

VOLUME ONE • READER'S GUIDE

PERSONAL WELLNESS PSYCHIATRIC SERVICES

When addiction and psychiatric medication *need the same plan.*

A guide for families and referring providers in Northwest Indiana. What bridge care is, what a visit looks like, what to ask, and how to start.

By Angela Vanderberg, PMHNP-C, FNP-BC, CARN-AP

About this *guide*.

This is a short, plain-language guide for two readers: the family member who is helping someone they love, and the referring provider who is sending a patient onward. Both are doing the same hard work from different sides of the desk. The vocabulary in this guide reflects that.

It is not a clinical reference. It will not replace a conversation with a prescriber. What it can do is give you enough orientation to ask the right questions, recognize what an honest answer sounds like, and know when to make the call.

The practice that publishes this guide, Personal Wellness Psychiatric Services in Merrillville, Indiana, is built around the specific clinical work the guide describes. The publication is also editorial: it reflects how one provider thinks about care. Other providers will think differently. Use what is useful, leave what is not.

Contents

- **i.** If you are reading this
- **ii.** What bridge care actually is
- **iii.** Why the two conditions cannot be separated
- **iv.** What a visit looks like
- **v.** For families: how to start the conversation
- **vi.** For referrers: how the handoff works
- **vii.** Local resources and how to use them
- **viii.** Contact

You are *already doing the work*.

If you are reading this, someone you care about is in the in-between. They finished detox and there is no good prescriber. They left IOP and the medication is running out. They are still using and you are trying to figure out which call to make. Or you are the one referring them onward, and you want a real handoff, not a name and a fax number.

In Northwest Indiana, this in-between is where outcomes are won or lost. The acute programs end. Routine life resumes. The conditions that made the situation hard in the first place are still there. Most of the time, several conditions are there at once: substance use, plus the trauma underneath, plus the anxiety alongside it, plus the ADHD that has been screaming for years.

"The patient is not the problem. The handoff is."

A COMMON OBSERVATION IN ADDICTION MEDICINE

A practice built for the in-between is a different kind of practice. It accepts that recovery is rarely linear, that medication regimens evolve, that families need to be looped in with the patient's consent, and that the referring provider needs to know what happened after they made the call.

This guide is short on theory and long on what to do next.

II. WHAT BRIDGE CARE ACTUALLY IS

Not detox. *Not a clinic.* Continuity.

Bridge care is sustained psychiatric and addiction-medicine prescribing for the period after an acute program ends and before long-term equilibrium is reached. It is not a level of care that has a name on most referral lists. That is part of why it is often missing.

What bridge care is not

- Not detox. The medical stabilization of acute withdrawal is something specific programs do; bridge care begins after.
- Not residential treatment. A bridge-care patient is living their life, not in a facility.
- Not a single-medication clinic. A clinic that only does one prescription is a useful resource for some patients; it is not bridge care.
- Not crisis services. If someone is in immediate danger, that is a 988 or 911 conversation, not a bridge-care intake.
- Not psychotherapy alone. Talk therapy is often part of the picture, sometimes integrated, sometimes provided by a partner therapist.

What bridge care is

A long-term prescribing relationship with one provider who handles both psychiatric medications and addiction medications, treats the conditions that travel together as one unified picture, and stays available across the months and years it takes for treatment to become stable.

The shape of the *relationship*.

The initial visit is long, usually 60 to 75 minutes. The provider takes a comprehensive history: mental health, substance use, trauma, medication history, what has worked, what has not, what life currently looks like. The visit produces a working diagnosis and a treatment plan. The patient leaves with prescriptions and a plan for the next visit.

Follow-up visits are shorter, usually 20 to 30 minutes. Sometimes longer when psychotherapy is part of the appointment. The cadence varies: weekly or biweekly during the first stretch, then often monthly once stability is reached, then sometimes less often once the patient is well established.

Coordination is part of the work. With the patient's written consent, the provider talks with the referring therapist, the primary-care prescriber, the recovery program. A treatment summary is sent back so the referring side can keep doing their part with full information.

"The handoff is a conversation, not a fax."

HOW COORDINATED CARE SHOULD SOUND

This shape is not exotic. It is what a regular outpatient psychiatric and addiction-medicine practice can look like when the work is taken seriously and the patient is treated as a whole person.

Mental health and addiction *travel together*.

In the United States, more than half of people with a substance use disorder also have a co-occurring mental-health condition. The reverse is also common: a sizable share of patients with mood, anxiety, trauma, or ADHD diagnoses have a substance use problem that has been masked, missed, or minimized for years.

Treatment that addresses one without the other rarely produces an outcome that holds. A common pattern: a patient is treated for depression with an antidepressant while their unrecognized alcohol use disorder continues to drive symptoms. The depression appears treatment-resistant. The prescriber adds another medication. The pattern repeats. The actual driver is never addressed.

The reverse pattern is equally common. A patient is treated for opioid use disorder with buprenorphine while their untreated PTSD continues to drive the use cycle. Without the trauma work happening alongside, the medication is asked to do something it cannot do alone.

The conditions that most often co-occur

- PTSD and complex trauma, with substance use as a self-management strategy
- Major depression, with alcohol or stimulant use as either driver or consequence
- Anxiety disorders, with substance use offering temporary relief
- Bipolar spectrum, frequently misdiagnosed and complicated by substance use
- Adult ADHD, with stimulant use that may be self-medication or escalation

What to *expect*.

An intake at this practice runs 60 to 75 minutes. The first portion is conversation: who you are, why you are here, what you have already tried. The second portion is a structured clinical assessment covering psychiatric symptoms, substance use history, medical context, social context. The third portion is shared decision-making about the treatment plan.

Specifically, the provider will ask about

- Your current symptoms and how they affect daily life
- Your full medication history, including what has worked, what has not, and side effects you remember
- Any substance use, current or historical: alcohol, cannabis, opioids, stimulants, benzodiazepines, others
- Mental-health history including any hospitalizations, programs, or prior diagnoses
- Trauma history, in whatever depth you choose to share
- Family history of mental health, substance use, and medical conditions
- Sleep, appetite, energy, motivation, focus, mood patterns
- Your goals, your concerns, what you want care to look like

You will not be asked to disclose more than you are ready to. The clinical conversation is paced for safety. A trauma-informed approach is not a slogan in this practice; it is a clinical requirement.

You will leave the first visit with: a working diagnosis, a clear medication plan if medication is appropriate, a follow-up scheduled, and the provider's direct number for the practice.

How to *start the conversation*.

If you are a family member trying to help, the practical realities matter. Adult patients have to be the ones who book and show up. You cannot enroll someone against their will. You can, however, do a great deal of the orientation work that often gets in the way of someone calling on their own.

Practical steps you can take today

- Call the practice yourself first. You can ask anything. You do not need to commit to anything. (219) 444-7946.
- Share this guide with your person. The phone number is on the back. Sometimes that is enough.
- If your person is willing, offer to sit with them during the first call. Or have them make the call from your home so the first step is supported.
- Once enrolled, your person can sign a release of information. With that, the practice can talk with you about treatment progress.
- For your own well-being, consider Al-Anon, NAMI Family-to-Family, or a therapist who specializes in family members of patients in recovery.

Framing matters

Most people in addiction or psychiatric distress have been told what they should do many times. What they often have not heard is what they are allowed to want. Framing the conversation as "here is a provider who might be a fit; the decision is yours" usually goes further than urgency.

If your person is in immediate danger: call 988 (Suicide & Crisis Lifeline) or 911. Do not wait for an intake appointment in a crisis.

How the *handoff works*.

If you are a therapist, primary-care prescriber, recovery program staff, or case manager, the practice's expectation is that referrals are conversations, not paperwork.

How to refer

- Call (219) 444-7946. A five-minute conversation usually confirms fit and capacity.
- If you prefer, email personalwellnessmed@gmail.com with a short note. Patient information should not be sent by unsecured email.
- Have your patient book their own intake through IntakeQ.
- With the patient's written consent, expect a brief treatment summary after intake. Updates follow at meaningful changes, not arbitrary intervals.
- When something requires a direct provider-to-provider conversation, it happens by phone. Not portal-only.

What this practice can and cannot do

Can: psychiatric medication management, addiction medicine including MAT, integrated care for co-occurring conditions, court-ordered evaluations on a case-by-case basis, telehealth across Indiana for established-patient follow-ups, integrated psychotherapy as an add-on inside medication visits, and coordination with your treatment plan.

Cannot: detox or inpatient stabilization, residential treatment, crisis services, primary medical care for non-mental-health concerns (referrals back to primary care are coordinated), and treatment of patients who are not stably able to attend outpatient appointments.

VII. LOCAL RESOURCES

Who else *to know*.

Bridge care is one piece of a larger ecosystem. The organizations below are part of the everyday referral network in Northwest Indiana. Listing them here is not an endorsement of every service; it is an acknowledgment that good care happens across multiple programs at once.

Harm reduction

- **Hope Alliance of Northwest Indiana** -- harm-reduction nonprofit serving Northwest Indiana. hopealliancenwi.com

Recovery and counseling

Multiple counseling and group-based treatment programs operate across Lake County. The practice coordinates referrals to and from established partners; ask at intake about which programs are currently active matches for your situation.

Crisis

- **988 Suicide & Crisis Lifeline** -- call or text 988. Free, confidential, 24/7.
- **911** for life-threatening emergencies.
- **Local hospital emergency departments** for acute psychiatric or medical crises.

Peer and family support

- **NAMI Northwest Indiana** -- education, support groups, advocacy for patients and family members.
- **Al-Anon / Nar-Anon** -- family member support meetings throughout the region.
- **SMART Recovery, Refuge Recovery, AA, NA** -- abstinence-based and alternative peer-support frameworks. Different fits for different people.

Questions *worth asking*.

Whether you are a patient evaluating a prescriber, a family member helping someone evaluate, or a referrer doing due diligence, here are the questions that usually distinguish a careful practice from a routine one.

Questions for a prescriber

- Do you treat substance use and psychiatric conditions together, or do I need separate providers?
- What is your approach when a patient relapses? Does care continue?
- How do you decide medication changes? Who is in that conversation?
- What is your usual cadence of visits, and how does it change once a patient is stable?
- How do you coordinate with my therapist or my primary-care provider?
- What credentials do you hold for addiction medicine specifically?
- What does it cost? Do you take my insurance? What is the self-pay rate?
- What happens between visits if something goes wrong?

Honest answers tend to share three traits

- They are specific rather than vague.
- They name what the practice does not do, not just what it does.
- They do not promise outcomes.

If a prescriber dodges, dismisses, or oversells, that is information too.

VIII. CONTACT

When you are ready, *or before.*

The practice is by appointment. The phone is answered by a real person during business hours.

PRACTICE

Personal Wellness
Psychiatric Services
7891 Broadway, Ste F
Merrillville, IN 46410

REACH

(219) 444-7946
personalwellnessmed
@gmail.com
personalwellness
psychiatricservices.com

PROVIDER

Angela Vanderberg, PMHNP-C, FNP-BC, CARN-AP. Dual board-certified nurse practitioner with 15+ years of advanced practice experience, including addiction nursing at the advanced-practice level (CARN-AP) -- a credential rare among prescribing psychiatric providers in Lake County.

IN A CRISIS

Call or text **988** (Suicide & Crisis Lifeline) -- free, confidential, 24/7. For emergencies, call **911** or go to your nearest emergency room.