APEC Guidelines
Perinatal Depression Screening and Treatment

Perinatal depression includes a major or minor depressive episode that occurs during pregnancy or in the first 12 months after delivery. It affects 1 in 7 women – making it one of the most common medical complications of the perinatal period. Untreated maternal depression is associated with poor compliance with prenatal care, increased alcohol and tobacco use, preterm birth, low birth weight, increased NICU admissions, deficits in mother-infant bonding and ultimately can have devastating effects on families. Maternal suicide now exceeds hemorrhage and hypertensive disorders as a cause of maternal mortality in the United States. There are known risk factors for perinatal depression such as unintended pregnancy and lack of social support – but depression during pregnancy and the postpartum period can affect any woman of any socioeconomic status.

ACOG recommends that clinicians screen *all* women at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool.(ACOG, 2015) Note that anxiety can be a prominent feature of perinatal mood disorders. Additionally, it is critical that women with bipolar disorder be appropriately screened and referred for psychiatric care, as antidepressant monotherapy in these women may trigger mania or psychosis, and experts recommend an additional short screen for a history of mania or bipolar disorder prior to the initiation of antidepressants.

Screening alone is inadequate. Per ACOG, clinical staff in Ob/Gyn practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources, or both and systems should be in place to ensure follow-up. (ACOG, 2015) The majority of data regarding psychotropic medicines in pregnancy are from selective serotonin reuptake inhibitors (SSRIs). SSRIs are not considered teratogens with the exception of paroxetine, which may be associated with a small increased risk of cardiac defects. (ACOG, 2008) SSRI exposure late in pregnancy has also been linked to persistent pulmonary hypertension of the newborn, however, the absolute risk is very small (3-12 per 1000 increased from 1-2 per 1000) and prospective studies have not replicated this finding. (Eke, Saccone, & Berghella, 2016) There are newer data accumulating that SSRI exposure itself is also associated with preterm birth; however in studies that control for cofounders this finding is eliminated. Neonatal withdrawal syndrome, or 'poor neonatal adaptation' has been reported; symptoms are mild and transient. Breastfeeding is not contraindicated for any antidepressant. While very low levels of SSRIs have been detected in breast milk, medication exposure during lactation is considerably lower than transplacental exposure during pregnancy. In sum, while there are theoretic risks of SSRI use, patients should be reassured that the magnitude of these risks are small and the benefit of treatment far outweighs any risk in the setting of perinatal depression.

This document should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Screening for depression

- An individual and family mental health history (including any past and current medications) should be included in the intake history
- All women should be screened at least once during pregnancy or postpartum. APEC recommends screening 3 times using the **Edinburgh Postnatal Depression Scale (see Appendix 1) at:**
  - The first prenatal visit
  - 24-28 weeks (with the BSST)
  - Postpartum [high-risk at 2 & 6 weeks; average risk at 6 weeks]
- Patients at high-risk for PP depression include those with any prior history of depression or other mental health disorder.

Assessment of EPDS

EPDS score	EPDS 0-9	EPDS 10-13	EPDS 14-18	EPDS $\geq$ 19
	Limited/no symptoms	*Mild symptoms*	*Moderate symptoms*	*Severe symptoms*
Treatment options			Consider inpatient hospitalization when safety or ability to care for self is a concern	Consider inpatient hospitalization when safety or ability to care for self is a concern
Medication		Consider medication	Recommend medication	Initiate medication
Additional	Counseling therapy Community/social support Physical activity Self-care	Counseling therapy Community/social support Physical activity Self-care	Counseling therapy Community/social support Physical activity Self-care	Refer for psychiatry consult in addition to counseling Community/social support Physical activity Self-care

*adapted from MCPAP For Moms

General management of depression

A score of $\geq$ 10 on the EPDS suggests a patient is depressed.

- Always consider comorbid psychiatric conditions (e.g. psychosis & substance use) and medical causes of depression (e.g. thyroid dysfunction)
- Assess best treatment options for individual patient using table above
- If antidepressant is indicated, screen for bipolar disorder prior to prescribing monotherapy SSRI
- Always refer for psychotherapy (Appendix 3: Resources) in addition to medication

Questions to screen for bipolar disorder (verbally ask these questions prior to starting SSRI monotherapy)

Initial screen:

1. Some people have periods lasting several days or longer when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period liked this lasting several days or longer?
2. Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you started arguments, shouted at people, or hit people?

If yes to questions 1 and/or 2, then continue to screen:

3. People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in ways they would normally think are inappropriate. Did you ever have any of these changes during your episodes of being excited and full of energy/very irritable or grouchy?

If yes to question 3, the patient may have bipolar disorder; refer to psychiatry

If no to question 3, OK to proceed with SSRI monotherapy

Management of suicidal ideation

A positive answer on question #10 of the EPDS suggests the patient is at risk for self-harm or suicide

- Immediately assess further a positive EPDS #10 or *any* disclosure of suicidal ideation with the Columbia-Suicide Severity Rating Scale (Appendix 2)
- Patients needing additional psychiatric consultation should be immediately evaluated in the Emergency Department or other clinical arena where access to Psychiatric Services are available.

Antidepressant medical therapy

Attempt to schedule patient with mental health provider. Use these guidelines if you do not have a mental health provider available or while you are attempting to schedule appointment.

- If patient has a history of taking an antidepressant that helped, prescribe that antidepressant

- If no history of taking an antidepressant, use Zoloft (sertraline) as to date there is the most literature and clinical experience with this SSRI. Alternatives are Prozac (fluoxetine) or Celexa (citalopram).
- Start with half the recommended dose for 2 weeks, then increase to recommended dose as tolerated to minimize side effects (e.g. GI disturbance, dizziness, drowsiness)
- A single medication at a higher dose is favored over multiple medications
- Once treatment is initiated, reevaluate using the EPDS and clinical assessment
  - If no/minimal clinical improvement after 4-8 weeks:
    - If patient has no or minimal side effects, increase the dose
    - If has been on therapeutic dose for ≥ 8 weeks without response, consider switching medication versus increasing dose
    - If patient has side effects, switch medication
  - If clinical improvement and no/minimal side effects:
    - Reevaluate every month and at PP visit
    - Refer to PCP or community psych provider for ongoing care at PP visit
- If an antidepressant has helped during pregnancy, continue it during breastfeeding. Sertraline (Zoloft), paroxetine (Paxil), and fluvoxamine (Luvox) are considered the safest during lactation as they have the lowest degree of translactal passage and fewest reported adverse effects compared to other anti-depressants. If starting an SSRI postpartum, choose one of these.

<table>
<tr><th colspan="4">First line treatment (SSRIs)</th></tr>
<tr><td>sertraline (Zoloft) 50-200 mg
Increase in 50 mg increments</td><td>fluoxetine (Prozac) 20-60 mg
Increase in 10 mg increments</td><td>citalopram (Celexa) 20-40 mg
Increase in 10 mg increments</td><td>escitalopram (Lexapro) 10-20 mg
Increase in 10 mg increments</td></tr>
<tr><th colspan="4">Second line treatment</th></tr>
<tr><td>SSRIS</td><td>SNRIs</td><td>Other</td><td></td></tr>
<tr><td>paroxetine (Paxil) 20-60 mg
Increase in 10 mg increments</td><td>venlafaxine (Effexor) 75-300 mg
Increase in 75 mg increments</td><td>bupropion (Wellbutrin) 300-450 mg
Increase in 75 mg increments</td><td rowspan="2">Consider using a second line medicine if it has worked in the past</td></tr>
<tr><td>fluvoxamine (Luvox) 50-200 mg
Increase in 50 mg increments</td><td>duloxetine (Cymbalta) 30-60 mg
Increase in 20 mg increments</td><td>mirtazapine (Remeron) 15-45 mg
Increase in 15 mg increments</td></tr>
</table>

*adapted from MCPAP For Moms

Doses are listed as **starting** dose – **max** dose

This document should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Additional resources for providers and patients:

- Massachusetts Child Psychiatry Access Project (MCPAP) For Moms Provider Toolkit: https://www.mcpapformoms.org/Toolkits/Toolkit.aspx
- Massachusetts Child Psychiatry Access Project (MCPAP) For Moms Provider Contact Number for consultation: 855-Mom-MCPAP (855-666-6272)
- NICHD Moms' Mental Health Matters: https://www.nichd.nih.gov/ncmhep/initiatives/moms-mental-health-matters/moms/Pages/default.aspx
- Council on Patient Safety in Women's Healthcare: http://www.safehealthcareforeverywoman.org/secure/maternal-mental-health.php

References

ACOG (2015 reaffirmed 2016) Committee Opinion # 630: Screening for perinatal depression. *The American College of Obstetricians and Gynecologists.*

ACOG (2008 reaffirmed 2016) Practice Bulletin # 92: Use of psychiatric medications during pregnancy and lactation. *The American College of Obstetricians and Gynecologists.*

Eke AC, Saccone G, Berghella V. Selective serotonin reuptake inhibitor (SSRI) use during pregnancy and risk of preterm birth: a ystematic review and meta-analysis. BJOG. 2016 Nov;123(12):1900-1907.

Massachusetts Child Psychiatry Access Project (MCPAP) For Moms: https://www.mcpapformoms.org/Default.aspx

Wisner KL, Sit DKY, Hanusa BH, Moses-Kolko EL, Bogen DL, et al .. Major depression and antidepressant treatment: Impact on pregnancy and neonatal outcomes. Am J Psychiatry. 2009 May;166(5):557-566.

Yonkers KA, Wisner KL, Stewart DE, Oberlander TF, Dell DL, Stotland, N, et al. The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists. Obstet Gynecol 2009;114:703-13. Reaffirmed 2014

Appendix 1: Edinburgh Postnatal Depression Scale

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: ______________________________ Address: ___________________________
Your Date of Birth: ____________________ Phone: ___________________________
Baby's Date of Birth: ___________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by ______________________________

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Users may reproduce the scale without further permission, providing they respect copyright by quoting the names of the authors, the title, and the source of the paper in all reproduced copies.

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

C-SSRS SCREENER WITH TRIAGE POINTS

I. SUICIDE IDEATION DEFINITIONS AND PROMPTS:	**Past month**	
Ask questions that are in bolded and underlined	**Yes**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan."* ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it."* ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

C-SSRS SCREENER WITH TRIAGE POINTS

I. SUICIDE IDEATION DEFINITIONS AND PROMPTS:	**Past month**	
Ask questions that are in bolded and underlined	**Yes**	**NO**
6) Suicide Behavior Question: ***<u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u>*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***<u>How long ago did you do any of these?</u>*** ☐Over a year ago? ☐Between three months and a year ago? ☐Within the last three months?		

II. Triage Protocol for C-SSRS Screening
(Items 1-5 linked to last item answered YES)

Item 1 – Outpatient Mental Health Referral at discharge
Item 2 – Outpatient Mental Health Referral at discharge
Item 3 – Psychiatric Consultation and Possible Patient Safety Monitor/ Procedures per their discretion
Item 4 – Psychiatric Consultation and Patient Safety Monitor/ Procedures
Item 5 – Psychiatric Consultation and Patient Safety Monitor/ Procedures

Item 6 – If over a year ago, Outpatient Mental Health Referral at discharge
If between 3 months and 1 year ago (and previously undisclosed)- Psychiatric Consult
If 3 months ago or less (and previously undisclosed)- Psychiatric Consultation and Patient Safety Monitor

This document should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Appendix 3: Community counseling and therapy resources

Autauga County

- Montgomery Area Mental Health Authority: (334) 365-2207 http://www.mamha.org/

Barbour County

- Spectracare Mental Health Center: (334) 687-2323 http://www.spectracare.org/
- Living Waters Counseling, Inc. in Headland, AL: (334) 693-3380
- Women's Hope Group in Dothan, AL: (334) 793-0002

Bibb County

- Indian Rivers Mental Health Center satellite office: (205) 926-4681 http://www.irmhc.org/_index.php

Blount County

- Eastside Mental Health Center: (205) 625-3882 http://eastsidemhc.org/

Bullock County

- East Central Alabama Mental Health Center: (334) 738-5279 http://www.eastcentralmhc.org/

Butler County

- South Central Alabama Mental Health Center: (334) 222-7794 http://www.scamhc.org/

Calhoun County

- Highland Health Systems: Calhoun/Cleburne Mental Health Center: (256) 236-3403 http://ccmhc.net/

Cherokee County

- Cherokee-Etowah-DeKalb (CED) Mental Health Center: (256) 927-3601 http://cedmentalhealth.org/

Chambers County

- East Alabama Mental Health: (334)742-2877 or (800) 815-0630 http://eamhc.org/

Chilton County

- Chilton/Shelby Metal Health Center: (205) 668-4308 http://www.chiltonshelby.org/

Choctaw County

- West Alabama Mental Health Center: (205) 459-2612 http://www.wamhc.org/

Clay County

- Cheaha Mental Health Center satellite office: (256) 396-2366 https://www.rehab.com/cheaha-regional-mental-health-center-outpatient/5139002-r

Cleburne County

- Highland Health Systems: Calhoun/Cleburne Mental Health Center: (256) 236-3403 http://ccmhc.net/

Coffee County

- South Central Alabama Mental Health Center: (334) 347-0212 http://www.scamhc.org/

Colbert County

- Riverbend Center for Mental Health: (256) 383-4048 http://www.rcmh.org/

Conecuh County

- Southwest Alabama Behavioral Health Care Systems: (251) 578-4545 http://www.swamh.com/

Clark County

- Southwest Alabama Behavioral Health Care Systems: (251) 275-4165 http://www.swamh.com/

Coosa County

- Cheaha Mental Health Center: (256) 245-1340 https://www.rehab.com/cheaha-regional-mental-health-center-outpatient/5139002-r

Covington County

- South Central Alabama Mental Health Center: (334) 222-2525 http://www.scamhc.org/

Crenshaw County

- South Central Alabama Mental Health Center: (334) 335-5201 http://www.scamhc.org/

Cullman County

- Cullman Mental Health Center: (256) 734-4688 http://www.mentalhealthcareofcullman.org/

Dale County

- Spectracare Mental Health Center: (334) 774-3052 http://www.spectracare.org/

Dallas County

- Cahaba Mental Health Center: (334) 875-2100 http://cahabamentalhealth.com/

This document should not be construed as dictating an exclusive course of treatment or procedure to be followed.

DeKalb County

- Cherokee-Etowah-DeKalb (CED) Mental Health Center: (256) 845-4571 http://cedmentalhealth.org/

Elmore County

- Montgomery Area Mental Health Authority: (334) 567-8408 http://www.mamha.org/

Escambia County

- Southwest Alabama Behavioral Health Care Systems: Atmore: (251) 368-1675, Brewton: (334) 867-3242 http://www.swamh.com/

Etowah County

- Cherokee-Etowah-DeKalb (CED) Mental Health Center: (256) 413-3470 http://cedmentalhealth.org/

Fayette County

- Northwest Alabama Mental Health Center: (205) 932-3216 http://www.nwamhc.com/

Franklin County

- Riverbend Center for Mental Health: (256) 332-3971 http://www.rcmh.org/

Geneva County

- Spectracare Mental Health Center: (334) 684-9615 http://www.spectracare.org/

Greene County

- West Alabama Mental Health Center: (205) 372-3106 http://www.wamhc.org/

Hale County

- West Alabama Mental Health Center: (334) 624-4905 http://www.wamhc.org/

Henry County

- Spectracare Mental Health Center: (800) 951-4357 http://www.spectracare.org/

Houston County

- Spectracare Mental Health Center: (334) 712-2720 http://www.spectracare.org/

Jackson County

- Mountain Lakes Behavioral Healthcare: (256) 259-1774 http://mlbhc-web.com/

Jefferson County

- JBS Mental Health Urgent Care: (205) 545-8420.
- Oasis Women's Counseling: (205) 933-0330.
- Jefferson County Mental Health Centers are divided into catchment areas:

  Eastside: (205) 836-7283 http://eastsidemhc.org/

  Western 1701 Ave D Ensley B'ham, Al 35211, (205) 788-7770

  UAB 1713 6th Ave So B'ham, Al 35233, (205) 934-7008

- Grayson & Associates: (205) 868-6702 private pay or insurance
- Capitol Care South: (205) 956-2000 private pay or insurance; for serious mental illness

Lamar County

- Northwest Alabama Mental Health Center: (205) 695-9183 http://www.nwamhc.com/

Lauderdale County

- Riverbend Center for Mental Health: (256) 764-3431 http://www.rcmh.org/

Lawrence County

- Mental Health Center of North Central Alabama, Inc.: (256) 974-6697 http://www.mhcnca.org/

Lee County

- East Alabama Mental Health: (334)742-2877 or (800) 815-0630 http://eamhc.org/

Limestone County

- Mental Health Center of North Central Alabama, Inc.: (256) 232-3661 http://www.mhcnca.org/

Lowndes County

- Montgomery Area Mental Health Authority: (334) 548-2578 http://www.mamha.org/

Macon County

- East Central Mental Health (334) 727-7001 http://www.eastcentralmhc.org/

Madison County

- Wellstone Mental Health Center of Madison County: (256) 533-1970 https://www.wellstone.com/

Marengo County

- West Alabama Mental Health Center: (334) 289-2410 http://www.wamhc.org/

Marion County

- Northwest Alabama Mental Health Center: (256) 921-2186 http://www.nwamhc.com/

Marshall County

- Mountain Lakes Behavioral Healthcare: (256) 582-3203 http://mlbhc-web.com/

Mobile County

- Alta Pointe Health Systems Adult Outpatient Services (205) 450-2211 http://altapointe.org/altapointe-services/adult-out-patient-services/

Monroe County

- Southwest Alabama Behavioral Health Care Systems: (251) 575-4203 http://www.swamh.com/

Montgomery County

- Montgomery Area Mental Health Authority: (334) 279-7830 http://www.mamha.org/

Morgan County

- Mental Health Center of North Central Alabama, Inc.: (256) 260-7300 http://www.mhcnca.org/

Perry County

- Cahaba Mental Health Center: (334) 683-9957 http://cahabamentalhealth.com/

Pickens County

- Indian Rivers Mental Health Center satellite office (205) 367-8159 http://www.irmhc.org/_index.php

Pike County

- East Central Alabama Mental Health Center: (334) 566-6022 or (800) 467-1208 http://www.eastcentralmhc.org/

Randolph County

- Cheaha Mental Health Center satellite office: (256) 863-2518 https://www.rehab.com/cheaha-regional-mental-health-center-outpatient/5139002-r

Russell County

- East Alabama Mental Health: (334)742-2877 or (800) 815-0630 http://eamhc.org/

Shelby County

- Chilton/Shelby Metal Health Center: (205) 668-1313 http://www.chiltonshelby.org/

St. Clair County

- Eastside Mental Health Center: (205) 338-7525 http://eastsidemhc.org/

Sumter County

- West Alabama Mental Health Center: (205) 652-6731 http://www.wamhc.org/

Talladega County

- Cheaha Mental Health Center: (256) 245-1340 https://www.rehab.com/cheaha-regional-mental-health-center-outpatient/5139002-r

Tallapoosa County

- East Alabama Mental Health: (256) 329-8463 http://eamhc.org/

Tuscaloosa County

- Indian Rivers Mental Health Center (205) 562-3700 http://www.irmhc.org/_index.php
- Family Counseling Services (205) 752-2504 http://www.counselingservice.org/
- Cahaba Mental Health Center (334) 875-2100

Walker County

- Northwest Alabama Mental Health Center: (205) 387-0581 http://www.nwamhc.com/

Wilcox County

- Cahaba Mental Health Center: (334) 682-4499 http://cahabamentalhealth.com/

Winston County

- Northwest Alabama Mental Health Center: (205) 486-4111 http://www.nwamhc.com/