

Plant Based Nutrition in Addiction Recovery

A recovery kitchen framework for vegetarian vegan and raw food practice

Cary Stratton (Chef Mason Green)

ABSTRACT

Nutrition programs for people recovering from alcohol and other substance use disorders must address nutritional depletion, cardiometabolic risk, and the practical ability to maintain adequate meals. This narrative review integrates plant-based nutrition research, addiction-care guidance, raw-food studies, and culinary education evidence to propose a recovery kitchen framework informed by retreat practice. Vegetarian and vegan interventions can improve selected cardiometabolic markers, but trials in general populations do not establish addiction treatment efficacy or a raw-food dose response. Strict raw diets may compromise energy intake and some micronutrient adequacy. The framework therefore treats medical stabilization and adequate nourishment as prerequisites, combines fresh produce with useful cooked and fortified foods, and prioritizes indication-based supplementation. Its distinctive proposition is that a retreat should be evaluated partly by the nutritional skills and food access participants retain after leaving. Practical meal designs and a staged implementation pathway are provided. A proposed randomized feasibility study would compare hands-on culinary training with attention-matched education while holding food provision and clinical care comparable. A separate controlled study would be needed to isolate raw-food exposure. The central hypothesis is that sustainable dietary quality, nutritional adequacy, and transferable meal skills offer a more defensible basis for recovery support than dietary strictness.

Keywords: *plant-based nutrition; substance use disorders; alcohol recovery; raw food diets; nutritional rehabilitation; culinary education; dietary adherence*

1 Introduction

A person can leave a retreat knowing which foods to avoid and still be unable to prepare a nourishing dinner. This is the practical problem at the center of this paper. A successful food program should restore the capacity to eat adequately, enjoy meals, and repeat useful habits in an ordinary kitchen. For people in addiction recovery, those tasks sit alongside medical treatment, psychological care, relationships, housing, and access to food.

My experience running a detox health retreat and working with people recovering from alcohol and other substance use problems motivates this inquiry. My contribution is a culinary perspective on translating nutrition into meals that people can prepare and sustain. No participant counts, laboratory records, or systematically collected outcomes are available for analysis here, and no recovery or cure rate is inferred from my data to keep personal information private.

The nutritional problems associated with substance use are heterogeneous. Inadequate intake can coexist with overweight, nutrient deficiencies, disrupted appetite, and changing food preferences during treatment. Consequently, body weight alone cannot establish nutritional recovery [1]. Appropriately planned vegetarian and vegan patterns can meet adult nutritional needs and support cardiometabolic health [2]. Whether a specific implementation improves addiction outcomes, however, remains a separate question.

I propose a recovery kitchen framework: a practical system that connects adequate food provision, safe preparation, individualized supplementation, and the ability to reproduce meals after discharge. Its originality lies in this particular integration and its proposed evaluation, not in a claim to have invented culinary medicine, nutritional rehabilitation, or plant-based eating. The framework makes a deliberate distinction between the proportion of food that is raw and the quality of nutrition a person actually achieves.

2 Review approach and boundaries

This is a targeted narrative review with a practice framework and prospective research proposal. Publicly accessible journal articles, PubMed-indexed records, publisher pages, professional guidance, and original polling reports were consulted. Searches combined terms for vegetarian and vegan diets, raw-food diets, cardiometabolic trials, substance use and nutrition, alcohol withdrawal, thiamine, dietary supplements, and culinary interventions. Reference selection emphasized controlled human studies for efficacy, observational studies for longer-term associations and potential harms, and clinical guidance for immediate safety decisions.

This was not a registered systematic review. There was no exhaustive database export, duplicate independent screening, formal risk-of-bias scoring, or new meta-analysis. Some studies were accessible only through their abstracts; conclusions drawn from those records remain limited to the reported information. The evidence table summarizes selected studies rather than every eligible publication. Polls are used for social context, not therapeutic inference.

Four types of statements are distinguished throughout: findings from published studies, recommendations from clinical or nutrition guidance, culinary proposals developed here, and hypotheses requiring future testing. The practical menus are illustrative adult meal patterns, not analyzed prescriptions. Children, pregnancy, eating-disorder treatment, severe malnutrition, advanced kidney disease, and decompensated liver disease require specialized assessment beyond this framework. Nutrition supports, but does not replace, evidence-based addiction care.

3 What the plant based evidence supports

Controlled studies support a useful but bounded conclusion: vegetarian and vegan interventions can improve selected cardiometabolic risk factors. In a meta-analysis of 20 randomized trials involving 1,878 participants with cardiovascular disease or elevated cardiovascular risk, Wang and colleagues reported average between-group changes of -6.6 mg/dL in LDL cholesterol, -0.24 percentage points in HbA1c, and -3.4 kg in body weight over approximately six months. The overall systolic blood-pressure difference was not significant [3]. These are averages across differing interventions and comparators, not promised individual outcomes.

In an eight-week trial of 22 identical-twin pairs, a healthy vegan diet improved LDL cholesterol, fasting insulin, and body weight relative to a healthy omnivorous diet. The estimated between-group LDL difference was -13.9 mg/dL, with a 95% confidence interval from -25.3 to -2.4 mg/dL [4]. A separate 16-week trial in 244 adults with overweight found benefits of a low-fat vegan intervention for weight and insulin sensitivity [5]. Neither study tested raw veganism, addiction remission, or the reversal of all chronic conditions.

Food quality also matters within plant-based patterns. Prospective cohort research associated a healthful plant-based index with lower coronary heart disease risk and an unhealthful plant-based index with higher risk [6]. Such associations remain vulnerable to confounding, but they undermine the assumption that excluding animal foods automatically creates an adequate diet. A menu of refined snacks and sweetened drinks can be vegan while poorly serving recovery needs.

The practical implication is to define a treatment target before choosing a dietary strategy. An adult with excess adiposity and elevated LDL may benefit from an approach that lowers energy density. An undernourished adult with poor appetite may need the opposite adjustment. The same weight change can represent benefit in one person and harm in another. Disease management should therefore track the relevant clinical outcomes, functioning, nutrient status, and medication changes.

Table 1 Selected human evidence and the limits of its application

Source and design	Finding relevant to this paper	What it does not establish
Wang et al. [3] 20 randomized trials; n = 1,878	Modest improvements in LDL, HbA1c, and weight; no significant overall systolic BP effect.	Raw-diet superiority or addiction recovery efficacy.

Source and design	Finding relevant to this paper	What it does not establish
Landry et al. [4] 22 twin pairs; 8 weeks	Healthy vegan assignment improved several cardiometabolic markers.	Long-term clinical events or a raw-food effect.
Koebnick et al. [7] Questionnaire study; n = 513	Underweight and menstrual disturbance occurred among long-term raw-food adherents.	Causation or harm from ordinary servings of raw produce.
Koebnick et al. [8] Cross-sectional study; n = 201	Favorable lipid measures coexisted with B12 and homocysteine concerns.	A complete risk–benefit assessment or a healing rate.
Wastyk et al. [22] Randomized study; 18 per arm	Fermented-food and high-fiber interventions produced differing microbiome and immune responses.	That every fermented food or probiotic treats addiction.
Hasan et al. [27] Systematic review and evidence map	Culinary education is promising for dietary and behavioral outcomes; evidence has limitations.	That the framework proposed here is already validated.

4 Raw food as a preparation choice

Vegetarian diets exclude meat and fish, with some including eggs or dairy. Vegan diets exclude animal-derived foods. Raw-food practice concerns preparation and can overlap either category; historical raw-food studies did not necessarily enroll only vegans. No single temperature cutoff or percentage defines every raw-food diet. Research must therefore specify the exposure rather than treat these labels as interchangeable.

Fresh fruit, salads, herbs, nuts, and seeds can improve variety and enjoyment. Raw preparation may preserve some heat-sensitive nutrients and offers valuable textures. Yet nutrient availability depends on the food and preparation method. Laboratory work on tomatoes found that heating increased bioaccessible lycopene while vitamin C declined [24]. This is evidence of a trade-off, not a clinical trial of faster healing. Cooking also makes useful staples available and can reduce particular food-safety hazards [25].

The strongest version of the raw-food hypothesis is testable: among nutritionally adequate diets, increasing the raw proportion independently improves a defined health outcome. The evidence assembled here does not establish that hypothesis. A questionnaire study of 513 long-term raw-food adherents reported underweight in 14.7% of men and 25.0% of women; approximately 30% of women younger than 45 reported partial or complete amenorrhea [7]. Selection, self-report, and the cross-sectional design limit causal interpretation. Nevertheless, these findings cannot be reconciled with a universal claim that increasing raw-food strictness always improves health.

In another cross-sectional study of 201 raw-food adherents, favorable LDL cholesterol and triglyceride findings coexisted with low vitamin B12 and elevated homocysteine concerns [8]. A lower cholesterol measurement therefore cannot stand in for a complete assessment of nutritional health. Similarly, an observational EPIC-Oxford analysis found greater fracture risk in vegans for several outcomes; residual confounding and differences in diet quality limit attribution, but the finding reinforces the need to attend to bone health [32].

For retreat practice, I propose an adequacy boundary: increase raw foods only while sufficient energy, protein, essential nutrients, gastrointestinal tolerance, and food safety remain protected. This is a decision principle, not a validated clinical threshold. There is no evidence-based requirement to reach 75%, 90%, or 100% raw intake. A participant who adds cooked lentils, organic soy milk, or a warm grain dish has made a nutritional adjustment, not failed a recovery test.

5 What detoxification should mean in recovery care

The word detoxification can refer to medically managed withdrawal, treatment of a specific toxic exposure, or commercial wellness practices that claim to remove unspecified toxins. These meanings must remain separate. Alcohol withdrawal can become life-threatening and requires appropriate clinical assessment and treatment. A retreat kitchen cannot substitute for withdrawal management. ASAM recommends thiamine to prevent Wernicke encephalopathy and favors intravenous or intramuscular administration in circumstances including poor nutrition, malabsorption, and severe withdrawal complications [9]. The treating clinician determines regimen and route.

Refeeding risk is a second concern. A person who has eaten very little, lost substantial weight, or has relevant electrolyte abnormalities may need supervised nutritional restoration. A history of alcohol misuse contributes to the NICE risk assessment when combined with other criteria [10]. It is unsafe to assume that a large fruit or juice intake is harmless simply because its ingredients are natural. The menu examples below begin only after medical clearance; they are not refeeding protocols.

For commercial cleanses, Klein and Kiat found little clinical evidence supporting the claimed elimination of toxins [11]. NCCIH likewise describes weak evidence and potential harms from restrictive regimens, laxatives, colon cleansing, and excessive fluid intake [12]. Feeling different after removing alcohol, sleeping regularly, receiving attention, and changing meals does not identify which component caused the improvement.

A credible detoxification claim should name the substance, identify a validated measure of exposure or burden, specify the elimination pathway, and demonstrate a clinically relevant benefit against a suitable comparator. Routine changes in stool frequency, perspiration, weight, or nonspecific symptoms do not meet that standard. Headache, dizziness, diarrhea, and exhaustion should prompt assessment rather than be celebrated as proof of cleansing.

The program proposed here therefore replaces a cleanse schedule with a coordinated restoration pathway. Medical staff manage withdrawal and deficiencies; food staff provide tolerable meals and instruction; participants retain access to addiction treatment and prescribed medicines. Juice may be a beverage within an adequate menu. It should not displace the protein, essential fats, and total energy needed for recovery. Fasting, colon irrigation, laxative teas, and supplement stacks have no routine place in this framework.

6 Building meals that can be sustained

6.1 Begin with sufficient energy and a protein source

Protein adequacy is compatible with vegetarian and vegan eating when the overall diet supplies enough energy and includes appropriate protein sources. A varied pattern does not require deliberate pairing of complementary proteins at every meal. Legumes, soy foods, grains, nuts, and seeds contribute different amino acid profiles [13]. For generally healthy adults, 0.8 g/kg/day is the standard protein reference intake; rehabilitation, older age, illness, or higher activity may change the appropriate target. Those situations need individual assessment rather than an automatic retreat-wide prescription.

My practical meal-building proposal begins with a recognizable protein component: tofu, tempeh, lentils, beans, chickpeas, edamame, or another suitable option. Add an energy source such as oats, rice, quinoa, bread, or potatoes; vegetables or fruit; and a source of unsaturated fat where useful. Adjust portions to appetite, weight trajectory, activity, and clinical goals. A large bowl of leaves is an accompaniment unless the rest of the meal supplies what it lacks.

For people who prefer more raw food, retain fruit, salads, seeds, and nut-based sauces while reviewing whether the total pattern is adequate. Nuts and seeds can help increase energy intake but should not automatically become the only substantial protein foods. A blended soup, soft tofu dish, or cooked cereal may be easier to manage during poor appetite or dental discomfort. These are proposed culinary adaptations, not evidence that a particular texture accelerates addiction recovery.

6.2 Choose plants for their nutritional contribution

A useful plant-based pantry is built from familiar, affordable foods. Beans and lentils contribute protein, fiber, and minerals. Whole grains provide energy and variety. Fruit and vegetables add fiber and micronutrients; nuts, seeds, and suitable oils help provide essential fats. Fortified foods deserve an explicit place when they close nutrient gaps [2,13–21]. Processing is not a single nutritional category: freezing vegetables, canning beans, and fortifying plant milk can make an adequate diet easier to sustain.

Vitamin C-rich produce can help the absorption of nonheme iron. A lentil dish with bell pepper, broccoli, or citrus is a useful combination [19]. For calcium, select only some fortified plant beverages or tofu according to the label and include suitable greens; spinach is a poor calcium cornerstone because its oxalate content limits calcium absorption [17]. Ground flaxseed, chia, and walnuts can contribute alpha-linolenic acid, while algae-derived supplements supply preformed DHA, with or without EPA [21].

Preparation should support enjoyment and intake. A lemon-tahini sauce can make cooked vegetables and raw salads appealing; mild spices can make lentils familiar rather than medicinal. Where bloating follows a sudden fiber increase, smaller portions and a gradual transition are practical adjustments. Persistent symptoms require assessment. More food variety is a useful direction, but a fixed number of plants per week is not an established treatment dose for substance use disorders.

6.3 Use microbiome evidence without overstating it

Diet can influence the intestinal microbiome, but translating microbial changes into clinical recovery requires evidence. In a small randomized study, Wastyk and colleagues compared high-fiber and fermented-food interventions. The fermented-food arm increased microbial diversity and reduced several inflammatory markers, whereas the high-fiber arm showed heterogeneous immune responses and did not change its primary cytokine response score [22]. The fermented-food intervention was not exclusively vegan and should not be presented as proof for a specific raw vegan menu.

Leclercq and colleagues associated intestinal permeability and microbial differences with psychological symptoms in a subgroup of people with alcohol dependence [23]. The study helps motivate research on gut–brain pathways; it does not establish that a probiotic, fermented drink, or raw-food diet prevents relapse. In this framework, unsweetened cultured plant foods are optional foods when tolerated. Their composition, sodium, food safety, and possible alcohol content require attention. Fermented beverages should not be assumed suitable for an alcohol-free recovery setting.

6.4 Maintain food safety

Wash produce using safe water, prevent cross-contamination, refrigerate perishable prepared foods, and follow local food-service requirements. Raw and lightly cooked sprouts have a recognized outbreak history [26]. A retreat should not rely on home sprouting as a safety-controlled protein strategy, especially for medically vulnerable participants. Raw or undercooked kidney beans can cause illness from phytohaemagglutinin; use properly cooked beans and validated preparation instructions [25]. Soaking alone does not make every raw food safe.

Food safety is part of nutritional quality. A dehydration temperature chosen to satisfy a raw-food definition is not necessarily a pathogen-kill step. Similarly, an unpasteurized beverage should not receive an automatic health advantage over a safer alternative. Staff should record allergies, ingredient substitutions, and the handling requirements of each recipe before service.

7 Supplements selected by need

The best supplement is one that reliably addresses an identified nutritional requirement or clinical indication. A vegan adult needs a dependable B12 strategy; a person at risk of Wernicke encephalopathy needs urgent clinician-directed thiamine care. Those needs should not be blurred with optional products marketed for energy, cleansing, or neurotransmitter optimization. Table 2 separates routine dietary planning from clinician-managed correction.

Daily reference intakes describe total intake from food and supplements; they are not automatically supplement doses. Before adding a product, review the menu, current supplements, medications, kidney and liver function, and relevant laboratory findings. Prefer products with clear ingredient quantities and independent identity or contaminant testing where available. Quality certification does not prove a product treats disease.

Table 2 A prioritized supplement and nutrient planning guide for adults

Priority	Practical role	Boundary
Vitamin B12 [14,15]	Essential reliable source for vegan diets. A commonly used maintenance option is cyanocobalamin at least 10 mcg daily or 2,000 mcg weekly.	These are alternative Vegan Society maintenance schedules, not deficiency-treatment regimens. Neurologic symptoms or suspected malabsorption require medical assessment.
Thiamine [9,10]	Clinical priority in alcohol-related risk, malnutrition, and refeeding assessment.	A standard multivitamin is not a substitute for prescribed treatment. Route and dose depend on risk and diagnosis.
Vitamin D [16]	Meet total adult reference intake of 600 IU/day through age 70 or 800 IU/day thereafter; supplementation may close a gap.	Deficiency treatment differs. Avoid routine megadoses; individual factors may warrant testing and prescribed dosing.
Iodine [18]	For nonpregnant adults, plan around 150 mcg/day total using a reliable source; supplement if diet does not cover need.	Kelp content is variable. Thyroid disease and existing iodine intake affect decisions; pregnancy needs differ.
Calcium [17]	Aim for the age- and sex-appropriate total of 1,000–1,200 mg/day. Use fortified foods first; supplement a documented shortfall.	Check labels and total intake. Higher supplement doses are not automatically more beneficial.
Omega 3 fats [21]	Include ALA-rich foods. Algal DHA/EPA is an optional way to obtain preformed long-chain omega 3.	No established algal-oil dose treats addiction. Consider indication, medicines, and total intake; avoid routine high-dose use.
Iron and zinc [19,20]	Assess dietary intake and deficiency risk; replace when indicated.	Do not use iron indiscriminately. Prolonged high-dose zinc can cause copper deficiency.
Protein or complete nutrition products [13]	Useful when ordinary meals do not meet assessed intake goals. Soy or blended plant protein may be convenient.	Protein powder alone is not a complete diet. A fortified nutrition product may better fit a broad intake deficit.

B12 deserves a written plan rather than a vague instruction to eat naturally. Fortified foods and appropriate supplements are reliable tools; unfortified nutritional yeast, seaweed, and fermented foods should not be treated as dependable substitutes. Serum B12 can be supplemented by methylmalonic acid testing when clinically indicated, with renal function considered in interpretation [14]. The maintenance schedules above are useful examples from a vegan nutrition organization, not proof that one schedule fits every medical circumstance [15].

A conventional multivitamin may help during limited intake if chosen with a clinician or dietitian, but it cannot supply adequate calories or protein and may not contain the required amounts of particular nutrients. The full label matters: combining several products can create unintended duplicate dosing. Improvement in a deficiency does not demonstrate benefit from further supplementation after that deficiency is corrected.

N-acetylcysteine illustrates the gap between a plausible mechanism and a dependable recommendation. In a 12-week randomized trial involving 302 adults with cannabis use disorder, NAC did not improve the primary abstinence outcome relative to placebo [30]. That result does not

settle every possible indication, but it argues against presenting NAC as a general recovery supplement. Likewise, clinical evidence for milk thistle in liver disease is conflicting or insufficient [31]. Neither belongs in a universal retreat protocol as a proven detoxifier. Proprietary amino-acid blends, broad probiotic stacks, and high-dose antioxidant products require indication-specific evidence rather than extrapolation from laboratory mechanisms.

8 The recovery kitchen in practice

8.1 A staged pathway

The following pathway is a proposal for implementation, not a validated treatment algorithm. Progress depends on readiness and clinical assessment rather than a fixed cleanse calendar.

Stage one is assessment and stabilization. Establish access to medical care, evaluate withdrawal and nutritional risk, document food allergies and medications, and identify practical barriers such as poor dentition, nausea, lack of refrigeration, or food insecurity. People with confusion, seizures, severe withdrawal symptoms, or inability to maintain fluids need prompt medical evaluation. Kitchen staff communicate observations without diagnosing a cleansing reaction.

Stage two is adequate, tolerable food. Offer predictable meals and snacks with flexible portions. Provide softer cooked options alongside appropriate fresh foods. Identify a protein source and a reliable B12 plan, and use nutrient fortification or prescribed supplements as needed. Reassess a menu that causes unintended weight loss, persistent hunger, or gastrointestinal distress.

Stage three is participation. Invite each person to choose familiar flavors, prepare a simple sauce, assemble a meal, and practice a safe storage task. Use demonstrations followed by hands-on preparation. Participation is voluntary and should accommodate disability, fatigue, cultural preferences, and recovery-related stress. A participant should not need an expensive blender, dehydrator, or specialty powder to reproduce the core meals.

Stage four is transfer home. Rehearse shopping, label reading, substitutions, and two fallback meals. Plan for limited time and equipment. Where possible, connect participants with food support and clinical follow-up. Record what they can actually obtain rather than prescribe a menu dependent on a retreat's purchasing power. The proposed success criterion is a safe, adequate pattern that remains usable after professional food service ends.

8.2 Three illustrative days

The following menu sketches are original practical examples. Portions should be individualized, and their full nutrient content has not been calculated. B12, iodine, calcium, vitamin D, and energy adequacy must be checked across the complete pattern. They are intended for medically stable adults and do not prescribe weight loss.

Day one, a vegan foundation. Breakfast: oats prepared with fortified soy milk, berries, ground flaxseed, and peanut or another tolerated nut butter. Lunch: a bowl of cooked lentils and rice with cucumber, tomato, herbs, and lemon-tahini dressing. Dinner: tofu with broccoli and a baked potato, plus fruit. Snack options include fortified soy yogurt, hummus with bread, or nuts. The raw elements provide freshness while cooked staples carry substantial nourishment.

Day two, a vegetarian adaptation. Breakfast: whole-grain toast, eggs or tofu, and fruit. Lunch: chickpea salad in a pita with vegetables and yogurt or a fortified plant alternative. Dinner: a bean-and-vegetable stew with a grain portion. Snacks can include fruit, seeds, or dairy if desired and tolerated. Eggs and dairy are optional choices, not guarantees that B12, iodine, or calcium intake is sufficient. Cheese should not displace legumes and other nutrient-rich foods throughout the day.

Day three, a raw-forward vegan adaptation. Breakfast: a fruit bowl with chia, hemp seeds, and a fortified soy accompaniment. Lunch: a substantial salad with avocado, pumpkin seeds, cooked chickpeas, and bread or a cooked grain. Dinner: raw zucchini ribbons mixed with warm lentils and tomato sauce, with a side of fruit or additional starch according to need. This is intentionally a mixed raw-and-cooked menu; its suitability depends on adequacy rather than a raw percentage. A strictly raw preference requires individualized analysis, dependable supplements, and willingness to modify the pattern if nutritional needs are not met.

8.3 Two meal skills and a fallback

A flexible sauce is a useful first skill. Whisk tahini with lemon juice and enough water to reach the desired consistency; add herbs and season to taste within any sodium restrictions. Serve it with beans, grains, or vegetables. For sesame allergy, use another tolerated base. The teaching objective is learning how flavor and texture can make staple foods satisfying.

A flexible bowl is a useful second skill. Assemble one cooked protein food, one grain or starchy food, two vegetables or fruits, and a dressing or other appropriate fat source. The portions are adjustable; the categories are a teaching aid rather than a nutritional scoring system. Participants should practice substituting what their own shop sells.

A fallback meal should remain possible on a difficult day: ready-to-eat canned beans, microwave rice or bread, frozen vegetables, and a simple sauce. Where heating is unavailable, use safe ready-to-eat foods suited to storage conditions. Fortified shelf-stable plant milk can be useful. The goal is to reduce the number of decisions required to eat adequately, without treating convenience foods as a moral failure.

9 Feasibility is a clinical and social question

Polls show why a retreat should not assume that strict vegetarian or vegan identity is a prerequisite for participation. Gallup's 2023 US survey reported 4% identifying as vegetarian and 1% as vegan [28]. A 2022 Vegetarian Resource Group poll conducted by YouGov reported 6% vegetarian including vegans, of whom 3% of the total adult population were vegan [29]. These are differently worded and differently conducted surveys; the numbers should not be pooled or read as evidence of change over time. Neither poll measured nutritional adequacy or treatment outcomes.

For the proposed framework, these surveys support only a modest implementation inference: many participants will approach plant-based food without an established dietary identity. A program can offer appealing plant-based meals and nutrition education without requiring people to adopt a label. Culture, ethics, finances, food access, and taste can each shape adherence.

Culinary-intervention research provides a rationale for teaching preparation skills, but findings are heterogeneous and do not validate this particular program [27]. The retreat should therefore track attendance, acceptability, food access, adverse experiences, and continuation after discharge. A low-cost bean dish that a participant can repeat has a different practical value from a technically impressive meal that depends on specialist equipment. This distinction is a proposed evaluation priority, not a demonstrated superiority result.

10 A research program that can test the framework

10.1 Culinary skills and continuation after discharge

I propose a randomized feasibility study in medically stable adults receiving ongoing treatment for alcohol use disorder. Restricting the initial study to one primary disorder would reduce clinical heterogeneity; later studies could examine other substance use disorders separately. Participants would enroll after acute withdrawal and refeeding risks have been addressed. Active medical instability, current severe eating disorders, or inability to meet nutritional needs through the study menus would require alternative care or an adapted protocol.

Both groups would receive the same nutritionally planned plant-based menu during the residential phase, equivalent food resources after discharge, and usual addiction care. One group would receive hands-on meal preparation and shopping practice. The other would receive attention-matched nutrition education without hands-on cooking. Contact time, staff encouragement, and access to ingredients would be kept comparable. The contrast would estimate the added effect of skill practice, not the effect of vegan eating versus another diet.

The proposed primary feasibility outcome is completion of the 12-week postdischarge assessment. Secondary feasibility outcomes would include recruitment, session attendance, acceptability, dietary assessment completion, and intervention delivery. Candidate clinical and behavioral outcomes include diet quality using a prespecified validated measure, meal preparation frequency, self-efficacy,

nutrient adequacy, weight trajectory, and treatment engagement. Substance use outcomes should use prespecified validated measures, with biomarkers where appropriate; they would be exploratory in a feasibility study.

A full protocol would determine sample size from the desired precision of the retention estimate, expected attrition, and recruitment capacity. No sample size or detectable clinical effect is claimed here. Allocation should be concealed, outcome assessors masked where feasible, and statistical plans registered before enrollment. Feasibility estimates should include confidence intervals. Exploratory between-group analyses should follow intention-to-treat principles, account for baseline values and repeated observations, and state assumptions about missing data. Participants who discontinue meals should remain eligible for follow-up.

10.2 Testing the claim about raw food separately

A second, independently powered trial would be needed to test whether increasing raw-food exposure improves a defined clinical outcome. It could compare nutritionally adequate menus with differing raw proportions in a suitable medically stable population. Energy, protein, fiber, saturated fat, counseling, food provision, and relevant micronutrients should be matched as closely as feasible and actual intake measured. When perfect matching is impossible, those differences become part of the intervention and limit claims about an isolated raw-food effect.

The protocol should define raw exposure as a percentage of energy, accompanied by food-weight data and a precise preparation definition. Percentages by weight can overrepresent water-rich foods. Fortified foods, commercial processing, soaking, fermentation, and dehydration need explicit classification. The trial should select one primary outcome and one main time point before recruitment; additional endpoints would require multiplicity control or an exploratory designation.

For a cardiometabolic trial, LDL cholesterol or HbA1c might be appropriate depending on eligibility and duration. For an addiction trial, a validated substance-use outcome would be necessary; microbiome shifts or inflammatory markers could not substitute for it. Safety monitoring should cover unintended weight loss, inadequate intake, nutrient deficiencies, foodborne illness, and relevant clinical deterioration. Participants must be able to leave the dietary intervention without losing treatment access.

The stronger claim that more raw food produces faster healing would require repeated measurements, a defined clinical endpoint, and a prespecified dose-response analysis. A two-arm comparison alone cannot establish a universal monotonic relationship. Similar improvement in matched diets, poorer tolerability at greater raw exposure, or inadequate intake would each count against that broad claim. Favorable results limited to one condition could not establish benefit across unrelated chronic diseases.

11 Discussion

The recovery kitchen framework treats a retreat as a place to practice sustainable nourishment. It brings the chef's expertise into a coordinated care model while leaving diagnosis, withdrawal treatment, medication management, and deficiency correction with qualified clinicians. Its proposed mechanism includes both dietary improvement and the practical ability to obtain and prepare meals. Those components should be measured separately rather than bundled into an undefined claim of detoxification.

A plausible objection is that raw-food strictness motivates some participants. Dietary identity can be meaningful, and a participant's preference deserves respect. The framework does not require abandoning that identity. It requires checking whether the chosen pattern supplies adequate nutrition and remains acceptable under everyday conditions. A preference becomes a clinical claim only when it is said to accelerate healing or treat disease, at which point comparative evidence is needed.

Another objection is that a carefully structured retreat may produce impressive improvements regardless of the menu. That is precisely why controlled comparisons matter. Alcohol reduction, medication adjustment, regular sleep, structured activity, social support, and regression to the mean can all complicate the interpretation of before-and-after observations. Testimonials may identify questions and meaningful outcomes, but they cannot isolate dietary causation.

The plant-based evidence is strongest when the conclusion remains specific: selected dietary patterns can improve selected risk factors in studied populations. Extending those findings to addiction recovery is an application to investigate, not an established treatment effect. Culinary training has a separate evidence base and should not borrow certainty from lipid trials. By separating these questions, the framework offers a stronger basis for both responsible practice and future research.

Chronic disease care also requires specificity. Better glycemic control is not equivalent to cure; reduced LDL does not establish reversal of cardiovascular disease; a change in a liver enzyme does not prove restored liver architecture. The relevant clinician should interpret outcomes and supervise any medication changes. Neither a dietary label nor a retreat certificate should determine that decision.

12 Limitations

The review is selective and may omit relevant evidence. The underlying literature varies in dietary definitions, comparator quality, duration, adherence, and participant characteristics. Raw-food studies are particularly limited and often observational. General-population cardiometabolic trials do not resolve outcomes in people with substance use disorders, and the framework has not been prospectively validated.

The retreat experience that motivates this paper is not accompanied by auditable clinical records in this manuscript. It therefore contributes context and practical questions rather than effect estimates. The menus have not undergone quantitative nutrient analysis, cost testing, or cultural adaptation across settings. The proposed studies require a complete protocol, ethics review, prospective registration, and independent clinical oversight before implementation. No claim of first-ever originality, established cure, or completed peer review is made.

13 Conclusion

A strong plant-based recovery program makes adequate eating possible and repeatable. Its foundations are medically appropriate care, sufficient nourishment, dependable nutrient planning, enjoyable food, and the skills and resources to continue at home. Fresh raw foods can contribute substantially, while cooked staples and fortified foods can make the same program more complete and accessible.

The available evidence does not justify promising that each increase in raw-food intake accelerates recovery from addiction or chronic disease. That proposition deserves a fair test with defined outcomes and safeguards against nutritional deterioration. The recovery kitchen framework offers a practical alternative research question: does teaching people to sustain an adequate plant-based pattern improve their nutritional health and daily functioning after structured care ends? A retreat's most consequential meal may be the one a participant learns to make after leaving.

Declarations

Competing interests. Cary Stratton works in plant-based culinary education and has authored books relevant to this subject. These professional interests however do not influence perspective. The data comes from not only first hand experience but experience in helping others. Funding; no specific funding was received.

Declaration of Generative AI and AI-Assisted Technologies

ChatGPT was used to assist with manuscript organization, editing, document preparation, and citation placement.

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Appendix A Author biography

Cary Stratton, known professionally as Chef Mason Green, is a chef and educator trained under Cherie Soria at Living Light Culinary Arts Institute. His work includes private chef services, catering, television food styling, and plant-based culinary education. A longtime vegetarian and raw-food practitioner, he brings retreat experience focused on people recovering from alcohol and other substance use problems. He is the author of two books and previously worked in the film industry. His approach emphasizes practical food preparation and sustainable eating habits.

Author page: [Chef Mason Green on Amazon](#)