Table 2: Number of included studies reporting associations with higher rates of the common mental disorders, by indicators of less privileged social position [3;6]

		Less education	*Unemployment*	*Lower income or material circumstances*	*Low social status*
Number of studies reporting associations	Total reporting	5	7	6	6
Positive association	Men & women separately	2	3*	2	2
	Men & women combined (separate data not given)	2	3	4	1
	Total positive	4	6	6	3
No clear association		1	1	0	3
Inverse association		0	0	0	0

Note: *one study, positive only for men; women equivocal.

sible. Response rates, not always high, (54% – 80%) also prejudiced interpretation.

Poverty, education, housing, occupation, employment, social status and social engagement are relatively tangible measures, for which 'Social Class' or 'Socio-Economic Status' are merely proxies, but these markers of social disadvantage are not independent of each other. Other factors are known to be important – childhood experience, physical illness, life events, working situations, and social networks – but they were barely acknowledged by these large-scale cross-sectional studies. If we wish to have evidence of the direction of causation for associations discovered, we need longitudinal studies. The evidence available from the UK birth cohort studies is briefly summarised below and is available in more detail in the source documents. [6]

Nevertheless, some comparison of the cross-sectional studies was possible. In each study, the categories which most nearly approximated to the 'common mental disorders' were examined; usually this meant 'all affective disorders', 'all depressive disorders', 'dysthymia', and 'all anxiety disorders'. Similarly, in most studies, three indicators of social disadvantage could be compared: education, employment, and material circumstances, as well as occupational social status. Although the studies used different taxonomies, differentials within the taxonomy could be recorded for each one.

For education, the highest and lowest groups were compared, whether measured by years of education or qualifications achieved. For employment the 'unemployed and seeking work' were compared with either 'all others of working age', or 'all employed'. Material circumstances were measured in many ways, but the lowest and highest in each hierarchy could be compared. The associations detected were subjected to statistical tests of significance, and odds ratios for each relationship quoted wherever possible.

Taking higher prevalence of disorder in less privileged groups as a 'positive' association, of the nine population-based studies with adequate measures of mental health and indicators of social disadvantage, eight provided evidence of an association between less privileged social position and higher prevalence of the common mental disorders, on at least one of the available indicators (Table 2). The one study showing no clear relationships had the lowest response rate (54%), which may have limited its capacity to demonstrate associations. Less education was 'positive' in four out of five studies. Unemployment showed positive associations in six out of seven studies, though in one study the association was positive only for men. Low income, wealth, assets, or other markers of material standard of living were positive in all six studies. Less privileged occupational social class was positive in three studies out of six. Perhaps most importantly, no study showed a contrary trend with any indicator.

These statistically significant positive associations do not reveal the degree of difference; compared to the most privileged groups, the most deprived groups seldom had more than a doubling in prevalence, that is odds ratios were almost always less than 2.

This simple overview suggests some robustness of findings despite the serious methodological limitations in reviewing such diverse studies. Education, employment and material circumstances provided better indicators than occupational social class, but there is remarkable consistency in the broad evidence from these nine large-scale population-based studies; the common mental disorders are significantly more frequent in socially disadvantaged populations.