Nutritional Deficiencies and Clinical Correlates in First-Episode Psychosis: A Systematic Review and Meta-analysis

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**Objective:** Diet is increasingly recognized as a potentially modifiable factor influencing the onset and outcomes of psychiatric disorders. Whereas, previous research has shown long-term schizophrenia is associated with various nutritional deficiencies, this meta-analysis aimed to determine the prevalence and extent of nutritional deficits in first-episode psychosis (FEP).

**Method:** A search of electronic databases conducted in July 2017 identified 28 eligible studies, examining blood levels of 6 vitamins and 10 minerals across 2612 individuals: 1221 individuals with FEP and 1391 control subjects. Meta-analyses compared nutrient levels in FEP to nonpsychiatric controls. Clinical correlates of nutritional status in patient samples were systematically reviewed.

**Results:** Significantly lower blood levels of folate (N = 6, n = 827, g = −0.624, 95% confidence interval [CI] = −1.176 to −0.072, P = .027) and vitamin D (N = 7, n = 906, g = −1.055, 95% CI = −1.99 to −0.119, P = .027) were found in FEP compared to healthy controls. Synthesis of clinical correlates found both folate and vitamin D held significant inverse relationships with psychiatric symptoms in FEP. There was also limited evidence for serum level reductions of vitamin C (N = 2, n = 96, g = −2.207, 95% CI = −3.71 to −0.71, P = .004).

No differences were found for other vitamins or minerals.

**Conclusions:** Deficits in vitamin D and folate previously observed in long-term schizophrenia appear to exist from illness onset, and are associated with worse symptomology. Further research must examine the direction and nature of these relationships (ie, mediator, moderator, or marker) with clinical status in FEP. Future trials assessing efficacy of nutrient supplementation in FEP samples should consider targeting and stratifying for baseline deficiency.

**Key words:** folic acid/cholecalciferol/nutrients/dietary/trace elements/nutrition/antioxidants

**Introduction**

Nutritional deficiencies, resulting from insufficient intake or absorption of nutrients critical to human health, are now a recognized risk factor for psychiatric disorders. For instance, excessive intake of nutritionally devoid foods is predictive of poor mental health, whereas a healthy diet reduces risk. Although previous research has focused on common mental disorders, recent attention has been drawn to the food intake of people with schizophrenia—who may have the worst diet, poorest metabolic health, and greatest premature mortality across all severe mental illnesses.

Blood levels of certain nutrients are also significantly reduced in psychiatric disorders. Folate (B9) and B12 are often deficient in schizophrenia and be associated with symptom severity. Furthermore, B-vitamin supplementation can significantly reduce symptoms of schizophrenia and reverse some neurological deficits associated with the disorder. This is perhaps due to the neuroprotective properties of these nutrients, or the ability of B vitamins to lower homocysteine levels, which adversely affect cognitive function. However, the role of folate and vitamin D supplementation in FEP remains unclear.

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stress are highest at this point of illness\(^1\)\(^,\)\(^3\)\(^3\); both of which contributing to the elevated oxidative stress observed in this population.\(^1\)\(^6\),\(^3\)\(^3\)

Additionally, vitamin D is implicated in schizophrenia onset, with a body of research showing developmental deficiencies in vitamin D3 increase later risk\(^1\)\(^7\)\(^–\)\(^2\)\(^0\). Furthermore, vitamin D deficiencies persist over long-term illness and may be associated with worsened physical and mental health outcomes\(^2\)\(^1\),\(^2\)\(^2\). Studies have also indicated that certain dietary minerals, such as zinc and selenium, are lowered in people with schizophrenia,\(^2\)\(^3\)\(^–\)\(^2\)\(^5\) as has been observed in other conditions such as depression.\(^2\)\(^6\),\(^2\)\(^7\). The direction of these nutrient/pathology associations however need to be clarified by prospective research.

Previous meta-analyses examining individual nutrient levels in individuals with long-term schizophrenia have shown clear deficits in B vitamins (folate\(^2\)\(^8\) and B12\(^2\)\(^9\)), antioxidant vitamins (C and E),\(^1\)\(^6\) and vitamin D.\(^3\)\(^0\) However, which nutritional deficiencies are present at the first episode of psychosis (FEP), independent of antipsychotic treatment, has yet to be determined. This is a particularly pertinent issue, given that diet quality appears reduced from psychosis onset,\(^3\)\(^1\),\(^3\)\(^2\) and inflammation and oxidative stress are highest at this point of illness\(^1\)\(^6\),\(^3\)\(^3\); both of which may be also linked to poor nutrition. Additionally, the FEP phase has been identified as a “critical period” as firstly it is the stage where the process of neuroprogression appears most active,\(^3\)\(^4\) and secondly for reducing physical health inequalities,\(^3\)\(^5\) as the initiation of antipsychotic treatment is associated with rapid weight gain and metabolic dysfunction.\(^3\)\(^6\). Therefore, determining which nutritional deficits are present from the onset of antipsychotic treatment, and identifying which nutritional deficiencies are associated with physical and mental health outcomes in FEP, will identify key targets for dietary/nutrient interventions to improve nutritional status and attenuate neuroprogression and metabolic risk. Indeed, randomized controlled trials (RCTs) in long-term schizophrenia have already indicated that vitamin supplementation has greatest efficacy among individuals with shorter illness duration.\(^1\)\(^2\).

In the current study, we used meta-analytic techniques to quantify the presence and severity of nutritional deficits in FEP, across every class of vitamin and/or dietary mineral examined in this population to date. Along with determining where deficits may exist, we also sought to systematically review the clinical correlates of nutritional status, to identify which vitamins and minerals are related to physical and mental health outcomes in FEP.

**Methods**

This meta-analysis followed the PRISMA statement\(^3\)\(^7\) to ensure comprehensive and transparent reporting (supplement 1).

**Search Strategy**

An electronic database search Cochrane Central Register of Controlled Trials, Health Technology Assessment Database, AMED, HMIC, MEDLINE, PsycINFO, and EMBASE was conducted on July 7, 2017. A keyword search algorithm (supplement 2) was developed to identify all studies assessing blood levels of any vitamins and/or minerals in FEP. The reference lists of retrieved articles and Google Scholar were also searched to identify any additional relevant articles.

**Screening and Selection Process**

Only peer-reviewed research articles available in English were included. Eligible samples were those in which >75% of individuals were specified as “first-episode psychosis.” Studies in which the term “first-episode psychosis” was not explicitly used were only eligible if the entire patient sample was specified as either (1) currently receiving treatment from “early intervention in psychosis” services, or (2) within the first 3 years of receiving antipsychotic treatment for schizophrenia or other non-affective psychotic disorders (this period is broadly accepted and used as an appropriate timeframe for “early intervention” programs for psychosis).\(^3\)\(^8\)–\(^4\)\(^0\) This criterion was applied to capture all relevant studies of patients in relatively early stages of illness and antipsychotic treatment, while excluding samples likely representative of those with more established illness. Eligible studies were those which either: (1) compared blood levels (including whole blood, plasma, serum, erythrocyte, leukocyte, or other blood components) of any vitamin and/or dietary mineral (as defined by the British Nutrition Foundation, 2016\(^4\)\(^1\)) in FEP to a non-FEP control sample, or (2) reported on clinical correlates (ie, any metabolic, psychiatric, or neurocognitive parameters assessed using a clinically validated measure) of vitamin/mineral levels in FEP samples. For inclusion in the systematic review, no restriction was placed on the nature of control sample used. However, meta-analyses used only the data from studies which compared FEP to “healthy” control samples (ie, individuals with no psychiatric diagnosis).

**Data Extraction**

Articles were screened for eligibility by 2 independent reviewers (J.F. and R.C.). Disagreements were resolved through discussion until consensus was reached. Where further information or study data were required, the corresponding authors of the respective articles were contacted twice over the period of 1 month to request this. This was attempted for one paper but data were not retrieved.\(^4\)\(^2\) A systematic tool was used to extract the following data from each study:

Downloaded from https://academic.oup.com/schizophreniabulletin/advance-article-abstract/doi/10.1093/schbul/sbx162/4675234 by Western Sydney University Library user on 05 December 2017
(1) **Study characteristics:** study design, country, sample size (*n*).

(2) **FEP sample:** age, % male, inpatient/outpatient status, duration of untreated psychosis, medication type, and duration of antipsychotic treatment.

(3) **Control sample:** age, % male, clinical/healthy population, any sociodemographic characteristics matched to FEP sample for.

(4) **Study findings:** blood levels of vitamin/minerals in FEP and controls, outcomes of all reported statistical comparisons between groups, relationships with any physical/psychiatric/neurocognitive assessment measures.

**Statistical Analyses**

Meta-analyses were performed in Comprehensive Meta-Analysis 2.0. A random effects model was applied to all analyses to account for methodological heterogeneity between eligible studies, in terms of differences in both blood sampling procedures and assay measures used across studies. Individual analyses were performed for each vitamin and mineral examined in FEP patients, using pooled comparisons with blood levels observed in nonpsychiatric control samples. Where studies used multiple measures of an individual vitamin or mineral, the more complex measure which best reflects bioavailable levels or long-standing nutrient was preferentially used. The overall difference between FEP and control groups for each vitamin/mineral was computed as Hedge’s *G* from the raw (ie, unadjusted) mean levels reported in each study.

Variance between studies was assessed using Cochran’s *Q* and *I*^2^ values, both of which estimate the degree of variance resulting from between-study heterogeneity, rather than chance. For all statistically significant findings, Egger’s regression test was applied to quantify the risk of publication bias. Additionally, a “Fail-Safe N” was calculated to determine the number of unpublished null studies which would invalidate the findings, and Duval and Tweedie’s trim-and-fill analysis was applied. We also performed post hoc sensitivity analyses to assess if comparable differences were still observed when excluding outlier studies with very high effect sizes.

Finally, for all individual study findings which could not be combined in meta-analyses, we produced a systematic narrative synthesis reporting on: (1) differences between FEP samples and other “non healthy” (ie, clinical/psychiatric) populations, and (2) all clinical correlates of vitamin/mineral levels in FEP.

**Results**

The initial database search was performed on July 7, 2017. The search returned 1578 results, reduced to 1176 after duplicates were removed. A further 1071 articles were excluded after and abstract screening. Full text versions were retrieved for 105 articles, of which were 26 eligible for inclusion. A further 2 eligible articles were identified from an additional search of Google Scholar. Full details of the search results and reasons for exclusion and are summarized in figure 1.

A total of 28 articles, reporting data from 24 unique samples of 2612 participants (1221 FEP, 1391 controls) were included. These assessed differences in blood levels of 6 vitamins (A, B12, C, D, E, and folate) and 10 minerals (zinc, magnesium, sodium, potassium, calcium, copper, chromium, iron, manganese, and selenium). Four studies were conducted in India, 3 in Pakistan and China, 2 in United States of America, United Kingdom, Turkey, Spain, and Nigeria, and individual studies in Poland, Romania, Norway, and Singapore. Full details and findings of all included studies are shown in table 1a–d.

**B Vitamins in FEP**

Nine studies, with 6 independent samples, reported on B vitamin levels across 872 participants: 425 with FEP, all of whom were medication-naïve (except for one study where this was not specified; table 1), and 447 controls. Two B vitamins were examined: folate (B9) and cobalamin (B12).

Random effects meta-analyses found significantly lower blood levels of folate in FEP compared with healthy controls (figure 2), with a moderately large effect size (*N* = 6, *n* = 827, *g* = −0.624, 95% CI = −1.176 to −0.072, *P* = .027). There was significant heterogeneity (*Q* = 66.0, *P* < .01, *F* = 92.4%), and a range of blood measures applied across studies, showing significant differences between FEP and controls in plasma, serum, and red blood cell levels (table 1). There was no evidence of publication bias (Egger regression, *P* = .16) and the trim-and-fill analysis did not identify any outlier studies. Furthermore, the fail-safe N was 71, indicating 71 additional null studies would be required to make the observed difference nonsignificant.

Four studies (*n* = 620) examined blood levels of vitamin B12, finding no significant difference between FEP and healthy controls (*g* = −0.059, 95% CI = −0.22 to 0.10, *P* = .468, *Q* = 2.96, *F* = 0%). A single study compared serum folate and vitamin B12 levels in FEP to people with depression, finding no significant differences between the 2 patient groups. However, no firm conclusions could this be drawn due to the low number of FEP patients examined (*n* = 14).

Table 1a shows all clinical correlates of B vitamin levels in FEP. Five studies examined relationships between folate levels and psychiatric symptoms (measured using the Positive and Negative Syndrome Scale; “PANSS”47). Only one found a significant correlation with PANSS total scores. However, 3 found significant correlations between serum folate and PANSS subscales; with lower
folate levels predicting more severe negative\textsuperscript{48,49} or gen-
eral\textsuperscript{53} symptoms. No associations were found for positive
symptoms or cognition.

Three studies examined clinical correlates of vita-
min B12 in FEP. One found trend-level correlation with
reduced positive symptoms,\textsuperscript{52} and 2 found significant
inverse correlation between B12 and negative symptom
scores.\textsuperscript{51,53} One further study examining the impact of
antipsychotic medications found significant reductions
in serum levels of both folate and B12 after 12 weeks of
treatment with olanzapine, but no reduction from risperi-
done in FEP.\textsuperscript{50} Finally, one study found that neither folate
or B12 levels were related to childhood trauma.\textsuperscript{53}

**Vitamin D in FEP**

Seven studies examined blood levels of vitamin D using
plasma and serum measures across 906 participants; 429
with FEP, 477 controls (table 1b). Meta-analyses com-
paring FEP to healthy control samples (all matched for age and ethnicity) showed that people with FEP had
reduced vitamin D levels; with a large, significant differ-
ence between the 2 groups ($g = -1.055$, 95\% CI = $-1.99$ to $-0.119$, \(P = .027\)) (figure 2). There was significant heter-
ogeneity but no evidence of publication bias ($Q = 216.6$, \(P < .01\), \(I^2 = 97.2\%\), Egger’s regression \(P = .27\), Fail Safe
\(N = 265\)). A sensitivity analysis excluding the single study
with large effect size ($g = -4.04$) which did not use estab-
lished FEP criterion (classifying patients as “newly diag-
nosed”)\textsuperscript{54} found the difference was still significant among
6 remaining studies ($g = -0.554$, 95\% CI = $-1.00$ to $-0.113$, \(P = .014\)). A study comparing vitamin D in FEP
and multi-episode schizophrenia found no significant
differences between groups.\textsuperscript{55} However, one study found
that the FEP patients later diagnosed with schizophrenia
had trend-level lower vitamin D than FEP patients who
were later diagnosed with other psychoses ($P = .06$).\textsuperscript{56}

Three studies examined correlations between vita-
min D and psychiatric symptoms; all finding some
link between low vitamin D and worse mental health
(table 1b). Graham et al\textsuperscript{57} found serum levels of vitamin
D were negatively associated with PANSS totals and neg-
ative subscale scores, overall neurocognitive function-
ing, and specific tests of verbal fluency. There was also
a trend-level association ($P = .054$) with PANSS positive
symptoms. Yee et al\textsuperscript{58} found low vitamin D levels were
only associated with greater PANSS negative symptoms,
whereas Nerhus et al\textsuperscript{55} only observed a significant rela-
tionship with depressive symptoms (PANSS factor scale).

**Antioxidant Vitamins in FEP**

Five studies assessed blood levels of antioxidant vitamins
(A, C, and E) in FEP (table 1c). As shown in figure 2,
significant differences were only observed for vitamin C
($g = -2.207$, 95\% CI = $-3.71$ to $-0.71$, \(P = .004\)) from
2 studies observing large deficits of vitamin C in FEP samples\textsuperscript{59,60} However, there was a small sample (\(n = 96\)),
substantial heterogeneity ($Q = 11.9$, \(P < .01\), \(I^2 = 91.6\%\)),
and studies did not report the specifics of FEP classifi-
cation (samples only described as “newly diagnosed for
schizophrenia”). Differences in vitamin E were nonsign-
ificant ($N = 4$, \(n = 253\), $g = -1.09$, 95\% CI = $-2.54$ to
0.36, \(P = .14\)). The sole study examining vitamin A levels
in FEP (\(n = 30\)) found no difference from healthy controls
(\(n = 30\)).\textsuperscript{61}
### Table 1. Study Details

<table>
<thead>
<tr>
<th>Study (Country)</th>
<th>Population Studied + Treatment Information</th>
<th>FEP Sample Age (Yrs) % Male</th>
<th>Ctrl Sample Age (Yrs) % Male</th>
<th>DUP (Yrs)</th>
<th>Study Design and Comparator</th>
<th>Vitamin/Minerals Measured</th>
<th>Differences Found</th>
<th>Clinical Correlates</th>
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</thead>
<tbody>
<tr>
<td><strong>a. B vitamin studies</strong></td>
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<tr>
<td>Ayesa-Arriola et al. (Spain)</td>
<td>In + outpatients Medication-naïve FEP classification</td>
<td>32.9 yrs 54% male</td>
<td>27.0 yrs 59% male</td>
<td>1.13</td>
<td>Cross-sectional with healthy controls</td>
<td>Vitamin B12 (serum) Folate (serum)</td>
<td>Serum folate and vitamin B12 did not differ between groups</td>
<td>None examined</td>
</tr>
<tr>
<td>Ipcioglu et al. (Turkey)</td>
<td>Inpatients Medication n/s FEP classification</td>
<td>21.8 yrs 50% male</td>
<td>30.6 yrs 53% male (Depression)</td>
<td>N = 30</td>
<td>Cross-sectional with healthy and psychiatric controls</td>
<td>Vitamin B12 (serum) Folate (serum)</td>
<td>Serum folate and vitamin B12 did not differ between groups</td>
<td>None examined</td>
</tr>
<tr>
<td>Kale et al. (India)</td>
<td>Outpatients Medication-naïve FEP classification</td>
<td>33 yrs 56% male</td>
<td>34 yrs 55% male</td>
<td>0.52</td>
<td>Cross-sectional with healthy controls</td>
<td>Vitamin B12 (plasma) Folate (plasma + RBC)</td>
<td>Significantly lower plasma folate (P = .02) and RBC (P = .01), and lower B12 plasma (P = .09)</td>
<td>Vitamin B12 showed trend level negative correlation with positive symptoms on PANSS, but no significant correlations for plasma folate and PANSS scores</td>
</tr>
<tr>
<td>Misiak et al. (Poland)</td>
<td>67% SGA 18% Medication-naïve 15% FGA FEP classification</td>
<td>27.2 yrs 56% male</td>
<td>27.6 yrs 46% male</td>
<td>1.16 yrs</td>
<td>Cross-sectional compared with healthy controls</td>
<td>Vitamin B12 (serum) Folate (serum)</td>
<td>Significantly lower serum folate in FEP group (P &lt; .001) but no difference in B12</td>
<td>Inverse correlation between PANSS negative scores and serum B12, but no relationship found for folate or other clinical correlates</td>
</tr>
<tr>
<td>Misiak et al. (Poland)</td>
<td>Subsample of above</td>
<td>N = 56 27.2 yrs 56% male</td>
<td>N = 53 25.7 yrs 49% male</td>
<td>Not specified</td>
<td>Cross-sectional compared with healthy controls</td>
<td>Vitamin B12 (plasma) Folate (plasma)</td>
<td>Significantly lower plasma folate in FEP group (P &lt; .001) but no difference in B12</td>
<td>Plasma B12 correlated inversely with severity of negative symptoms. Higher folate levels were associated with lower general symptom scores.</td>
</tr>
<tr>
<td>Misiak et al. (Poland)</td>
<td>Subsample of above</td>
<td>N = 39 26.0 yrs 60% male</td>
<td>N/A</td>
<td>12 week observational study of SGAs</td>
<td>Vitamin B12 (serum) Folate (serum)</td>
<td>N/A</td>
<td>12 weeks of treatment with olanzapine, but not risperidone, was associated with significant reductions in folate and B12</td>
<td></td>
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</tbody>
</table>
### Table 1. Continued

<table>
<thead>
<tr>
<th>Study (Country)</th>
<th>Population Studied + Treatment Information</th>
<th>FEP Sample Age (Yrs) % Male</th>
<th>Ctrl Sample Age (Yrs) % Male</th>
<th>DUP (Yrs)</th>
<th>Study Design and Comparator</th>
<th>Vitamin/Minerals Measured</th>
<th>Differences Found</th>
<th>Clinical Correlates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misiak et al.⁹¹ (Poland)</td>
<td>Subsample of above</td>
<td>N = 83 25.1 yrs (m) 28.8 yrs (f) 57% male</td>
<td>N/A</td>
<td>Not specified</td>
<td>Cross-sectional</td>
<td>Vitamin B12 (serum) Folate (serum)</td>
<td>N/A</td>
<td>Folate or B12 plasma were not associated with childhood trauma</td>
</tr>
<tr>
<td>Song et al.⁴⁶ (China)</td>
<td>Inpatient Medication-naïve FEP classification</td>
<td>N = 46 22.5 yrs 61% male</td>
<td>N = 30 24.3 yrs 57% male</td>
<td>0.65 yrs</td>
<td>Cross-sectional compared with healthy controls</td>
<td>Folate (serum)</td>
<td>Serum folate did not differ between groups</td>
<td>Inverse relationship between serum levels of folate and PANSS total and PANSS negative symptom scores</td>
</tr>
<tr>
<td>Xuimei et al.⁴⁹ (China)</td>
<td>Inpatient Medication-naïve FEP classification</td>
<td>N = 60 22 yrs 57% male</td>
<td>N = 60 23 yrs 53% male</td>
<td>Not specified</td>
<td>Cross-sectional compared with healthy controls</td>
<td>Folate (serum)</td>
<td>Serum folate significantly lower in the FEP group (P &lt; .01).</td>
<td>Negative correlation between serum levels of folate and negative symptoms (PANSS) but not positive symptoms, general psychopathology or cognitive function scores</td>
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### b. Vitamin D studies

<table>
<thead>
<tr>
<th>Study (Country)</th>
<th>Population Studied + Treatment Information</th>
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<th>Vitamin/Minerals Measured</th>
<th>Differences Found</th>
<th>Clinical Correlates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crews et al.⁹² (UK)</td>
<td>Inpatient 86% antipsychotic (not specified) 25% SSRIs 6% anticonvulsant FEP</td>
<td>N = 69 31 yrs 39% male</td>
<td>N = 69 31 yrs 39% male</td>
<td>Cross-sectional with healthy controls</td>
<td>Vitamin D (serum)</td>
<td>Serum level vitamin D significantly lower in FEP group than controls (P &lt; .001) and higher level of deficiencies (OR = 2.99, P = .008)</td>
<td>No correlation between vitamin D and time as an inpatient. No difference according to antipsychotic or anticonvulsant use but vitamin D levels higher in SSRI users than nonusers (P = .04).</td>
</tr>
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</table>
Table 1. Continued

<table>
<thead>
<tr>
<th>Study (Country)</th>
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<tbody>
<tr>
<td>Graham et al. [57] (USA)</td>
<td>Outpatient Medicated &lt;16 weeks FEP</td>
<td>N = 20 23 yrs 60% male</td>
<td>N = 20 25 yrs 60% male</td>
<td>&lt;5 yrs</td>
<td>Cross-sectional with healthy controls</td>
<td>Vitamin D (serum)</td>
<td>No significant difference in vitamin D serum levels</td>
<td>More severe negative and total symptoms (PANSS) associated with lower vitamin D levels ($P = .03$). Trend level association found for positive symptoms. No relationship with depressive symptoms (CDRS). Lower vitamin D associated with more severe cognitive deficits including verbal fluency scores in patient group.</td>
</tr>
<tr>
<td>Malik et al. [54] (Pakistan)</td>
<td>Inpatients Unmedicated “newly diagnosed”</td>
<td>N = 100 Age and gender not reported</td>
<td>N = 100 Age and gender not reported</td>
<td>Not specified</td>
<td>Cross-sectional with general population</td>
<td>Vitamin D (serum)</td>
<td>Vitamin D levels significantly lower in people with newly diagnosed schizophrenia compared with controls</td>
<td>None reported</td>
</tr>
<tr>
<td>Nerhus et al. [55]</td>
<td>In + outpatient 83% medicated 77% AP; 3% lithium; 6% antiepileptic; 24% AD; 6% hypnotic FEP classification</td>
<td>N = 71 27 yrs 65% male</td>
<td>N = 142 28 yrs 65% male [HC]</td>
<td>2.8 yrs</td>
<td>Cross-sectional with healthy controls and established SZ</td>
<td>Vitamin D (serum)</td>
<td>No significant differences in vitamin D with healthy controls</td>
<td>Lower levels of vitamin D related to higher levels of depressive symptoms in FEP. No significant relationship between vitamin D and positive or negative symptoms (PANSS).</td>
</tr>
<tr>
<td>Study (Country)</td>
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<tr>
<td>Salavert et al.* (Spain)</td>
<td>Medication-naïve FEP</td>
<td>$N = 45$ 33.7 yrs 60% male</td>
<td>$N = 22$ 36.1 yrs 27.3% male</td>
<td>Not specified</td>
<td>Cross-sectional with healthy controls</td>
<td>Vitamin D (serum)</td>
<td>Significantly reduced vitamin D levels in FEP sample compared to control condition</td>
<td>Patients who later received diagnosis of schizophrenia had trend-level lower vitamin D than those who were diagnosed with other psychoses ($P = .06$)</td>
</tr>
<tr>
<td>Yee et al.58 (Singapore)</td>
<td>&lt;4 weeks AP FEP classification</td>
<td>$N = 31$ 29 yrs 48% male</td>
<td>$N = 31$ 29 yrs 43% male</td>
<td>1.8 yrs</td>
<td>Cross-sectional with healthy controls</td>
<td>Vitamin D (serum and bioavailable levels) Calcium (serum)</td>
<td>No significant difference in serum levels of vitamin D between groups, but controls had significantly higher levels of serum bioavailable vitamin D ($P = .05$)</td>
<td>Significant negative association between vitamin D and negative symptoms (PANSS) even after controlling for gender, ethnicity, and DUP</td>
</tr>
<tr>
<td>Zhu et al.93 (China)</td>
<td>Outpatients &lt;16 weeks AP FEP classification</td>
<td>$N = 93$ 30 yrs 41% male</td>
<td>$N = 93$ 43 yrs 52% male</td>
<td>&lt;5 yrs</td>
<td>Cross-sectional with family members</td>
<td>Vitamin D (plasma)</td>
<td>Plasma vitamin D significantly lower in FEP than healthy family members ($P &lt; .001$). Mean vitamin D levels 40% lower in patients. People in lower quartiles of vitamin D levels had significantly increased proportions of SZ.</td>
<td>None reported</td>
</tr>
</tbody>
</table>

### c. Antioxidant vitamin studies

| Dadheech et al.59 (India) | <40 years old “Newly diagnosed” | $N = 30$ 72% male | $N = 40$ 73% male [HC] | Not specified | Cross-sectional with healthy controls and older SZ | Vitamin E (plasma), Vitamin C (plasma + leukocyte) | Patient sample had significantly lower vitamin E and C. Older patients had lower vitamin E than younger patients. | Not reported |
Table 1. Continued

<table>
<thead>
<tr>
<th>Study (Country)</th>
<th>Population Studied + Treatment Information</th>
<th>FEP Sample Age (Yrs) % Male</th>
<th>Ctrl Sample Age (Yrs) % Male</th>
<th>DUP (Yrs)</th>
<th>Study Design and Comparator</th>
<th>Vitamin/Minerals Measured</th>
<th>Differences Found</th>
<th>Clinical Correlates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dakhale et al.  (India)</td>
<td>Inpatients Unmedicated</td>
<td>$N = 40$ 38.5 yrs</td>
<td></td>
<td>Not specified</td>
<td>RCT of vitamin C</td>
<td>Vitamin C (plasma)</td>
<td>N/A</td>
<td>Negative symptoms (BPRS) were significantly reduced after 8 weeks of treatment with 500 mg/day of vitamin C compared with placebo ($P &lt; .01$). Significant and negative correlation was found between plasma ascorbic acid levels and BPRS score ($r = -0.38$, $P &lt; .05$).</td>
</tr>
<tr>
<td>Sarandol et al. (Turkey)</td>
<td>Medication naïve FEP classification</td>
<td>$N = 26$ 26 yrs 39% male</td>
<td>$N = 25$ 24 yrs 40% male</td>
<td>Not specified</td>
<td>Longitudinal single arm trial + cross-sectional with healthy controls</td>
<td>Vitamin E (plasma)</td>
<td>No significant difference in plasma levels of vitamin E</td>
<td>None reported</td>
</tr>
<tr>
<td>Scottish Schizophrenia Research Group (UK)</td>
<td>Inpatients Medication-naïve FEP classification</td>
<td>$N = 30$ 28 yrs (m); 33 yrs (f) 70% male</td>
<td>$N = 30$ 30 yrs 70% male</td>
<td>Not specified</td>
<td>Cross-sectional with general population</td>
<td>Vitamin E (serum) Vitamin A (serum)</td>
<td>Serum levels of vitamin E significantly lower in FEP group, but no difference for vitamin A. 77% of FEP and 70% controls had ratio of vitamin E to cholesterol $&lt; 5$ (level necessary to protect against heart disease).</td>
<td>Vitamin levels not related to psychiatric symptoms (PANSS, CGI).</td>
</tr>
<tr>
<td>Surapaneni (India)</td>
<td>“Newly diagnosed”</td>
<td>$N = 48$ 63% male</td>
<td>$N = 48$ 63% male</td>
<td>Not specified</td>
<td>Cross-sectional with healthy controls</td>
<td>Vitamin E (plasma) Vitamin C (plasma)</td>
<td>Significantly lower vitamin E and vitamin C in patient sample</td>
<td>None reported</td>
</tr>
</tbody>
</table>
### Table 1. Continued

<table>
<thead>
<tr>
<th>Study (Country)</th>
<th>Population Studied + Treatment Information</th>
<th>FEP Sample Age (Yrs) % Male</th>
<th>Ctrl Sample Age (Yrs) % Male</th>
<th>DUP (Yrs)</th>
<th>Study Design and Comparator</th>
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<tr>
<td><strong>d. Dietary mineral studies</strong></td>
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</tr>
</tbody>
</table>
| Akinladel et al.
(Nigeria) | <3 years illness Medication naïve FEP classification | *N* = 19 | *N* = 30 [HC] | *N* = 41 [Established SZ] | Cross-sectional compared with healthy controls and long term SZ | Sodium, potassium (serum) | Significantly lower potassium and sodium in FEP than controls. No difference between FEP and long-term SZ. | None reported |
| Arinola and Idonije
(Nigeria) + Arinola et al.
(Nigeria) | Inpatient Medication-naive | *N* = 15 24 yrs 73% male | *N* = 20 28 yrs 60% male[HC] | 0.15 yrs | Cross-sectional compared with healthy controls and medicated SZ | Zinc, iron, manganese, chromium, selenium, magnesium, copper (all plasma) | Iron, selenium, and chromium were all significantly higher in unmedicated FEP patients compared with healthy controls (*P* < .01). No significant difference was found for other minerals. | Zinc was significantly lower and manganese and chromium were significantly higher in unmedicated than medicated SZ |
| Gunduz-Bruce et al.
(USA) | <6 months medication FEP classification | *N* = 16 25.7 yrs 75% male | *N* = 28 28.3 yrs 36% male | Not specified | Cross-sectional compared with healthy controls | Sodium (plasma) | Plasma sodium levels significantly higher in patient group (*P* = .05) | None reported |
| Jamil et al.
(Pakistan) | Inpatient Unmedicated “Newly diagnosed” | *N* = 75 Age and gender not reported | *N* = 25 Age and gender not reported | Not specified | Cross-sectional compared with healthy controls. | Calcium (serum) Sodium (serum) Potassium (serum) Magnesium (serum) | Higher levels of serum calcium (*P* = .04) and sodium (*P* = .01), and lower levels of potassium (*P* < .01) and magnesium (*P* = .06) were observed in newly diagnosed patients compared with controls | None reported |
<table>
<thead>
<tr>
<th>Study (Country)</th>
<th>Population Studied + Treatment Information</th>
<th>FEP Sample Age (Yrs) % Male</th>
<th>Ctrl Sample Age (Yrs) % Male</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Nawaz et al. <em>(Pakistan)</em></td>
<td>Outpatients Unmedicated “Newly diagnosed”</td>
<td>$N = 12$ Age and gender not reported</td>
<td>$N = 19$ Age and gender not reported [Sibling]</td>
<td>Not specified</td>
<td>Cross-sectional compared with siblings and established SZ</td>
<td>Chromium, zinc, copper, magnesium, iron, manganese, selenium (all plasma)</td>
<td>No significant difference in any trace metals in the newly diagnosed group compared with their siblings</td>
<td>None reported</td>
</tr>
<tr>
<td>Nechifor et al. <em>(Romania)</em></td>
<td>Inpatient 71% SGA 29% FGA “Newly treated”</td>
<td>$N = 56$ 38 yrs (median) 43% male</td>
<td>$N = 20$ Not reported</td>
<td>Not specified</td>
<td>Longitudinal: 3 week trial of haloperidol vs risperidone compared with controls</td>
<td>Magnesium (plasma + erythrocyte) calcium, zinc, copper</td>
<td>Significantly lower erythrocyte magnesium and zinc levels in FEP group ($P &lt; .01$) but no difference in plasma magnesium, calcium or copper</td>
<td>Both haloperidol and risperidone treatments were associated with increased levels of erythrocyte Magnesium and plasma zinc after 3 weeks</td>
</tr>
</tbody>
</table>

Note: AP, antipsychotic; DEP, depression; DUP, duration untreated psychosis; FEP, first-episode psychosis; FGA, first generation antipsychotics; N/A, not applicable; PANSS, Positive and Negative Syndrome Scale; RBC, red blood count; RCT, randomized controlled trial; SANS, Scale for the assessment of negative symptoms; SAPS, Scale for the assessment of positive symptoms; SGA, second generation antipsychotics; SSRI, selective serotonin reuptake inhibitors; SZ, schizophrenia; yrs, years.
Regarding clinical correlates of antioxidant vitamins, neither A or E levels correlated with psychiatric symptoms (measured with PANSS or Clinical Global Impression scales). Nonetheless, Dakhale et al found that higher plasma vitamin C in newly diagnosed schizophrenia patients receiving vitamin C supplementation \((n = 40)\) were associated with greater symptomatic improvement over 8 weeks (assessed with the Brief Psychiatric Rating Scale) \((r = -0.38, P < .05)\).

**Dietary Minerals in FEP**

Ten dietary minerals were assessed across 8 studies (table 1d) with 480 participants (224 FEP, 173 healthy controls, 83 older/longer-term schizophrenia). Only one study used the term “first-episode psychosis,” with all others describing their samples as “medication-naïve” or “newly treated/diagnosed schizophrenia.” There were 3 studies examining blood levels of calcium, copper, magnesium, sodium, and zinc; 2 studies for iron, manganese, potassium, and selenium; and 1 study for chromium. Meta-analyses found no significant differences between FEP samples and healthy controls for any dietary mineral (figure 3).

When comparing patient groups, 2 studies found no difference in mineral levels between newly diagnosed patients and those with established schizophrenia. However, Arinola et al found that zinc, manganese, and chromium were all significantly lower in newly diagnosed, medication-naïve patients \((n = 15)\) compared to medicated schizophrenia patients \((n = 20)\). Furthermore, in a longitudinal study, Nechifor et al found that both magnesium and zinc were raised significantly following antipsychotic treatment (with either haloperidol or risperidone). No studies examined correlations between mineral levels and symptomology in FEP.

**Discussion**

This is the first study to examine serum nutrient status in FEP, and the first to show that compared to nonpsychiatric controls, reduced nutritional status exists independently, and in some cases, before antipsychotic treatment. To date, meta-analyses have only examined nutritional status in people with long-term schizophrenia, and each of these have focused on single nutrients in isolation. In this study, we included all vitamins and minerals examined in FEP to date, to identify which particular nutrient levels may act as specific biomarkers and/or therapeutic targets for this population. Our systematic search found 28 studies with 24 independent samples comparing blood levels of 6 vitamins and 10 dietary minerals in 1221 people with FEP to 1391 controls. Random effects meta-analysis found significant reductions in folate, vitamin D, and vitamin C among people with FEP compared to nonpsychiatric controls, with no significant differences for other vitamins or minerals.

The strongest evidence was found for vitamin D deficits; with pooled data from 7 independent studies showing a large, significant reduction across 429 individuals with FEP compared to 477 nonpsychiatric controls \((g = -1.1, P = .027)\), all matched for age and ethnicity.
Nutritional Deficits in Early Psychosis

Given the prevalence of vitamin D deficiencies in long-term schizophrenia, and the compelling evidence for low vitamin D status during brain development being linked to schizophrenia onset, it is perhaps unsurprising that FEP is associated with lower vitamin D. However, the extent of the deficit in FEP samples compared to the general population observed in this meta-analysis is troubling, especially considering that vitamin D levels are often low even among healthy adults, with 20%–40% of young adults in the UK population showing insufficiencies. Furthermore, within the FEP samples, lower vitamin D levels were found to be associated with more severe symptomology.

Currently, there is an absence of RCTs examining the efficacy of vitamin D supplementation as an adjunctive treatment in FEP—although previous studies have shown vitamin D supplements used during childhood can reduce the risk of developing schizophrenia. The efficacy of vitamin D supplementation in young people with FEP is currently being examined in a placebo-controlled RCT, the “D-Fend” study (“Vitamin D First Episode Neuroprotection Design”) (ISRCTN12424842). This will provide the first insights into potential benefits for this population. Vitamin D is an essential nutrient for both metabolic and neurological health. Thus, supplementing at the first-episode phase may attenuate the metabolic and neurological abnormalities which arise during the early stages of treatment. Indeed, preliminary research has already shown that vitamin D levels hold positive correlations with metabolic health, along with brain structure and function in people with psychosis.

We also found that FEP samples had significantly lower serum folate than nonpsychiatric controls; as has previously been observed for long-term schizophrenia. Folate deficiencies, even in the general population, are among the most widespread of all nutritional deficiencies globally, and adversely affect intellectual development and mortality risk. Folate also plays an important role in maintaining neuronal integrity and lowering levels of homocysteine—which has been linked to aetiology of schizophrenia. Indeed, 2 studies also found higher serum folate correlated with reduced negative symptoms as has been previously observed in long-term schizophrenia.

Interestingly, the one study which measured dietary folate intake found that reduced folate levels in FEP could not be accounted for by differences in diet. Instead, genotypic differences in folate absorption efficiency may be responsible for deficiencies observed in schizophrenia. In long-term schizophrenia, this hypothesis is supported by strong experimental evidence showing that symptomatic benefits from standard folic acid supplements are moderated by genotypic differences in absorption, whereas administration of “L-methylfolate” (the most bioactive folate type; readily absorbed regardless of genotype) significantly reduces negative symptoms.
caution is warranted, as in disorders such as cardiovascu-
lar disorders and cancer, where nutrient deficiencies have
also been noted, the research has been underwhelming in
supporting supplementation. For instance, while vitamin
D insufficiency is widespread across noncommunicable
medical conditions, RCTs of vitamin D supplementation
in cardiovascular disorders, cancer, and osteoporosis have
generally failed to robustly support causative hypoth-
eses.\textsuperscript{80,82} It should also be considered that although nutri-
tional deficiencies could feasibly exacerbate psychiatric
symptoms, it is also possible that therapeutic benefits of
supplementation may not be reliant upon vitamin/min-
eral deficiencies. For instance, beneficial effects of other
nutrient-based adjunctive treatments (such as NAC\textsuperscript{83} and
Taurine\textsuperscript{84}) are not due to restoring specific nutritional def-
icits, but instead attributed to these amino acids targeting
pathological neurological processes.\textsuperscript{83,84} Therefore, even
in the absence of clear deficiencies, certain nutrients may
confer positive effects in FEP through the neurochemical
properties of these compounds, regardless of deficiency
status.

Given the marked reductions in vitamin D and folate
observed in FEP compared to nonpsychiatric samples,
future research should also examine what proportion of
individuals with FEP reach clinical thresholds for nutri-
tional deficiencies in comparison to established reference
values, which in turn could have implications for routine
screening of nutritional deficiencies in FEP. Additionally,
much of the emphasis for dietary intervention in schiz-
ophrenia so far lies with reducing over-consumption of
obesogenic foods.\textsuperscript{7,85} Thus, this review also holds implica-
tions for dietary interventions to further emphasize the
importance of consuming a good quality diet containing
adequate nutrients. Indeed, large-scale epidemiolog-
ical studies show that low levels of both vitamin D and
folate are linked to cardiovascular mortality.\textsuperscript{86,87} Further
efforts toward resolving these deficiencies holds prom-
ise to reduce the physical health inequalities observed
in schizophrenia. Additionally, multi-ingredient “nutra-
ceuticals,” which combine various beneficial nutrients
target specific nutritional deficits and neurological
processes implicated in psychiatric disorders,\textsuperscript{88,89} may
also provide safe and effective adjunctive treatments for
FEP. These data also support stratification of individuals
based on nutrient intake/status as criteria for nutraceuti-
cal interventions and in trial design. Given the clear lack
of experimental evidence in this area,\textsuperscript{12} there is a now a
clear need for clinical trials to evaluate the use of whole
diet interventions as well as nutrient-based interventions
for improving the typically poor recovery rates observed
among people with FEP.

Supplementary Material

Supplementary data are available at Schizophrenia
Bulletin online.
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References


