Approaches to addressing crimes within the justice system typically do not differentiate between younger and older adults. However, approaches to addressing elder abuse cases—which involve older adult victims exclusively—often rely on the preconception that abuse can only occur if a visible physical injury exists. This preconception is driven in part by perceptions of frailty and ease-of-injury in older, vulnerable victims. We aimed to quantify the prevalence of physical injuries among older victims of violent crimes. We used data reported by the U.S. National Incidence-Based Reporting System (NIBRS) in 2015 to quantify the frequency of reported crimes which resulted in visible, physical injuries to victims aged 60+. Logistic regression was used to determine effects of age, race/ethnicity, type of crime, relationship to offender, and victim locality on physical injury from crime. Among 1,373,417 crime victims, 80.63% of older adults (60+) sustained an injury, as opposed to 65.17% of younger adults (<60). The proportion of individuals who showed physical injuries consistently increased with age until age 90. Knowing the offender was associated with higher odds of sustaining a visible injury (OR 1.47, 95% CI 1.38-1.58). Although older adults show higher risk of visible physical injuries from violent crimes than younger adults, it is possible for a crime against an older adult to have occurred without a visible injury. Medical and criminal justice practitioners should utilize this evidence on elder crime victimization to aid in expert witness testimony and other activities related to justice in crimes against older adults.

ELDER SELF-NEGLECT: REPORTING AND RESPONSE WITHOUT APS OVERSIGHT

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Self-neglect is generally considered a geriatric phenomenon and subsumed within the category of elder abuse and neglect. In the U.S., self-neglect is the most commonly reported form of elder abuse and neglect and has been linked to decreased physical and psychological well-being, higher mortality rate, and increase health care services utilization. While self-neglect typically falls under the purview of a state's adult protective service (APS) system, there are several states where this is not codified and/or practiced. This study examined the state of existing laws, policies and programs that address elder self-neglect in the U.S. in an effort to better understand how self-neglect reporting and response is handled, particularly in states where APS does not have oversight. A 50-state review of existing policies and laws addressing elder self-neglect was followed by key stakeholder interviews with those who oversee self-neglect reporting and response in states where APS does not have oversight. Findings indicate that a range of rationales explain variation in responsibility for self-neglect cases, including a lack of specificity in statutes, concerns that self-neglect does not fit into legal/criminal models due to the lack of perpetrator/victim relationship, and strong sentiments that those engaging in self-neglect need human services and support rather than investigatory or legal approaches. While the inclusion of self-neglect into the broad category of elder abuse and neglect is often perceived as vital for the provision of services, findings indicate it may exacerbate the complex challenges inherent in defining and conceptualizing both the term and its response.

SESSION 2325 (POSTER)

ALZHEIMER'S DISEASE AND RELATED DEMENTIAS: POLICIES, PRACTICES, AND RESEARCH

LONGITUDINAL CHARACTERISTICS OF INFORMAL CAREGIVERS OF COMMUNITY-DWELLING PERSONS WITH DEMENTIA

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Alzheimer's disease and related dementias (ADRD) affect >5 million Americans. Persons with ADRD experience functional limitations and often require support from informal caregivers (e.g., help with feeding). Little is known about how caregiving evolves over the full course of the disease. We used data from the Health and Retirement Study to identify incident predicted community-dwelling persons with ADRD (n=565), their informal caregivers, and the total hours of care they received in a month from predicted incidence up to 8-years post incidence. We estimated linear mixed-effects models to determine the characteristics of the person with ADRD that are associated with trajectories of caregiving hours. At predicted incidence, persons with ADRD received 120 hours of care in a month of which spouses provided 30% of care hours, adult children provided 32% of care hours, other relatives provided 12% of care hours, and non-relatives (including paid support) provided 25% of care hours. By 8-years post incidence, persons with ADRD still in the community (n=23) received 303 hours of care in a month of which spouses provided 28% of care hours, adult children provided 41% of care hours, other relatives provided 3% of care hours, and non-relatives provided 28% of care hours. Having great grandchildren and more functional limitations were associated with receiving more hours of informal care. Attrition (mortality and residing in a nursing home) was influenced by hours of care received in the previous interview and resulted in those that remained in the community being persons that required less care.

THE ROLE OF DEMENTIA FRIENDS IN CREATING STRONGER NETWORKS WITHIN FAITH-BASED COMMUNITIES

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Faith-based communities are uniquely positioned to support members of their congregation with dementia and their caregivers. Aligned with their ministry and service work, congregations can identify individuals who need help and provide needed instrumental and emotional support. This