



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.

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

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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
	<i>Limited/no symptoms</i>	<i>Mild symptoms</i>	<i>Moderate symptoms</i>	<i>Severe symptoms</i>
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

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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 like 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

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- 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 antidepressants. If starting an SSRI postpartum, choose one of these.

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

*adapted from MCPAP For Moms

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

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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/ncmhcp/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>

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References

ACOG Committee Opinion Number 630: Screening for perinatal depression. May 2015.

ACOG Practice Bulletin Number 92: Use of psychiatric medications during pregnancy and lactation. April 2008.

Eke AC, Saccone G, Berghella V. Selective serotonin reuptake inhibitor (SSRI) use during pregnancy and risk of preterm birth: a systematic 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 D KY, 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

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Appendix 1: Edinburgh Postnatal Depression Scale

Edinburgh Postnatal Depression Scale¹ (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:

- | | |
|--|--|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"><input type="checkbox"/> As much as I always could<input type="checkbox"/> Not quite so much now<input type="checkbox"/> Definitely not so much now<input type="checkbox"/> Not at all <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"><input type="checkbox"/> As much as I ever did<input type="checkbox"/> Rather less than I used to<input type="checkbox"/> Definitely less than I used to<input type="checkbox"/> Hardly at all <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, some of the time<input type="checkbox"/> Not very often<input type="checkbox"/> No, never <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> No, not at all<input type="checkbox"/> Hardly ever<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> Yes, very often <p>*5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite a lot<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> No, not much<input type="checkbox"/> No, not at all | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time I haven't been able to cope at all<input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual<input type="checkbox"/> No, most of the time I have coped quite well<input type="checkbox"/> No, I have been coping as well as ever <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> Not very often<input type="checkbox"/> No, not at all <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, quite often<input type="checkbox"/> Not very often<input type="checkbox"/> No, not at all <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, quite often<input type="checkbox"/> Only occasionally<input type="checkbox"/> No, never <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite often<input type="checkbox"/> Sometimes<input type="checkbox"/> Hardly ever<input type="checkbox"/> Never |
|--|--|

Administered/Reviewed by _____

¹Source: 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 .

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

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Edinburgh Postnatal Depression Scale¹ (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)

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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.

¹Source: 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.

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

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Appendix 2: Columbia-Suicide Severity Rating Scale

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? <u><i>Have you wished you were dead or wished you could go to sleep and not wake up?</i></u>		
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." <u><i>Have you actually had any thoughts of killing yourself?</i></u>		
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." <u><i>Have you been thinking about how you might do this?</i></u>		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as oppose to "I have the thoughts but I definitely will not do anything about them." <u><i>Have you had these thoughts and had some intention of acting on them?</i></u>		
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. <u><i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i></u>		

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C-SSRS SCREENER WITH TRIAGE POINTS

I. SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past month	
Ask questions that are in bolded and underlined	Yes	NO
<p>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.</p> <p>If YES, ask: <u>How long ago did you do any of these?</u> <input type="checkbox"/>Over a year ago? <input type="checkbox"/>Between three months and a year ago? <input type="checkbox"/>Within the last three months?</p>		

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

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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/>

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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/>

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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/>

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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.mhcna.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.mhcna.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/>

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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.mhcna.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/>

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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/>