SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-000728-09T3

ADVANCE HOUSING INC., AND ADVANCE HOUSING 2000, Plaintiffs-Appellants, v. TOWNSHIP OF TEANECK, BOROUGH OF BERGENFIELD, BOROUGH OF LITTLE FERRY, BOROUGH OF RAMSEY, BOROUGH OF RIDGEFIELD PARK, BOROUGH OF LODI, BOROUGH OF FAIRVIEW, BOROUGH OF LEONIA,AND CITY OF HACKENSACK, Defendants-Appellees	**CIVIL ACTION** **ON APPEAL FROM:** The Tax Court of New Jersey Docket Nos. 4767-02, 4769-02, 4770-02, 5241-03, 5242-03, 7285-04, 7292-04, 7294-04, 4758-02, 5232-03, 6391-04, 4771-02, 5229-03, 6399-04, 4772-02, 5240-03, 6400-04, 4762-02, 5231-03, 7297-04, 5234-03, 6389-04, 4760-02, 5230-03, 6393-04, 4763-02, 4764-02, 4765-02, 4766-02, 5235-03, 5236-03, 5237-03, 5238-03, 6394-04, 6395-04, 6396-04, 6397-04 Sat Below: Hon. Peter D. Pizzuto, J.T.C.

JOINT BRIEF AND APPENDIX OF AMICI CURIAE THE JUDGE DAVID L. BAZELON CENTER, et al.

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

RULES

REGULATIONS

OTHER AUTHORITIES

On behalf of millions of individuals with disabilities and hundreds of organizations that represent them, this broad range of national and New Jersey based non-profit entities -- the Judge David L. Bazelon Center for Mental Health Law (the "Bazelon Center"), Disability Rights New Jersey ("DRNJ"), the New Jersey Department of the Public Advocate (the "Public Advocate"), the Alliance for the Betterment of Citizens with Disabilities, the American Association of People with Disabilities, Mental Health America, Mental Health Association in New Jersey, the National Alliance on Mental Illness, the National Alliance on Mental Illness of New Jersey, the Supportive Housing Association of New Jersey -- respectfully submit this joint brief pursuant to Rule 1:13-9 as amici curiae[1] to address the Tax Court's denial of a tax exemption under N.J.S.A. 54:4-3.6 to Advance Housing, Inc., and its subsidiary Advance Housing 2000, Inc. (collectively "Advance Housing") a non-profit "supportive housing" agency.

INTEREST OF THE AMICI CURIAE

The Tax Court's decision would devastate the ability of mental health professionals to treat and house people with mental disabilities using the most efficient and successful approach: the housing first supportive housing model. Because of the broad impact of the decision below, this group of amici,

[1] The Bazelon Center and the Public Advocate were granted leave to appear as amici curiae on February 8, 2010. A true and correct copy of the order granting the Bazelon Center and the Public Advocate leave to appear as amici curiae is included in the attached Appendix as Aa1.

have joined together to support the present appeal, Advance Housing, Inc., et al. v. the Township of Teaneck, et al.

The Amici have a significant interest in this matter based on their respective experiences in New Jersey and across the nation advocating for the rights of individuals with mental disabilities to live in the most integrated setting in the community. Due to their extensive knowledge of supportive housing, the Amici have advocated compellingly for expansion of the supportive housing model at issue in the present matter as the most effective model for providing housing and treating individuals with mental disabilities.

Through their work, the Amici are well aware that supportive housing has significantly better treatment outcomes than the older models of community-based treatment and that the Tax Court's decision, if left intact, would effectively preclude the most effective and successful approach. Supportive housing results in lower rehospitalization rates, greater housing and treatment stability, and better employment outcomes. It also affords greater dignity, choice and independence to individuals with disabilities. Amici's work has also confirmed that supportive housing is less expensive for government entities to develop. For these reasons, the State of New Jersey and the federal government have actively promoted supportive housing. Through their legal advocacy, Amici have helped enforce the federal law that requires public entities to administer their services to individuals with disabilities in the most integrated setting appropriate to their needs; in most cases, as the

outcomes of several recent court cases have confirmed, that setting is supportive housing. See, e.g., Disability Advocates Inc. v. Paterson, 653 F. Supp. 2d 184, 218-28(E.D.N.Y. 2009)

IDENTITY OF THE AMICI CURIAE

A. The Bazelon Center

The Bazelon Center was founded in 1972 as the Mental Health Law Project. The Bazelon Center is a national nonprofit advocacy organization that provides legal assistance to individuals with mental illness and mental retardation. The mission of the Bazelon Center is to protect and advance the rights of adults and children who have mental disabilities. The Center envisions an America where people who have mental illnesses or developmental disabilities exercise their own life choices and have access to the resources that enable them to participate fully in their communities. Through litigation, policy advocacy, training and education, Bazelon promotes the rights of individuals with mental disabilities to participate equally in society, including the rights to safe, affordable, and suitable housing.

B. Disability Rights New Jersey

Disability Rights New Jersey, Inc. ("DRNJ") is a private, non-profit, consumer-directed corporation that serves to further New Jersey's protection and advocacy system for people with disabilities.[2] DRNJ is responsible for protecting

[2] DRNJ was previously organized under the name New Jersey Protection and Advocacy, Inc.(NJP&A). It adopted the DRNJ name in 2008.

and advocating for the human, civil and legal rights of persons with disabilities under the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C.A. §§ 15041 to 15045; the Protection and Advocacy System for Individuals with Mental Illness Act, 42 U.S.C.A. § 10801 to 10851; and the Vocational Rehabilitation Act of 1973, as amended, 29 U.S.C.A. § 732 (Client Assistance Program) and § 794e (Protection and Advocacy of Individual Rights Program) and 29 U.S.C.A. § 2201 et seq. (Technology Assistive Resource Program).

The Bazelon Center and DRNJ are counsel in a case on behalf of almost 1,000 people who have remained warehoused in New Jersey state psychiatric hospitals because supportive housing and other community services are not sufficiently available. The case resulted in a July 2009 settlement with the State of New Jersey under which the State is required to create over 1,000 new units of housing embodying the key principles of supportive housing. See DRNJ vs. Velez, No. 05-civ-1784 (FLW) (D.N.J.), [Dkt. 69] settlement agreement dated July 29, 2009.

C. The Public Advocate

The New Jersey Department of the Public Advocate was reconstituted on January 17, 2006, in recognition of the fact that "[t]here is a great need for consumer protection and advocacy on behalf of the indigent, the elderly, children, and other persons unable to protect themselves as individuals or a class." N.J.S.A. 52:27EE-2(a). On reconstituting the Department, the Legislature created a Division of Mental Health Advocacy with the Department, in order to: "promote, advocate,

and ensure the adequacy of the care received, and the quality of life experienced, by persons with mental illness, including patients, residents, and clients within the mental health facilities and programs operated, funded, or licensed by the State." N.J.S.A. 52:27EE-30(a).

The Legislature has charged the Division with providing "such legal representation and medical consultation as the director deems appropriate for any indigent mental hospital admittee in any proceeding concerning the admittee's admission to, and retention in, or release from confinement in such hospital, institution or facility," thereby transferring this constitutionally mandated civil commitment representation from the Public Defender's Office to the Department. N.J.S.A. 52:27EE-37. In order to carry out its broad advocacy duties, the Department is specifically instructed to represent "the interest of indigent mental health hospital admitees in such disputes and litigation as will, in the discretion of the Public Advocate, best advance the interests of indigent mental hospital admitees with any principal department or other instrumentality of State, county or local government." N.J.S.A. 52:27EE-31.

D. Alliance For The Betterment Of Citizens With Disabilities

The Alliance for the Betterment of Citizens with Disabilities ("ABCD") is dedicated to improving the lives of people with complex physical and neurological developmental disabilities so that they may have the opportunity to attain the highest level of purpose and dignity. ABCD represents member

agencies that provide a broad array of community-based services to approximately 10,000 people with developmental disabilities and their families statewide. ABCD includes among its priorities leadership activities in Medicaid, community services, education, affordable and accessible housing, and Early Intervention issues.

E. American Association of People with Disabilities

With over 100,000 members, the American Association of People with Disabilities (AAPD) is the largest national nonprofit cross-disability member organization, dedicated to ensuring political empowerment and economic self-sufficiency for the more than 50 million Americans with disabilities.

F. Mental Health America

Mental Health America (MHA), formerly the National Mental Health Association, is a national membership organization consisting of individuals with mental illnesses and their family members. It is the country's oldest and largest nonprofit mental health organization. MHA has over 320 affiliates who are dedicated to improving the mental health of all Americans, especially the 54 million people who have severe mental disorders. Through advocacy, education, research, and service, MHA helps to ensure that people with mental illness are accorded respect, dignity, and the opportunity to achieve their full potential.

G. Mental Health Association In New Jersey

The Mental Health Association in New Jersey ("MHANJ") strives for mental health for children and adults through

advocacy, education, training, and services. Since 1948, MHANJ has worked to fulfill its mission by responding to issues and concerns raised by consumers of mental health services and suggesting changes and promoting policies that protect their rights, as well as fight the stigma that surrounds mental illness and makes recovery difficult. MHANJ has taken a leadership role in promoting supportive housing policies, a vibrant consumer movement, and a paradigm of wellness and recovery.

H. The National Alliance Of Mental Illness

The National Alliance of Mental Illness ("NAMI') is the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. Founded in 1979, NAMI has over 1100 state and local affiliates that engage in research, education, support and advocacy. A vital part of NAMI's mission is to promote and advocate for access to treatment and services, including supportive housing, that foster recovery and enable individuals living with mental illnesses to achieve the highest possible level of functional independence and productivity in the community.

I. National Alliance on Mental Illness of New Jersey

The National Alliance on Mental Illness of New Jersey ("NAMI NEW JERSEY") is a statewide non-profit organization dedicated to improving the lives of individuals and families who are affected by mental illness. NAMI NEW JERSEY provides education, support, and systems advocacy to empower families and

persons with mental illness. Affiliate self-help and grassroots advocacy groups located in each county offer emotional support and information about treatment and community resources.

J. Supportive Housing Association of New Jersey

The Supportive Housing Association of New Jersey ("SHA") is a statewide, nonprofit organization whose mission is to promote and maintain a strong supportive housing industry in New Jersey serving persons with special needs through strengthening the capacity of member organizations to provide supportive housing services through information, training, and collaboration, promoting systems changes to provide more flexible funding and increased mainstream housing opportunities, educating policy makers, elected officials, and the public on the use and benefits of the supportive housing model. SHA's 80 members include developers of supportive housing for people with special need, providers of residential support services for persons with disabilities, and advocacy organizations.

PRELIMINARY STATEMENT

The Tax Court's denial of the tax exemption to Advance Housing's supportive housing units was based on a fundamental misunderstanding of this well established model of housing and treating people with mental disabilities. In its bench opinion, the court erroneously held that the housing did not qualify for a tax exemption under N.J.S.A. 54:4-3.6 because it was "essentially a subsidized housing program for clients who happen to be eligible for the supportive and counseling services." 4T, P9, lines 19-25. In reaching this conclusion, the court wrongly held that Advanced Housing essentially offered two separate programs, one for housing and one for treatment, and that the housing was not sufficiently linked with the participation in the treatment programs to qualify for the tax exemption. 4T, P9 lines 1-15. A proper understanding of supportive housing and its key elements makes clear that the court's reasoning was incorrect and the decision below should be reversed for the following reasons.

First, contrary to the Tax Court's findings, it is precisely this combination of affordable, lease-based permanent housing linked with flexible support services that characterizes supportive housing and contributes so greatly to its success. The supportive housing model at issue in this appeal, known as the "Housing First" model, in which housing is offered first and is not contingent on the acceptance of treatment services - is well established, and in most cases the most effective modality

for treating and housing individuals with psychiatric disabilities.

The State of New Jersey, several agencies of the federal government, including the Department of Health and Human Services (HHS), the Department of Housing and Urban Development ("HUD"), United States Surgeon General, and the National Council on Disability (NCD), as well as numerous health professionals and organizations nationwide also trumpet the Housing First model as a necessary replacement for institutional and congregate housing programs precisely because this model is founded on the principle that stable housing is an essential element of treatment and recovery.

In accord with this fundamental principle of supportive housing, New Jersey state regulations and federal guidelines explicitly prohibit supportive housing providers from requiring participants to accept treatment as a prerequisite to receiving housing. As demonstrated by numerous studies, the voluntary nature of the treatment is a tool employed to *increase* participation in the treatment services and clearly not something that decreases treatment. Older types of programs, such as group homes, that mandate treatment have been found to be largely ineffective in treating people with mental disabilities. The Tax Court's decision effectively deems the less effective model worthy of the tax exemption under N.J.S.A. 54:4-3.6, while denying an exemption to the more effective, efficient, and professionally recommended model. The Tax Court's decision turns the findings of mental health

professionals, the State government, and the federal government on their head by requiring residency to be contingent on acceptance of treatment services.

Second, failure to reverse the decision below will impair supportive housing programs across the State and undermine the continued viability of a major state mental health policy initiative. Under the court's reasoning, the entire Housing First model would fail to meet the charitable exemption. Significantly, the likely result of affirming the Tax Court's decision will be the closing of many of these vital programs. Such a result will seriously diminish the State's efforts to deinstitutionalize individuals and enable them to live in the most integrated setting appropriate, as required by the Supreme Court in Olmstead v. L.C., 527 U.S. 581, 119 S.Ct. 2176, 144 L. Ed. 2d 540 (1999).

Finally, the Tax Court's analysis went further astray by assuming that the housing at issue was a "burden" on the government and taxpayers. As demonstrated below, rather than being a burden, supportive housing programs are actually the most cost effective means of housing individuals with mental disabilities and in fact save taxpayers and all levels of government money, thereby relieving a significant public expense.

For these reasons, and the reasons set forth more fully below, the Amici respectfully submit that the Tax Court's decision be reversed and the Court find that the subject property is entitled to a tax exemption under N.J.S.A. 54:4-3.6.

PROCEDURAL HISTORY

The Amici adopt and incorporate by reference the Procedural History section set forth in the Brief for the Appellants.

STATEMENT OF FACTS

The Amici adopt and incorporate by reference the Statement of Facts section set forth in the Brief for the Appellants.

ARGUMENT

I. SUPPORTIVE HOUSING USING THE HOUSING FIRST MODEL IS THE MOST EFFECTIVE METHOD OF HOUSING AND TREATING INDIVIDUALS WITH MENTAL DISABILITIES

A. Elements and Principles of Supportive Housing

In finding that the housing provided was not integrated with the treatment services and therefore not entitled to an exemption, the Tax Court failed to understand the essence of supportive housing and failed to appreciate the development of mental health treatment services and housing over the past forty (40) years. Indeed, as the evolution of this modality demonstrates, critical to the success of supportive housing is the fact that housing is coupled with voluntary treatment services; the model simply does not succeed if the two are separated.

Three basic principles guide supportive housing. First, supportive housing gives participants' immediate, permanent housing in their own apartments or homes. Supportive housing provides housing first, allowing participants

the opportunity to focus on recovery next. Adequate, stable housing is a prerequisite for improved functioning for people with mental disabilities and a powerful motivator for people to seek and sustain treatment.[3] Studies find that providing immediate, permanent housing leads to more long-term housing stability when compared to housing conditioned on treatment.[4]

Supportive housing participants have the same rights and responsibilities as any other tenant. They may lose their unit, for example, for disruptive behavior or drug use.[5] Supportive housing staff, however, is able to avoid this situation by providing supports and the accommodations necessary to help ensure successful tenancy. Indeed, Advance Housing has never had to evict a tenant. Pb22.

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[3] See Sam Tsemberis et al., Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis, 94.4 Am. J. of Public Health, 655 (2004).

[4] Sam Tsemberis & Ronda F. Eisenberg, Pathways to Housing: Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities, 51.4 Psychiatric Services, 487 (2000); Martha R. Burt & Jacquelyn Anderson, AB2034 Program Experiences in Housing Homeless People with Serious Mental Illness, 3 (2005),available at http://www.csh.org/index.cfm/?fuseaction=Page.viewPage&pageID=3621.

[5] Appellees cite the fact that Advance Housing can evict a tenant for non-payment of rent in support of their argument that housing is separate from services. In so doing, Appellees fail to understand that one of the therapeutic principles of supportive housing underlying its success is that participants must be afforded the same rights *and responsibilities* as other tenants, including the obligation to pay rent on time and abide by other provisions of the standard lease. By treating participants like "normal" people who rent homes, supportive housing programs help instill the motivation to succeed in the community.

As a second key element of the model, individuals in supportive housing have access to a comprehensive array of services and supports, from crisis mental health services to cooking tutors. Available services and supports include mental health and substance abuse treatment and independent living services, including help in learning how to maintain a home and manage money as well as training in the social skills necessary to get along with others in the community. Medication management, crisis intervention and case management are also available. For individuals who are unable to do certain tasks, such as cooking and cleaning on their own, personal care and/or home-care services are provided until no longer needed.

Services are provided as needed to ensure successful tenancy and to support the person's recovery and engagement in community life. Services and supports are provided in the home and other natural settings, allowing individuals to learn and practice skills in the actual environment where they will be using them.[6] Services are available whenever people need them, including after working hours and on weekends when necessary. Service providers are highly flexible and supports are highly individualized. A creative "whatever it takes" approach is pursued. Over time, individuals in supportive housing typically require a lesser intensity of services as they learn or regain independent living skills. "Program" attendance is not required and services are increased, tapered or discontinued as decided

[6] Tsemberis, supra note 4, at 488-89.

by the individual in consultation with the provider. Treatment compliance or sobriety is not a requirement for receiving or remaining in housing.[7] As a result, individuals "buy in" to the treatment plan – the most important predictor of plan success.[8]

As its third key element, supportive housing facilitates full integration into the community. Individuals are encouraged to integrate into the community through employment, volunteer work and social activities. People are encouraged to participate in neighborhood activities or become members of community organizations of their choosing. Vocational training, training in managing symptoms in the workplace and conflict-management skills are available to those ready to seek employment. Moreover, unlike the case with traditional disability housing, supportive housing participants do not live and interact only with other mental health clients; nor are they in an identifiable mental health program.[9]

Supportive housing is effective for various reasons. First, housing is a key aspect of well-being and recovery.[10]

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[7] The strict admission criteria and program rules of traditional mental health housing often deny housing to those most in need. See Pathways to Housing, Inc., Providing Housing First and Recovery Services for Homeless Adults with Severe Mental Illness, 56.10 Psychiatric Services, 1303 (2005).

[8] Id.; Geoffrey Nelson et al., Shifting the Paradigm in Community Mental Health: Toward Empowerment and Community, 160 (Univ. of Toronto Press)(2001).

[9] Nat'l Council on Disability, Inclusive Livable Communities for People with Psychiatric Disabilities, 22-23 (2008), available at http://www.ncd.gov/newsroom/publications/index.htm.

[10] Id.

People with mental disabilities cannot be expected to succeed without a safe, secure home, particularly if they are struggling to recover from a mental illness.[11] Moreover, stable housing can act as a motivator for people to seek services and supports and to engage in and sustain treatment.[12]

A second key to its success lies in the fact that supportive housing is built around individuals' preferences and strengths. Client-driven planning provides an opportunity for individuals to gain control over their lives and determine their own path of recovery. Supportive housing participants are involved in the process of choosing their housing unit, rather than unilaterally being placed in a residence.[13] The services offered are highly flexible and individualized to meet the participant's needs and preferences, rather than defined by a "program." Residents are not required to participate in specific programs, but instead are able to choose whether and what services they need. Research shows that greater choice of residence not only correlates positively with consumer satisfaction but also is a significant predictor of housing

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[11] Id.

[12] Tsemberis, supra note 3, at 655.

[13] The federal government has recognized the importance of consumer choice in housing and the role of housing in promoting recovery. U.S. Substance Abuse & Mental Health Services Admin., Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders (2003), available at http://mentalhealth. samhsa. gov/publications/allpubs/sma04-3870/Chapter6.asp#C6TocEvidence.

stability.[14] Research also establishes that consumer choice and buy-in to service plans is a great predictor of success. A "good" plan that a consumer is forced to accept as a prerequisite for housing is not likely to work.[15]

Supportive housing takes advantage of the clear preferences of people with mental disabilities about how they want to live. Studies show that consumers prefer living in their own homes, either alone or with one or two roommates, rather than in congregate settings with many other people with mental disabilities, particularly when they receive supports to help them engage socially in their own communities.[16] "They want to be able to choose, among other things, the type of housing in which they live, the neighborhood, with whom they live (if they choose not to live alone), what and when to eat, whether or not to participate in mental health services (and, if they want services, to choose the ones they want) and how to schedule their days."[17] Hence, it is no surprise that study after study

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[14] Debra Srebnik et al., Housing Choice and Community Success for Individuals with Serious and Persistent Mental Illness, 31.2 Cmty. Mental Health J. 139(1995).

[15] Tsemberis, supra note 3, at 651; Nelson, supra note 8, at 160; CSH, Supportive Housing Research FAQs: Do Voluntary Services Work?, available at http://documents.csh.org/documents/policy/FAQs/VoluntaryServicesFAQFINAL.pdf.

[16] Susan Yeich et al., The Case for a "Supported Housing" Approach: A Study of Consumer Housing and Support Preferences, 18.2 Psychosocial Rehabilitation J. 75-77(1994); Beth Tanzman, An Overview of Surveys of Mental Health Consumers' Preferences for Housing and Support Services, 44 Hosp. & Cmty. Psychiatry 450-55(1993); Nat'l Council on Disability, supra note 9, at 21.

[17] Nat'l Council on Disability, supra note 9, at 22-23. Of course not all people with mental disabilities prefer supportive

has found that supportive housing programs work for people with mental disabilities, even those who are hardest to serve, such as chronically homeless individuals with mental illnesses.[18] Research has shown that providing immediate, permanent housing leads to greater long-term housing stability when compared to traditional housing programs.[19] Other positive outcomes for supportive housing participants include reduced hospitalization, decreased involvement with the criminal justice system, participants' greater satisfaction with their quality of life and improvement in mental health symptoms.[20]

B. History of Supportive Housing

Supportive housing is rooted in the deinstitutionalization movement that began in the 1960's, when

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housing. Some do not. Individuals with disabilities should have choices, like everyone else, about their living options.

[18] Tsemberis, supra note 3 at 654-55. U.S Dep't of Housing & Urban Dev. Office of Policy Dev. & Research, The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness, 80-104 (2007), available at http://www.huduser.org/publications/homeless/hsgfirst.html.

[19] Tsemberis, supra note 3, at 654-55.

[20] U.S Dep't of Housing & Urban Dev., supra note 18, at 82-84. Dennis P. Culhane et al., The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York-New York Initiative, 13.1 Housing Policy Debate 137-38 (2002), available at: http://works.bepress.com/metraux/16; Nat'l Council on Disability, supra note 9, at 23; U.S. Dept. of Health & Human Services, Substance Abuse and Mental Health Services Admin. Transforming Housing for People with Psychiatric Disabilities: Report, 25 (2006), available at http://download.ncadi.samhsa.gov/ken/pdf/SMA06-4173/Housing_booklet.pdf.

mental health professionals and advocates sought to replace the reliance on state institutions with community based care. The initial outgrowths of this move away from formal institutionalization were congregate programs such as group homes, which made treatment compulsory.[21] While an improvement over prolonged psychiatric hospitalization, these earlier models came to be criticized by mental health professionals because of certain basic flaws. Much of the criticism stemmed from the requirement that acceptance of treatment was the only way to access the housing. This requirement restricted access to consumers who were initially unable or unwilling to comply with strict inflexible program terms. Many of the neediest residents were being denied housing because it was contingent on accepting treatment.[22] Because of these and other limitations, this older model failed to lead to consistent permanent independent housing for people with mental disabilities and failed to integrate them with the community.[23] See Sam Tsemberis, Ph.D., et al, Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities. See also Nat'l Council on Disability, supra note 9 ("While most people with psychiatric disabilities no longer live in large state

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[21] Nat'l Council on Disability, supra note 9, at 17-26.

[22] Tsemberis, supra note 3, at 651.

[23] Tsemberis, supra note 4, at 488. See also Nat'l Council on Disability, supra note 9, at 6 ("While most people with psychiatric disabilities no longer live in large state institutions . . . many are living in congregate housing that often does not meet their housing preferences, and they remain segregated from other people.").

institutions … many are living in congregate housing that often does not meet their housing preferences, and they remain segregated from other people.")

As a consequence of these and other flaws of the traditional group home model, supportive housing based on the Housing First principles has emerged as the most appropriate methodology for treating and housing virtually all individuals with mental disabilities. Mental health treatment providers, consumers, and advocates have found that the Housing First model possesses significant advantages over the prior modalities by placing individuals with psychiatric disabilities in independent housing that is integrated with the community and in which the resident has choice and control over the support services.

C. Promoting "Housing First" Supportive Housing is the Policy of The State of New Jersey

Consistent with the findings of mental health professionals, New Jersey has wholeheartedly "embraced [this] Supportive Housing approach" and has "endorsed [it] as an opportunity to support innovative, person-centered service provision and to champion the inclusion of consumers as full partners in treatment and recovery."[24] Thus, the State has

[24] N.J. Dep't of Human Services, Home to Recovery-CEPP Plan: Plan to Facilitate the Timely Discharges of CEPP Patients in NJ's State Psychiatric Hospitals (2008), available at http://www.state.nj.us/humanservices/dmhs/olmstead/CEPP_Plan_1_23_08_FINAL.pdf; N.J. Dep't of Human Services, Home to Recovery Supportive Housing Initiative for Consumers Discharged from State Psychiatric Hospitals RFP (2007), available at http://www.state.nj.us/humanservices/GR-RFP/DMHS_SuppHous_HospDischarge_125.doc.

adopted a policy to utilize supportive housing coupled with voluntary treatment services as the primary way to repair the damaged mental health care system in the state. Indeed, New Jersey has recognized that the provision of permanent, lease-based, affordable housing to residents with mental illness, even prior to treatment, is integral to the successful treatment of these residents.

It is the explicit policy of the State that supportive housing for people with mental disabilities should not be conditioned upon acceptance of treatment services -- the precise type of housing offered by Advanced Housing at issue below before the Tax Court. Indeed, state regulations prohibit supportive housing providers from making treatment participation a prerequisite to housing. See N.J.A.C. 10:37A, which defines "Supportive housing residence (SHR)" as one in which "[n]o lease or residential agreement shall contain the provision of mandatory mental health program participation as a requirement for the consumer resident to maintain housing."

1. The Findings of the Governor's Task Force on Mental Health

In November of 2004, then Governor Richard J. Codey created a task force to recommend specific improvements to the failing mental health system in New Jersey. The mental health task force found that New Jersey had an "over-reliance on institutional care" to serve individuals with serious mental

illness due to insufficient rehabilitative services and supported housing options to facilitate recovery and treatment.[25]

The report recommended that the public mental health system in New Jersey continue to move from an institutional based system to a community care system based upon the principles of "wellness and recovery." The report found that because "securing and maintaining permanent, affordable housing is a crucial step along the road to recovery," New Jersey needed to shift its focus to a supportive housing model -- or "Housing First."[26] The report suggested that the new model couple permanent supportive housing with vital support services to help ensure the long-term wellness and recovery of persons with mental illness.[27] The report further found that residents wanted more lease-based permanent supportive housing, with varied and flexible levels of support and did not want to live in boarding homes.[28]

The report cited the well established benefits of supportive housing:

> Support for this approach is well documented across the country in various media including Surgeon General Thatcher's report on mental illness in 1999, President Bush's

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[25] Governor's Task Force on Mental Health, New Jersey's Long and Winding Road to Treatment, Wellness and Recovery, Final Report, 5 (2005), available at http://www.state.nj.us/humanservices/dmhs/recovery/Governor_final_report.pdf.

[26] Id. at 15.

[27] Ibid.

[28] Id. at 88-89.

> Freedom Commission report, other state commissions on mental health and scholarly research. The need for quality, affordable, permanent housing, coupled with a flexible, comprehensive service delivery system yields very high consumer satisfaction, positive outcomes and significant cost savings to the tax payer. Yet, despite these findings, the State of New Jersey has yet to take advantage of these opportunities.[29]

The report further noted the success of supportive housing and the need to couple the support services with the housing, finding that "[c]onsumers are much more responsive to accepting treatment after they have housing in place [and] people with mental illnesses consistently report that they prefer an approach that focuses first on providing housing for consumers or families."[30]

As a result of the report, Governor Richard Codey issued Executive Order No. 78, mandating that the "the financing of the State of New Jersey's mental health system should be changed to promote state-of-the-art treatment alternatives. These alternatives would include, but not be limited to, *permanent supportive housing*, supportive employment, in-home services and consumer self-help."[31]

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[29] Id. at 106.

[30] Id. at 107-09.

[31] See State of New Jersey Executive Order No. 78, available at http://www.state.nj.us/humanservices/dmhs/recovery/Wellness_Recovery_transform_statemnt.pdf (emphasis added). Appellees try to diminish the significance of the Governor's Task Force Report by noting that the author of the housing section of the report was Kevin Martone, then head of Advance Housing. Appellees ignore the fact that the entire Task Force adopted the report, the Governor accepted its recommendations and ordered that they be implemented, and the State government "is currently implementing

2. The Report of the Housing Transition Policy Group Submitted to Governor-Elect Jon S. Corzine

Reinforcing the findings of the Governor's Task Force on Mental Health, the Housing Transition Policy Group to then Governor-Elect Jon Corzine recommended that the Governor adopt the Housing First model.[32] Specifically, the report recommended that the Governor "[a]dopt a Housing First Policy for those with special needs, as appropriate, to provide housing upfront and supplement housing with wrap-around services, such as substance abuse or other health care services" and to create 10,000 supportive housing units within ten years.[33] The report concluded that the "Housing First models have demonstrated that providing housing assistance, case management and supportive services responsive to individual needs is an effective way of sustaining a person's wellness [and] [c]urrent policies that require those with substance abuse or mental health conditions to complete treatment programs in order to receive housing fail to recognize the importance of stable housing to successful treatment."[34]

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the recommendations put forth in the Governor's Task Force on Mental Health final report (herein referred to as the Task Force report) issued March 2005." See N.J. Dep't of Human Services, Home to Recovery Supportive Housing Initiative for Consumers Discharged from State Psychiatric Hospitals RFP, supra note 24.

[32] See The Report of the Housing Transition Policy Group Submitted to Governor-Elect Jon S. Corzine: Final Report (2006), available at http://www.njstatelib.org/digit/r424/r4242006k.pdf.

[33] Id. at 1, 6.

[34] Id. at 7.

3. New Jersey Department of Human Services Division of Mental Health Services Home to Recovery - CEPP Plan

In light of the findings of these reports, the New Jersey Department of Human Services' Division of Mental Health Services (DMHS) has "embraced a Supportive Housing approach that incorporates a 'Housing First' philosophy in order to assist consumers with mental illness."[35] Under DMHS's policy, housing is provided upfront and is not contingent on treatment services. "It recognize[s] the importance of stable housing for successful treatment and does not require the consumer to complete treatment programs in order to receive housing."[36]

In December 2006, the Division created an Office of Housing and Community Development with the major goal of developing more supportive housing for consumers with mental illness utilizing the Housing First model - *i.e.*, providing rental housing upfront with completion of treatment, rehabilitation or other services not being conditioned on continued occupancy. According to the Division, the "strategy is twofold: *(1)* facilitating lease based housing; and *(2)* the development of new affordable housing to ensure a lasting legacy of affordable, permanent housing for very low income people with mental illness."[37]

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[35] See N.J. Dep't of Human Services, Home to Recovery-CEPP Plan, supra note 24, at 29.

[36] Ibid.

[37] Ibid.

As part of this initiative, the Division provides funding for tenant based rental assistance paired with support services. Under this program individuals pay 40% of their income and DMHS subsidizes the remainder of the rent up to the fair market rent (FMR) as set by the US Department of Housing and Urban Development (HUD) for a given county. The individuals receive assistance to find an apartment and to negotiate the lease. The Division requires that "consumers have individual leases or similar occupancy agreements [and] … support services will be available and delivered in a flexible manner according to the changing needs of the consumer." Critically, the Division requires the housing to *not* be contingent upon participation in treatment or acceptance of services.[38] See also, N.J.A.C. 10:37A-1.1 ("[n]o Lease or residential agreement shall contain the provision of mandatory mental health program participation as a requirement for the consumer resident to maintain housing").

DMHS has issued requests for proposals for supportive housing providers, proclaiming that, "The recommendations of the Task Force serve as a catalyst for the transformation of the mental health system, focusing on treatment, wellness and recovery."[39] This RFP "focuses on the Task Force's recommendation for the expansion of permanent supportive housing

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[38] Id. at 29-30.

[39] See N.J. Dep't of Human Services, Home to Recovery Supportive Housing Initiative for Consumers Discharged from State Psychiatric Hospitals RFP, supra note 24.

opportunities for mental health consumers and is consistent with the U.S. Supreme Court Olmstead decision."[40] As a reflection of the extent to which the State of New Jersey relies upon the Housing First model, the RFP requires that program performance must encompass the following values and practices:

- *consumer driven and centered*- a fully collaborative partnership that encourages growth toward independence by recognizing consumer strengths and resources and addressing consumer identified needs and priorities;
- *flexible, individualized services*- a mix of assistance, support and services provided in the individual's home, including 24/7 (evenings and weekends) on-site when needed, and 24 hour on-call rapid response; coordination with other programs (including but not limited to supported employment, self-help centers, outpatient, educational resources and partial care) to comprehensively support achievement of consumer goals;
- *outcome orientation*- service provision will result in the attainment of measurable consumer outcomes as described below.
- *team based service delivery*- a clinically enhanced residential support staff with a primary emphasis on housing retention and community integration, inclusive of specialists such as those with experience in co-occurring

[40] Ibid.

substance abuse disorders, medical disorders, or behavioral training, rehabilitation, peer support and housing.

- *personal assistance approach-* a personal assistance style with an emphasis on education and skill development in activities of daily living, volunteer or paid employment, social relationships, recreation and appropriate use of primary mental health services.
- *Integration of Wellness and Recovery approach* - knowledge and application of Evidence Based, Best and Promising Practices in mental health treatment and use of those practices or elements of those practices, including Illness Management and Recovery IMR), Supported Employment interventions, Advance Directives, Peer Support, Cognitive-behavioral techniques, Motivational Interviewing, stages of change approach to behavior change, and Wellness and Recovery Action Plans (WRAP) to facilitate engagement, competence, increased personal responsibility, establishing and using a community based support system.

D. Promoting "Housing First" Supportive Housing is the Policy of the Federal Government

In addition to the State's support, the federal government has embraced the Housing First supportive housing methodology. Specifically, such support is evident in the requirements of federal rental subsidy programs offered by the United States Department of Housing and Urban Development("HUD"), the findings of the United States Surgeon

General, and the "core" recommendations of the National Council on Disability.

1. HUD's Rental Subsidy Programs

HUD has endorsed the Housing First model in its rental subsidy programs, finding that "the Housing First programs have successfully increased housing stability for most of their clients.[41] One such HUD program - the Section 811 program - was established "to enable persons with disabilities to live with dignity and independence within their communities by expanding the supply of supportive housing that--(1) is designed to accommodate the special needs of such persons; and (2) provides supportive services that address the individual health, mental health, and other needs of such persons." 42 U.S.C.A. § 8013(a). Critically, the program requires that in order to receive funding under Section 811, the services offered with the housing must be *voluntary* and the applicant "must not require residents to accept any supportive services as a condition of occupancy or admission."[42] The funding requirements also state that: "Any prospective resident of a Section 811 project who believes

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[41] See U.S Dep't of Housing & Urban Dev. Office of Policy Dev. & Research, supra note 18, at 1.

[42] See U.S Dep't of Housing & Urban Dev., Section 811 Supportive Housing for Persons with Disabilities, available at www.hud.gov/offices/hsg/mfh/progdesc/disab811.cfm; see also, U.S. Dep't of Housing & Urban Dev., Docket No. FR-5300-N-19, Notice of Funding Availability (NOF) for Fiscal year (FY) 2009 Section 811 Housing for Persons with Disabilities (Section 811 Program), § III.C.2.b.5(b) (August 20, 2009), available at http://www.disasterhousing.gov/offices/adm/grants/nofa09/sec811sec.pdf.

he/she needs supportive services *must be given the choice* to be responsible for acquiring his/her own services or to take part in your Supportive Services Plan which must be designed to meet the individual needs of each resident."[43] (emphasis added).

2. The United States Surgeon General

The United States Surgeon General has expressed equally enthusiastic backing for supportive housing. The Surgeon General recognized that supportive housing empowers individuals by giving them the choices in treatment and housing options, noting that supported housing "moves away from 'placing' clients, grouping clients by disability, staff monopolizing decisionmaking, and use of transitional settings and standardized levels of service [and] [i]nstead, supported housing focuses on consumers having a permanent home that is integrated socially, is self-chosen, and encourages empowerment and skills development."[44]

3. The National Council on Disability

Supportive housing based on a Housing First model is also endorsed by the National Council on Disability ("NCD"), the independent federal agency established to promote policies and practices that "empower individuals with disabilities to achieve economic self-sufficiency, independent living, and inclusion and

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[43] Ibid.

[44] U.S. Surgeon General, Mental Health: A Report of the Surgeon General, Other Services and Supports, available at http://www.surgeongeneral.gov/library/mentalhealth/chapter4/sec6.html

integration into all aspects of society."[45] In furtherance of this mission, the NCD observed that "[w]hile most people with psychiatric disabilities no longer live in large state institutions ... many are living in congregate housing that often does not meet their housing preferences, and they remain segregated from other people."[46] In place of congregate housing, the NCD noted that "a 'Housing First' approach, which moves people directly from homelessness to their own apartments, is one of the most exciting developments in housing for people with mental illness."[47] Indeed, one of the "core" recommendations from the Council is to "implement changes in federal and state funding and policy to encourage housing models that are integrated, in accordance with individual choice, and delinked from mandatory health services, while providing ongoing flexible supports."[48]

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[45] Nat'l Council on Disability, supra note 9, at 74.

[46] Id. at 6.

[47] Ibid.

[48] Id. at 8; see also Nat'l Council on Disability, The State of Housing in America in the 21st Century: A Disability Perspective, Nat'l Council on Disability, 310 (2010), available at http://www.ncd.gov/newsroom/publications/2010/NCD_Housing_Report508.pdf ("The best types of supportive housing maximize tenant empowerment by unlinking housing from support services and allowing tenants to choose from a broad array of voluntary support services that can be provided onsite or offsite at the tenant's option.")

II. THE TAX COURT ERRED IN FINDING THAT THE HOUSING PROVIDED BY ADVANCED HOUSING WAS NOT ACTUALLY USED FOR THE EXEMPT PURPOSE.

Advance Housing claims an exemption for its property pursuant to the sections of N.J.S.A. 54:4-3.6, which exempt from taxation property used for: (1) "all buildings actually used in the work of associations and corporations organized exclusively for the moral and mental improvement of men, women and children"; and (2) "all buildings actually used in the work of associations and corporations organized exclusively for ... charitable purposes." Id. In order for a property to receive an exemption under the above sections, the property must satisfy the following three-part test: (1) the owner of the property must be organized exclusively for the exempt purpose; (2) its property must be actually used for the tax exempt purpose;[49] and (3) its operation and use of its property must not be conducted for profit. Paper Mill Playhouse v. Millburn Twp., 95 N.J. 503, 506.

In applying the test, the court correctly found that Advance Housing satisfied prongs one and three. The court stated that both Advance Housing, Inc. and Advance Housing 2000, Inc., were organized for "charitable" purposes and for the "mental and moral improvement of men." See 2T, p18, lines 11-12 The court also found that they owned the property in question and operated on a non-profit basis. Id. However, the court

[49] A 2001 amendment deleted the exclusive requirement. Prior to amendment, the test required that the property be both "actually and exclusively" used for the tax exempt purpose. See L. 2001, c. 18, § 1.

erred in finding that Appellants did not meet the second prong of the test: whether the properties in question are actually used for the eligible purpose. The court ruled that the housing failed to meet this prong, in large part, because of the court's erroneous conclusion that the housing and services were two separate programs and because of its misplaced emphasis on the voluntary nature of the services. See 4T, p9, lines 5-18. The court therefore found that the housing was not being used for the exempt purpose. Id. at p9, lines 16-18. In so finding, the court misunderstood the nature of the supportive housing program at issue and misinterpreted the exemption statute.

The Tax Court erred by failing to develop a full understanding of the supportive housing model. It is appropriate in the tax exemption context to look at factors outside a mechanical constrained reading of the statute in determining an exemption. Any interpretation of the statute should be informed by the adopted policies of the federal and state governments, and mental health professionals nationwide recognizing that Housing First coupled with voluntary treatment services is the most effective method for housing and treating people with mental disabilities. Considering the overwhelming authority supporting the Housing First methodology, it is clear that the property was actually being used for the exempt charitable purpose and for the moral and mental improvement of men, women and children.

A. The Tax Court's Decision Should be Reversed Because the Property was Being Used for the Exempt Purpose

As set forth in detail in Appellants' brief, it is clear that Advance Housing followed the Housing First model. Pb 6-25. Significantly, Advanced Housing received funding under the state and federal programs supporting this modality, both of which expressly require that housing be coupled with services and expressly prohibit providers from making housing contingent on acceptance of treatment services. Pb14. Further, although Advance Housing does not and cannot force participants to undergo treatment as a condition to receiving housing, in actuality each and every resident of Advance Housing units has voluntarily entered into a treatment plan. Pb18.

As discussed supra, the overwhelming majority of mental health professionals, the federal government, and the State of New Jersey wholeheartedly endorse the Housing First supportive housing model. They readily recognize and fully appreciate the fact that supportive housing is based on the premise that treatment services are fully integrated with the provision of housing, and together constitute a comprehensive housing and treatment program. Contrary to the Tax Court's conclusion, the housing component of supportive housing is not and cannot be separate and distinct from the treatment services. Thus, the program offered by Advance Housing is not, as the Tax Court erroneously held, simply "a subsidized housing program for clients who happen to be eligible for the supportive and

counseling service."[50] Indeed, the Tax Court's decision stands *alone* in failing to appreciate the Housing First model as a valid comprehensive program for both treating and housing people with disabilities.

B. The Tax Court's Decision Represents an Outdated View

The Court's requirement of mandatory treatment services to qualify for the tax exemption under N.J.S.A. 54:4-3.6 should be reversed because it represents an archaic and outdated view of the provision of housing and treatment for people with mental disabilities. There is clear authority in interpreting tax exemption statutes to take account of modern understanding of appropriate treatment paradigms and protocols.

In Hunterdon Medical Center v. Township of Readington, 195 N.J. 549 (2007), the Supreme Court of New Jersey rejected a similar outdated view when deciding an exemption for "hospital purposes." In Hunterdon, the Court found that when determining exemptions under N.J.S.A. 54:4-3.6, courts should consider modern realities and should recognize the changing circumstances and trends regarding the subject property. Id. at 553-54.

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[50] In reaching its erroneous conclusion that housing and services are not integrated, the Tax Court finds misplaced significance in the fact that Advance Housing provides services to many people who do not live in housing owned by Advance Housing. Regardless of who owns the housing, the key factor for the supportive housing model to work is that the housing and services must be provided in conjunction with one another. It is irrelevant who owns the housing. Moreover, as a practical matter, more often than not, the housing and service components of supportive housing are provided by two separate agencies because of the different skills required for each.

Applying that reasoning, the Court affirmed, in part, a tax exemption for "hospital purposes" because the existing framework for determining what constituted "hospital purposes" was outdated and failed to take into account the "modern" view of hospitals. Id. Significantly, the Court observed:

> In our view, the analysis for "hospital purposes" must take into consideration the many medical pursuits permitted to the "modern" hospital in New Jersey. A hospital can no longer be restrictively equated with a nineteenth, or even twentieth, century vision of a monolithic building, in which is offered continuous inpatient care or emergency treatment, twenty-four hours per day, to the sick, disabled, and infirm. Licensing authorities have allowed hospital activities to evolve as inpatient stays have diminished. Today, treatment often is delivered on an outpatient basis at a hospital's main facility, as well as at off-site facilities, backed up by the promise of ready inpatient care from the general, acute-care hospital when necessary. Thus, a fair definition of core "hospital purposes" must acknowledge the variety of activities that a modern hospital can be expected to perform for patients, be they inpatients or outpatients.
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> [Id.]

Significantly, the Court looked to regulatory agencies to determine the scope and meaning of the modern hospital purpose, adopting the definition promulgated by the Department of Health and Senior Services. Id. at 569-70.

Here, as in Hunterdon, the Tax Court's outdated and static nineteenth and twentieth century conception of the provision of housing and mental health services should be

rejected as failing to recognize that the "modern" paradigm for treatment and housing for people with mental disabilities is leased based, non-congregate, affordable housing coupled with *voluntary* services -- the model adopted by the Federal government and the State of New Jersey. In addition, the regulations of Division of Mental Health Services require that supportive housing residency can not be contingent on acceptance of treatment services. N.J.A.C. 10:37A-1.1. Thus, the Tax Court's rejection of this professionally recommended and highly successful method is not in keeping with modern practice and contrary to state regulation.

III. FAILURE TO REVERSE THE OPINION BELOW WILL IMPAIR THE STATE'S OBLIGATION TO PROVIDE HOUSING TO PEOPLE WITH MENTAL DISABILITIES IN THE MOST INTEGRATED SETTING

The Tax Court's decision presents a Hobson's choice to Advance Housing and other providers of supportive housing. On one hand, in order to receive the tax exemption, the court requires the services to be mandatory; however, if Advance Housing makes the services mandatory, it would lose all federal and state funding for these programs. Thus, the Tax Court's opinion contravenes the current state and federal rules governing receipt of funding for this program and penalizes organizations, like Advance Housing, who utilize a Housing First approach, because they followed state and federal guidelines.

As noted above, the Division of Mental Health Services relies on supportive housing organizations utilizing the Housing First model -- like Advance Housing -- as a way of

"deinstitutionalizing" individuals unnecessarily confined in state psychiatric hospitals and to meet its obligations under Olmstead v. L.C., 527 U.S. 581, 119 S.Ct. 2176, 144 L. Ed. 2d 540 (1999). That decision and "subsequent federal appellate decisions elevates community integration as a significant state responsibility."[51] In Olmstead, the United States Supreme Court determined that Title II of the Americans with Disabilities Act (ADA) "may require placement of persons with mental disabilities in community settings rather than in institutions." Id. at 587. (emphasis added). Critically, the decision noted the ADA's requirement that public entities must administer services and programs "in the most integrated setting appropriate to the needs of the qualified individuals with disabilities." Id. at 581. This setting is one "that enables people with disabilities to interact with people who do not have disabilities within their community to the fullest extent possible." Id. at 592 (quoting 28 C.F.R. pt. 35, App. A, p. 450 (1998))[52]

Under the lower court's reasoning the entire supportive Housing First model would be ineligible for a tax

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[51] See N.J. Dep't of Human Services, Home to Recovery-CEPP Plan, supra note 24, at 14.

[52] This summer, after an eight week trial a federal district court ruled that the State of New York violated the ADA by keeping people with mental illness confined in adult homes instead of allowing them to live in the most integrated setting appropriate to their needs, which the court found to be supportive housing. See Disability Advocates Incorporated v. Paterson, 653 F.Supp. 2d 184, 311(E.D.N.Y. 2009). The court's opinion contains a lengthy description of supportive housing, its features and benefits, and its advantages over congregate housing. Id. at 217-23.

exemption. Thus, affirming the Tax Court's decision will inevitably result in a diminishing of the State's ability to fulfill its obligations to provide suitable integrated housing in a community setting for individuals with mental disabilities pursuant to the ADA as mandated by Olmstead.

IV. SUPPORTIVE HOUSING RELIEVES A PUBLIC EXPENSE AND IS NOT A BURDEN TO STATE AND LOCAL GOVERNMENTS

The Tax Court adopted the oft-cited standard for determining whether a property is being used for charitable purposes enunciated by the New Jersey Supreme Court in Presbyterian Homes v. Division of Tax Appeals, 55 N.J. 275 (1970). In that case, although the court acknowledged that there was not a precise definition for what is charitable, the Court stated: "As a guide, however, it should be borne in mind that a sometimes stated justification for charitable tax exemptions is that if the charitable work were not being done by a private party, it would have to be undertaken at public expense." Id. at 284.

Although the court below adopted the correct standard, it erroneously assumed that providing the exemption to Advance Housing's property would create a burden for other taxpayers of the community. Specifically, *in dicta*, the Tax Court stated:

> [t]he Court really needs to be persuaded and needs to have a basis to conclude that they are used directly, actually and exclusively for the sake of the counseling program .... Ultimately, it seems to me the question that is at issue in this case is whether or not the property tax burden that is to be -- whether the property tax burden for this

> particular property is to be sustained at the local level or at a different level of government. And for me to conclude that the burden should remain at the local level, in other words, by allowing an exemption in placing the burden on the other taxpayers of the community I would wish to find a clear basis for doing so.
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> [2T, P20, lines 21-25, P21, lines 16-24]

While the court did not rely on its "burden" assessment in denying the exemption -- choosing instead to rely on its lack of integration argument -- the court's erroneous assumption requires correction.

As set forth below, it is well established that supportive housing is not a burden on the state and local governments, but is rather the most cost efficient way to house people with mental disabilities and actually relieves the burden on all levels of government.

A. The State of New Jersey Has Recognized that Supportive Housing Alleviates a Significant Financial Burden

The State of New Jersey has also recognized the cost savings associated with supportive housing using the housing first model. Among the findings embodied in the final report of Governor's Task Force on Mental Health, noted supra, which stressed the numerous benefits of supportive housing, was that supportive housing results in significant cost savings. The task force report noted that research across the country found the following cost savings realized through the use of supportive housing: (1) 80% of tenants coming from streets and shelters achieve housing stability for at least a year; (2)

Emergency room and hospital visits drop by more than 50%; (3) Decreases in tenants' use of emergency detoxification services by more than 80%; (4) Increases in use of preventive health care services, primary care and services to address substance abuse; (5) Positive impact on employment status; (6) Increases of 50% in earned income and 40% increase in rate of participant employment when employment services are provided in supportive housing; (7) Significant decrease in tenant dependence on entitlements.[53]

In addition, the cost of supportive housing in New Jersey is far less expensive than other methods of housing people with mental disabilities in New Jersey - e.g., state institutions, homeless shelters, hospitals, prisons, and group homes. For example, as argued by Appellants, the average cost to maintain one State hospital bed, such as at Greystone, is $146,000 annually, significantly more than the cost of $20,000 per year for supportive housing. Martone Cert., ¶ 41, Pa825. Similarly, for a group home setting in a community with 24 hours supervision the annual cost per individual is approximately $60,000. Id., ¶ 42, Pa825.[54]

Furthermore, the Tax Court of New Jersey has also recognized that supportive housing relieves a significant public expense. See Community Access Unlimited, Inc v. City of Elizabeth, 21 N.J. Tax 604, 617 (Tax 2003) ("If not for the

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[53] Governor's Task Force, supra note 25 at 5-6.

[54] Id. at 6, 130-33, 178.

housing and social services [Community Access Unlimited] provides to its members, a public facility like Greystone Psychiatric Hospital would have to care for them at public expense.").

Finally, many of the costs of institutionalization are already borne by the local government, so granting the exemption will not result in any shift of the burden from the state to local governments. Rather, granting the exemption will alleviate the burden local governments already carry. For example, New Jersey counties currently pay 15 percent (15%) of the costs to institutionalize a patient committed in the State.[55] Counties must also cover a number of costs associated with providing patients sufficient due process protections in the commitment process. For example, when a county seeks to commit an adult to its county hospital it pays for the cost of the commitment hearing. These costs include paying a judge, one or more sheriff's officers to provide protection, and an attorney to serve as county counsel. It also includes paying for appointed counsel to represent the person facing commitment, as is required under the due process clause and by statute. N.J.S.A. 30:4-27.11; In re S.L., 94 N.J. 128, 136-37 (1983). Continued institutionalization compounds these costs because

[55] See Office of Mgmt. & Budget, Fiscal 2010 Budget in Brief, 87, available at http://www.state.nj.us/treasury/omb/publications/10bib/BIB.pdf (stating that the Mental Health Hospital County Share increased from 12.5% to 15%); See also, N.J.S.A. 30:4-78; County of Camden v. Waldman, 292 N.J. Super., 268, 277 (App. Div. 1996).

people are also entitled to periodic review hearings to determine whether their continued commitment remains necessary. State v. Fields, 77 N.J. 282, 294, 301 (1978); N.J. Ct. R. 4:74 (f). Additionally, there are periodic hearings for people who have been released from commitment but nonetheless remain in hospitals on "conditional extension pending placement" ("CEPP") status while the State finds placement for them. See In re S.L., 94 N.J. at 140-42. As set forth above, supportive housing alleviates this burden by providing the most cost effective and successful alternative to institutionalization.

B. Studies of Communities Across the Nation Have Invariably Concluded That Supportive Housing Programs Result in a Cost Savings to State and Local Governments

Supportive housing is designed to serve tenants with long histories of homelessness who often face persistent obstacles to maintaining housing, such as a serious mental illness, a substance use disorder, or a chronic medical problem. While homeless, these individuals often cycle through countless local and state public institutions - emergency rooms, police stations, community hospitals, homeless shelters, jails and prisons. These patterns of service utilization not only fail to address the underlying causes of homelessness, but they are extremely costly to the public systems involved. Supportive housing helps tenants end homelessness and access the services they need to address their health and mental health problems effectively. As such, supportive housing leads to decreases in

the inappropriate utilization of emergency services and public institutions.[56]

Numerous studies examining the use of supportive housing in communities across the nation, employing both voluntary and involuntary services, have invariably concluded that these programs result in significant cost savings to state and local governments, as well as the federal government. The cost savings are realized, in part, because supportive housing creates a reduction in the use of social services by its residents -- particularly, reduction in use of emergency shelters, community hospitals, law enforcement personnel, hospitals, prisons and local jails.[57] Indeed, the cost of serving a person in supportive housing is half the cost of a shelter, a quarter the cost of being in prison and a tenth the cost of a state psychiatric bed.[58] One 2004 study analyzing the

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[56] CSH, supra note 15.

[57] See CSH, The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals (2001) (the "NY Study "), available at http://www.csh.org/html/NYNYSummary.pdf; The Heartland Alliance Mid-America Institute on Poverty: Supportive Housing in Illinois: A Wise Investment (2009) (the "Illinois Study"), available at http://www.heartlandalliance.org/whatwedo/advocacy/reports/study-of-supportive-housing-in-illinois-final.pdf; Melany Mondello et al., Cost of Homelessness: Cost Analysis of Permanent Supportive Housing (2007) (the "Maine Study"), available at http://www.mainehousing.org/Documents/HousingReports/CostOfHomelessness.pdf.

[58] See Bazelon Center Report: Supportive Housing: The Most Effective and Integrated Housing for People with Mental Disabilities, available at http://www.bazelon.org/pdf/Supportive Housing3-09.pdf.

costs of housing the homeless in nine communities across the country: (Atlanta, Boston, Chicago, Columbus, Los Angeles, New York, Pheonix, San Francisco, and Seattle) found that supportive housing was by far the most cost-effective housing option.[59] For example, this report found that the cost of housing a single homeless person in supportive housing in New York was $41.85 per day as compared to: $164.57 per day for jail; $74.00 per day for prison; $54.42 per day for a homeless shelter; $467 per day for a mental hospital; and $1,185 per day for a hospital stay. Similar results were found for the other eight communities' analyzed b the study. Id.

In addition, supportive housing produces significant cost savings by effectuating a redistribution of more expensive social services to less expensive ones. For example, residents in supportive housing are more likely to seek less expensive preventive patient care for an illness that utilizes expensive emergency hospital services. See NY Study, Illinois Study, and Maine Study.

C. Analysis of Specific Case Studies

1. The NY Study

The NY Study tracked 4,679 homeless individuals with psychiatric disabilities who were placed into supportive housing created by the New York/New York Agreement to House Homeless

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[58] Lewin Group for the CSH, The Costs of Serving Homeless Individuals in Nine Cities (2004), available at http://www.rwjf.org/files/newsroom/cshLewinPdf.pdf.

[59] Ibid.

Mentally Ill Individuals (a joint initiative between New York City and New York State that created and maintains 3,615 units of affordable housing supported with clinical and social services) from July 1, 1989 to June 30, 1997. This housing fell into three different categories: Researchers first examined the individuals' use of emergency shelters, psychiatric hospitals, medical services, prisons and jails in the two years before placement and the two years after placement. They compared these results to homeless individuals who had not been placed in NY/NY housing.

The study revealed significant reduction in the use of numerous social services by its residents once in supportive housing. Specifically, the report found the following: *(1)* A homeless mentally disabled person in NYC used an average of $40,449 of publicly funded services over the course of the year before housing; once placed into service-enriched housing, a homeless mentally disabled individual reduced his or her use of publicly funded services by an average of $12,145 per year; *(2)* the use of emergency shelters dropped 85% from an average of 68.5 days per year per person, to less than 10 days per year; *(3)* the use of state psychiatric centers decreased 60%, from an average of 28.6 days per year per person before placement into housing, to less than 12 days after the placement; *(4)* the use of publicly funded acute hospitals for both psychiatric and medical treatment, dropped from 8.25 days to just 1.65 days per person per year; *(5)* the use of hospitalization in Veterans Administration and private voluntary hospitals also dropped

after placement into housing, by 59% and 39.9%, respectively; *(6)* the use of Medicaid-reimbursed outpatient services almost doubled as a result of housing placement, from an average of 31.1 days per person per year to 60.8 days annually; and *(7)* The use of state prisons and city jails dropped precipitously, by 74% and 40%, respectively.[60]

The study also broke down the savings to the public per placement of each individual in supporting housing. The report found that the service reductions resulting from NY/NY housing saved the public $12,145 annually for each individual placed.[61] For example, the study noted that it cost $1,425 to place one homeless mentally ill individual into non-supportive housing unit for a year.[62] By contrast, a homeless mentally ill person placed into supportive housing built cost an average of $744 per year.[63]

2. The Illinois Study

Like the NY Study, the Illinois Study compared the costs of services of 177 Illinois adults two years before the use of supportive housing to the costs incurred two years after and found similar costs savings found in the NY Study. The study found a 39% reduction in total cost of services from pre-to-post supportive housing with an astounding overall savings of $854,477 -- or an average savings in the cost of social services

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[60] NY Study, supra note 57.

[61] Id. at 1.

[62] Id. at 8.

[63] Ibid.

from 4,828 per resident for the 2-year time period.[64] The savings resulted, in part, from supportive housing residents changing the type and volume of services they utilized.[65] Prior to admittance into supportive housing, the study found that residents relied heavily on expensive inpatient/acute services before supportive housing to less expensive Outpatient/Preventative services after supportive housing.[66]

There were also significant cost savings regarding the use of medical services. For example, living in supportive housing decreased the cumulative cost of Medicaid services resulting in cost savings of over $183,000 from pre-to-post supportive housing.[67] The use of supportive housing also decreased the amount of *uncompensated* hospital services residents' use. For example, emergency room total use decreased over 40% and the use of inpatient medical care decreased 83% resulting in a total cost savings of $27,968 from pre to post supportive housing.[68] Overall, the study found that living in supportive housing decreased the cumulative cost of mental health hospitalizations - a $400,000 cost savings pre to post supportive housing.[69]

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[64] Illinois Study, supra note 57, at 3.

[65] Ibid.

[66] Ibid.

[67] Id. at 13.

[68] Id. at 15.

[69] Id. at 17

Finally, the study found that use of supportive housing decreased the cumulative cost of time in state prison and time spent in county jails. Prior to supportive housing, costs for individuals in state jails was $215,000; after supportive housing, the study found that residents did not spend any time in prisons - resulting in a 100% cost savings.[70] Savings for reduced use of county jails were also realized, saving over $27,000.[71]

3. The Maine Study

The Maine Study analyzed residents who had been living in supporting housing, supported by both involuntary and voluntary ("Housing First") services for one year. The study found that the total annual cost savings to the system of care for these residents was $93,436.[72] The study further found that the most dramatic reduction in cost occurred because of the reduction of emergency shelters use by participants, which fell by 98%.[73] As a result, the cost of emergency shelter decreased from $241,469 in the year prior to housing entry to $9,108 in the year following - a savings of $232,361.[74]

In addition, as with the NY and Illinois studies, the report found a decrease in use of emergency services such as ambulance, police, and incarceration costs in the year following

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[70] Id. at 21.

[71] Id. at 22.

[72] Maine study, supra note 57, at 2.

[73] Id. at 5.

[74] Ibid.

the residents' entry into supportive housing. Specifically, ambulance costs decreased 66% for a savings of $30,501; police costs decreased 66% for a savings of $15,109; and jail nights decreased 62% representing a reduction in costs of $38,261.[75]

The study also found a reduction in health care costs. These costs were reduced by 59% for a savings of $497,042.[76] Emergency room costs also decreased by 62% for a savings of $128,373 and general inpatient hospitalizations decreased by 77% for a savings of $255,421.[77]

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[75] Id. at 8

[76] Id. at 8.

[77] Id.

CONCLUSION

For the reasons set forth above, the Amici Curiae respectfully request reversal of the Tax Court's decision.

Respectfully submitted,
LOWENSTEIN SANDLER PC

Date: March 26, 2010

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Center, et al.

NEW JERSEY DEPARTMENT OF THE
PUBLIC ADVOCATE

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Date: March 26, 2010

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APPENDIX TO JOINT BRIEF OF AMICI CURIAE

TABLE OF CONTENTS

A-728-09T3 ORDER ON MOTION

SEND TO COURT WHEN L

ADVANCE HOUSING INC AND ADVANCE HOUSING 2000
VS
TOWNSHIP OF TEANECK ET AL

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A -000728-09T3
MOTION NO. M -002882-09
BEFORE PART: F
JUDGE(S): CARCHMAN

MOTION FILED: JANUARY 14, 2010 BY: JUDGE DAVID L BAZELON CENTER
ANSWER(S) FILED:

FILED
APPELLATE DIVISION
FEB 08 2010

RECEIVED
APPELLATE DIVISION
FEB 08 2010
SUPERIOR COURT
OF NEW JERSEY

SUBMITTED TO COURT: FEBRUARY 04, 2010

CLERK

O R D E R

THIS MATTER HAVING BEEN DULY PRESENTED TO THE COURT, IT IS ON THIS 4th DAY OF February, 2010, HEREBY ORDERED AS FOLLOWS:

MOTION BY RESPONDENT	GRANTED	DENIED	OTHER
- TO APPEAR AS AMICUS CURIAE	(X)	( )	( )
- PARTICIPATE IN ORAL ARGUMENT			
- FOR LEAVE TO FILE JOINT BRIEF			

SUPPLEMENTAL:

All motions are granted. Oral argument shall be limited to fifteen minutes.

SWT 4767-02

FOR THE COURT:

I hereby certify that the foregoing is a true copy of the original on file in my office.
CLERK OF THE APPELLATE DIVISION

UZTOL0

PHILIP S. CARCHMAN P.J.A.D