MENTALLY SOUND MAGAZINE

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This magazine uses a combination of factual and fictional materials to highlight and discuss mental health advocacy. Pieces without any named narrator are typically fictional or semi-fictional.

Publisher and Editor: Morten Rand

www.abigailgeorge.org/advocacy

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Introduction

Welcome to this issue of *Mentally Sound Magazine*, where we shine a light on the complex and vital intersection of mental health and advocacy. In this issue, we explore how mental health is often overlooked in some of the most critical areas of society, including within prison systems. The reality of mental health challenges faced by individuals in these environments is alarming yet seldom discussed. As we delve into this topic, we aim to foster a deeper understanding of the systemic barriers that prevent proper care and the advocacy efforts working to change this.

Prisons are not just holding cells; they are spaces where individuals—many of whom have been affected by mental health issues long before their incarceration—are often denied the support they need. From limited access to counseling services to the stigmatization of mental health struggles, inmates face tremendous obstacles in their journey toward healing. Yet, there are those within the prison systems—activists, mental health professionals, and even inmates themselves—fighting tirelessly for better care and improved conditions.

This issue of *Mentally Sound Magazine* explores multiple dimensions of this challenge, offering personal stories of resilience, expert opinions on mental health care behind bars, and an overview of the initiatives making waves in this critical area of advocacy. It's our hope that through these pages, we can start not only a conversation but a call to action. Mental health advocacy is crucial everywhere—no one should be left behind, especially in places where individuals are most vulnerable.

Join us as we explore the transformative power of mental health care in prisons, the ongoing battle for change, and the importance of recognizing that mental health is not a privilege, but a right.

Mental Health Advocacy in Prisons: Combating Depression Behind Bars

Mental health advocacy in correctional facilities is an often overlooked but essential aspect of broader public health efforts. Advocates working to improve mental health care in prisons, particularly for those suffering from depression, face numerous challenges—logistical, institutional, and cultural.

Depression is one of the most common mental health conditions affecting incarcerated individuals. Studies have consistently found that prisoners are significantly more likely to experience major depressive episodes than the general population. This vulnerability is compounded by environmental stressors such as isolation, lack of privacy, limited access to supportive relationships, and the constant presence of potential violence or trauma. For many, incarceration either exacerbates pre-existing mental health conditions or contributes to the onset of new ones.

Advocates striving to address these issues often encounter systemic barriers. Funding for mental health services in prisons is typically limited, with staffing shortages and under-resourced programs being common. Mental health professionals working within these environments may be overburdened, making it difficult to offer consistent and individualized care. Additionally, correctional facilities often prioritize security and discipline over therapeutic approaches, creating a culture in which mental health needs are sidelined.

There is also the challenge of stigma—both institutional and personal. Inmates may avoid seeking help due to fear of being perceived as weak or being further isolated from the prison population. Likewise, prison staff may lack sufficient training to recognize the signs of depression or may view mental health concerns as behavioral issues rather than clinical conditions.

Advocates must also navigate complex bureaucracies to push for reforms, such as increased funding, improved training for correctional staff, and the expansion of evidence-based treatment programs. Efforts to integrate mental health services with reentry support are essential, as untreated depression is closely linked to recidivism and difficulty reintegrating into society after release.

Despite these hurdles, progress is being made. Some prison systems have begun implementing cognitive behavioral therapy, peer support groups, and telepsychiatry services with promising results. Partnerships between advocacy organizations, mental health professionals, and departments of corrections have shown that reform is possible when there is a shared commitment to improving outcomes.

Ultimately, improving mental health care in prisons is not only a moral imperative—it also serves the broader goals of public safety, rehabilitation, and social justice. Continued advocacy remains critical to ensuring that individuals living with depression behind bars are not forgotten.

Inside Angola: A Mental Health Advocate's Perspective

When I first stepped through the gates of Louisiana State Penitentiary—better known as Angola—I wasn't sure what to expect. Angola is the largest maximum-security prison in the United States, often associated with harsh conditions and long sentences. But over the past three years, I've come to see another side of this place—one marked by resilience, quiet transformation, and human dignity reclaimed through mental health care.

As a mental health advocate working within Angola, my job involves more than just talking about services or policies. I work one-on-one with incarcerated individuals, support group therapy initiatives, coordinate with clinicians, and regularly meet with prison staff and administrators to find ways to improve mental health outcomes inside the walls.

One of the first men I worked with—I'll call him James—had been incarcerated for more than two decades. He'd stopped speaking during his third year inside, and for years was considered "unreachable." Through gentle persistence, a patient therapist, and eventually group therapy with others who had experienced long-term isolation, James began talking again. Today, he leads a peer-support circle and helps others navigate their own depressive episodes. Watching him help someone else through the same darkness he once faced is the kind of moment that keeps me going.

The staff, too, have shown a willingness to engage, especially when they see how mental health support can ease tensions on the tiers. I remember an officer telling me, "I used to think these guys were just trying to get out of work detail. But I see now, when they get help, the whole place runs smoother." That shift—from skepticism to cooperation—has opened doors for more consistent programming and less stigma around mental health.

Working with the administration has had its own set of challenges, but even there, progress is visible. The warden approved a pilot program we proposed: a therapeutic writing workshop for men dealing with long-term depression. To our surprise, the workshop filled up within days. One participant told me afterward, "This is the first time I've put my thoughts on paper in 15 years. I didn't know I still had anything to say." His writing has since been shared with new inmates as part of orientation—showing them that healing is possible, even here.

The gains we've made are small, incremental, and often fragile. But they are real. Depression doesn't vanish in a place like Angola—but it can be named, managed, and slowly unwound. For some, it's through talk therapy; for others, it's creative expression, structured routines, or peer mentoring.

One of the most encouraging developments has been the formation of a peer mental health council—incarcerated men trained to offer basic support, recognize crisis signs, and refer others to licensed professionals. It's a model that brings agency back to those who often feel powerless and creates a sense of community responsibility that benefits everyone.

People often ask me how I can work in a place like this. My answer is always the same: because it matters. Each small success—each moment of clarity or relief—ripples outward. A man less burdened by depression is less likely to lash out, more likely to participate in programs, and more prepared for life beyond these walls, if that chance ever comes.

Change in a place like Angola is slow. But I've learned to see progress not as a grand leap forward, but as a steady, quiet resistance to despair. And that resistance, I believe, is worth everything.

A Voice at the Hearing: Advocacy, Redemption, and the Long Road to Parole

Last fall, I was asked to speak at a parole hearing for an inmate I had worked with for several years—I'll call him Aaron. He was serving a life sentence with the possibility of parole after 25 years. That milestone had come, and now, sitting across from a table of parole board members, with the victim's family and the district attorney's office present, Aaron's future was being weighed.

Aaron's crime, committed when he was just 19, was violent and devastating. There's no erasing that. But over the years, through hundreds of counseling sessions, peer work, journaling, and raw, painful self-reflection, Aaron had changed. He hadn't just followed a program—he had done the emotional work of rebuilding his mind and accepting responsibility. Depression had played a significant role in his actions back then, manifesting as numbness, hopelessness, and a terrifying detachment from the world around him.

I had been asked to provide a professional statement about Aaron's mental health progress. Sitting in that room, looking at the board members—stoic but not cold—I felt the weight of every word. This wasn't theory; this was a life.

The prosecutor's tone was sharp, his questions focused on the crime itself and the impact on the victim's family. The district attorney echoed those points, arguing that Aaron should serve the rest of his natural life behind bars. It was difficult to listen without feeling defensive—not on behalf of Aaron's past, but on behalf of his present. I respected their grief and duty to protect the public, but I also knew the man they were describing no longer existed.

When I spoke, I focused on two things: Aaron's diagnosis of major depressive disorder at the time of the crime, and the tangible progress he had made. I explained how untreated depression can

distort thinking and flatten moral judgment, especially in young people. I pointed to his participation in group therapy, his consistent emotional regulation, his leadership in peer mental health programs, and how, in the years I had known him, he had not once shown signs of regression or denial. I made it clear—rehabilitation was not just possible; in his case, it was well underway.

Aaron's family sat quietly during most of the hearing, but when his mother spoke, her voice trembled. "He's not the same boy who went in," she said. "He's a man now, and he's tried to become a good one." That moment struck me harder than anything. We talk so much about systems and policy, but here was a mother asking for mercy—not because her son was innocent, but because he had changed.

Ultimately, the parole board voted in favor of release, pending final reviews. I won't pretend that moment was joyous—it was solemn, heavy, and filled with complicated emotions. But it was also a moment of possibility.

As a mental health advocate, I've seen how depression can twist lives and how healing can occur in even the hardest places. That day, I felt that my voice helped tip the scale toward compassion—not blind forgiveness, but informed understanding. It reminded me why this work matters: because every now and then, it can help open a door that had been shut for decades.

Walking the Line: A Mental Health Advocate's Challenge with Families

As a mental health advocate, one of the most delicate parts of the job isn't just supporting those struggling with depression—it's building trust with their families. While most loved ones deeply care and want the best for the person affected, their initial reaction to an outside advocate can be complicated.

I've been met with skepticism, polite silence, even outright resistance. "We're handling it," some say. Others worry that sharing too much could betray a loved one's privacy or shame the family. There's pride at play, too—a natural instinct to shield a loved one from judgment, and perhaps from

the pain of being labeled.

It's never about blame. Most families are doing their best in a confusing, emotional landscape. But the stigma surrounding mental health often leaves people afraid to speak openly. When I approach them, I'm asking them to trust me with something raw and deeply personal.

The key is patience. I've learned to listen more than I speak. I ask questions gently, respect boundaries, and let them see that my goal isn't to intrude—it's to walk alongside them. Over time, many families come to see me not as an outsider, but as someone who can help translate their loved one's experience and connect them to real support.

And when that moment comes—when a parent says, "Thank you for helping us understand," or a sibling reaches out for guidance—it's deeply meaningful. It reminds me that trust, once earned, can be the bridge that brings light into the darkest corners of depression—not just for the person struggling, but for everyone who loves them.

As a mental health advocate, some of my most difficult conversations don't happen with the people experiencing depression—they happen with their families. Reaching out to offer help is never simple, especially when pride, fear, or deep love make people hesitant to let someone in.

One case stands out. I had been asked by a clinic to follow up with a young man in his early twenties who had stopped attending classes and had recently withdrawn from his friends. I called his parents first. His mother answered. She was polite but cautious. "He's just going through a rough patch," she said. "We don't want to push him." I asked if I could come by, not to intervene, but simply to introduce myself. I emphasized that my role wasn't to diagnose or pressure, but to listen and offer support if and when he was ready.

When I arrived, I sat at their kitchen table for over an hour—just talking to them. We didn't speak about depression right away. We talked about music, school, the town. Eventually, his father asked quietly, "Do you think it's more than just being tired?" That was the opening. They were worried, but unsure how to help without overstepping. They needed permission, in a way, to acknowledge something deeper was going on.

That visit didn't end with a breakthrough. But a week later, their son agreed to meet with me. It was the start of a long process—but one made possible because his family felt seen, not judged.

Another time, I was referred to an older woman whose sister had grown increasingly reclusive. The family was hesitant about involving "outsiders." When I called, the sister told me, "She's private. She wouldn't want someone poking around in her business." I acknowledged that completely—and then asked if I could send a letter instead. "No expectations," I said. "Just something for her to read, in her own time." A few days later, I got a call. "She read your letter," the sister said. "She'd be willing to talk."

These encounters taught me that families aren't obstacles—they're protective. They're often scared of doing the wrong thing, of betraying trust, of saying too much. My role is to meet them in that space of uncertainty, and to build a bridge they can walk across when they're ready.

When families let me in, even just a little, it changes everything. They become allies in the healing process. And for the person suffering, knowing they are surrounded by people who care enough to learn, wait, and support—that's often the beginning of hope.

Fitting In: How a Mental Health Advocate Complements the Circle of Care

One of the most rewarding—and sometimes most complicated—parts of being a mental health advocate is working within an existing web of support. Often, by the time I'm called in, there are already doctors, therapists, family members, and community figures involved. My role isn't to replace them, but to fill in the spaces between—to connect, clarify, and carry the threads forward.

Still, it's not uncommon for tensions to arise. A psychiatrist may be focused on medication management, a therapist on emotional processing, and a parent on day-to-day stability. Each sees their work as vital—and it is. But when someone new enters the picture, there can be a quiet wariness: Who are you? What are you here to do?

I remember once being brought into a situation involving a teenage girl recovering from a severe depressive episode. Her parents were attentive, her school counselor was involved, and a local church group had rallied around her. During our first group meeting, the psychologist raised an eyebrow. "We have a treatment plan already," she said. "We just don't want too many voices confusing her."

She was right to be protective. But instead of asserting a new direction, I asked questions. Where were the communication gaps? Did the family feel supported between sessions? Were they overwhelmed trying to coordinate care? As I listened, I found my place—not as a leader, but as a connector.

In time, I became the person who made sure the family understood the therapist's feedback, who helped coordinate follow-ups with the primary care doctor, who reminded the church volunteers to maintain boundaries while staying supportive. I wasn't in charge—I was the thread tying it all together.

There have been situations where friends or family felt displaced by my presence, worried that an "advocate" might signal they were doing something wrong. In those moments, I make it clear: I'm not there to replace their care—I'm there to support it. Sometimes, I even step back deliberately, encouraging them to lead with my quiet backup. One mother said it best after a few months: "It's like you're part of the scaffolding. We're still doing the building, but you keep us steady."

Occasionally, I've encountered resistance from religious leaders who believe spiritual support should be enough. When that happens, I listen and acknowledge their importance, but I also gently offer perspective: that faith and mental health care can work hand in hand. I've even partnered with pastors to hold joint conversations about depression—where I speak from a clinical standpoint and they from a spiritual one. The result is a fuller kind of care, one that honors both science and belief.

The truth is, healing doesn't happen in silos. It's collective work. My role is to observe, adapt, and make sure that no one—especially the person at the center—is left lost in the shuffle. I find the spaces where communication breaks down, where burnout is creeping in, where a little clarity or coordination could make the whole system stronger.

An advocate doesn't need to be the loudest voice in the room. Often, we're most effective when we're the quiet one—listening closely, tying things together, making sure every piece of the circle holds.

In the Wake: A Mental Health Advocate in a Post-Traumatic Moment

The hallway was too quiet. You could feel the weight of what had just happened still hanging in the air, like the hush after an explosion. Down at the end of the corridor, two paramedics were just closing their equipment cases. A school counselor stood near the doorway, hands gripping a file folder she wasn't reading. And in the center of the room, sitting on the edge of a vinyl couch with her hands clenched in her lap, was a girl who had just survived an attempt to take her own life.

As a mental health advocate, I've learned to read a room quickly—read it for pain, for risk, for readiness. This room was full of shock. Her family had been called, but hadn't arrived yet. A teacher was sitting beside her, gently saying her name every so often, as if afraid that silence would take her back under.

I sat down across from her, not directly in her line of sight, but near enough that she knew I was there. I didn't say much at first. You can't rush people out of a storm—they have to find the ground again on their own.

After a few minutes, I asked, "Do you want some water?"

A small nod. Good. A start.

Later, when we were alone, I sat with her in that torn, suspended space—the strange place trauma leaves you in, where everything feels unreal and too real at once. I didn't ask her to explain anything. Instead, I told her what would happen next in concrete steps: "They'll bring you to the hospital for evaluation. Not as a punishment, but to help keep you safe. Your mom's on her way. I'll be nearby, if that's okay with you."

She asked, "Do they think I'm crazy?"

I said, "No. I think they're scared because they care. And I think you're still here, which means you get to decide what happens now."

The hours that followed were filled with logistics—coordinating with the crisis response team, briefing the hospital intake counselor, gently advising the family when they arrived and flooded the room with questions and quiet tears. But all of it was about containment: stabilizing a moment that had nearly shattered.

The next day, I followed up at the hospital. She looked tired, but clearer. We talked about the future—not in big, sweeping terms, but in small things: journaling, taking walks, trying one group session. She told me she didn't want to go back to school yet. I told her that was okay.

In post-traumatic work, you walk a strange line: part firefighter, part architect. First, you douse the flames. Then you start to sketch what comes next—not a grand blueprint, just a path through the debris. Sometimes you're holding back collapse. Sometimes you're handing someone the first brick to start rebuilding.

But always, you're there. Not to erase what happened, but to say: This isn't where your story has to end.

The Power of Presence: The Advocacy Legacy of Glenn Close

In the world of film and theater, Glenn Close is known for her commanding presence, fierce intelligence, and deeply emotional performances. But beyond the screen and stage, she has also become one of the most influential mental health advocates in the United States—a voice that has helped bring visibility and compassion to a subject long mired in stigma and silence.

Close's advocacy began not as a public campaign, but as a personal reckoning. When her sister, Jessie, was diagnosed with bipolar disorder, and her nephew Calen with schizoaffective disorder, Close witnessed firsthand the pain, confusion, and isolation that mental illness can cause—not only for those living with it, but for their families. For years, the suffering remained unspoken, even within the family itself. That silence is what Glenn Close has since worked to break.

In 2010, she co-founded Bring Change to Mind, a nonprofit dedicated to ending the stigma surrounding mental illness. The organization has become a powerful force, particularly among young people, through public service announcements, peer-led high school clubs, and partnerships with major mental health institutions. Rather than focusing solely on clinical information, Bring Change to Mind invites people to share stories—personal, raw, and honest accounts that illuminate the lived experience of mental illness.

What sets Close apart is the way she uses her platform. As a celebrity, she has access to attention and influence, but she never centers herself in the narrative. Instead, she defers to the voices of those directly affected, amplifying them rather than overshadowing them. She speaks not as an expert, but as a sister, a mother, a witness.

Her advocacy has also extended to public policy. She has testified before Congress, participated in White House discussions, and spoken at international mental health forums. Her message remains consistent: that mental illness is a health issue, not a character flaw; that it deserves compassion, treatment, and open dialogue.

Perhaps most powerfully, Glenn Close has helped to normalize the idea that families—regardless of background or fame—are not immune to mental health challenges. By publicly acknowledging her family's struggles, she has given permission to others to do the same. That act alone—of speaking openly and without shame—has saved lives.

In a field that can sometimes feel impersonal or clinical, Close brings the human element back to the forefront. Her work reminds us that advocacy is not just about raising awareness; it's about making people feel seen, understood, and never alone.