UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

Keith Rogers, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	No. 15-cv-11632
-*vs*-	)	
	)	Hon. Edmund E. Chang
Sheriff of Cook County and Cook County,	)	
	)	
Defendants.	)	

DEFENDANTS' JOINT MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION FOR SUMMARY JUDGMENT

Defendants Cook County and Sheriff Thomas Dart, by their attorney Eileen O'Neill Burke, Cook County State's Attorney, through her respective Assistant State's Attorneys, pursuant to Federal Rule of Civil Procedure 56, move for summary judgment, and in support of this state:

INTRODUCTION

During the class period, detainees in the Cook County Department of Corrections (CCDOC) received more treatment for their Opioid Use Disorder (OUD) than inmates in 95% of correctional institutions in the nation. Defendants' L.R. 56.1 Statement of Material Facts ("SOF") at ¶ 23. The treatment they received was inarguably better than what they would have received in any other correctional facility in Illinois. SOF at ¶¶ 22, 54-55, 58. The policies of the CCDOC Opioid Treatment Program (OTP) were reviewed and approved by multiple federal and state licensing agencies and complied with the medical guidelines of the governing bodies at the time. SOF at ¶¶ 26, 28, 61. The policies were neither unreasonable nor deliberately indifferent, and Plaintiffs' rights were not violated. Further, the individual Plaintiffs' claims are not cognizable under the ADA or Rehabilitation Act. As a matter of law, summary judgment should be entered for Defendants.

LEGAL STANDARD

Summary judgment is warranted "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). A dispute is "genuine" "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). A fact is "material" if it might affect the outcome of the suit. *Id.* At summary judgment, the court's role is not to weigh evidence or make credibility determinations, but to determine whether there is a genuine issue for trial. *Id*. at 249. Courts draw all reasonable inferences in favor of the nonmovant. *Beard v. Banks*, 548 U.S. 521, 529 (2006). "'With cross summary judgment motions, [courts] construe all facts and inferences therefrom in favor of the party against whom the motion under consideration is made.' *Markel Ins. Co. v. Rau*, 954 F.3d 1012, 1016 (7th Cir. 2020) (quoting *In re United Air Lines, Inc.*, 453 F.3d 463, 468 (7th Cir. 2006)). However, they distinguish between "disputed facts and disputed matters of professional judgment. In respect to the latter, our inferences must accord deference to . . . prison authorities." *Beard*, 548 U.S. at 530.

ARGUMENT

I. PLAINTIFFS' CLASS CLAIMS FAIL BECAUSE THE OTP POLICIES WERE NEITHER UNREASONABLE NOR INDIFFERENT TO INMATES' MEDICAL NEEDS.

A. Defendants' Methadone Tapering Policy Did Not Amount to Deliberate Indifference to Post-Sentence Inmates' Serious Medical Needs.

"To prevail on a claim of inadequate medical care under the Eighth Amendment, a plaintiff must establish that a prison official acted with deliberate indifference to the prisoner's objectively serious medical need." *Dean v. Wexford Health Sources, Inc.*, 18 F.4th 214, 234-35 (7th Cir. 2021). "[A] complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment." *Estelle v.*

Gamble, 429 U.S. 97, 106 (1976). This standard is "a high hurdle," requiring more than mere negligence or even gross negligence. *Petties v. Carter*, 836 F.3d 722, 728 (7th Cir. 2016). Plaintiffs must show that Defendants were subjectively aware of, and consciously disregarded, a substantial risk to inmate health. *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

1. Plaintiffs cannot show deliberate indifference where risks were mitigated rather than disregarded by instituting the tapering policy to manage withdrawal and providing additional medications to treat symptoms.

Post-sentence Plaintiffs must show that Defendants were aware of, and consciously disregarded, a substantial risk of harm. *Id.* They cannot do so. Here, the risk of harm to Plaintiffs was directly addressed and mitigated through observation, secondary medications, and conservative treatment. SOF at ¶¶ 29, 32-33, 35, 41. These were not Plaintiffs' preferred options, but they are a far cry from deliberate indifference.

Defendants offered Plaintiffs medically accepted, if conservative, treatment for their OUD and withdrawal symptoms. SOF at ¶¶ 17-18, 28, 41. Even assuming arguendo that the treatment Plaintiffs received fell below an accepted standard of care within the medical field, the Eighth Amendment is not a vehicle for medical malpractice claims. *Forbes v. Edgar*, 112 F.3d 262, 266 (7th Cir. 1997) ("Ordinary malpractice does not rise to the level of an Eighth Amendment claim."). "Medical malpractice does not become a constitutional violation merely because the victim is a prisoner." *Estelle*, 429 U.S. at 106. "Prisoners are not entitled to state-of-the art medical treatment." *Petties*, 836 F.3d at 731. Rather, they are entitled to "reasonable measures to meet a substantial risk of serious harm." *Forbes*, 112 F.3d at 267. Here, Defendants exceeded that standard.

In the OTP, the rate of taper was determined by a physician individually for each patient. SOF at ¶ 31. It was re-evaluated and could be slowed or paused based on the patient's tolerance of the taper as needed. SOF at ¶¶ 32-33. Further, a physician in the OTP had the ability to seek a

waiver to maintain even non-pregnant detainees on a constant dose of methadone on an individual basis if they believed it was necessary. SOF at ¶ 36. Defendants' policy of tapering methadone doses reflected a medical judgment, not a wanton infliction of pain or disregard for inmates' serious medical needs. Courts have repeatedly held that disagreements over treatment decisions, including medication protocols, do not rise to the level of constitutional violations. *See Snipes v. DeTella*, 95 F.3d 586, 591 (7th Cir. 1996) ("Whether and how pain associated with medical treatment should be mitigated is for doctors to decide free from judicial interference, except in the most extreme situations."). The fact that another physician may have adopted a different tapering schedule does not demonstrate that Defendants acted with the requisite deliberate indifference. *See Johnson v. Doughty*, 433 F.3d 1001, 1013 (7th Cir. 2006) ("A medical decision not to order an X-ray, or like measures, does not represent cruel and unusual punishment.") (quoting *Estelle*, 429 U.S. at 107).

Nor does the fact that an inmate would have preferred a different treatment. "Under the Eighth Amendment, [a prisoner] is not entitled to demand specific care." *Forbes*, 112 F.3d at 267. Methadone tapering, when implemented as part of a withdrawal management strategy, is a clinically accepted and commonly utilized method for treating OUD.[1] In addition to this recognized treatment protocol, the OTP prescribed additional medications to manage symptoms of withdrawal that patients might have, including nausea, body aches, and trouble sleeping. SOF at ¶¶ 33, 41. Patients in the OTP had daily contact with medical staff who dispensed their methadone and could request to see a provider by submitting a request at any time. SOF at ¶ 34.

The decision to implement a methadone tapering program is itself proof that Defendants were not deliberately indifferent to the medical needs of detainees. The consensus among experts

[1] *See* Substance Abuse and Mental Health Services Administration (SAMHSA), *Medications for Opioid Use Disorder* (Treatment Improvement Protocol 63), at 3–10 (rev. 2021) (recognizing methadone tapering as a medically supervised withdrawal strategy).

is that tapering is the more humane method of methadone cessation. SOF at ¶ 58. Tapering causes less severe side effects and withdrawal symptoms than an abrupt "cold turkey" stop. SOF at ¶ 54. In fact, some individuals have no symptoms at all if they are tapered. SOF at ¶ 57. No other county jail in Illinois during the time period offered any methadone treatment at all. SOF at ¶ 22. Additionally, the Illinois Department of Corrections did not offer methadone tapering. *Id.* A detainee in any of those facilities would be forced to withdraw from methadone cold turkey, rather than through medically supervised tapering like the OTP. Thus, any detainee transferred from the CCDOC to a state prison or another county jail undoubtedly benefited from a methadone taper rather than a cold turkey stop. SOF at ¶ 62. The OTP offered methadone users better treatment than 95% of correctional facilities in the country, including any other facility in Illinois. SOF at ¶ 23. Defendants' tapering protocol was not only medically appropriate but comparatively more humane. Defendants reasonably relied on existing protocols to mitigate the risks to inmates, precisely the opposite of deliberate indifference.

2. Plaintiffs cannot demonstrate subjective awareness of a substantial risk where the OTP provided substantially more care than most correctional institutions during the class period.

Nor can Plaintiffs meet the subjective knowledge prong of the Eighth Amendment analysis. "[A] prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." *Forbes*, 112 F.3d at 266. Plaintiffs must show that Defendants "knew of facts from which he could infer that a substantial risk of serious harm existed, and . . . did, in fact, draw that inference." *Walker v. Wexford Health Sources, Inc.*, 940 F.3d 954, 964 (7th Cir. 2019) (citing *Farmer*, 511 U.S. at 837). All evidence shows that Defendants' subjective understanding is that they were providing cutting edge

care to the detainees in the OTP that was among the best care provided in any correctional institution during the class period. SOF at ¶¶ 22-24.

"[M]edical professionals may choose from a range of acceptable courses based on prevailing standards in the field." *Walker*, 940 F.3d at 965 (cleaned up). "[Courts] defer to medical professionals' treatment decisions unless there is evidence that no minimally competent professional would have so responded under those circumstances." *Id.* (cleaned up). The OTP was well within the range of competent medical care as one of the most comprehensive correctional health opioid treatment programs in the nation. During the class period, the OTP provided more extensive care for OUD than the vast majority of correctional systems, including medically supervised methadone tapering, daily in-person medication administration, mental health support, additional as-needed treatment for specific withdrawal symptoms, and opportunities for dosage adjustment and clinical review. SOF at ¶¶ 32-35. This protocol designed to mitigate risk directly contradicts the notion that there was deliberate disregard for Plaintiffs' wellbeing.

While it is true that "evidence from which a reasonable jury could infer a doctor knew he was providing deficient treatment is sufficient to survive summary judgment," no such inference can be drawn in this case. *Petties*, 836 F.3d at 726. The Seventh Circuit in *Petties v. Carter* details several ways in which an inference of deliberate indifference could arise. Each is distinguishable. The OTP did not ignore inmates' requests for medical care where there was an entire program dedicated to treating the needs of opioid dependent individuals. *Id.* at 729. Nor was the OTP's protocol "'such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment.'" *Id.*, (quoting *Cole v. Fromm*, 94 F.3d 254, 261-62 (7th Cir. 1996)). Plaintiffs' experts both engaged in similar practices during the class period and beyond when treating correctional populations, and

the OTP was better than 95-99% of other correctional institutions. SOF at ¶¶ 46, 49-50. If every testifying expert engaged in similar patterns of care, surely there was at least the semblance of an accepted professional judgment. The OTP's practices and written policies complied with and were approved by multiple governing agencies. SOF ¶¶ 25-27, 61. There can be no inference based on deviation from protocols. *Petties*, 836 F.3d at 729.

In the OTP, physicians set the rate of taper and could slow or pause the taper based on their medical judgment. SOF at ¶¶ 31-33. They could also seek a waiver to avoid tapering and maintain a pre-incarceration dose if they believed it was necessary. SOF at ¶ 36. Tapering methadone is known to be effective at reducing or even eliminating withdrawal symptoms. SOF at ¶¶ 54-55, 57. Defendants did not persist with treatment "known to be ineffective" or opt for the "'easier and less efficacious treatment' without exercising professional judgment." *Petties*, 836 F.3d at 730. Finally, "another type of evidence that can support an inference of deliberate indifference is an inexplicable delay in treatment which serves no penological interest." *Petties*, 836 F.3d at 730. Here any delays experienced were generally due to difficulty confirming detainees' prior methadone dosages—necessary to prevent potentially fatal overdose. SOF at ¶¶ 16, 29.

Here, Plaintiffs simply do not have the evidence to make a constitutional claim against Defendants. The subjective knowledge cannot be proven or reasonably inferred from the facts adduced in this litigation. Additionally, there were concrete actions taken to mitigate potential harm to Plaintiffs. There was no constitutional deprivation.

B. Defendants' Tapering Protocol During the Class Period Was Objectively Reasonable Care for Pretrial Detainees in the OTP Considering the Totality of the Circumstances.

Pretrial detainees' claims arise under the Fourteenth, rather than Eighth, Amendment. *Miranda v. Cnty. of Lake*, 900 F.3d 335, 350 (7th Cir. 2018). "Claims of inadequate medical care while in pretrial detention are subject to an objective-reasonableness standard." *James v. Hale*, 959

F.3d 307, 318 (7th Cir. 2020). "The plaintiff bears the burden to demonstrate objective unreasonableness, and he must make a twofold showing." *Id.* "First, he must show that the defendant acted purposefully, knowingly, or recklessly when considering the consequences of his response to the medical condition." *Id.* (citing *McCann v. Ogle Cnty.*, 909 F.3d 881, 886 (7the Cir. 2018)). "Second, the plaintiff must show that the challenged conduct was objectively unreasonable in light of the totality of the relevant facts and circumstances." *Id.*

The OTP provided objectively reasonable care for Plaintiffs. Medically supervised withdrawal is an accepted treatment approach. SOF at ¶¶ 17-18, 28. Multiple accrediting bodies were involved in reviewing the OTP's policies, conducting on site visits, and approving certification of the program. SOF at ¶¶ 15, 26. Plaintiffs' preference for a different treatment protocol does not make the OTP's policies objectively unreasonable. *Williams v. Ortiz*, 937 F.3d 936, 944 (7th Cir. 2019) (failure of staff to follow detainees preferred course of treatment "does not mean that the course of treatment was objectively unreasonable."). "[D]etainees are not entitled to receive 'unqualified access to healthcare.'" *Burton v. Downey*, 805 F.3d 776, 785 (7th Cir. 2015). In this case, detainees received an approved protocol for medically supervised withdrawal. SOF at ¶¶ 17-18, 25-28. They also were provided with medication to treat additional symptoms of withdrawal as needed. SOF at ¶¶ 33, 41. Further, the OTP provided mental health programming in addition to the medical treatments offered. SOF at ¶ 35.

Additionally, the OTP provided the care that they were licensed to provide during the class period. SOF at ¶ 27. The OTP was licensed to provide detoxification services during the class period. SOF at ¶ 27. In order to provide maintenance treatment outside the scope of the OTP's detoxification licensing, a physician had to apply for a waiver for an individual patient based on the specific circumstances. SOF at ¶ 36. The OTP was among the leading correctional institutions

in the country in providing methadone tapering rather than forcing cold turkey withdrawal, as the lion's share of institutions did. SOF at ¶¶ 22-24. As all experts noted, medically supervised withdrawal is far preferrable to a cold turkey withdrawal. SOF at ¶¶ 54-55, 58. Consideration of the "totality of the relevant circumstances" includes acknowledging that the OTP provided better care than 95-99% of similarly situated institutions by providing detoxification treatment and that no facility was providing the care that Plaintiffs' experts now espouse during the relevant time period. *James*, 959 F.3d at 318; SOF at ¶¶ 22-24. The Defendants' conduct was reasonable.

Moreover, there were legitimate penological purposes to tapering doses of methadone rather than offering maintenance treatment. CCDOC had a penological interest in limiting the quantities of methadone moving through the facility due to the risk of diversion unique to correctional settings. SOF at ¶ 21. Additionally, the size of the program faced limitations due to the security needs, both in personnel and secure locations to manage the program. *Id.* These were difficulties acknowledged by Plaintiffs' experts from their own work in correctional settings. *Id.* Correctional facilities are permitted to consider administrative burden and cost when making decisions about what treatments to make available. *See Petties*, 836 F.3d at 730. Experts noted that cost was a significant barrier faced by correctional institutions in providing Medications for Opioid Use Disorder (MOUD), and the OTP was not immune to this issue—evidenced by the fact that the policies changed when the OTP received a grant, allowing the program to hire more staff and relieving both administrative and financial burdens. SOF at ¶¶ 20, 37.

The OTP provided methadone tapering allowed by its licensure status as a detoxification facility as well as individualized care for specific withdrawal symptoms. SOF at ¶¶ 32-33, 41. The limitations on care were related to legitimate penological concerns. Despite the limitations, the OTP still provided more MOUD than nearly all similar facilities. SOF at ¶¶ 22-24. Under the

"totality of the relevant facts and circumstances," the OTP provided Plaintiffs with reasonable care. *James*, 959 F.3d at 318.

C. The Sheriff in His Official Capacity Is Entitled to Summary Judgment Because Plaintiffs Cannot Show Deliberately Indifferent or Unreasonable Policies.

Sheriff Dart is entitled to summary judgment because, for the reasons stated above, the OTP did not violate the Constitution. Prisoners need not receive the best care possible or their treatment of choice, and disagreement among medical professionals does not mean one course of care is unconstitutional. *Pulera v. Sarzant*, 966 F.3d 544 (7th Cir. 2020); *Williams*, 937 F.3d at 944; *Forbes*, 112 F.3d at 267; *Arnett v. Webster*, 658 F.3d 742, 754 (7th Cir. 2011); *Petties*, 836 F.3d at 729, 731; *Steele v. Choi*, 82 F.3d 175, 179 (7th Cir. 1996). Additionally, Sheriff Dart is entitled to summary judgment because the OTP was run by Cook County. As a matter of law, the Sheriff is distinct from the County, which operates as the healthcare provider for all detainees housed at the CCDOC.[2] Courts "have long recognized that correctional institutions typically engage in the division of labor between medical professionals and other security and administrative staff" and that "non-medical jail staff may generally trust the professionals to provide appropriate medical attention [and] defer to the professional medical judgments of the physicians and nurses . . . without fear of liability." *McGee v. Parsano*, 55 F.4th 563, 569 (7th Cir. 2022) (cleaned up). "An exception exists only if a jail official 'had reason to know that the[] medical staff w[as] failing to treat or inadequately treating an inmate.'" *Id.* (quoting *Miranda*, 900 F.3d at 343).

Plaintiffs' *Monell* claim fails unless they can prove three elements: "(1) an action pursuant to a municipal policy, (2) culpability, meaning that policymakers were deliberately indifferent to a known risk that the policy would lead to constitutional violations, and (3) causation, meaning the

[2] See *Winfield v. Dart*, 2014 U.S. Dist. LEXIS 32509 at *2-3 (N.D. Ill. 2014); *DeGenova v. Sheriff of DuPage Cnty.*, 209 F.3d 973, 976 (7th Cir. 2000); *Boyce v. Moore*, 314 F.3d 884, 887 n.1 (7th Cir. 2002).

municipal action was the 'moving force' behind the constitutional injury." *Hall v. City of Chicago*, 953 F.3d 945, 950 (7th Cir. 2020). The Supreme Court has cautioned "[w]here a court fails to adhere to rigorous requirements of culpability and causation, municipal liability collapses into *respondeat superior* liability. . . . Congress did not intend municipalities to be held liable unless *deliberate* action attributable to the municipality directly caused a deprivation of federal rights." *Bd. of Cnty. Comm'rs v. Brown*, 520 U.S. 397, 415 (1997) (emphasis in original). To establish liability on the part of Sheriff Dart, Plaintiffs must establish that its policymakers acted with deliberate indifference.[3]

While the Sheriff is responsible for the general oversight of CCDOC, he can reasonably defer to the judgment of medical professionals in handling specific treatment protocols. *See McGee v. Parsano*, 55 F.4th 563, 569 (7th Cir. 2022). The OTP was managed by Cook County medical professionals. SOF at ¶ 4. It was accredited by multiple governing bodies responsible for overseeing access to MOUD and correctional healthcare. SOF at ¶¶ 15, 25-27. And it offered greater access to care than 95-99% of correctional institutions at the time. SOF at ¶ 23. It was reasonable for Sheriff Dart to rely on the medical judgment of accreditors and regulatory bodies as well as the OTP staff that care was appropriate.

Sheriff Dart cannot be held liable because no constitutional deprivation occurred. If it did, Plaintiffs can offer no evidence to suggest the Sheriff believed the OTP violated the Constitution and acted recklessly or deliberately indifferently in allowing the tapering policy to continue.

[3] *See Hildreth v. Butler*, 960 F.3d 420, 426 (7th Cir. 2020) (stating that to succeed on a *Monell* claim, a plaintiff "must show *policymakers* knew of the deficiencies and failed to correct them, manifesting deliberate indifference" (emphasis added)); *Braun v. Village of Palatine*, 56 F.4th 542, 552 (7th Cir. 2022). "Deliberate indifference goes beyond a failure to act—[the] conduct must rise to the level of criminal recklessness." *Harvey v. Dart*, No. 19-cv-2996, 2023 U.S. Dist. LEXIS 45235, at *40 (N.D. Ill. Mar. 17, 2023) (citing *Flores v. City of South Bend*, 997 F.3d 725, 729 (7th Cir. 2021)). "Negligence or even gross negligence on the part of the municipality is not enough." *First Midwest Bank ex. rel Est. of LaPorta v. City of Chicago*, 988 F.3d 978, 987 (7th Cir. 2021).

D. As a Matter of Policy, the Standard That Plaintiffs Urge Is Untenable Because Every U.S. Correctional Institution Would Fail During the Class Period.

While the law alone is sufficient for this Court to find in Defendants' favor, the policy implications are so sweeping that they must be emphasized as well. Plaintiffs urge this Court to determine that every correctional institution in the nation was behaving unconstitutionally during the class period. The majority would still fail Plaintiffs' standards today. While access to treatment is increasing, medication-based options are still the minority.[4]

Methadone remains highly regulated—vanishingly few correctional institutions offer methadone maintenance for inmates. *See* Scott, et al. (Methadone treatment available to a subset of inmates in 9% of the 583 prisons in the surveyed states; of those facilities providing any methadone, 57% provide methadone only to pregnant women and only 38% provided maintenance treatment to those being treated prior to admission). But growing availability of other MOUD like buprenorphine and naltrexone is allowing more correctional institutions to offer some version of medication-based treatment to inmates with OUD. Scott, et al. In some cases, the facilities offer maintenance only but do not initiate new patients. *See* NIDA Study. In others, the only medication-based intervention is a single injection of the long-acting opioid antagonist naltrexone immediately before release to help with the re-entry period, when individuals are at the highest risk of relapse and overdose. *See* Scott, et al. This changing treatment landscape reinforces why Plaintiffs'

[4] *Fewer than half of U.S. jails provide life-saving medications for opioid use disorder*, Nat'l Inst. Drug Abuse (Sep. 24, 2024), https://nida.nih.gov/news-events/news-releases/2024/09/fewer-than-half-of-us-jails-provide-life-saving-medications-for-opioid-use-disorder ("NIDA Study") ("The researchers found that more than half of the surveyed jails did not offer [MOUD]"); Christy K Scott, et al., *The impact of the opioid crisis on U.S. state prison systems*, Health Justice (Jul. 24, 2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8310396/ (finding that 61% of the institutions included in the survey provided no type of MOUD for any inmate). Laura M. Maruschak, *Opioid Use Disorder Screening and Treatment in Local Jails*, 2019, U.S. Dep't of Justice (Apr. 2023), https://bjs.ojp.gov/document/oudstlj19.pdf (finding that in 2019, 24% of local jail jurisdictions continued at least one type of MOUD for persons admitted with a current prescription).

proposed one-size-fits-all paradigm is inappropriate, and why the Supreme Court has repeatedly advised against courts making decisions that are best left to prison administrators. *Turner v. Safely*, 482 U.S. 78, 84-85 (1987); *Bell v. Wolfish*, 441 U.S. 520, 547 (1979); *Block v. Rutherford,* 468 U.S. 576, 589 (1984).

It is concerning that the benchmark Plaintiffs advocate would condemn the care provided at well over half of U.S. jails and prisons today as unconstitutional. Even more troubling is that Plaintiffs' experts cannot name a single correctional institution that did meet the standards they endorse during the class period. SOF at ¶ 24, 46, 49-50. Instead, Plaintiffs reason that everyone, Plaintiffs' experts included, acted unconstitutionally. This is a sweeping and dramatic conclusion for Plaintiffs to request this Court to draw, and the far-reaching implications bear consideration. The Constitution calls for medical care that is not deliberately indifferent or objectively unreasonable. Defendants were neither indifferent nor unreasonable in providing care that exceeded 95% of other correctional institutions in the U.S. Here, both the constitutional framework and the policy implications support summary judgment for Defendants.

II. PLAINTIFFS' INDIVIDUAL CLAIMS FAIL BECAUSE THEY WERE NOT DISCRIMINATED AGAINST BY REASON OF DISABILITY AND THE ADA AND REHABILITATION ACT ARE NOT AVENUES FOR MEDICAL MALPRACTICE SUITS.

A. The Individual Plaintiffs' Claims do not fall under the ADA or Rehabilitation Act.

To bring a claim under the ADA, a plaintiff must be a "qualified individual with a disability" who "by reason of such disability" was "excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. Similarly, under the RA a plaintiff must be an "otherwise qualified individual with a disability" who "solely by reason of her or his disability" was "excluded from the participation in, be denied the benefits of, or be subjected to discrimination

under any program or activity receiving Federal financial assistance." 29 U.S.C. § 794. The statutes use largely overlapping analysis, except that the RA requires federal funding to be involved (not at issue here, *see* dkt 138 at ¶¶ 5, 7), and the relevant causation standards. *Monroe v. Ind. DOT*, 871 F.3d 495, 504-05 (7th Cir. 2017) (noting that the ADA asks "whether his disability was the 'but for' reason" for discrimination while the RA requires a "'solely by reason of' standard of causation").

Plaintiffs' claims fail under either causation standard. Discrimination based on Plaintiffs' OUD was not the "but for" or sole cause of the delay in provision of methadone. Plaintiff Rogers experienced a delay due to difficulty verifying his dose and miscommunication about when he was supposed to be brought to the clinic. SOF at ¶ 63-65. Plaintiff Hill entered the CCDOC on December 23, 2013, and received his first dose of methadone on December 25, 2013. SOF at ¶¶ 66-67. That short delay was likely due to slower response times from clinics around the holidays. SOF at ¶ 68. Plaintiff Hollins also experienced a short delay of about one day while the OTP verified her dose from her prior clinic. SOF at ¶¶ 69-70. These necessary regulatory safety measures or even administrative errors are not discrimination by reason of Plaintiffs' disabilities. And, because the circumstances of each delay are unique, they cannot support a *Monell* claim based on an alleged widespread practice or policy.

B. The RA and ADA are not avenues for medical malpractice actions.

"The Rehabilitation Act and the Americans with Disabilities Act do not create a remedy for medical malpractice." *Reed v. Columbia St. Mary's Hosp.*, 915 F.3d 473, 486 n. 6 (7th Cir. 2019). "[A]lthough outright denials of medical care are actionable under the ADA, provision of improper medical care is not." *Thomas v. Dart*, No. 17-cv-4233, 2021 U.S. Dist. LEXIS 130618, at *10 (N.D. Ill. July 14, 2021); *Williams v. Ill. Dep't of Corr.*, No. 3:19-CV-739-MAB1, 2023 U.S. Dist.

LEXIS 17867, at *90-91 (S.D. Ill. Feb. 2, 2023) (a claim regarding whether a plaintiff "received *adequate* mental health care *for* his disability" is not a claim that a plaintiff was "denied mental health care *because* he had a disability" and a claim that a plaintiff should have received a particular treatment is a claim of inadequate treatment not an ADA claim). "[T]he ADA and the Rehabilitation Act do not apply when a prisoner simply disagrees with his course of medical treatment." *McDaniel v. Syed*, 115 F.4th 805, 828 (7th Cir. 2024). Plaintiffs here all acknowledge that they were provided with treatment; they take issue with the delay in initiating it and the treatment provided. Dkt 133 at ¶¶ 19, 23, 27. This is not actionable under the ADA or RA.

For these reasons, the individual claims in Plaintiffs' Complaint fall as well. The OTP, even if flawed, provided significantly more care than its contemporaries and more than the Constitution requires. Plaintiffs cannot win under the ADA or the RA any more than under the Eighth or Fourteenth Amendment. Summary judgment in favor of Defendants is proper.

CONCLUSION

WHEREFORE, Defendants respectfully request that this Court grant judgment in favor of Defendants, and for any other relief that this Court deems just and proper.

Dated: June 9, 2025

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I, Dortricia Penn, Assistant State's Attorney, hereby certify that I served a copy of the attached document on the parties of record via the ECF electronic filing system on June 9, 2025.

/s/ Dortricia Penn