EXHIBIT F

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF ILLINOIS

EASTERN DIVISION

KEITH ROGERS,

Plaintiff,

v. No.

SHERIFF OF COOK COUNTY and COOK COUNTY, ILLINOIS, 15-cv-11632

Defendant.

VIDEOCONFERENCE DEPOSITION OF

ADEYEMI FATOKI, M.D.

DATE: Monday, October 3, 2022

TIME: 10:02 a.m.

LOCATION: Remote Proceeding

Chicago, IL 60606

REPORTED BY: Maureen Foody, Notary Public

JOB NO.: 5468516

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Illinois?

A No, no, no. But the one that I said, with the overdose, it was -- the attorney was Tim Tyler. That was the plaintiff's attorney, but I don't remember the name of the patient that time.

Q Can you repeat the name of the plaintiff?

A Attorney Timothy Tyler.

Q Okay. Doctor, I'm just going to introduce our first exhibit, Exhibit 1.

(Exhibit 1 was marked for identification.)

Is this your resume?

A Yes.

Q And I am cognizant of your time, so I'll try to go through it briefly, but I just want to get an idea of your educational and medical background.

Q What undergraduate college did you attend?

A Western Illinois University in Macomb, Illinois.

Q And what year did you graduate?

A 1985.

Q And when did you attend medical school?

A From 1986 to 1990.

Q And what was the university or college that

Q And what was the master's in?
A One was -- one is a Master's in Public Health, and the other one is a Master's in Addiction Studies from Governors State University.
Q And when did you get your Masters in Addiction Studies?
A I have to refer to my CV, if you don't mind. Scroll up, or I can look at my copy.
Q Sure.
A Just to be exact here. 2011.
Q 2011, okay.
A Yeah.
Q And how long was that program?
A I believe it was for one year.
Q Do you recall what type of courses you took while getting your Master's in Addiction Studies?
A Yes. We did psychopharmacology. We -- there was some research involved. There were classes on counseling techniques. There were classes on how to do group. There were also classes on the disease model of addiction.
Q Were there any classes that were specific to opioid use disorder?
A I believe there were some, because we did

Q And what's the difference between an antagonist and an agonist?

A An agonist is similar to the medication that you're using it for, meaning that it works just the same way as an opioid. But an antagonist is something that blocks the opioid receptors completely, so you don't have the same effect that you would from an opioid.

Q Do patients who are taking opioid agonists experience any sort of high associated with them?

A Well, on methadone, they can if the dose is high. But if the dose is effective, they should not experience a euphoria, and they should not, also, feel sick. So if the dose is where it's supposed to be, should maintain, and they should feel more normal.

Q So under an opioid agonist, it's possible to experience some sort of euphoria associated with the drug?

A Yes, with a pure opioid agonist.

Q And what about with an antagonist? Is that possible?

A No, but with -- buprenorphine is a partial agonist and antagonist, so that, also, patients don't experience euphoria with that, because it has a

ceiling effect.

Q On your resume, I might skip around a little bit, but I'm not going to go through every single job you have listed on here. But looking at Exhibit 1, it looks like you worked at the Treatment Alternatives for Safer Communities from October 2017 to December 2020. Is that accurate?

A Yes.

Q And can you just describe what type of organization this was and what type of patients you treated?

A So TASC is an organization that contracts with the court system to try to -- to treat patients who have opioid or substance use disorder. So at the time that I worked for them, they were trying to get more into treatment using medications. So what I did, mainly, was meeting with the staff, making treatment recommendations, and also signing off on treatment plans.

Q And it lists you as a physician consultant. Is that an accurate description?

A Yes.

Q Approximately how many hours a week were you working for TASC during this time?

A It was about maybe 10 to 15 hours a week.

Q Did you have any face-to-face time with patients?

A No.

Q Did you prescribe any medications?

A No.

Q Was this organization, TASC, a licensed opioid treatment provider?

A No, they were not. At least not at the time. I don't know if they are now, but at the time, they were not licensed.

Q What's your understanding about what it means to be a license opioid treatment?

A Well, you have to be licensed, because -- I do have two licensed opioid treatment programs. I run one in Calumet City, Illinois that I started in 2007. And I have one in Ottawa that I believe we started around 2013, and both are licensed and accredited. So basically, we went through the regulations.

We're approved by SUPR, which was formerly known as DASA. We have a DEA license. We also have a -- the federal OTP license, and we're accredited by CARF. So we are licensed to provide methadone treatment for both detox and maintenance, and we also

do buprenorphine.

We provide counseling. So basically, I mean, it means that we can treat patients with opioid use disorder using methadone and other FDA-approved modalities.

Q So were patients at TASC receiving either methadone or any other medications to treat opioid use disorder at TASC?

A They were not receiving it at TASC, but they were receiving it from programs in the community.

Q Okay. So they weren't actually administering any methadone or other treatment?

A No.

Q You also have on your resume here in Exhibit 1 that you worked at Wellpath from July 2017 to present. Is that accurate?

A I actually resigned that position in October of last year.

Q So you worked there until October of 2021?

A Yes.

Q And was there any reason for your resignation from that organization?

A I guess I was more or less burned out, but if -- I will tell you what happened. I had a lawsuit

that I didn't feel I had enough support from them, and I did win the lawsuit. So after that lawsuit, I resigned from them. And they all tried to get me to come back on part-time, but I -- so far, I mean, my life is a whole lot less stressful, so I have resisted that.

Q So you filed a lawsuit against Wellpath?

A No. A patient filed a lawsuit against Wellpath, the jail where the incident happened, the nurses and myself. It was a patient who committed suicide while she was in the -- in the work release program.

But basically, the -- I guess the bottom line is they said the reason she committed suicide was because we did not provide her clonazepam which is a benzodiazepine that she was on. But at the same time, the reason she was in jail is because she attempted suicide with an overdose of clonazepam that another physician has prescribed her months earlier.

But Wellpath, like, they settled, themselves, and the nurses. But I went to trial, and I did win the case, you know, so the case against me was dismissed, since I had nothing to do with it. But I resigned after that.

program. They hired a medical director to oversee the implementation and treatment in the jails that they currently have contracts with.

Q I think you testified a second ago that you may have provided treatment to inmates at these facilities who had opioid use disorder because of your ability to prescribe medication. Is that accurate?

A Yes.

Q And so there were physicians at these facilities who did not have the ability to prescribe methadone or buprenorphine to inmates at the facility.

A That's correct. But, I mean, the methadone is different, because, again, someone could bridge there for three days, up to three days, and continue their methadone. But for buprenorphine, you needed to have a waiver, and I was licensed in all the states where I had jails. I also had my own DEA numbers and my X waivers, so I was able to prescribe the medication in the state where I worked.

Q When you say "waiver," what is that a waiver from?

A It's from the federal government, from SAMHSA and CSAT. And that's just -- you go through a training, and that qualifies you to be able to

licensed by the State of Illinois through -- it used to be called DASA, but it's called SUPR now, S-U-P-R, Substance Use Prevention and Recovery Department, which is a division of the Department of Human Services, and we accredited by CARF, C-A-R-F.

Q Approximately how many patients would you have at a given time at Great Heights OTP?

A We are licensed to treat, I believe, 200 patients at each location that we have. so we have two locations, one in Calumet City, and one, Ottawa, Illinois.

Q And have you ever treated patients at the capacity that you were allowed to?

A Not to the full capacity, no.

Q Would you have more than 100 patients at a time?

A Yes.

Q And approximately how many physicians worked at Great Heights OTP?

A I'm the main person, but I also have a friend who works part-time.

Q In order to provide any treatment for opioid use disorder at Great Heights OTP, would your patients need to be insured?

it's actually addiction medicine. It's a subspecialty board through the preventive medicine. So I'm boarded in family medicine and addiction medicine.

Q Okay. And it also says bariatric medicine.

A Yeah, but I did not retake the exam for that. I was -- that expired in -- I think in September, but I'm not going to get recertified.

Q What is bariatric medicine?

A Obesity medicine.

Q Obesity. I believe you testified earlier you're licensed to provide medically assisted opioid treatment.

A With the buprenorphine waiver? Yes, I have the buprenorphine waiver. I'm licensed to do that.

Q And are you licensed to provide methadone?

A Yes, through the OTP. The OTP is licensed to provide methadone.

Q Yeah. I was just going to ask you: Is the program, itself, licensed to provide methadone?

A Yes. For methadone, only licensed OTPs can use methadone to treat methadone; okay? But as a physician, I can prescribe methadone for pain, but I don't do that. But only a licensed OTP is allowed to prevent -- or to the prescribe methadone for the

treatment of substance use disorder.

Q Physicians that work within a licensed OTP, do they have to go through a separate process in order to work for that OTP?

A No.

Q So they just have to be a licensed physician?

A Yes.

Q But in order to prescribe buprenorphine, you would have to have a waiver.

A Yes, you have to go through an eight-hour course and get a waiver.

Q And I think you testified before the Great Heights OTP was licensed by SAMHSA.

A Yes, it's licensed by SAMHSA, or CSAT, which is a division of SAMHSA.

Q Have you written any literature on addiction treatment?

A No.

Q Do you have any published work on either addiction treatment or OTP?

A No.

Q Have you ever been sanctioned by any licensing board?

A No.

Q Have you ever faced discipline by any of your employers, as a physician?

A No.

Q Have you ever been convicted of a felony?

A No.

Q And we touched on them already, so we don't have to spend a lot of time on this, but I just want to kind of go through the different type of treatments for opioid use disorder.

A Okay.

Q And we mentioned before, one of them is the forced withdrawal.

A Yes.

Q And how would you describe forced withdrawal?

A I mean, it's the -- just stopping the medication that patient was on. If the patient was using illicit opioids like heroin or methadone, if they don't have it -- not methadone, heroin or prescription opioids like Norco or oxycodone. If they don't get the medicine after certain hours, you know, they start withdrawing from the medication.

So forced withdrawal is not giving them

anything to alleviate their symptoms. But also, if someone is maintained on the medication -- so, for example, you have someone who is maintained on buprenorphine or methadone, you just stop giving them the medication, they will go into withdrawals after a few hours, depending on the half-life of the medicine.

You know, but when that happens, either you -- I mean, you know, I've been -- I've been working in jails since around, I think, 2005. And when I first got into the jails, you know, honestly, we didn't do anything for the withdrawals. It's just like -- it's just like having a bad case of the flu. They will be okay. You know, but that's part of the reason I got into addiction treatment.

I did not think that it was fair to treat people like that. And I also realized that once people got detoxed, they were actually very normal human beings, like me, and I could have reasonable conversations with them. And I also refused to believe that people ruining their -- or intentionally trying to ruin their own lives.

That's why I got into the treatment of addiction, and forced withdrawal is just not the right thing to do. That's why I worked from the inside to

make the changes that I could. That's why I went to get the extra training that I have.

Q Other than forced withdrawal, is maintenance medication a form of treatment of opioid use disorder?

A Yes, it is.

Q And how would you describe maintenance treatment?

A Maintenance treatment is mainly giving the -- there are three medications that are approved, or three classes. So methadone is the one that's been around the longest, and that's the one that most of the research was done on. So basically, whatever is approved has to work at least as well as methadone or work almost as well methadone.

So giving someone maintenance treatment is basically the same thing as giving someone blood pressure medicine, or giving a patient with diabetes insulin or medications to control their blood sugar. So giving someone maintenance medication is controlling their addiction. It's preventing the physical withdrawal. It's helping them to be able to function around it.

Q And are some people on maintenance medication indefinitely?

A Yes.

Q And are some gradually taken off the medication?

A Yes.

Q Is that process known as tapering?

A It is. It's -- it is, but again, that's something the patient should work with the provider to decide if that will be appropriate for them. But again, it has to be individualized.

Q Okay. And with respect to tapering, are there different ways to approach tapering a patient off of an opioid maintenance medication?

A Yes.

Q What would be those differences?

A I mean, again, if someone comes in, they're withdrawing from illicit medications, sometimes, we'll do a five-day detox, which will help with alleviating some of the symptoms that they are having. It also depends on how comfortable the patient is, so it's just gradually reducing the dose of the medication over time.

You know, and it depends on how the patient feels, what they really want to do, what they are trying to accomplish. Some patients, depending on

what their situation is, they may choose to be detoxed quicker. You know, and some patients may just decide to be gradually over time.

Q What would be some of the reasons that someone would want to taper at a more rapid pace, as compared to a slower place?

A I mean, sometimes, it might because they are going to be going to a jail that doesn't have an OTP, or they're going to prison. A lot of prisons don't provide medication assisted recovery. Sometimes, it might be because they are trying to get a job that will not allow them to take the medication that they are on. Sometimes, it's from the stigma. Sometimes, it's from the family pressure. I mean, so it just depends on whatever reason the person has.

Q And have you personally treated patients who have elected to undergo the tapering process?

A Yes.

Q And how do you determine at what rate you taper them?

A It really depends on the patient and how they feel, for the most part, if they have a choice in it. You know, so -- well, and what I do is maybe decrease by 5 milligrams, but it depends. Like, the

will -- if they tell me over a period of time, but I don't do a standing order, meaning that I'm not going to add an order to put down by 5 milligrams every day or whatever. So it depends on the patient, and I'll work with them to see how they feel.

Whenever they say, "I need to stop right here," then we'll stop, but it's just working with the patient. But if they're going to jail, like if someone is like, "Oh, I'm going to jail," or, "I'm going to prison next week, and I need to be off the medicine," then we'll do it within a week. It just depends on the patient.

Q And would one of the reason to undergo a taper as opposed to, I guess -- let's just say cold turkey would be a term for just stopping the medication abruptly; correct?

A Yes.

Q And would a patient who undergoes a taper, is that more beneficial than going cold turkey?

A I mean, obviously, yes, it is. And it's because cold turkey means that you are just stopping the medicine and not really providing any symptomatic relief to the patient. The risk of suicide is higher when people are detoxing like that, and also, the risk

of death.

They can become dehydrated, you know, from diarrhea and vomiting. They could end up dying. So it's just increased morbidity and mortality when you do that. It's not a humane way to treat people.

Q So a tapering offers better treatment for the mental and physical effects of withdrawal, as compared to cold turkey. Would that be accurate?

A I mean, I won't say it offers better treatment. It offers -- it's a more humane way. It offers a little more relief to the patient than just not giving them anything. You know, the reason I say that, I'm not going to -- if someone comes into the jail with high blood pressure, I'm not going to say, "Oh, I'm going to withdraw them off of their blood pressure medicine quickly and call that treatment." That's not treatment.

Q Generally speaking, with respect to tapering, would a slow taper, as opposed to a more rapid taper, result in less withdrawal symptoms?

A Yes.

Q Is there any literature or standard practice in the medical industry regarding what is an appropriate rate of taper?

A Yes.

Q So what is your understanding of exactly what authority SAMHSA has over OTPs?

A I mean they are the licensing agent -- agency for the federal government, and they provide the guidelines on how the programs run. But also the -- the DEA is involved, also, when it comes to the security of the medication, and also order the medication.

Q So a correctional facility that operates an OTP will have certification from SAMHSA.

A Yes. I mean, all OTPs do, so it's not just the correctional. We all have to have certification from SAMHSA.

Q And then one in the correctional setting will also have to have accreditation by the NCCHC?

A No, all OTPs have to have an accreditation by an accrediting agency, which is your choice. So NCCHC is one of the accrediting agencies, but it could also be CARF. It could be JCO, you know, so that's your choice, depending on which one you want to go through.

Q So you can petition to be accredited by the NCCHC as a correctional facility?

treatment, I don't see where they asked them to choose if they wanted to be maintained or to be detoxed on the program.

Q I guess I'm having trouble following exactly --

A Okay. If you are looking at the whole document, right, the patients can choose whether they want to be medically detoxed or whether they want to be maintained on methadone, and that's where I see the probably lying there.

The guidelines -- there is nothing in this guidelines that says that Cermak should medically withdraw all the patients who are admitted there on methadone. I don't see any guidelines saying that Cermak should medically withdraw the patients when they come into the jail.

Q And are you aware that Cermak's OTP program was certified by SAMHSA during the class period?

A Yes.

Q Are you aware that, as part of their certification, they had to submit their OTP policies to SAMHSA?

A Yes.

Q And is your understanding that SAMHSA

approved those OTP policies for Cook County Jail?

A Yes.

Q And going back, looking at these, and direct me to scroll up or scroll down at any point to help provide your answer, but where does it say in these policies that the patient is able to choose which treatment they receive?

A I mean, it says on line -- if you look at -- after -- under the "1 year." "In addition, a program physician shall ensure that each patient voluntarily chooses maintenance treatment." You know, so they're choosing that they want -- they can choose to start on maintenance, but if you go to the detox, I don't see anything that tells the -- that says that the patient should be medically forced to withdraw from methadone. So we can go back to the detox place where you were showing me before.

So it also says that, "A program shall not admit a patient for more than two detoxification treatment episodes in one year." Again, the guidelines are not saying that the patient has no say so in what gets done to them. The patients have a say so.

Q Okay. But you would agree with me that

NCCHC for accreditation?

A I believe they did, but again, I don't recall. I know they had to be accredited, so if NCCHC is who they used for accreditation, I'm sure they submitted the policies to them.

Q And that would include Cook County Jail's tapering policy?

A Yes.

Q Turning to the sixth page of the document, which is page 61 of the NCCHC guidelines, are you familiar with these specific guidelines on this page with respect to OTPs at correctional facilities?

A Yes. I mean, they don't differ too much from the other guidelines.

Q They don't differ too much from what?

A From the one we looked at earlier. They are just adapted from the same SAMHSA guidelines.

Q And pursuant to these guidelines, is it your understanding that Cermak's OTP had to verify the dose amount and the last date for methadone that was prescribed to them prior to them entering Cook County Jail?

A Yes. I mean, all OTPs have to do that. You have patients coming from other OTPs, so that's just

standard practice.

Q And what's your understanding of why you need to confirm the level of dosage and the date of last dosage prior to administering methadone at an OTP facility?

A I mean, again, that's something you have to do at all OTPs. It's not restricted just to jails. But the reason we do that is to make sure that you don't overdose a patient. Methadone, I mean, it's a very good drug. It works very well, but in the wrong hands, it can be misused, and people can overdose from it. So a lot of people overdose while you're inducing them on methadone, when you first start it. So that's why it's highly regulated.

So, I mean, I have to verify with other OTPs when I have a new patient coming in, because if they haven't taken the -- if someone, for example, hasn't taken methadone or any medication in a week, and you give them the same high dose they were on, the risk of overdose is pretty high. You know, but if you verify the dose, and they are still on it, then they have more tolerance to medication.

Q So administering their first dose in an OTP, you have to obtain that information from another

organization?

A Yes, if they are currently in treatment somewhere else.

Q So you're reliant on them communicating back to you before you can even administer a methadone dose?

A Yes, and the same goes for when a patient is admitted to the hospital. The hospital has to call the OTP to verify the dose.

Q Turning to page 7 of the document, paragraph 3. Okay, paragraph 4. So it says -- this involves the guidelines for, "Patients leaving the program voluntarily, with or against medical advice, must follow a therapeutic protocol appropriate to their situation." And so is this policy governing medically supervised withdrawal?

A I mean, it's just a guideline. It doesn't say anything about how to reduce the dose and stuff like that. I mean, I don't have any problem with what the document says.

Q Okay. And so paragraph 3, that's what I meant to reference. It says, "The facility has a policy that addresses the management of inmates, including pregnant inmates, on methadone or similar

substances. Inmates entering the facility on such substances have their therapy continued, or a plan for appropriate treatment of the withdrawal syndrome is initiated."

Is that accurate?

A Yes.

Q So under NCCHC guidelines, they provide for policies where an inmate undergoes medically supervised withdrawal.

A Yes.

Q And is it your understanding that Cermak OTP had a policy in place regarding withdrawal treatment of methadone during the class period?

A Yeah, they did have a withdrawal plan in place.

Q And is this the policy with respect to tapering?

A Yes.

Q And is this the policy that you're criticizing here today, as an expert?

A No. Again, what I'm criticizing as an expert is that the patients do not have a -- I mean, is at Cermak -- we can go back to the document that you showed me. There were some other paragraphs that

A Well, looking at the purpose there, it's to detox the inmates who were already in an OTP, and also to maintain pregnant women who are opioid dependent.

Q Okay. So maintain pregnant detainees on their methadone treatment?

A Well, it didn't say if they were -- for pregnant women, it's not saying whether they are on methadone or not. It's just saying if they are dependent on opioids, so it could be someone who is on heroin, or oxycodone, or anything.

Q Okay. But the policy was to maintain them on a treatment medication for their opioid use disorder for pregnant detainees?

A Yes.

Q And what was your understanding for the treatment of non-pregnant detainees that had opioid use disorder at Cook County Jail?

A It's basically that they will be detoxed.

Q When you say "detoxed," does that mean the policy directed them to basically go cold turkey?

A No. It's just saying that we are not going to continue your medication. We are going to take you off medication, and, you know, no, it doesn't specify how it's going to be done or that it's going to be

cold turkey. But, I think, further down, it says in the document, how it's going to be done.

Q Okay. We'll come back to that in a second. Looking at your expert report, under page 3, opinions about Cermak Health Services policy, and again, at the top here, it's referring to the G-06.1.

A Yeah.

Q And it says, "For pregnant patients, prescribed a constant daily dose; for other patients, prescribe a linear taper to zero, with daily doses decreasing at an integer rate proportional to the initial dose."

Do you see that?

A Yes.

Q And again, this is differentiating between pregnant patients and non-pregnant patients.

A That's correct.

Q All other things being considered, do pregnant present the same risks with respect to methadone treatment as non-pregnant patients?

A I mean, I guess the only extra risk is the risk to the unborn fetus, but as far as, if you're looking at the pregnant woman, they have the same withdrawal risks that non-pregnant patients would

have, but you have an added risk to the fetus, to the baby that they are carrying in the womb.

Q So would tapering a pregnant patient would involve risk to the unborn child?

A Yes.

Q And that's not a risk that's present in non-pregnant patients.

A That's correct.

Q It goes on, in the third paragraph, "Waiting for three days to restart or continue methadone for a patient who is maintained on methadone can destabilize the patient and put him/her at risk for withdrawal and adverse consequences."

A Yes.

Q And then it goes on to say that, "Standard of care is to verify the patient's methadone dose and continue treatment as soon as possible to avoid delay in the patient's treatment."

Do you see that?

A Yes.

Q Now, is it your opinion that Cermak's OTP policies did not seek to verify a dose and continue treatment as soon as possible?

A Quite -- I think some of the statements that

A Well, it says you're decreasing by a rate proportional to the initial dosage. It then says decreasing no more than 7 milligrams each day, 10 to 21.

Q Okay. So it --

A Okay. So it gives you an example of how to do it, so it says if someone is on 40 milligrams, just go down by 2 milligrams every day, so that by 21 days, they will be off. So that is a standing order.

Q Okay. And the standing order has an upper amount of taper that you are not to pursue; correct?

A Right.

Q Does the policy state there is a lower dosage of taper that you are not to pursue?

A I don't recall if I saw it or not. But I also don't see anywhere where -- you know, again, you don't know -- you don't reassess the patient on a regular basis to see how they're feeling and whether you need to adjust that taper.

Q Okay. Going to page 6. We'll go up. So going to page 6, so the standing order --

MR. FLAXMAN: Page 6 of the standing order, or page 6 of the exhibit?

MR. MORRIS: Page 6 of the standing

set schedule.

Q Do you know how a detainee at Cook County Jail is able to access a physician?

A I don't recall if -- I don't -- I think they have to put in a request from the depositions, but I'm not sure how quickly the request gets sent over.

Q Okay. So it is your understanding, though, that detainees can seek an appointment with a physician at Cook County Jail?

A Yes. They can -- I know they can request an appointment.

Q Going to page 7 of Exhibit 5, page 6 of the standing order. Looking at the top, under paragraph 3, it says, "The program medical director will request a waiver from CSAT for these special cases: Number 1" -- sorry. "Request a waiver from CSAT in these special cases," and then in subparagraph 2, it says, "Maintenance rather than detoxification, for a reason other than pregnancy." Do you see that?

A Yes.

Q So would you agree with me that this policy provides for a detainee, on an individual basis, to receive maintenance treatment rather than detoxification?

A Yes.

Q So there was nothing in this policy that prevented a physician from seeking a waiver to provide maintenance therapy for a detainee, based on their individual assessment.

A Yes, but I don't believe that I saw -- that I read in the deposition that that was done for any of the patients.

Q And what deposition was that?

A In Dr. Richardson's that I reviewed.

Q Okay. Going back to Exhibit 4, your expert report, page 4 of the document, at the top here, it says, "The delay in providing methadone as well as the practice of tapering patients off methadone without clinical justification contributed to the pain and suffering experienced by James Hill, Wanda Hollins, Keith Rogers, and other persons who were treated based on policy G-06.1, while they were incarcerated at Cook County Jail."

Do you see that?

A Yes.

Q And that's an accurate reading of your expert opinion in this case?

A Yes.

Q Do you know if any of the named plaintiffs in this case were taken off of their medication while at Cook County Jail?

A I know they were tapered.

Q Do you know if any were tapered to zero?

A I don't recollect if they were that low to be taken to zero.

Q And is it your opinion that they suffered because they suffered withdrawal symptoms while being tapered at Cook County Jail?

A Yes.

Q What are the symptoms of methadone withdrawal?

A They are the same symptoms of any op withdrawal. People get anxious. They get, like, rapid heartrate. They have sweating, abdominal pain. They are dysphoric, meaning that their mood may be more like a depressed mood. They have joint pain. They can have dehydration from vomiting and diarrhea.

Q Is withdrawal from methadone the same as withdrawal from heroin, with respect to symptoms?

A They are similar, yes. They are opioid withdrawal.

Q Are you aware of whether any of the named

plaintiffs were also taking heroin prior to entering Cook County Jail?

A I believe that there were some of them who were still using heroin when they came to the jail.

Q When stopping methadone, as compared to stopping heroin, do withdrawal symptoms arise in a similar timeframe?

A No. The heroin withdrawal symptoms happen quicker, because the half-life of heroin is shorter.

Q So how would you know whether or not one of the named plaintiffs was withdrawing from a lack of methadone, as opposed to heroin?

A I mean, it would be hard to tell, you know, but again, the methadone is longer acting. So with the doses they were on, the withdrawal from heroin shouldn't be that severe.

Q With the dose of what the --

A The dose of methadone that they were taking.

Q So because they came in taking a high dose of methadone, they should not have been suffering withdrawal symptoms?

A It would not have been as severe, as if they were just taken off heroin by itself.

Q Would it be fair to say that you would

suffer withdrawal symptoms from a lack of heroin before you would from not obtaining methadone?

A Yes.

Q How soon do withdrawal symptoms usually set in from methadone?

A Usually about 24 to 36 hours.

Q And what about with respect to heroin?

A Within four to six hours.

Q And the rate at which those withdrawal symptoms set in since your last dose depends, in part, on how high your dose is; correct?

A Yeah, but again, it depends on the individual. So, I mean, because the way the body processes the medication, I mean, you can have an idea, but each individual is different. You know, you don't know what medications they've been taking, what other psychological issues may be going on. So it's just difficult to pinpoint a time or rate.

Q But generally speaking, if you're on a higher methadone dose, and no longer take it, in most patients, it'll take longer to experience withdrawal than if you're on a lower dose.

A Not really. Because again, the -- based on the pharmacokinetics, like, the half-life of

facility?

A Yes.

Q What other -- okay. We covered that. Similar to last question, in your experience, is there any limitation on provided medically assisted treatment in jail that do not exist at a community-based OTP program?

A I mean, I think the biggest thing is the stigma that's associated with it, and also, you have to worry about diversion in a jail, which may make it more difficult. You know, there are staffing issues, so yeah, and also with the security. So there are more things that you have to worry about when providing medication assisted treatment in a jail.

Q And what would one of those be a security concern?

A That, again, the patients may divert the medication, you know, they cheek it and go give it to other inmates who are not prescribed the medication, which can lead to an overdose. I've worked in jails.

Many times, you have to wait for security to bring the patient to a designated area so you can administer the medication, you know, so you have to have security with you. It's a controlled drug, so

you have to have the medicine in a secure area.

Q Putting security aside, on sort of the individual patient level, one of the concerns in maintaining a patient who is in a correctional OTP program is that they may be transferred to another facility that doesn't have an OTP program.

A That's correct.

Q And the concern is that they would essentially be forced into a situation where they were quitting cold turkey.

A And that's correct. And I guess that's the reason why you have to coordinate the care to see, you know, how long they might be at the jail, and, you know, talk to the patient, and discuss the options with them. You know, and also see where they might be transferred to, if they are other charges, or if they are going to prison, so that you have enough time to taper them off, if you need to taper them off.

Q Looking back at Exhibit 4 here, there's a sentence that states, "Criminal justice DrugFacts show that starting treatment for OUD while patients are incarcerated reduces the risk of fatal and non-fatal overdose after release."

Do you see that?

people with opioid use disorder in jail and prison settings receive medication treatment."

Do you see that?

A Yes.

Q So would you agree with me that at the time of this article, detainees at Cook County Jail were approximately one of the five percent of people who were receiving medically assisted treatment for OUD?

A I mean, I would consider detoxing someone the same thing as treatment, you know? So if I'm looking at treatment, I'm looking at maintenance treatment. Yeah, there is still some kind of treatment. I don't think it's the proper treatment.

Q Do you know if this study differentiates between those that receive a taper versus those that receive no medication?

A No, I don't. Because, like, this article that you're sending, it also goes further down to say what effective treatment is, so that's what I would, I guess, assume that they are referring to as treatment, which is in addition to getting medicine, getting good counseling.

Q Going back to -- also, Doctor, anytime you need a break, just let me know; we can take one.

Otherwise, I'm good to keep going. It's up to you, though.

A I don't care.

Q Okay. Going back to Exhibit 4, the expert report, under section 4, titled Other Opinions, do you see that?

A Yes.

Q It says, "Opioid use disorder is best treated by a stable maintenance dose of methadone (or similar medications), or by tapering medication over time with the goal of taking the patient off medication entirely."

Do you see that?

A Yes.

Q So you would agree with me that treating OUD with tapering is medically accepted treatment option for patients with OUD?

A If that is a decision that's made by the patient and the provider, if that's what the patient wants.

Q Skipping to opinion 3, it says, "Tapering" -- and this is page 5 of the expert report. "Tapering results in painful and difficult symptoms, such as 'anxiety, chills, muscle pain (myalgia) and weakness,

tremor, lethargy, and drowsiness, restlessness and irritability, nausea and vomiting and diarrhea.'"

Do you see that?

A Yes.

Q And that is your understanding of symptoms that are associated with withdrawal?

A Some of the symptoms, yes. And again, I mentioned that dysphoria is something that happens. I mean, I've seen reports of patients committing while they're withdrawing. The suicide rate is higher when patients are withdrawing from opioids.

Q Does every patient who is tapered off of methadone suffer withdrawal symptoms?

A No.

Q In your experience, what patients are less likely to suffer withdrawal while they're being tapered off methadone than those that are?

A I mean, it depends on how -- on the dose that they're on. It also depends on how slowly the taper is done, and also depends on what the patient's tolerance is and what their situation may be.

Q Do you have an understanding of what the rate of tapered patients at Cook County Jail underwent during the class period?

for patients in treatment for less than three months. For patients on methadone, 12 months is considered the minimum duration of treatment to reduce relapse." That opinion you rendered here, are you aware if that was the standard prior to 2018?

A Yeah, I'm pretty sure, because, like I said, I got my master's degree in 2015, and I was using that reference then, and even before then. So I'm pretty sure that that was the standard before 2018.

Q Do you know when it first became a standard?

A I don't know, but again, like I said, I've been using this reference for quite a few years, because I've done presentations and talks using it before 2018.

Q Now, when you were working for Wellpath, you were not able to treat patients in compliance with this standard. Is that correct?

A Sometimes, I was not, because of the restrictions there, but it's not for not trying, because again, I knew what the right thing to do was, and I had the qualifications, the training, and the license to do that.

So I was not going to do something that was not the standard of care. I knew that the potential

of me getting sued was much higher than those who had no idea or did not have the qualifications that I have.

Q And there were physicians at that facility that could not provide some of that treatment, though; correct?

A Yes.

Q So those facilities you oversaw were violating the standard of care at the time you worked there, with respect to --

A I -- I wouldn't say that, because again, I was the one who was taking calls; I was supervising those sites, so I just ended up being overworked, because I was the one being called who had to take care of all those issues.

Q But many of the facilities did not have an OTP program; correct?

A Right, but, when possible, we tried to use buprenorphine.

Q All right. Going back to Exhibit 6 and this article that's referenced, and specifically on page 12, it states under, "How long does drug addiction treatment usually last," it says, "Individuals progress through drug addiction treatment at various

A Yes.

Q And when did this standard of care become the medical consensus?

A I can't tell you exactly when, but I can tell you at least as far back as 2007, when I started my methadone program. That's the scientific thinking, where I think it was even before that. I mean, there's a lot of resistance in jails and prisons to following that standard of care. So I know that's something that I know people in the field of addiction have been fighting for over the past few years.

Q So is it your understanding, then, that as far back as 2007, any correctional facility who was not offering methadone maintenance treatment, specifically, was violating a standard of care?

A Of general medical practice, yes, but again, I mean, it's been a hard road trying to convince correctional facilities that this is the right thing to do for the patient. And now, recently, more of them are starting to realize that, you know, that this saves lives, and it's the right thing to do. But it hasn't always been that way, so I know in correct -- because I've been working from the inside out, so I know what kind of struggles are to fight with the

probation officers, with the jail authorities, trying to make sue that this is the standard of care.

Q Would it be the standard of care to treat a detainee with methadone maintenance who was sentenced to state prison that did not have an OTP program?

A I mean, the other thing I can say to do is that they'll need to -- if the jail has an OTP program, then they'll need to withdraw the patient before they go to prison, to a state facility.

Q And that would apply to them being transferred to any facility that did not have an OTP program?

A That's correct. I mean, to lessen the withdrawal that they will have, instead of having them quit abruptly.

Q Do you know how many detainees at Cook County Jail are released to another correctional facility that does not have an OTP program?

A I don't. I did not have access to those kind of records.

Q Do you know of how many county or state correctional facilities in Illinois have an OTP program, other than Cook County?

A I don't believe there is any, and like I

could provide the treatment to patients.

Q Do you have an opinion as to how the medical team at Cermak would have been able to determine which inmates would be released in the community, versus those conducted and sent to IDOC?

A I mean, it's a -- you know when it comes to substance abuse treatment, it's more of a collaborative team. You have the physician. You have the nurse. You have the social workers, and then it has to involve the drug system -- I mean the court system, also, the attorneys. So, for example, some patients have been considered for drug court, you know, for their alternate treatment. So that's about the only way they can determine that, is to work collaboratively, or see, based on their experience, what the patient's charges are, and what's typical for those kind of -- what's typical for the sentence that those kind of charges carry.

Q Would you agree with me that it requires a lot of resources to make those sort of analyses, determining which detainees are going to be sentenced to prison time, and which ones will not?

A I mean, I'll say it requires resources. I won't say -- I mean, it requires significant -- I

won't say a lot, but again that's just part of the territory.

Q So between 2017 and 2020, you oversaw a correctional system that did not have OTP programs; correct?

A That's correct.

Q And you mentioned that it was difficult to get them to do so.

A Yes.

Q To have an OTP program.

A Yes.

Q And what were the difficulties in a correctional facility to start an OTP program?

A So some of the jails, again, they were small jails, they did not have the personnel. They did not have the resources. They didn't have the money that it would take to be able to get accredited, and, you know, to put the nurses, to hire a physician who was knowledgeable in addiction medicine.

They did not have all those resources in place, and that's why I will suggest that buprenorphine was probably easier for them to maintain at those sites, and also, to collaborate with OTPs in the local communities to get the treatment going. You

know, so those were some of the workarounds that I thought about having to make.

Q Are you aware that Cermak began doing analysis of determining which detainees were likely to be convicted and sent to an IDOC facility without an OTP program, versus those that were likely to be released only after they were awarded a grant?

A I don't know any of those specifics.

Q So during the class period, which, again, started in 2013, beginning in 2013, were you aware of how many jails in the country provided some sort of methadone treatment, whether it be tapering or methadone maintenance programs?

A I don't have a specific number.

Q Was it the majority of them had them, or less than a majority?

A I mean, it's way less than the minority, because only five percent of correction facilities provided some kind of treatment. So we know it was less, but I know the numbers have been going up since then, as people are starting to realize that it's probably more economical and safer for the patients and for the community as a whole to provide treatment, instead of the stigma and the lock them up and throw

away the keys approach that society has had to addiction treatment in the past.

Q Would you agree with me that, during the class period, Cook County was providing objectively more medically assisted treatment for OUD than the vast majority of jails in the country?

A Well, if you consider that detox as MAT, you know. So they are providing detox, but I don't think they were providing a lot of maintenance treatment. But I guess you are comparing it to other jails; right?

Q Yeah, and I guess my question would be: Is having no methadone versus having a program in place where they're tapered off methadone the same?

A No, it's not. I mean, apparently, tapering people off methadone is better for the patient than no methadone.

Q And during at least a part of the class period, you were working in a facility that did not even offer any methadone tapering treatment.

A That's correct.

Q So during this class period, Cook County Jail was providing more methadone treatment to inmates than those facilities that you oversaw.

A That's correct.

Q Okay. I don't have much more. Just going to go over a couple of the articles you referenced.

A Okay.

Q Just so I can verify, in your expert report, one of your references is -- hold on, sorry. Yeah. So Principles of Drug Abuse Treatment for Criminal Justice Populations, in NIDA, April 2014.

A Yes.

Q And that appears to be reference number 2 in your report. Is that accurate?

A Yes.

Q And this article that you reference, this is an authoritative article or publication?

A It's from the federal government, yes.

Q And it was published in April 2014; correct?

A Yes.

Q Does that mean it was based on the medical community's understanding prior to 2014? Do you want me to rephrase that one?

A You froze.

Q Oh, sorry. It was a bad question. I'll strike that question anyway. On page 3 of this document, it says, under 3, "Treatment must last long

maintenance treatment, based on an individual assessment?

A Yes, but I guess the question I have is: did they seek the waiver for that, or how often was that done? I didn't see any info in the documents I reviewed to show that was being done.

Q And on number 4, the NCCHC, in 2018, prescribed guidelines for medically managed withdrawal treatment. Do you see that?

A Yes.

Q So in 2018, under the NCCHC guidelines, it was medically acceptable to manage withdrawal treatment without providing any maintenance?

A It says that, but it's also determined that it's appropriate for a specific patient. So again, it's individualizing the treatment. It's not just a blanket order for everyone.

MR. MORRIS: Okay. I'm just going to go through my notes. I think I might be done or have just a few follow-up questions. Can we take seven minutes again?

MR. FLAXMAN: Let's take eight minutes.

MR. MORRIS: How about nine?

MR. FLAXMAN: You got it. You got it.

MR. MORRIS: Okay.

THE REPORTER: Okay. We are off the record at 1:15 p.m.

(Off the record.)

THE REPORTER: Okay. We are back on the record at 1:25.

BY MR. MORRIS:

Q Okay, Dr. Fatoki, just one or two more questions, and then I will pass it. So your opinion that you expressed in this case is that Cermak's OTP policies violated the standard of care, with respect to treatment of opioid use disorder; correct?

A Yes. As far as maintaining patients who needed the treatment.

Q And --

A And -- sorry. And not conferring with the patient, as far as whether they wanted to continue treatment or not.

Q And more specifically, with respect to the policy requiring detainees to undergo a taper of methadone.

A Yes.

Q And you also testified today, though, that, to your knowledge, Cook County was one of the few

facilities during the class period, nationwide, offering some form of methadone treatment to detainees; correct?

A Yes.

Q Based on your understanding, and in your experience, you've worked in correctional facilities during the class period; correct?

A Yes.

Q Based on your knowledge of OTP programs within correctional facilities, can you state any facilities that, in your mind, abided by the standard of care, with respect to their OTP program?

A During that period of time, I don't -- I can't tell you that I know off the top of my head any program any program that was proving maintenance treatment.

MR. MORRIS: Okay. That's all I have.

MR. FLAXMAN: Mr. Catania?

MR. CATANIA: Yes, sir. Thank you, very much.

EXAMINATION

BY MR. CATANIA:

Q Dr. Fatoki, my name is Frank Catania. I represent the Sheriff of Cook County in this matter.

Q And is that done in hour-long sessions?
A It depends on the -- on the patient's individual circumstances.
Q So it could be longer than an hour per session?
A Yes, and it could be shorter, also, depending on how stable the patient is.
Q It's a requirement to run an OTP program to provide counseling. Isn't that right?
A Yes.
Q So it's not enough just to provide medication. Is that right?
A That's correct. Medication alone by itself is not enough treatment.
Q Do you know what kind of counseling programs are available to people that are accepted to the OTP at Cermak?
A No, I don't.
Q You mentioned a few times, actually, twice, I believe, when you were talking about the withdrawal from methadone, you used the word "dysphoria" a couple of times.
A Yes.
Q What does that mean?

Q Forcing a detainee to -- providing him with no treatment is also -- well, let me just step back. You used the term -- was it forced withdrawal?

A Yes.

Q Okay. But there's a difference between forced withdrawal where you're not giving them any medication, versus those situations where you're tapering them.

A Yes.

Q And one is considered, medically, more appropriate than the other.

A I think it's more humane. That's what I'll say.

Q Okay. And is there any literature or study that you're aware of during the class period that does not considering tapering a form of treatment for opioid use disorder?

A I mean, in general terms, the way you're asking it, I guess it's a form of treatment, in general terms.

Q Okay. And Counsel was just asking you about your knowledge of the plaintiffs' specific treatment in this case. Do you recall that?

A About what? I'm sorry.