Table 4: German National Health Survey 1999, Mental Health Supplement [12].

12 month prevalence:	Any mood disorder			Any anxiety disorder		
	%w	OR	CI	%w	OR	CI
Education						
Hauptschule (2nd y school)	13.2	1.0		15.4	1.0	
Mittlere Reife (= 'GCSE')	12.2	0.9	0.7–1.1	14.8	0.9	0.7–1.1
Abitur (= 'A levels')	9.5	0.7	0.5–0.9	11.3	0.7	0.5–0.9
Employment						
FT employed		1.0			1.0	
Unemployed	20.0	2.3	1.6–3.2	23.2	2.2	1.6–3.0
Social Class (an index combining education, income, and current job status)						
Low	16.4	1.0		18.6	1.0	
Medium	12.0	0.7	0.6–0.9	14.4	0.8	0.6–0.9
High	8.8	0.5	0.4–0.7	11.3	0.6	0.4–0.8

nurse. 6,572 GHQ-30 questionnaires were completed, a score of 5 or more being considered positive; scores were continuously varied for both men and women [18]. Data on occupation of head of household, income, housing tenure and education were recorded. Though not designed as a cohort study, after 7 years 5,352 people (59% of the original sample), were traced and re-interviewed [18]. GHQ scores related to occupational social class showed no consistent pattern. Unemployment was clearly related to high scores in 1984/85, but not in 1991/92.

Of special interest was the finding that positive scores in 1984/85 were associated with significantly increased all-cause mortality after seven years, even after adjusting for age, sex, social class, smoking behaviour, and limiting long-standing illness, and after removing 'un-natural' deaths which might have been specifically related to psychiatric disorder. There was an approximately linear relationship between the risk of dying and the number of symptoms on the GHQ-30, especially for men [19].

The British Household Panel Survey (BHPS), 1991–92

Of 7,488 British households selected, 5,511 were contacted, involving 10,264 individuals aged 16 and over, of which 9,064, 88% of subjects, completed the GHQ-12. They were followed up a year later. A score of 3 or more was considered 'positive'. Occupation of subject, parents, and head of household were recorded, together with employment data [20]. An indicator of material standard of living combined income, and elements of housing and possessions.

The results gave a gradient with occupational social class (subject or head of household, but not parents), which disappeared in men up to age 55 after adjusting for material standard of living, but was still true for women of all ages [21]. Material standard of living was strongly associated with high frequency of GHQ positives (3+), but possibly only maintainance, not onset of common mental disorders. 'Subjective financial strain', (one question with three possible answers), was correlated with onset of symptoms [22]. Physical illness was associated with GHQ-12 positives. Using also one-year follow-up data, unemployment was also associated with maintenance but not onset of symptoms, which diminished in those gaining employment in the year, and increased in those losing employment in the year, unless for looking after the family or retirement. Scores also decreased during the year for those marrying, and increased for those divorcing or separating.

The Netherlands Mental Health Survey & Incidence Study (NEMESIS), 1996

7,147 individuals aged 18–64 (64.2%) were interviewed from 11,140 eligible households using the CIDI (and SCID if psychosis was indicated). 43.6% of those refusing the CIDI completed the GHQ-12. Refusers proved to have similar mental health profiles to responders. Family income, average net income per person, employment status, and years of education were recorded [23]. 5,618 adults were interviewed after one year, 79.4% of the cohort [24].

The three commonest disorders, anxiety, depression and alcohol were often present together. Men had more alcohol and other drug disorders; women had more anxiety and depressive disorders. Very poor education, low income, and 'non-employment' were associated with both mood and anxiety disorders [23]. The one-year fol-