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FROM VITAL & HEALTH STATISTICS OF THE NATIONAL CENTER FOR HEALTH STATISTICS
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OFFICE VISITS TO PSYCHIATRISTS: NATIONAL AMBULATORY MEDICAL CARE SURVEY, UNITED STATES, 1975-76[1]

During combined calendar years 1975 and 1976 psychiatrists' offices were the settings for 30.6 million ambulatory care visits by patients who presented a broad spectrum of emotional, ideational, and behavioral problems.

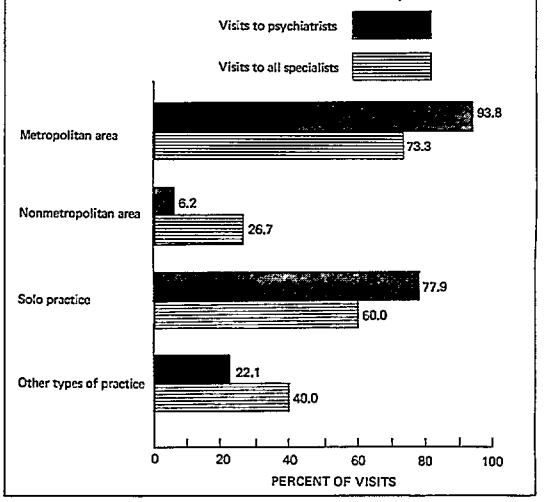
The data were obtained during the National Ambulatory Medical Care Survey (NAMCS), a sample survey conducted by the Division of Health Resources Utilization Statistics of the National Center for Health Statistics. The estimates in this report are based on information recorded by participating psychiatrists on brief encounter forms (see Technical Notes) during sampled office encounters. A brief description of the sample design and an explanation of the sampling errors associated with selected aggregate statistics can be found in the Technical Notes of this report.

Most visits to psychiatrists were to offices located in metropolitan areas (94 percent); this was a higher proportion than that for all specialists (figure 1).

The proportion of visits to psychiatrists engaged in solo practice (78 percent) exceeded those to other types of arrangements. In this respect office based psychiatric practice also differed from the average of 60 percent for all specialists.

Reflecting the continuous nature of psychiatric care, 9 of 10 visits were made by patients the physician had seen before and who returned for care of a problem the physician had treated previously (figure 2). The ratio of return visits to new problem visits was higher for psychiatrists than for any other specialty. New problem visits included initial visits and those made by patients known to the physician but presenting a new problem. For each new problem visit to a psychiatrist there were 8.6 "old" problem visits in contrast to an old to new ratio of 1.6 for all specialists.

Figure 1. PERCENT DISTRIBUTIONS OF OFFICE VISITS TO PSYCHIATRISTS AND TO ALL SPECIALISTS BY LOCATION AND TYPE OF PRACTICE: UNITED STATES, 1975-76



Of the 2.1 million *new* patients seen by psychiatrists, 30 percent were referred by another physician or agency.

Distributions of visits by patient age, sex, and race are shown in table 1. The majority of visits included patients between the ages of 25 and 44 years. The visit rate was also higher for this age range than for any other group. Patients 65 years and over comprised the smallest group visiting. For each 100 persons of that age in the

[1]This report was prepared by Beulah K. Cypress, Ph.D., Division of Health Resources Utilization Statistics.

Figure 2. PERCENT DISTRIBUTIONS OF OFFICE VISITS TO PSYCHIATRISTS AND TO ALL SPECIALISTS BY VISIT STATUS: UNITED STATES, 1975-76

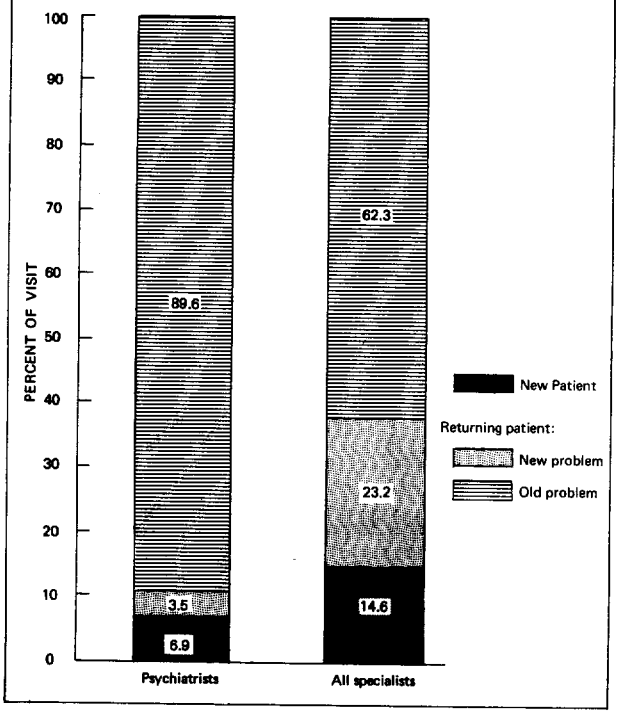


Table 1. Number, percent distribution, and rate of office visits to psychiatrists by patient age, sex, and race: United States, 1975-76

Age, sex, and race	Number of visits in thousands	Percent distribution	Visit rate per 100 in population
All visits	30,616	100.0	7.3
Age			
Under 15 years	2,632	8.6	2.5
15-24 years	4,662	15.2	6.0
25-34 years	9,109	29.8	15.0
35-44 years	7,053	23.0	15.8
45-54 years	4,294	14.0	9.2
55-64 years	1,934	6.3	4.9
65 years and over	933	3.0	2.2
Sex			
Female	18,406	60.1	8.5
Male	12,210	39.9	6.1
Race			
White	29,319	95.8	8.1
Black and other races	1,297	4.2	2.4

population only two visits were made to psychiatrists' offices, whereas there were about 15 visits for each 100 persons aged 25-44 years. Females visited at a significantly higher rate than did males. Members of the white race clearly outnumbered other persons in visits with the visit rate for the former group about three times the rate of the latter group. The distribution of mental disorders among different races, or the total pattern of psychiatric care by race, should not be inferred from these data. First, disease incidence and prevalence cannot be equated with visits for a disease; and second, care may be obtained from facilities other than physicians' offices. For example, in 1975 members of black and all other races utilized outpatient departments of hospitals and freestanding psychiatric clinics, settings not presently included in NAMCS, at a higher rate than did white persons.[2]

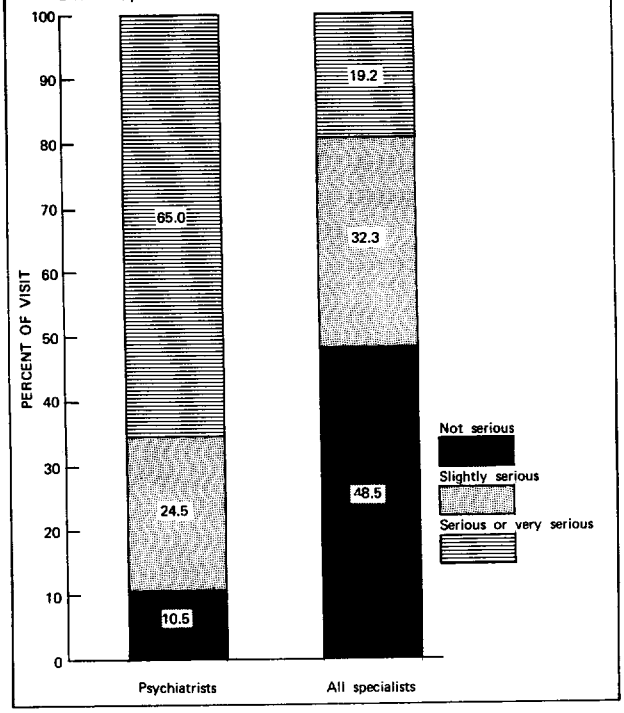
Seriousness of the patient's problem was evaluated by the psychiatrist using the criterion of the extent of impairment that might result if no care were available. On a four-point scale ranging from not serious to very serious, psychiatrists judged 65 percent of their visiting patients to be serious or very serious. Only 11 percent were considered not serious in contrast to the finding of about 49 percent for all specialists (figure 3).

Patients' problems were more often diagnosed in the nonpsychotic group of mental disorders (79.5 percent) then in the psychotic (20.5 percent). Despite a broad array of symptoms and complaints presented by visiting patients, 84 percent of the visits were diagnosed by psychiatrists in only seven diagnostic classes (table 2). Primary diagnoses listed on the Patient Record by participating physicians were classified according to the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).[3] Another

[2] Division of Biometry and Epidemiology, National Institute of Mental Health. Unpublished data from the National Reporting Program of the National Institute of Mental Health.

[3] National Center for Health Statistics: *Eighth Revision International Classification of Diseases, Adapted for Use in the United States*. PHS Pub. No. 1693. Public Health Service. Washington. U.S. Government Printing Office, 1967.

Figure 3. PERCENT DISTRIBUTIONS OF OFFICE VISITS TO PSYCHIATRISTS AND TO ALL SPECIALISTS BY DEGREE OF SERIOUSNESS OF THE PATIENT'S PROBLEM: UNITED STATES, 1975-76



taxonomy of mental disorders, the *Diagnostic and Statistical Manual of Mental Disorders, Second Edition* (DSM-II), which is also used by the mental health community, is compatible with ICDA at the three-digit level of specificity, which is used in this report.[4] DSM-II includes a glossary of operational definitions of terms which the nonmedical reader may find useful.

A diagnosis of neurosis was clearly the foremost clinical determination made by psychiatrists, accounting for 42-percent of all visits. Personality disorders (about 14 percent) increased the total to more than half of all visits. Two psychotic states, schizophrenia (11 percent) and affective psychosis (about 5 percent) were among the highest ranking illnesses.

The group of visits which were coded in the symptoms and ill-defined conditions ICDA class of senility and ill-defined diseases (790-796) were chiefly listed as depression (790.2). Apparently the physician indicated that these visits were not of psychotic or psychoneurotic origin, which are usually assigned to mental disorders (290-315).

An examination of the characteristics of psychiatric office practice is largely a study of treatment of mental disorders in the setting of ambulatory office care. While not all patients with mental problems visited psychiatrists' offices in preference to other physicians, almost all visits to psychiatrists involved mental ailments, as previously shown. Of the 48.5 million visits to all specialists for mental disorders during 1975-76, 54 percent, or 26.2 million, were to office based psychiatrists. As illustrated in figure 4, visits to other specialists were mainly diagnosed as neuroses. Psychiatrists had the major portions of visits for the psychotic problems schizophrenia (92 percent) and affective psychoses (73 percent). Visits by patients requiring guidance for transient and situational disturbances also occurred more frequently in

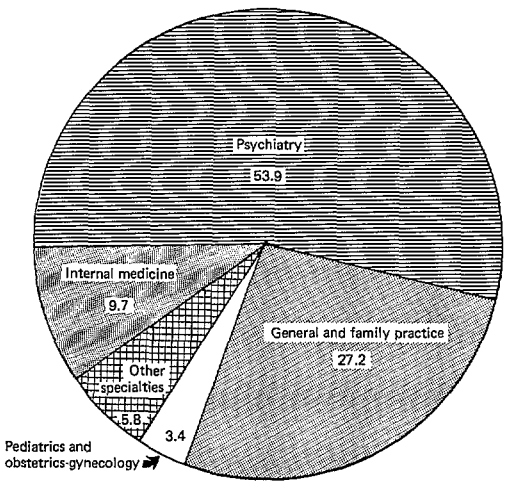
[4] American Psychiatric Association Committee on Nomenclature and Statistics: *Diagnostic and Statistical Manual of Mental Disorders, 2d ed.* American Psychiatric Association. Washington, D.C. 1968.

Table 2. Number, percent, and cumulative percent of office visits to psychiatrists by 7 most common principal diagnoses classified by ICDA code in rank order of number of visits: United States, 1975-76

Rank	Principal diagnosis and ICDA code[1]	Number of visits in thousands	Percent of visits	Cumulative percent
1	Neuroses 300	12,824	41.9	41.9
2	Personality disorders 301	4,117	13.5	55.4
3	Schizophrenia 295	3,445	11.3	66.7
4	Transient and situational disturbances 307	2,188	7.2	73.9
5	Affective psychoses 296	1,404	4.6	78.5
6	Nervousness and debility (depression) 790	1,115	3.6	82.1
7	Medical or special examination Y00	570	1.9	84.0

[1] Diagnostic groupings and codes are based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States.*

Figure 4. PERCENT DISTRIBUTION OF OFFICE VISITS FOR MENTAL DISORDERS BY MOST VISITED SPECIALTY: UNITED STATES, 1975-76



psychiatrists' offices than in those of other specialists (table 3).

The Patient Record used in NAMCS was developed as a general purpose data collection instrument for the purpose of capturing the most pertinent information about ambulatory office care visits. The practice of psychiatry, unique in its diagnostic and therapeutic procedures, cannot be as succinctly characterized by the NAMCS data as can some other specialties. The types of diagnostic procedures described on the Patient Record were not heavily utilized during visits to psychiatrists as table 4 shows. Only from about 3 to 9 percent of visits included the usual medical procedures. However,

Table 3. Number of office visits to all specialists and percent of office visits to psychiatrists, by selected diagnoses classified by ICDA codes: United States, 1975-76

Diagnosis and ICDA code[1]	Number of visits to all specialists in thousands	Percent of visits to psychiatrists
Schizophrenia.....295	3,764	91.5
Affective psychoses.....296	1,923	73.0
Neuroses 300	25,698	49.9
Transient and situational disturbances.....307	2,913	75.1
Nervousness and debility (depression) 790	6,132	18.2

[1]Diagnostic groups and codes are based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States.*

Table 4. Number and percent of office visits to psychiatrists, by selected diagnostic and therapeutic services ordered or provided: United States, 1975-76

Diagnostic or therapeutic service	Number of visits in thousands	Percent of visits
Limited history and examination.....	2,745	9.0
General examination	1,263	4.1
Clinical lab test	751	2.5
Blood pressure check	1,639	5.4
Drug prescribed.....	7,732	25.3
Injection or immunization	814	2.7
Counseling	1,597	5.2
Psychotherapy	26,337	86.0

since NAMCS did not provide separately for diagnostic procedures more common to psychiatry such electroencephalograph and psychological testing, there is no way to estimate the scope of diagnostic activity. Many of these techniques are embedded in the single NAMCS category, "psychotherapy." Unable to select a more specific category, psychiatrists checked this term for 86 percent of their visits. The definition of "psychotherapy" as used in NAMCS, shown in the Technical Notes, covers a wide variety of techniques, some diagnostic and some therapeutic. Therefore it is not possible to determine whether the 86 percent includes diagnostic, therapeutic, or other types of services.

As with diagnostic services, data regarding certain therapeutic techniques such as psychoanalysis, sociological services, hypnotherapy, group therapy, or shock therapy were not available through NAMCS. Drugs were administered or prescribed for about 25 percent of visits which was less than the average proportion of 44 percent of visits to all specialists. Drug therapy was selected more often for the psychotic diagnoses, schizophrenia and affective psychoses, than for the nonpsychotic diagnoses, personality disorders and neuroses.

Highly correlating with the proportion of return visits, 89 percent of psychiatrists' visits resulted in the instruction to return at a specified time. In only 4 percent of visits was no followup planned. The disposition of very few visits was admittance to a hospital.

In view of the importance of direct physician-patient communication during psychiatric visits, it is not unexpected that the average dura-

Table 5. Number and percent distribution of office visits to psychiatrists by duration of visit: United States, 1975-76

Duration of visit	Number of visits in thousands	Percent distribution
All visits	30,616	100.0
0-5 minutes	759	2.5
6-10 minutes	892	2.9
11-15 minutes	1,197	3.9
16-30 minutes	5,434	17.8
31-60 minutes	21,181	69.2
61 minutes or more	1,153	3.8

tion of psychiatric encounters exceeded that of other physicians. The mean contact duration was 15.3 minutes (±0.2) for all physician visits and 46.9 minutes (±1.85) for psychiatrists' visits. According to the data listed in table 5 over 69 percent of visits to psychiatrists lasted from 31 to 60 minutes. Only 4 percent were more than 60 minutes long, and 9 percent consumed less than 16 minutes.

TECHNICAL NOTES

SOURCE OF DATA: The information presented in this report is based on data collected in the National Ambulatory Medical Care Survey (NAMCS) during 1975 and 1976. The target population of NAMCS encompasses office visits within the conterminous United States made by ambulaory patients to physicians who are principally engaged in office practice. The National Opinion Research Center, under contract to NCHS, was the organization responsible for the survey's field operation.

SAMPLE DESIGN: NAMCS utilized a multistage probability design that involves samples of primary sampling units (PSU's), physician practices within PSU's, and patient visits within practices. Each year a sample of practicing physicians is selected from master files maintained by the American Medical Association and the American Osteopathic Association. The 1975-76 sample included 468 psychiatrists with a response rate of 88 percent for the 2 years. These physicians are requested to complete Patient Records[5] for a systematic random sample of office visits taking place within their practice during a randomly assigned weekly reporting period. Participating psychiatrists completed 7,462 Patient Records during the 2 year period. Characteristics of the physician's practice, such as primary specialty and type of practice, are obtained during an induction interview. A detailed description of the NAMCS design and procedures may be found in Series 13, Number 33, of *Vital and Health Statistics*.

SAMPLING ERRORS: Since the estimates for this report are based on a sample rather than the entire universe, they are subject to sampling variability. The relative standard error of an estimate is primarily a measure of sampling variability. The relative standard error of an estimate is obtained by dividing the standard error of the estimate by the estimate itself and is expressed as a percent of the estimate. Relative standard errors of selected aggregate statistics are shown in table I. The standard errors appropriate for the estimated percentages of office visits are shown in table II.

Table I. Approximate relative standard error of estimated numbers of office visits, NAMCS 1975-76

Estimate in thousands	Relative standard error in percentage points
600	30.2
1,000	23.5
2,000	16.7
4,000	12.0
10,000	8.0
40,000	4.8
200,000	3.4
1,000,000	3.1

Example of use of table: An aggregate estimate of 25,000,000 visits has a relative standard error of 6.4 percent or a standard error of 1,600,000 visits (6.4 percent of 25,000,000).

[5] See figure I.

Table II. Approximate standard errors of percentages for estimated numbers of office visits, NAMCS 1975-76

Base of percentage (number of visits in thousands)	Estimated percentage					
	1 or 99	5 or 95	10 or 90	20 or 80	30 or 70	50
	Standard error in percentage points					
600	3.0	6.5	9.0	12.0	13.8	15.0
1,000	2.3	5.1	7.0	9.3	10.7	11.6
2,000	1.6	3.6	4.9	6.6	7.5	8.2
4,000	1.2	2.5	3.5	4.7	5.3	5.8
10,000	0.7	1.6	2.2	2.9	3.4	3.7
40,000	0.4	0.8	1.1	1.5	1.7	1.8
200,000	0.2	0.4	0.5	0.7	0.8	0.8
1,000,000	0.1	0.2	0.2	0.3	0.3	0.4

Example of use of table: An estimate of 20 percent based on an aggregate estimate of 80,000,000 visits has a standard error or 1.3 percent. The relative standard error of 20 percent is 6.5 (1.3 percent ÷ 20 percent).

ROUNDING: Aggregrate estimates of office visits presented in the tables are rounded to the nearest thousand. The rates and percents, however, were claculated on the basis of original, unrounded figures. Due to rounding of percents, the sum of percentages may not equal 100.0 percent.

DEFINITIONS: An *ambulatory patient* is an individual presenting himself for personal health services who is neither bedridden nor currently admitted to any health care institution on the premises.

An *office* is a place that the physician identifies as a location for his ambulatory patients. Responsibility over time for patient care and professional services rendered there generally resides with the individual physician rather than an institution.

Figure I. PATIENT RECORD

ASSURANCE OF CONFIDENTIALITY—All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

BN#

1. DATE OF VISIT Mo / Day / Yr

PATIENT RECORD
NATIONAL AMBULATORY MEDICAL CARE SURVEY

2. DATE OF BIRTH Mo / Day / Yr

3. SEX
1 ☐ FEMALE
2 ☐ MALE

4. COLOR OR RACE
1 ☐ WHITE
2 ☐ NEGRO/BLACK
3 ☐ OTHER
4 ☐ UNKNOWN

5. PATIENT'S PRINCIPAL PROBLEM(S) COMPLAINT(S), OR SYMPTOM(S) THIS VISIT *(In patient's own words)*
a. MOST IMPORTANT _____
b. OTHER _____

6. SERIOUSNESS OF PROBLEM IN ITEM 5a *(Check one)*
1 ☐ VERY SERIOUS
2 ☐ SERIOUS
3 ☐ SLIGHTLY SERIOUS
4 ☐ NOT SERIOUS

7. HAVE YOU EVER SEEN THIS PATIENT BEFORE?
1 ☐ YES 2 ☐ NO
If YES, for the problem indicated in ITEM 5a?
1 ☐ YES 2 ☐ NO

8. MAJOR REASON(S) FOR THIS VISIT *(Check all major reasons)*
01 ☐ ACUTE PROBLEM
02 ☐ ACUTE PROBLEM, FOLLOW-UP
03 ☐ CHRONIC PROBLEM, ROUTINE
04 ☐ CHRONIC PROBLEM, FLARE-UP
05 ☐ PRENATAL CARE
06 ☐ POSTNATAL CARE
07 ☐ POSTOPERATIVE CARE → _____ *(Operative procedure)*
08 ☐ WELL ADULT/CHILD EXAM
09 ☐ FAMILY PLANNING
10 ☐ COUNSELING/ADVICE
11 ☐ IMMUNIZATION
12 ☐ REFERRED BY OTHER PHYS/AGENCY
13 ☐ ADMINISTRATIVE PURPOSE
14 ☐ OTHER *(Specify)* _____

9. PHYSICIAN'S PRINCIPAL DIAGNOSIS THIS VISIT
a. DIAGNOSIS ASSOCIATED WITH ITEM 5a ENTRY
_____
_____
b. OTHER SIGNIFICANT CURRENT DIAGNOSES *(In order of importance)*
_____
_____

10. DIAGNOSTIC/THERAPEUTIC SERVICES ORDERED/PROVIDED THIS VISIT *(Check all that apply)*
01 ☐ NONE
02 ☐ LIMITED HISTORY/EXAM
03 ☐ GENERAL HISTORY/EXAM
04 ☐ CLINICAL LAB. TEST
05 ☐ BLOOD PRESSURE CHECK
06 ☐ EKG
07 ☐ HEARING TEST
08 ☐ VISION TEST
09 ☐ ENDOSCOPY
10 ☐ OFFICE SURGERY
11 ☐ DRUG PRESCRIBED
12 ☐ X-RAY
13 ☐ INJECTION
14 ☐ IMMUNIZATION/DESENSITIZATION
15 ☐ PHYSIOTHERAPY
16 ☐ MEDICAL COUNSELING
17 ☐ PSYCHOTHERAPY/THERAPEUTIC LISTENING
18 ☐ OTHER *(Specify)* _____

11. DISPOSITION THIS VISIT *(Check all that apply)*
1 ☐ NO FOLLOW-UP PLANNED
2 ☐ RETURN AT SPECIFIED TIME
3 ☐ RETURN IF NEEDED, P.R.N.
4 ☐ TELEPHONE FOLLOW-UP PLANNED
5 ☐ REFERRED TO OTHER PHYSICIAN/AGENCY
6 ☐ RETURNED TO REFERRING PHYSICIAN
7 ☐ ADMIT TO HOSPITAL
8 ☐ OTHER *(Specify)* _____

12. DURATION OF THIS VISIT *(Time actually spent with physician)*
_____ MINUTES

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DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS

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EXPIRATION DATE 12/31/75

A *visit* is a direct personal exchange between an ambulatory patient and a physician or a staff member working under the physician's supervision for the purpose of seeking care and rendering health services.

A *physician* is a duly licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) currently in practice who spends time in caring for ambulatory patients at an office location. Excluded from NAMCS are physicians who specialize in anesthesiology, pathology, radiology; physicians who are federally employed; physicians who treat only institutionalized patients; physicians employed full time by an institution; and physicians who spend no time seeing ambulatory patients.

Medical counseling: Instructions and recommendations regarding any health problem, including advice or counsel about diet, change of habit, or behavior. Physicians are instructed to check this category only if the medical counseling is a *significant* part of the treatment.

Psychotherapy/therapeutic listening: All treatments designed to produce a mental or emotional response through suggestion, persuasion, reeducation, reassurance, or support, including psychological counseling, hypnosis, psychoanalysis, and transactional therapy.

SYMBOLS

Data not available	- - -
Category not applicable	. . .
Quantity zero	-
Quantity more than 0 but less than 0.05	0.0
Figure does not meet standards of reliability or precision	*

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