

Cohort 07 of 08

Long-Term Stability for Complex and Enduring Mental Illness

An Assertive Community Treatment (ACT) campus model: co-located clinical team, unconditional tenure, and a design that accommodates fluctuating capacity.

Maggie Hall · Researcher and Founder, Project Humanity · Newcastle NSW

First prepared May 2026 · Revised for publication October 2026

Schizophrenia · Bipolar I · Schizoaffective · Complex PTSD · ACT Model · Unconditional Tenure

The Revolving Door

People with complex and enduring mental illness cycle through psychiatric inpatient units, crisis accommodation, and homelessness at rates that represent one of the most preventable failures in the Australian health system. The revolving door between hospital, crisis accommodation, and the street is not a system failure. It is a system designed without housing at the centre.

"Stability is not the absence of symptoms. It is the presence of somewhere safe to have them."

The ACT team is co-located with the residents (available, known, and trusted) rather than visiting from outside. Support intensifies when someone is unwell and steps back when they are well. The tenancy is never at risk.

ZONE 1 · RESIDENTIAL: STABILITY THROUGH DESIGN

- 16 units: smaller campus enables intensive support without institutional scale
- No shared bedrooms: private space is non-negotiable for this cohort
- Medication storage: lockable, temperature-controlled cabinet in each unit
- Emergency call system: tenant-activated, alerts ACT team member on duty

- Blackout blinds in all units: sleep disruption is prodrome and consequence of serious mental illness
- Quiet hours enforced: 10pm–8am; noise is a significant trigger for psychosis and mania
- Maintenance team briefed: patient, clear, predictable communication; minimum disruption

ZONE 3 · CLINICAL SUPPORT: ACT TEAM ON-SITE

- ACT team co-located in hub: psychiatrist, psychiatric nurse, social worker, peer support worker
- Medication management: depot injections on-site, blister packs, clozapine monitoring
- Psychiatric review monthly minimum: no waiting list, no GP referral required
- Crisis protocol: ACT team responds first; hospital as last resort, not first response
- Clozapine clinic on-site: blood monitoring removes hospital barrier
- Physical health monitoring: metabolic, cardiovascular, respiratory risk managed on-site
- Relapse prevention plan: co-designed with tenant; tenant holds their own copy

ZONE 2 · COMMUNITY HUB: RECOVERY AND MEANING

- Low-stimulation default: calm lighting, no loud music, predictable layout
- Structured daily programme optional: coffee at 9, lunch at 12, activity at 2
- Peer workers with lived experience of serious mental illness: paid staff, not volunteers
- Occupational therapy: gardening, cooking, art, craft, music; meaningful activity as clinical intervention
- Smoking area: designated, comfortable, non-stigmatised; harm reduction for a cohort in which around two in three people smoke (Survey of High Impact Psychosis, 2010)
- No forced participation: the hub is available; it does not demand

Key Clinical Protocols

Psychiatric crisis	ACT team responds first. Involuntary admission only when legally required. Tenant's advance directive consulted.
Tenancy during admission	Tenancy held through any psychiatric admission. Tenant returns to their home. No eviction for hospitalisation.
Fluctuating capacity	Support plan has two tiers: stability mode and crisis mode. Tenant consulted when well.

Police protocol	Police not first responder. ACT team has non-police crisis pathway. Police only when clinical team cannot safely manage.
Visitor policy	Tenant manages their own visitor access. Campus is not a closed ward. Freedom of movement is a right.
Unit mix	12 × 1-bed, 4 × 2-bed: 16 units. All with medication storage and blackout blinds.

Maggie Hall · Researcher and Founder, Project Humanity · Newcastle NSW
 Part of Project Humanity's housing work · co-synthesist.com/housing