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The McKinney Act

New England Responses to Federal Support for Assistance to Homeless Mentally Ill Persons

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The Stewart B. McKinney Homeless Assistance Act of 1987 builds on the work of state mental health authorities and the National Institute of Mental Health in the early 1980s. The act and its subsequent amendments are designed to organize, coordinate, and enhance federal support to the states in financing the development of shelter, health, housing, employment, and support services to homeless persons. There is a special focus in the act on assisting homeless persons with handicaps. In the main, the New England states have met the requirements of the act to provide mandated essential services, which include outreach; community mental health, crisis, and rehabilitation services; health and substance-abuse services; training of homeless service providers; case management, including service planning, benefits assistance, and service coordination; and supportive residential services. While the federal funds available are insufficient to cover the majority of costs associated with serving homeless and mentally ill persons, states report their utility in targeting high-needs areas, supporting demonstrations of service innovations, creating incentives for state and local matching funds, and focusing on vulnerable sub-populations. State advocates credit the McKinney Act mental health programs for stimulating localities' interest in and ability to attract HUD funding for housing special needs persons among those homeless. Within the contrary New England economic context, the federal contribution is an important resource and stimulus to state spending.

The New England Mental Health Commissioners Association and the Massachusetts Association for Mental Health have worked collaboratively during the last five years to address major policy, financing, and service issues affecting the region's citizens with mental illnesses. Key issues of concern include poverty; affordable housing; financing of medical and psychiatric services; treatment of co-occurrence of mental illness and substance abuse; organization of service delivery; and empowerment of consumers. There is perhaps no more poignant case of these

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issues coming together than that of persons who are homeless and mentally ill. The work of the state mental health authorities in New England with this population underscores the findings of the Massachusetts Association for Mental Health in its seminal work on homelessness, which began in the late 1970s. As reported in a 1985 association report, the causes of homelessness are many, among them poverty, illness, lack of affordable housing, weak social networks, and limitations in the support services delivery network.¹

Given the multiple causes of homelessness, it should not be surprising that the population of persons without stable housing represents a diverse group with equally diverse needs. Levine notes, "The homeless are a heterogeneous population comprised of many subgroups, including runaway children, immigrants, migrants, so-called bag ladies, displaced families, a certain number of the unemployed, battered women, minorities, the elderly, and an overrepresentation of persons with serious alcohol, drug abuse, and mental health disorders."²

The precise number and proportion of the homeless population who have serious and persistent mental illness is still a matter of some debate. As Robertson says, the empirical research in this area does not provide consistent and reliable estimates across studies.³ Methodological problems, including inconsistent definitions of psychiatric morbidity, differences in sampling frames, and different case-finding methods, make generalizations difficult. However, there appears to be a consensus that approximately one third of single adult homeless persons have severe and persistent mental illness.⁴

In some respects, persons who are homeless and mentally ill are similar to the larger homeless population. Tessler and Dennis, in a review of NIMH-funded studies, concluded that this subgroup mirrored the larger group with respect to age, gender, ethnicity, and extent of substance abuse.⁵ However, the chronic nature of the disabilities affecting those individuals who are both homeless and mentally ill is apparent in their low educational level, poor employment histories, truncated social networks, low marital rate, and high rate of arrest and incarceration.⁶

Policymakers and service providers alike have been challenged as they attempt to meet the myriad needs of this population. It is clear that people who are homeless and mentally ill require assistance in numerous areas, including basic subsistence (food, clothing, and shelter); treatment of mental health, substance-abuse, and physical health problems; and access to income supports. Characterizing homeless mentally ill clients served through a series of NIMH-funded community support program demonstration programs in 1986 through 1987, Hopper, Mauch, and Morse say,

Homeless mentally ill persons are often the most disturbed and most difficult to serve clients within the mental health field. The reasons derive from the difficulty of trying to serve individuals whose needs and circumstances, including a stance of mistrust adapted as a central strategy of survival, badly frayed if not altogether absent social ties, a plethora of basic human service needs, and a high frequency of multiple disorders (i.e., alcohol and drugs, and physical as well as psychiatric problems), pose serious challenges to a service system that is both inadequate in resources and often insensitive to the special problems of the homeless.⁷

The NIMH, as well as other agencies of the federal government and state mental health authorities, has sponsored numerous research and demonstration projects to evaluate service delivery strategies designed to meet the service needs of homeless

mentally ill individuals. While there is, to date, no single simple solution, there is an emerging consensus concerning the attributes of services that are more successful. First, it is clear that the needs of this population transcend the traditional boundaries of mental health systems. Most of these individuals are responsive to offers of assistance; however, their view of their own service needs is frequently different, and more concrete, from that of service providers.⁸ This suggests that more traditional mental health services should be bundled with other services that address people's immediate daily living needs.

Second, the developing body of research suggests that aggressive outreach and intensive case management must be keystone services for this population. Program planners must be sensitive to the extensive amount of time required to engage homeless mentally ill persons in the service system and the stress and fatigue that this causes for front-line workers.⁹ With respect to case management, models that involve low caseloads and long-term support appear to be more successful than models that involve higher caseloads and "brokering" of services.¹⁰

Housing remains a critical need for homeless mentally ill persons. In many states, the supply is dwarfed by the need for affordable housing. Clearly, more housing is needed. However, more housing options are also needed. It is becoming apparent that no single type of housing format will meet the needs of all homeless mentally ill persons.¹¹ What is required is an array of housing options with continuing supports that will last indefinitely.¹² Without these continuing supports, the cycle of homelessness is unlikely to be affected.

While a number of discrete federal government programs were implemented during the early part of the 1980s to address homelessness, the passage of the Stewart B. McKinney Homeless Assistance Act (PL 100-77) in 1987 was designed to organize, coordinate, and enhance federal support to states, cities, and counties. The 1987 act and its subsequent amendments (PL 100-628 and PL 100-625) embody the major commitments of the federal government to combat homelessness and provide states key financial support in the development of shelter, health, housing, employment, and support services to homeless persons.

As Title I, General Provisions, states, the purpose of the act is "to meet the critically urgent needs of the nation's homeless, with special emphasis on elderly persons, handicapped persons, families with children, Native Americans, and veterans." Other titles of the act provide the following:

Title II: establishes an interagency council on the homeless as part of the executive branch to coordinate the federal effort on homelessness.

Title III: establishes a national board to disburse funds to private nonprofit organizations for the Emergency Food and Shelter Program. Authorization of \$134 million for fiscal year 1990.

Title IV: outlines housing assistance initiatives, requiring a Comprehensive Homeless Assistance Plan of eligible states, cities, and counties; provides for emergency shelter grants to open and operate essential shelter services; provides for a supportive housing demonstration program to develop transitional housing and permanent housing with support services for persons with handicaps; provides for a supplemental assistance program to meet special needs of families and elderly and handicapped persons who are homeless that cannot be met under the emergency shelter or supported housing programs; and provides for Section 8 assistance for single-room-occupancy units (SRO) for moderate rehab of SROs. Authorizations

for fiscal 1990 total \$125 million for emergency shelter grants, \$105 million for supported housing demonstrations, \$11 million for the supplemental assistance program, and \$50 million for Section 8 assistance.

Title V: requires the secretary of HUD to identify unused and underutilized federal buildings that are suitable for use by homeless persons.

Title VI: establishes the Health Services for the Homeless Grant Program to support the delivery of primary health care and substance-abuse services to homeless persons — the fiscal 1990 authorization totaled \$63.6 million; establishes the Mental Health Services for the Homeless Block Grant Program (MHSH) and subsequent Programs to Aid in the Transition from Homelessness to support a required set of mental health services to mentally ill persons who are homeless or at risk of homelessness — the fiscal 1990 authorization totaled \$35 million. Also establishes demonstration projects for chronically mentally ill homeless persons — \$11.5 million authorized for 1990 to provide community-based treatment and support to such persons. Also establishes demonstration projects for alcohol- and drug-abuse treatment to homeless persons — fiscal 1990 authorization totaled \$17 million.

Title VII: establishes the Education Training and Community Services Programs to fund adult literacy, education for homeless children, job training for the homeless, homeless veterans' employment reintegration, emergency community services grants, and jobs for employable dependent individuals — fiscal 1990 authorizations totaled \$10 million, \$5 million, \$2.5 million, \$13 million, \$2.2 million, and \$42 million for the respective programs.

Title VIII: provides for shelter and medical care opportunities for homeless veterans — \$30 million authorized for fiscal 1990.

Title IX: provides for Aid to Families with Dependent Children and unemployment compensation, lifting restrictions on states' ability to use AFDC funds for temporary housing needs and funding demonstrations to divert families from welfare hotels to transitional facilities — \$20 million authorized for 1990.

The Stewart B. McKinney Homeless Assistance Act was passed to provide assistance to homeless persons with handicaps. In the act, two provisions directly addressed the needs of persons who are homeless and mentally ill: the Mental Health Services for the Homeless Block Grant (section 611) and the Community Mental Health Services Demonstration Program (section 612, as amended by section 621). Recent amendments created PATH (Programs to Aid in the Transition from Homelessness) to supplant the MHSH Block Grant in 1991. In addition, the provisions of Title I through Title IX of the act address in part the needs of the population. While each of the New England states has applied for and received varying awards of funds from these programs, only the MHSH Block Grant, succeeded by the PATH Program, provide guaranteed funding to the states for the target population.

The Mental Health Services Block Grant provided funds to each of the states and territories to implement services designed to relieve the dual conditions of homelessness and mental illness that affect the target population of the legislation. In 1989, \$14.128 million was allocated to this program. In contrast to the prior year, in which states received grants of varying size according to a formula based on a combined 1987/1988 fiscal year appropriation of \$43.689 million, the 1989 grants were set at \$267,944 for each of the fifty states, the District of Columbia, and Puerto Rico

and \$48,717 for the four territories (Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands).¹³

In order to receive MSHH Block Grant Funds, states and territories were required to submit an application to the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) describing high-need geographic areas and services to be provided. All applicants had to execute an agreement assuring compliance with the provisions of the act, including, (1) an agreement that funds would be spent only for the statutory purposes; (2) an agreement to match federal funds with state or local funds at a rate of \$1.00 to \$3.00; and (3) an agreement not to expend McKinney funds on property costs, inpatient costs, and cash payments to service recipients.

States were required to provide services from among six essential categories to persons who were severely mentally ill and homeless or significantly at risk of becoming homeless. Under the provisions (section 524) of the McKinney Act, these included

- outreach services
- community mental health services, diagnostic, crisis intervention, habilitation and rehabilitation services
- referral to medical facilities for inpatient services, and to provider entities for primary health and substance-abuse services
- training to service providers at sites serving homeless people
- case management services, including service planning, service coordination, benefits assistance, service referral, and representative payee services
- supportive and supervisory services in residential settings.

Finally, using a voluntarily agreed-upon uniform format, states were required to report annually on the purpose and amount of expenditures.

In the main, states utilized a range of criteria to distribute MSHH funds. These included:

- Population density: states often referenced population density as the key criterion utilized in evaluating proposals for MSHH Block Grant funds. Others reported equity in allocations to urban areas as their guiding principle, in some cases reserving a small amount to distribute to other areas.
- High-needs target areas: several states, for example, Massachusetts, structured the selection criteria around the results of their survey analyses and needs assessments. Only applications from the highest-ranked need areas, those with the highest percentage of citizens in poverty or with housing problems, were funded. A few states required applicants to demonstrate need and awarded funds according to the ranked percentage of the state's homeless and/or chronically mentally ill population.

- **Qualified agency type:** in other states, the key selection criterion was the type of agency applying for funds. Often, only community mental health centers or state and county mental health entities qualified as applicants. Connecticut and New Hampshire are examples of this practice. Entities in several cases were required to meet the states' community mental health program standards to qualify.
- **Formal review and award criteria:** in a few cases, states awarded funds based on a competitive-bid process, accompanied by a committee review structure utilizing clearly defined award criteria, which included the factors listed above. Review committees were in some cases the State Mental Health Planning Council, in others a specially constituted body of planners and advocates working as part of a state or county homeless task force.
Vermont's process was unique in both its carefully drawn selection criteria and its review group composition. The review group included homeless advocates, providers, and mental health consumers.
- **Other criteria:** other factors utilized by states in the selection process included designation of target service areas; identification of service gaps; previously neglected areas; local availability of housing; proximity to the state hospital; willingness to serve persons with severe mental illness; experience with serving homeless persons; utilization of research data; and ability to collect data. Rhode Island and Maine are examples of this multiple-factors approach.

A diverse array of agencies received McKinney MSHS grant moneys; at least two dozen distinct agency types were reported across the states. The most frequently cited type was a nonprofit outpatient mental health center. The majority of states chose to develop the capability to serve homeless persons within the mental health system as opposed to the generic human service system.

The range of agencies receiving funding included

- **mental health entities:** community service boards, community mental health centers, psychosocial rehabilitation centers, and psychiatric day centers
- **government structures:** a state department of human resources and counties
- **homeless service agencies:** drop-in centers, day shelters, multiservice centers, shelters, Salvation Army, and Travelers Aid Society
- **crisis services:** help hotlines and crisis units
- **health care organizations:** RWJ Healthcare for the Homeless programs, community health centers, a downtown clinic, general hospital, and mobile medical units
- **housing programs:** a neighborhood development agency, transitional living center, and mental health residential programs

- consumer/family organizations: mental health consumer-operated drop-in center and affiliates of the National Alliance for the Mentally Ill.¹⁴

Within New England, New Hampshire is representative of states exclusively funding their community mental health centers. Vermont is representative of a more diverse approach to funding mental health, shelter, community action, housing, and consumer organizations.

The MSHH Block Grant funds have provided states with the opportunity to develop and expand innovative service delivery strategies and improve the lives of homeless and severely mentally ill persons. Some examples cited in the state reports serve to illustrate the magnitude of this impact. Connecticut, for example, noted that prior to the 1989 MSHH Block Grant project, only sixteen of the twenty-two areas in the state designated as the areas of highest need were offering services dedicated specifically to homeless persons with serious mental illness. The 1989 allocation allowed the state to expand services into three areas (encompassing forty-four cities and towns) which previously had no such specialized services.

Other examples of MSHH-funded activities in New England include:

- New Hampshire funded outreach workers in each of its mental health regions. Workers either traveled with a mobile treatment team or were based at a shelter or soup kitchen. They provided a full range of services.
- Rhode Island established a drop-in center offering screening, referral, educational services, and job counseling.
- Rhode Island established a mobile mental health treatment team to provide outreach, mental health services, diagnosis, crisis intervention, case management, and supportive residential services on site wherever homeless persons were contacted.
- Maine established two outreach programs to serve homeless youth. One street outreach worker was based at a group home and the other was based at a counseling program.
- Massachusetts established case management services, assigned to the shelters in its major urban area, Boston, charged with integrating homeless and mentally ill persons into the local mental health system.

A number of state reports provided quantitative evaluation data on the success of programs. Rhode Island, for example, cited the results of an evaluation of its mobile treatment team conducted by the Psychiatric Research and Training Center, a unit of the Division of Mental Health. This longitudinal study of thirty-three dually diagnosed homeless individuals documented success in several areas, including improved housing stability, a 66 percent decrease in contacts with the criminal justice system, a 50 percent reduction in crisis contacts, a 60 percent reduction in hospital admissions, and a 75 percent reduction in the use of detoxification services.

In addition to these notable successes, the reports also document continuing problems and frustrations that plague those attempting to serve this extremely vul-

nerable population. Some states noted that their efforts to evaluate program performance were hampered by the lack of a statewide client-tracking system. This made it difficult to arrive at unduplicated counts of clients served and to document more than the most rudimentary demographic and clinical data on clients. In addition, the nature of service delivery to homeless mentally ill clients, occurring as it often does on the street, in alleys, or in congested shelters, makes it difficult to collect data in any systematic fashion.

Several states also noted that the co-occurrence of psychiatric and substance-abuse disorders presents an extraordinary challenge to service providers. Information in these reports, as well as elsewhere in the literature, suggests that this is a problem of substantial proportions.

States also reported that transitioning clients from homeless team caseloads to mainstream mental health agency caseloads were complicated by limitations in service capacity and the philosophical orientations of more traditional service providers. Similarly, transitions from shelters to housing and from transitional to permanent housing were complicated by a lack of available housing and delays in housing development. These gaps and delays thwarted efforts of homeless program staff to provide effectively for the needs of their clients and increased stress and mistrust among a client population that was difficult to engage.

The McKinney legislation and the resources that were provided to the states through the MSHH Block Grants are important in several ways.

- They have focused awareness on the population of persons who are homeless and mentally ill and provided a template, based on NIMH research findings, for the services needed by this population.
- The legislation has encouraged states to assume responsibility for working with locations to fill gaps in the existing service system.
- The requirement of a match has helped states to leverage state and local funds to assist this population.
- As more and more state economies constrict, this federal assistance assumes greater importance.

The state reports on the 1989 MSHH Block Grant Program provide ample evidence of innovative and creative uses of federal assistance in designing and providing services to homeless persons with serious and persistent mental illness. As a result of this funding, many states were able to develop new services and expand existing services to previously unserved or underserved areas and populations.

In addition, these resources allowed states to increase coordination of services at both the client and system level. States brought together numerous interests, including local advocacy agencies, other agencies of local and state government, and local agencies. Several states also involved consumers in service delivery and oversight roles.

The importance of other federal grant programs was evident in the states' reports of their needs assessment activities. In determining local need, many states relied heavily on data from the NIMH Community Support Program Homeless Demon-

stration grants, the NIMH McKinney Homeless Demonstration grants, the State Mental Health Planning (PL 99-660) grants, and the HUD Comprehensive Homeless Assistance Plans.

States used the federal MSHH Block Grant funds to develop or expand a wide array of services, all aimed at homeless persons with severe mental illness. Funded programs were most frequently embedded within the mental health system, as opposed to the generic human service system providing assistance to homeless persons. Providers concentrated most often on outreach, case management, and referral. Few states provided quantitative data on the effectiveness of the services funded with MSHH money. However, states that conducted formal evaluation were able to document considerable success in the areas of housing stability, hospitalization rates, use of crisis services, use of detoxification services, and integration of clients into the permanent mental health service system.

Several states noted that their monitoring and reporting efforts were hampered by underdeveloped client-tracking systems. The NIMH Mental Health Statistics Improvement Program was developed in recognition of this deficit and the work currently being conducted under this program should assist states considerably in the development of useful systems.

In summary, the federal MSHH Block Grant Program was an important resource for states as they attempted to meet the needs of homeless adults with severe mental illness. It is anticipated that the new Projects for Assistance in Transition from Homelessness (PATH) formula grant program will provide states with increased opportunities to use federal allocations to develop housing and residential services and to develop stronger linkages among treatment, housing, and support services for this population. While annual reports are not due, preliminary reports from the New England states indicate that this is the case. Examples of PATH support activities are as follows.

Connecticut identifies 18,450 persons in the state as homeless. The state estimates that 8 percent to 35 percent of homeless persons are in need of some type of mental health services. PATH funds recently allocated to Connecticut's five mental health regions based on a state allotment formula were then distributed to local mental health agencies. McKinney funds have stimulated the development of a variety of services targeted to homeless and mentally ill persons, including a drop-in center providing outreach, treatment, and referral; an outreach team to streets and shelter; mobile community support to local housing; and case management services to previously unserved persons.

Massachusetts undertook a comprehensive needs assessment of its homeless population, conducted through the Bureau of Census, Shelter and Street Night Operation, in March 1990 and supplemented in February 1991. It identified 6,800 adults who are homeless on a given evening. Of these, 2,500 reside in Greater Boston. Three thousand are single persons, 9 percent of whom have a serious mental illness and 12 percent of whom have a co-occurrence of mental illness and substance-abuse problems.

Based on the survey information, Massachusetts designated the PATH Grant to fund fifteen full-time equivalent (FTE) master-level clinicians to provide outreach, treatment, and support to the major shelters in Massachusetts. An additional 2.5 FTE housing advocates would be funded to identify and access housing support. Massachusetts provides outreach and case management services to sixty-one

shelters, offers four training sessions to shelter staff, and has a goal to place 50 percent of identified homeless clients with serious mental illness in affordable housing and secure income support for 70 percent of them.

Maine estimates that it has 350 to 450 homeless persons, of whom 117 to 150 have serious mental illness. The annualized number of homeless is ten times this figure. In addition, the state has 52,000 adults and 3,000 children who are at risk of becoming homeless, according to the study of the Maine Task Force to Study Homelessness.

Maine uses PATH funds to provide outreach and case management programs in six of its seven regions. All services are delivered through private mental health agencies, usually community mental health centers and specialized adolescent programs with experience in serving mentally ill youth with substance-abuse problems. Adult services focus on outreach and case finding to most of the major shelters in the state, case management for identified clients, and training for shelter staff. Children's services involve outreach to adolescent agencies and specialized children's shelters.

The state expects to engage a significant portion of these in mental health services, with a limited number being placed in stable housing. Services provided include street outreach, home-based counseling, and group residences for youth; case management, benefits advocacy, and residential support to adults; and training and technical assistance to shelter providers.

New Hampshire identified 14,415 homeless persons who were served in 1988. New Hampshire uses PATH moneys to support existing (MHS) case manager and homelessness coordinator positions at each of its ten regional community mental health centers. It provides assertive case management in three regions and supports continuous treatment teams at seven regional CMHCs. The teams offer community mental health services, habilitation and rehabilitation, referrals, and training. All the centers also provide substance-abuse services in their respective regions. New Hampshire is distinguished in its work with individuals with co-occurring mental illness and substance-abuse problems.

The homeless coordinators provide linkages to housing agencies, shelters, and the general public on homelessness issues. Each is also the contact person within the agency to coordinate mental health support to individuals in shelters, through referral to other center clinical staff. New Hampshire emphasizes that services to homeless persons are a high priority and that there is coordination of services through the New Hampshire Task Force of Homelessness, as well as through ongoing communication between the State Office of Alcohol Abuse and Drug Prevention and the Division of Mental Health and Disability Services.

Rhode Island statistics indicate that 18 percent of Rhode Island's homeless citizens have a serious mental illness and 10 percent have a co-occurrence of mental illness and substance abuse. Rhode Island funds CMHCs in three counties, using five nonprofit agencies to deliver services. In Providence it funds a drop-in center at the Travelers Aid Society that serves 2,000 homeless persons annually and an outreach team from the Providence Mental Health Center that generates a similar number of contacts. In Newport it funds the CMHC's mobile treatment team, as well as support services at a transitional shelter and drop-in center. Mobile treatment teams from the Kent County and northern Rhode Island community mental health centers are also supported with PATH resources.

The Providence and Newport programs provide outreach, case management, community mental health services, and substance-abuse treatment to persons who are actually homeless. Similar services are offered in Kent County and northern Rhode Island to individuals who are at risk of becoming homeless. Rhode Island's CMHCs are licensed providers of substance-abuse services and therefore have the capacity to ensure integrated services to homeless persons with a co-occurrence of mental illness and substance abuse.

Vermont estimates that there are approximately 700 homeless and mentally ill citizens it targets for service through McKinney funds. PATH funds are contracted to six areas of the state. The types of agencies funded range from consumer-directed drop-in centers to community mental health centers to neighborhood development organizations. Each provider is required to target individuals unserved by mainstream mental health agencies, to provide services in clients' natural settings, and to meet the full range of needs, including housing and support services. Although the majority of programs focus on adults, one agency targets children and youth. Vermont is distinguished in the application of its nationally recognized supported housing model to meeting the needs of homeless persons.

In summary, the Stewart B. McKinney Homeless Assistance Act and the recent PATH provisions offer opportunities for the states to address the needs of homeless citizens across the nation. While the funds available are insufficient to cover the majority of costs associated with services to homeless persons, states report their value in targeting high-need areas, supporting demonstrations of service innovations, creating incentives for state and local matching funds, and focusing on vulnerable subpopulations of homeless persons like those with severe mental illness. Of particular value in the effort to serve homeless individuals with mental illness are the recent McKinney Act provisions designed to foster cooperation between the homeless provider network and mainstream mental health agencies, integration of health care and mental health care to homeless persons, coordination of mental health and substance-abuse services to those with co-occurring disorders, and joint funding of NIMH service demonstrations to complement HUD-supported housing initiatives.

States' advocates credit the McKinney Act mental health programs for stimulating localities' interest in and ability to attract HUD funding for housing special needs persons among those homeless. The interplay of multiple federal programs, state dollars, and private matching funds within local service organizations has produced innovation, filled gaps in the continuum of care, and supported alternative service approaches more effective in meeting the needs of those homeless and mentally ill persons who have been disconnected from traditional mental health services. In most jurisdictions, McKinney funds have provided the support needed for surveys to identify the scope of the problem of homelessness among mentally ill persons. While resources remain woefully inadequate to meet the need, within the contrary New England economic context, the federal contribution is an important resource and stimulus to state spending. 🐼

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