Metabolic Psychiatry and Psychotherapy Practice

Table of contents

Executive Summary 3

Section 1. Why Metabolic Psychiatry Is Now Reaching Psychotherapy Settings 8

Section 2. Why This Matters for Psychotherapy Organizations 11

Section 3. The Evidence Context Clinical Leaders Need to Know 14

Section 4. The Clinical Boundary Problem 17

Section 5. What Competent Organizational Response Looks Like 20

Section 6. Why Training Is the Appropriate Organizational Response 23

Section 7. About the Author and Training Focus 26

Appendix A: Metabolic Psychiatry in U.S. Clinical Settings (2024–2026) 28

Appendix B. Representative U.S. Settings and Sources 32

Sources 36

Executive Summary

Patients and families are increasingly requesting information about ketogenic and other metabolic interventions both alongside psychotherapy and as adjunctive or even standalone approaches to the treatment of mental illness. Psychotherapy clinicians are often the first point of contact for these questions, even when metabolic interventions are not offered or medically overseen within the organization. When psychotherapy clinicians lack training, responses can default to personal beliefs, outdated assumptions, or informal opinion rather than evidence-based frameworks. This undermines evidence-based treatment and creates variability in clinical communication.

For psychotherapy organizations, the resulting challenge is organizational. Clinical leadership must ensure that psychotherapy clinicians can respond knowledgeably and responsibly to metabolic interventions without drifting beyond scope (American Psychological Association, 2017). Without shared language and supervisory guidance, clinicians may disengage to avoid overstepping, or they may speak beyond competence to appear helpful (American Counseling Association, 2014). Both patterns create inconsistency in care, strain supervision, and weaken ethical defensibility.

The evidence context is now sufficient to require informed clinical responses, even as the literature remains uneven and interventional effectiveness remains under evaluation. Most accredited education in metabolic psychiatry has been designed for prescribers or medical audiences and rarely addresses the distinct role of psychotherapy clinicians. Psychotherapy organizations therefore need training that translates the current evidence landscape into psychotherapy grounded guidance that supports accurate communication, bias reduction, and consistent supervision.

The clinical boundary problem is best addressed by clarifying that psychotherapy clinicians are not expected to recommend, direct, or medically oversee metabolic therapies. They are expected to use established psychotherapeutic paradigms to support clients who choose to adopt and maintain metabolic interventions. This includes addressing motivation, ambivalence, discouragement,

behavior change, family dynamics, identity shifts, and long-term maintenance challenges, all while remaining grounded in evidence-based psychological care.

A competent organizational response emphasizes readiness rather than advocacy. Leadership establishes clear boundaries, shared language, and supervisory standards so psychotherapy clinicians can respond consistently and ethically. Training is the appropriate response because it creates a common foundation across clinicians and supervisors, prevents ad hoc improvisation, and aligns organizational governance with evidence-based standards as clinical realities evolve.

Institutions Mentioning Metabolic Psychiatry (Research or Publications)

Beyond those offering services, a number of U.S. institutions mention "metabolic psychiatry" on their websites, publications, or clinical materials that signal growing interest and planned uptake.

Academic and Research Centers: Many universities and hospitals discuss metabolic psychiatry in research news or educational content. For instance, Stanford Medicine's news site has profiled the "relatively new field of metabolic psychiatry" and its potential to improve serious mental illness outcomes. Similarly, Harvard/McLean publications and NPR interviews have highlighted patients' success with ketogenic diets for mental illness, bringing attention to the field (NPR, Jan 2024; San Francisco Chronicle and Washington Post, Apr 2024 – as cited on Stanford's Metabolic Psychiatry site). These mentions indicate institutional recognition of the approach.

Clinical Trial Sites: Even where no clinic exists yet, some centers are turning focus onto metabolic psychiatry via clinical studies. UCLA Health is conducting a pilot study of ketogenic diet in bipolar disorder and University of Pittsburgh and UCSF are similarly involved in trials on metabolic interventions for mental health. Their websites and press releases describe these studies, thereby mentioning metabolic psychiatry concepts (e.g. addressing brain energy metabolism). While these institutions may not advertise "metabolic psychiatry services" per se, their publications show engagement with the field's research.

Professional and Advocacy Groups: The Baszucki Group's Metabolic Mind initiative and others have created communities of practice that list collaborators. Press releases in 2024–2025 announced Metabolic Psychiatry Scholar Awards to early-career scientists at multiple universities. As a result, university departments (e.g. at Mayo Clinic, Ohio State, NYU, etc.) have featured news about receiving funding to explore metabolic psychiatry. These are indirect mentions on institutional news pages, reflecting acknowledgment of the field.

Integrative Psychiatry Clinics: Smaller clinics that emphasize holistic or integrative psychiatry often include metabolic psychiatry in-patient education without a standalone program. For example, Luvita (MT) provides a detailed FAQ on what metabolic psychiatry is and how metabolic issues (like insulin resistance or vitamin deficiencies) can be addressed alongside therapy. Even if such clinics do not run separate “metabolic psychiatry” departments, the fact they discuss it on websites or blogs means they are aware of and promoting the concept. This trend extends to functional medicine-oriented psychiatrists who write and educate about metabolic health and mental health connections.

Overall, metabolic psychiatry remains a rapidly growing field. The number of U.S. treatment settings offering such services is still relatively small (on the order of ten or fewer as of 2025), but the level of authority inherent in the sites they are being offered is noteworthy. Meanwhile, many more centers are “metabolic psychiatry-aware,” incorporating the principles into research or adjunct care. We can expect these numbers to rise as clinical evidence builds and as more providers receive training in this specialty.

Section 1. Why Metabolic Psychiatry Is Now Reaching Psychotherapy Settings

Across mental health care settings, patients and families are increasingly requesting information about ketogenic and other metabolic interventions both alongside psychotherapy and as standalone approaches to the treatment of mental illness. These requests are not limited to specialty practices or academic centers.

They are appearing in outpatient clinics, group practices, community agencies, and integrated care environments where psychotherapy clinicians are often the primary point of contact. A small but growing number of United States treatment settings now publicly describe metabolic psychiatry services or structured programs. Current public listings suggest approximately 8 to 10 identifiable clinical settings across academic centers, specialty outpatient clinics, and at least one residential program, with a larger group referencing metabolic psychiatry in research or educational materials without a dedicated service (Appendix A, Appendix B). This matters for psychotherapy organizations because client demand is being shaped by visible clinical adoption, even when metabolic interventions are not offered within the psychotherapy setting.

In many cases, psychotherapy clinicians are being asked to comment on or respond to these interventions without formal education, shared language, or supervisory guidance. Clients may seek clarification about what these approaches are, how to interpret changes they are experiencing, or how to evaluate claims they have encountered elsewhere. When clinicians lack grounding in the existing research literature or emerging clinical practice, responses may rely on personal beliefs, outdated assumptions, or informal opinion rather than evidence-based frameworks.

This creates a subtle but consequential problem for psychotherapy organizations. Even when metabolic interventions are not offered, endorsed, or medically managed within the organization, their presence in the clinical conversation is unavoidable. Psychotherapy clinicians inevitably shape how clients understand and evaluate these approaches. In the absence of training, clinicians may unintentionally convey bias, dismissiveness, or overconfidence that is not supported by current evidence, undermining the principles of evidence-based treatment and informed clinical care.

For medical and clinical directors, this represents an organizational issue rather than an individual clinician issue. Variability in clinician responses, uncertainty about appropriate scope of practice, and lack of supervisory consistency can all emerge when a clinically relevant topic enters routine care without preparation. Over time, this variability affects service quality, ethical defensibility, and organizational credibility.

This white paper addresses this emerging intersection at the organizational level. It is written for clinical leaders responsible for governance, supervision, and service quality who need a clear understanding of why metabolic psychiatry is now a relevant context for psychotherapy practice, and why focused, evidence informed training for psychotherapy clinicians is necessary to support consistent and defensible care.

Section 2. Why This Matters for Psychotherapy Organizations

When metabolic interventions enter routine clinical conversations without organizational preparation, the impact extends beyond individual clinician encounters. Psychotherapy organizations are accountable for how care is delivered, supervised, and justified across providers, and this accountability increasingly includes how clinicians respond to questions about nontraditional and adjunctive treatment approaches that clients are already pursuing.

Without a shared framework, psychotherapy clinicians respond inconsistently. Some may dismiss metabolic interventions outright. Others may express cautious neutrality without sufficient grounding. Still others may inadvertently overstate risks or benefits based on incomplete understanding. None of these responses reliably reflect evidence-based practice when clinicians have not been trained to situate metabolic interventions accurately within the current research and clinical landscape.

For organizations, this variability creates multiple points of vulnerability. Supervisors may struggle to provide guidance when clinicians bring forward questions they themselves were never trained to address. Clinical leadership may lack clear internal standards for what constitutes appropriate psychotherapeutic commentary versus what falls outside scope. Over time, this can lead to uneven care experiences, internal confusion, and difficulty articulating defensible positions if concerns are raised by clients, families, or external stakeholders.

There is also a reputational dimension. Psychotherapy organizations are increasingly evaluated not only on the treatments they offer, but on how competently they navigate emerging clinical realities. When patients and families encounter dismissive or misinformed responses to widely discussed interventions, trust can erode even if no formal complaint is made. Conversely, organizations that demonstrate informed, measured, and ethically grounded responses signal clinical maturity and leadership.

Importantly, this is not a call for psychotherapy organizations to practice metabolic medicine or to expand beyond their scope. It is a call for organizational readiness. Clinical leaders need their psychotherapy clinicians to understand what metabolic interventions are, what they are not, what the current evidence does and does not support, and how to respond without transmitting bias or misinformation. Training at the organizational level ensures that individual clinicians are not left to navigate this alone and that responses align with evidence-based standards of care.

In this context, metabolic psychiatry is not a niche interest. It is a growing external factor that psychotherapy organizations must interpret, contextualize, and manage responsibly. Addressing it proactively through structured training protects clinical integrity, supports supervisors, and reinforces organizational commitment to evidence-based practice.

Section 3. The Evidence Context Clinical Leaders Need to Know

For clinical leaders, the most important question is not whether metabolic interventions are fully settled within psychiatric care. It is whether there is a sufficiently established and credible evidence context to warrant informed, disciplined responses from psychotherapy clinicians.

At this point, the answer is yes.

Research on ketogenic and related metabolic interventions for mental illness now spans multiple domains. Human clinical studies, including case series and early trials, have documented psychiatric symptom change across diagnostic categories. Parallel work in neuroscience and psychiatry has examined metabolic mechanisms relevant to brain function, energy regulation, and neurobiological stress systems. This literature has moved beyond theoretical speculation and into applied clinical observation, even as standards of care and prescribing guidelines continue to evolve.

At the same time, the evidence base remains uneven. Findings vary by diagnosis, study design, and clinical context. Some claims circulating in popular media or online communities exceed what the data currently support, while other areas of legitimate inquiry are dismissed prematurely due to unfamiliarity or historical bias. This mixed landscape creates risk for psychotherapy clinicians who are asked to respond without training. In the absence of evidence literacy, clinicians may default to overgeneralization, oversimplification, or categorical rejection, none of which reflect evidence-based reasoning.

Despite this growing body of research, most accredited education in metabolic psychiatry has been developed for prescribers or medical audiences, with limited attention to the distinct role, scope, and ethical responsibilities of psychotherapy clinicians. As a result, psychotherapy organizations often lack training resources that translate the evidence base into clinically appropriate guidance for psychological practice.

For psychotherapy organizations, the relevance of the evidence base does not hinge on whether clinicians are expected to adopt metabolic interventions. It hinges on whether clinicians can accurately distinguish between established findings, emerging evidence, and unsupported claims when responding to clients and families. Evidence based practice requires not only fidelity to validated psychotherapeutic interventions, but also informed contextualization of external treatment choices that shape client narratives, symptom interpretation, and therapeutic process.

Importantly, the relevance of this evidence for psychotherapy does not lie in adopting metabolic treatments, but in understanding how existing psychotherapeutic paradigms can be appropriately applied to support clients who are choosing to engage with metabolic therapies over time.

Section 4. The Clinical Boundary Problem

As metabolic interventions enter psychotherapy settings through patient and family demand, the primary challenge for organizations is not whether psychotherapists should practice metabolic medicine or provide medical care, but whether psychotherapy clinicians can knowledgeably and responsibly inform patients about metabolic interventions without drifting beyond their scope.

Without clear guidance, boundaries blur in predictable ways. Some psychotherapy clinicians avoid the topic entirely, viewing metabolic interventions as outside the relevance of psychological care. Others offer opinions that unintentionally cross into medical interpretation or recommendation, despite lacking training or authority to do so. Still others respond with skepticism or reassurance based on personal beliefs rather than established psychotherapeutic frameworks.

The core boundary problem is not metabolic. It is psychotherapeutic. Psychotherapists are trained to work with behavior change, motivation, adherence, meaning making, emotional regulation, identity shifts, family dynamics, and long-term maintenance of demanding lifestyle changes. These competencies are directly relevant when clients engage with metabolic therapies, even when psychotherapists are not recommending, directing, or overseeing the intervention itself.

When this distinction is not articulated at the organizational level, psychotherapy clinicians may mistakenly assume that supporting a client who is adopting a metabolic therapy requires medical expertise rather than psychotherapeutic skill. In reality, the psychotherapist's role remains grounded in familiar paradigms. Supporting ambivalence, addressing cognitive distortions, working with relapse and discouragement, helping clients integrate improvements in functioning, navigating family responses, and sustaining long-term behavioral change all fall squarely within psychotherapy scope.

The absence of training creates a false binary. Either psychotherapy clinicians disengage to avoid overstepping, or they speak beyond their competence to appear helpful. Neither response reflects evidence-based psychotherapy practice. Clear boundaries allow psychotherapy clinicians to remain fully in role while offering informed, ethically grounded support that aligns with established therapeutic models.

For psychotherapy organizations, this boundary problem has practical consequences. Supervisors need shared language to guide clinicians. Directors need defensible standards that distinguish informing from recommending, and psychotherapeutic support from medical management (Aoki et al., 2022). Without this clarity, organizations risk inconsistent practice, clinician anxiety, and avoidable ethical tension.

Addressing this boundary problem does not require new therapy models or expanded scope. It requires intentional translation of existing psychotherapy paradigms into a metabolic context. When psychotherapy clinicians are trained to apply what they already know to this emerging clinical reality, organizations can respond with confidence rather than improvisation.

Section 5. What Competent Organizational Response Looks Like

A competent organizational response to metabolic psychiatry does not involve adopting new treatment services or expanding clinical scope. It involves establishing shared standards for how psychotherapy clinicians are prepared to respond when metabolic interventions enter the therapeutic space through client choice.

At the organizational level, competence begins with clarity. Clinical leaders articulate that psychotherapy clinicians are not expected to recommend, direct, or evaluate metabolic treatments. They are expected to understand the evidence context well enough to respond accurately, avoid bias, and remain grounded in evidence based psychological care. This clarity reduces clinician anxiety and prevents both overreach and disengagement.

Prepared organizations invest in shared language. Psychotherapy clinicians and supervisors use consistent terms to describe what metabolic interventions are, what the evidence does and does not support, and how these interventions relate to psychological treatment. This shared language allows supervision to function effectively when questions arise and ensures that clinicians are not improvising responses in isolation.

Supervision plays a central role. In competent organizations, supervisors are equipped to help psychotherapy clinicians think through clinical situations involving metabolic therapies using familiar psychotherapeutic frameworks. Rather than defaulting to medical interpretation, supervision focuses on meaning making, motivation, behavior change, emotional regulation, identity shifts, family dynamics, and maintenance challenges.

Another hallmark of competence is consistency across clinicians. Patients and families receive responses that are informed, measured, and aligned with organizational standards rather than dependent on individual clinician beliefs or knowledge gaps. This consistency reinforces trust and supports ethical defensibility.

Importantly, competent organizations treat this as a training issue rather than an individual clinician problem. Leadership recognizes that expecting psychotherapy clinicians to independently interpret a rapidly evolving clinical area without guidance is neither realistic nor fair. Structured, evidence informed training ensures that all clinicians have a baseline level of understanding and that supervision is supported rather than strained.

Finally, competent organizations adopt a posture of preparedness rather than advocacy. The goal is not to promote metabolic interventions, but to ensure that psychotherapy clinicians can support clients engaging with them in ways that are accurate, ethical, and clinically grounded. This posture allows organizations to remain aligned with evidence based practice while responding effectively to a changing mental health landscape.

Section 6. Why Training Is the Appropriate Organizational Response

The challenges metabolic psychiatry introduces into psychotherapy settings are not best addressed through policy statements, informal guidance, or ad hoc consultation. They are best addressed through structured training. The issues involved are not isolated clinical questions, but recurring interpretive demands placed on psychotherapy clinicians across settings, populations, and modalities.

When patient driven metabolic interventions enter care, psychotherapy clinicians are repeatedly asked to interpret information, respond to uncertainty, and support behavior change without drifting into medical judgment or personal opinion. These are skills that require shared conceptual grounding, not individual improvisation. Training provides a common foundation that allows clinicians to respond accurately and consistently while remaining firmly within psychotherapeutic scope.

Training protects evidence-based practice. Without education, clinicians may unknowingly transmit bias, dismiss emerging evidence prematurely, or rely on outdated assumptions. Training equips clinicians to distinguish what is known, what is still emerging, and what falls outside the evidence base, and to communicate those distinctions responsibly.

From an organizational standpoint, training supports supervision and governance. Supervisors cannot reasonably guide clinicians through these issues unless they share the same baseline understanding. Training aligns clinicians and supervisors around shared language, boundaries, and expectations, reducing variability and preventing supervision from drifting into uncertainty or avoidance.

Training addresses this issue at the correct level of responsibility. Expecting individual psychotherapy clinicians to independently educate themselves creates inequity and risk. Some clinicians will overeducate themselves, others will disengage, and many will rely on informal sources of variable quality. Organizational training ensures competence is based on shared professional standards rather than personal interest.

Training is also scalable and adaptable. As the evidence base evolves, training frameworks can be updated without requiring organizations to revise scope of practice or service offerings. This allows organizations to remain responsive without committing to interventions they do not provide.

In this context, training is not an optional enhancement. It is the most appropriate, proportionate, and defensible organizational response to the growing presence of metabolic psychiatry in psychotherapy practice.

Section 7. About the Author and Training Focus

Nicole Laurent is a licensed psychotherapist, educator, and researcher who has delivered American Psychological Association (APA) and National Board for Certified Counselors (NBCC) accredited continuing education trainings addressing metabolic psychiatry from a psychotherapy practice perspective. They equip psychotherapy clinicians and supervisors to interpret the evidence context accurately, avoid transmitting bias or misinformation, and apply established psychotherapy paradigms to support clients engaging with metabolic therapies over time. This guidance draws on Nicole Laurent's real-world experience training psychotherapy clinicians in nationally recognized clinical settings such as Ellenhorn's care programs and the metabolic-focused Accord program, reinforcing its relevance to organizational readiness. In 2022, she was named a Metabolic Mind Award recipient, one of seven clinicians recognized by the Baszucki Brain Research Fund and the Milken Institute.

To date, her trainings have been among the first to address metabolic psychiatry specifically from a psychotherapy practice perspective. While most education in this area has been designed for prescribers or medical audiences, her trainings have focused on the distinct role of psychotherapy clinicians, helping them understand how to respond to metabolic interventions entering care through patient and family demand without exceeding professional scope.

These trainings do not teach clinicians to initiate, prescribe, or manage metabolic therapies. They are explicitly trainings in metabolic psychiatry for nonprescribers and are designed to support psychotherapy clinicians in remaining grounded in evidence based psychological care. Through this approach, psychotherapy clinicians learn how to apply established psychotherapeutic paradigms effectively to support the emotional, cognitive, and behavioral demands faced by clients who are adopting and maintaining metabolic therapies.

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> Psychotherapists can learn to respond consistently and ethically, avoid transmitting bias or misinformation, and navigate complex clinical conversations with confidence. Clinical leaders are supported when there is shared language and conceptual clarity that strengthen supervision, governance, and organizational standards of care. Organizations interested in preparing psychotherapy clinicians for this emerging clinical reality are invited to explore whether this training approach aligns with their scope, setting, and supervisory needs. Conversations will focus on readiness, fit, and organizational context rather than on predefined packages or generalized solutions.

Nicole Laurent, LMHC

Appendix A: Metabolic Psychiatry in U.S. Clinical Settings (2024–2026)

Metabolic psychiatry is an emerging subspecialty at the intersection of metabolic health and mental health, focusing on interventions like nutrition (e.g. ketogenic diets) and metabolic treatments to improve psychiatric outcomes. The field was pioneered at Stanford University, where Dr. Shebani Sethi founded the first academic Metabolic Psychiatry Clinic in 2019. Since then, a growing number of U.S. hospitals and clinics have begun incorporating metabolic psychiatry into their services. This appendix is not an endorsement and not an exhaustive list.

Category	What it means	Representative U.S. examples	Why it matters for psychotherapy leadershiop
Operational, hospital and academic medical center clinics	Patient facing clinics or named programs embedded in health systems or academic medical centers that publicly describe metabolic psychiatry care pathways	Stanford Metabolic Psychiatry Clinic, McLean Hospital Metabolic and Mental Health Program, Mayo Clinic precision nutrition psychiatry initiative	Real world implementation inside mainstream medicine, raising the probability that psychotherapy teams will receive referrals, coordination requests, and patient questions that require scope grounded, evidence literate responses
Residential, intensive, and structured treatment programs	Higher acuity settings or structured programs where metabolic interventions are integrated into a defined model of care with monitoring, routines, and interdisciplinary coordination	Accord residential program MA, LGTC Group program CA	Metabolic approaches are being operationalized in complex psychiatric care contexts, which increases leadership demand for staff guidance on informed consent language, risk communication, and continuity of psychotherapy support across levels of care

Category	What it means	Representative U.S. examples	Why it matters for psychotherapy leadership
Specialized private clinics and multi-site outpatient practices	Private, outpatient delivery models that advertise metabolic psychiatry or ketogenic clinical services directly to consumers, often with faster uptake than hospital systems	Metabolic Psychiatry Labs CA, MH2 (MA), Amae Health clinics CA, Lighthouse Clinic WI, Luvita Integrative Psychiatry MT, TouchPoints180 CT, MetaBridge Health & Wellness, GA	Consumer facing market adoption increases patient driven demand entering psychotherapy sessions and creates reputational and ethical exposure if clinicians respond with misinformation, dismissal, or unsupported certainty
Institutional research and public signaling without a formal clinic	Universities and affiliates that reference metabolic psychiatry through trials, publications, press, or educational materials without advertising a dedicated patient service line	UCLA, University of Pittsburgh, UCSF, NYU, Stanford Medicine news, Harvard and McLean academic materials, integrative psychiatry practices publishing patient education	Legitimacy and diffusion of ideas ahead of service availability, increasing client exposure to claims and expectations that psychotherapy leaders must manage through clinician training, documentation standards, and clear scope of practice guidance

Appendix B. Representative U.S. Settings and Sources

Several clinical practices and programs now offer metabolic psychiatry as part of patient care. As of 2025, we identified roughly 8–10 U.S. institutions with formal services in this area.

Institutions Actively Offering Metabolic Psychiatry Services

Stanford Medicine (California) – Home of the first academic Metabolic Psychiatry Clinic. Established by Dr. Sethi, this clinic integrates psychiatry with obesity medicine and nutrition science. Stanford's program has led the way in using ketogenic therapy for serious mental illness, with research showing improvements in psychiatric symptoms and metabolic health.

McLean Hospital, Harvard Medical School (Massachusetts) – In 2024, McLean launched a Metabolic and Mental Health Program under Dr. Chris Palmer. This program unites research, education, and clinical care to apply metabolic interventions (like ketogenic diets) for treatment-resistant psychotic and mood disorders. It includes a consulting service to support patients interested in metabolic approaches.

Mayo Clinic (Minnesota) – In 2025 Mayo Clinic announced a collaboration to develop an interdisciplinary precision-nutrition psychiatry service. Backed by a Baszucki Group gift, Mayo is conducting a clinical trial of ketogenic therapy in bipolar disorder, with plans to launch a precision nutrition clinical service uniting psychiatry, endocrinology and cardiology. This indicates Mayo's active steps toward offering metabolic psychiatry in practice.

Metabolic Psychiatry Labs (California) – A private telehealth clinic founded by Dr. Sethi after Stanford, offering metabolically informed psychiatric care nationwide. This clinic's model addresses insulin resistance, inflammation, and nutrition as root causes of mental health symptoms. It is staffed by psychiatric and metabolic experts and provides personalized treatment through a digital platform.

MH^2 (MA) – A private mental and metabolic health clinic in Wellesley, MA that integrates psychiatric care with metabolic assessment and lifestyle medicine. The clinic offers ketogenic therapy as a medically supervised metabolic intervention delivered with multidisciplinary support when clinically indicated, with in-person appointments in MA and virtual appointments for patients in MA, FL, and VT.

Amae Health (California) – An outpatient mental health provider focused on serious mental illness, integrating metabolic psychiatry into care. Amae's clinics combine psychiatry with metabolic monitoring and ketogenic dietary support. In partnership with the Baszucki Group, Amae has implemented a metabolic intervention (keto meal program) across its clinics, reporting early improvements in mood and energy for patients. This suggests that Amae's model explicitly includes metabolic psychiatry as a core component of treatment.

Accord Residential Program (Massachusetts) – Accord is a first-of-its-kind metabolic psychiatry residential treatment program in Arlington, MA. Launched in partnership with Ellenhorn, it provides immersive care for up to 7 clients at a time. Accord's team (psychiatrist, dietitian, chef, nurse, etc.) uses ketogenic diets, lifestyle changes, and metabolic monitoring in a 4–12 week residential setting. This program reflects the extension of metabolic psychiatry into intensive treatment settings.

Lighthouse Clinic (Wisconsin) – A private clinic in Milwaukee offering a Metabolic Psychiatry program as part of its services. Lighthouse's team which includes a psychiatrist and dietitian, focuses on nutritional ketogenic therapy and metabolic counseling for mental health patients. Their approach addresses metabolic drivers of conditions like depression, bipolar disorder, and schizophrenia by reducing sugars/carbohydrates and improving mitochondrial function. The clinic explicitly markets metabolic psychiatry-informed care to empower clients in their wellness journey.

LGTC Group (California) – A mental health group practice in California with multiple locations that introduced a Metabolic Psychiatry Program addressing weight gain, insulin resistance, and other metabolic challenges in psychiatric patients. The program combines psychiatric care with nutrition counseling, weight-management and metabolic monitoring. This reflects a holistic approach to mitigate psychiatric medication side effects and improve both mood and metabolic health within an outpatient practice.

Luvita Integrative Psychiatry (Montana) – An outpatient clinic in Helena, MT that offers Metabolic Psychiatry alongside therapy and medication management. Luvita's website educates patients on how blood sugar, insulin resistance, and inflammation may contribute to depression or anxiety. Luvita's inclusion of metabolic psychiatry in its service menu suggests active incorporation of metabolic assessments and lifestyle guidance in patient care.

Touchpoints180 (Connecticut) - Outpatient metabolic psychiatry services providing collaborative, wrap around pathway that spans clinic-based care plus lifestyle and nutrition focused supports, positioned within a medicine, metabolism, and psychiatry frame.

MetaBridge Health and Wellness (GA, UT, CO) – A functional and metabolic psychiatry practice offering in person and telehealth services in Atlanta, GA, with telehealth availability in UT and CO. The practice describes a metabolic frame for mental health care that includes sleep, inflammation, insulin resistance, gut health, micronutrients, and hormones.

Note: Several other independent providers across the country are beginning to advertise specialization in metabolic psychiatry as well. For example, some dual-certified psychiatrists in California and Florida highlight "metabolic psychiatry" in their practice descriptions. These are usually solo or concierge practices integrating weight management with mental health.


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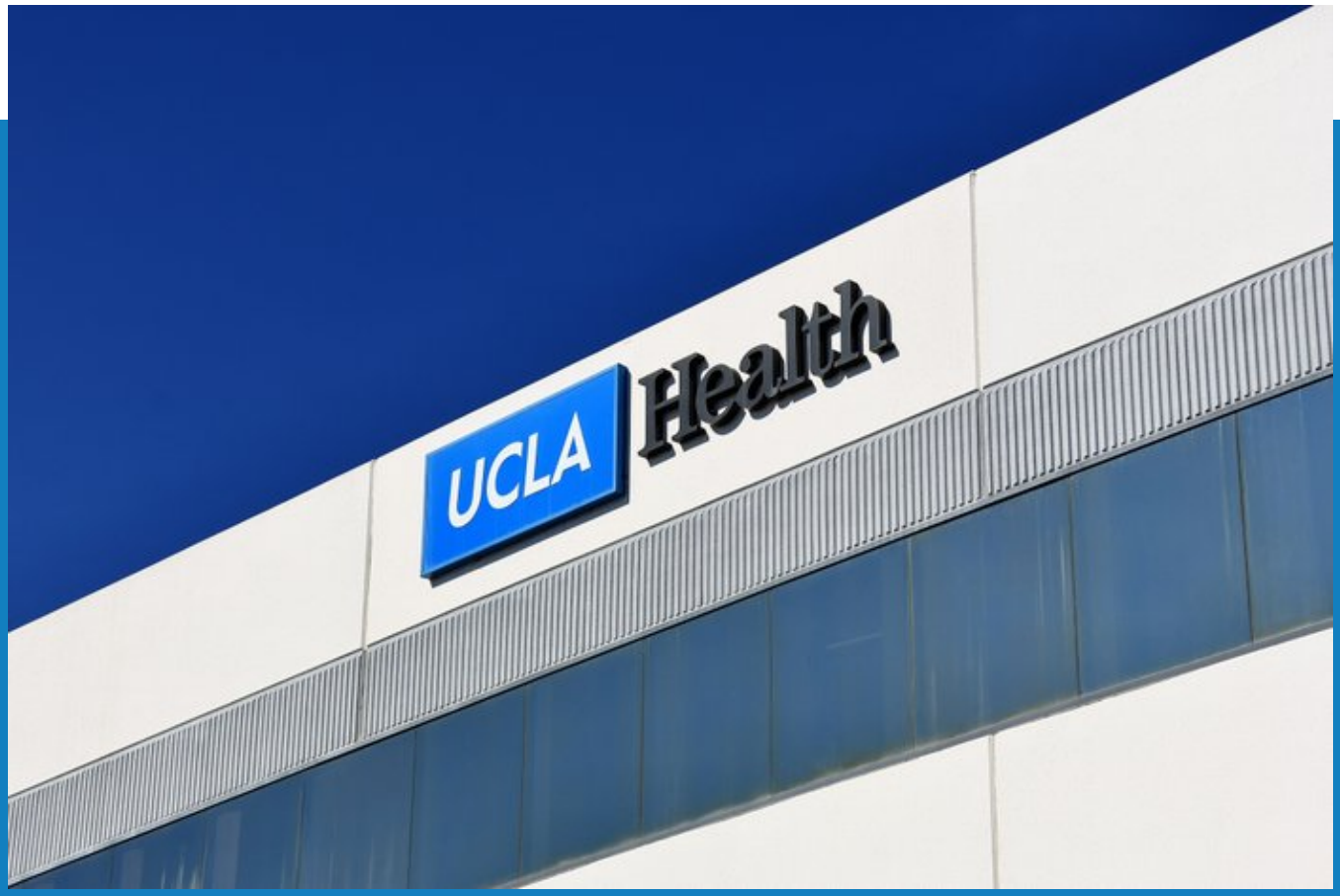

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