IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

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

PLAINTIFFS' MEMORANDUM ON CROSS-MOTIONS FOR SUMMARY JUDGMENT

I. Introduction

This case involves a written policy that required interrupting methadone maintenance for persons who entered the Cook County Jail between December 23, 2013 and July 1, 2017.

Until at least July 1, 2017, the Jail enforced a written policy requiring all non-pregnant persons entering the Jail while in a methadone maintenance program to undergo a linear taper designed to reduce their methadone dosage to zero over 21 days. Tapering causes immediate short-term harm and well-documented suffering from opioid withdrawal. Tapering also causes long term harm of increased likelihood of relapse, overdose, and death.

Plaintiffs contend that the linear taper-to-zero policy interferes with "treatment once prescribed," a practice the Supreme Court condemned in *Estelle v. Gamble*, 429 U.S. 97, 105 (1976) and reaffirmed in *Erickson v. Pardus*, 551 U.S. 89 (2007) (pro se complaint about prison's interference with prescribed treatment for Hepatitis-C).

The two subclasses consist of persons who entered the Cook County Jail between December 23, 2013, and July 1, 2017, while enrolled in a methadone maintenance program. The subclass of sentenced prisoners challenges the written policy as violative of the Eighth Amendment, while the subclass of pretrial detainees contends that the policy violates the Fourteenth Amendment.

The three individual plaintiffs also bring individual damage claims under the Americans with Disability Act and the Rehabilitation Act. Two of the individual plaintiffs (Rogers and Hollins) bring claims under 42 U.S.C. § 1983 about the delay in continuing methadone after intake to the jail.

Defendants have moved for summary judgment on the class claims and the individual ADA/RA claims.[1] Plaintiffs cross-move for summary

[1] Defendants do not address the individual delay in treatment Section 1983 claims, either in their bare-bones motion (ECF No. 274) or their memorandum. (ECF No. 275.) While defendants acknowledge the delay in treatment claim, they address to it only to assert that such delay is not actionable under the ADA or the Rehabilitation Act. (ECF No. 275 at 15.) Plaintiffs do not seek relief for the delay in treatment under either statute.

judgment on the class claims, leaving the ADA/RA claims and the individual Section 1983 delay in treatment claims for trial. Plaintiffs file this memorandum in support of their motion for summary judgment and in opposition to defendants' cross-motion.

II. The Individual Plaintiffs

A. Keith Rogers

Plaintiff Keith Rogers was enrolled in a methadone program when he entered the Cook County Jail on January 20, 2014, to serve a 90-day sentence for driving on a suspended license.[2] ((Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 12)

The Jail verified Rogers' participation in a methadone program on January 21, 2014, when a physician at the Jail ordered that Rogers receive "methadone 200mg then taper per protocol." (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 13)

Rogers began to receive methadone on January 26, 2014, with his dosage reduced (or "tapered") by 7 mg per day. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 13) Thus, Rogers received his regular dosage of 200 mg on January 26, 193 mg on January 27, 186 mg on January 28, and so on until he left the Jail on February 16, 2014, when his dosage had been tapered to 53 mg. (*Id.)*

[2] A person serving a sentence for misdemeanor offenses that does not involve physical harm will receives day for day credit under 730 ILCS 130/3, meaning that Rogers was required to serve no more than 45 days to satisfy his sentence.

Rogers experienced withdrawal symptoms (nausea, diarrhea, aching pain) before he received his first dose of methadone. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 14) The diarrhea would last "[p]retty much all day." (*Id.*) The symptoms subsided when he began to receive methadone, but returned shortly after the tapering began. (*Id.*) Rogers filed a grievance on February 14, 2014 stating: "at times pain gets quite severe. I break into sweats and get nausea. Sometimes resulting in vomiting or dry heaves." (*Id.*) Rogers re-enrolled in his methadone program when he left the Jail and returned to his previous dose of 200 mg. (*Id.*) Rogers filed a grievance on February 14, 2014, stating: "at times pain gets quite severe. I break into sweats and get nausea. Sometimes resulting in vomiting or dry heaves." (*Id.*) Rogers re-enrolled in his methadone program when he left the Jail and returned to his previous dose of 200 mg. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 15.)

B. James Hill

Plaintiff James Hill was enrolled in a methadone program when he entered the Cook County Jail on December 23, 2013.[3] (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 17.) Hill entered as a pre-trial detainee following his arrest for misdemeanor theft (*Id.*)

[3] The date of entry into the Jail is encoded into the first 8 digits of Hill's jail identification number of 20131223105, meaning that Hill was detainee 105 on 12/23/2013.

The Jail verified Hill's participation in a methadone program, and on December 25, 2013, a physician at the Jail ordered that Hill receive "methadone 80mg today then taper per Cermak protocol. Decrease by 4 mg daily until finished." (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 18.) Hill received his regular dosage of 80 mg on December 25, 2013, 76 mg on December 26, 72 mg on December 27, and so on until he left the Jail on December 31, 2014, when his dosage had been tapered to 56 mg. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 19.)

Hill experienced withdrawal symptoms during the tapering: he had trouble sleeping, felt nauseous, was throwing up, and experienced running diarrhea. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 20.) Hill pleaded guilty and received a sentence of time considered served on December 1, 2013. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 21.) Hill re-enrolled in his methadone program when he left the Jail. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 22.)

C. Wanda Hollins

Plaintiff Wanda Hollins was enrolled in a methadone program when she entered the Cook County Jail on September 12, 2013. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 22.) Hollins entered as a pre-trial detainee following her arrest for misdemeanor domestic battery. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 23.) The Jail verified Hollins' participation in a methadone program on September 21, 2013, when a physician at the Jail ordered that

Hollins receive "methadone 85 mg po on 9/21/13 taper by 3 mg/day until finished." (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 25.)

Hollins received her regular dosage of 85 mg on September 21, 2013, 82 mg on September 22, 79 mg on September 23, and so on until she left the Jail on October 5, 2013, when her dosage had been tapered to 46 mg. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 26.)

Hollins experienced withdrawal symptoms while being tapered: she felt cold, experienced body aches and stomach cramps. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 27.) Hollins also experienced nausea. (*Id.*)

Hollins re-enrolled in her methadone program when she left the Jail and returned to her previous daily dose of 85 mg. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 28.)

III. Application of the Tapering Policy to Each Subclass

There were 1,847 admissions to the Jail's methadone program between December 13, 2013 and July 1, 2017. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 29.) 759 of these persons left the jail in 21 days or less. (*Id.*, ¶ 42.)

Everyone who received methadone at the jail was given a tapering dose, except for 39 individuals—each identified in jail records as female—who were not tapered. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 30.) The Sheriff's records show 99 admissions of persons to serve misdemeanor sentences, all for less than one year; 66 served less than 30 days in the Jail.

(Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 41.) The Sheriff's records also show that of the 759 persons who left the Jail within 21 days after admission, 174 were released on bond, 324 were released because charges were dropped, and 21 were transferred to the Illinois Department of Corrections.[4] (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 42.)

IV. Standards for Cross-Motions for Summary Judgment

On cross-motions for summary judgment, the Court adopts "a dual, 'Janus-like' perspective" and interprets disputed facts in favor of each non-movant." *Hotel 71 Mezz Lender LLC v. Nat'l Ret. Fund*, 778 F.3d 593, 603 (7th Cir. 2015). Plaintiffs challenge many of defendants' contentions and it is likely that defendants will do the same.

The Court's task on summary judgment starts with "first, identifying the material issues in terms of the applicable substantive law and, second, evaluating the evidence in the record to determine whether disputes about these issues are genuine." *Feliberty v. Kemper Corp.*, 98 F.3d 274, 277 (7th Cir. 1996). This means that the Court must start with the substantive law in order to "identify which facts are material." *Anderson v. Liberty Lobby, Inc.*,

[4] The persons who left the Jail for the penitentiary within 21 days all appear to have entered the Jail as persons on probation who were accused of having violation conditions of probation. Plaintiffs therefore request that the sentenced prisoner subclass be redefined to limit to persons entered the Jail to serve misdemeanor sentences. *See infra* at 9 n.5.

477 U.S. 242, 248 (1986). Plaintiffs therefore offer the following summary of the controlling legal principles in this issue.

A. The Substantive Law on the Class Claims

Each subclass raises a single claim. As the Court stated in its order granting class certification,

> Pretrial detainees' rights are governed by the Due Process Clause of the Fourteenth Amendment. *Bell v. Wolfish*, 441 U.S. 520, 535–36 (1979). On the merits, pretrial detainees "can prevail by providing only objective evidence that the challenged governmental action [here, the linear-taper-to-zero policy] is not rationally related to a legitimate governmental objective or that it is excessive in relation to that purpose." *Kingsley v. Hendrickson*, 576 U.S. 389, 398 (2015). It is true that, before *Kingsley*, the Seventh Circuit generally applied the Eighth Amendment deliberate-indifference standard to the medical-care claims of pretrial detainees. But in the wake of *Kingsley*, the Seventh Circuit has since explicitly changed course on the claims of pretrial detainees. *See Miranda v. County of Lake*, 900 F.3d 335, 352 (7th Cir. 2018). Thus, "medical-care claims brought by pretrial detainees under the Fourteenth Amendment are subject only to the objective unreasonableness inquiry identified in *Kingsley*." *Id.* Liability still requires that the defendant acted "purposefully, knowingly, or perhaps even recklessly," but that action is then measured against objective reasonableness. *Id.* at 353–54.

(ECF No. 178 at 10-11.)

A different standard applies to the claims of the sentenced prisoner subclass because

> [P]ost-sentencing prisoners' claims are governed by the Eighth Amendment, *see Farmer v. Brennan*, 511 U.S. 825, 834 (1994), which requires that prisoners show "deliberate indifference," that is, "a showing that the defendant had a 'sufficiently culpable state of mind' and asks whether the official actually believed

> there was a significant risk of harm." *Miranda*, 900 F.3d at 350. So, at a minimum, the Fourteenth and Eighth Amendment claims differ in the required state of mind in devising the taper-to-zero policy.

(*Id.* at 11.)

Plaintiffs propose the following as the controlling question for each subclass:

1. Did the linear-taper-to-zero policy cause harm to plaintiffs and, if so, is the policy rationally related to a legitimate governmental objective and objectively reasonable?

2. Did defendants act with "deliberate indifference" to a significant risk of harm in applying the linear-taper-to-zero policy to prisoners who entered the Jail to serve misdemeanor sentences?[5]

Defendants do not disagree with these formulations, discussing the standard for pre-trial detainees at pages 7-8 of their memorandum (ECF

[5] In preparing this memorandum, plaintiffs' counsel became aware that, as presently defined, the sentenced prisoner class includes persons who were returned to the Jail because of a court order entered on a petition for violation of probation. Unlike prisoners entering the Jail to serve misdemeanor sentences, persons facing a hearing to revoke probation face the possibility of serving time in the Illinois Department of Corrections. This difference "calls into question the propriety" of the present subclass definition of sentenced prisoners. *Fonder v. Sheriff of Kankakee County*, 823 F.3d 1144, 1147 (7th Cir. 2016).

Plaintiffs therefore request that the Court amend the definition of subclass 2 to change the "who were not then on parole or held on a warrant from another jurisdiction" to be "who were not then on parole or held on a warrant from another jurisdiction or in custody on a petition for violation of probation."

No. 275) and the standard for sentenced prisoners at 2-3. The parties disagree about the evidence that is material to both claims.

B. Evidentiary Issues

1. Defendants' reliance on percipient witness testimony from plaintiffs' experts

Defendants select to rely on deposition testimony of plaintiffs' experts to support their request for summary judgment. (ECF No. ____, ¶¶ COLLECT PARAGRAPHS.

The Court should not consider any of defendants' contentions based solely on the testimony of either of plaintiffs' experts unless that testimony is based on personal knowledge and would be admissible at trial. *Widmar v. Sun Chemical Corp.*, 772 F.3d 457, 460 (7th Cir. 2014).

2. Plaintiffs are prepared to authenticate their tables at trial

The charts plaintiffs submit with their cross-motion are based on data produced in discovery in this case, or in response to FOIA requests. Plaintiffs are prepared to authenticate each chart at trial using the sampling methodology described by their expert, _____. (Plaintiffs' Exhibit __.) The Court should therefore consider the charts under Federal Rule of Civil Procedure 56(c)(1)(B) because plaintiffs can "produce admissible evidence" at trial.

V. The Court Should Not Consider Factual Assertions that Are Immaterial to the Class Claims

Defendants support their motion for summary judgment with many immaterial factual contentions. The Court should not consider the contentions discussed below.

A. Evidence about a "Standard of Care for Correctional Medicine" Is Not Material

Defendants argue in their summary judgment motion that the Jail's mandatory tapering policy met the standard of care for correctional medicine (ECF No. 275 at 3-5) as practiced "at well over half of U.S. jails and prisons." (*Id.* at 13.) The Court should not consider this contention for two reasons. First, defendants fail to support this claim with admissible evidence. Second, reliance on the practice in the correctional medicine community is inconsistent with the standard adopted by the Seventh Circuit in *Thompson v. City of Chicago*, 472 F.3d 444, 453–55 (7th Cir. 2006).

B. Defendants Fail to Present Admissible Evidence to Support their Defense

Defendants cite paragraphs 24, 46, and 49-50 of their Rule 56.1(a)(2) statement, ECF No. 276, to support their contention about the standard of care for correctional medicine. (ECF No. 275 at 13.) These paragraphs fail to establish any undisputed questions of material fact:

> 24. No expert presented by Plaintiffs is aware of any correctional facility where all patients who were admitted with a

> prescription for MOUD were maintained on their pre-incarceration dose during the class period.
>
> 46. Dr. Mangat believes that the Rikers Island OTP under his direction violated the standard of care that he advocates adopting.
>
> 49. Dr. Fatoki concedes that at least some of the facilities that he worked at or oversaw during the class period (and later) violated the standard of care that he advocates adopting.
>
> 50. During and after the class period, Plaintiffs' experts believe that the care they themselves provided fell below what they now propose should be considered the standard of care.

There is nothing in these paragraphs to support a claim about the standard of care "at well over half of U.S. jails and prisons." In addition, plaintiffs object to each contention.

In response to paragraph 24, plaintiffs state that they "did not attempt to present any expert opinion testimony on this issue and no inference should be drawn from plaintiffs' trial strategy." (Plaintiffs' Response to Defendant's Rule 56.1(a)(2) Statement, ¶ 24.)

Plaintiffs object to paragraphs 46, 49, and 50 as only relevant to credibility, which is not material on summary judgment, and as not supported by the cited material. Plaintiffs also cite an authoritative treatise which reports that methadone maintenance was first employed at New York Riker's Island Jail in 1987. (Plaintiffs' Response to Defendant's Rule 56.1(a)(2) Statement, ¶¶ 46, 49, and 50.)

Defendants' argument about the standard of care is inconsistent with the standard adopted by the Seventh Circuit in *Thompson v. City of Chicago*, 472 F.3d 444 (7th Cir. 2006). There, the Seventh Circuit made plain that the standard of care should not be conflated with violations of the Constitution. *Id.* at 453-55.

The plaintiff in *Thompson* argued that "general orders" of the Chicago Police Department were admissible to provide the jury with "an objective criteria with which to judge the officer's action." 472 F.3d 453. The district judge rejected this argument and the Seventh Circuit affirmed. The Court of Appeals reasoned,

> While the CPD's General Order may give police administration a framework whereby commanders may evaluate officer conduct and job performance, it sheds no light on what may or may not be considered "objectively reasonable" under the Fourth Amendment …

472 F.3d at 454.

This Court applied *Thompson* in *Gomez v. City of Chicago*, No. 13-cv-05303, 2015 WL 13651138, at *10 (N.D. Ill. June 29, 2015), when it granted a motion in limine to bar evidence about police department rules and procedures "because they tend to cause the jury to conflate violations of the policies with violations of the Constitution." *Id.* The same reasoning applies here: Assuming that defendants are able to offer competent evidence about

the standard of care in correctional medicine, it should not be considered, either at trial or on summary judgment.

C. Evidence that state and federal oversight agencies may have approved the Jail's methadone policies is immaterial

Defendants argue in their summary judgment motion that the policies plaintiffs challenge in this case were reviewed and approved by "state and federal oversight agencies," (ECF No. 275 at 1), by "[m]ultiple accrediting bodies" (ECF No. 275 at 8), and that the Jail was only "licensed to provide detoxification services." Defendants cite paragraphs 15, 26, 28, and 61 of their Rule 56.1(a)(2) Statement, ECF No. 276, to support these contentions. Nothing in these contentions supports the inference, urged by defendants, that approval of the policies endorsed the tapering-to-zero policy. These paragraphs provide as follows:

> 15. Licensing for OTPs involves obtaining certification from both state and federal oversight agencies. The certification involves a review of the written policies of the OTP as well as site visits to the program facilities by an accrediting agency.
>
> 26. As part of the accreditation, the OTP maintained written policies which were reviewed and approved at the federal level by the Substance Abuse and Mental Health Services Administration (SAMHSA) and at the state level by the Division of Substance Use Prevention and Recovery (SUPR). [Footnote omitted.] Because the OTP was within a correctional institution, accreditation was performed by the National Commission for Correctional Healthcare (NCCHC).

> 28. SAMHSA and the NCCHC each had protocols during the class period specifically relating to detoxification facilities or tapering/medically supervised withdrawal protocols.
>
> 61. The CCDOC OTP was in compliance with accrediting body NCCHC guidelines regarding correctional facility opioid treatment programs generally and detoxification in particular during the class period.

As with the standard of care evidence, testimony about approvals by accrediting bodies and licensing by government agencies is not material to the constitutional questions presented this under *Thompson*, *supra*.

VI. Defendants Fail to Establish Their Case

1. The linear-taper-to-zero policy harmed the members of the sentenced prison subclass

Defendants assert that sentenced prisoners were not harmed by the linear-taper-to-zero policy. (ECF No. 275 at 3-5). Defendants seek to support this assertions with paragraphs 17, 22, 23, 28, 28, 32, 33, 34, 35, 36, 41, 54, 57, 58, and 62 of their Rule 56(a)(2) Statement. Nowhere in any of these paragraphs do defendants attempt to rebut the opinion of Dr. Mangat that mandatory tapering "can cause undue harm and suffering, while placing these individuals at an increased risk of relapse, overdose, and death." (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 3, citing Mangat Report, Plaintiffs' Exhibit 23 at 1.) Nor do defendants attempt to rebut the opinion of Dr. Fatoki that "Tapering patients off medication during incarceration destabilizes the patient and significantly increases the risk of relapse and overdose upon release

back into the community. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ _, citing Fatoki Report, Plaintiffs' Exhibit 21 at 2.)

Rather than address the serious harm caused by interrupting methadone maintenance, defendants misread deposition testimony by plaintiffs' experts. For example, paragraph 17 of defendants' Rule 56(a)(2) statement states as follows:

> 17. MOUD, also known as Medication Assisted Treatment (MAT) can be used for maintenance therapy of patients with OUD or may be part of supervised withdrawal off of opioid medications.

The citation for this contention is the deposition of Dr. Fatoki, one of plaintiffs' experts. But the entirety of the cited excerpt of Dr. Fatoki's deposition is the following:

Question:	And are some people on maintenance medication indefinitely?
Dr. Fatoki:	Yes.
Q:	And are some gradually taken off the medication?
Dr. Fatoki:	Yes.

(Plaintiffs' Exhibit 12, Complete Deposition of Dr. Fatoki, 42:23-43:4.)

Nothing in the portion of Dr. Fatoki's deposition cited by defendants supports their claim that the mandatory tapering policy did not harm any of the sentenced prisoners at the Jail. The same is true for the other paragraphs defendants cite to support this proposition.

2. Defendants fail to establish that tapering is preferable to cold turkey withdrawal

Defendants ask the Court to view this case as a choice between tapering and cold turkey withdrawal. (ECF No. 275 at 5.) Defendants rely on paragraphs 22, 24, 54, 55, and 58 of their Rule 56.1(a)(2) Statement, ECF No. 276, to support this argument. The Court should reject this attempt to reframe plaintiffs' claims.

The paragraphs on which defendants rely state as follows:

> 22. No jail in the state of Illinois other than CCDOC provides methadone to detainees, nor does the Illinois Department of Corrections state prison system.
>
> 24. No expert presented by Plaintiffs is aware of any correctional facility where all patients who were admitted with a prescription for MOUD were maintained on their pre-incarceration dose during the class period.
>
> 54. Medically supervised withdrawal including a tapering of a dose of opioid agonist medication will result in less severe symptoms than an abrupt cessation or "cold turkey" withdrawal from the medication.
>
> 55. If an opioid agonist medication is to be stopped, tapering or medically supervised withdrawal is the more humane method of stopping the medication.
>
> 58. Medically supervised withdrawal or tapering of the dose of opioid agonist medication is preferable to abrupt "cold turkey" cessation of the medication.

While plaintiffs dispute paragraph 22, Plaintiffs' Response to Defendants Rule 56.1(a)(2) Statement, ¶22, the more important issue is that this is not a case about whether tapering methadone to zero is "more humane" than

an abrupt, "cold turkey" cessation of methadone. Plaintiffs contend that the Jail should continue methadone maintenance the same way that it would continue medication for diabetes, hypertension, or other serious medical condition. The comparison between tapering and "cold turkey" cessation is not material and could only confuse a jury.

3. The linear-taper-to-zero policy is not a medically appropriate "accepted treatment approach" to substitute for continuing methadone maintenance

Defendants attempt to show that their taper-to-zero policy was "an accepted treatment approach" (Defendants Rule 56.1(a)(2) Statement, ¶¶ 17, 18, 28), or "an approved protocol for medically supervised withdrawal," (*id.* at ¶¶ 17-18, 25-28), that tapering was permissible because symptoms were treated "as needed" (*id.* at ¶¶ 33, 41), and because the Jail offered mental health treatment. (*Id.* at ¶ 35.) None of the cited paragraphs support this contention.

Plaintiffs discussed paragraph 17 above at 16. Paragraph 18 states as follows:

> 18. The use of MOUD for detoxification or medically supervised withdrawal from opioids is a well-recognized treatment protocol.

Defendants base this paragraph on the deposition testimony of Dr. Fatoki. Again, though, defendants have misread the deposition. Dr. Fatoki, in the cited portion of his deposition, stated that detoxing is not "the proper

treatment." (Plaintiffs Response to Rule 56.1(a)(3) Statement, ¶ 18.) Plaintiffs' Exhibit 12, Fatoki Dep. 101:5-13.)

Paragraphs 25 through 28 are an improper attempt to use the fact of accreditation to show that mandatory tapering meets the constitutional standard. Plaintiffs dispute paragraphs 26, 27, and 28, (Plaintiffs Response to Rule 56.1(a)(3) Statement, ¶¶ 26-28), pointing out in response to paragraph 28 that defendants' expert, Dr. Richardson, stated that there is nothing else in the SAMHSA standards or the NCCHC guidelines that "speaks to tapering." (*Id.*) The Court should therefore conclude that defendants have failed to show that the linear-taper-to-zero policy is an accepted treatment approach to substitute for continuing methadone maintenance.

4. Defendants fail to show a legitimate penological purpose for the linear-taper-to-zero policy

Defendants argue that there is a legitimate penological purpose for the challenged policy, asserting that the policy is justified by "limitations due to the security needs" of the Jail. (ECF No. 275 at 9.) Defendants base this contention on deposition testimony from plaintiffs' experts, but, once again, defendants have misread those materials.

Paragraph 21 states as follows:

> 21. Providing medications like methadone in a correctional environment provides a unique set of challenges for an already highly controlled substance, including requiring a secure area for storage of the medication and a secure area to dispense the

> medication, medical and correctional staff availability in getting the medication to detainees, and risk of diversion or abuse of the medication by detainees.

Plaintiffs explained defendants' error in their response to this paragraph:

> RESPONSE: Disputed. This contention is not supported by the cited material. Dr. Fatoki answered questions about "any limitation on provid[ing] medication assisted treatment in a jail" and answered that the "biggest thing is the stigma that's associated with it … there may be staffing issues … and also with security." (Plaintiffs' Exhibit 12, Fatoki Dep. 97:3-14.) Dr. Fatoki then answered a question about security issues in a jail. (*Id*, 97:15-98:1.) Dr. Mangat stated that the "biggest limitation is, for one, getting all of the jail and prisons in the system to offer medication assisted treatment." (Plaintiffs' Exhibit 11, Mangat Dep. 70:5-9.) Dr. Mangat continued: "The second limitation is being that the individuals are incarcerated or detained, having to do daily observed therapies for every individual … while dealing with the challenges of housing, escorting patients to get their medication, to go see medical, alarms that might be going off during these circumstances …" (*Id.* at 78:10-18.)

(Plaintiffs' Response to Defendants' Rule 56.1(a)(2) Statement, ¶ 21.)

Defendants also rely on claimed financial concerns (ECF No. 275 at 9, citing defendants' Rule 56.1(a)(2) Statement, ¶¶ 20 and 37.) Paragraph 37 does not support defendants' argument; that contention asserts that the Jail ended its mandatory-taper-to-zero policy in July of 2017 "because new grant money became available to help administer the program." (Defendants' Rule 56.1 Statement, ¶37.) Equally unhelpful is paragraph 20:

> 20. Many jails and prisons are resistant to offering MOUD in their facilities for a variety of reasons including stigmas and

> attitudes around addiction, lack of resources, and security concerns.

Defendants base this contention on the deposition testimony of plaintiffs' experts; defendants have again misread the source materials, as plaintiffs point out in their response to paragraph 20:

> RESPONSE: Disputed. This contention is not supported by the cited material. Dr. Mangat did not offer any opinion about reasons why jails and prisons may be resistant to offering MOUD in the cited excerpt of his deposition; his testimony at page 70 consists of his opinion about "limitations on providing MAT's in jail that are different from limitations in the community." (Plaintiffs' Exhibit 11, Mangat Dep. 70:1-18.) Dr. Fatoki likewise did not offer any opinions about why jails and prisoner may be resistant to offering MOUD. The question at page 126, line 19 of Dr. Fatoki's deposition is, "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?" After Dr. Fatoki answered this question by stating that the analyses would not take a lot of resources, the examination turned to Dr. Fatoki's experience working in a correctional system that did not have an OTP program. (Plaintiffs' Exhibit 12, Fatoki Dep. 127:3-128:2.)

(Plaintiffs' Response to Defendants' Rule 56.1(a)(2) Statement, ¶ 20.)

The Court should therefore conclude that defendants have failed to show any legitimate penological purpose for the mandatory taper-to-zero policy.

5. The Sheriff Is Liable for the Mandatory Tapering Policy

There is no merit in the Sheriff's argument that he cannot be liable for the mandatory taper-to-zero policy because he has delegated his

responsibility for health care to Cook County. (ECF No. 275 at 10-11.) The Seventh Circuit rejected this argument in *Daniel v. Cook County*, 833 F.3d 728 (7th Cir. 2016), holding that "the constitutional duty under the Eighth and Fourteenth Amendments to provide adequate health care rests on the custodian." *Id.* at 737.

6. Defendants Are Not Entitled to Summary Judgment on the ADA and Rehabilitation Act Claims

Title II of the ADA prohibits public entities, including units of local government, from discriminating based on disability in the provision of their "services, programs, or activities." 42 U.S.C. §§ 12131(1)(A)–(B), 12132. To prevail on such a claim, the plaintiff must show: (1) "that he is a 'qualified individual with a disability'"; (2) "that he was denied 'the benefits of the services, programs, or activities of a public entity' or otherwise subjected to discrimination by such an entity"; and (3) "that the denial or discrimination was 'by reason of' his disability." *Lacy v. Cook Cnty., Illinois*, 897 F.3d 847, 853 (7th Cir. 2018).

There is a growing consensus of authority that a Jail violates the ADA when it refuses to allow an incoming detainee to continue to receive methadone. *See, e.g., Smith v. Aroostook County*, 376 F. Supp. 3d 146 (D. Me. 2019), *aff'd*, 922 F.3d 41 (1st Cir. 2019); *Johnson v. Dixon*, No. 23-CV-23021, 2023 WL 6481252, at *2 (S.D. Fla. Oct. 5, 2023); *M.C. v. Jefferson*

Cnty., N.Y., 2022 WL 1541462, at *4 (N.D.N.Y. May 16, 2022); *Rokita v. Pa. Dep't of Corr.*, 273 A.3d 1260, 1274 (Pa. Commw. Ct. 2022).

Defendants seek to rewrite the individual ADA/RA claim of the named plaintiffs as limited to "delay in provision of methadone." (ECF No. 275 at 14.) This is incorrect: Plaintiffs' individual ADA/RA claim is that by failing to modify its mandatory taper-to-zero policy, defendants have violated the ADA and the RA by failing to make the "reasonable modification" required by 28 C.F.R. § 35.130(b)(1)(i)-(iv).

Plaintiffs alleged the following in paragraph 41 of their second amended complaint,

> 41. The application of defendants" tapering policy violated the Americans with Disabilities Act, the Rehabilitation, and the United States Constitution.

(ECF 133, ¶ 41.) The Court, while suggesting that this claim was not pleaded with specificity, acknowledged that plaintiffs' "best foot forward" on the ADA/RA claims "would be to argue that the linear-taper policy is *per se* unreasonable under the ADA and the Rehabilitation Act." (ECF No. 178 at 12.) This is precisely how plaintiffs view their disability claims.

Defendants have not engaged with plaintiffs' ADA/RA claims. The Court should therefore deny the defense motion for summary judgment on those claims.

VII. Plaintiffs Are Entitled to Summary Judgment on the Class Claims

A. Opioid Use Disorder Is a Serious Medical Condition that Is Best Treated With Medication

3. Opioid use disorder ("OUD") is a chronic disease with symptoms characterized by uncontrollable cravings for opioids, loss of control, increased tolerance to opioids, and withdrawal symptoms. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 3, App. 1627.)

4. The most serious risks of OUD include overdose and death: Over a thousand people in Cook County die each year from opioid overdose; 467 persons died in the first six months of 2021 in Chicago. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 3, App. 1627.)

5. There is significant suffering associated with withdrawal: Symptoms can include anxiety, irritability, restlessness, chills, muscle pain, weakness, tremor, nausea, and vomiting; psychological symptoms from withdrawal can also be painful and debilitating. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 3-4, App. 1627-28.)

6. Withdrawal symptoms can last up to several weeks. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 4, App. 1628.)

7. Moreover, patients do not return to their pre-OUD baseline after withdrawal symptoms diminish, but often continue to experience

symptoms of OUD, such as cravings for opioids, indefinitely. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 4, App. 1628.)

8. OUD is best treated by a stable dose of medication assisted treatment ("MAT"), such as methadone maintenance. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 5, App. 1629.)

B. Interruption of Medication Assisted Treatment for Opioid Use Disorder Causes Harm

9. Tapering the dosage of medication assisted treatment induces painful withdrawal symptoms that places the patient at a higher risk of relapse. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 5, App. 1629.)

10. Withholding medication or tapering medication from someone with OUD triggers symptoms of withdrawal and increases the risk for relapse. Withdrawal and relapse are serious and potentially dangerous medical conditions that require appropriate medical attention. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 3, App. 1627.)

11. The consensus in the medical community since at least 2007 is that opioid use disorder is a chronic brain disease and patients need to be maintained on their treatment. (Plaintiffs' Exhibit 12, Dr. Fatoki Dep. 106:13-23, App. 279.)

C. Defendants Were on Notice of the Harm Caused by heir Mandatory Tapering Program

In *Davis v. Carter*, 452 F.3d 686 (7th Cir. 2006), the Seventh Circuit considered a case brought for the estate of a person who, like plaintiff Rogers, entered the Cook County Jail while enrolled in a methadone maintenance program to serve a brief misdemeanor sentence. The Jail failed to provide the plaintiff with his prescribed medication for five days while he experienced painful withdrawal symptoms. *Id.* at 689-91. The district court granted summary judgment for defendants, but the Seventh Circuit reversed. The Court of Appeals concluded that a person in a methadone maintenance program has a "medical need" to continue to receive methadone. *Id.* Thereafter, the district court in *Bradley v. Sheriff of Rock Island*, relied on *Davis* to hold that "[i]t was well-established in August 2011 that people entering jail at significant risk of withdrawal are entitled to adequate medical treatment." *Bradley v. Sheriff of Rock Island County.*, No. 4:12-cv-04008, 2016 WL 9775233, at *10 (C.D. Ill. Mar. 2, 2016).

Defendants were on notice about the flaws in the Jail's methadone tapering policy as a result of *tv. Sheriff of Cook County*, No. 07-cv-4369 (N.D. Ill.), a class action that challenged, *inter alia*, the Jail's methadone policy.

The policy at issue in *Parish* is identical to the policy at issue here. As summarized by the district judge in *Parish*, "CCJ utilized

a methadone tapering program for detainees who needed drug treatment. For non-pregnant program participants, the program typically reduced the dosages of methadone given to them over a twenty-one-day period, until they were eliminated altogether." *Parish v. Sheriff of Cook County.*, No. 07 C 4369, 2019 WL 2297464, at *4 (N.D. Ill. May 30, 2019). The district court in *Parish* denied cross-motions for summary judgment, 2019 WL 2297464 (N.D. Ill. May 30, 2019), and the case eventually settled.

D. Defendants do not have any penological justification for their mandatory tapering policy

The record in *Parish* included the Rule 30(b)(6) deposition of defendant Cook County about the reasons for the 21 day methadone tapering policy. The County designated Dr. Avery Hart, then the Chief Medical Officer at the Jail, to testify about the policy. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 10.)

Dr. Hart was asked at the Rule 30(b)(6) deposition in *Parish* to explain the reason for the mandatory tapering policy. (*Id.*, Hart Dep. 10:9-18.) Hart answered as follows:

> Dr. Hart: Well, the -- our goal is not to run a methadone maintenance program. Our goal is to alleviate the symptoms of withdrawal from methadone. The exception, as I said, being pregnant women.
>
> Q: Now, do you know why it is that your goal is not to run a methadone maintenance program?

Dr. Hart: Our positive goal is to alleviate the symptoms of methadone withdrawal.
Q: But my question is do you know why your goal is not to run a methadone maintenance program?
***
Dr. Hart: That's not part of our mission.
Q: And when you say "our mission," who is the "our?"
Dr. Hart: Cermak Health Services of Cook County.
Dr. Hart: [O]ur goal is not to run a methadone maintenance program.
(Plaintiffs' Exhibit 35, Hart Dep. 10:5-11:6,.)

The record in *Parish* also included expert reports from three of plaintiff's experts explaining flaws in the Jail's methadone policies. Dr. Steven Whitman, a biostatistician, concluded that most inmates who go on a methadone tapering program are released before completing the tapering program. (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 21.) Dr. Lambert King and Dr. Pablo Stewart, described by the district judge in *Parish* as expert who "have experience managing, monitoring, and reforming health systems in correctional settings," *Parish*, 2019 WL 2297474 *5, were each critical of the mandatory tapering policy. Dr. King described the mandatory tapering policy as causing "gratuitous physical pain and psychological discomfort" and concluded that the policy is "an arbitrary and capricious practice whereby proper dosages of a legitimately prescribed medication needed to treat severe drug addiction are withheld, thereby placing patients at high risk for subsequent death or disability associated with drug overdoses and life-

threatening infections, including HIV infection." (Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 22.) Dr. Stewart offered a similar opinion:

> Methadone tapering can cause severe withdrawal discomfort. There is no justification to require a person to undergo opiate withdrawal syndrome when he (or she) has been receiving lawfully prescribed methadone. Methadone is a medically accepted treatment for opiate abuse/dependence and should not be arbitrarily withdrawn, as required by the Jail's automatic tapering policy.

(Plaintiffs' Rule 56.1(a)(2) Statement, ¶ 23.)

The *Parish* litigation placed defendants on notice about the flaws in their methadone program and provided them with "subjective awareness" (ECF No. 275 at 5), as required for the Eighth Amendment claim for persons serving misdemeanor sentences and the unreasonableness of their mandatory tapering policy for pre-trial detainees.

E. The Eighth and Fourteenth Amendments requires continuation of medication prescribed for a serious medical need absent reasonable medical decision to discontinue or alter the prescription

The legal principle governing the class claims was articulated by the Seventh Circuit in *King v. Kramer*, 680 F.3d 1013 (7th Cir. 2012): "[A] municipality would violate the Eighth Amendment under *Monell* if it had a policy requiring jail staff to throw away all prescription medications without implementing an appropriate mechanism for providing alternative

treatment." *Id.* at 1021. This is an apt description of defendants' mandatory tapering program.

All members of each subclass were in treatment for opioid use disorder. Each had been prescribed methadone to treat that serious medical condition. The Jail refused to continue the medication, and provided each class members with tapered amount of methadone, designed to be a zero dosage in 21 days.

The Jail did not base its tapering policy on any medical advice. The Jail refused to continue persons (unless pregnant) on their prescribed medication because, as Dr. Hart admitted, the Jail did not believe it was "part of our mission" to continue treatment for opioid use disorder.

The policymakers at the Jail knew that there was no legitimate penological purpose for their mandatory taper policy. The policymakers also knew that interfering with treatment would cause short term harm from withdrawal symptoms and long term harm in interference with treatment.

None of the cases cited by defendants support the mandatory tapering policy. Those cases involved judgment by a physician that was challenged as being substandard. For example, in *Cole v. Fromm*, 94 F.3d 254, 261-62 (7th Cir. 1996), the claim was that a physician had failed to recognize that the plaintiff's decedent was suicidal. The physician "balanced the risks

that a 'potential' suicide patient faced and determined, in essence, that there was not a "substantial risk of serious harm" given the precautions attendant to a placement on "potential" suicide status." *Id.* at 261-62. Defendants' mandatory tapering policy did not involve any medical judgment; the only judgment involved was to divide the prisoner's last dosage by 21 and order a linearly reducing dosage of methadone until zero dosage was reached.

The Court should therefore grant summary judgment on liability to each sub-class and deny defendants' cross motion in its entirety.

Respectfully submitted,

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