ASHLEY RULE
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I know a lot of a lot of prisoners, I mean I tell my children this when they get worried about burglars, I say, ‘You don't need to worry, I know all the burglars. I've met them all, they're all my friends.’

So I am Ashley Rule, I'm a psychiatrist. I'm a consultant psychiatrist, and part of my job is that I am the consultant psychiatrist for the local big prison. The first prison I visited was as a trainee, and I was in London, in one of the big old Victorian prisons, and it's very much like the movies - you know, big brick walls behind big gates. There's a sense, ‘are these people going to be different to me and the other patients that I see? Are they are all going to be scary?’ Again, like you might see in the movies, sort of it's like the Wild West, you know, that the prisoners are all sort of in charge of the wing and the officers are sort of cowering in the corner and what have you. Which it isn't like that at all - but those were the thoughts that certainly went through my head at first. So, sort of, one in four, you know, something like that is I think the national average for mental health problems in the normal population, the non-prison population. Within the prison, depending on different measures and what type of prison it is, and what type of prisoner you are, you're talking of the vast majority. You know, there are figures as high as, saying that remand prisoners - so that's prisoners who are in prison, having not yet been convicted of an offence - it's as high as 80%, so it's much, much higher - have got a mental health problem.

If you want good mental health, you would not choose to put yourself in an environment like a prison. It's a stressful environment, you're not going to sleep well and a lot of people with psychotic illnesses, sleep is really important. If they don't sleep well, that will often trigger an episode of something, of mania or something like that. Beds are uncomfortable, you're sharing a cell, it's noisy, it's cold. There are some conceptual issues within the prison that I was aware of when I first came in, in terms of being a psychiatrist there, the idea of 'What is depression?' For example, in a prison - you're meant to be being punished when you're in prison and therefore, by implication, you're not meant to be happy. So at what point does being appropriately unhappy, because you're in prison, equal depression? I get a lot of referrals of patients who are prisoners, who are, who are depressed, and you get to see them and sure enough they are, they're unhappy and they don't enjoy their life and they don't sleep well and they can't get any pleasure from things - but, they're in prison, and you think, ‘Well, I don't want to say “Look, I'm terribly sorry, but you know, it's my job to ensure that you are appropriately unhappy.”’ I mean that certainly can't be right. It isn't my job at all to do that - if somebody is depressed, they're depressed. You know, if I see somebody out of hospital who's depressed, it doesn't really matter *why* they're depressed, if they’re depressed, and it would seem wrong in the prison to say, ‘Yes, if you're depressed because you've had relationship problems, then that's fine and all and I'll take you under my wing and look after you. But if you're depressed because you're in prison, then, you know, tough luck buster, you know, that's why you're here, and so that's not an illness, and just get on with it.’ That's difficult.

There's often a conflict in our role, as to who we're there for, if you like. It's very clear from my job description that I'm there for my patients, and my patients happen to be prisoners, and I don't work for the prison, I work for the NHS, whereas most of the other people who work in the prison *do* work for the prison service and their role is very different. Their role is to contain and manage and it's all about discipline. We're often seen as the do-gooders, who go in and are nice to prisoners who really should be given a hard time, because that's what the prison officer sees, you know, you come into prison and you're not there to be, you know, there to be treated nicely, it's a punishment.

So, yes, you know it does feel different for us. You know, we would call prisoners by their first name but the officers would all call them by their surname. Often, if you go in and say, you know, ‘Do you know where Jimmy Smith is?’ - that's not a real patient's name! - they'll not know, because they didn't know that his name was Jimmy. They'll say, ‘Well what's his number?’ If you say, you know, 8947 something, they'll say, ‘OK, yeah, I know where *he* is but not Jimmy Smith.’ So they try to not have that relationship.

Prisoners aren't allowed to have cash. And so there are alternative currencies, the main one being 'burn', tobacco, and the interesting thing there, is that most prisoners are supposed to be going smoke free this year, which I think is going to be very challenging. The way it works is a premise called ‘double bubble’, which means, if you give somebody a certain amount of tobacco, you expect two in return. But prisoners will also trade any amount of medication, and that's an issue that I have. Particularly medication that makes you sleep, which the vast majority of medications that I prescribe as a psychiatrist do. And so prisoners will trade and swap and sell their medication. I suppose, if you're in prison and you just you just want time to pass, the easiest way to do that is to sleep.

If a patient tells you that, for example, they're hearing voices or that they believe that you know that people are spying on them or they're at risk or they're a secret agent or whatever it is that they tell you - at the end of the day it comes down to your clinical impression as to whether they're telling the truth or not and they, and they might well not be, but there's nothing I can do to prove or disprove. And so, often you have your suspicions that they're making it up but you never know! There are various little tricks of the trade that the average person who's trying to pretend to be unwell just wouldn't know. There are some symptoms I think of psychosis that you might see on telly that aren't real, that you just never really see in patients who are obviously unwell. Um, for example, the idea about hearing voices. I think the average person would think that somebody with an illness like schizophrenia hears voices in their head, which is what somebody who doesn't know might tell you, whereas, if in fact patients with schizophrenia don't hear voices in their head, they hear voices coming from around them. The voice is coming through their ears, it's from external space, and so an obvious question is, if somebody says they're hearing voices, you ask where the voice is, where does it come from. If they say ‘It’s in my head,’ it's probably not really a hallucination. If they say it's coming from the light fittings or it's coming from underneath my bed or it's coming from the telly, that would be more convincing. And you'd say, ‘Well, what are the voices saying?’ If somebody is hearing voices they'll tell you, because they can hear them. If they're, if they're not, and they haven't actually thought this through, they'll stumble. You know, I've heard prisoners tell me, they say, ‘I'm hearing voices,’ and I say, ‘OK, well, you know, what is it the voices are saying?’ and they'll say, ‘Oh well, you know the kind of thing that voices say,’ and you say, ‘Yes, but what is that they say?’ ‘Well the kind of things that people who hear voices hear’!

And they can have themes as well, you know, depending on what's going on in the world. I can remember, you know, back in 1999, having a run of patients who were all infected by the millennium bug whatever that meant. And, of course, you never see that at all now. But now, you know, a lot of patients who are unwell will talk about ISIS. You know, a couple of years ago, everybody who was unwell was talking about the Illuminati and about the Freemasons. So there are sort of various themes like that come up, you often have people with ideas that are very much like The Matrix - that was another good one. You need to keep abreast of popular culture in order to spot these things, as they, as they go on very much so.

And, of course, there's incentives for the patients to lie as well, not just in terms of wanting medication, but patients who haven't yet been convicted of an offence, if they are up for a very serious offense might want to either be able to give an argument in court that they were unwell at the time of the offence in order to get a lesser sentence or to get off their conviction altogether. Or to be given a hospital order - they might think if they were sent to hospital, which a judge can do under the Mental Health Act, rather than sent to prison, then it'll be an easier time. So you do

sometimes need to have a sense that patients are telling you they're unwell when they're not, because they're hoping that you'll send them to the hospital.
There are people who are in there now who I first met with, you know, on my first day, who have maybe been out several times. And they're still there, and they come back every few months and it's like, 'Oh, hello what are you doing back in here again?' 'Oh, you know, Doc, I got caught doing X Y and Z'. 'OK, how long are you going to be in?' 'Oh, probably six months or probably two years.' 'Oh, OK, I'll come and see you next week.'

It's not a friendship but a, it's a friendly relationship, but I sometimes stop and think to myself, 'Actually this guy isn't a nice guy by society's standards.' And not just because they're a menace, it's because they've committed a series of antisocial offences like, you know, burglaries or criminal damage. You know, sometimes people who've murdered people, who've killed people or been involved in a, you know, sex offence and what have you, that are undoubtedly horrible things, you know, that would have had a terrible impact on somebody, and they haven't done them because they were unwell, they've done them because, you know, they chose to do them. But it might have been a few years ago and, I've got to know them, and thought, you know, 'I quite like that person.' And then you think, 'Well how can I? They're a murderer, how can that be? How can I possibly think positive thoughts about them?' Again, it makes you, I suppose, reflect that we're all human, that they've done things that they, maybe regret it, maybe they don't, and often, they do feel as if it was something going on in their life. There was always a reason for it, and it's not, it's not always a straight cut, selfish reason. You know, it would often be out of anger, or it would be a mistake, or it would just be something like an argument went too far, or a fit of jealousy, or something like that.

So, it's not a justification, but it's a way of understanding what happened, rather than just being a cold blooded psychopath who's just killed somebody because it's good fun - you know, there are very few of those, most people kill somebody because they're drunk and they're young and they're stupid and they do something that they didn't really mean to do and it's sort of gone a bit too far and they regret it. Maybe not in terms of murders and sex offences, but many a time I thought to myself, you know, they had that 'For the Grace' kind of thing, 'I could see how, if I was in your shoes, at that time, and I'd had your life experiences, and I was in this stage of my life, and these were the people I was hanging around with, I could see how I could have maybe found myself doing similar things to you.' It's easier in life to have monsters and angels. I mean, it's, it's clear, that's why, I think, we, we teach children, it's a simple way of understanding ethical code, or, you know, right and wrong, and it isn't easy, or even comfortable, to get your head around the idea, I think, the world isn't like that, and that we all have aspects of ourselves that are nice and an aspect that are maybe less nice. It's something I think we have to accept, as I think that is the reality.