Table 3: Characteristics of European studies included in Maudsley review [6] with the German Health Survey, 1999 [11]. (Adapted from [6])

	European Surveys	Year	Type of study	Population sampled	Size of sample (achieved)	Response rate	Mental health instrument
1	Annual Health Surveys for England	1993, repeated annually	population survey	All adults in England, children from 1995	16,569 (1993)	76% for full interview, 66% for nurse tests (1993)	GHQ-12, cut-off 4+
2	National Psychiatric Morbidity Survey of Great Britain (household sample)	1993	population survey	All adults in England, Wales and Scotland (excluding Highland and Islands)	10,108	80%	Clinical Interview Schedule (CIS revised)
3a	Health and Life-style Survey	1984–85	population survey	Adults 18+, England, Wales, Scotland	9,003	73% for interview, 54% for self-completed questionnaire	GHQ-30 (+ a malaise measure)
3b	Health and Life-style Survey – follow-up	1991–92	follow-up of 84/85 respondents	Adults 18+, England, Wales, Scotland	5,352	59% of those interviewed in 1984/5 were re-interviewed	GHQ-30 (+ a malaise measure)
4	British Household Panel Survey	1991–92	population survey, with follow-up after one year	Adults aged 16+, households in Great Britain, south of Caledonian Canal	10,264	74% of 7,488 households	GHQ-12, cut-off 3+
5	Netherlands Mental Health Survey and Incidence Study (NEMESIS)	1996	population survey with follow-up at one and three years	Adults 18–64 resident in The Netherlands	7,147	64%	Composite International Diagnostic Interview (CIDI); GHQ-12
6	National German Health Survey (GHS)	1999	population survey	Adults 18–65 resident in Germany	4181	?	Composite International Diagnostic Interview (CIDI – Munich version)

clinician. Year by year there has been little variation in results; in 1998 for example, 13% of men and 18% of women were recorded as 'positive', correlated highly with perceived lack of social support, recent acute sickness, and long-standing illness. There were weak associations with occupational social class, but significant and progressive associations with low 'equivalised household income', especially among men (9% in the highest income quintile to 20% in the lowest income quintile, in 1998).

The First UK National Household Psychiatric Survey, 1993

12,000 adults aged 16–64 were selected from a representative sample of 15,000 households in Great Britain, and over 10,000 interviews achieved, a response rate of 80% [5]. Trained lay interviewers used the Clinical Interview Schedule – Revised (CIS-R); scores were converted into ICD-10 diagnoses; 12 or more was taken to indicate 'likely to have a neurotic disorder'. A separate alcohol and drug schedule was used, and people with 'possible psychosis' were identified for a SCAN interview with a clinician. Occupational social class, income, material standard of living, housing status, education and employment were recorded [16].

An occupational social class gradient for women largely disappeared with adjustment for more precise indicators of social disadvantage. For men, the highest social class had about half the positive scores of other classes, unchanged by adjustment [17]. Unemployment was associated with higher positive scores, and was the factor most strongly associated with symptom prevalence in men and women, while low material standard of living and poor education had the highest rates of probable neurosis. However, the association with education disappeared when adjusted for other socio-demographic variables.

The Health and Life-style Survey (HLS), 1984–85 and 1991–92

9,003 residents of Great Britain aged 18 years or over, were interviewed, and 82.4% of these examined by a