MONASH University

CLINICAL PRACTICE GUIDELINE FOR THE APPROPRIATE USE OF METHYLENEDIOXYMETHAMPHETAMINE (MDMA)-ASSISTED PSYCHOTHERAPY FOR POST-TRAUMATIC STRESS DISORDER

Summary of Recommendations
and Good Practice Statements

Suggested citation

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Publisher

Monash University, Parkville, Australia

Funding

This Guideline was supported by philanthropic funding to the Neuromedicines Discovery Centre, Faculty of Pharmacy and Pharmaceutical Sciences, Monash University. Funding to develop the Guideline was also provided by Monash University, the University of Melbourne, and The Florey Institute of Neuroscience and Mental Health. The philanthropic donor had no role in the design, data collection and analysis, decision to publish, or preparation of the Guideline.

Disclaimer

This document is a general guide for appropriate use and practice, to be followed subject to a clinician or healthcare professional's judgement and the preferences and values of the person living with diagnosed post-traumatic stress disorder. The Guideline is designed to provide information to assist decision-making and is based on the best available evidence up until 20 February 2025.

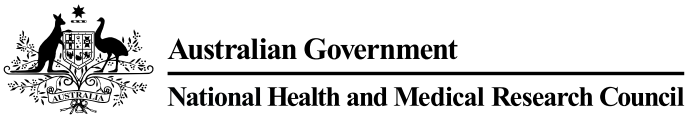
Acknowledgements

We are grateful to all members of the Expert and Stakeholder Groups for generously sharing their time, experiences, and insights. We also acknowledge and thank people living with mental health conditions, their carers, and support groups who contributed their experience and expertise to help ensure the Guideline is relevant to people living with mental health conditions.

External reviewers have contributed their time and expertise to provide independent feedback and review on the Guideline. This includes organisations and individuals who provided submissions and responses to the public consultation and NHRMC-nominated independent reviewers.

Organisations endorsing this guideline

Publication Approval



The guideline recommendations were approved by the Chief Executive Officer of the National Health and Medical Research Council (NHMRC) on 22 December 2025 under section 14A of the *National Health and Medical Research Council Act 1992*. In approving the guideline recommendations, NHMRC considers that they meet the NHMRC standard for clinical practice guidelines. This approval is valid for a period of five years.

NHMRC is satisfied that the guideline recommendations are systematically derived, based on the identification and synthesis of the best available scientific evidence, and developed for health professionals practising in an Australian health care setting.

This publication reflects the views of the authors and not necessarily the views of the Australian Government.

CONTENTS

PURPOSE OF GUIDELINE

The Guideline has been developed to support evidence-based use of Methylenedioxymethamphetamine (MDMA)-assisted Psychotherapy (MDMA-AP) for people living with diagnosed PTSD. In Australia, patients can access MDMA-AP in specific private specialist clinics. However, the efficacy of specific MDMA products has not yet been established through the routine drug approval pathway. This Guideline is intended to support clinical use. The Guideline has been developed to support clinicians in understanding the existing evidence, and deliver appropriate care, while also supporting patients to make informed decisions about MDMA-AP treatment.

Specifically, the objectives of this Guideline are to:

- Provide clinicians with evidence-based recommendations
- Provide people living with PTSD and their carers with clear, accessible, and evidence-based information about MDMA-AP for diagnosed PTSD treatment
- Highlight current gaps in knowledge and propose directions for future research

The full Guideline can be found online at https://app.magicapp.org/#/guideline/Ee438n

SCOPE OF GUIDELINE

The Guideline relates to the medical use of MDMA-AP under the Authorised Prescriber scheme in Australia. The Guideline does not provide guidance in relation to the overall management of PTSD. This Guideline should be read in conjunction with other evidence-based resources related to the management of PTSD.

The Guideline addresses the clinical question “In people living with PTSD, should we use MDMA-AP or no MDMA-AP (other or no treatment)?”.

The Guideline focuses on the safety and efficacy of MDMA-AP in adults (aged 18 years and over) living with PTSD. The evidence review process did not identify any evidence relating to the use of MDMA-AP in people aged under 18 years.

The use of MDMA outside of clinical settings for PTSD is illegal in Australia. MDMA obtained illicitly is often of unknown dose and purity and might result in harm or death. Possession, manufacture, or supply of MDMA without authorisation is a legal offence. Under the current approval framework, MDMA-AP in Australia should only occur in controlled conditions, under the supervision of an authorised psychiatrist, and with close monitoring for efficacy and safety.

What the Guideline does not address

This Guideline does not address the use of MDMA as a stand-alone treatment without psychotherapy.

The Guideline is focused solely on the use of MDMA-AP for PTSD and does not extend to other mental health conditions such as depression, anxiety disorders, obsessive-compulsive disorder, substance use disorders, or eating disorders. The use of MDMA-AP in the context of end-of-life or palliative care is beyond the scope of this Guideline. The Guideline is not intended to address the quality and regulatory requirements in the manufacturing, processing, procurement, storage, or supply of the active pharmaceutical ingredients and finished product related to MDMA.

Target Audience

The Guideline is mainly intended for clinicians, including general practitioners, nurses, pharmacists, psychiatrists, psychologists, therapists, and other medical/allied health professionals involved in the management of PTSD. The Guideline will be supported by a Companion Guide produced in a concise and easily accessible format for people living with PTSD, carers, family members, other support persons, and members of the public. A Guideline implementation and dissemination plan has been developed in consultation with various stakeholders.

Updating the Guideline

We intend that the Guideline will be updated within five years or earlier if and when new evidence emerges that is likely to impact or change one or more of the recommendations. The update of the Guideline will include a systematic search of new primary studies. The Evidence Review Team will review the new evidence. If the evidence is deemed likely to change the strength or direction of the recommendations, the Guideline Development Group will be convened for decision-making. The Guideline has been developed on the MAGICapp platform, which facilitates updates if required.

SUPPORTING MATERIALS TO IMPLEMENT THE GUIDELINE

To support the implementation and dissemination of the Guideline, Monash University will develop the following resources.

COMPANION GUIDE

The Companion Guide will be written in an easily accessible language for people impacted by post-traumatic stress disorder. This includes people living with PTSD, their carers, and families. The Companion Guide is also for the wider public. Health and care professionals may find the Companion Guide useful for shared decision-making.

ALIGNMENT WITH OTHER GUIDELINES OR GUIDANCE DOCUMENTS

This Guideline is intended to complement existing guidance on PTSD and psychedelic-assisted therapies (PAT). It should be read in conjunction with other relevant guidelines, memorandums, and guidance documents, including but not limited to:

- Australian Guidelines for the Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex PTSD [1]
- Royal Australian and New Zealand College of Psychiatrists (RANZCP) Clinical Memorandum: Therapeutic use of MDMA for PTSD and psilocybin for treatment resistant depression [2]
- Australian Psychological Society's Position Statement [3]
- Authorised Prescriber Scheme: Guidance for medical practitioners, Human Research Ethics Committees, specialist colleges and sponsors [4]
- Therapeutic Goods (Standard for MDMA) (TGO 112) Order 2024 [5]
- Therapeutic Goods Administration: MDMA and psilocybine hub (includes information for consumers, psychiatrists, pharmacists, MDMA sponsors and manufacturers)
- Therapeutic Goods Administration: Becoming an authorised prescriber for unapproved therapeutic goods in Australia
- Therapeutic Goods Administration: Access to MDMA (3,4-methylenedioxymethamphetamine) and psilocybin for therapeutic purposes- Information for psychiatrist prescribers
- Checklist for prescribing psychiatrists of MDMA and psilocybine (key obligations for psychiatrists applying Authorised Prescriber scheme)

Legislation may differ across states or territories. Local regulations or governance frameworks should be referred to, including:

- ACT - https://www.act.gov.au/health/prescribing-controlled-and-monitored-medicines/prescribing-or-supplying-psychedelic-medicines
- NSW - https://www.health.nsw.gov.au/pharmaceutical/Pages/psilocybine-and-mdma.aspx

- NT - https://health.nt.gov.au/professionals/medicines-and-poisons-control2/medical-practitioners-schedule-8-medicines
- QLD - https://www.health.qld.gov.au/__data/assets/pdf_file/0028/1246780/mpa-s8-mdma-S8-psilocybine.pdf
- SA - https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/conditions/medicines/mdma+and+psilocybine
- TAS - https://www.health.tas.gov.au/health-topics/medicines-and-poisons-regulation/medicines-and-poisons-regulation-information-health-professionals
- VIC - https://www.health.vic.gov.au/public-health/schedule-8-mdma-and-schedule-8-psilocybine
- WA - https://www.health.wa.gov.au/Articles/J_M/monitored-medicines/esketamine-MDMA-and-psilocybine

BACKGROUND

What is Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is a group of stress- and trauma-related reactions that can develop after exposure to an actual or threatened horrific event or series of events. Traumatic events that may lead to PTSD include motor vehicle accidents, serious injuries, crime, sexual assault, natural disasters, terrorism, war, domestic violence, and emotional abuse [1][6]. DSM-5 and ICD-11 diagnostic criteria characterise PTSD by symptom clusters including re-experiencing the traumatic event or events (e.g., intrusive memories, flashbacks, nightmares), avoidance of reminders, and a persistent sense of current threat (e.g., hypervigilance, alterations in arousal or reactivity). The DSM-5 additionally describes negative alterations in cognition and mood (e.g., persistent negative beliefs, emotional numbness).

PTSD has a considerable impact on daily functioning [7] and may be associated with suicidal ideation [8], chronic disease [9][10][11], and premature death [12]. People living with PTSD also frequently struggle with alcohol and drug use [13], which may create additional challenges for managing the disorder.

It has been estimated that up to 11% of Australians will experience PTSD in their lifetime [14]. Women are at almost twice the risk of men (14% and 8% respectively) [15], while people who experience homelessness, refugees, people experiencing domestic violence, LGBTQIA+ people, First Nations people, and certain occupation groups (emergency services, armed forces, and veterans) are at higher risk of experiencing PTSD in their lifetime [1].

Treatments for PTSD

The Australian Guidelines for the Treatment of Acute Stress Disorder, Post-traumatic Stress Disorder, and Complex PTSD provide “strong recommendations” for several psychological interventions for treating PTSD, including cognitive processing therapy (CPT), cognitive therapy (CT), eye movement desensitisation and reprocessing (EMDR), prolonged exposure (PE), and trauma-focused cognitive behavioural therapy (TF-CBT) [1]. These guidelines also include “conditional recommendations” for other psychological interventions such as guided internet-based trauma-focused CBT, narrative exposure therapy, present-centred therapy, stress inoculation training, and group-based TF-CBT. For pharmacological interventions, the guidelines provide “conditional recommendations” on the use of selective serotonin reuptake inhibitors (SSRIs) (e.g., sertraline, paroxetine, fluoxetine) and serotonin and noradrenaline reuptake inhibitors (SNRIs) (e.g., venlafaxine).

What is MDMA

3,4-methylenedioxymethamphetamine (MDMA) is a synthetic psychoactive compound that increases feelings of empathy or connectedness with others. MDMA is chemically related to amphetamine and mescaline; however, it produces a distinct combination of effects that differ from classical psychedelics such as psilocybin, lysergic acid diethylamide (LSD), dimethyltryptamine (DMT), and mescaline. MDMA is classified as an empathogen (enhancing feelings of empathy or social connectedness with others) and entactogen (increasing introspection and self-awareness) [16][17]. MDMA primarily acts by increasing the release of serotonin, noradrenaline, and dopamine in the brain, and it also stimulates the release of oxytocin, a hormone associated with social bonding [18][19]. Similar to other psychedelics, MDMA has been described as a 'psychoplastogen' due to effects on increased neuroplasticity facilitated by upregulation of brain-derived neurotrophic factor (BDNF) which may produce long lasting, positive behavioural changes [18][20]. MDMA is a racemate in which the S-(+) enantiomer causes the psychostimulant and empathogenic effects and the R-(-) enantiomer the hallucinogenic effects [21].

Unlike other currently approved medications for PTSD, such as SSRIs and SNRIs, MDMA is not administered as a daily medication. SSRIs act by inhibiting the reuptake of serotonin at the synapse, thereby increasing serotonergic activity, while SNRIs inhibit the reuptake of both serotonin and norepinephrine, leading to increased synaptic concentrations of these neurotransmitters [22]. Both SSRIs and SNRIs are characterised by a delayed onset of clinical improvement, typically taking several weeks, with longer term effects on synaptic plasticity gradually emerging with chronic administration [23]. MDMA causes the release and inhibits reuptake of serotonin, norepinephrine and dopamine [24], it also binds to presynaptic transporters, primarily The Serotonin Transporter (SERT), to rapidly induce neurotransmitter release into the synaptic cleft [25][26] which might underpin its subjective effects of empathy, emotional openness and interpersonal closeness [21][27]. It also has affinity for 5-HT2A and 2C receptor subtypes which may contribute to its psychoactive effects [28]. Its dopaminergic effects caused by expediting the release of and inhibiting dopamine reuptake has been suggested to increase the feeling of euphoria and increased energy [29]. Finally, MDMA's noradrenergic effects are likely to contribute to its effects on heart rate and blood pressure [30].

Regulatory landscape of MDMA

To date, no MDMA-containing product has been approved by any regulatory agencies worldwide. Following the Breakthrough Therapy Designation for MDMA-assisted psychotherapy (MDMA-AP) by the US Food and Drug Administration (FDA) in 2017, Lykos Therapeutics filed a new drug application for MDMA-AP to be used for adults with PTSD, which was granted a Priority Review by the FDA on 9 February 2024 [31]. However, the application was rejected as of 9 August 2024, with the FDA requesting additional Phase 3 trials to further investigate MDMA's safety and efficacy [32].

In July 2023, the Australian Therapeutic Goods Administration (TGA) rescheduled MDMA and psilocybin from prohibited (Schedule 9) to controlled (Schedule 8) drugs for the treatment of PTSD and treatment resistant depression, respectively [33]. This change permitted authorised psychiatrists to prescribe MDMA and psilocybin for these conditions outside of the clinical trial setting. To be an Authorised Prescriber, a psychiatrist is required to develop a clinical treatment protocol and obtain approval from a human research ethics committee [4]. The treatment protocol is required to include the clinical justification, evidence for use, monitoring of efficacy and safety, participant selection, consent process, and psychotherapy [4].

However, there are currently no MDMA products included in the Australian Register of Therapeutic Goods. This means the efficacy of specific MDMA products has not been established through the routine drug approval pathway. Hence, there is a need for a clinical practice guideline to systematically examine the available evidence, consider potential benefits and risks, and provide clear guidance on its potential use.

MDMA-assisted psychotherapy

In clinical settings, MDMA is not administered as a stand-alone therapy; instead, MDMA is administered alongside psychotherapy. Psychotherapy commonly refers to any psychological service provided by a trained mental health professional that "primarily uses forms of communication and interaction to assess, diagnose, and treat dysfunctional emotional reactions, ways of thinking, and behavior patterns" [34].

During MDMA-AP, the acute pharmacological effects of MDMA create a unique psychological state that is thought to facilitate the therapeutic process by reducing defensiveness and the fear of emotional injury when discussing and processing traumatic experiences. The prosocial effects of MDMA have been shown to increase positive psychological and neural responses to social stimuli (e.g. happy faces) while decreasing response to negative stimuli (e.g. sad or angry faces) [35][36]. Additionally, MDMA modulates activity in brain regions implicated in emotional processing such as the amygdala, hippocampus and medial prefrontal cortex (mPFC), which is believed to enhance fear extinction and memory reconsolidation - the 'unlearning' of fearful memories associated with trauma [18].

To date, most published trials, including phase 3 randomised controlled trials (RCTs), have used a manualised therapeutic approach developed by the Multidisciplinary Association for Psychedelic Studies (MAPS) [37]. This approach was described as fundamentally "non-directive", with the therapist acting as an "non-invasive empathetic witness" to facilitate the patient's "innate capacity to heal from the wounds of trauma". The MAPS manual discussed other considerations in supporting the patient through MDMA-AP, including creating a safe and conducive physical setting, therapeutic use of music, and use of "nurturing touch", focused bodywork, and breathing techniques to support healing of somatic manifestations of trauma. Although described as standardised, the manual was described as being flexible, to allow therapists to "apply their own intuition and training" [37]. However, this flexibility has been described as a possible challenge for achieving standardisation and replicability across studies, especially when the therapists may have diverse training and backgrounds, and may opt to use techniques from a range of therapeutic modalities. This so-called "inner directed method" has not been investigated alone for PTSD and is not a treatment option recommended in current Australian PTSD treatment guidelines [1]. There are ongoing clinical trials evaluating the use of MDMA as an adjunct to established evidence-based psychotherapies, such as PE (NCT05709353, NCT06117306) and CPT (NCT05067244, NCT05837845).

Based on Lykos' Phase 3 clinical trial protocols, an MDMA-AP treatment course typically consisted of three phases: **preparatory, dosing, and integration sessions (Figure 1).**

- **Preparatory sessions:** The preparatory sessions involved building a therapeutic alliance and trust, preparing patients in terms of both expectations of MDMA-AP ("set") and logistics of dosing sessions, and providing guidance on managing memories and emotions that may arise during treatment. The Phase 3 trials used 3 preparatory sessions, each of 90 minutes duration.
- **Dosing sessions:** Phase 3 trial protocols used three 8-hour dosing/medication sessions. During the first dosing session, participants received 80mg of MDMA (as per Phase 3 clinical trial protocol), followed by a supplemental dose of 40 mg if the initial dose was well-tolerated and not declined by the patient. During the second and third dosing sessions (spaced ~1 month apart), the dose was escalated to 120mg (if well-tolerated and not declined), followed by a supplemental dose of 60mg. In the clinical trials, most participants stayed overnight at the study site, but some went home with a support person.
- **Integration sessions:** Each dosing session was followed by three integration sessions that were spaced approximately 1 week apart. The first integration session typically took place in the morning after the dosing session. These sessions helped participants understand and incorporate their experiences during the dosing sessions, and generalise these learnings into their everyday life. The therapeutic approach during integration was described as a "non-directive approach [which] pertains to inviting inquiry and providing suggestion rather than directing the participant in the therapeutic approach" in the Phase 3 clinical trial protocol. In the Phase 3 clinical trials, the entire treatment protocol involved **42 hours of contact time** with healthcare professionals (psychiatrists, psychologists, or therapists), including three preparatory sessions (1.5 hours each), three dosing sessions (8 hours each), and nine integration sessions (1.5 hours each).

In the control group, the intervention mirrored the treatment group, but MDMA was replaced by either an active or inactive placebo. In some Phase 2 trials, a low MDMA dose (25–40 mg) served as an active placebo to enhance the blinding effect.

Most published clinical trials on MDMA-AP for PTSD followed the process outlined above, with some variations in the MDMA dosage, the number of dosing and integration sessions, and the types of placebo used in the control group.

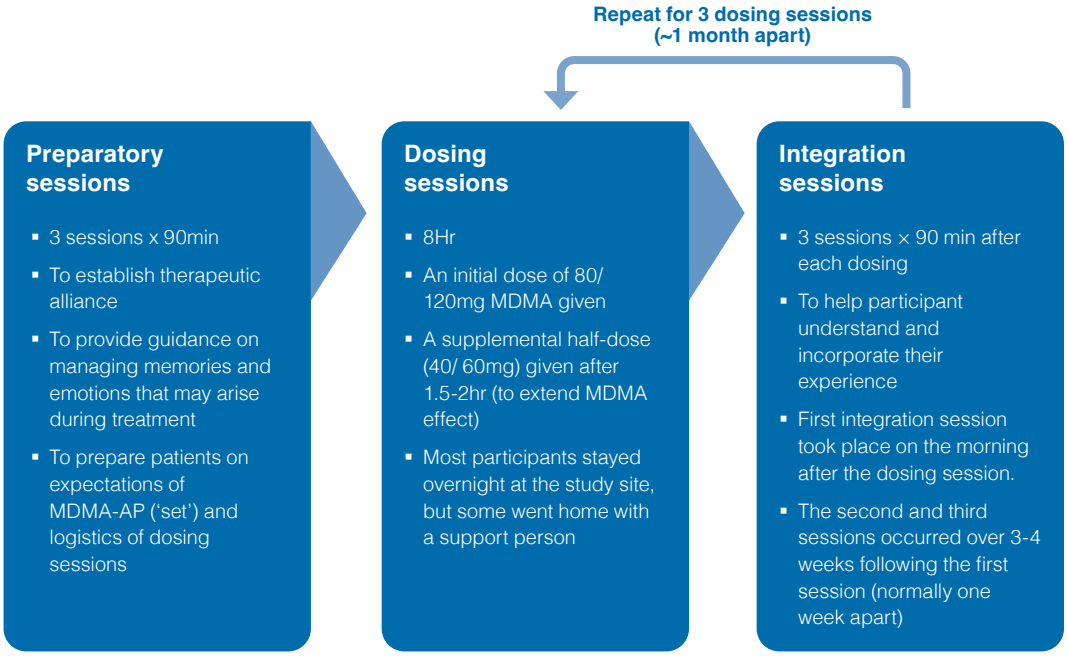


Figure 1. Treatment process of MDMA-AP based on Phase 3 clinical trial protocols.

Provision of care

Currently, MDMA-AP is mostly provided in private clinics. MDMA-AP is prescribed by a psychiatrist who is approved by the TGA under the Authorised Prescriber Scheme. The delivery of psychotherapy is provided by trained mental health professionals, including psychiatrists, psychologists, or therapists.

MDMA-containing product has not been assessed by the TGA for quality, safety, or efficacy, and is not listed on the Australian Register of Therapeutic Goods (ARTG). It is the responsibility of the sponsors of MDMA products to obtain pharmaceutical-grade MDMA that complies with therapeutic goods orders (TGOs) and all other relevant standards. More information on the sponsors and the quality guidance of the product can be found on the TGA website.

CONSIDERATION OF ISSUES FOR SPECIFIC POPULATION GROUPS

This Guideline has been developed with a strong emphasis on inclusivity, recognising that population groups such as Aboriginal and Torres Strait Islander peoples, individuals from culturally and linguistically diverse (CALD) backgrounds, people living in rural and remote areas, and veterans and emergency service workers, may be disproportionately affected by trauma and face unique challenges in accessing mental healthcare.

An umbrella review of 33 systematic reviews identified being female, of Indigenous heritage (in the United States of America), and low socioeconomic status as key sociodemographic risk factors for developing PTSD [38]. However, to date, there has been limited research on the safety and efficacy of MDMA-AP in the interest groups outlined in this Guideline. A systematic review of psychedelic studies (including 1393 participants) reported that 85% were identified as non-Hispanic White [39]. There is also a lack of data relating to the pharmacokinetics, pharmacodynamics, and safety of MDMA-AP in non-White, minority, and vulnerable population groups. Where possible, the Guideline Development Group (GDG) has considered issues related to delivery of MDMA-AP in these population groups as part of the Evidence-to-Decision framework, particularly in the domains of values and preferences, equity, acceptability, and feasibility. This Guideline aims to promote safe, equitable, and culturally-responsive care in the use of MDMA-AP for PTSD.

Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples have been reported to be three times more likely than other Australians to experience potentially harmful traumas and develop PTSD, with a 12-month prevalence of PTSD at 13.3% [40]. The delivery of MDMA-AP to Aboriginal and Torres Strait Islander peoples should be grounded in an understanding of the diverse cultural perspectives of Aboriginal and Torres Strait Islander peoples.

Classical psychedelics have played a role in the rituals of specific Indigenous groups worldwide, used for healing, ceremonies, or other practices that foster a sense of collective belonging or aid in the transmission of cultural values and beliefs [41][42]. In recognition of these connections, it has been proposed that spiritual, existential, religious, and theological components be integrated in PAT to honour traditional knowledge systems and support cultural safety [42][43].

However, due to its distinct effects, MDMA is not typically considered a classical psychedelic. In Australia, the use of MDMA is not known to be a current practice among the Aboriginal and Torres Strait Islander peoples.

It is important that therapy offered to Aboriginal and Torres Strait Islander peoples is provided in a way that is culturally responsive. To ensure that MDMA-AP does not cause further inequity, treatment must be culturally safe and tailored to the community [44][45]. This requires authentic partnership with Aboriginal and Torres Strait Islander peoples in the development, implementation, monitoring, and evaluation of treatment protocols.

This Guideline should be used in tandem with other published resources and tools that support the mental healthcare of Aboriginal and Torres Strait Islander peoples, such as:

- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 [46]
- Aboriginal and Torres Strait Islander Peoples in Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder (2020) [47]
- Primary Health Networks (PHNs) and Aboriginal Community Controlled Health Organisations – Guiding Principles [48]
- Stolen Generations Collective Healing Initiatives Rounds 1–6: impacts and findings [49]
- Local or state guidelines and tools, such as the Aboriginal Mental Health Consultation Guideline [50], Aboriginal Mental Health Clinical Practice Guideline and Pathways [51]
- Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice [52]

Culturally and linguistically diverse (CALD) populations

There is limited recent data on the prevalence of mental health conditions among people from culturally and linguistically diverse (CALD) backgrounds in Australia. However, individuals from these communities may be at increased risk due to factors such as low socioeconomic status, underemployment, cultural or language barriers, housing distress, experiences of racism or discrimination, and limited access to mental health services [53]. Adults seeking asylum may be at particularly high risk, with studies suggesting asylum seekers are up to 10 times more likely to experience PTSD than the general population, with reported prevalence rates ranging from 37% to 77% [53].

The Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder highlight additional considerations while providing services to people from CALD backgrounds, particularly refugees and asylum seekers, including additional assessments, practices to facilitate engagement, and potential barriers to access mental healthcare [54].

The GDG recognised the importance of providing culturally responsive care. This may include, but is not limited to, providing information using culturally inclusive language; pairing patients with clinicians of the same ethnoracial background, particularly in cases involving race-based trauma; and creating a culturally inclusive environment for treatment sessions, such as through the setup of overnight rooms or the use of inclusive music [55][44][56].

The importance of training in cultural competency for clinicians has been described [57], as people may be especially physically and emotionally vulnerable during treatment sessions [58]. This necessitates high standards of cultural awareness and sensitivity when discussing issues related to race, gender, sexuality, and spirituality [59] [60]. The potential role of interpreters in MDMA-AP has not been explored in current research, and it is not clear to what extent interpreter use may impact therapeutic effectiveness and engagement.

Rural and remote areas

Living in rural and remote areas has been associated with lower use of mental health services [61]. Limited resourcing is considered a major barrier to care, in addition to complexity in using and navigating the system, technological limitations, distance to services, insufficient culturally-sensitive practice, and lower mental health literacy. Such systemic barriers can cause delays in accessing care and increase the associated cost [62].

There are workforce and other resource considerations associated with implementing clinical practice guideline recommendations in rural and remote areas. Travel and accommodation costs are inherent common barriers for many treatments, and are not unique to MDMA-AP. In developing the Guideline, resource, equity, and feasibility issues were considered as part of the Evidence-to-Decision framework.

Veterans and emergency service workers

Emergency services workers, military personnel, and members of the veteran community are among the occupational groups at highest risk of experiencing PTSD [63]. Cumulative exposure to work-related traumatic events is associated with increased risk of PTSD. In 2015, a survey reported that the estimated 12-month prevalence of PTSD among current serving members of the Australian Defence Force (ADF) was 8%, while the estimated prevalence among members who had transitioned from full-time service between 2010 and 2014 was 18% [1][64]. The prevalence of PTSD among emergency service workers based on the Answering the Call national survey was estimated at around 10% in Australia [65].

The Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder highlight that veterans often experience multiple (and repeated) traumatic exposures over prolonged periods [63]. Veterans may also experience unique challenges associated with transitioning into and out of military service, stigma surrounding seeking help for mental health conditions, poorer treatment responses to some PTSD therapies compared to civilians, and higher rates of comorbidity (e.g., substance use disorders, sleep disturbance, emotional numbing, physical symptoms including chronic pain) [63]. Similarly, the presentation of PTSD in emergency service workers may differ from the general

population due to the nature of repeated trauma exposure, resulting in different initial symptom presentation at diagnosis and delayed diagnosis [66]. It is also worth noting that PTSD is associated with increased risks of cardiovascular diseases (in both veterans and non-veterans), with reported hazard ratios as high as 46% [67][9][68]. Uncertainties remain about how these factors might influence both the overall safety and effectiveness of MDMA-AP in veterans and emergency service workers.

There may be stigma-related barriers associated with PAT among veterans. In one survey on the beliefs and perceived barriers regarding PAT among American service members and veterans (n=21), common stigma-related barriers identified were fear of workplace consequences (29%) and fear of judgment (24%) [69].

The need for tailored approaches that respect the core values, align with the communication styles, and enhance cultural awareness and understanding of potential barriers and clinical complexities has been described [70][71].

Autistic and ADHD individuals

Autistic and attention deficit hyperactivity disorder (ADHD) individuals experience significantly higher rates of exposure to potentially traumatic events and elevated prevalence of PTSD compared to the general population. International studies have reported that up to 70% of Autistic adults meet criteria for at least one mental health condition, with PTSD being among the most common [72]. Similarly, ADHD in adulthood is strongly associated with increased risk of trauma exposure, cumulative adversity, and subsequent PTSD [73]. These elevated risks are further compounded by frequent co-occurrence of depression, anxiety, and substance use disorders, as well as systemic barriers to appropriate diagnosis and care [74].

Autistic and ADHD individuals may face unique challenges in engaging with conventional psychological therapies for PTSD, due to differences in sensory processing, executive functioning, communication styles, and relational expectations [75][76]. These factors can influence how trauma is experienced, expressed, and processed in therapy. Reports of medical trauma, stigma, and invalidation are also common, further impacting trust and safety in therapeutic settings [77].

There is currently very limited research directly examining the safety, pharmacokinetics, or efficacy of MDMA-AP in Autistic and ADHD populations. Due to underrepresentation in clinical trials, evidence for safe and effective use of MDMA-AP cannot be confidently extrapolated to these groups. The GDG recognises that adaptations may be necessary to ensure accessibility and effectiveness of MDMA-AP for Autistic and ADHD individuals. These may include modifications to the sensory environment; the use of plain language and multimodal communication supports and additional scaffolding for executive functioning during preparation and integration. Clinicians providing MDMA-AP should be trained in autism- and ADHD-informed practice, and the design, delivery, and evaluation of treatment protocols should incorporate lived experience expertise.

SUMMARY OF RECOMMENDATIONS AND GOOD PRACTICE STATEMENTS

This Guideline has been developed using The Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach [78]. The types of recommendations in this Guideline are as follows:

Strong recommendation against: The Guideline Development Group is confident that the harms of an intervention outweigh its benefits. The intervention will likely not benefit most or all individuals.

Conditional recommendation against: The harms probably outweigh the benefits, but appreciable uncertainty exists. The intervention may not be suitable for all individuals. There is a need to carefully consider the individual patient's circumstances, preferences, and values.

Recommendation to use intervention only in research: There is to date insufficient evidence to support a decision for or against an intervention. Further research has large potential for reducing uncertainty about the effects of the intervention. Further research is considered to be of good value for the anticipated costs

Good practice statement: A good practice statement is an ungraded statement that represents the Guideline Development Group's view of optimal practice. Good practice statements are used in instances where high quality indirect evidence is available, however conducting a formal evidence review would not be a good use of resources.

Please refer to the full Guideline and supporting documents for more information.

RECOMMENDATIONS

Recommendation 1 (Conditional recommendation against)

For people living with PTSD, the Guideline Development Group does not recommend the routine use of MDMA- AP.

If MDMA-AP is used, it should be limited to adults (≥18 years old) who:

- have had PTSD symptoms for at least 6 months duration post-diagnosis,
- have moderate or severe PTSD symptoms in the past month (CAPS-5 total severity score ≥28),
- have received an adequate trial of first-line evidence-based treatments, and
- are not likely to be re-exposed to the index or other significant trauma during treatment.

Evidence from current clinical trials relates to a single course of MDMA-AP (3 dosing sessions, 80-120mg MDMA with optional supplemental half dose at each dosing).

Recommendation 2 (Only in research settings)

Do not use MDMA-AP for the treatment of PTSD outside of clinical trials with appropriate ethical approval in people less than 18 years old.

Recommendation 3 (Only in research settings)

Do not use MDMA-AP for the treatment of PTSD outside of clinical trials with appropriate ethical approval in people who 1) have not had PTSD symptoms for at least 6 months duration post-diagnosis; 2) did not have at least moderate PTSD symptoms in the past month (CAPS-5 total severity score ≥28); 3) have not received an adequate trial of first-line evidence-based treatments; or 4) are likely to be re-exposed to the index or other significant trauma during treatment.

Recommendation 4 (Strong recommendation against)

For people living with PTSD, the Guideline Development Group strongly recommends against the use of MDMA-AP in patient groups who have been excluded from existing clinical trials for safety reasons. These patient groups include but are not limited to those who are pregnant or breastfeeding, with cardiovascular disease (e.g., uncontrolled hypertension, cardiac arrhythmia), psychotic disorder, suicide-related distress (i.e., currently experiencing suicidal thoughts and/or behaviour), and people who are currently using medications that may interact with MDMA.

GOOD PRACTICE STATEMENTS

PRIOR TO INITIATING MDMA-AP

Good Practice Statement 1

People living with PTSD have varying values, preferences, and lived experiences that should be central to the planning and delivery of MDMA-AP. Trauma-informed, participatory, and culturally-responsive care should be planned using a shared decision-making approach between the clinicians and patients. Care should be responsive to the needs of individuals from diverse cultural backgrounds, neurodivergent communities, and other priority populations. Clinicians and services should apply core trauma-informed care principles, including safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, and recognition of cultural, historical, and gender issues. Integrating MDMA-AP into a trauma-informed model of service delivery ensures that treatment is provided in a way that minimises the risk of re-traumatisation, supports patient autonomy, and promotes healing within a safe and responsive therapeutic environment.

Good Practice Statement 2

Prior to initiating MDMA-AP, appropriate medical, psychiatric, psychological, financial, and social screening should be conducted by the treating psychiatrist to maximise potential benefits and minimise potential harms. Screening should include careful assessment of symptoms of dissociation and psychosis, substance use, trauma history, suicidal thoughts and self-harm risk, and potential contraindications related to cardiovascular, neurological, or psychiatric conditions. Given the risk of MDMA in causing prolonged QT interval and increased blood pressure, an ECG should be performed prior to commencing treatment. It is the authorised prescriber's responsibility to refer to relevant medical and prescription records before prescribing MDMA to ensure patients are not on any medications that could potentially interact with MDMA or are indicative of conditions that contraindicate MDMA use. All findings from the screening process should be documented in appropriate records.

Good Practice Statement 3

Prior to initiating MDMA-AP, the treating psychiatrist is responsible for explaining to potential patients that the current evidence on the efficacy and safety of MDMA-AP is limited. The treating psychiatrist should also discuss the probability of treatment effectiveness and adverse events based on the clinical trial results. Patients should be advised that the MDMA-containing product has not been assessed by the TGA for quality, safety, or efficacy, and is not listed on the Australian Register of Therapeutic Goods (ARTG). Potential patients should be provided with comprehensive information about what to expect before, during, and after treatment. Clinicians and people with lived experience of PTSD reported that some patients who have trialled established PTSD treatments without success may overestimate potential benefits and minimise potential risks.

Good Practice Statement 4

Prior to initiating MDMA-AP, the treating psychiatrist should obtain written informed consent from potential patients. This consent should address likely benefits and harms of treatment (including potential serious adverse events); potential physical, psychological, and financial risks (including out-of-pocket costs of treatment); and what to expect before, during, and after treatment. Informed consent documentation should also include considerations specific to psychedelic therapies, such as potential media attention, social stigma, and confidentiality challenges that may differ from conventional psychiatric treatments. The psychiatrist is responsible for ensuring that any actual or potential conflicts of interest related to their association with companies that manufacture, market, or promote MDMA are declared to the patient. An opinion from a second psychiatrist may be obtained if there is a financial conflict of interest for the treating psychiatrist. Obtaining informed consent should be treated as an ongoing process, with regular review and adaptation based on the patient's evolving needs and experiences. The consent should be documented in appropriate records.

Good Practice Statement 5

Patients should be encouraged, or otherwise given the option to involve a support person (such as a next of kin, family member, carer, or advocate) before and after treatment, including during the process of obtaining informed consent. Upon consent by the patient, the support person should be provided with information about what to expect before, during, and after treatment.

Good Practice Statement 6

Prior to initiating MDMA-AP, the psychiatrist and other clinicians involved in treatment delivery should explore patient preferences around supportive touch. Evidence is lacking about the value of supportive touch during MDMA-AP. There are important ethical and clinical considerations related to supportive touch. MDMA may heighten suggestibility, increase the perceived pleasantness of touch, and impair a patient's capacity to provide or withdraw consent during dosing sessions. It is likely that people living with PTSD have variable values and preferences in relation to supportive touch. The default approach should be no supportive touch unless the patient explicitly opts in. If the patient opts in, clear boundaries, guided by patient preference, should be established during the informed consent process. This should be followed by a dynamic and ongoing consent process at each treatment phase (preparation, dosing, and integration). In situations where supportive touch is offered, therapists must have received appropriate training in its ethical and therapeutic application.

Good Practice Statement 7

Clinicians should assess and accommodate individual differences that may influence the experience and outcomes of therapy. This includes sensory sensitivities, communication preferences, executive functioning needs, cultural identity, and co-occurring health conditions. Particular consideration should be given to Autistic and ADHD individuals, who may have higher rates of trauma exposure and distinct sensory and cognitive profiles. Current evidence of benefits and harms may not be directly extrapolated to Autistic and ADHD individuals.

WHEN PROVIDING MDMA-AP

Good Practice Statement 8

To ensure continuity of care, people who provide MDMA-AP should do so in consultation with the person's regular healthcare providers (e.g., general practitioners, psychologists, psychiatrists, therapists) and establish clear expectations for the broader care team in advance. Best practice involves inviting the general practitioner to be involved in the shared care. MDMA-AP should be integrated into, rather than replace, a patient's broader treatment plan. Where possible, a designated provider (such as the patient's usual general practitioner) should remain primarily responsible for overall patient care.

Good Practice Statement 9

All clinicians involved in the delivery of MDMA-AP should develop a strong therapeutic alliance with patients prior to and throughout MDMA-AP for building trust, ensuring emotional safety, and supporting the effectiveness of therapy.

Good Practice Statement 10

Safeguarding measures should be implemented during MDMA-AP sessions, including ensuring that only authorised personnel are present during dosing sessions, video-recording sessions where appropriate for accountability, and having two trained therapists who have only a professional (i.e. not a personal) relationship in the room during dosing sessions. The presence of two therapists who do not have a personal association is recommended as a risk mitigation strategy to provide a safeguard for both patients and therapists in the event of any concerns or allegations of misconduct. Safeguarding protocols should be documented and regularly audited, with particular attention to secure storage of session recordings and establishment of independent oversight mechanisms.

Good Practice Statement 11

Clinics delivering MDMA-AP should ensure the presence of appropriately trained personnel, such as medical doctors, to oversee medical or pharmacological interventions in managing adverse events. Appropriate clinical support and emergency management procedures should be rapidly available in case of medical emergencies, such as:

- Equipment and appropriately trained staff on-site to provide comprehensive clinical care, monitoring, and emergency resuscitation,
- An authorised Prescriber available to treat any complications that arise,
- Readiness to address treatment emergent adverse events and rescue medications available on-site,
- Close monitoring of patients during medication administration by appropriately trained staff; and
- Access to an accredited healthcare facility for the treatment of potential episodes of acute deterioration.

Good Practice Statement 12

Clinicians should advise patients that MDMA may impair the ability to drive or operate heavy machinery. Patients should be informed of, and comply with, relevant State legislation regarding not driving under the influence of MDMA and the potential for a positive amphetamine result on a roadside drug test.

Good Practice Statement 13

Treatment should be discontinued if a patient develops any conditions that contraindicate the use of MDMA (e.g., psychotic symptoms, significant physical health concerns). Decisions regarding discontinuation should be guided by comprehensive risk assessment, clinical judgement, and patient's and carer's preference.

POST-TREATMENT CARE

Good Practice Statement 14

Patients should only leave the treatment clinic once the acute effects of MDMA have fully worn off. This involves clinically assessing vital signs, level of awareness, mental stability, and ensuring a prearranged support person is available to accompany the patient home.

Good Practice Statement 15

Clinicians should set clear expectations about post-treatment care at the outset of treatment, including the possibility of continuing care with the therapist from MDMA-AP if a strong therapeutic alliance has been established. Clinicians providing MDMA-AP should facilitate the patient's transition back to routine care after MDMA-AP treatment, including developing a comprehensive communication plan.

Good Practice Statement 16

Clinicians should discuss potential post-treatment care models (such as peer support groups, group integration sessions, or regular check-ins with clinicians) and communicate a clear process of follow-up or referral in order to provide patients with ongoing support after completing MDMA-AP. Clinicians should consider the model of post-treatment care for individuals living in rural and remote areas, including the role of primary health care professionals in ongoing management.

EDUCATION AND TRAINING

Good Practice Statement 17

The evidence in relation to MDMA-AP is rapidly evolving and there is potential value in a living evidence approach to future guideline development. Clinicians and people living with PTSD should make themselves familiar with the current best available research about possible benefits and harms as the basis for treatment decision-making.

Good Practice Statement 18

The Guideline Development Group concurs with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) that the clinicians involved in the delivery of MDMA-AP should be registered with the Australian Health Practitioner Regulation Agency (AHPRA) or their equivalent governing body and operate within their recognised scope of practice. One of the therapists in the psychotherapy sessions should be a clinical psychologist or registered psychiatrist.

Good Practice Statement 19

Clinicians involved in the delivery of MDMA-AP should complete specific training. Psychiatrists should follow the Psychedelic Training Framework for Psychiatrists developed by the RANZCP. There is a need for formal and independent regulation or credentialing of training programs for psychiatrists and other clinicians to ensure consistent quality and standards for the delivery of MDMA-AP.

Good Practice Statement 20

Training should be available for the broader healthcare workforce to increase awareness and understanding of MDMA-AP, provide relevant and evidence-based information, and support making appropriate referrals. People with lived experience of PTSD emphasise the importance of clinician awareness, particularly among primary healthcare professionals who have an important role in providing evidence-based information for people living with PTSD.

Good Practice Statement 21

Patient information about MDMA-AP should be provided in a format that is accessible to the patient. Information may need to be tailored for different target populations such as culturally and linguistically diverse (CALD) communities, Aboriginal and Torres Strait Islander peoples, and emergency service workers. With permission, this information should also be made available to the patient's support person.

RECOMMENDATIONS FOR FURTHER RESEARCH

Research Recommendation 1

It should be mandatory for data on treatment outcomes (including clinical efficacy, adverse events, and misuse potential), to be collected using a systematic and structured approach and recorded in an independently funded registry. With appropriate privacy safeguards in place, registry data should be made available for research, guideline development, and regulatory decision-making.

Research Recommendation 2

Further research is needed to determine the most appropriate psychotherapeutic approach to be used alongside MDMA in the treatment of PTSD. This includes evaluating whether MDMA can enhance the effectiveness of existing evidence-based psychotherapies, and identifying which therapeutic modalities or techniques are the safest and most effective when combined with MDMA.

Research Recommendation 3

Future research is needed to understand the extent to which symptoms may worsen before improving in people who receive MDMA-AP, and whether temporary worsening of symptoms is associated with significant distress or harm. Research should seek to distinguish between transient distress induced by revisiting the trauma and persistent distress that causes more harm than good.

Research Recommendation 4

Evidence from current clinical trials relates to a single course (3 dosing sessions, 80-120mg MDMA with supplemental half dose at each dosing) of MDMA-AP delivered over an 18-week period. There is a lack of safety and efficacy data on the use of MDMA for a longer or shorter term or at a different dosage. Further research is needed into the benefits and harms of delivering more than one course of MDMA-AP.

Research Recommendation 5

Future research is needed to investigate the safety and efficacy of MDMA-AP in people living with PTSD who are re-exposed to their index or other significant trauma during the course of treatment. Current clinical trials have excluded people likely to be re-exposed to trauma.

Research Recommendation 6

Future research is needed into the role of MDMA-AP in relation to other evidence-based treatments for PTSD, including whether earlier use of MDMA-AP may improve treatment outcomes.

Research Recommendation 7

Future research should explore the possible value of adapting treatment protocols according to the complexity of each patient's PTSD presentation. This may include variations in treatment duration, intervals between dosing sessions, number of dosing and integration sessions, or group integration sessions.

Research Recommendation 8

Future research should investigate the safety and efficacy of MDMA-AP for PTSD in the context of specific comorbid conditions for which the therapeutic value of MDMA-AP is currently being evaluated (e.g., alcohol use disorders, eating disorders without active purging, substance use disorders).

Research Recommendation 9

Existing phase 3 clinical trial protocols for MDMA-AP in PTSD used fixed-dose regimens and excluded individuals who weighed less than 48 kg. Further research should be conducted to better understand the relationship between dose, plasma concentration, and the overall therapeutic effect of MDMA-AP (e.g., concentration-response, pharmacokinetic-pharmacodynamic simulations).

Research Recommendation 10

People from different cultures might view MDMA-AP differently. Future research should investigate the acceptability of treatment protocols for MDMA-AP in different cultural groups, including Aboriginal and Torres Strait Islander peoples.

Research Recommendation 11

Future research should investigate whether there is a need for tapering or discontinuation of all other medications prior to MDMA-AP. People with lived experience report significant challenges in discontinuing other mental health medications prior to MDMA-AP.

Research Recommendation 12

Future research should develop, validate, and define standardised measures of outcomes beyond symptom reduction in PTSD, such as functional recovery, quality of life, and quality of interpersonal relationships. Measurement of outcomes should also include long-term efficacy, such as sustained symptom relief, functional recovery, and relapse prevention.

Research Recommendation 13

Future research should investigate the safety, efficacy and feasibility of telehealth-integrated delivery of MDMA-AP, including the delivery of preparation and integration sessions remotely.

Research Recommendation 14

Autistic and ADHD individuals are at increased risk of trauma exposure and PTSD yet remain underrepresented in current clinical trials. Research is needed to determine how factors such as sensory processing, communication styles, and executive functioning differences influence outcomes, and whether tailored protocols improve accessibility, safety, and effectiveness.

Research Recommendation 15

Dissociation is common in PTSD and may influence treatment response, including risk of abreactions, emotional flooding, or the emergence of dissociated material during or after dosing sessions. Research is needed to clarify the safety, efficacy, and potential treatment adaptations for individuals presenting with symptoms of dissociation.

ABBREVIATIONS

CALD	Culturally and Linguistically Diverse
CAPS-5	Clinician-Administered PTSD Scale for DSM-5
CPT	Cognitive Processing Therapy
CT	Cognitive Therapy
EMDR	Eye Movement Desensitisation and Reprocessing
FDA	US Food and Drug Administration
GDG	Guideline Development Group
GPS	Good Practice Statement
GRADE	Grading of Recommendations, Assessment, Development and Evaluation
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual + other identities
MDMA	3,4-methylenedioxymethamphetamine
MDMA-AP	MDMA-Assisted Psychotherapy
NHMRC	National Health and Medical Research Council
PTSD	Post-Traumatic Stress Disorder
RCT	Randomised Controlled Trial
SNRIs	Serotonin and Noradrenaline Reuptake Inhibitors
SSRIs	Selective Serotonin Reuptake Inhibitors
TF-CBT	Trauma-focused Cognitive Behavioural Therapy
TGA	Therapeutic Goods Administration

GLOSSARY

TERM	DEFINITION
Aboriginal and Torres Strait Islander peoples	According to the High Court of Australia (1983), a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which the person lives. Also referred to as Indigenous or First Nations peoples.
Adverse event	Any undesirable experience associated with a medication or health intervention. Adverse events can be serious and result in hospitalisations, persistent disability or death. Adverse events are sometimes known as side effects.
Authorised prescriber	A medical practitioner who, in the context of this Guideline, is a psychiatrist who has been granted approval by the Therapeutic Goods Administration (TGA) to prescribe a specified unapproved therapeutic good (e.g., MDMA) to patients with particular medical conditions (e.g., PTSD). The psychiatrist must have obtained Human Research Ethics Committee (HREC) approval and operate within their scope of practice, supported by appropriate training and clinical protocols.
Autistic person	There is not one universally accepted definition of autism that captures everyone's experience. The term 'Autistic person' is used throughout this Guideline in line with identity-first language preferences widely endorsed in recent research [79] and the National Autism Strategy in Australia, while recognising that some individuals may prefer person-first language (e.g., 'person with autism').
Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)	A 30-item semi-structured interview assessing PTSD in the past month through diagnostic and symptom severity scores anchored to a DSM-5-defined traumatic event. The CAPS-5 produces a Total Severity Score based on the severity of PTSD domains described in the DSM-5, as well as a categorical rating indicating whether a participant meets PTSD diagnostic criteria. The total symptom severity scores range from 0 to 80, with higher values indicating greater symptom severity. CAPS-5 assigns PTSD diagnosis as being present or absent.
Carer / Support person	People who provide the primary ongoing support and care in a non-professional, unpaid capacity for a person living with PTSD. The carer is generally a spouse/partner, child, other family member, relative or friend. Not everyone in this role prefers to be referred to as 'carer' and the person's preferences should be sought before using the term. Carers are distinguished from care workers.

Clinical question	The key questions about treatment and care. The clinical question in the current Guideline was addressed by systematic reviews of the evidence.
Consumers	In the context of this Guideline, consumers are people with lived or living experience with PTSD and/or their carers.
Culturally and linguistically diverse populations	The Australian Institute of Health and Welfare has defined culturally and linguistically diverse populations as those born overseas, have a parent born overseas or who speak a variety of languages. Pham (2021) suggested that CALD status be defined according to being born in a non-English speaking country and/or not speaking English at home.
Culturally-responsive care	Culturally-responsive refers to the capacity for healthcare professionals to effectively provide healthcare services that acknowledge, respect, and meaningfully integrate patients' and families' cultural values, beliefs, and practices into care. Here, "culture" extends beyond the identification of a person's race and ethnicity to include other variables such as faith/religion, occupation, sexual orientation, region of residence, and level of acculturation, and closely related factors such as socioeconomic status and literacy level.
Cultural safety	According to the Australian Institute of Health and Welfare, cultural safety refers to healthcare that is provided in a way that is safe, accessible and responsive for individuals from all cultural backgrounds, as determined by the experience of the individual receiving care. It requires practitioners to reflect on and address their own cultural values, beliefs and attitudes that consciously or unconsciously affect their behaviours, and to actively work toward creating an environment that respects all cultural identities and addresses racism and inequity.
First-line treatment	APA Dictionary of Psychology defines first-line treatment as an intervention (such as a specific therapy, procedure, or medication used alone or in combination) that is recommended as the initial choice for treating a particular condition. This recommendation is typically based on high-quality evidence of safety and efficacy demonstrating that it is the most effective and has the lowest likelihood of causing harm compared with other available options.
Emergency services workers	Workers who protect public health and safety by responding to and preventing emergency situations. In Australia, these include police, fire and rescue, and ambulance services, along with individuals who perform these functions in a volunteer capacity (e.g., coast guard, rural fire service). Workers and volunteers in these roles are often exposed to potentially traumatic events as part of their duties.
Index trauma	The specific traumatic event(s) used as the basis for diagnosing and assessing the severity of PTSD symptoms [80]. When someone has experienced multiple traumatic events, the "index trauma" can be defined as the worst single incident, or it can include up to three qualitatively distinct traumatic events.

Informed consent	A process of communication between a patient and healthcare professional about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention and participate in planned care. The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.
MAPS (Multidisciplinary Association for Psychedelic Studies)	A nonprofit organisation that 'develops medical, legal, and cultural contexts for people to benefit from the careful uses of psychedelics and marijuana'. MAPS formed Lykos Therapeutics, a drug-development public benefit company that submitted the New Drug Application for MDMA-AP to be used for adults with PTSD to the US FDA.
MDMA (3, 4-methylenedioxymethamphetamine)	A synthetic compound classified as an entactogen or empathogen (a compound that increases feelings of empathy or connectedness with others), with minor psychedelic properties. Also known as midomafetamine (the United States Adopted Name, USAN), and colloquially as ecstasy.
MDMA-Assisted Psychotherapy	A combined pharmacologic and psychotherapeutic intervention, in which MDMA is administered as an adjunct to psychotherapy sessions to enhance therapeutic outcomes. A course of treatment typically includes preparatory sessions, active dosing session(s) where MDMA is administered, and integration sessions. Also known as MDMA-assisted therapy.
Post-Traumatic Stress Disorder (PTSD)	DSM-5 and ICD-11 diagnostic criteria describe PTSD as a trauma- and stressor-related disorder that develops following exposure to a threatening or horrific event or series of events (e.g., actual or threatened death, serious injury, or sexual violence). PTSD is characterised by symptoms including re-experience the traumatic event(s) (e.g., intrusive memories, flashbacks, nightmares), avoidance of reminders, and a persistent sense of current threat (e.g. hypervigilance, alterations in arousal/ reactivity). The DSM-5 additionally describes negative alterations in cognition and mood (e.g., persistent negative beliefs, emotional numbness). These symptoms cause significant distress or impairment in functioning.
Psychedelics	Psychedelics (also known as hallucinogens) are a class of psychoactive substances that produce changes in perception, mood and cognitive processes. Examples of psychedelics include psilocybin, ayahuasca, LSD, DMT, NBOMes, and mescaline. MDMA is classified as an empathogen or entactogen, but for simplicity, it will be referred to as a psychedelic throughout this Guideline.
Randomised controlled trial (RCT)	A prospective study design used to evaluate the effectiveness of an intervention or treatment. Participants are randomly assigned to either the intervention or comparator group, which balances participant characteristics and reduces bias. The study population, interventions and outcomes are carefully selected, and experimental conditions are often blinded. RCTs are generally considered to provide the strongest level of evidence below a systematic review.
Safeguard measures	Actions taken to protect the rights and dignity of people living with mental illness or psychological distress.

Shared decision making	A collaborative and participatory process in which clinicians and patients work together to make healthcare decisions and develop a care plan that aligns with the patient's individual preferences, values, and goals.
Supportive touch	Physical contact intended to communicate empathic care to participants during psychedelic-assisted dosing/ experimental sessions. This is different from safety, procedural, and therapeutic forms of touch found in other healthcare disciplines, and is not intended to have direct healing purposes beyond empathic support [81].
Trauma-informed care	The Australian Institute of Family Studies defined trauma-informed care as a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage.
Veterans	According to the Australian Institute of Health and Welfare, veterans are people who have any experience in the Australian Defence Force, including permanent, reserve, and former (ex-serving) personnel. Australian Defence Force members have unique experiences as a result of their service in the military, which can influence their health and wellbeing relative to the rest of the Australian population.

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