suggested. The use of a device whose main purpose has been pioneered by the criminal justice system seems to take us closer to making our hospitals prisons. A recent report published by the Criminal Justice Joint Inspection reiterates their 2008 findings that enforcement thresholds were not sufficiently stringent.[2] With notable problems implementing this system within the criminal justice system, is it justifiable to implement it within the forensic services, given the cost of such a system?[3]

Given the recent concerns about certain international security companies, the provision of such tags also raises ethical issues. Confidentiality must also be considered – would said companies have access to patient names and locations? The comparison of electronic monitoring with other uses of technology within psychiatry, such as mood monitoring via text message, is bizarre. The principles approach[4] gives us a framework in terms of judging whether an intervention respects autonomy, beneficence, non-maleficence and justice. Debate of these principles will exceed the remit of this letter; however, it is worthwhile considering autonomy and beneficence in particular relating to the patient: we suggest that there is a breach in both. The weighing of these principles will not be easy and it will be a matter of debate whether the principle of justice will outbalance the former.

As the authors state, robust research in this area is needed, and we look forward to reviewing the evidence.

1 Tully J, Hearn D, Fahy T. Can electronic monitoring (GPS 'tracking') enhance risk management in psychiatry? *Br J Psychiatry* 2014; **205**: 83–5.

2 HM Inspectors of Probation. *It's Complicated: The Management of Electronically Monitored Curfews*. Criminal Justice Joint Inspection, 2012.

3 Shaw D. Satellites used to track mentally-ill violent criminals. *BBC News*, 25 August 2010.

4 Gillon R. *Philosophical Medical Ethics*. Wiley, 1985.

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Authors' reply: We had hoped that our article would stimulate a balanced discussion about this complex issue. We entirely agree with the view expressed in both letters that trust and therapeutic alliance between the patient and the treating team are critical components of the recovery process. We do not believe, however, that use of electronic monitoring necessarily indicates a lack of trust. It was envisioned that the device be used primarily for patients in the initial stages of taking leave as part of their clinical pathway towards discharge into the community. Our clinical experience, supported by as yet unpublished data, confirms that this has been the case in our service. In these circumstances, electronic monitoring may even help to further develop a trusting relationship between the wearer and the team, by granting earlier and more frequent leave and by allowing the patient to demonstrate avoidance of exclusion zones when on unescorted leave. There must be a balance between trust and therapeutic optimism in our treatment of our patients. Furthermore, viewing trust as being simply 'present' or 'absent' would be a naive approach in forensic services. These questions are being explored in quantitative and qualitative research of electronic monitoring in our service.

Both letters raise concerns about granting of leave for high-risk patients. Watson *et al* point out that decisions surrounding leave are complex, a view that we share. However, the implied view in both letters that patients can be discretely classified into high risk for absconding or not is again overly simplistic. Clinical impression alone in risk assessment has been shown to be unreliable and validated risk assessment tools have been shown to be more useful in identifying individuals at low rather than high risk.[1] No validated tool for the assessment of absconding risk yet exists, though we are currently working on developing one. Risk management, therefore, involves a component of positive risk-taking aided by creative management strategies. We propose that electronic monitoring is such a strategy.

Watson *et al* are liberal in their use of the term 'coercion'. A policy was put in place whereby patients were informed that use of electronic monitoring was optional and if they chose to decline to wear the device, their leave would be risk assessed as per normal procedure. Consent is another complex issue in psychiatry and can be defined in degrees, rather than as a binary concept.[2] It is true that patients' decisions about consent to electronic monitoring are likely to be influenced by their wish to move more quickly towards leave and discharge. This has parallels with consent to medication and engagement in psychotherapies and occupational activities, particularly in the forensic setting.

Watson *et al* express concern about forensic services being closely aligned with the prison system. We believe that the use of secure units with locked wards and secure perimeters represents a level of coercion much more closely aligned to this system than does electronic monitoring. Any strategy that can help minimise the amount of time spent in such units would then surely be a welcome development for those concerned about patient liberty and overall progress. Far from making our units more like prisons, one of the key aims of our strategy was to allow for engagement in community leave and activities at the earliest possible stage. As Simpson & Penney point out, electronic monitoring may allow the person more apparent personal freedom than their clinical risk would otherwise allow.

The article referenced in *The Sun* was chosen as an example of media coverage of such absconding events. That such reports are often sensationalised or biased is one of the many challenges facing mental health services and patients. Media coverage of absconding events leads to reputational damage for services and can undermine the confidence of the community. We cannot and should not ignore community attitudes towards system breaches, especially as clinicians will be held to account when they occur. Another of our aims is therefore to reduce the frequency of these incidents, for the protection of the public and the reputation of our service.

Watson *et al* are correct in saying that electronic monitoring cannot directly prevent violent incidents. We believed that this was self-evident and therefore we did not address this issue in our article. Regarding costs, a cost–benefit analysis is currently underway. As our article states, our service was acutely aware of the important ethical considerations and we sought legal and ethical advice. A commentary addressing legal and ethical issues in more depth is currently being prepared. The questions Simpson & Penney raise about reoffending, recovery and longer-term outcomes are valid and we hope to address these in our future research.

1 Fazel S, Singh JP, Doll H. Use of risk assessment instruments to predict violence and antisocial behaviour in 73 samples involving 24 827 people: systematic review and meta-analysis. *BMJ* 2012; 345: e4692.

2 Konow J. Coercion and consent. *J Inst Theor Econ* 2014; **170**: 49–74.

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