Witness Name: Dr Nuwan Dissanayaka

Statement No: WITN0412001

Dated 23/02/2026

THE NOTTINGHAM INQUIRY

First Witness Statement of Dr Nuwan Dissanayaka

I, Dr Nuwan Dissanayaka, will say as follows: -

The Author

1. I am Doctor Nuwan Dissanayaka. I am the Consultant Psychiatrist for the Assertive Outreach Team for Leeds and York Partnerships NHS Foundation Trust. I have held this post substantively since November 2003.

2. My qualifications are MBBS (Newcastle 1995), Diploma MMedSc (September 2001), MRCPsych (June 2000), Single CCST in General Adult Psychiatry with an endorsement in rehabilitation from the Royal College of Psychiatrists (31st of October 2003). I have previously been the representative for Assertive Outreach on the executive committee of a faculty of the Royal College of Psychiatrists.

3. I approached the inquiry by sending an email dated 5 February 2026 **[WITN0412002]** identifying the contribution I felt I could make as a national expert in Assertive Outreach.

4. I received a rule 9 request dated 12 February 2026 in response to my email and am addressing, by my statement, matters raised in that request.

Summary

5. This statement describes in detail the origins and evolution of the Assertive Outreach Model and outlines its evidence base for the dedicated specialist support of the group of patients with severe mental illness who are disengaged from mental health services and who pose significant risks of violence during relapse. It highlights the importance of the fidelity scale of the model and its direct relevance to the care and risk management of this group. It summarises the 1994 Ritchie Report which identified systemic deficits in the care of this patient group, and which generated wide ranging recommendations including the national implementation of Assertive Outreach Teams as part of the 1999 National Service Framework, before then charting the subsequent disbanding of many of these teams and the possible reasons for this. Violence risk in the context of severe mental illness is explored and the continued relevance of Assertive Outreach in managing this, as well as wider patient care needs. These are illustrated by means of a detailed description of the operation of the Leeds Assertive Outreach Team. The Theemis Report (including its findings and omissions) and the NHS England review of Assertive Outreach are described. Finally, recommendations are made relating to the clinical need for high-fidelity Assertive Outreach and, more generally, to risk management, resource constraints, the use of mental health legislation, the importance of a qualified workforce and the challenges of multiagency working.

The Assertive Outreach Model

6. Assertive Outreach is a high intensity, flexible and creative, patient-centred model of community mental healthcare which requires a standalone team specialising in engaging patients who have severe mental illness and complex health and social needs.

7. Patients appropriate for the service have the following characteristics:
    - A severe and persistent mental disorder (e.g. Schizophrenia, Major Affective Disorders) which may be associated with a high level of disability
    - A history of high use of acute inpatient care, particularly detained admissions
    - Difficulty in maintaining lasting and consenting contact with services

8. In addition, patients may have multiple complex needs which might include the following:
    - A history of violence or persistent offending
    - Significant risk of persistent self-harm or neglect
    - Poor response to previous treatment
    - Dual diagnosis of substance use and serious mental illness
    - Unstable accommodation or homelessness

9. The model is underpinned by assertive engagement in the community, a whole team approach with a shared caseload rather than individual case management, longer term continuity of care with no “dropouts”, increased

intensity of care, experience with working with higher risk thresholds, and a varied staff team to avoid brokerage of needs to outside agencies. The keys to engagement include consistency of contact and treatment, extensive practical support with issues such as housing and finances, The constructive (as opposed to restrictive) principles of support are described in greater detail in paragraph 24 below.

10. As a model it evolved during the early 1970s in Madison, Wisconsin as Assertive Community Treatment (ACT) in response to the deinstitutionalisation movement in the United States and Stein and Test's landmark study was published in 1980 [**WITN0412003**]. It arose from the observation that many people discharged from psychiatric hospitals had very poor outcomes with homelessness, readmission or offending behaviour resulting from inadequate community support. The study which showed benefits in reduced hospital use and better housing stability spread rapidly across the United States before its implementation in Canada and Australia. ACT developed in parallel to other models including Crisis Resolution Services which provided short term intensive support for people experiencing a mental health crisis and more traditional outpatient care. The emergence of ACT, however, acknowledged the need for more continuous, intensive, holistic and coordinated care for those with severe mental illness.

11. Assertive Community Treatment is one of the most extensively evaluated mental health interventions, with 15 systematic reviews and over 75 randomised controlled trials, showing good evidence for its efficacy. For

example, Bond et al. found that ACT was effective at reducing psychiatric admissions, improving housing stability, reducing symptom severity and improving quality of life **[WITN0412004]**. The authors concluded that fidelity to the model was crucial.

12. Assertive Outreach has been used in many countries around the world. To my knowledge there has been use of the model, to varying degrees, in the United States, Australia, the United Kingdom, Canada, Denmark, France, Japan, the Netherlands, New Zealand, Norway, Spain, Sweden and Switzerland.

13. Assertive Outreach is a very clearly defined model of community mental healthcare and it has a 28-point fidelity scale, the Dartmouth Assertive Community Team Fidelity Scale **[WITN0412005].** It is only effective when it is delivered by a dedicated standalone team that meets these fidelity standards. Indeed, there is no such thing as an "Assertive Outreach approach" as key components cannot be delivered without a dedicated team. For example, it requires a dedicated multidisciplinary team with the key skills and experience required for working with poorly engaged high risk psychotic patients, a shared caseload brings continuity of care and knowledge of the patients (including needs and risks) to allow a whole team approach, very frequent team meetings to comprehensively review care of the patients on the caseload, high intensity community involvement including the in-house management of crises, admissions and discharges which all rely on reduced caseload sizes, a capped overall team caseload size and extended team working hours. The team must maintain sufficient flexibility to allow for

unpredictable increased needs which can require more than daily contact and multiple unsuccessful visits whilst trying to locate patients.

14. Patients suitable for Assertive Outreach engage poorly with multiple services so are not easily signposted for their complex needs to be met. In addition to prescribing psychiatrists and nurses, teams therefore need to have team members used to engaging with this group from different backgrounds including occupational therapy/vocational specialists, psychology, substance use workers, housing workers and physical health promotion. Standard community teams cannot offer this and hybrid approaches, as well as lacking a positive evidence base, have been shown to lose the benefits such as decreased hospitalisation rates. Low fidelity teams drift towards office-based interventions, decreased intensity, less intensive reactive care as well as increased staff burnout due to the risks and complexity of the patient group.

The Ritchie Report **[DHSC0000160]**

15. A tragic catalyst in 1992 significantly boosted the uptake of Assertive Outreach in England. On the 17th of December 1992, a man named Christopher Clunis fatally stabbed a stranger Jonathan Zito on a platform at Finsbury Park Station in London. Clunis had no history of a dysfunctional early background, mental illness or abnormal personality traits during childhood or violence predating his illness. Prior to becoming ill, he became isolative, he distanced himself from his family, and he became increasingly suspicious of others. His self-care deteriorated and his early symptoms were poorly defined with some disorganised and disinhibited behaviour. He had contact with the police due to his behavioural disturbance. His risks, which

included weapon use, escalated as he became more unwell and he was treated in a secure forensic psychiatric ward. As he became ill, he moved around different areas with frequent changes of address as well as being homeless. His admissions were treated separately as if he was a new patient, they were often brief and with limited aftercare or being discharged due to disengagement.

16. The subsequent independent inquiry, recorded in the 1994 so-called Ritchie Report, highlighted a systemic failure of mental healthcare for those with severe mental illness who were poorly engaged with services, inadequate clinical assessment and a lack of robust risk management and poor coordination of care between hospitals, the community and primary care. The provision of resources was insufficient with inadequately trained staff, shortages of beds and problems associated with the use out of area beds. The after effects of the Ritchie Report were tangible, with increased investment in mental healthcare, statutory strengthening of treatment plans within the Care Programme Approach and Section 117 aftercare, an emphasis on the need for trained staff including psychiatrists and social workers, and the introduction of additional mental health legislation (Section 25 Supervised Discharge) as a safeguard for those too unwell to recognise the need for treatment.

17. With specific regard to Assertive Outreach, in its section on "The Special Supervision Group of Patients Who Need Special Care", The Ritchie Report stated that it had taken evidence about the setting up of Specialist Teams with

a cap of 12 patients per worker in the team. The Inquiry received evidence from two Professors of Psychiatry that such specialist teams (the aforementioned Assertive Community Treatment Teams) had been tried and tested in other countries, including the United States and Australia and that they had proved enormously successful. The Inquiry heard that although the approach was intensive, the work done in other countries had shown it cost effective when compared to inpatient care. The corresponding recommendations were that:

- Every psychiatric service should identify patients as part of a Special Supervision Group and should provide a Specialist Team to supervise and support the group
- New funding should be provided for that purpose
- A nationally based Supervision Register for the Special Supervision Group should be set up where information which leads to the ready identification of the patient would be stored and which would indicate from where confidential information about the patient could be obtained
- Every psychiatric service should appoint Specialist Community Psychiatric Nurses to the team responsible for the Special Supervision Group whose only job is to supervise a very limited caseload
- Community Psychiatric Nurses should follow patients across health boundary borders until care is formally transferred to another specialist team.

The National Service Framework

18. The 1999 National Service Framework (NSF) for Mental Health [**DHSC0000097**] was a 10-year strategy by the UK government which set mandatory evidence-based standards for adult mental health services in England. It covered mental health promotion, primary care access, and care for severe, acute and dementia-related mental illness. It introduced Assertive Outreach, Crisis Resolution and Early Intervention Teams. The intention of introducing Assertive Outreach Teams was part of the strategy to address the gaps in the care available to those with severe and enduring mental illness. A milestone was established in the NSF that by 2002 Assertive Outreach would be in place for all service users on CPA who were at risk of losing contact with services. Policy Implementation Guidance [**NHFT0004881**] was developed for the service which identified the role of Assertive Outreach and by 2004 there were 263 teams in England.

The National Reduction in Assertive Outreach Provision

19. A key outcome attached to the implementation of the NSF was an expected reduction in the days spent in hospital by patients, but this was not found in a small number of UK studies, most notably the 2006 REACT study [**WITN0412006**]. This study did not find a difference in inpatient bed use or other clinical outcomes, but it did find that those receiving Assertive Outreach were better engaged, less likely to lose contact with services and more likely to be satisfied with their support. These are highly important findings given the nature of this patient group and arguably of far more relevance to the prevention of violence than a reduction in hospital bed use. It could indeed

be further argued that the prevention of access to hospital beds when this is the most appropriate intervention increases the risk of violence in the community.

20. Various explanations for this difference in bed usage between the UK and other countries have been suggested including lower fidelity to the Assertive Outreach model (including working hours, staffing levels, dedicated team psychiatrist, substance use and vocational specialists), the level of "in vivo" contact (home visits), greater similarity between Assertive Outreach and "treatment as usual" (the Community Mental Health Team) and the variation in hospital admission thresholds in different countries. In the UK, particularly in inner city areas like London where the REACT study was undertaken, admission thresholds are high, so the effectiveness of interventions are less likely to be reflected in reduced bed days. It is reasonable to question whether the findings of the REACT study generalise to other areas in the UK or whether the findings would be replicated if repeated today. In my area of Leeds, West Yorkshire our high-fidelity Assertive Outreach Team has consistently demonstrated significant bed usage reductions, but our local data is unpublished. **[WITN0412007, WITN0412008, WITN0412009]** Whatever the reasons for this difference in the published outcomes, in a climate of austerity, in subsequent years there followed significant cuts in the provision of Assertive Outreach to the current position where in England there is now estimated at 32% coverage and a significant variation in the fidelity of the remaining teams. It is suggested that NHS England may be able to provide an up-to-date figure but the important caveat to any estimate they

may provide is that many teams presented as Assertive Outreach Teams in their data are now likely to be low fidelity services.

Violence Risk in Mental Illness

21. Whilst the primary outcome of interest from the REACT study was the use of hospital beds, what had been lost was the fact that the main impetus for the implementation of Assertive Outreach had not been hospital bed use but rather the violence risk of those who were severely mentally ill and disengaged from services. The subject of violence risk is fraught with misinformation, fear and stigma and one that is largely still avoided. There is however evidence to support the role of treatment in the mitigation against serious violence. In appropriate cases, consistent treatment of those with serious mental illness with antipsychotic medication and mood stabilisers can reduce violent crime, and the use of depot medication can be appropriate when compliance is a concern [**WITN0412010**].

22. Fazel and his colleagues, in their umbrella review of 22 meta-analyses examined the risk factors for interpersonal violence, including in mental illness. The meta-analyses included multiple countries, but data was mostly drawn from high income countries in North America and Western Europe. The main areas for effective intervention were treatment adherence, substance use treatment, and protective social factors including housing stability [**WITN0401002**]. To maintain treatment and address the relevant social factors, an approach is required to maintain contact with the patients who pose the highest risks. Assertive Outreach is the obvious evidence-based approach for this group. These findings are echoed by Baird et al's national

case-control study of homicide by men diagnosed with Schizophrenia [**WITN0069005**] one of the authors being Professor Sir Louis Appleby who is a Director of NCISH (National Confidential Inquiry into Suicide and Safety in Mental Health). NCISH, which until 2018 collected detailed data on patient homicide, has been commissioned to resume the National Confidential Inquiry into Homicide in England, to reflect current public concerns regarding patient care. NCISH has repeatedly included outreach teams as an essential intervention for improving safety.

23. The Royal College of Psychiatrists Good Practice Guide on the Assessment and management of risk to others 2016 [**NHFT0015099**] specifically suggests that assessors should consider the use of Assertive Outreach in the management of risk to others. The Department of Health's Best Practice in Managing Risk 2009 [**DHSC0000038**] similarly references the work of NCISH and specifically one of its 12 recommendations for safer services being "assertive outreach teams to prevent loss of contact with vulnerable and high-risk patients". [**WITN0412011**]

<u>The Leeds Assertive Outreach Team</u>

24. The Leeds Assertive Outreach Team, which has been operating since around 2000, is a tertiary service that receives referrals from multiple sources. This includes the core Community Mental Health Teams (CMHT), the acute psychiatric wards and Psychiatric Intensive Care Unit, the Early Intervention in Psychosis Team, The Crisis Service, Psychiatric Rehabilitation and Forensic Services as well as occasional referrals from other areas in England. Our service has no upper age limit, so we also receive referrals from the Older

People's Service. The service comprises two teams covering the West and East of the city, the reason for the split being to adhere to the fidelity scale in not exceeding the overall caseload size to preserve cohesion for a manageable shared knowledge of the patients. The population served is approximately 850,000 and the total caseload across the two teams is 150 patients.

25. The patients are assessed against the referral criteria given at paragraph 6 above and discussed in the multidisciplinary team meeting. If they are appropriate and it is found that their needs cannot be met by the referring team, then they are accepted onto the team caseload. Typically, patients who are accepted have a psychotic illness, usually Schizophrenia, Bipolar Affective Disorder and Schizoaffective Disorder. They often demonstrate poor awareness of their illness, not recognising they are unwell and, consequently, non-compliance with treatment, disengagement from community services and frequent relapses associated with high risks. This results in repeated detentions for treatment in hospital. On my caseload approximately two thirds of patients have history of keeping or using weapons as part of their previous relapses and they often have a poor appreciation of the risks they present when unwell. Their contact with hospital services is often restrictive and traumatic with patterns including the use of Section 135 warrants to force entry, police involvement including police detention under Section 136, hospital detention, the use of seclusion, restraint and acute injectable medication, treatment in Psychiatric Intensive Care Units and sometimes care in secure forensic units. In the community they have a history of avoiding

psychiatric services, not attending appointments or agreeing to home visits. As a consequence, some are subject to Community Treatment Orders.

26. Severe mental illness can directly contribute to a failure to engage in other essential activities which results in financial and sometimes food insecurity, housing instability and homelessness. In part, it also contributes to substance use as self-medication which in turn leads to further destabilisation of illness and a worsening of the overall social situation. In most cases they are estranged from their families and have few supportive social connections. The group we support do not engage with peer support, voluntary agencies or faith organisations. Ethnic minorities are overrepresented on our team caseload and very few are well connected with their communities. There has been an increase in refugees and asylum seekers with significant trauma histories and English is often not their first language, adding to the complexity.

27. Patients are informed that a referral to our service has been made but immediate consent is not expected as they mostly have a deep, and sometimes understandable, mistrust of services. Many are detained in hospital under the Mental Health Act at the time of referral. Alongside a thorough review of their clinical records the team assessors meet them face to face, either in hospital or in the community, often on multiple occasions, to build trust and to explain the purpose of the service. Part of this process is an explanation of the areas in which we can assist the person and generally they will agree to some level of future contact. In some cases, when the pattern is of consistent disengagement and non-compliance a Community Treatment

Order is used with specific conditions of treatment and accepting community contact.

28. Unfortunately, the referral information that is received is often superficial and incomplete. The electronic patient records are difficult to navigate and a historical information about the clinical presentation, hospital admissions, previous treatment and risks is hard to locate. It is usually not provided by referrers in sufficient detail and retrieving it is time consuming and can cause delays. This is significantly more problematic when patients are referred from out of area services or from private providers using different, inaccessible electronic patient records. There is generally little or no collateral information from other agencies who may have had involvement including the police. Inadequate and incorrect information is a significant barrier to providing high quality and safe patient care.

29. Once accepted onto the caseload, the team maintains close involvement in all aspects of care. In addition to frequent direct contact, every patient is reviewed by the whole multidisciplinary team including me as the Consultant Psychiatrist every week. This includes patients in the community, on mental health wards, on physical health wards, in out of area placements, in prison and indeed anywhere else they may be. This also applies to patients who may be out of the country on holiday as contact may still be maintained with them or their family. The contact with patients in hospital includes both directly with them, with staff visiting the ward, as well as with the hospital clinical team. The team has a protocol which includes the sharing of information on admission which outlines key aspects of the history, the clinical presentation

and circumstances of admission, the risks and the purpose of admission including recommendations for treatment. On discharge from hospital, the wards do not have a similar protocol and the information provided varies. Assertive Outreach Team members do inreach into the wards in their efforts to be included in and to inform discharge plans. There is scope for improvement in this aspect of communication.

30. In the community, patients are mostly seen face to face in their homes. This includes a range of accommodation from people's own properties to various levels of supported or staffed accommodation. Homeless people are supported by the team, and it can be very challenging to locate them for support, assessment and treatment, especially when rough sleeping, a scenario which has become increasingly common over recent years. Many people on the caseload are digitally excluded and do not have a reliable phone number so multiple unsuccessful visits are inevitably required to maintain contact. During COVID full face to face contact was essential rather than remote working for this this group. Regular working with informal networks, when they are present, is important to maintain contact, support carers and gain collateral information on progress and concerns.

31. The frequency of contact depends on a variety of variables. Patients can be seen as often as twice daily and multiple attempts may be necessary during the course of a day to see individuals when earlier visits are unsuccessful. Planned contact attempts are decided during daily morning planning meetings and the team works extended hours including evenings until 8pm and weekends to offer increased flexibility. There are many unpredictable

urgent situations which arise with this group and the team frequently flexes to accommodate additional urgent visits. I, as the team consultant psychiatrist must also offer flexibility in order to undertake urgent same-day medical assessments, especially given the high-risk profile of this group. Urgent situations include deterioration of mental and physical health as well as periods of escalating risks. When contact is lost, the team reviews the risks and take appropriate action which generally includes increased efforts to locate the person involving support networks and other agencies including the police. When concerns are high the patient may be placed in the team's Red Zone which ensures daily review and frequent contact.

32. In addition to responding to urgent situations, planned supportive and rehabilitative work requires a high level of contact. This may be for face to face support with appointments, help with housing and benefit issues, occupational therapy, substance use work and psychology input and supporting attendance at the team's in-house groups. This foundational work is essential to promote longer term recovery. It is legitimate to maintain other patients on less frequent contact when they are more stable to test out whether they can be transferred to a lower-intensity service or discharged to the care of their GP.

33. In all of this, there must be consideration of the patient's wishes. These must not dictate care if their mental state and risks make that unsafe, but it is important to strike a fair balance between autonomy and beneficence, even when a statutory framework such as a CTO is being used, as collaboration yields the best outcomes. As detailed in paragraph 35 below, the fidelity scale

dictates that Assertive Outreach operates a no dropout policy and is time unlimited. Patients are not discharged because they "fail to engage" or because they are considered "hard to reach". This means that patients are supported by the service for long periods. Most people do report benefit from the consistent practical and psychological support they receive and, in almost all cases, a good therapeutic relationship is eventually formed.

34. There are cases in which it is not possible to achieve this therapeutic relationship, but it is largely still possible with this minority to maintain contact and treatment. They may not accept additional support but the risks they pose to both themselves and others as a result of relapse are significantly reduced and they are maintained out of hospital in the community. In Leeds the use of adult acute beds was calculated for patients accepted by the Assertive Outreach Team over a 5-year period in the 18 months before and after being accepted onto the team's caseload. The number of "bed days" before Assertive Outreach involvement was 27,464 and the number after was 9677. This equates to an indicative saving of 17,787 acute bed days which in turn equates to the running cost of 10 beds for that 5-year period.

35. Patients with the Assertive Outreach Team invariably have a history of poor medication concordance. However, with the approach described above, this improves in almost all cases. This improvement might involve the use of depot antipsychotic medication, a regular injection given at intervals of between one and four weeks, with one specific medication (Paliperidone) allowing a three-monthly injection. Alternatively in cases of treatment resistance the use of the medication Clozapine may result in significant improvement, although the

required mandatory blood monitoring limits its use in this group. My experience of working exclusively with this patient group for over 20 years is that regular treatment can vastly improve the capacity of the patient to engage in discussions about the benefit of medication as well as making them more amenable to accepting other support. This may not involve full recovery but instead being able to reach a shared understanding of the need for treatment and collaboratively finding an acceptable and effective medication.

36. Regular review of treatment is essential, and this is one aspect of care that is reviewed in all patients on a weekly basis. Patients frequently complain of side effects with psychiatric medication and listening to these concerns is important. Undertaking thorough reviews of treatment is an important aspect of this more indepth approach to establish which medications might best suit patients with a history of poor compliance. The Assertive Outreach Team has dedicated senior pharmacy input, and this is helpful in formulating strategies for treatment in complex cases of treatment resistance, in the use of combination therapies and when high dose treatment is required. In some cases, this might start with the use of a CTO to ensure medical treatment and mitigate against the risks associated with relapse. If compliance is poor, then recall to hospital can be used. When oral medication is being used then direct prescription and monitoring compliance within the Team rather than by the GP is vital. This is labour intensive and requires adequate qualified nurse staffing for the limited caseload.

37. There is a small minority of patients who are extremely challenging to support in the community. This group comprises patients who are more often male,

use large amounts of illicit drugs and who pose high violence risks. They lack the skills to live independently and have a history of significant self-neglect and an inability to maintain a property. There are antisocial aspects to their behaviour which in combination with their risk profiles prohibit them from accessing supported accommodation. They do not easily engage in rehabilitative work and are rejected by high dependency rehabilitation and forensic wards. Consequently, they often experience homelessness which makes it very difficult to maintain contact and treatment. They may have contact with the criminal justice system and spend time in prison. A typical scenario is repeated emergency admissions to acute psychiatric wards or PICUs and eventually acceptance into more restrictive hospital settings. They are overrepresented in private out of area placements.

The Theemis Report [**NHSE000298**]

38. The Theemis Independent investigation into the Care and Treatment provided to Valdo Calocane was commissioned by NHS England and published in January 2025. It covered the period from his first contact with mental health services to the time of the killings. The stated purpose of was to identify learning and provide recommendations at a local, regional and national level to reduce the likelihood of a reoccurrence of the tragic events. The report gives a brief outline of Assertive Outreach and then a timeline of the introduction and evolution of this approach in England. It refers to "various models of assertive outreach across the country until the 2010s" and the subsequent effects of austerity in the reduction of Assertive Outreach provision over subsequent years, stating that, "With the reduction in budgets, many Trusts combined the function of assertive outreach within the local

mental health team, and it became part of the role of the care coordinator to assertively outreach to those on their caseload" but went on to comment that, "with reduced staff, higher caseloads and an increased acuity of illness amongst the caseload experts spoken to as part of this investigation questioned if the assertive outreach function has been delivered as imagined". The report authors state that, "we heard that part of the demise was due to the lack of research evidence and a growing body of people who considered that it was not always therapeutic. Experts by lived experience told the independent investigation that some people felt it was more of a monitoring service".

39. The Theemis Report unfortunately represents a missed opportunity to properly consider the potential benefits of Assertive Outreach in this specific case. As has already been stated, Assertive Outreach is a very clearly defined team-based model of care. Whilst various hybrids may have been used in different areas, these cannot be accurately referred to as Assertive Outreach Teams. Their results, derived from quasi-experimental evaluations, lack the rigour of RCT studies and cannot compare to wealth of long-term international evidence for high-fidelity ACT/Assertive Outreach. It is emphatically not the case that the term Assertive Outreach can ever be used to describe the work of individual staff within a wider Community Mental Health Team. The authors' stated concerns about the research base are not evidenced in their report and it is uncertain what direct experience either the authors and consultees for this report had of Assertive Outreach either as practitioners or recipients, especially as the model appears to have been disbanded in the locality

concerned from around 2012. To my knowledge, there is no mention of an Assertive Outreach specialist having been consulted in the preparation of this report. Clearly, high-fidelity teams do still exist, and experts could easily have been approached.

40. The Report then describes the Trust's EIP Service Operational Policy which includes a comment about an "assertive approach" to care. There are few similarities between EIP and Assertive Outreach services, in the patient demographic, structure, philosophy and operation and the former cannot realistically be expected to deliver "assertive outreach in its intended format".

41. The comment which concludes the section on Assertive Outreach bears little resemblance to the reality of the daily work of an Assertive Outreach Team. It states that even if adequate resource is available, the effect of Assertive Outreach might be to worsen engagement due to paranoia and talks about how developing a shared understanding would have been beneficial. It is very disappointing that the authors did not consult with an experienced Assertive Outreach clinician as they would have discovered that this is exactly how such highly skilled teams do indeed collaborate and engage with the majority of patients who are often very paranoid, over periods which may extend to years and how effective they are at forming very strong therapeutic relationships. Assertive Outreach is not as the authors suggest "a monitoring and support mechanism".

42. From its inception Dr Stein, one of the founders of the model was clear that the assertive approach adopted in the model, whilst involving careful patient

monitoring and acting quickly and decisively to avert negative consequences, is not about keeping them "under control", but is also directed towards shaping team members' behaviour and an ethos of increasing the individual's independence. The main goal is to help people to live successfully in the community rather than spending lengthy periods in hospital **[WITN0412013].**

43. In the UK, The Sainsbury Centre for Mental Health stressed that, "The foundation for effective Assertive Outreach Services will be "engagement" and "persistence" with a constructive rather than a restrictive approach to keeping track of people". As described in Assertive Outreach in Mental Health: A Manual for Practitioners, strategies by which this is achieved include frequent and persistent direct and indirect contact rather than repeated hospital detention, regular support for family and carers, collaboration with the individual and working with third parties (informal social networks), home and community based interventions (rather than hospital based), strength based practice, a non-judgemental approach, advocacy, practical assistance and problem solving, involvement in social and recreational activities, employment assistance and support and help supporting and maintaining accommodation **[WITN0412014].**

44. Conversely, the Theemis report makes a recommendation across the Trust for a robust peer support offer for those under community mental health services with access to culturally appropriate groups with lived experience. Whilst peer support may be generally very helpful, the evidence base for peer support is limited in this very disengaged psychotic group who demonstrate such low levels of insight, and this accords with my 23 years of clinical

experience as a consultant in this field. I am not aware of any research which supports the influence of peer support in this group in the key areas relating to violence risk in psychosis, namely maintaining clinical contact and treatment adherence, substance use and homelessness.

Fidelity to the Assertive Outreach Model

45. With no comment on the specific facts in this case, the specific factors taken from the Dartmouth Fidelity Scale which would potentially have been beneficial in this case are as follows:

- access to specialist care as the explicit inclusion criteria were met
- assertive engagement
- small caseloads and a team caseload size allowing for a shared team approach
- daily planning of care
- continuous assessment of risk
- a dedicated Assertive Outreach consultant psychiatrist with specific expertise of supervising this patient group
- dedicated nursing staff with similar experience
- high intensity of contact
- increased work with the social network (explicitly expected in the model) and agencies such as the police
- in house responsibility for crisis management
- responsibility for hospital admissions (no crisis team involvement required)
- increased hospital inreach

- responsibility for hospital discharges
- community based care and no expectation for patients to attend hospital/healthcare bases
- time unlimited care, no dropouts
- no discharges to primary care due to disengagement
- responsibility for prescribing and close monitoring of treatment
- extended hours service including evenings and weekends

46. These are all specific features of Assertive Outreach which were not referenced in the Theemis Report.

NHS England's Guidance on Intensive and Assertive Community Mental Health Treatment [**DHSC0000163**].

47. I have been asked to comment on NHS England's 2024 guidance on intensive and assertive community mental health treatment. I was one of the authors this guidance, which was intended to support Integrated Care Boards (ICBs) to "review their community services by Q2 2024/25 to ensure that they had clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up, but where engagement is a challenge". The guidance also stated that, "Systems have a responsibility to ensure they commission the right mix of services to support the needs of their local populations. This includes a dedicated resource to provide intensive and assertive care for those individuals who need it."

48. The document highlighted key themes from previous serious untoward incidents and went on to discuss the use of depot medication, Community

Treatment Orders and then the features of "intensive and assertive community care".

49. It should be made clear that that this umbrella term, unlike Assertive Outreach, is not a clearly defined model of care. What this document describes therefore is what might be considered good general principles of care, and then separately, the gold standard of Assertive Outreach. It was never the intention that the two be seen as equivalent. There was a clear statement at the outset of this work that NHSE was not proposing to ICBs that Assertive Outreach should be available in all areas and there was no guarantee that funding would be available to provide this. What followed this paper was the 2025 system review into intensive and assertive community treatment [**WITN0412012**] in which all ICBs reviewed their community mental health services to ensure effective, assertive support for people with Severe Mental Illness (SMI). It is my opinion that these reviews were not designed specifically enough to capture the needs of severely mentally ill patients who are disengaged, poorly compliant and pose high risks during relapse, and as a consequence they do not provide adequate assurance that the needs of this group are effectively met. My view, which is supported by discussions with clinical colleagues around the country, is that they are not.

Recommendations

50. Patients who meet the criteria for Assertive Outreach Team involvement as described in paragraph 6 have complex and long-term needs:

    - They have a severe and mental illness which may be resistant to treatment. They therefore require skilled input from qualified

professionals who have experience in the medical treatment of psychosis. This includes pharmacological and psychological treatment, nursing interventions, habilitation and rehabilitation. These specialist skills exist within Assertive Outreach Teams.

- These patients demonstrate poor insight into their illness and for this reason they do not engage with services or take medication. They are very easily lost to follow up or discharged when under the care of standard Community Mental Health Teams or when supported by single workers. They require a team that maintains contact with patients with these characteristics and whose progress is closely monitored by dedicated and experienced specialists within a team structure which has the resource to offer a high level of contact and daily review and maintain a shared team understanding of their needs and risks.
- They have histories characterised by repeated relapses and hospitalisations and require a team, including qualified nursing staff, that can closely monitor compliance, make repeated visits as necessary to deliver medication and administer depot antipsychotic injections. The individual and overall caseloads must be limited to maintain capacity to allow this, as offered by an Assertive Outreach Team.
- They have high risks which may include significant violence risks. They require a team led by a consultant psychiatrist dedicated to and experienced in the assessment and management of higher risk

thresholds. They require close monitoring of these risks with robust longitudinal risk assessment and regular review.

- They frequently have comorbid physical illness (obesity, diabetes, heart disease, smoking related illness etc.) and do not engage with their GPs. They suffer significantly premature mortality and need support from a team which is appropriately skilled and experienced in supporting their physical healthcare.
- They have multiple social needs relating to housing, finances, daily living skills and substance use. Some factors do potentially specifically increase their violence risk. They do not engage with the standard services provided and therefore need dedicated in-house support from their supporting community team. They are often at a pre-contemplative motivational stage regarding their substance use and benefit from the harm reduction approach which is offered within the Assertive Outreach model.
- They are socially excluded and require assertive support from a multidisciplinary team including occupational therapists skilled in engagement to develop in the areas of meaningful daily routines, social activities, education, employment, and community connection including with family.
- They often have distressing psychotic experiences which persist even with treatment and significant trauma histories from life experiences both before and after their entry into psychiatric services. They do not engage with standard psychological services and require an approach

which is more flexible and opportunistic, and which is offered within the Assertive Outreach.

- Their needs are long term and due to this and their engagement issues, they need a team which offers time unlimited support and who will not discharge them for disengagement.

51. The Theemis Report did not consider Assertive Outreach in detail. It neither details its review of the evidence base, including the international evidence, nor does it seem to have included an Assertive Outreach specialist as either an author or a consultee. Importantly the case of Christopher Clunis is mentioned only in passing, despite this case being the catalyst for the national rollout of Assertive Outreach in the late 1990s/early 2000s. The Ritchie Report itself is not referenced. It is uncertain therefore how much the similarities in the characteristics of the cases of Clunis and Calocane were appreciated, the valuable learning within the Ritchie Report and its detailed recommendations including the national implementation of Assertive Outreach.

52. It is therefore respectfully recommended that the Inquiry directly considers the information contained within the full Ritchie Report including its recommendations. Clunis's care was described as a "catalogue of failure and missed opportunity". It was also said that "we are concerned that these failures may well be reproduced all over the country, in particular in poor inner-city areas. We have heard time and time again throughout the inquiry that Christopher Clunis is not alone, that there are many more like him living in the community who are either a risk to themselves or others". My opinion

is that, whilst most people who have severe mental illness are never violent and they are more likely to be the victims rather than the perpetrators of violence, this concerning statement nevertheless holds true today and I have spoken to many senior clinicians who agree. The killings in Nottingham were not an isolated incident and could have happened in many other places. This is contributed to by the inadequate level of care for this patient group as most areas have lost their Assertive Outreach Teams. Both the individual and systemic factors which contributed to the homicide perpetrated by Clunis, as detailed in the Ritchie Report are still highly pertinent today and factored in the homicides committed by Calocane.

53. Recommendations to the Inquiry, not specifically related to Assertive Outreach:

- That the planned statutory community careplans retain the ethos of the Care Programme Approach. Whilst the process may have become bureaucratic, the principle of CPA and a focus on longer term needs in severe mental illness is supported by most clinicians
- Specifically, the principle of qualified care coordination should remain. The Ritchie Report specified that the nominated keyworker providing Section 117 aftercare should always be a qualified community psychiatric nurse or social worker. The mental healthcare workforce is becoming increasingly unqualified, and this is a concern as qualified staff have additional skills in the assessment of mental illness, the assessment of risk and the use of statutory authority including the Mental Health Act which unqualified staff do not have. Additionally,

formal registration carries accountability, requirements of fitness to practice and suspension if professional standards are not met. Teams caring for those with patients with severe mental illness should have adequately qualified staff.

- Similarly, patients should have a dedicated consultant psychiatrist. Doctors with this level of training have skills required in the management of severe mental illness which other professional groups do not have. Reduced fidelity to the model including a lack of dedicated consultant time significantly reduces the effectiveness of the model.
- Recent developments in risk assessment have been detrimental to patients who present violence risk. The focus of risk assessment has moved almost exclusively towards suicide risk. Whilst there has been a welcome shift away from risk ratings/scores, this has included a failure to acknowledge the utility of structured professional judgement and risk formulation. The guidance on violence risk assessment should be clear. There should also be a requirement to include any history of violence in transfer letters and hospital discharge summaries.
- Community Treatment Orders provide an important framework for treatment for some patients. The available research does not provide adequate evidence against their use, and their scope should not be narrowed with the implementation of the Mental Health Act 2025.
- Research, including that relating to CTOs, focusses on hospitalisations as a proxy measure for their effectiveness. For the reasons given in paragraph 18, this is now a poor measure of effectiveness. Also, a recall of a CTO or any other form of hospital admission may well be

the most appropriate and effective intervention in the prevention of violence in a non-compliant or relapsing patient. For this reason, "bed days "should no longer be used as a measure of the effectiveness of psychiatric interventions. In the consideration of whether the criteria are met for CTOs, Tribunals more explicitly consider the nature rather than simply the degree of a patient's illness.

- Specific attention should be paid to the patient cohort described in paragraph 34. This group are often excluded from all support until their risks eventually dictate that they enter the most restrictive care environments. Options for more risk-tolerant supported accommodation and collaborations between health services and housing providers should be carefully explored. More broadly, given the association between homelessness and violence risk in the severely mentally ill, there should be a mandatory social work assessment for patients in this situation whether in hospital or the community.
- There should be a clear requirement for inpatient services to involve community services in discharges and to provide high quality discharge information.
- Nationally, there are inadequate locally available beds in the acute pathways, rehabilitation and in forensic services. This prevents access to appropriate care as well as contributing to premature discharges. Both factors increase violence risk in the community. Additionally, whilst the trend towards less restrictive practice is welcomed there will be patients described in paragraph 34 who will not be catered for within

the proposed changes to level 2 rehabilitation beds, but who will also not meet the criteria for low secure forensic beds. In the future they will have very few remaining options for inpatient rehabilitation and will be rejected by supported accommodation placements. They pose high and potentially unmanageable risks in the community.

- The needs of ethnic minorities and in particularly asylum seekers should be considered. They often have significant trauma histories, very limited access to resources and support and have additional cultural and language needs which can make assessment and management of violence risk more complex.
- Multiagency working is problematic. Information sharing across health, social care and other agencies including the police, probation and prison services is inconsistent and often poor. Bureaucratic barriers exist which delay information being shared in a timely manner and this is not significantly improved by multiagency frameworks such as MARAC (Multi-Agency Risk Assessment Conference) and MAPPA (Multi-Agency Public Protection Arrangements). From my extensive experience as a senior frontline clinician caring for high-risk patients, these meetings do not effectively facilitate interagency participation and are not responsive to acute changes in circumstances. These frameworks are not sufficiently dynamic and do not ensure timely communication of information about risk across agencies even when serious incidents are known by an involved agency to have happened. They do not provide assurance that serious violence risks are being safely managed in a coordinated fashion. There is no consistent way

of flagging concerns across agencies, for example with police or emergency departments and police forces in different areas operate in a similar disconnected fashion to local health services and local authorities. The introduction of Right Care Right Person has seen less interest in mental health patients by the police even when the involvement of the police is appropriate due to the risks. Joint working is currently very limited, even when Mental Health Act assessments pose significant risks to those assessing patients in the community.

Main Conclusion Relating Specifically to Assertive Outreach Provision

54. It must be emphasised that Assertive Outreach is very clearly defined and that its evidence base makes it the only community mental healthcare model which is specifically designed to meet the needs of patients with severe mental illness who are disengaged from services, poorly compliant with treatment, prone to repeated relapses and identified by their histories as being at high risk of committing acts of violence during these periods of deterioration. Its effectiveness relies on a high-fidelity standalone team. There is no such thing as "an assertive outreach approach", it cannot be delivered by isolated workers within a standard CMHT and the hybrid models lack any robust evidence. It is my recommendation that all patients who require this type of support have equitable access to it. The Ritchie Report, which examined a case which was similar in many respects to the focus of the current Nottingham Inquiry, was unequivocal in drawing this conclusion.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: GRO-B

Dated: 23/02/2026

Index to First Witness Statement of Dr Nuwan Dissanayaka

No.	Inquiry URN	Document Description
1.	WITN0412002	Email dated 5 February 2026 from Dr Nuwan Dissanayaka to the Nottingham Inquiry.
2.	NHFT0015099	RCPsych Good Practice Guide - Assessment and management of risk to others.
3.	DHSC0000038	Department of Health - Best Practice in Managing Risk
4.	DHSC0000163	NHS England – Guidance on intensive and assertive community mental health treatment
5.	WITN0412003	Stein, L.I Test, M.A. (1980). Alternative to mental hospital treatment: 1. Conceptual model, treatment program, and clinical evaluation. Archives of General Psychiatry, 37(4), 397-397
6.	WITN0412004	Bond, G.R., Drake, R.E., Mueser, K.T., Latimer, E.(2001) Assertive Community Treatment for People with Severe Mental Illness. Disease Management and Health Outcomes, 9(3), 141 -159
7.	WITN0412005	Teague, G.B., Bond, G.R., and Drake, R.E. (1998). Program Fidelity in Assertive Community Treatment: Development and Use of a Measure. Psychiatric Services, 49(2), pp 216 – 220
8.	DHSC0000160	Ritchie, J (1994) Report of the inquiry into the care and treatment of Christopher Clunis. London: HMSO
9.	DHSC0000097	Department of Health (1999) National Service Framework for Mental Health. London. Department of Health.
10.	NHFT0004881	Department of Health (2001) Mental Health Policy Implementation Guide. London. Department of Health.

11.	WITN0412006	Killaspy, H., Bebbington, P., Blizard, R., Johnson, S., Nolan, F., Pilling, S., King, M. (2006). REACT: A Randomised Evaluation of Assertive Community Treatment in North London. British Medical Journal, 332: 815-819.
12.	WITN0412007	Leeds AOT – Number of adult acute bed days used pre- and post- AOT involvement (n=121 service users)
13.	WITN0412008	Leeds AOT – Bed usage
14.	WITN0412009	Unpublished Leeds, West Yorkshire our high-fidelity Assertive Outreach Team data.
15.	WITN0412010	Hodgins S. (2014) Antipsychotics, Mood Stabilisers, and Reductions in Violence. The Lancet 2014 Sep; 384(9949)
16.	WITN0401002	Fazel S., Smith E.N., Chang, Z., Geddes J.R. (2021). Risk Factors for Interpersonal Violence: An Umbrella Review of Meta-Analyses. The British Journal of Psychiatry, 218 (4), 198 -206
17.	WITN0069005	Baird A., Webb R.T., Hunt I.M., Appleby L., Shaw J. (2020). Homicide by Men Diagnosed With Schizophrenia: National Case-Control Study. BJPsych Open, 6(6), p.e143
18.	WITN0412011	University of Manchester, Avoidable Deaths. Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2006, University of Manchester
19.	NHSE0000298	Theemis Report – Independent Investigation into the care and treatment provided to VC – January 2025
20.	WITN0412013	Stein L.I. and Santos A.B. (1998). Assertive Community Treatment of Persons with Severe Mental Illness. New York: W.W. Norton and Company
21.	WITN0412014	Burns T. and Firn M. (2002) Assertive Outreach in Mental Health: A Manual for

		Practitioners. Oxford, Oxford University Press.
22.	WITN0412012	NHS England (2026) Outcome of the 2025 system review into intensive and assertive community treatment.