Bipolar Disorder and Nursing Homes: Amending Training Requirements Set Forth In § 19a-562a of The Connecticut General Statutes to Encompass Geriatric Mental Illness

STEPHANIE C. GREER*

ABSTRACT

The current aging population in the United States is increasing rapidly. Connecticut has implemented many programs to assist seniors in remaining in the community, but little has been done regarding training requirements for staff working in memory care facilities across the state. Though the focus of enacted legislation is dementia care, there remain unmet needs that can be solved through legislative amendments. Those living with bipolar disorder are significantly more likely to develop dementia, therefore likely to be placed in memory care units. Because of this correlation, current training requirements should be amended to include mental health training requirements that encompass illnesses such as bipolar disorder.

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INTRODUCTION

It is no secret that the population in the United States is aging. It is predicted that in the next five to ten years, the United States population over the age of sixty will grow "3.5 times more rapidly than the general population."[1] Due to this rapid increase, it is critical that Connecticut works to develop medical care suited to meet the health needs of this growing population of older adults.[2]

When one thinks of health issues faced by older adults, one may quickly consider various dementias and related memory disorders, but mental illnesses such as bipolar disorder are prominent factors in a person ultimately requiring skilled nursing care. Nursing home staff are often "ill-equipped" to serve mentally ill residents "despite the high prevalence of mental illness other than dementia in nursing homes."[3] However, nursing homes are often where loved ones will be placed[4] based on whether the individual's safety can be ensured through other means such as home-based programs.[5] Though necessary, nursing homes suffer from a lack of staff, high turnover rates, and other factors[6] that serve to limit the experience of staff and the care available to manage residents' needs.[7]

Patients living with bipolar disorder are more likely than the general population to develop dementia.[8] Therefore, this patient population is likely

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[1] Martha Sajatovic, Sergio A. Strejilevich, Ariel G. Gildengers, Annemiek Dols, Rayan K. Al Jurdi, Brent P. Forester, Lars Vendel Kessing, John Beyer, Facundo Manes, Soham Rej, Adriane R Rosa, Sigfried NTM Schouws, Shang-Ying Tsai, Robert C. Young, & Kenneth I. Shulman, *A Report on Older-Age Bipolar Disorder from the International Society for Bipolar Disorders Task Force*, 17 BIPOLAR DISORDERS 689, 689 (2015) [hereinafter Sajatovic].

[2] *See id.*

[3] David C. Grabowski, Kelly A. Aschbrenner, Vincent F. Rome, & Stephen J. Bartels, *Quality of Mental Health Care for Nursing Home Residents: A Literature Review*, 67 MED. CARE & RSCH. REV. 627, 628 (2010) [hereinafter Grabowski].

[4] *Staffing is the Key to Quality Care*, CONN. LONG-TERM CARE OMBUDSMAN PROGRAM, https://portal.ct.gov/LTCOP/Content/Advocacy-Center/Nursing-Home-Staffing (last visited Sept. 23, 2023) ("[M]ore than 40% of Americans who reach the age of 65 will spend some time in a nursing home during their remaining years."). *See Better Staffing: The Key to Better Care*, THE NAT'L CONSUMER VOICE FOR QUALITY LONG-TERM CARE, https://theconsumervoice.org/betterstaffing (last visited Sept. 23, 2023).

[5] Paul Wynn, *Nursing Home Requirements: Who's Eligible?*, U.S. NEWS (July 13, 2023, 9:43 AM), https://health.usnews.com/senior-care/articles/nursing-home-requirements ("Two-thirds of people admitted to a nursing home for short-term post-acute nursing or rehabilitation care are able to return home . . . .").

[6] *Staffing is the Key to Quality Care*, *supra* note 4 ("[H]igher levels of staffing lead to better care, but the federal government does not require nursing homes to have at least a minimum number of staff on duty. . . . Under-staffing harms nursing home residents and can lead to pressure ulcers [bedsores], infections, malnutrition, dehydration, and injuries from falls." Connecticut has "one of the lowest staffing requirements in the country. . . .").

[7] CONN. AGENCIES REGS. § 19-13-D8t (proposed Nov. 21, 2022). This regulation is marked as "proposed" as of January 27, 2023, despite a proposed implementation date of November 21, 2022. *See also* Medicare and Medicaid Requirements for Long Term Care Facilities, 54 Fed. Reg. 5300 (Feb. 2, 1989) (to be codified at 42 C.F.R. § 483.30).

[8] Kuan-Yi Wu, Chia-Ming Chang, Hsin-Yi Liang, Chi-Shin Wu, Erin Chia-Hsan Wu, Chia-Hsiang Chen, Yeuk-Lun Chau, & Hui-Ju Tsai, *Increased Risk of Developing Dementia in Patients with Bipolar Disorder: A Nested Matched Case–Control Study*, 15 BIPOLAR DISORDERS 787, 790 (2013) [hereinafter Wu].

to be statistically significant in memory care units, warranting additional training requirements for nursing staff as to frequently occurring comorbidities to dementia, such as bipolar disorder.

I. DISCUSSION

A. *The Current System*

Currently, options for long-term residential skilled nursing care are limited for older adults with cooccurring dementia and bipolar disorder.[9] But why does the population with co-occurring bipolar disorder and dementia require attention? Studies have examined the association between bipolar disorder and the development of dementia and have found that those with bipolar disorder had a significantly higher risk of developing dementia, but have not clearly identified the correlation between the two disorders.[10] This is confirmed by other studies as patients diagnosed with bipolar disorder had a greater risk of developing dementia both before and after reaching the age of sixty-five,[11] and "4.5% to 19% of elderly individuals with [bipolar disorder] have dementia."[12]

When considering options for psychiatric skilled nursing care, the State of Connecticut provides no listing of nursing homes offering psychiatric services.[13] Additionally, even a Connecticut State document, updated in 2021, listing "State Options for Older Adults" makes no mention of skilled nursing facilities, aside from one program, Small-Housing Nursing Home Pilot Program,[14] which has not been implemented.[15] This report notes that while the pilot has not begun, one home in Bridgeport is a "small house

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[9] While there are options for mental health care such as iCare facilities, there are few older adult-specific facilities equipped to handle the complexities of geriatric mental health conditions coupled with non-geriatric specific conditions. Facilities such as Masonicare or the Institute of Living offer care for acute situations, but patients must be discharged to a capable facility or caretaker. *Behavioral Health Hospital*, MASONICARE https://www.masonicare.org/services/health-wellness/behavioral-health, (last visited Jan. 18, 2024); *Home*, ICARE HEALTH NETWORK, https://www.icarehn.com/ (last visited Jan. 18, 2024); *About Us*, HARTFORD HEALTHCARE: INSTITUTE OF LIVING, https://instituteofliving.org/about-us (last visited Feb. 28, 2024).

[10] Wu, *supra* note 8, at 790 ("[S]ubjects with bipolar disorder had a 4.07-fold higher risk of dementia."). *See id.* at 791 tbl.2 (noting crude and adjusted odds ratio of developing dementia in patients with bipolar disorder, but not clearly identifying a correlation between the two disorders).

[11] *Id.* at 792. *Id.* at tbl.3 (explaining that senile dementia is that in which the onset is after age 65, and pre-senile dementia is that in which the onset is before age 65).

[12] Sonali V. Lala & Martha Sajatovic, *Medical and Psychiatric Comorbidities Among Elderly Individuals with Bipolar Disorder: A Literature Review*, 25 J. GERIATRIC PSYCHIATRY & NEUROLOGY 20, 20 (2012).

[13] HELGA NIESZ, CONN. GEN. ASSEMBLY, NURSING HOMES AND PSYCHIATRIC SERVICES, 2001-R-0034 (2001) https://www.cga.ct.gov/2001/rpt/2001-R-0034.htm ("There is no official listing of nursing homes that offer psychiatric services, but six homes list 'psychiatric care' as one of the programs they offer in the Department of Public Health's 1999-2000 directory."). It is important to note that this response has not been updated since 2001.

[14] CONN. GEN. STAT. § 17b-372 (2014).

[15] *See* NICOLE DUBE, CONN. GEN. ASSEMBLY, STATE PROGRAMS FOR OLDER ADULTS, 2021-R-0110 at 16 (2021). The report does note the presence of one long-term care facility meeting the requirements and designated as a small long-term care home, but it also notes that there are only fourteen beds available in each unit. *Id.*

nursing home" with fourteen beds.[16] While there *are* options, the problem lies in patients' quality of life which is at the pinnacle of the State of Connecticut's goals for elder care. This pilot program is designed to improve quality of life for older adults and offers the opportunity for such homes to specialize in particular communities whose needs are not being met.

Current training requirements for memory care staff depend on the licensure status of staff members.[17] Those licensed to provide direct care must receive ten hours of annual training,[18] while unlicensed staff need only receive one hour of annual training.[19] There are no requirements designed to address mental health conditions aside from dementia. The strong correlation between bipolar disorder and dementia demonstrates the importance of specific training to care for this population.

The simple comorbidity of bipolar with dementia is not necessarily in itself a concern warranting legislative reform; however, the quality of life for patients experiencing such comorbidities does warrant significant legislative action. The Connecticut State Department of Aging and Disability Services aims to maximize opportunities for the independence of older adults in Connecticut,[20] and the "No Wrong Door" initiative works to support older adults by providing resources to remain in the community.[21] It is clear that Connecticut state agencies want to improve the way older adults receive help,[22] and through many of the State of Connecticut's departments, missions, and past reforms, it is evident that quality of life and quality of care is a high priority. That leads to the question: why is dementia the only condition warranting additional training?

B. *Bipolar Disorder in the Elderly*

Bipolar disorder is a mental disorder which causes "dramatic shifts in mood, energy, and activity levels."[23] These shifts affect ability to complete daily tasks and are "more severe than the normal ups and downs that are

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[16] *Id. See also* Mozaic Jewish Home, MOZAIC SENIOR LIFE, https://www.mozaicsl.org/services/long-term-care/the-jewish-home (last visited Jan. 18, 2024).

[17] CONN. GEN. STAT. § 19a-562a (2022).

[18] *See* § 19a-562a(b).

[19] *See* § 19a-562a(c).

[20] *Programs and Services*, DEP'T AGING & DISABILITY SERVS., https://portal.ct.gov/AgingandDisability/Content-Pages/Main/Programs-and-Services (last visited Sept. 23, 2023) (noting that it "provides many programs and services to maximize opportunities for the independence and well-being of people with disabilities and older adults in Connecticut").

[21] *No Wrong Door Initiatives–Improving Behavioral Health Services for Older Adults*, DEP'T AGING & DISABILITY SERVS., https://portal.ct.gov/AgingandDisability/Content-Pages/Programs/No-Wrong-Door-Initiatives--Improving-Behavioral-Health-Services-for-Older-Adults (last visited Sept. 23, 2023) ("The No Wrong Door describes the way State, Federal and local agencies work together to help individuals needing long term services and supports [to] remain in the community.").

[22] *Id.* ("The Department of Aging and Disability Services State Unit on Aging, the Connecticut Department of Social Services, and other state agencies are working together to . . . improve the way older adults . . . receive help.").

[23] *Bipolar Disorder*, NAT'L INST. MENTAL HEALTH, https://www.nimh.nih.gov/health/statistics/bipolar-disorder (last visited Sept. 16, 2023).

experienced by everyone."[24] Bipolar disorder affects about 1% of adults, which may not seem significant, but this number solely represents those remaining in the broader community.[25] In the United States, it is estimated that 4.4% of adults live with bipolar disorder.[26] The United States Census Bureau notes that the United States population as of the April 1, 2020 census was 331,449,281 and the population over the age of 18 was 77.8%.[27] It is then estimated that about 11.3 million adults in the United States will suffer from bipolar disorder at some point during their lifetime, and, once diagnosed, there is no "cure," and episodes can be intermittent, with sometimes years between them.[28]

Late-life bipolar disorder is often referred to as "BD in individuals aged ≥ 60 years" living with bipolar disorder, but refers to this population as OABD.[29] This population, although seemingly specified, "represent[s] as much as 25% of the population with [bipolar disorder]."[30] Sajatovic notes that topics related to OABD have previously been the subjects of little research and training, because the population is aging, "we can no longer conceptualize OABD as a 'special population' for whom understanding of the disorder and recommended management can simply be extrapolated from experience in mixed age groups."[31] Additionally, despite bipolar disorder *appearing* "to become less common with age . . . , it is present in 6% of geriatric psychiatry outpatient visits and 8% to 10% of geriatric inpatient admissions."[32] North American studies report that patients living with bipolar disorder constitute a notable percentage of nursing home residents (3%) and elderly patients in psychiatric emergency rooms (17%).[33] This population makes up a significant portion of nursing home residents and elderly community members, yet there are no current statutory training requirements for staff working with these patients. Training is necessary due to the specificity of the interplay between dementia and bipolar disorder and the frequency of co-occurrence. Perhaps with additional training, there would come to be fewer elderly bipolar patients in psychiatric emergency rooms, and instead, hopefully, experiencing a better quality of life due to an improved quality of care.

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[24] *Id.*

[25] Akshya Vasudev & Alan Thomas, *'Bipolar Disorder' in the Elderly: What's in a Name?*, 66 MATURITAS 231, 231 (2010).

[26] *Bipolar Disorder*, *supra* note 23.

[27] *Quick Facts, United States,* U.S. CENSUS BUREAU, https://www.census.gov/quickfacts/fact/table/US/POP010220 (last visited Sept. 9, 2023).

[28] *See* Mauricio Tohen, *Expert Q&A: Bipolar Disorder*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/patients-families/bipolar-disorders/expert-q-and-a (last visited Sept. 16, 2023) ("Studies have shown that approximately 10 percent of patients have a single episode only. However, the majority of patients have more than one.").

[29] Sajatovic, *supra* note 1.

[30] *Id.*

[31] *Id.*

[32] *Id.* at 691.

[33] *Id.*

C. *Interplay Between Bipolar and Dementia*

Dementia, and the various types of dementias, such as Alzheimer's, are such common diagnoses in the elderly population that the State of Connecticut has established the opportunity for nursing homes to create specific "memory care" units. These units are required to ensure that staff undergoes training specific to the unit population meeting statutory requirements.[34]

Current training requirements for memory care staff depend on whether staff members are licensed to provide direct care, or support those who are licensed.[35] Licensed individuals must receive ten hours of training annually.[36] Eight hours of which must be dementia-specific, and two hours must be related to pain recognition and pain management techniques.[37] Unlicensed staff members, need only attend one hour of training annually.[38] The statute does not enumerate specific requirements as to training contents and does not require training for any mental health conditions aside from dementia. While the training itself offers an opportunity to include such topics, a requiring such training would assure that it is provided and received.

While training of this kind is necessary, there remains a gap in Connecticut's care options for elderly patients. The CDC estimated that as of 2020,[39] there were 1.3 million nursing home residents, and as of 2002, "an estimated 560,000 nursing home residents . . . had a mental illness other than dementia."[40] "Among persons with mental illness, a diagnosis of schizophrenia or bipolar disorder was found to be associated with a greater likelihood of admission to a nursing home over a three-year period."[41] Moreover, "individuals admitted with mental illness or dementia differed from other nursing home residents (and from one another) in their demographic characteristics, co-morbid conditions, and treatments received."[42] Among others, these differences included marital status, the more frequent use of antipsychotic medications, less frequent training to allow individuals to reenter the community, and more frequent use of restraints.[43]

Though the State of Connecticut has recognized that caring for dementia patients requires unique training through the approval of

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[34] CONN. GEN. STAT. § 19a-562a.
[35] *Id.*
[36] *Id.* at § 19a-562a(b).
[37] *Id.*
[38] *Id.* at § 19a-562a(c).
[39] *Nursing Home Care*, CTRS. FOR DISEASE CONTROL & PREVENTION (last visited Jan. 18, 2024), https://www.cdc.gov/nchs/fastats/nursing-home-care.htm.
[40] Catherine Anne Fullerton, Thomas G. McGuire, Zhanlian Feng, Vincent Mor, & David C. Grabowski, *Trends in Mental Health Admissions to Nursing Homes, 1999–2005*, 60 PSYCHIATRIC SERVS. 965, 965 (2009).
[41] *Id.*
[42] *Id.* at 967.
[43] *Id.* at 968

legislation requiring specialized training for staff employed in a memory care unit,[44] bipolar disorder has a set of symptoms unique from dementia.[45] Reviews suggest that bipolar disorder experienced later in life is likely "a distinct diagnostic entity compared to the younger bipolar patients."[46] This conclusion is drawn from the observation that in elderly patients, bipolar disorder "has a different presentation, etiology and hence perhaps needs different treatment strategies."[47]

D. *Memory Care Units*

The amendment to section 19a-562a in 2014,[48] which set specialized training requirements for memory care facilities and other care providers, led to general improvements in these units. A 2018 study found that "among residents with dementia admitted to a nursing home with [a memory care unit]," there was a "significant reduction in the use of inappropriate antipsychotics, restraints, pressure ulcers, feeding tubes, and hospitalizations."[49] While the study found the presence of a memory care unit to have "a direct effect" on quality of care, researchers also found characteristic differences between those facilities with and without a memory care unit.[50] The study concluded that it is possible that "facilities with [memory care units] tend to provide better quality overall, and the [memory care unit] also provides better quality care for patients with dementia."[51] This leads to the possibility that the implementation of comparable training requirements or units for patients with bipolar disorder may yield similar results.

E. *Connecticut Programs for Psychiatric Care*

Many Connecticut programs for psychiatric care focus on home care or community resources;[52] however, there is no available list of nursing homes with psychiatrists on staff or a simple means of finding facilities or beds available. One requirement of the nursing home reform provisions, passed

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[44] § 19a-562a.

[45] *See generally,* Lala & Sajatovic, *supra* note 12.

[46] Vasudev & Thomas, *supra* note 25, at 231.

[47] *Id.*

[48] § 19a-562a.

[49] Nina R. Joyce, Thomas G. McGuire, Stephen J. Bartels, Susan L. Mitchell, & David C. Grabowski, *The Impact of Dementia Special Care Units on Quality of Care: An Instrumental Variables Analysis*, 53 HEALTH SERVS. RSCH. J. 3657, 3673 (2018). This is likely due to better understanding of the condition and appropriate means of responding in various situations.

[50] *Id.*

[51] *Id.*; *see* Jane M. Cioffi, Andrew Fleming, Lesley Wilkes, Melissa Sinfield, & Jenny Le Miere, *The Effect of Environmental Change on Residents with Dementia*, 6 DEMENTIA 215, 223, 227 (2007); *see also* Andrea Gruneir. Kate L. Lapane, Susan C. Miller, & Vincent Mor, *Does the Presence of a Dementia Special Care Unit Improve Nursing Home Quality?*, 20 J. AGING & HEALTH 837, 851 (2008).

[52] *Behavioral Health Homes*, DEP'T MENTAL HEALTH & ADDICTION SERVS., https://portal.ct.gov/DMHAS/Divisions/Behavioral-Health-Division/Behavioral-Health-Homes (last visited Sept. 9, 2023).

through the 1987 Omnibus Budget Reconciliation Act (OBRA-87), stipulates that:

> nursing home applicants receive preadmission screening for mental illness . . . to identify the proper residential settings to accommodate their needs[]. The Centers for Medicare and Medicaid Services (CMS[]) . . . .[53] developed what is now called Preadmission Screening and Resident Review (PASRR) as the interpretive guidelines regulating how states implement the preadmission requirements . . . . For residents with both a mental illness and a need for nursing assistance, the regulations require that facilities provide active mental health treatment.[54]

Unfortunately, "[d]espite the high prevalence of mental illness in the nursing home, most nursing homes do not have access to mental health providers with training in psychiatry and mental health treatment."[55] Federal regulation requires that the nursing facility "provide mental health or intellectual disability services which are of a lesser intensity than specialized services to all residents who need such services."[56]

Not having psychiatrists on staff further limits options for those with mental illness and leads to increased hospitalizations to receive appropriate care.[57] Frequent environmental changes such as being transferred to a hospital and back to one's residence can exacerbate behavioral and psychiatric symptoms in dementia patients.[58] Often, psychiatric problems, which could be addressed or avoided through timely mental health services, worsen until they require hospitalization.[59] Early intervention would likely decrease hospitalizations, leading to cost savings for state programs providing medical benefits; but more importantly, ensuring that residents receive the best care possible.

Providing care for mentally ill residents has proven to be challenging for nursing facilities. In a case of requested involuntary transfer of a mentally ill patient by a nursing home, the court found that the nursing home "'must provide' mental health services which are of a lesser intensity than 'specialized services' to all residents who need such services." The court

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[53] Ann D. Bagchi, James M. Verdier, & Samuel E. Simon, *How Many Nursing Home Residents Live with a Mental Illness?*, 60 PSYCHIATRIC SERVS. 958, 958 (2009) (at the time CMS was the HealthCare Financing Administration).

[54] *Id.*

[55] Grabowski, *supra* note 3, at 634 (noting that many psychiatrists or those who can provide specialized care respond on an "as needed" basis rather than as an employee at the residential facility).

[56] 42 C.F.R. § 483.120 (2021).

[57] *Id.*

[58] Davina Porock, Philip Clissett, Rowan H. Harwood, & John R.F. Gladman, *Disruption, Control and Coping: Responses of and to the Person with Dementia in Hospital*, 35 AGING & SOC'Y 37, 42 (2015).

[59] Grabowski, *supra* note 3, at 640.

then found that, although the resident's "special needs" were a challenge for the nursing home, under federal law, the nursing home could not transfer or discharge the resident "without first trying to provide the required services." Despite attempts to provide mental health services, the court found that the attempts were insufficient to comply with the required "plan of care and treatment" for the resident's mental health needs.[60]

Though frontline providers play an important role in the detection and treatment of mental illness in nursing homes,[61] their training is often limited.[62] The court above hypothesized that the nursing home could substantially reduce "problem behaviors" by acquiring a better understanding of the patient's "mental condition and needs through an assessment and care plan."[63]

In accordance with the notion above, the American Geriatrics Society and the American Association for Geriatric Psychiatry report recommended that CMS "develop standards that promote and support the implementation of training models with demonstrated effectiveness"[64] and provides numerous recommendations worth consideration.[65] It is clear that there are options to ensure a better quality of life for elderly persons living with mental illness, but implementation, or simply a pilot, of such options are necessary.

II. PROPOSAL

It is clear from this discussion that there are many problems to be addressed in nursing home regulation; however, this proposal focuses on one way Connecticut could address this issue. Similar to the court's view in *In re Involuntary Discharge or Transfer*, better understanding of mental conditions allows for improved assessment of residents' needs and the services best able to meet those needs.

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[60] *In re* Involuntary Discharge or Transfer of J.S. by Hall, 512 N.W.2d 604, 611–12 (Minn. Ct. App. 1994).

[61] *Id.* (citing Judy A. Glaister & Charles Blair, *Improved Education and Training for Nursing Assistants: Keys to Promoting the Mental Health of Nursing Home Residents*, 29 ISSUES MENTAL HEALTH NURSING 863 (2009)).

[62] Am. Geriatrics Soc'y & Am. Ass'n for Geriatric Psychiatry, *The American Geriatrics Society and American Association for Geriatric Psychiatry Recommendations for Policies in Support of Quality Mental Health Care in U.S. Nursing Homes*, 51 J. AM. GERIATRICS SOC'Y 1299, 1302 (2003) ("Innovative approaches to ongoing training and support for nursing home staff are needed in assessment and interventions for mental health and behavioral needs of residents." Additionally, "[n]urse training requirements inadequately address many mental health problems or require coverage of so many other topics that mental health problems cannot be adequately emphasized. Training focuses on medical care, with minimal attention to behavioral health care.").

[63] *In re Involuntary Discharge or Transfer of J.S. by Hall*, 512 N.W.2d at 612.

[64] Am. Geriatrics Soc'y & Am. Ass'n for Geriatric Psychiatry, *supra* note 62, at 1302. These recommendations include incentives for psychiatrists and other specialized providers to work at nursing homes, such as peer training programs; the recommendations also include improved access to services and insurance changes to provide broader coverage. Although insightful, these recommendations are outside the scope of this project.

[65] Grabowski, *supra* note 3, at 648.

Connecticut must first account for the current situation in nursing homes within the state. As Senator Kelly noted in the Connecticut General Assembly Senate Proceedings, Florida and Connecticut were matched with the number of elderly citizens.[66] Compared to other states and federal resources, Connecticut provides little data allowing assessment or knowledge of current nursing facilities across the state.[67] With more attenuated data specific to Connecticut, it would better allow for assessment as to what training is needed and in which facilities. This would be the first step necessary to assess the subject matter and the form of training necessary to mitigate the current shortfalls.

The State of Connecticut should consider addressing this issue through statutory and regulatory changes like the 2007 amendment to Connecticut General Statutes section 19a-562a, which created training requirements for healthcare providers working with dementia patients.[68] Changes in training requirements will provide a basis for providers to consider in assessing patients' needs. Though psychiatrists and other doctors may meet with patients occasionally, it is the staff and aides who spend the most time with these patients. For this reason, requiring additional training for nursing home staff would allow for a broader understanding and assessment of needs better in accordance with 42 C.F.R. § 483.120.

CONCLUSION

The State of Connecticut believes in training. In the hearing committee on May 2, 2014, Senator Andres Ayala presented a training bill that came to the floor after a task force was assembled and experts were consulted;[69] therefore, it is likely that here a similar process would take place.

Senator Ayala pointed out, and other members of the Senate agreed, that it is important to have knowledgeable, aware, and understanding caretakers for those going through the "disease."[70] It is unclear why this sentiment would not hold true for other common mental health disorders experienced by elderly persons.

We may hear less about bipolar disorder compared to dementia, but that does not mean that there is no need in this population. The stigma surrounding bipolar disorder and related illnesses leads many to avoid discussing symptoms or the diagnosis, which is not indicated to reduce with

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[66] Conn. Gen. Assemb., S. Proc., 2014 Sess. 2231 (2014) (statement of Senator Andres Ayala, Jr.), http://hdl.handle.net/11134/30002:719752747.

[67] *Id.*

[68] CONN. GEN. STAT. § 19a-562a (2006) (amended 2007).

[69] Conn. Gen. Assemb., S. Proc., 2014 Sess. 2231, *supra* note 66, at 69.

[70] *Id.* (Senator Ayala notes that the bill, "asks individuals that deal with our senior population and individuals that have Alzheimer's and dementia to get training in the disease to ensure that we have people who are knowledgeable, who know what to look for, who understand the different signs of patients that are actually going through the disease at that particular moment.").

age.[71] Additional training requirements will allow care providers to better assess mental health challenges aside from dementia and will improve residents' quality of life.

[71] Lisa D. Hawke, Sagar V. Parikh, & Erin E. Michalak., *Stigma and Bipolar Disorder: A Review of the Literature*, 150 J. AFFECTIVE DISORDERS 181, 188 (2013) (noting that "[s]ince stigma is experienced not only in the proximal social environment, but also from the general public, in the workplace and in the healthcare industry, these diverse populations must not be forgotten in future attempts to understand and address stigma and its impacts"). *See generally* Patrick W. Corrigan & Amy C. Watson, *Understanding the Impact of Stigma on People with Mental Illness*, 1 WORLD PSYCHIATRY 16, 16–17 (2002).