Analysis of 2006 State Legislation Amending Adult Protective Services Laws

A product of the National Center on Elder Abuse (NCEA)
Prepared by the American Bar Association Commission on Law and Aging, an NCEA Partner
Lori A. Stiegel, J.D., and Ellen M. VanCleave Klem, J.D.

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Introduction

This analysis summarizes amendments to Adult Protective Services (APS) laws that were enacted or became effective during 2006. While there may have been other state legislative activity related to elder abuse or to APS during 2006, this analysis only addresses amendments to APS laws. For a list of citations to state APS laws, visit http://www.elderabusecenter.org/pdf/publication/APS%20Statutes%20Citations.pdf.

Trends

In 2006, state legislatures continued making adjustments to the APS programs. Ten states enacted eleven laws addressing a variety of topics. These laws affected provisions concerning:

- APS Access to Victims (Illinois)
- Civil Liability for Perpetrators (South Carolina)
- Collaboration with Other Agencies (Florida, Illinois, Utah, and Wisconsin)
- Collection/Management of APS Data (Illinois and Massachusetts)
- Definitions of Elder/Adult Abuse (Illinois, Iowa, Washington, and Wisconsin)
- Emergency/Involuntary APS (Illinois and Wisconsin)
- Fatality Review Teams (South Carolina)
- Government Oversight of APS (Massachusetts)
- Information/Record Disclosure (Florida, Illinois, Massachusetts, South Carolina, and Wisconsin)
- Investigations (Illinois, South Carolina, Utah, and Wisconsin)
- Notification/Referral to Other Agencies (Florida, Illinois, South Carolina, and Wisconsin)
- Outreach to Victims/Public Awareness (South Carolina)
- Registry of Perpetrators (Arizona)
- Reporting (Illinois, South Carolina, Utah, West Virginia, and Wisconsin)
- Restraining/Protection Orders (Wisconsin)

As these amendments to state APS laws are highly diverse and sometimes address multiple issues, the changes made are discussed on a state-by-state basis, rather than clustered by trends. A chart showing broad categories of amendments and the states that made them follows the summary. In addition, a combined chart reflecting the amendments enacted in 2003, 2004, 2005 and 2006 is available at http://www.elderabusecenter.org/pdf/publication/APSLegSummaryChart.pdf.

Arizona

H.B. 2558, effective on September 21, 2006, establishes an APS registry to include substantiated reports of abuse, neglect, and exploitation of vulnerable adults. The bill also creates a process enabling a person about whom the Department of Economic Security (DES) has substantiated an accusation of abuse, neglect, or exploitation of a vulnerable adult to receive notice that the DES intends to add his or her name to the registry and to appeal the decision of the DES. This new registry supplements the state's existing elder abuse central registry, which is administered by the attorney general's office and contains information about (1) convicted perpetrators of elder abuse and (2) perpetrators who have been the subject of (a) an administrative decision substantiating abuse by a state agency other than APS or (b) a civil lawsuit brought by a state agency other than APS.

The DES will maintain the APS registry, which will include information about the perpetrator and the allegation and exclude information about the victim and the reporter. The DES is required to remove reports from the registry after ten years. Upon request from a formerly listed individual, the DES shall provide written confirmation that agency staff has removed information about that person from the registry. Information in the APS registry is available to the public upon written request and the DES can charge a fee for processing requests.

The new section on the hearing process is effective for allegations of abuse, neglect, and exploitation received on or after July 1, 2007. The section requires the DES to notify, within fifteen days of an investigation's conclusion, persons suspected of abusing, neglecting, or exploiting a vulnerable adult of: (1) the DES intent to enter a substantiated report in the APS registry; (2) the person's right to receive a copy of the report; and (3) the person's right to request a hearing before entry into the registry. If a request for a hearing is made, the DES is required to: (1) conduct a review before the hearing and allow the accused person to submit information in support of dismissal of the case; and (2) notify the reporting source, the vulnerable adult, and the vulnerable adult's representative and allow them to respond to information provided by the accused person. If the DES determines, based on a preponderance of the evidence presented at the pre-hearing review, that the alleged perpetrator did not engage in the alleged conduct, it must amend the information or finding in the report, notify the alleged perpetrator, and withdraw the plan for a hearing. If the DES fails to amend the report within 60 days of the pre-hearing review, the alleged perpetrator has a right to a hearing on that issue unless: (1) he or she is a party in a civil, criminal, or administrative proceeding in which the allegations of abuse, neglect, or exploitation are at issue; or (2) a court or administrative law judge has made findings as to the alleged abuse or neglect. If the pre-hearing review results in support of the DES determination, the alleged perpetrator has a right to a hearing within five days by the office of administrative hearings.

Under the bill, hearings must be confidential and held in accordance with the Uniform Administrative Hearing Procedures statute, with the following exceptions:

- Vulnerable adults who are victims or witnesses to abuse, neglect, or exploitation and reporting sources are not required to testify;
- The identity of the reporting source cannot not be disclosed without his or her permission;

- A written statement of the reporting source is admissible if circumstances indicate it is reliable;
- If the alleged perpetrator fails to appear for the hearing, a substantiated finding can be entered in the registry. However, if good cause is shown and the alleged perpetrator makes a request within 15 days of the date of notice vacating the original hearing, the hearing may be rescheduled.

At the hearing, the administrative law judge is required to determine if a preponderance of evidence exists to uphold the DES substantiation finding. If a preponderance of evidence is not found, the DES must amend the report (i.e., change the finding from substantiated to unsubstantiated). If the DES finding is upheld, the allegations must be reported to the APS registry within thirty days.

The bill requires the DES to notify the vulnerable adult who is the subject of a report and the reporter of the result of the investigation: (1) at the end of the investigation if the report is unsubstantiated or a perpetrator has not been identified; (2) after the time to request a hearing has lapsed without a request for a hearing being made; and (3) after a final administrative decision has been made.

Florida

H.B. 1503, effective on July 1, 2006, made the following substantive and technical changes to provisions of the APS statute, reflecting the creation of a new state agency, the Agency for Persons with Disabilities (APD):

- Added the APD to the departments and agencies required to work with the Department of Children and Family Services (DCF) to ensure that every facility serving vulnerable adults informs residents of their right to report abusive, neglectful, or exploitative practices.
- Added the APD to the list of departments and agencies in the section titled "Notification to Administrative Entities." The addition requires the DCF to notify the local prosecutor upon receipt of a report alleging that an employee or agent of the APD, acting in official capacity, has committed abuse, neglect, or exploitation of a vulnerable adult. The addition also requires the DCF, upon receipt of a report of abuse, neglect, or exploitation of a resident of a facility licensed by the APD, to provide the APD with a copy of its investigation.
- Added employees, agents, and officials of the APD to the list of entities authorized to access otherwise-confidential reports and records.

Additionally, the bill amended the definition of "facility" by removing "group home" and adding licensed "residential facility licensed under chapter 393" and "adult day training center."

Illinois

H.B. 4676, effective on January 1, 2007, amended the Elder Abuse and Neglect Act by authorizing APS to investigate cases of self-neglect and provide protective services to persons who self-neglect. The bill defined self-neglect as "a condition that is the result of an eligible adult's inability, due to physical or mental impairments, or both, or a diminished capacity, to perform essential self-care tasks that substantially threaten his or her own health, including:

providing essential food, clothing, shelter, and health care; and obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety."

The bill also clarified the definition of "domestic living situation" by adding the following to the list of what a "domestic living situation" is *not*: "an assisted living or shared housing establishment as defined in the Assisted Living and Shared Housing Act" and "a supportive living facility as described in Section 5-5.01a of the Illinois Public Act Code."

"Christian Science Practitioner" was removed from the list of mandatory reporters and replaced with "any religious practitioner who provides treatment by prayer or spiritual means alone in accordance with the tenets and practices of a recognized church or religious denomination, except as to information received in any confession or sacred communication enjoined by the discipline of the religious denomination to be held confidential."

The definition of "neglect" was also amended to reflect terminology in the new definition of "self-neglect." Specifically, the phrase "medical care" was changed to "health care."

A new provision requires the Department on Aging (DOA) to develop protocols, procedures, and policies for: (1) responding to reports of possible self-neglect; (2) protecting the autonomy, rights, privacy, and privileges of adults during investigations of possible self-neglect and consequential judicial proceedings regarding competency; (3) collecting and sharing information and data among the relevant agencies "and seniors" involved; (4) developing working agreements between provider agencies and law enforcement; and (5) collecting data regarding incidents of self-neglect. The bill requires the DOA to accomplish these tasks in cooperation with an Elder Self-Neglect Steering Committee – a multidisciplinary group of professionals appointed at the request of or by the DOA director and other entities.

The bill also:

- Amended the section on reports of abuse or neglect by adding suspicion of self-neglect to the types of abuse any person "may report." The bill did *not* however, add suspicion of self-neglect to the types of abuse mandatory reporters must report.
- Provided that if agencies designated to receive and investigate reports ("provider agencies") lack "sufficient appropriation" to conduct face-to-face assessments, casework, and follow-up of self-neglect reports, those agencies "shall refer all reports of self-neglect to the appropriate agency or agencies as designated by the Department on Aging for any follow-up."
- Provided that a provider agency "may report its findings to the appropriate law enforcement agency" if the agency determines, after assessment, that the case is substantiated.
- Mandated that a provider agency consult with law enforcement if any person, other than the alleged victim, refuses to allow the agency to investigate, interferes with the investigation, or refuses to grant access to an eligible adult.
- Made several changes to the provisions regarding access to records, including:
    - Added records concerning reports of self-neglect to the list of confidential records that may be obtained by the staff of the DOA, provider agencies, other aging network agencies, regional administrative agencies, and law enforcement agencies; physicians; eligible adults about whom reports have been filed or their guardian; and a coroner or medical examiner;

  - Added "staff of the Chicago Department on Aging while that agency is designated as a regional administrative agency" to the list of persons who can request records;
  - Added a guardian ad litem to the list of persons authorized to have access to records but only regarding self-neglect; and
  - Excluded self-neglect cases from the existing provision governing access to records by a court or a guardian ad litem as "necessary for determination of an issue before the court."
- Added self-neglect to the list of emergency circumstances for which the DOA or another agency designated under the law may seek an ex parte order authorizing the delivery of protective services.
- Added a new section providing that if a court enters an ex parte order for an assessment of the need for services or for the provision of services in an emergency involving self-neglect, the court must appoint a guardian ad litem (GAL) for the alleged self-neglecter as soon as possible following the order. The GAL is required to review the order for reasonableness and if the GAL thinks the order unreasonable, he or she must file a petition with the court requesting that the order be vacated.

Iowa

S.F. 2253, effective on August 15, 2006, amended the section governing actions that are deemed by statute to *not* constitute dependent adult abuse. It did this by adding attorney-in-fact to the list of persons who can request withholding or withdrawing of health care from a dependent adult who is terminally ill.

Massachusetts

H.B. 1490 revised the requirements for data management of protective services records. It changed the amount of time the Department of Elder Affairs has to either destroy or physically remove all personal data from unsubstantiated reports and records from three months to three years. The bill also created a requirement that relevant government agencies annually report statistical records kept for the purpose of planning and reporting to the Executive Office of Elder Affairs. The bill was effective January 3, 2007.

South Carolina

S.B. 1116 made significant revisions to the APS law, in part to make the APS law consistent with other provisions in the bill that created a "vulnerable adult investigations unit" (unit) within the State Law Enforcement Division (SLED). The purpose of that unit is to "receive and coordinate referrals of reports of abuse, neglect, and exploitation of vulnerable adults in facilities operated by, or contracted with, the Department of Mental Health or the Department of Disabilities and Special Needs." The bill, effective May 23, 2006, amended the definition of "facility" to include residential programs operated by, or contracted with, the Department of Mental Health or the Department of Disabilities and Special Needs. It also amended the definition of "investigative entity" to clarify that the investigative entities to which the SLED must refer non-criminal matters are the Long Term Care Ombudsman Program (LTCOP) and the APS Program. The bill amends the APS law to provide that the SLED unit is

responsible for investigating reports made about facilities operated by the two referenced departments or their contractors or for referring those reports to other law enforcement agencies. The amendments also state that the LTCOP is responsible for investigating non-criminal reports regarding facilities (not just facilities run by the two referenced departments or their contractors) and the APS Program is responsible for investigating non-criminal reports in all settings other than facilities, and that both investigative entities must refer reports to the SLED unit if criminal activity is suspected. The bill authorized the investigative entities to have access to facilities to conduct investigations. It also revised and clarified the reporting provision for consistency with the investigative responsibilities of the SLED unit, the LTCOP, and the APS Program.

The bill also added extensive provisions regarding the detection, investigation, and review of fatalities, particularly those occurring within the facilities operated by the two referenced departments or their contractors. Mandatory reporters and persons who investigate cases under the APS law must now report to the medical examiner or coroner any deaths of vulnerable adults suspected to have resulted from abuse or neglect. Following investigation, which may include autopsy, the coroner or medical examiner must report the findings to the SLED unit. Deaths of a vulnerable adult in a facility operated by the two departments or their contractors must be referred to the SLED unit for investigation. The bill also established time frames for investigation of reports of death by the SLED unit, the LTCOP, and the APS Program. The amendments added provisions governing the SLED unit's access to information and records. They also established a multidisciplinary "Vulnerable Adults Fatalities Review Committee"; set forth the committee's membership, purpose ("decrease the incidence of preventable vulnerable adult deaths"), and responsibilities; and provided that the committee's discussions about individual deaths are not open to the public, not subject to the Freedom of Information Act, and may not be disclosed to the public or in legal proceedings. The same confidentiality rules apply to information and records obtained by the SLED unit or the fatalities review committee in connection with their responsibilities.

Other provisions in the bill (1) require that facilities must "prominently" display a notice developed by the LTCOP and the SLED unit about the duties of facility personnel under the APS law; and (2) authorize the attorney general, upon referral from the LTCOP or the SLED unit, to bring an action "against a person who fails through pattern or practice to exercise reasonable care in hiring, training, or supervising facility personnel or in staffing or operating a facility, and this failure results in the commission of abuse, neglect, exploitation, or any other crime against a vulnerable adult in a facility."

Utah

S.B. 53 amended the Utah Human Services Code to require the Division of Aging and Adult Services to make rules to avoid the duplication of investigations and services by APS and the LTCOP. Under the bill, the Division of Aging is responsible for establishing procedures to: (1) determine whether APS or the LTCOP will be responsible for investigating or providing services in a case where an allegation is made regarding abuse, neglect, or exploitation of a vulnerable adult who resides in a long-term care facility; and (2) determine whether and under what circumstances, the agency that is not designated as the responsible agency will provide assistance to the responsible agency. The bill also provides that APS shall be the agency

responsible for receiving all reports of alleged abuse, neglect, or exploitation of a vulnerable adult, regardless of whether APS or the LTCOP is responsible for investigating or providing services. The bill was effective May 1, 2006.

Washington

S.S.S.B 6239 amended the definition of "neglect" by adding that neglect includes, but is not limited to, endangerment with a controlled substance ("conduct prohibited under RCW 9A.42.100"). The bill was effective June 7, 2006.

West Virginia

S.B. 13 amended section 9-6-9 by adding "humane officer" to the list of mandatory reporters of elder and adult abuse. It also added a new section, 9-6-9a, mandating that APS workers who, in response to a report of abuse, suspect an animal is the victim of cruel or inhumane treatment must report their suspicion to the county humane officer within twenty-four hours of responding to the report of abuse of an incapacitated adult or facility resident. The bill was effective June 6, 2006.

Wisconsin

Following years of work by Wisconsin's APS Modernization Project, the Legislature's Joint Legislative Council Special Committee on Recodification of Chapter 55, Placement and Services for Persons with Disabilities, and others, Wisconsin's legislature enacted two laws significantly affecting the state's APS systems. The following summary has been excerpted from "Landmark Reforms Signed into Law: Guardianship and Adult Protective Services," written by Betsy Abramson and Jane Raymond, and published in the Wisconsin Lawyer, Vol. 79, No. 8 (August 2006). It is excerpted with permission of the August 2006 Wisconsin Lawyer, the official publication of the State Bar of Wisconsin, and the authors. The full article is available online at http://www.wisbar.org/AM/Template.cfm?Section=Wisconsin_Lawyer&template=/CM/ContentDisplay.cfm&contentid=59778

This summary significantly abbreviates the article. Unless otherwise indicated, however, the text is copied from the article. Text in italics is NOT quoted from the article; underlined text reflects emphasis in the original.

A.B. 785, effective November 1, 2006, primarily revises chapter 55, which governs voluntary and involuntary protective services and placement.

Chapter 55 has never had a procedure for establishing court-ordered protective services, only for placements. This new law therefore creates a procedure for pursuing court-ordered protective services, nearly identical to the protective placement procedure, with the same due process rights as for protective placement.

… *A.B. 539, effective December 1, 2006,* updates and modernizes Wisconsin's elder abuse reporting law, found in Wis. Stat. section 46.90, and then creates a parallel system of reporting and response for younger adults at risk (that is, people age 18-59) in chapter 55. Counties will be required to designate their lead "elder adult-at-risk" and "adult-at-risk" agency(ies). The bill identifies the categories of individuals who may be a subject of a report: "elder adults at risk" and "adults at risk."... An "elder adult at risk" is "a person age 60 or older who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self-neglect, or financial exploitation." An "adult at risk" is "any adult who has a physical or mental condition that substantially impairs his or her ability to care for his or her needs who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, or financial exploitation." …

The law also expands what is reportable. It includes within the definition of abuse, and separately defines, emotional and sexual abuse. *Emotional abuse is defined as "language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and that does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed." Sexual abuse is "a violation of s. 940.225 (1), (2), (3), or (3m)."*

It also includes as forms of abuse "treatment without consent" and "unreasonable confinement or restraint." The less descriptive term "material abuse" is changed to the term "financial exploitation," and wherever appropriate, the statutes use the same definitions as in criminal statutes (for example, "sexual abuse" is defined according to Wis. Stat. section 940.225, and "theft" under financial exploitation is based on theft under criminal law).

Changes to voluntary reporting system. The law also makes some changes to Wisconsin's traditional voluntary reporting system. For the most part, the new law continues the voluntary system. It does, however, create exceptions to the *old* law's exclusively voluntary reporting system, recognizing that *the old* law misses egregious situations in which *(elder)* adults at risk are not capable of self-reporting and other *(elder)* adults at risk may be in vulnerable positions. The following professionals are subject to the limited required reporting: employees of any entity licensed, certified, approved by, or registered with the DHFS *(Department of Health and Family Services)*; a health care provider as defined in Wis. Stat. section 155.01(7); and social workers, professional counselors, and marriage and family therapists certified under chapter 457.

These professionals must make a report to the county's lead adult-at-risk or elder-adult-at-risk agency only if the adult at risk or elder adult at risk is seen in the course of the person's professional duties and one of the following is true:

1) the elder adult at risk or the adult at risk has requested the person to make the report; or
2) there is reasonable cause to believe that the elder adult at risk or adult at risk is at imminent risk of serious bodily harm, death, sexual assault, or significant property loss and is unable to make an informed judgment about whether to report the risk; or
3) other *(elder)* adults at risk are at risk of serious bodily harm, death, sexual assault, or significant property loss inflicted by the suspected perpetrator.

The second category requires a concern about future, serious risk; it is not applicable to situations that involve past incidents only. The third category, however, applies to reporting past abuse perpetrated on an (elder) adult at risk only if there is a possibility of harm to others. Nevertheless, even if the case falls into one of the above categories, no reporting is required if the professional believes that filing the report would not be in the best interest of the (elder) adult at risk and the professional documents the reasons for this belief in the suspected victim's case file.

Due to the increased reporting provisions, the law also enhances protections for good faith reporters. Immunity provisions apply to all reporters, including for situations when a report is filed with an incorrect agency if the reporter had a good faith belief that the initial report was filed appropriately. The penalty for retaliating against a reporter is increased to $10,000. Plus, the new law creates a rebuttable presumption that any discharge or act of retaliation or discrimination taken against a reporter within 120 days of making the report is retaliatory.

… **Investigating abuse.** The new law treats investigations of financial exploitation the same as investigations of other types of abuse, requiring counties to begin their investigation within 24 hours of receiving a report of abuse, not counting weekends and legal holidays. … It also requires that reports regarding clients of DHFS-regulated entities be referred to the DHFS for investigation if the suspected abuser is a caregiver or nonclient resident of the entity. Further, the new law authorizes multi-agency responses, including strengthening law enforcement involvement, and authorizes exchanging investigative information and reports with appropriate agencies. The law authorizes additional investigative tools, such as the ability to: interview *(elder)* adults at risk with or without the consent of any court-appointed guardian or any agent under an activated power of attorney; interview the guardian or agent; transport the *(elder)* adult at risk for medical examination; and review financial records without consent.

Agency response to substantiated complaints. The law provides additional specificity about the types of services and responses that an agency may make if a complaint is substantiated, including seeking a revised vulnerable adult restraining order. County *(elder)* adults-at-risk workers may request immediate assistance in initiating a protective services action or contacting a law enforcement or other public agency, as appropriate. Specifically, the county *(elder)* adults-at-risk agency may bring or refer a case for a petition for guardianship and protective services or placement, including emergency protective placement. County *(elder)* adults-at-risk agencies also may refer cases to: local law enforcement for further investigation; the district attorney if the agency believes a crime has been committed; licensing or certification authorities within the DHFS or other regulatory bodies if the residence, facility, or program is or should be regulated; or the Department of Regulation and Licensing if the case involves an individual required to hold a credential under Wis. Stat. chapters 440 to 460.

… [T]he new law provides directly in the appropriate *(elder)* adult-at-risk chapters governing investigations and services the authorization for county workers to pursue a new "Restraining order and injunction for adults at risk." (*Note: The restraining order and injunction also covers elder adults at risk.)* In addition, the new law creates a true restraining order for *(elder)* adults at risk, expanding who may request it and what behavior may be restrained. The revised *(elder)* adult-at-risk restraining order may be petitioned for by an (elder) individual at

risk, his or her guardian, an interested person acting on behalf of an *(elder)* individual at risk, or an (elder) adult-at-risk agency. If, however, someone other than the (elder) adult at risk petitions for a restraining order, the person must notify the *(elder)* individual at risk and the court must then appoint a guardian ad litem. Actions that may be enjoined include: interfering with the investigation or provision of services, actions or threats to engage in abuse, financial exploitation, neglect, harassment, stalking of an *(elder)* individual at risk, and mistreating the animal of an (elder) adult at risk.

Confidentiality requirements. The law clarifies confidentiality requirements and differentiates between "reports" and "records," specifying to which individuals and entities reports and records can be released. In brief, "records" involve the entire case file while "reports" are documentation of an agency's response to a report, including a summary of the case. Reports will be releasable to various government agencies that need the reports to carry out responsibilities of protecting *(elder)* adults at risk and to reporters of abuse who made the report in a professional capacity, regarding the actions taken to protect or provide services. A holder of the report may not release it, however, if to do so might cause harm to the subject individual or jeopardize an on-going civil or criminal investigation.

Records may be released only to: an (elder) adult at risk who is the named victim; the victim's legal guardian, conservator, or other legal representative (unless that person is the alleged abuser); law enforcement officials and district attorneys for their purposes; the DHFS and law enforcement for death investigations required under law; the county department providing services to determine if the victim should be transferred to a less restrictive or more appropriate treatment modality; the victim's attorney or guardian ad litem to prepare for certain court hearings; the DHFS for management, audit, and monitoring purposes; the state's protection and advocacy agency staff; a coroner, pathologist, or other professional investigating deaths in unexplained or suspicious circumstances; the probation or parole agency that is supervising an alleged perpetrator in certain circumstances; and grand juries, courts, and administrative agencies under Wis. Stat. section 968.26.

2006 CHART OF APS AMENDMENT CATEGORIES

Note: Bill numbers are only listed alongside state abbreviations when more than one bill affecting the APS law was enacted or became effective during a calendar year.

Categories	**2006**
APS Access to Victims	IL
Civil Liability for Perpetrators	SC
Collaboration with Other Agencies	FL, IL, UT, WI (A.B. 539)
Collection/Management of APS Data	IL, MA
Definitions of Elder/Adult Abuse	IL, IA, WA, WI (A.B. 539)
Emergency/Involuntary APS	IL, WI (A.B. 785)
Fatality Review Teams	SC
Government Oversight of APS	MA
Information/Record Disclosure	FL, IL, MA, SC WI (A.B. 539)
Investigations	IL, SC, UT, WI (A.B. 539)
Notification/Referral to Other Agencies	FL, IL, SC, WI (A.B. 539)
Outreach to Victims/Public Awareness	SC
Registry of Perpetrators	AZ
Reporting	IL, SC, UT, WV, WI (A.B. 539)
Restraining/Protection Orders	WI (A.B. 539)