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Reproductive Rights Project

March 2002

Minors and Rape Crisis Treatment Q&A

This Q&A discusses New York law relating to minors (persons under age 18) and their right to consent to and receive confidential health services following a sexual assault. It seeks to assist health care providers in understanding that capable adolescents are entitled to make their own decisions regarding sexual offense treatment and related services and that any resulting treatment generally must remain confidential. Health care providers who work with adolescent victims of sexual assault—including doctors, nurses, rape crisis counselors and social workers—often face difficult questions about their duties of confidentiality¹ to these patients, including whether they must involve third parties such as parents and police. Frequently, professionals can encourage communication between young people and their parents, helping adolescents find needed support as they confront these and other health issues. However, sometimes a teenager seeking care for sexual assault cannot or will not speak to their parents or guardians and would avoid necessary health care if forced to involve them. Similarly, if forced to involve the police, some assault survivors also would forgo treatment. By clarifying the obligations of health care providers to maintain confidentiality in treating adolescent sexual assault survivors, this guide seeks to increase adolescents' access to care even if they cannot or will not confide in parental figures and/or choose not to involve the police.

1. What medical treatment is available following a sexual assault?

Sexual assault services involve two components: medical care and the sexual assault evidence collection kit (the "rape kit"). Medical care may include the following services: a medical history, a physical examination, treatment of injuries from the assault, pregnancy testing and counseling, testing and prophylaxis for HIV and sexually transmitted infections (STIs), emergency contraception (EC), and rape crisis counseling,² although some of these services may be offered through referrals or on follow-up visits. The rape kit usually involves collecting the victim's clothing; head and pubic hair combings; vaginal, penile and anal swabs and smears; oral swabs; saliva or blood samples; and fingernail scrapings and/or clippings. Not all health care facilities are equipped with rape kits. Even among those that do treat rape survivors, some do not offer comprehensive sexual offense care, such as provision of on-site EC,³ even though Department of Health protocols require that minor sexual assault survivors be offered EC if subjected to unprotected intercourse in the preceding 72 hours and where medically appropriate.⁴

2. Can a minor consent to rape crisis treatment on his or her own?

Yes. An adolescent sexual assault survivor can consent to all components of sexual assault care.

Although generally, minors cannot obtain health care services without parental consent, the New York Legislature and the United States Supreme Court have carved out several notable exceptions to this general rule. Thus, minors in New York who can give informed consent (i.e., who understand the risks and benefits of the proposed and alternative treatments)⁵ can consent to contraceptive services, including EC;⁶ abortions;⁷ pregnancy care;⁸ mental health care in most circumstances;⁹ STI testing and treatment;¹⁰

and HIV testing¹¹ without parental involvement. In addition, minors in New York may consent to rape crisis counseling¹² and forensic evidence collection.¹³

Providers cannot require parental consent or disclosure for other parts of the sexual assault services, such as treatment of related injuries.¹⁴ Requiring parental consent for related services would violate laws protecting the confidentiality of the confidential portions of the sexual assault treatment and also would jeopardize the confidentiality of the essential family planning and STI services that are independently protected from disclosure.¹⁵ Therefore, capable minors may consent to care for all medical services provided in the post-sexual assault visit.

3. Can a minor be forced to receive medical care following a sexual assault?

No. Minors who can give informed consent to rape crisis services also can refuse to consent to such services.¹⁶ For example, this issue has presented when a parent requests that a sexual offense examination be performed on their minor child to determine whether the minor has engaged in consensual sexual activity, or where a parent or the police wish to collect evidence to determine the identity of the assailant. A minor who is capable of giving informed consent cannot be forced to submit to such examinations, and medical ethics would probably preclude such tests as they lack medical purpose or benefit. If a minor consents under pressure from a parent, health care workers still can choose to decline to perform the examination if they determine that the consent was the result of force or coercion. Forced consent is not valid consent. Medical guidelines require that providers interview the patient separately from the parent to make this determination.¹⁷ Note that even the wishes of a minor who does not have the capacity to consent to treatment should be taken into account.¹⁸

4. When a minor consents to rape crisis treatment, must it be confidential?

Generally, yes. Confidentiality, with regard to medical treatment, means that information about the treatment, such as medical records, cannot be disclosed or released without the permission of the person who consented to the care.¹⁹ Therefore, when a minor can give informed consent for rape crisis services, information relating to such services may not be released to third parties without the minor's consent, unless otherwise required by law (*see* Questions 6 & 8).

5. Can a minor consent to confidential rape crisis counseling?

Yes. The New York statute governing rape crisis counseling defines the rape crisis client without regard to age: "*any person* who is seeking or receiving the services of a rape crisis counselor for the purpose of securing counseling or assistance concerning any sexual offenses, sexual abuse, incest or attempts to commit sexual offenses, sexual abuse, or incest, as defined in the penal law."²⁰ Communications made by all rape crisis clients to a rape crisis counselor are confidential, and may not be disclosed without the consent of the client, unless otherwise required by law.²¹ Therefore, minors can consent to rape crisis counseling without parental consent or notification, and it must be kept confidential. Note that these laws refer to communications made to certified rape crisis counselors who work in conjunction with state-approved rape crisis programs.²² Other mental health counselors, such as social workers and psychologists, are independently bound by confidentiality rules.²³ However, other persons to whom a survivor may turn for support, such as guidance counselors and teachers, do not have the same confidentiality obligations.

6. Must a hospital or health care provider report the rape or rape crisis treatment of a minor to the police?

No. Health care providers may not report crimes—including rape and "statutory

rape”—committed against their patients to the police, with one exception: when the patient sustained a gunshot or serious stab wound, such injury must be reported to the police, although the provider or facility should not report the circumstances surrounding how the injuries were incurred.²⁴ Reporting without such a mandate would breach patient confidentiality and subject the provider to potential legal and professional sanctions. Thus, only the minor may decide whether or not to report the sexual assault to the police.²⁵

Sometimes, health care providers are required to disclose information relating to an assault if the police or district attorney makes a request by court order or subpoena.²⁶ One such circumstance requires that some providers disclose “evidence indicating that a patient who is under the age of sixteen years has been the victim of a crime.”²⁷ This means that if the police or district attorney prosecuting the rape of a minor age 15 or younger subpoenas a rape kit, because it is evidence that the patient was the victim of a crime, the provider must turn it over.²⁸ Note, however, that this law cannot be invoked for minors aged sixteen or seventeen, or for any adults.

7. Must a hospital or health care provider report the rape or rape crisis treatment of a minor to the minor’s parents?

No. When treatment is confidential, a provider may not release any related medical information—including the circumstances that lead to the treatment—to any third party, including the minor’s parents, without the minor’s consent, unless otherwise required by law (See Questions 6 & 8). Further, even when a minor does not have capacity to consent, New York law requires that minors over the age of 12 be notified of any requests that parents or guardians make to review the minor’s medical records; if the minor objects to disclosure, the provider may deny the request.²⁹

8. Must a hospital or health care provider report the rape or rape crisis treatment of a minor to a child protective services agency?

Generally, no. Confidentiality means that a provider also may not report the crime or treatment to outside agencies, unless otherwise required by law.³⁰

However, when the provider³¹ has reasonable cause³² to believe that a minor patient is abused³³ or neglected,³⁴ the provider must report this suspicion to the State Central Register of Child Abuse and Maltreatment.³⁵ New York law limits child abuse and neglect to those offenses committed by a parent or other person responsible for a child’s care, or where the caregiver allowed³⁶ abuse or neglect to occur. Thus, a report would be proper where the minor was sexually abused by a parent or legal guardian, or where a parent or legal guardian should have known about the abuse and did not take steps to prevent or stop it. No report should be made of minors who engage in consensual sex with a non-relative,³⁷ or who are raped by a peer or by a stranger, unless the rape was the result of parental or guardian abuse or neglect. For a more complete discussion of the responsibilities of health care providers to make reports to child protective services agencies relating to a minor’s sexual activity, please refer to the NYCLU RRP’s “Statutory Rape and Child Abuse Summary Sheet.”

Footnotes

¹ Providers including nurses, doctors, pharmacists, physical therapists, physician assistants, psychologists and social workers are bound by confidentiality rules. 8 N.Y.C.R.R. § 29.2 (2001).

² Health care facilities must advise a survivor of the availability of a local rape crisis organization that can provide an advocate to accompany the survivor through the sexual offense examination. N.Y. PUB. HEALTH LAW § 2805-i(3) (McKinney 2001).

³ In New York City, 57% of hospitals do not offer or provide EC to rape survivors as a basic standard of care. NARAL/NY, FIVE-POINT AGENDA FOR A HEALTHIER NYC (2001).

⁴ DEPARTMENT OF HEALTH, DEPARTMENT OF SOCIAL SERVICES, CHILD AND ADOLESCENT SEXUAL OFFENSE MEDICAL PROTOCOL 49 (n.d.) [hereinafter DOH ADOLESCENT PROTOCOL].

⁵ See N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2001).

⁶ *Carey v. Population Services International*, 431 U.S. 678, 691-96 (1977); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

⁷ Under federal constitutional law, minors have a fundamental privacy right to choose whether or not to have an abortion. *Planned Parenthood v. Casey*, 505 U.S. 833, 899-900 (1992); *Hodgson v. Minnesota*, 497 U.S. 417, 458 (plurality opinion), (O'Connor, J., concurring) (1990); *Planned Parenthood Assn. v. Ashcroft*, 462 U.S. 476, 490-91 (1983); *Akron v. Akron Ctr. for Reproductive Health*, 462 U.S. 416, 439-40 (1983); *Bellotti v. Baird*, 443 U.S. 622, 643 (1979) (plurality opinion). New York State does not limit this right by requiring parental consent or notification in order for a minor to access services.

⁸ N.Y. PUB. HEALTH LAW § 2504(3) (2001) (McKinney 2001).

⁹ N.Y. MENTAL HYG. LAW § 33.21(c) (McKinney 2001) (allowing minors to consent to outpatient mental health services without parental consent if they voluntarily seek the treatment and (1) the provider determines parental involvement would be detrimental to the minor's treatment, or (2) the parent or guardian refuses treatment and a physician deems it necessary and in the best interest of the child).

¹⁰ N.Y. PUB. HEALTH LAW § 2305(2) (McKinney 2001) (testing); N.Y. PUB. HEALTH LAW § 2305(2) (McKinney 2001) (treatment).

¹¹ N.Y. PUB. HEALTH LAW §§ 2780(5), 2781(1), 2783 (McKinney 2001) (testing). Although not expressly provided for by the Legislature, some practitioners allow minors with HIV/AIDS to consent to their own care when the minor is mature enough to give informed consent and adhere to the particular treatment and where parental involvement is impossible or could cause harm.

¹² N.Y. C.P.L.R. 4510(a)(3) (2001); see Question 5.

¹³ DOH ADOLESCENT PROTOCOL at 49 (directing providers to obtain consent from sexual assault survivors, including capable minors, before collecting sexual offense evidence).

¹⁴ New York law specifically includes "evidence which is associated with the hospital's treatment of injuries sustained as a result of a sexual offense" within its definition of "privileged sexual offense evidence." 10 N.Y.C.R.R. § 405.9(c)(4) (2001).

¹⁵ N.Y. PUB. HEALTH LAW § 17 (McKinney 2001); N.Y. PUB. HEALTH LAW § 2306 (McKinney 2001).

¹⁶ Having the capacity to provide informed consent includes the ability to choose the option of no treatment at all. See N.Y. PUB. HEALTH LAW § 2805-d (2001).

¹⁷ DOH ADOLESCENT PROTOCOL at 20.

¹⁸ *Id.* at 15, 33 (noting that refusal to consent by any minor be considered and that child protective services guidelines require providers to honor the refusal to consent by a minor who is capable of understanding the nature and consequences of the choice).

¹⁹ A provider who discloses confidential communications without the prior consent of the patient is guilty of professional misconduct, 8 N.Y.C.R.R. §29.1(8) (2001); N.Y. EDUC. LAW § 6509(9) (McKinney 2001), and also may be sued by his or her patient, see, e.g., *Anderson v. Strong Memorial Hosp.*, 531 N.Y.S.2d 735, 739 (Sup. Ct. Monroe Co. 1988).

²⁰ N.Y. C.P.L.R. § 4510(a)(3) (McKinney 2001) (emphasis added).

²¹ N.Y. C.P.L.R. § 4510(b) (McKinney 2001).

²² N.Y. C.P.L.R. § 4510(a)(1)-(3) (McKinney 2001).

²³ See note 1.

²⁴ N.Y. PENAL LAW § 265.25 (McKinney 2001). New York law also *allows* psychologists and psychiatrists to breach confidentiality to notify an endangered person and/or the police if a patient presents a serious and imminent danger to that individual, but the law does not mandate that a provider do so. N.Y. MENTAL HYG. LAW § 33.13(c)(6) (McKinney 2001).

²⁵ 10 N.Y.C.R.R. § 405.9(c) (2001) (giving the sexual assault survivor the authority to decide whether evidence is to be collected and turned over to the police).

²⁶ See, e.g., N.Y. C.P.L.R. § 4504(b) (McKinney 2001) (mandating disclosure of dental records for purposes of identification).

²⁷ N.Y. C.P.L.R. §§ 4504(b), 4508(a)(3) (McKinney 2001). This exception only applies to physicians, registered professional nurses, licensed practical nurses, dentists, podiatrists, chiropractors and social workers.

²⁸ Any provider who is uncomfortable with the terms of a subpoena should consult an attorney.

²⁹ N.Y. PUB. HEALTH LAW § 18(3)(c) (McKinney 2001).

³⁰ For example, providers must report certain injuries to the police, *see* Question 6; cases of syphilis, chlamydia and gonorrhea to the State Department of Health (DOH) for statistical purposes, 10 N.Y.C.R.R. §§ 2.5, 2.10 (2001); and initial positive tests or diagnoses of HIV or AIDS-related illnesses to the DOH for statistical purposes and contract tracing, N.Y. PUB. HEALTH LAW § 2130 (McKinney 2001); 10 N.Y.C.R.R. § 63.4 (2001).

³¹ Most health providers, social services providers and school officials are “mandatory reporters.” N.Y. SOC. SERV. LAW § 413(1) (McKinney 2001).

³² A reasonable suspicion must be based upon “articulable facts which, when examined objectively, would lead others to the...conclusion” that a child has been abused or neglected. *Vacchio v. St. Paul’s United Methodist Nursery Sch.*, NYLJ, July 21, 1995, p. 32, col. 2 (Sup. Ct. Nassau Co.) (Alpert, J.) (holding that a teacher’s immediate reporting of a student’s black eye without first inquiring as to the cause of the black eye could support a finding of gross negligence).

³³ A minor is sexually abused when a caregiver commits or allows to be committed a sex offense against the child. N.Y. FAM. CT. ACT § 1012(e)(iii) (McKinney 2001).

³⁴ A minor is neglected when a caregiver fails to exercise a minimum degree of care, thereby causing, allowing or creating a substantial risk of the infliction of harm which can or does result in an impairment of the child’s physical, mental or emotional condition. N.Y. FAM. CT. ACT § 1012(f)(i)(B) (McKinney 2001).

³⁵ N.Y. SOC. SERV. LAW § 413(1) (McKinney 2001). Mandatory reporters who willfully fail to report suspected abuse or neglect may be guilty of a misdemeanor, N.Y. SOC. SERV. LAW § 420 (McKinney 2001), and may be liable for civil damages. Further, reports that are made without a reasonable suspicion may lead to charges of misconduct or gross negligence, N.Y. SOC. SERV. LAW § 419 (McKinney 2001). Reports made in good faith immunize the reporter from civil liability, N.Y. SOC. SERV. LAW § 419 (McKinney 2001), although criminal sanctions may be imposed for reporting “an alleged occurrence...of child abuse or maltreatment which did not in fact occur or exist.” N.Y. PENAL LAW § 240.50(4) (McKinney 2001). No court has addressed this contradiction; however, due process considerations would make difficult the prosecution of a good faith report that turned out to be unfounded.

³⁶ “Allows” refers to the legal caregiver who knew or “should have known about the abuse and did nothing to prevent or stop it.” In the Matter of Katherine C., 471 N.Y.S.2d 216, 219 (Fam. Ct. Richmond Co. 1984) (finding a mother guilty of neglect because she should have known that her daughter was being sexually abused by the stepfather and failed to act to protect her).

³⁷ Although the question arises whether a parent who knows that his or her underage child is in a sexual relationship is liable for neglect, *see* N.Y. PENAL LAW §§ 130.05(2)(b), 130.05(3)(a), 130.20(1) (McKinney 2001) (making all minors under the age of seventeen who engage in vaginal, anal or oral sex victims of sexual misconduct), New York courts that have addressed this question have held that it is not child abuse for a parent to know that a minor child has chosen to be sexually active and to do nothing to stop it. *See* In re Leslie C., 614 N.Y.S.2d 855 (Fam. Ct. Kings Co. 1994) (dismissing charges of abuse and neglect against the mother of a sexually active fifteen-year-old girl); In re Philip M., 589 N.Y.S.2d 31 (App. Div. 1st Dep’t 1992), *aff’d*, 82 N.Y.2d 238 (1993) (noting that at trial, the court found that a 15-year-old with a sexually transmitted disease could not be presumed to be the victim of child abuse because the minor’s age indicated that he could have been engaged in “consensual sexual activity”); In the Matter of Toni D., 579 N.Y.S.2d 181 (N.Y. App. Div. 3d Dep’t 1992) (affirming the dismissal of a petition of abuse and neglect against the parents of a sexually active thirteen-year-old girl whose boyfriend was twenty-three).