

[10] OSHA requires that when levels above forty are found, the worker must be notified in writing within 15 days after the receipt of the results or any monitoring performed, and provided with a medical examination.