this population, aptly noting that rates of active substance use among ACT recipients has been shown to grow over time in some studies.

Measuring and studying active substance use is challenging, and with a shift toward harm-reduction approaches, active substance use may not be a fair proxy of full cost to a community or the overall well-being of the person enrolled in ACT. Substance use disorders are often chronic conditions highly prevalent among the ACT population and responsible for much of the variation in outcomes and clinical stability over time. It is hard to imagine more intensive programs than integrated ACT for persons with serious mental illness and co-occurring conditions that would be better suited to deliver a comprehensive suite of services to this population. Furthermore, delivering consistent and high-quality substance abuse treatment services is challenging even among highly skilled professionals if there is not consistent monitoring or attention. Over time, ACT team staff can grow demoralized and complacent and lose creativity when working with some individuals, which may further complicate full recovery. While possibly responsible for some dilution of the return on investment for ACT services, it is equally possible that ACT saves more money for these relatively complex cases and that substance abuse treatment services within ACT should be given more overt emphasis and attention. I agree with the comment that more study is needed in this area, because many questions remain unanswered about the optimal service delivery system for the complex needs of people with co-occurring disorders.

The authors also describe their positive experience in identifying and treating medical conditions within an ACT team, which is in line with our experience as well. As I and my colleagues have argued, ACT is an overlooked service delivery gem with great opportunity for integration of multiple services, including general health care. Over time, ACT has shown itself to be an adaptable service delivery platform capable of addressing many of the holistic needs of persons qualifying for its services. In an era of integrated care, health care reform, health homes and the like, it should be dusted off, polished up, and allowed to shine.

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Flexible Assertive Community Treatment

TO THE EDITOR: The article by Huz et al. (1) described an initiative to improve flow through assertive community treatment (ACT). We recognize the observation that without adequate flow, ACT capacity becomes "silted up" as individuals become entrenched in intensive service provision, sometimes to the detriment of self-management. We concur with them that successful transition from ACT to less intensive and costly services is possible when appropriate follow-up services are in place. Indeed, our own follow-up study, in the English National Health Service system, has shown that ACT patients "are remarkably resilient to significant reductions in the intensity of care and this holds for up to four years" (2).

In the Huz et al. study, patients were identified as suitable for step-down treatment through use of a transitional readiness scale. In our study, we were faced with the closure of ACT teams and used flexible assertive community treatment (FACT [3]) as an alternative to ACT.

FACT offers, from within the same team, standard community mental health care where possible plus an intensive ACT equivalent, if needed. For a typical locality, about 10% of the FACT caseload is receiving ACT care, incorporating shared caseloads and frequent visits, at any one time. Flow between the two levels of care is mediated without referrals by using routine team decision making.

Although FACT was developed as an affordable model in rural areas in the Netherlands, our research has shown that it can also be effective in cities, specifically London, and could be considered more widely as an alternative to ACT.

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