Maria Michelle Uzeta, pro hac vice
Cal. Bar No. 164402
DISABILITY RIGHTS EDUCATION
AND DEFENSE FUND
3075 Adeline Street, Suite 210
Berkeley, CA 94703
Tel: (510) 644-2555
muzeta@dredf.org

Attorneys for Amici Curiae

Emily Cooper, OSB #182254
DISABILITY RIGHTS OREGON
511 SW 10th Avenue, Suite 200
Portland, Oregon 97205
Tel: (503) 243-2081
ecooper@droregon.org

Local Counsel for Amici Curiae

UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

EUGENE DIVISION

JAY CUSKER, LMFT; ALISON GRAYSON; KATHRYN KLOOS, ND; and YOLANDA SUAREZ, DO, Plaintiffs, v. OREGON HEALTH AUTHORITY, an agency of the State of Oregon; and SEJAL HATHI, MD, Director of the Oregon Health Authority, Defendants.	Case No.: 6:24-cv-00998-MTK [PROPOSED] *AMICUS CURIAE* BRIEF OF DISABILITY RIGHTS EDUCATION AND DEFENSE FUND AND SIXTEEN OTHERS IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

COMPLETE LIST OF AMICI

1. Disability Rights Defense and Education Fund
2. Disability Rights Oregon
3. Autistic People of Color Fund
4. Autistic Women & Nonbinary Network
5. Disability Rights Bar Association
6. Disability Rights California
7. End of Life Psychedelic Care
8. Multidisciplinary Association of Psychedelic Studies
9. Not Dead Yet
10. Oregon Hospice & Palliative Care Association
11. Organization of Psychedelic and Entheogenic Nurses
12. Patients Rights Action Fund
13. Psilocybin Assisted Therapy Association
14. Survivorship Collective
15. Ann Jackson, MBA
16. Hannah Whitmore, PhD, RN, CHPN
17. Marne Lucas, End of Life Doula

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

Regulations

Constitutional Provisions

INTERESTS OF AMICI CURIAE

This case challenges a central feature of Oregon's Psilocybin Services Act ("PSA"): its requirement that psilocybin services may only be provided at licensed service centers. Or. Rev. Stat. § 475A.498. Because services are categorically restricted to those locations, individuals who cannot physically travel to a service center — including many disabled and terminally ill people — are effectively excluded from accessing the program. This exclusion constitutes unlawful discrimination under Title II of the Americans with Disabilities Act ("ADA") — a federal mandate that Oregon's service-center requirement cannot override.

Amici are a unique coalition of disability and patients' rights leaders, medical and end-of-life care professionals, psychedelic therapy researchers and advocates, and individuals with lived and professional experience in serious illness and palliative and hospice care. They share a common interest in ensuring that psilocybin services under Oregon's Psilocybin Services Act ("PSA") are administered consistent with Title II of the Americans with Disabilities Act ("ADA"), including its mandate that public entities provide reasonable modifications to afford disabled people equal and meaningful access to public programs.

Amici bring complementary expertise in the design and delivery of healthcare and supportive services for disabled people, including those with serious illness who cannot safely access facility-based care. Their work reflects sustained engagement with the barriers that arise when public programs are built around assumptions of physical mobility, stamina, and access that many disabled people do not share. Amici also include organizations and professionals with experience in psychedelic-assisted therapy and its emerging role in palliative and end-of-life care, as well as those engaged in related research, education, and best-practices development.

Through their work, Amici routinely encounter programs that are formally open to all yet functionally inaccessible — designed around nondisabled norms in ways that deny equal access to people with disabilities, a community that already faces profound inequities in health care and public services. This combined expertise positions Amici to assist the Court in understanding how the PSA's rigid service-location requirement, applied without the possibility of reasonable modification, operates to exclude disabled people from the program altogether.

Amici appear at the district court stage because this case presents an urgent and foundational civil rights question with immediate consequences: whether a state may categorically refuse to consider reasonable modifications to statutory program requirements when those requirements deny disabled people meaningful access to a public program. Amici submit this brief in support of Plaintiffs' Motion for Summary Judgment to address that question now — before exclusionary program design becomes entrenched as lawful by default — and to provide the Court with practical, clinical, and policy context regarding the real-world consequences of denying such modifications to individuals with life-threatening disabilities.

SUMMARY OF ARGUMENT

This case asks whether a state may enforce a statutory service-delivery model that, by design, excludes disabled individuals from accessing a public health program — without considering reasonable modifications required by federal law. The PSA's service-center-only requirement operates as such a barrier, and the ADA supplies the governing legal standard.

The ADA is a core health equity and civil rights statute. Title II of the ADA requires public entities to make reasonable modifications to policies, practices, and procedures when necessary to ensure that people with disabilities can access public programs on equal terms — an obligation that applies equally to statutory and regulatory requirements as to agency practices and administrative rules. Courts have long recognized that when state law operates as a barrier to access, it must yield to federal disability rights protections unless modification would fundamentally alter the nature of the program.

Defendants' assertion that they are categorically barred from permitting any modification of the PSA's service-location requirement — despite its exclusionary effects

— because it is written into state law is incompatible with that settled doctrine. If accepted, that theory would allow states to avoid federal civil rights obligations simply by embedding access barriers into statutes or ballot measures — precisely the result the ADA was enacted to prevent. Where state law conflicts with a valid federal civil rights mandate, the Supremacy Clause resolves the question: federal law governs.

The exclusion at issue here reflects a broader and longstanding problem in public health and social service systems: programs are frequently designed around assumptions about physical mobility, stamina, and transportation access that many disabled people do not share. When those assumptions are built into program requirements, disabled people are not merely inconvenienced; they are effectively denied access to services the State has chosen to make available to the public. The ADA requires public entities to address these structural barriers through reasonable program modifications, not to treat exclusion as an unavoidable byproduct of regulatory design.

That obligation is especially urgent here, where Oregon makes one end-of-life pathway — the prescription and use of lethal medication[1] — comparatively accessible to disabled people while failing to ensure equally accessible alternatives in palliative care. A system that is structurally open along one end-of-life pathway but effectively closed along another cannot be said to provide the equal access the ADA guarantees. Genuine patient autonomy requires that all legally available options be meaningfully within reach.

Through this litigation, Plaintiffs do not seek to dismantle Oregon's regulatory framework or to weaken legitimate health and safety protections. They seek only what federal law already requires: that the State provide reasonable modifications when necessary to ensure disabled people have safe, meaningful access to public programs consistent with their objectives. Because Defendants' categorical refusal to consider such modifications conflicts with the ADA's guarantee of meaningful access, summary judgment in Plaintiffs' favor is warranted.

---

[1] This practice is referred to variously in literature, statutes, and case law as "assisted suicide," "physician-assisted death," and "medical aid in dying," among other formulations.

ARGUMENT

I. The Supremacy Clause Requires That Federal Disability Rights Protections Prevail Over Conflicting State Law

Before turning to the ADA's specific requirements, it is worth stating the foundational principle that governs this case. The Supremacy Clause of the United States Constitution provides that federal law is "the supreme Law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2. As then-Judge Gorsuch observed, "a state law at odds with a valid Act of Congress is no law at all." *Barber ex rel. Barber v. Colorado Dep't of Revenue*, 562 F.3d 1222, 1234 (10th Cir. 2009) (Gorsuch, J., concurring) (citing *M'Culloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 4 L. Ed. 579 (1819)).

In the Ninth Circuit, this principle is well-settled in the disability rights context. Courts have consistently held that where state law — whether enacted by a legislature or adopted by ballot measure — conflicts with Title II of the ADA, federal law controls. *Crowder v. Kitagawa*, 81 F.3d 1480, 1485 (9th Cir. 1996); *McGary v. City of Portland*, 386 F.3d 1259, 1265 (9th Cir. 2004); *Townsend v. Quasim*, 328 F.3d 511, 517 (9th Cir. 2003). The mechanism is not complicated: Title II was enacted pursuant to Congress's Fourteenth Amendment enforcement authority, and its requirements operate as a federal floor that state law may not undercut. *Tennessee v. Lane*, 541 U.S. 509, 533–34 (2004). Oregon's service-center-only requirement is state law. The ADA is federal law. Where they conflict, the ADA governs.

II. Title II Of The ADA Requires States To Modify Program Requirements When Necessary To Ensure Disabled People Have Meaningful Access To Public Services

Title II's central command is that public entities must operate programs so that people with disabilities are not excluded from participation or denied the benefits of public services. 42 U.S.C. § 12132. This obligation is not satisfied by formal eligibility alone; it requires that programs be accessible in practice. 28 C.F.R. § 35.149; see also

Crowder, 81 F.3d at 1483-84 ("[S]tairs can deny the wheelchair-bound access to services provided on the second floor of a government building . . ."). Federal regulations implementing Title II therefore require public entities to make reasonable modifications to policies, practices, and procedures when necessary to avoid disability-based exclusion, unless doing so would fundamentally alter the nature of the program. 28 C.F.R. § 35.130(b)(7)(i); see also *K.M. v. Tustin Unified Sch. Dist.*, 725 F.3d 1088, 1096-97 (9th Cir. 2013).

Courts have repeatedly emphasized that meaningful access is the touchstone of Title II compliance. *K.M.*, 725 F.3d at 1102 (citing *Alexander v. Choate*, 469 U.S. 287, 105 S. Ct. 712, 83 L. Ed. 2d 661 (1985)); *Crowder*, 81 F.3d at 1485; *Disabled in Action v. Bd. of Elections*, 752 F.3d 189, 197 (2d Cir. 2014); *Luke v. Texas*, 46 F.4th 301, 306 (5th Cir. 2022). Where program rules prevent disabled people from using a service in the manner it is offered to others, the ADA requires changes to how the program operates. 28 C.F.R. § 35.130(b)(7); *Crowder*, 81 F.3d at 1485 ("When a state's policies, practices or procedures discriminate against the disabled in violation of the ADA, Department of Justice regulations require reasonable modifications . . ."); see also *Cohen v. City of Culver City*, 754 F.3d 690, 699 (9th Cir. 2014) (where equal access was possible, it was unreasonable to require a disabled individual to take a longer route).

This reflects Congress's recognition that discrimination often arises not from hostility, but from systems designed without disabled people in mind. See 42 U.S.C. § 12101; see also *Lane*, 541 U.S. at 524-26; *Crowder*, 81 F.3d at 1484. Public entities therefore have an affirmative duty to evaluate whether their program structures function as barriers and to modify them when they do. See 28 C.F.R. §§ 35.105 (self-evaluation) and 35.150 (transition plan); *Lane*, 541 U.S. at 533 (discussing states' "affirmative obligation" to provide meaningful access); *Indep. Living Ctr. of S. Cal. v. City of L.A.*, 973 F. Supp. 2d 1139, 1149 (C.D. Cal. 2013) ("Public entities have the affirmative duty to 'make reasonable modifications . . .'") (quoting *Zukle v. Regents of the Univ. of Cal.*, 166 F.3d 1041, 1042 (9th Cir. 1999)).

Here, Plaintiffs challenge a program design feature that determines where services may be delivered. When a design feature excludes disabled people whose disabilities make travel or access to fixed sites inaccessible, Title II requires the State to consider alternatives that preserve program goals while ensuring access — <u>including the very alternative requested by the Plaintiffs</u>. 28 C.F.R. § 35.150(b)(1) (a public entity may comply with the program accessibility requirements of the ADA through such means as "reassignment of services to accessible buildings, ... home visits, delivery of services at alternate accessible sites, ... or any other methods that result in making its services, programs, or activities readily accessible to and usable by individuals with disabilities."). See *Pierce v. Cty. of Orange*, 526 F.3d 1190, 1221 (9th Cir. 2008) (a public entity may provide program access via reasonable alternatives, but it "may not shunt the disabled into facilities where there is no possibility of access to those programs."); *Helen L. v. DiDario*, 46 F.3d 325, 335 (3d Cir. 1995) ("The ADA is intended to insure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides, and ignores them.").

A. Statutory And Regulatory Requirements Are Subject To The ADA's Reasonable Modification Mandate

The ADA's reasonable modification requirement applies to all "policies, practices, and procedures" of public entities, including those mandated by statute or regulation. 42 U.S.C. § 12131(2). See *Crowder*, 81 F.3d at 1485 (holding Hawaii was required to exempt visually-impaired individuals from a state regulation); *Mary Jo C. v. N.Y. State & Local Ret. Sys.*, 707 F.3d 144, 162 (2d Cir. 2013) ("[W]e find nothing in the statutory phrase 'reasonable modification' to suggest that Congress intended to exclude modifications that require violation or waiver of mandatory state statutes."). Courts have therefore consistently held that state law cannot be invoked as a justification for disability discrimination, because federal civil rights law preempts conflicting state requirements. See, e.g., *Crowder*, 81 F.3d at 1485 (requiring modification of state quarantine law); *McGary*, 386 F.3d at 1265 (requiring consideration of modification to municipal ordinances); *Townsend*, 328 F.3d at 518 ("When a state's policies discriminate against the disabled in violation of the ADA, the ADA's regulations mandate reasonable modifications to those policies in order to avoid discrimination on the basis of disability."). See also *Mary Jo C.*, 707 F.3d at 162; *Fry v. Saenz*, 98 Cal. App. 4th 256, 264–66 (2002) (applying the ADA and Section 504 to the CalWORKS program and holding that a statutory age-based benefit cutoff discriminated against disabled children); *Nat'l Fed'n of the Blind v. Lamone*, 813 F.3d 494, 508 (4th Cir. 2016) ("[D]efendants' argument — that the mere fact of a state statutory requirement insulates public entities from making otherwise reasonable modifications to prevent disability discrimination — cannot be correct.").

These cases reflect a foundational principle of Title II: legislative enactment does not place a rule beyond the reach of the ADA. The operative question is not whether the barrier appears in a statute rather than an agency manual, but whether modification is reasonable and consistent with the program's essential nature.

In *Crowder v. Kitagawa*, a Hawaii statute permitted the Hawaii Department of Agriculture ("HDOA") to make rules for the quarantine of animals entering the state. 81 F.3d at 1481. HDOA established a 120-day quarantine which applied to all carnivorous animals, including service dogs, regardless of the owner's place of residence. *Id.* at 1481-82. The Ninth Circuit held that the law impermissibly discriminated against disabled users of service animals. *Id.* at 1485. The court reasoned that "[w]hen a state's policies, practices or procedures discriminate against the disabled in violation of the ADA, Department of Justice regulations require reasonable modifications in such policies, practices or procedures." *Id* (citing 28 C.F.R. § 35.130(b)(7)). Therefore, the state was required to consider whether the law could be reasonably modified. *Id*

In *McGary v. City of Portland*, the plaintiff was cited for trash on his property and was given a deadline to clean it up per a municipal ordinance. 386 F.3d at 1261. However, the plaintiff had HIV and was hospitalized before he could complete the cleaning. *Id*. The plaintiff requested an extension of the deadline, but the City refused and levied a fine. *Id.* at 1261-21. The Ninth Circuit held that the ordinance impermissibly discriminated against disabled individuals. *Id.* at 1265.

Lastly, in *Townsend v. Quasim*, Washington promulgated a regulation for the distribution of Medicaid. 328 F.3d at 513-15. Under the regulation, different classes of eligibility were determined by income. *Id.* at 514. The plaintiff was receiving community-based services, but when he received an increase in income, he was reclassified and could only receive services in a nursing home. *Id.* The Ninth Circuit held that the law impermissibly discriminated against disabled individuals by isolating them in nursing homes based on arbitrary standards. *Id.* at 517-18 (citing *Olmstead v. L.C.*, 527 U.S. 581 (1999)). Relevant to this case, the court determined that the regulation's eligibility criteria were irrelevant in considering whether a disabled individual qualified for community-based services. *Id.* at 516-17. Rather, "[w]hen a state's policies discriminate against the disabled in violation of the ADA, the ADA's regulations mandate reasonable modifications to those policies." *Id.* at 517.

Defendants argue that reasonable modifications for home-visits are not achievable because the PSA only permits the program in designated service centers. Yet decades of Ninth Circuit precedent has been repeatedly and unambiguously clear in holding that limitations imposed by a state law are subject to reasonable modifications to avoid disability discrimination. Accepting Defendants' argument that legislative enactment insulates a rule from Title II would further invert ADA supremacy by allowing states to immunize exclusionary policies simply by codifying them — effectively a contention that they are exempt from [the] reasonable modification requirement. That result would directly contradict Congress's intent to establish a uniform national floor of disability rights and enforceable standards applicable to all levels of government. See 42 U.S.C. § 12101(b). Title II does not permit public entities to define the scope of civil rights protections through legislative drafting; it requires them to adapt program requirements when necessary to ensure that people with disabilities can actually participate. Where in-home service delivery would allow qualified individuals to receive the same substantive services without undermining the program's core objectives, refusal to consider that option is not neutral administration — it is a failure to provide meaningful access in violation of the ADA. *Wong v. Regents of the University of California*, 192 F.3d 807, 818 (9th Cir. 1999) ("[M]ere speculation that a suggested accommodation is not feasible falls short of the reasonable accommodation requirement.").

For the same reasons, it makes no difference that the PSA was adopted by ballot measure rather than by the legislature. Title II was enacted pursuant to Congress's authority under the Fourteenth Amendment to enforce equal protection guarantees against state discrimination, and the Supremacy Clause makes clear that valid federal law preempts conflicting state requirements regardless of how those requirements were enacted. *Lane*, 541 U.S. at 533–34; *Lamone*, 813 F.3d at 508. Civil rights protections exist precisely because political processes have historically failed to protect marginalized communities from exclusion. State sovereignty does not include the authority to operate public programs in ways that deny disabled people the access federal law guarantees. *Mary Jo C.*, 707 F.3d at 163.

B. Programs Designed Around Nondisabled Norms Must Be Adjusted When They Exclude Disabled People From Participation

Public programs are often structured around assumptions about physical mobility, transportation access, scheduling flexibility, and physical stamina. These assumptions reflect nondisabled norms, not neutral realities. When embedded in program requirements, they exclude disabled people not because they are ineligible for services, but because program design fails to account for disability-related access needs.

Title II was enacted to address precisely this form of structural exclusion. The statute recognizes that equality requires more than identical treatment; it requires removing barriers that predictably block participation by people with disabilities. *See Crowder,* 81 F.3d at 1485 (facially neutral quarantine law violated ADA where it disproportionately burdened blind individuals using guide dogs); *McGary,* 386 F.3d at 1265–66 (neutral enforcement deadline violated ADA where disability made compliance predictably impossible without modification); see also *Gambini v. Total Renal Care, Inc.,* 486 F.3d 1087, 1095 (9th Cir. 2007) ("[I]dentical treatment is often not equal treatment with respect to disability discrimination."). Under this settled framework, a public entity must reasonably modify its policies, practices, or procedures when necessary to ensure meaningful access, unless doing so would fundamentally alter the nature of the program.

The *Crowder* court held that identical treatment is not enough: although Hawaii's quarantine applied equally to all, "its enforcement burdens visually-impaired persons in a manner different and greater than it burdens others," effectively denying them meaningful access while the program "remain[ed] open and easily accessible by others." 81 F.3d at 1484. Identical treatment, the court concluded, constituted disability discrimination. *Id.* at 1485.

McGary reached the same conclusion. The Ninth Circuit reversed dismissal of an ADA claim challenging a facially neutral nuisance abatement ordinance, holding that "facially neutral policies may violate the ADA when such policies unduly burden disabled persons, even when such policies are consistently enforced." 386 F.3d at 1265. The "very purpose" of the reasonable modifications requirement, the court explained, is to "guard against the facade of 'equal treatment' when particular accommodations are necessary to level the playing field." *Id.* at 1267.

That reasoning controls here. The PSA requires that services can only be provided at licensed service centers. However, individuals unable to leave their homes due to disability or disability-related barriers have no possibility of accessing the service centers. Therefore, although the PSA "applies equally to all persons" seeking such services, "its enforcement burdens [disabled] persons in a manner different and greater than it burdens others." *Crowder*, 81 F.3d at 1484. As such, the PSA "effectively denies these persons . . . meaningful access to state services, programs, and activities while such services, programs, and activities remain open and easily accessible by others." *Id.* Therefore, any argument that the PSA is valid "since non-disabled residents [are] also subject" to the service center requirement runs headlong into the Ninth Circuit's holdings. *McGary*, 386 F.3d at 1265. As the Ninth Circuit has "repeatedly recognized," identical treatment "may violate the ADA when such policies unduly burden disabled persons, even when such policies are consistently enforced." *Id.* Such is the case here.

A State does not satisfy Title II merely by offering services in a single, fixed location if that design predictably excludes individuals whose disabilities prevent them from traveling to or using that site. Where participation depends on attendance at a designated service center, individuals who cannot safely or feasibly travel because of mobility, health, or functional limitations are denied meaningful access unless the State reasonably modifies how and where services are delivered. The ADA squarely contemplates such modifications when necessary to avoid discrimination. 28 C.F.R. § 35.150(b)(1) (other methods of service delivery may include home visits, alternative sites); see also *Pierce*, 526 F.3d at 1221-22 (where program services were offered at an inaccessible site, County was required to consider, for example, reassignment of services to an alternative site); *Rodde v. Bonta*, 357 F.3d 988, 998 (9th Cir. 2004) ("While the disabled could theoretically seek service from the remaining facilities, the evidence [suggests] that the services designed for the general population would not adequately serve the unique needs of the disabled, who therefore would be effectively denied services that the non-disabled continued to receive.").

This principle is especially critical in health and social service systems, where disabled people already face substantial barriers to medical care and transportation. *See*, e.g., Mesmar, Amer et al., Bridging Healthcare Disparities: A Systematic Review of Healthcare Access for Disabled Individuals in Rural and Urban Areas, 5 *Frontiers Health Servs*. Art. 1695320 (Nov. 18, 2025), https://doi.org/10.3389/frhs.2025.1695320; Swendener, Alexis et al., Barriers to Health Care Among Rural Adults by Disability Status, 41 *J. Rural Health* 4 (Oct. 2025); Laura Barrie Smith et al., More Than One in Five Adults with Limited Public Transit Access Forgo Health Care Because of Transportation Barriers, *Urban Inst.* (Apr. 27, 2023), https://www.urban.org/research/publication/more-one-five-adults-limited-public-transit-access-forgo-health-care-because-transportation-barriers. When state programs impose rigid access conditions that align with and amplify these structural inequities, they deepen existing disparities rather than serving the public equitably. Reasonable modification is therefore not an extraordinary remedy; it is the ordinary mechanism by which public programs fulfill their civil rights obligations to disabled residents.

C. Legislative Judgment Does Not Establish Fundamental Alteration

As the Ninth Circuit has repeatedly held, the question is not whether a state must consider reasonable modifications to its laws. That question is settled. The question is whether a modification exists which would not result in a fundamental alteration. *Crowder*, 81 F.3d at 1485-86; *McGary*, 386 F.3d at 1269-70; *Townsend*, 328 F.3d at 516-18. A public entity is not required to modify its policies, programs, or procedures only when no reasonable modification exists. 28 C.F.R. § 35.130(b)(7). A modification is unreasonable if it would fundamentally alter the program. *Id.* Fundamental alteration is an affirmative defense, and defendants bear the burden of proof. *Dixon v. United States*, 548 U.S. 1, 3, 126 S. Ct. 2437, 2440 (2006); *Lamone*, 813 F.3d at 508; *Disabled in Action*, 752 F.3d at 202.

Here, Defendants have claimed that a modification to allow home-visits is unreasonable "because using or administering psilocybin outside of a licensed service center remains illegal under Oregon law," and the ADA "cannot be interpreted to mandate an expansion of the scope of the state's limited decriminalization of psilocybin." Def. Mot. to Dismiss at pp. 8, 11. Thus, Defendants argue that state law requirements cannot be modified, and any modification of a state law is a fundamental alteration. However, as explained above, the Ninth Circuit and several sister circuits have held that the ADA requires reasonable modification of state law. It cannot be that a state law is subject to reasonable modification, yet no modification of a state law is reasonable. Defendants appear to argue that because the Oregon legislature has only permitted services in service centers, any modification of the legislature's mandate is a fundamental alteration. However, the Ninth Circuit has expressly rejected this reasoning.

In *Crowder*, the Ninth Circuit observed that the District Court had held that the plaintiffs' proposed modifications were unreasonable "in light of the legislature's own consideration of the issue." 81 F.3d at 1485. However, the Ninth Circuit rejected such a defense, finding that "in virtually all controversies involving the ADA and state policies that discriminate against disabled persons, courts will be faced with legislative (or executive agency) deliberation." *Id.* The court's obligation is to ensure that the state's conclusions are valid under the ADA. *Id.* Otherwise," the court reasoned, "any state could adopt requirements imposing unreasonable obstacles to the disabled, and when hauled into court could evade the antidiscrimination mandate of the ADA merely by explaining that the state authority considered possible modifications and rejected them." *Id.*

In *Townsend*, the state argued that providing community-based care would fundamentally alter "the state legislature's considered policy decisions" to offer long-term care only in nursing homes. 328 F.3d at 518. The Ninth Circuit again rejected this defense, holding that "policy choices that isolate the disabled cannot be upheld solely because offering integrated services would change the segregated way in which existing services are provided." *Id.* at 519.

The Ninth Circuit's holdings align with its sister circuits. In *Nat'l Fed'n of the Blind v. Lamone*, for instance, the state argued that plaintiffs' requested modification of an online ballot marking tool amounted to a fundamental alteration because the state legislature had not approved it. 813 F.3d at 509. The Fourth Circuit held that the state failed to meet its burden in proving a fundamental alteration. *Id.* at 509-10. The court reasoned that "the strong form of defendants' argument — that the mere fact of a state statutory requirement insulates public entities from making otherwise reasonable modifications to prevent disability discrimination — cannot be correct." *Id.* at 509.

The case law makes clear that legislative findings do not foreclose reasonable modifications. While the ADA does not require public entities to abandon legitimate regulatory objectives, it does require that those objectives be pursued in ways that do not unnecessarily exclude disabled people. Here, Plaintiffs do not seek exemption from safety, training, supervision, or licensing standards. They seek flexibility in where services may be delivered when necessary to accommodate disability-related access needs. Public health systems routinely deliver regulated services outside of fixed facilities, including through mobile clinics, home-based care, and community-based service models, while maintaining rigorous safety protocols.

Thus, allowing reasonable modifications to service location does not inherently conflict with regulatory integrity. It reflects a widely accepted approach to delivering health-related services equitably, particularly for individuals whose disabilities make fixed-site models inaccessible. See *Helen L.*, 46 F.3d 325, 335 (providing services at a disabled person's home did not fundamentally alter the State's program).

III. Ensuring Equal Access to Psilocybin Services Serves Critical Palliative Care Needs

Access to psilocybin-assisted therapy carries particular importance for individuals facing serious or terminal illness, further underscoring the need for accessible service delivery models. A growing body of clinical research demonstrates that psilocybin therapy can provide significant benefits for individuals experiencing end-of-life distress

— including reductions in depression, anxiety, and existential suffering[2] — and confirms the feasibility and safety of delivering such therapy in home settings.[3]

The therapeutic effects of psilocybin are directly relevant to palliative care. Individuals with life-threatening disabilities frequently experience profound psychological and emotional distress that is not fully addressed by conventional medical interventions. Psilocybin-assisted therapy has been shown to improve quality of life, enhance a sense of meaning and peace, and reduce fear associated with dying. For many patients, these outcomes are central to receiving humane and comprehensive care at the end of life.

Amici's experiences underscore this point. For example, Amicus End of Life Psychedelic Care shares the story of "Jerry" — who has lived with quadriplegia for 32 years after a water-skiing accident and would not have been able to access care in a center-based setting due to his disability. Two years ago, debilitating pain led Jerry to consider ending his life. Instead, he chose to work with psilocybin through Psanctuary Church's Sacred Passages program, receiving care at home (outside Oregon). The results

---

[2] See, e.g., P. D. Petridis et al., *Psilocybin-Assisted Psychotherapy Improves Psychiatric Symptoms Across Multiple Dimensions in Patients with Cancer*, 2 Nature Mental Health 1408 (2024), https://doi.org/10.1038/s44220-024-00331-0; D. E. Johnson & J. D. Rosenblat, *Psilocybin-Assisted Psychotherapy as an "Anti-Distressant" with Multidimensional Properties*, 2 Nature Mental Health 1275 (2024), https://doi.org/10.1038/s44220-024-00332-z; C. L. Raison et al., *Single-Dose Psilocybin Treatment for Major Depressive Disorder: A Randomized Clinical Trial*, 330 JAMA 843 (2023), https://doi.org/10.1001/jama.2023.14530; E. Whinkin et al., *Psilocybin in Palliative Care: An Update*, 12 Current Geriatrics Reports 50 (2023), https://doi.org/10.1007/s13670-023-00383-7; G. M. Goodwin et al., *Single-Dose Psilocybin for a Treatment-Resistant Episode of Major Depression*, 387 New England Journal of Medicine 1637 (2022), https://doi.org/10.1056/NEJMoa2206443; M. M. Sweeney et al., *Comparison of Psychedelic and Near-Death or Other Non-Ordinary Experiences in Changing Attitudes About Death and Dying*, 17 PLoS One e0271926 (2022), https://doi.org/10.1371/journal.pone.0271926; C. L. Yu et al., *Psilocybin for End-of-Life Anxiety Symptoms: A Systematic Review and Meta-Analysis*, 18 Psychiatry Investigation 958 (2021), https://doi.org/10.30773/pi.2021.0209; R. R. Griffiths et al., *Psilocybin Produces Substantial and Sustained Decreases in Depression and Anxiety in Patients with Life-Threatening Cancer: A Randomized Double-Blind Trial*, 30 J. Psychopharmacology 1181 (2016), https://doi.org/10.1177/0269881116675513.

[3] Federico Seragnoli et al., *Psychedelic-Assisted Therapy for Palliative Care Within a Home Treatment Setting: A Case Report*, 12 Clinical Case Reports e9305 (2024), https://doi.org/10.1002/ccr3.9305 (case study describing the feasibility and safety of psychedelic-assisted therapy as a home-based intervention for a patient with throat cancer experiencing significant existential distress).

have been profound: his desire to die has lifted, his pain is now manageable, and his quality of life has greatly improved. He has found peace with death, met a partner, and now lives with joy and love, for himself and for all others.

Jerry's experience is not isolated. Amicus Anne Hamilton, founder of the Survivorship Collective and a cancer survivor, has described the profound psychological distress that can persist even after successful treatment, including debilitating fear of recurrence despite comprehensive conventional care. After exhausting traditional supports, Hamilton turned to psilocybin-assisted therapy, which she reports enabled her to confront her mortality and achieve a sustained sense of peace. Drawing on both her personal experience and her professional work supporting other cancer patients, Hamilton founded the Survivorship Collective to expand access to safe, supported psilocybin-assisted therapy. Her experience underscores that these benefits depend on care models that can be tailored to patients' medical and psychological needs — including, where necessary, delivery outside of fixed service-center settings.

Oregon's decision to authorize regulated psilocybin services reflects recognition of these potential benefits. However, the value of this therapeutic option depends on whether it is actually accessible to those who need it most. Individuals with life-threatening disabilities are among those least able to travel to licensed service centers due to pain, fatigue, medical fragility, or mobility limitations. As a result, the very population for whom psilocybin therapy may be most beneficial is effectively excluded by rigid service-location requirements.

This exclusion has real-world consequences. Amicus Marne Lucas, a Portland-based end-of-life doula, shares the story of "Doug," a client with cancer who sought to participate in this litigation because the PSA prohibited him from working with a licensed facilitator for a psilocybin end-of-life journey at home. Doug's declining health made travel to a facility impossible. Tragically, Doug died before this case could be resolved. His exclusion from the PSA is not hypothetical.

Outcomes like Doug's are precisely what the ADA was designed to prevent. A public program that offers meaningful benefits cannot be administered in a manner that systematically denies access to disabled individuals. *See* 28 C.F.R. § 35.130(b)(7). Where in-home or alternative-site delivery would allow qualified individuals to safely receive psilocybin services, the ADA requires that such modifications be considered.

Importantly, expanding access through reasonable modification would not undermine the State's regulatory objectives. Psilocybin services can be delivered pursuant to the same training, supervision, and safety protocols regardless of location, as is true in many other areas of health care. Indeed, home-based delivery models are widely used in palliative care precisely because they accommodate the needs of individuals who cannot access facility-based services.[4]

Ensuring access to psilocybin therapy for individuals with serious illness is therefore consistent with both public health principles and the ADA's mandate of meaningful access. It allows the State to deliver on the therapeutic promise of its program while avoiding disability-based exclusion. Conversely, maintaining rigid service-location requirements without accommodation denies disabled individuals access to a potentially transformative form of care at the moment when that care matters most.

IV. Ensuring Equal Access To Palliative Care Is Especially Critical In Jurisdictions That Have Legalized The Prescribing And Use Of Lethal Medication For People With Terminal Illness.

The need for meaningful access to palliative and supportive care services is particularly acute in jurisdictions like Oregon, where the prescription and use of lethal medication is legal and comparatively accessible. Or. Rev. Stat. §§ 127.800–127.897. In such settings, barriers that prevent disabled people from accessing comprehensive palliative operate within a system that simultaneously holds one end-of-life pathway open

---

[4] *See*, e.g., Sophie Pask et al., Models, Components and Outcomes of Palliative and End-of-Life Care Provided to Adults Living at Home: A Systematic Umbrella Review of Reviews, *Palliative Med.* (2025); D.R. Ferreira & P.R. Pimentel, Enhancing End-of-Life Care with Home-Based Palliative Interventions: A Systematic Review, 68 *J. Pain & Symptom Mgmt.* e356 (Nov. 2024); Benjamin Roberts et al., Home Based Palliative Care: Known Benefits and Future Directions, 10 *Current Geriatrics Rep.* 208 (2021).

— effectively channeling disabled people toward assisted death not by choice, but by default.

Title II's mandate of meaningful access applies with full force to health care systems that offer a range of end-of-life care options. Where the State facilitates access to death while failing to ensure equally accessible palliative care, it risks creating a structurally imbalanced and discriminatory system. If disabled individuals cannot access palliative care services due to mobility limitations, transportation barriers, or rigid service-delivery requirements, while other end-of-life options remain readily available, the State has failed to provide equal access to its health care system as a whole.

Ensuring equal access to palliative care is essential to preserving genuine autonomy in the dying process. Choice, in any meaningful sense, requires that options be equally accessible. The Supreme Court recognized this principle in *Olmstead v. L.C.,* holding that unjustified isolation from community life is itself a form of discrimination under the ADA. 527 U.S. 581, 597 (1999). That reasoning applies with equal force here: where one end-of-life pathway is functionally foreclosed by disability-related barriers, a disabled person's decision cannot be understood as fully voluntary. When disabled individuals have meaningful access to palliative care — including services delivered in their homes where necessary — they are able to make end-of-life decisions based on preference rather than constraint.

The State's obligation under Title II is not to favor any particular end-of-life outcome. It is to ensure that disabled people have equal access to the full spectrum of legally available care. Failure to provide such access risks not only discrimination, but the preventable loss of life. That result is fundamentally incompatible with the ADA's purpose of ensuring that disabled people can participate fully and equally in all aspects of public life, including decisions about their own medical care.

V. Permitting States to Enforce Inaccessible Statutes Without Modification Would Undermine the ADA Across Public Health and Social Service Systems

If state statutes are deemed categorically immune from reasonable modification, the implications would extend far beyond this case. States could effectively bypass ADA obligations in Medicaid service delivery, housing assistance, public benefits, court access, and educational programs — precisely the systems on which disabled people rely most heavily for equal participation in public life. Any access barrier could be preserved simply by legislative enactment, rendering Title II protections hollow in precisely the systems where disabled people rely most heavily on public services. The Supremacy Clause does not permit that result. U.S. Const. art. VI, cl. 2. States have no authority to insulate exclusionary programs from federal civil rights law simply by the act of legislative codification — yet that is precisely the rule Defendants urge. If accepted, it would allow any state to hollow out Title II across the full range of public programs by embedding access barriers in statutes rather than agency rules.

VI. Plaintiffs Seek Only What the ADA Already Guarantees: Access to Public Programs Through Reasonable Modification

It is important to emphasize the limited nature of the relief Plaintiffs seek. They do not ask the Court to mandate specific service models or to eliminate regulatory oversight. They ask only that the State comply with the ADA by permitting reasonable modifications when necessary to ensure access – specifically the ability to receive services at home.

Under Plaintiffs' requested relief, eligibility requirements remain intact, safety standards remain enforceable, and individualized assessments of reasonableness remain available to address any specific modification request. What would change is that disability-related access needs could no longer be categorically excluded from consideration. That is not an expansion of ADA doctrine; it is the doctrine as it has always existed.

CONCLUSION

Because Defendants' refusal to permit any modification of service location conflicts with Title II's guarantee of meaningful access, Plaintiffs are entitled to summary judgment as a matter of law.

Dated: April 22, 2026

/s/ Maria Michelle Uzeta

Maria Michelle Uzeta, pro hac vice
Cal. Bar No. 164402
DISABILITY RIGHTS EDUCATION
AND DEFENSE FUND
3075 Adeline Street, Suite 210
Berkeley, CA 94703
Tel: (510) 644-2555
muzeta@dredf.org

Attorneys for Amici Curiae

Emily Cooper, OSB #182254
DISABILITY RIGHTS OREGON
511 SW 10th Avenue, Suite 200
Portland, Oregon 97205
Tel: (503) 243-2081
ecooper@droregon.org

Local Counsel for Amici Curiae

CERTIFICATE OF COMPLIANCE

This brief complies with the applicable word-count limitation under LR 7-2(b), 26-3(b), 54-1(c), or 54-3(e) because it contains 6206 words, including headings, footnotes, and quotations, but excluding the caption, table of contents, table of cases and authorities, signature block, exhibits, and any certificates of counsel.

Dated: April 22, 2026

/s/ Maria Michelle Uzeta

Maria Michelle Uzeta, pro hac vice
Cal. Bar No. 164402
DISABILITY RIGHTS EDUCATION
AND DEFENSE FUND
3075 Adeline Street, Suite 210
Berkeley, CA 94703
Tel: (510) 644-2555
muzeta@dredf.org

Attorneys for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that on April 22, 2026, an electronic copy of the foregoing [PROPOSED] AMICI CURIAE BRIEF OF DISABILITY RIGHTS EDUCATION AND DEFENSE FUND AND SIXTEEN OTHERS IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT was filed with the Clerk of Court for the United States District Court for the District of Oregon using the Court's CM-ECF system. The participants in this case are registered CM/ECF users and were served through the Notice of Electronic Filing.

Dated: April 22, 2026

/s/ Maria Michelle Uzeta

Maria Michelle Uzeta, pro hac vice
Cal. Bar No. 164402
DISABILITY RIGHTS EDUCATION
AND DEFENSE FUND
3075 Adeline Street, Suite 210
Berkeley, CA 94703
Tel: (510) 644-2555
muzeta@dredf.org

Attorneys for Amici Curiae