Health Status and Needs in Nevada's Adult Incarcerated Population

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Introduction

Prisons contain disproportionate numbers of individuals with physical and mental health concerns compared to the general population (Wang, 2022). Despite such health disparities, few health assessment or surveillance activities take place in prisons, and fewer still occur in a state specific manner. The growth of the aging population in prisons–both nationwide and in Nevada–heightens this problem; most chronic health conditions emerge during later years (Nevada Department of Corrections [NDOC]; 2023; Widra, 2023). Considering these factors, inmate health needs are important to address and, if not attended to, can lead to detrimental physical and financial losses to both incarcerated individuals and state facilities. While we know Nevada's prison demographics and have limited nationwide data indicating health disparities present among incarcerated individuals, a lack of specific information regarding health status and needs of the state's incarcerated population prevents us from taking targeted steps to address what issues may exist (NDOC, 2023; Wang, 2022). To alleviate this, the organization Return Strong (RS) conducted an exploratory health survey in the fall of 2021. What follows is a report on the results of this survey.

Methods

Surveys

In 2021, RS designed a paper-based survey containing 37 closed and open-ended questions such as "have you seen or requested to see a healthcare professional for urgent needs during your time at NDOC?" and "are you considered disabled?" Certain questions also prompted respondents to "please explain" if they desired to expand upon their NDOC medical experiences. RS team members developed these questions with the intent to gain deeper understanding regarding the care individuals received in NDOC facilities on an exploratory level. Participants could choose to answer any question, thus, tables and statistics reflect only those who responded. We indicated how many individuals did not answer each question in the tables presented.

To gain participants, RS invited all subscribers to their free newsletter to participate via mailing them blank surveys. Thus, to participate, respondents needed to complete a survey and mail it back to the RS address. RS also encouraged readers of their newsletter and survey participants to invite others to complete surveys. If individuals expressed they would like to distribute more surveys, RS sent the requested materials. Thus, through convenience and snowball sampling methods, RS sent over 100 surveys throughout the rest of 2021 and 2022. By July 2023, the organization received 105 completed surveys. When completed surveys arrived, RS volunteers created scans of responses and uploaded them to their secure letter database. For the current report, letters were de-identified to preserve confidentiality. Additionally, respondents signed consent forms, received explanations regarding the purposes of the MAT surveys, and were assured of the voluntary nature of participation. If individuals expressed that they did not want RS to use specific information they disclosed, we honored their requests.

Chronic Conditions Grouping Methodology

When classifying chronic conditions experienced by respondents, we primarily used data from the "Chronic Care" section of the survey—specifically the question "if you are willing, please list your chronic conditions." However, if individuals noted chronic conditions they experienced in other survey sections (e.g., mental health, medications, etc.) we included these as chronic conditions. Diseases/conditions appeared as reported by respondents; we did not diagnose conditions during the

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k1

coding process. However, if respondents reported history of a specific type of surgery that strongly indicated a certain disease, we included it under a broad category of the likely condition (e.g., open heart surgery indicating cardiovascular disease). If individuals were unclear about their listed conditions, the “undiagnosed” specifier preceded their condition or symptoms (e.g., undiagnosed back pain).

In classifying conditions, we used common Centers for Disease Control and Prevention (CDC) groups on the Behavior Risk Factor Surveillance System (BRFSS) to initially guide the process. However, given the abundance of conditions listed beyond BRFSS variables in addition to still-undiagnosed conditions, we expanded the classifications to include variables such as musculoskeletal conditions, untreated injuries, mental illness, etc. While these groups are broad in nature, individually listed diseases remain in our dataset and were used to create these larger groups. If individuals had multiple conditions that fell under the same group classification (e.g., seizures and nerve damage; both are coded as “Any Neurological Damage/Disorder”) only 1 condition contributed towards the overall frequency which appears in the "any neurological condition" group for that individual. Statistics that appear in tables regarding chronic conditions (unless otherwise stated) reflect the percentages of a particular chronic condition among individuals with chronic conditions (n = 100).

Qualitative Methodology

For other qualitative variables that appear in this report, we used thematic analysis to identify notable themes that emerged across survey respondents’ letters. Given the majority open-ended question format of the survey, analysis was not tied to a particular question; rather, themes arose using responses across each individuals’ survey. However, should a particular theme arise several times within one individual’s survey, it was not double counted in terms of frequency (e.g., an individual notes their feeling that “no one cares” 3 times in their survey, but contributes only 1 count towards the overall “Feel medical needs are “ignored” or that “no one cares "" frequency). Lastly, we considered all individuals who provided qualitative data when calculating the percentages in tables; the only individuals not included provided no supplemental data save for yes/no closed-ended responses.

Results

Demographic Characteristics

In total, 105 individuals returned completed surveys to RS. Of those who returned surveys, 96 men (91.43%), 8 women (7.62%), and 1 transgender woman participated (.95%; see Table 1). Most participants were white (64%, n = 64), followed by individuals who identified as black (16.35%, n = 17), Hispanic/Latino (13.46%, n = 14), Native American (4.81%, n = 5), Asian or Pacific Islander (1.92%, n = 2), and “Other” (1.92%, n = 2). Most individuals were housed in High Desert State Prison (n= 33, 31.73%) and Lovelock Correctional Center (n = 22, 21.15%; see Table 2). All operating NDOC correctional facilities had at least 1 respondent.

The average age of respondents was 50.91 (*SD* = 12.20) which closely resembled the median age of 50 (Table 3). When examining age categories further, most respondents were between ages 35 – 44 (29.13%, n = 30), closely followed by those aged 55-64 (28.16%, n = 29) and 45 – 54 (23.3%, n = 24). Note that the sample for this survey, according to recent NDOC quarterly statistics, is older than NV’s general prison population (see Table 4; NDOC, 2023). Thus, our sample may contain individuals with more chronic conditions than the general NV prison population. Regardless, the sample remains one of the few existing public sources of health information on this population and can provide a guide for future surveys that can utilize sampling methods which capture a wider, more representative range of ages.

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Dental Care Survey Questions and Qualitative Analysis

In terms of dental care, 88.5% of all respondents indicated that they had seen or requested to see a dentist during their time at NDOC. While many dental concerns/experiences were reported (see Table 5), most frequently reported were tooth decay or cavities (n = 27, 25.71%), followed by needing dentures, bridge, or a partial (n = 17, 16.19%), and broken or cracked teeth (n = 13, 12.38%). In qualitative analyses, 40 respondents (44.94% of individuals who provided qualitative data) mentioned that it took over 6 months to visit a dental provider after requesting to see one for an immediate dental need (e.g., tooth abscess) and 9 individuals explicitly mentioned their concern at the lack of preventive dentistry. To illustrate, one respondent noted:

> "Had to have several teeth pulled when they become problematic as NDOC does not fill cavities or do preventative dentistry."
>
> - Respondent 32

Additionally, 5 individuals expressed concerns regarding how NDOC does not fill teeth; they only pull cavities. One individual wrote:

> "Had a toothache**[.]** It needed to be pulled out and the dentist lady actually pulled 4 on the left side, 1 pulled on the right side. When they wanted to pull 4 more I didn't go back…"
>
> - Respondent 29

Given the expressed concerns surrounding lacking preventive dentistry and the long wait to receive care for urgent dental needs, the high frequencies of dental-related issues is not surprising.

Mental Health Survey Questions and Qualitative Analysis

Among all respondents, 56.31% (n = 58) had seen or requested to see a mental health provider during their time at NDOC (Table 6). Twenty-nine-point-five-two percent of all respondents (n = 31) reported some mental health condition. Anxiety or panic disorder was reported most frequently (n = 14) followed by PTSD (n = 11), and depression (n = 10). When qualitatively analyzing data, 18 individuals of the 58 who requested to see a mental healthcare provider during their time at NDOC noted that it took over 6 months to see a mental health provider after requesting one.

Chronic Conditions Qualitative Analysis

The following section contains conditions reported by individuals who chose to disclose them. Overall, 100 individuals indicated they experienced at least one chronic condition (97.1% of all respondents; Table 7). Of those with a chronic condition, 10% of respondents (n = 10) had at least one "chronic infectious or fungal disease"–most of which had Hepatitis (n = 8; see Table 8 for all chronic condition frequencies). Other highly represented chronic conditions included "chronic musculoskeletal conditions." Specifically, 26% (n = 26) of respondents experienced at least one chronic musculoskeletal condition (not including arthritis). Most frequent conditions included "chronic back conditions" (n=21). Many individuals also dealt with "any neurological damage/disorder" (n = 30; 30%)--the majority of whom experienced "nerve damage, nerve pain, and/or Neuropathy" (n = 15, 15%). Fifteen individuals had "arthritis (not including osteoarthritis), lupus, or fibromyalgia" (15%). Seventeen individuals (17%) had "any lung disease"–the majority of whom had COPD (n=9) followed by asthma (n = 8).

Alao among those reporting chronic health conditions, 18 reported experiencing “any cardiovascular condition” (18%), however, most in this category did not specify what heart disease they experienced or did not yet have a diagnosis (n = 11). While not included among the cardiovascular disease indicator count, both “high blood pressure” and “high cholesterol” occurred frequently among respondents. High blood pressure specifically occurred in 30% of individuals with a chronic condition (n = 30) and high cholesterol in 7% (n = 7). Other highly represented chronic conditions included individuals with “gastrointestinal diseases” (e.g., IBS and acid reflux; n = 21), “untreated injuries” that led to chronic pain (n = 17), “any urologic condition” (n = 14; 8 had “non-prostate related conditions” and 7 had “prostate-related conditions”) and “eye diseases/conditions” (n = 12).

Overall, among individuals who reported a chronic condition, the most frequently reported was any mental health condition (n = 31), followed closely by both high blood pressure (n = 30) and any neurological damage/disorder (n = 30), and any chronic musculoskeletal condition (not including arthritis; 26). However, we must note that many individuals experienced comorbid conditions which could heighten risk for developing further complications with existing illnesses or other chronic conditions.

Medication-Related Survey Questions and Qualitative Analysis

In terms of medication, 83 respondents indicated they took medication unrelated to pain management, however, 50 of these individuals reported not receiving these medications as prescribed and 76 responded affirmatively when asked if they had difficulties receiving or refilling medications (see Table 9). Fewer individuals reported taking pain-management medication vs non-pain-related medication (n = 12; see Table 10). However, some respondents may have reported pain medication as non-pain management medication given the question ordering/separation of questions. While confusion surrounding the interpretation of the medication-related questions may contribute to some discrepancies seen in our results, further responses suggest possible issues with medication prescribing/refilling itself may be the cause. For instance, when asked whether individuals received pain medication as prescribed, 50 individuals responded they were not, and 60 individuals responded affirmatively when asked if they had difficulties receiving or refilling their pain medications. Additionally, 74 individuals responded “no” when asked if their pain was adequately managed.

Qualitative analysis sheds further light on the issue (Table 11). For instance, 19 individuals noted that NDOC did not prescribe the needed medication they entered with and/or were told to take by another provider (18.63% of the 102 individuals who provided qualitative data). One individual described this common occurrence:

> “Didn't receive my medication for antidepressant **[named medication]** I came in with.
>
> Later in the survey, they also noted that
>
> “I came in with my **[named an additional medication].** They will not allow me to take it. It helps with my seizures, panic disorder, pain from fibromyalgia and degenerative disc disease ”
>
> - Respondent 48

man down.” It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k4

Respondents also described how NDOC stopped their prescribed medication without any explanation or warning (n = 22, 21.57%), in addition to how providers reduced their prescribed medication dosages in a similar fashion (n = 12, 11.76%). Below demonstrate more lived experiences of individuals experiencing these medication-related complications:

> "When I went to the **[hospital name]** the emergency doctor prescribed several antibiotics, and some kind of oxygen treatment. The then **[named NDOC medical staff member]** changed my medications and denied me the oxygen treatment. I have also noticed that the same **[NDOC medical staff member]** will also countermand the medical doctors here at **[facility]** and give less or something entirely different that what a medical doctor prescribes."
>
> - Respondent 26

> "When our latest doctor began here, **[named doctor]** he promptly began discontinuing most of everyone's medication, including my emergency inhaler."
>
> - Respondent 7

Lastly, a common medication-related theme emerged among respondents that entailed the following complication: to get refills for medications, individuals needed to see a doctor, however—as will receive further attention below—it takes a great period of time to access the doctor. Thus, respondents documented going extended amounts of time without medications (n = 12, 11.76%). The below quotes capture this phenomenon:

> "Medical sees me and gives me a few prescriptions for a few months…then, I must revisit medical and request for more plus pay for visits…thus I find myself in a cycle…"
>
> - Respondent 31

> "Every time I run out of KOPs or daily pill call meds I have to go months without them trying to see the dr. to renew them."
>
> - Respondent 80

Considering the multiple barriers individuals face in terms of receiving medications, we hoped to determine the time-lapse one might face between medication doses. When asked how long participants have gone without needed medication, periods ranged from days to over 1 year, however, the non-specific "weeks" most frequently occurred (n = 22, 20.59%) followed by "more than 2 months" (n = 9, 7.84%) and "months" (n = 6, 5.88%; see Table 12 for more details). Notably, of the 43 individuals who offered insight regarding time lapse between receiving medications, 51.16% stated it took weeks to get a refill.

Given the qualitative and quantitative data surrounding the state of medication reception in NDOC facilities, we have cause for concern regarding the care of individuals within the carceral setting. The below respondents provide examples of what this looks like in practice:

> "I'm still waiting on my meds for my heart condition**[.]** It's been 2 weeks."
>
> - Respondent 16

> “I take 3 different psych meds. The psych dr. is good, but medical does not get our necessary psych meds from pharmacy and we go without our medications for days, and sometimes weeks. I've gone without my psych meds for 15 days before.”
>
> - Respondent 47

> “Its been 10 months I havent gotten my **[blood pressure medication]**. I don't know if they took me off the medication but they haven't sent it to me.”
>
> - Respondent 66

Given the life and death nature of appropriate medication schedules, this area remains viable for reform. Concerns raised by incarcerated individuals and other parties regarding medication reception have led to legislative action. Specifically, in the 2023 legislative session, AB121 passed which requires individuals in custody who take prescription medications to have their medications refilled on/before the date they run out (A.B. 121, 2023) If implemented appropriately by NDOC, this could save time and resources for NDOC while maintaining important medication regimens that keep those in their custody medically safer than before. However, for this to prove beneficial, providers must prescribe appropriate medications and dosages based on needs of their patients. Unfortunately, AB121 does not cover this aspect of medical care.

General Medical Care: Survey and Qualitative analysis

In addition to medication-related questions, the survey contained questions pertaining to quality of care, whether NDOC complied with healthcare-related treatment plans, disabled status of respondents, etc. (Table 7). Many of these questions provided opportunities for open-ended answers and invited participants to elaborate on responses. Thus, results of the qualitative, thematic analysis will appear alongside quantitative survey results. These instances will be noted throughout this section.

Of the 104 individuals who responded to the survey question asking if they requested to see a healthcare provider for urgent needs during their time at NDOC, 88.4% (n = 92) responded “yes.” Additionally, over half of respondents (56.31%, n = 58 of 103 individuals who responded to the question) saw or requested to see an outside specialist for healthcare needs. Of those who saw an outside specialist, 80.7% (n = 46) indicated that NDOC was not following treatment plans prescribed by the outside specialist. Interestingly, 14 individuals indicated that a provider outside of NDOC refused to treat them due to their incarceration or because they terminated their contract with NDOC. One individual elaborated (and provided copies of the termination letter; several other respondents shared this experience):

> “**[Outside provider]** will no longer provide medical care due to NDOC’s repeated failures to follow his medical orders. ”
>
> - Respondent 56

Overall, 40.82% of respondents, when asked in the survey whether they were considered disabled, indicated they were (n = 40), however, 89.74.% (n = 30) of individuals who identified as disabled noted that NDOC did not abide by ADA requirements for their disability. One individual elaborated on this question in detail:

man down.” It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k6

"I'm deaf (or nearly so). There are no visual warning signs/lights in case of emergency evacuation or to notify those impaired re: medical calls, pills, mail, door calls, property, canteen, urine tests, etc."

And notes later in the survey that,

"NDOC's idea of helping me was to issue a bright yellow shirt with big black letters printed on it "deaf inmate." Might as well be a target on me to mark me as prey for the handful of true jerks who think it's fun to suddenly point behind me after getting my attention out in the yard, or who pretend to be talking to me by silently mouthing words to me. I could say more but what's the point, really?"

- Respondent 23

Similarly, as noted in the chronic condition section, most respondents dealt with at least one chronic condition. When the survey asked if they felt they were receiving adequate care for chronic conditions, of the 84 individuals who responded to the question, 92.86% stated they felt they were not receiving adequate care (n = 78). Of the 102 individuals who provided qualitative data, 27 mentioned (26.47%) their concern about not receiving *any* follow-up or continued care for their chronic conditions (Table 13). Respondents elaborated:

"Was taking **[medication]** to cure Hep C and med staff missed 9 total days of my medication and 6 of them were in a row**[...]**My blood isn't monitored for the damage to my liver."

- Respondent 38

"I have seizures and **[I'm]** supposed to see the dr. every 90 days but haven't seen him once in 2 years."

- Respondent 96

"There are no follow up chronic care appointments, I have not seen an **[type of needed specialist]**, nor have any treatment plans for COPD, Hep C, high blood pressure or tests done for the bleeding inside of me."

- Respondent 49

"I got prostate cancer and haven't received treatment for it."

- Respondent 67

Additionally, among respondents who provided qualitative data, a lack of preventative care remained a concern among them (n = 5) along with unscheduled or canceled medical tests/procedures (n = 17) and issues surrounding not having any provider that offers eye-related care (n = 7). One individual stated:

"A cataract specialist told me they could restore my vision. That was almost 2 years ago. I'm still blind and starting to lose vision in my other eye. When I kite them they just say that they don't have an eye doctor."

- Respondent 11

Among respondents, another theme of importance involved the cost of care (for medication, doctor visits, cost of calling a man-down, etc.) being a burden or inhibitor to seeing a provider. Twenty-five individuals expressed this as a concern—especially when considering how their chronic health condition requires constant care and follow up. Specifically, individuals were charged at the time of the survey $8 per doctor visit and $25 for a "man-down." As of the 2023 legislative session, this particular area of concern received attention in SB416—a bill passed that will eliminate medical co-pays in NV state prisons (Shepack, 2023). This may prove helpful in reducing the financial burden placed on individuals who need medical care and prevent those with chronic health issues from accumulating medical debt. However, given responses to the survey, it appears that accessing a doctor regardless of monetary cost is the barrier most likely to cause medical harm.

For instance, of the 103 individuals who responded to the survey question "do you feel NDOC responds to requests for healthcare needs timely and to your satisfaction?," 96.12% (n = 99; Table 7) responded they did not feel this way. The qualitative analysis sheds further light on this issue; the most frequently reported wait times to see a doctor for an immediate health request or need was 6 months or above (Table 14). Specifically, 25 individuals attested to this (24.51% of all individuals who provided supplementary qualitative data)—or 69.44% of all individuals who provided insight regarding the time it takes to see a doctor for immediate health needs. Regarding wait times, respondents note:

> "They refuse to answer any form of a medical request or kite, and if you do get seen it takes 1 to 2 years of a wait."
>
> - Respondent 14
>
> "I've written kites and talked to nurses for years trying to get an appointment to see a doctor. My requests just go into a black hole and are never seen or heard of. It takes years to see a doctor."
>
> - Respondent 74

The time to see providers yielded problematic outcomes for many respondents; 15 expressed that the long wait to receive care/see a doctor led to their condition worsening (14.71%; Table 13). Several individuals provided accounts of how their medical concerns went unaddressed for too long.

> "I had Hep C and it took 8-9 years and a lawsuit to get them to give me treatment. I have slight sclerosis of the liver now because they waited so long to treat me."
>
> - Respondent 39
>
> "The NDOCs failure to treat my heart condition has resulted in me being admitted to the hospital at least six times."
>
> - Respondent 70
>
> "I had lost about 100lbs in a 4 month period, was experiencing vision problems and severe balance issues. After nearly a year of waiting, the prison doctor had blood taken for labs. Over 3 more years of worsening problems, I ended up having to go "new about it from the labs but

never let me know and didn't begin treatment until I was nearly dead. Now I have diabetic neuropathy that is so advanced that I can hardly function. "

- Respondent 63

Yet, when some patients finally received appointments, 11 noted that providers said they would not provide care because they were "not sick enough." Consider the case below:

"In the past those with a hernia go years without treatment and nothing gets done until it looks like the bulge is about to explode. I want mine fixed now while small and easy to fix. The bottom line is we are on our own and must endure pain and suffering."

- Respondent 7

"Once I requested help for ankle pain, was put off for years. X-rayed, diagnosed with bone spurs. Would they fix? No. When it cuts your achilles we will give you a wheelchair. Pain and achilles trauma for years ended in rupture of tendon, which they did give me surgery for."

- Respondent 90

"I sent several requests for having anxiety. They told me my score was too low. I have no idea what that means."

- Respondent 102

Or the brief, but weighty statement:

"I have not broke yet. It's what they wait for. "

- Respondent 34

Another outcome expressed when individuals saw a provider involved staff blaming patients for their problems or dismissing/mitigating their concerns (n = 10). Consider the below examples:

"Their response to my emergency grievances always is this is not an emergency."

- Respondent 6

"No matter the condition, all our doctors seem to think everything wrong with us is our fault and suggest drinking more water is the answer to our problems. I have lost several friends recently due to lack of health care."

- Respondent 7

"I was prescribed on "NSAID" for the nerve pain in my leg. It did not help at all so I told the doctor and he accused me of lying."

- Respondent 9

"When I fell in **[date]** the staff just laughed at me and said I was high."

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k9

- Respondent 29

Individuals also expressed concerns about how they only received pain meds rather than having their underlying conditions addressed (n = 10, 9.8%). For instance, an individual described:

> "This is all new to me dealing with major medical issues in prison and hope to help people like myself and others that get pushed aside and or just ignored altogether. Since **[date]** medical staff has even informed of my hernia which was repaired on the streets and has since failed and caused me pain every day. I've been to the ER once back in **[date]** and was told surgery is required to repair damage….my hernia measures 12.5 inches across and 10.5 inches wide. The only medical help I get is the pain meds acetaminophen and Naproxen. This hernia affects my health everyday life. I am unable to exercise to any real extent besides walking laps and can only walk for short periods of time before I start to hurt. It's been almost 11 months and nothing. "

- Respondent 10

and others stated

> "The NDOC doesn't respond to the medical need…they give you a bandaid (i.e. IBU, Aspirin, Allergy pill as the fix all) make you wait months to see a doctor only to tell you to either lose weight or there's nothing wrong…then you complain more then a specialist says "oh you need help" yet the nDOC doesn't give it to you."

- Respondent 60

> "Surgery for torn meniscus was not approved. Now I limp and my knee gives out or locks up. I take a combined of 4 ibuprofen and 3 aspirin four to 5 times a day."

- Respondent 23

These themes, consequently, lead to another often occurring theme: respondants felt that medical would only see someone if they requested a "man down," were dying, or suicidal (n = 13, 12.75%). Yet, in the survey, though 53 individuals said they called a "man down" for a prompt emergency response, only 17 of those who had requested one reported the response as "prompt" (Table 15). This understanding that help would only (perhaps) come in dire circumstances led to 4 individuals in the qualitative analysis (Table 13) explicitly voicing their fear that medical neglect would lead to their death. Several quotes below demonstrate these themes:

> "It does not matter your condition, unless you drop dead, you won't see the doctor for years. Our doctor shows up only 1 day per week."

- Respondent 7

> "As we joke here "if you didn't die, it wasn't an emergency."

- Respondent 27

> "**[Facility name**] I honestly feel is actively trying to kill me, and yes, they are succeeding."

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k10

- Respondent 63

"By the time we see anybody we are either over being sick, sick worse, or dead. Put it this way, if I suffered a heart attack, by the time I seen somebody I would be dead period."

- Respondent 105

Understandably, given the medication-related issues, the lack of medical care in a timely manner, and the general feelings of dissatisfaction regarding medical treatment in NDOC facilities, one of the most frequent themes that emerged in qualitative analysis involved individuals expressing that "medical needs are ignored or that "no one cares" about their health" (n = 26, 25.49%). Considering the most frequent theme of medical kite issues (medical request forms getting ignored/not getting responses/etc.)--which also relates to ignoring medical-related needs (n = 41, 40.2%)—we cannot feign surprise when individuals express sentiments such as those below:

"It took around 5 years to get a hernia surgery. I've been grieving and kiting them to help me with my vision loss and it doesn't feel like anyone cares."

- Respondent 11

"To be honest, they look at us like zoo animals. They don't care about our needs. We are medically neglected and things are getting worse."

- Respondent 34

"This is about the worst possible health care you could imagine. and if you can't imagine it you aren't far off from what it really is, non-existent!"

- Respondent 68

"Medical care in the NDOC especially **[facility]** is almost non-existent. Medically they are so indifferent to us it is very dehumanizing. Also what little alleged treatment is available is a joke."

- Respondent 77

Perhaps most indicative of dissatisfaction, when the survey asked if individuals submitted a grievance or emergency grievance for healthcare needs, 79.38% had submitted at least one (77 of 97 individuals who responded to the question; Table 7). In qualitative analysis, 25 individuals noted filing a health-related lawsuit relating to a lack of proper care (24.51%; Table 13). Unfortunately, 7 individuals who noted filing a health-related lawsuit also mentioned experiencing medical retaliation such as in the case below:

"I been waiting for over a year close to 2 to be seen. I've filed so many grievances. I'm in constant pain. They refuse to see me at all as punishment for grieving and filing lawsuits/civil suits. I need help."

- Respondent 19

Limitations

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k11

The initial exploratory nature of this survey lends itself to several limitations. Firstly, while the multiple open-ended questions allowed many opportunities for respondents to share their experiences with NDOC healthcare, it may also have created fatigue when answering questions or early termination of the survey. Even further, some questions could lead to confusion in interpretation (e.g., medication questions) for both respondents and in analysis. A lack of specificity regarding time-variables, for instance (e.g., "how long you went without your life sustaining medications"), led to an inability to gain potentially relevant information regarding frequency of long waits for specific services (e.g., do individuals wait multiple weeks every time they run out of medications, or was this experience many years ago?). Other instances regarding phrasing and open-endedness of questions may have created similar issues regarding coding and specificity. Respondents may also have found it difficult to recall all the chronic medical conditions they experienced without prompts that one could encounter in a list-format–thus leading to an underrepresentation of conditions. While potential issues such as these may have limited analysis, the open-ended format brought about insights and ideas that other methods of questioning may not have otherwise allowed.

Aside from survey-development-related limitations, the demographics of respondents to our survey did not reflect the NDOC prison population in terms of race/ethnicity (see Table 16). Considering how health disparities exist in terms of race and ethnicity outside of incarcerated settings, obtaining representative samples of the NDOC population remains a major concern. One reason for discrepancy in our respondents' demographics could result from the survey's open-ended race identification question. Specifically, difficulties arose when coding this item because few—if any—individuals separated Hispanic/Latino ethnicity from race; most individuals only put one classification of race and, at times, they only responded "hispanic/latino"--which differs from how government agencies typically report race/ethnicity. In order to preserve how respondents to the MAT survey self-identify, we included hispanic/latino as a stand-alone race/ethnicity classification; otherwise no representation of Hispanic/Latino identity would appear in the dataset. If respondents received the standard choices for race and ethnicity that one might encounter in CDC questionnaires rather than an open-ended question, perhaps survey demographics would better reflect true NDOC categories. Additionally, while percentages of gender roughly reflect those seen in the NV prison population, oversampling women in NDOC facilities (7.62% in our survey vs 8.38% in NDOC; NDOC, 2023) may lead to insights otherwise unable to emerge from our 8 women respondents.

Lastly, another concern lies in the difference among respondents' age from the general NDOC population vs survey respondents. While briefly noted previously, we must again consider how the high prevalence of chronic conditions seen in our sample may result from the higher average age of respondents (refer to Table 4). This could, consequently, lead to an overrepresentation of chronic conditions than one would encounter in the general prison population. However, this does not negate the importance of addressing healthcare; while the average age of individuals in NDOC facilities is lower than our sample, nearly half of individuals housed in NV's state prisons have sentences over 16 years (48.37% of inmates; NDOC, 2023). Thus, it stands to reason that chronic health condition-related concerns will remain an issue in NDOC. Still, including younger individuals will benefit facilities in understanding the health needs of all members of the population—not just older individuals.

Conclusions and Future Directions

Even in the midst of limitations, the survey provided a foundation for future analyses that can provide further, more specific insights into the present state of NDOC healthcare and the needs of those incarcerated in NV State Prisons. Given the majority of respondents with chronic health

conditions—nearly all of whom find that NDOC does not address their medical concerns—the necessity to understand the health of this population remains important. Considering the aging population behind bars, the projected growth of the NV prison population, and the majority of sentences being indeterminate to life, chronic health conditions will not disappear any time soon (NDOC, 2023). Rather than, as one individual stated, "wait[ing]...to break," implementing health-promoting procedures and processes that focus on the most cost and life-saving methods in the long-run—prevention—would benefit both NDOC and the individuals in their custody.

Even further, as previously mentioned, legislators and laypeople are taking notice of incarcerated individuals' health needs as evidenced by SB416 and AB121. While such bills demonstrate movement towards better healthcare practices, to achieve any measure of benefit to impacted individuals, we must continually monitor whether specifics of these bills get implemented. Additionally, addressing issues further upstream such as procedures to access healthcare in general, methods of prescribing medication, whether prescriptions are being followed, etc., also ought to receive legislative attention rather than downstream effects alone that may not assist individuals who, for instance, have yet to see a provider and remain without vital medication they entered prison with.

However, rather than haphazardly initiating programs (or ignoring a looming health crisis), we must first seek to understand the health needs of the population–wisely targeting processes to serve individuals in the most effective ways. To do this, beneficial early steps could include redesigning and redistributing another health assessment survey. This survey, however, should use primarily closed-ended questions with examples and explanations when appropriate. For instance, utilizing a list-like format with chronic conditions and providing examples/explanations could benefit respondents if they have not ever received written documentation regarding their medical conditions. This would also allow for better recall and reduce fatigue when responding to the survey. Breaking up double-barreled questions and adding specific time-based prompts and responses when applicable would also allow for higher quality responses. However, having optional sections in which respondents can provide additional information that forced choice questions could not capture would also give us deeper understanding of respondents' experiences that future survey questions and analysis can explore. Additionally, oversampling based on certain demographic variables that may not appear adequately represented in survey responses (e.g., specific race categories, genders, NDOC facilities) proves important in accurately capturing health needs of the NDOC prison population. A sampling strategy more random in nature would ideally serve the purposes of such a health survey, however, this would likely require coordination and cooperation with multiple agencies that may not have the capacity to assist in this endeavor.

While taking even these initial steps of assessing health care needs (much less addressing needs that arise) seems daunting, attempting to understand health needs of this population—as evidenced by the majority of respondents who expressed feelings ranging from fear, to anger, to despair at the seeming lack of healthcare in NDOC facilities—is vital to both prisoners and NDOC itself. Taking steps to assess and, consequently, respond to healthcare needs of incarcerated individuals not only benefits those suffering from illness, but can save NDOC facilities' time, human resources, and finances; focusing on prevention rather than emergency/tertiary care, frees up such resources. While change does not happen quickly, by approaching it collaboratively and with the humanity of impacted individuals at the forefront of our efforts, we can take needed steps that will get us closer to alleviating the issues surrounding prison healthcare for all parties involved.

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Table 1. Respondents' Ages and Race/Ethnicity		
	Frequency	**Percent**
Gender		
Man	96	91.43
Woman	8	7.62
Transgender Woman	1	0.95
Race/Ethnicity		
White	64	61.54
Black	17	16.35
Hispanic/Latino	14	13.46
Native American	5	4.81
Asian or Pacific Islander	2	1.92
Other	2	1.92
Missing	1	

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k15

Table 2. Respondents' NDOC Facilities		
Facility	**Frequency**	**Percent**
ESP	6	5.77
FMWCC	8	7.69
HDSP	33	31.73
LCC	22	21.15
NNCC	16	15.38
SDCC	7	6.73
TLVCC	1	0.96
WNCC	1	0.96
WSCC	10	9.62
n = 104		

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k16

Table 3. Ages of Participants					
	Frequency	**Percent**	**Mean (SD)**	**Median**	**Min - Max**
Age			50.91 (12.20)	50	26 - 77
25-34	8	7.77			
35-44	30	29.13			
45-54	24	23.30			
55-64	29	28.16			
65-74	9	8.74			
75-90	3	2.91			
n = 103					

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k17

Table 4. NDOC vs Survey Respondents: Ages of Participants (Percentages)		
Age Range	**NDOC***	**Survey**
25-34	30.08	7.77
35-44	29.46	29.13
45-54	16.23	23.30
55+	16.07	39.81
*(NDOC, 2023)		

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k18

Table 5. Dental Variables Among All Respondents		
	Frequency	**Percent**
Saw or requested to see a dentist during time at NDOC	93	88.57
Note it took 6+ months to see a dental provider after requesting one for immediate dental need	40	39.22*
Mention no preventative dentistry	9	8.82*
Mention concern because NDOC only pulls teeth and does not fill cavities	5	4.90*
n = 105 *n = 102		

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k19

Table 6. Mental Health Indicators Among all Respondents		
	Frequency	**Percent**
Seen or requested to see mental health provider during time at NDOC	58	56.31
Note it took 6+ months to see a mental health provider after requesting one	18	31.03*
Any mental health condition	31	29.52
n = 105 *Percentage out of individuals who requested to see mental health provider		

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k20

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k21

Table 7. General Survey Questions		
	Frequency	**Percent**
Have chronic conditions that require continuous or consistent treatment	**100**	**97.1**
No	3	2.9
Missing	2	
Feels NDOC does not respond to requests for healthcare needs timely and to satisfaction	**99**	**96.12**
No	4	3.88
Missing	2	
Seen or requested to see a healthcare provider for urgent needs during time at NDOC	**92**	**88.46**
No	12	11.54
Missing	1	
Feels NOT receiving adequate care for chronic conditions	**78**	**92.86**
No	6	
Missing	21	
Submitted grievance or emergency grievance for healthcare needs	**77**	**79.38**
No	20	20.62
Missing	8	
Seen or requested to see outside specialist for healthcare needs	**58**	**56.31**
No	45	43.69
Missing	2	
NDOC NOT following treatment plans prescribed by outside specialist	**46**	**80.70**
No	11	19.30
Missing	48	
Considered disabled	**40**	**40.82**
No	58	59.18
Missing	7	
NDOC NOT abiding by ADA requirements for disability	**35**	**89.74**
No	4	10.26
Missing	66	
Provider outside of NDOC refused to treat because incarcerated or terminated contract with NDOC	**14**	**15.91**
No	74	84.09
Missing	17	

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k22

Table 7. General Survey Questions		
	Frequency	**Percent**
Dismissal letter received from provider because incarcerated	**8**	**8.16**
No	90	91.84
Missing	7	

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k23

Table 8. Chronic Condition Types Among Individuals with Chronic Conditions		
	Frequency	**Percent**
Any Mental Health Condition	31	31
High Blood Pressure	30	30
Any Neurological Damage/Disorder	30	30
Any Chronic Musculoskeletal Condition (not including arthritis)	26	26
Gastrointestinal diseases	21	21
Any Cardiovascular Disease	18	15
Any Lung Disease	17	17
Untreated injuries	17	17
Arthritis (not including osteoarthritis), Lupus, or Fibromyalgia	15	15
Any Urologic Conditions (including prostate)	14	14
Eye Diseases/Conditions	12	12
Any Infectious or Fungal diseases	10	10
High Cholesterol	7	7
Untreated hernia	7	7
Liver Diseases/Damage	6	6
Thyroid Issues	5	5
Hearing Conditions	5	5
Uses Walker or Wheelchair	4	4
Sleep Disorders	3	3
Autoimmune conditions	2	2
n = 100		

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k24

Table 9. Non-Pain Medication Survey Questions		
	Frequency	**Percent**
Takes prescription medications that are not related to pain management	**83**	**79.05**
No	22	20.95
Not receiving meds as prescribed	**50**	**56.18**
No	39	43.82
Missing	16	
Experienced difficulties receiving or Refilling medications	**76**	**81.72**
No	17	18.28
Missing	12	

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k25

Table 10. Pain Medication/Pain Management Questions		
	Frequency	**Percent**
Currently taking pain management medications	**12**	**18.75**
No	52	81.25
Missing	41	
NOT receiving pain medication as prescribed	**50**	**56.18**
No	39	43.82
Missing	16	
Pain NOT being adequately managed	**74**	**96.10**
No	3	3.9
Missing	28	
Difficulties receiving or refilling these pain meds	**60**	**86.96**
No	9	13.04
Missing	36	

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k26

Table 11. Qualitative Analysis: Medication-Related Concerns		
	Frequency	**Percent**
NDOC medical provider stopped prescribed medication without information/warning	22	21.57
NDOC did not prescribe needed medication they entered with/were told to take by a provider	19	18.63
To get refills, required to see a doctor, however, it takes months to see the doctor and are left without needed medication during this period	12	11.76
NDOC medical provider reduced prescribed medication dosage without information/warning	10	9.80
n = 102		

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k27

Table 12. Qualitative Analysis: Time Lapse Between Medication Doses		
	Frequency	**Percent**
Takes “weeks” to get refill for any meds	22	20.59
Specifically note takes more than 2 months to get refill for any meds	9	7.84
Specifically note takes more than 3 months to get refill for any meds	2	1.96
Specifically note takes more than 6 months to get refill for any meds	2	1.96
Takes “months” to get refill for any meds	6	5.88
Specifically note takes more than 1 year to get refill for any meds	2	1.96
n = 102		

man down.” It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k28

Table 13. Qualitative Analysis: General Health Care Concerns		
	Frequency	**Percent**
Medical kite issues (ignoring kites, not getting responses, etc.)	41	40.20
Not receiving any follow-up or continued care for chronic conditions	27	26.47
Feel medical needs are "ignored" or that "no one cares"	26	25.49
Cost of care (for medication, doctor visits, cost of calling a man-down) being a burden or inhibitor to proper treatment	25	24.51
Has filed a health-related lawsuit	25	24.51
Unscheduled or arbitrarily canceled medical procedures/tests	17	16.67
Discuss how the long wait to receive care/see doctor leads to condition worsening	15	14.71
Providers will only see someone if they request a man down, "are dying," or are suicidal	13	12.75
Providers would not provide care because they were "not sick enough"	11	10.78
Medical under-staffing	11	10.78
Only pain meds are prescribed instead of addressing the underlying condition	10	9.80
Experience staff blaming patients for problems/medical gaslighting ("you're fine," "just lose weight," etc.)	10	9.80
Experience medical retaliation (e.g., file lawsuit and medications withheld)	7	6.86
No optometrist	7	6.86
No preventive health care	5	4.90
Fear medical neglect will lead to their death	4	3.92
n = 102		

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k29

Table 14. Qualitative Analysis: Time to See a Doctor for an Immediate Health Request/Need		
	Frequency	**Percent**
Note that seeing a doctor for an immediate health request/need takes 6+months	25	24.51
Note seeing doctor takes "months"	7	6.86
Note seeing doctor takes "weeks"	4	3.92
n = 102		

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k30

Table 15. Man Down Questions		
	Frequency	**Percent**
Called man down for prompt emergency response?	53	52.48
No	48	47.52
Missing	4	
Prompt man down response given the respondent called a man down?		
No	30	63.83
yes	17	36.17
Missing	58	

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k31

Table 16. NDOC vs Survey Race Percentages		
	NDOC*	**Survey**
White	55.1	61.54
Black	32.5	16.35
Native American	6.3	4.81
Asian or Pacific Islander	3.6	1.92
Other	2.4	1.92
Hispanic/Latino**	26.2	13.46

*(NDOC, 2023)
**Listed as ethnicity in NDOC statistics vs separate race classification in survey

man down." It turned out I had stress-induced type 2 diabetes for over 4 (nearly 5) years. The NDOC k32