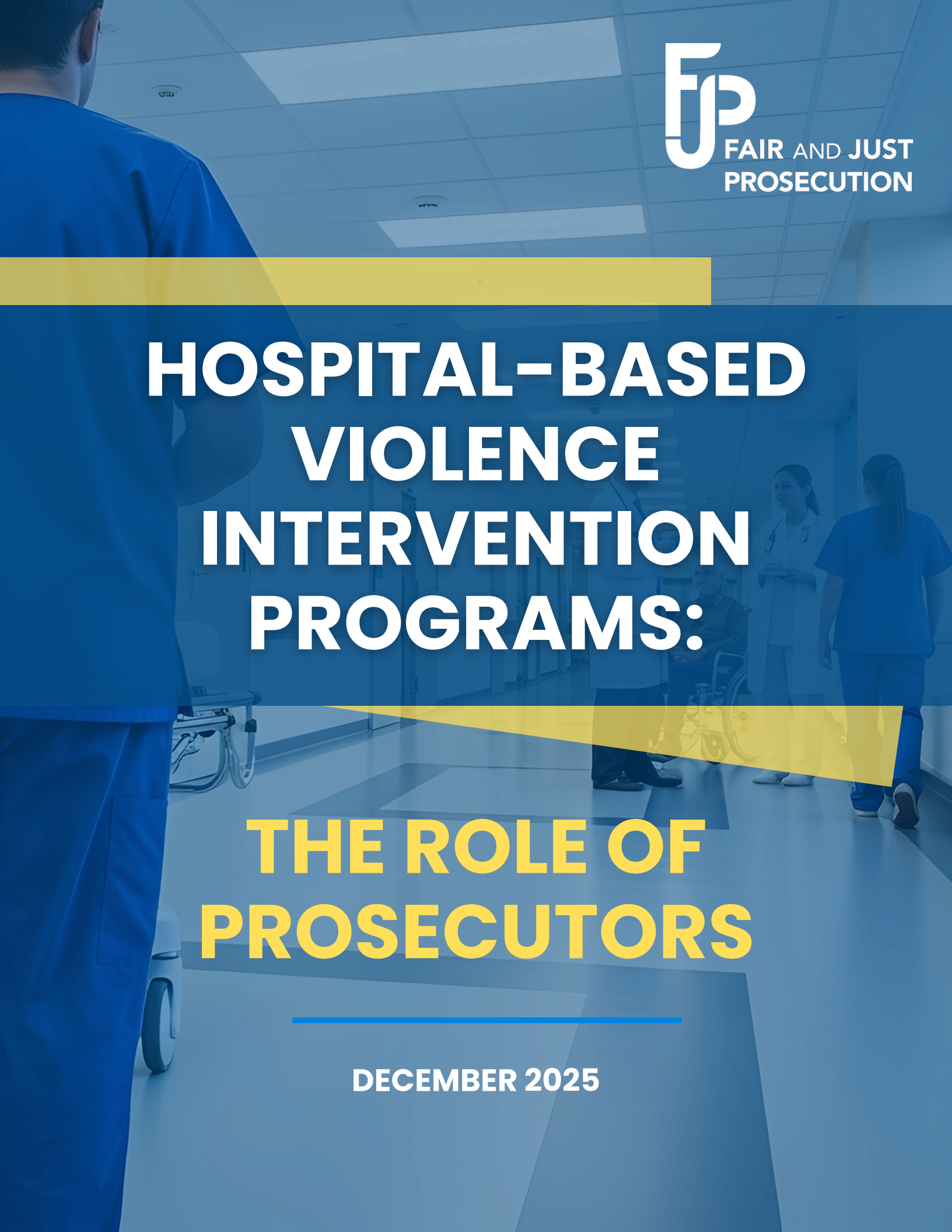


FAIR AND JUST PROSECUTION

HOSPITAL-BASED VIOLENCE INTERVENTION PROGRAMS:

THE ROLE OF PROSECUTORS

DECEMBER 2025

ABOUT FJP & ACKNOWLEDGEMENTS

Fair and Just Prosecution (FJP) brings together elected district attorneys[1] as part of a network of like-minded leaders committed to change and innovation. FJP hopes to enable a new generation of prosecutive leaders to learn from best practices, respected experts, and innovative approaches aimed at promoting a justice system grounded in fairness, equity, compassion, and fiscal responsibility. In furtherance of those efforts, FJP's "Issues at a Glance" briefs provide district attorneys with information and insights about a variety of critical and timely topics.

Thanks to the many people who contributed to this "Issues at a Glance" brief, including primary authors Kyle Barry and Dawn Milam, and members of FJP's team who provided guidance, input, research, and assistance: Monica Fuhrmann, Jennifer Krantz, and Robin Olsen. FJP is also grateful to Dr. Kyle Fischer, Dan Hafetz, Joe Kim, Heather Warnken, Lydia Watts, and Johnnie Williams for their invaluable comments, insights, and input.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This FJP Issue Brief provides an overview of Hospital-based Violence Intervention Programs (HVIPs) that reduce community violence, along with guidance on how elected prosecutors can ensure their success. In emergency trauma care settings, HVIPs provide services designed to improve the long-term physical, mental, and economic wellbeing of victims and their families, thereby also reducing retaliatory violence and promoting better health outcomes in the community.

While law enforcement has necessary investigatory duties, these programs can be needlessly undermined by the pervasive presence of law enforcement in hospitals where victims of violence (who may also be perpetrators of violence) are treated. HVIPs effectiveness depends on providing treatment and services in accordance with best practices in medical care, including protecting patient privacy and building patient-provider trust. These practices can conflict with law enforcement agencies that are focused on arrests and investigations. When police officers use aggressive investigative tactics inside healthcare facilities, they can disrupt everything from acute medical care to a victim's sense of safety and cooperation. These conflicts are exacerbated when victims are young Black men who are targets of racial profiling and disparate law enforcement, and with whom HVIPs cannot build trust if the lines between the police and healthcare providers are blurred.[2] A critical component of effective HVIPs, therefore, is properly constraining police activity inside hospitals while fostering a collaborative relationship that respects HVIPs' role in promoting public safety and allows law enforcement to fulfill their investigatory duty.

Yet there is no standardized policy to guide these police interactions, an absence due in part to the myriad legal standards and facility practices governing patient privacy, mandatory reporting, and criminal investigations.

Broadly, elected prosecutors have a dual role in supporting these violence-reducing programs. First, prosecutors can use their position as local elected leaders, legal experts, and public safety officials to advocate a public health approach to reducing community violence and build cross-disciplinary support for the HVIP model. In Travis County (Austin), Texas, for example, DA José Garza has been integral to "collaborative efforts to implement a comprehensive countywide gun violence reduction ecosystem," including a trauma-center HVIP "to address the needs of violence victims, connect survivors with

supportive services, and intervene in crisis situations to prevent future incidents."[3] At a press conference in April 2025, DA Garza and other community leaders announced that the HVIP, then only six months old, had already served over 350 people.[4]

Second, prosecutors can implement their own administrative and accountability policies to regulate police activity in these settings and protect the integrity of HVIPs' public safety goals. This issue brief suggests three core areas where prosecutors should consider focusing policy and accountability measures in partnership with hospitals: (1) providing guidance to law enforcement regarding access to trauma facilities and victims, including by promoting police investigations that are consistent with trauma-informed practices; (2) protecting individual privacy rights; and (3) safeguarding patients' property.

Importantly, the need to provide guidance to law enforcement that will support effective HVIP programming, and to erect boundaries that constrain harmful policing tactics, applies equally to traditional hospital emergency departments and trauma centers, even absent a formal HVIP.

Hospital-Based Violence Intervention Programs

Breaking the cycle of violence

INTERVENTION
Connect survivors with trauma-informed support at the bedside

CARE
Provide medical, mental health, and safety planning services

FOLLOW UP SERVICES
Offer ongoing mentoring, counseling, and community-based support

ADDRESS SOCIAL DETERMINANTS OF HEALTH

Link survivors to education, employment, and resources that promote stability

HVIPs PLAY A CRITICAL ROLE IN VIOLENCE PREVENTION & PUBLIC HEALTH

On a summer night in 2009, 17-year-old Jonathan Baldwin was shot seven times by masked gunmen who ambushed his family reunion in Milwaukee.[5] Jonathan was rushed to Children's Hospital, where surgeons successfully repaired wounds to his stomach and legs. But treating the physical injuries was only the first step to recovery. After leaving the hospital, young victims like Jonathan face the psychological toll of violent trauma along with heightened rates of reinjury — as high as 45% within five years of discharge — and, given the cyclical nature of retaliatory violence, the risk of becoming perpetrators of violence themselves.[6] That's why, when Jonathan woke up in the hospital, a counselor from Project Ujima was at his bedside, asking if he could help.

Project Ujima (the Swahili word for "collective work and responsibility") is Children's Hospital Wisconsin's HVIP, and it has long-served as a national model for similar programs. Since 1995, it has used a multidisciplinary team of community health advocates, mental health professionals, and nurses to provide a comprehensive array of hospital, home, and community-based services — from mental health treatment to summer camps and leadership development — that help young victims find stability and avoid future violence.[7] The program serves hundreds of people annually, and since 2004 its participants have a recidivism rate of less than 1%.[8] When Jonathan agreed to speak with them after the shooting, it started a years-long relationship that Jonathan credits for saving his life: "I know one thing, I wouldn't be here. Without that support, I don't know what life would've turned out to be."[9]

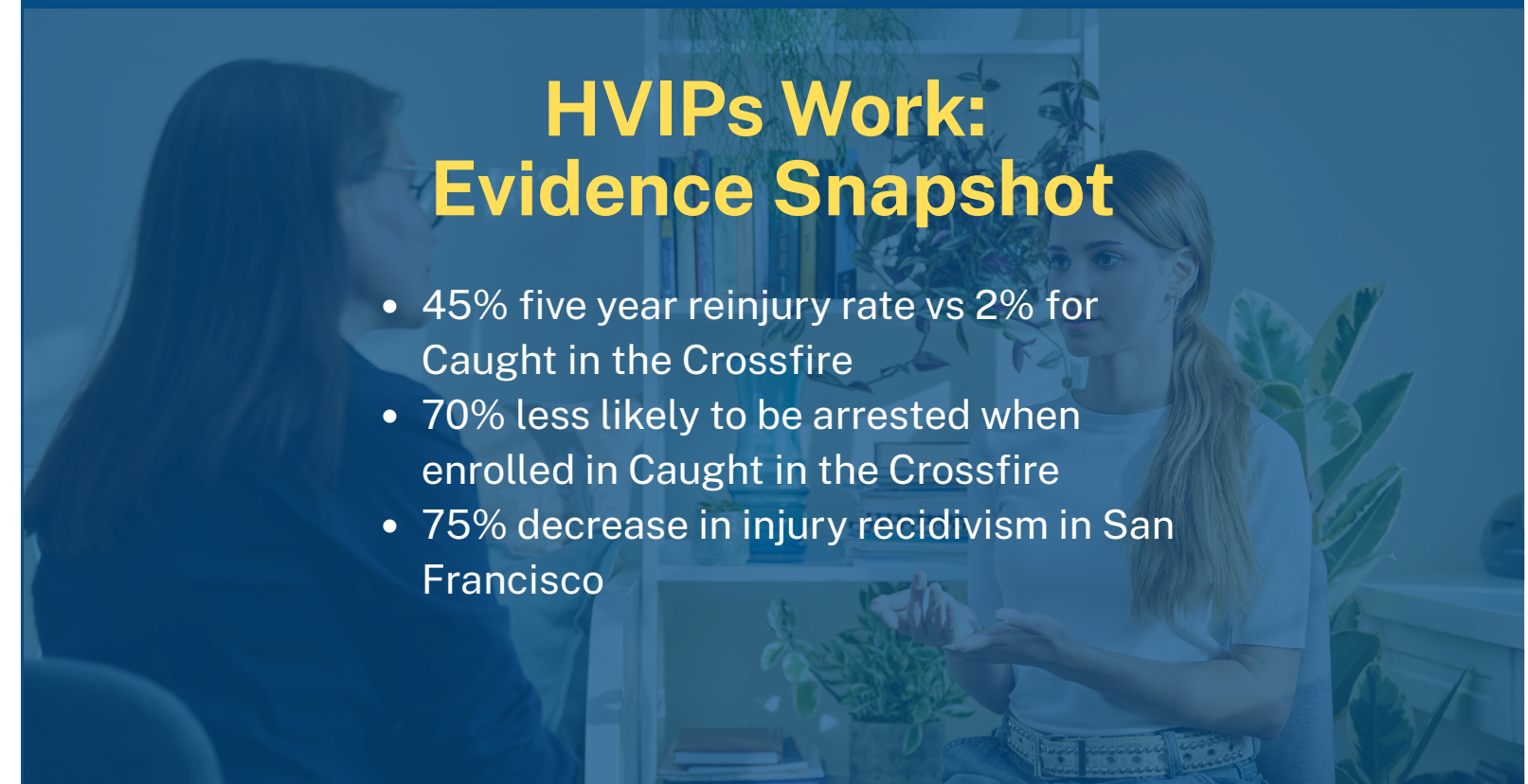
Hospital-based Violence Intervention Programs like Project Ujima are designed to ensure that victims fully recover physically and psychologically while feeling safe in their communities. As a result, HVIPs reduce retaliatory violence, reinjuries, and criminal system involvement.[10] Wraparound services are tailored to the participant's needs, which may include counseling, mentoring, referrals for education or employment, and safety planning to reduce re-injury or retaliation. HVIP case managers work with victims, and often their families, to cope with trauma and connect them to community services from their time in the hospital through at least six months post-discharge.[11] In Jonathan's case, four of his siblings also participated in Project Ujima, and his mother later became a family support specialist with the program at Children's Hospital.[12]

Situating violence intervention programs in hospitals engages victims at a critical personal moment to break cycles of trauma and interpersonal violence. Trauma-informed practice is a core component of HVIPs and means "understanding that experiences like violence affect the way someone thinks, feels and behaves in specific ways — including hyperarousal and depression — and tailoring their approaches to, at

least, not punish or retraumatize someone for exhibiting trauma symptoms."[13] In addition, HVIPs address the reality that victims of violence are more likely to become perpetrators of violence, and that a violent injury doubles the risk of death due to a future violent injury.[14]

HVIPs are relatively new — Youth Alive!, a nonprofit in Oakland, CA, pioneered the model with its Caught in the Crossfire initiative 30 years ago — but already studies suggest they are effective.[15] An analysis of the Caught in the Crossfire program found that, compared to a control group, participants were 70% less likely to be arrested and 60% less likely to have any criminal involvement, plus 98% of participants were not re-hospitalized for violence-related injuries.[16] Similarly, a study of San Francisco's Wraparound project found a 75% decrease in injury recidivism rates from 16% to 4% in the six years following implementation, with the most critical predictors of success being connections to mental health services and employment.[17] While more research is needed, studies of HVIPs in Baltimore, Chicago, Indianapolis, Richmond, and elsewhere provide promising evidence that these programs not only reduce violence and reinjury, but also result in significant health care cost savings.[18]

This makes sense from a public safety perspective. People interact with HVIPs at a critical moment when they may be more receptive to help. In addition to alleviating the immediate crisis, positive experiences with HVIP services can build trust in health care and other social programs. This is especially important given that many of the individuals in these programs are young Black men who may have a strong distrust of both the medical establishment and the criminal legal system. As people feel that the system is working to meet their needs, they may in turn be more likely to cooperate with law enforcement. A system that offers a chance at stability to people in crisis is more than a safety net, it can be the turning point for that person's relationship with other government programs and actors.



HVIPs Work: Evidence Snapshot

- 45% five year reinjury rate vs 2% for Caught in the Crossfire
- 70% less likely to be arrested when enrolled in Caught in the Crossfire
- 75% decrease in injury recidivism in San Francisco

REGULATING POLICE ACTIVITY IN HOSPITALS

Victims of gun violence typically end up in hospital emergency departments (EDs), which is why EDs are often centers of police activity. Police accompany and sometimes transport victims or incarcerated/detained patients. They may also be called in for security, to respond to suspected abuse or violence, or to investigate patients who are themselves suspected of committing violence.

While it is important for law enforcement to investigate violent crime, their presence in healthcare settings presents numerous challenges[19], especially as hospitals increasingly use public health strategies to curtail interpersonal violence and improve outcomes for victims and the community.[20] Because HVIPs depend on building trust with economically and medically vulnerable people, they can easily be undermined by criminal investigations.

While a victim and the hospital are focused on medical care, law enforcement is focused on conducting a thorough investigation into the circumstances surrounding the violence. Police investigatory practices may conflict with the protocols of emergency health care and can threaten patients' privacy and due process rights. Trauma patients are seldom in a state to understand, much less advocate for, their medical needs or legal rights. Furthermore, police presence in treatment areas can disrupt both the care and the trust between patients and their providers.

Abusive and aggressive law enforcement activities in EDs or HVIPs may arise from a lack of hospital policies to curtail them or a lack of awareness regarding policies that already exist. The absence of such policies often results in "ad hoc negotiations for when, where, and how law enforcement activities take place in health care institutions. This may lead to unintended, informal, and even illegal access to patients and disclosures of their health information to police."[21] Without well-enforced policies that protect the privacy and health of patients as the top priority, medical staff who lack the legal expertise to appropriately protect patients may improperly defer to law enforcement or unwittingly disclose private information in police presence.

For example, law enforcement may try to interview victims who are not yet stabilized, or who are under heavy sedation or otherwise impaired and disoriented. Police may also request unnecessary procedures to test for illegal substances or search for contraband, even if the patient is unable to consent. Interrogations of patients can easily exploit their vulnerability when they aren't medically stable and are incompatible with trauma-informed practices. Officers may overhear comments or notice personal belongings that prompt them to seek more information or collect evidence that exceeds their original purpose. Investigative activity also threatens the privacy rights of other patients — for example, body-cam videos can potentially record multiple patients at a time.

While constitutional rights limit law enforcement tactics (such as the Fourth Amendment prohibition on "unreasonable" searches and seizures), such rights are generally no greater for hospital patients than they are for people on the street. For this purpose, courts have recognized EDs as public spaces that law enforcement personnel are free to enter with no warrant or particular urgency, a rule that allows police to approach and question vulnerable people in the wake of violent trauma.[22] Where courts have declined to find robust constitutional protections for ED patients, the practices and policies of medical providers become pivotal factors in the outcomes of these interactions.

To support the public safety goals of HVIPs, local prosecutors should, therefore, coordinate with hospitals and police departments to set clear boundaries and protocols for how police engage with hospital patients and with HVIP staff. Such protocols protect providers and patients, support the integrity of police investigations, reduce the likelihood of mistakes or confrontation, and ultimately ensure that victims receive the trauma-informed care and services that make future violence less likely. In jurisdictions that do not have an HVIP, these principles apply equally in the EDs where victims of violence receive care.

The variety of federal, state, and local policies make it difficult to prescribe a uniform set of rules for law enforcement behavior in hospitals and HVIPs. However, a review of the existing literature and feedback from leading HVIP policy advocates suggest three target areas for policy interventions: (1) setting parameters and providing guidance on police access to facilities and hospitalized patients; (2) protecting patients' civil rights by limiting health disclosures; and (3) safeguarding patients' property.

How Prosecutors Can Support HVIPs

Advocacy

Promote a public health approach to reducing community violence

Collaboration & Policy Creation

Collaborate with hospitals to implement measures regarding police access, privacy rights, and patients' property

Access to Emergency Departments and Trauma Victims

The most obvious preventive measure is regulating whether and how police have access to hospitals and patients. While law enforcement officers are generally free to enter publicly-accessible emergency departments, they do not have a special privilege or legal *right* to enter, and therefore hospitals can restrict access via internal policy, absent exigent circumstances. Even when the law or a court order authorizes law enforcement officials to enter hospital settings without the facility's permission, such authorization typically has a limited scope.

The need for clear administrative guidance on access to patients becomes particularly relevant in the Fourth Amendment context, as courts consider emergency departments to be an extension of the public street, where privacy protections are relaxed or nonexistent.[23] In the absence of strong constitutional limits, hospital policies regulating law enforcement access — the contours of which may depend on particular state and local law — become critically important.

Proposals to control access to patients include, at a minimum, requiring outside law enforcement to sign in with their name, badge number, and reason for entry; and to wear visitor identification while at the facility. Police and security officers employed by the hospital should be held to hospital standards safeguarding patients' rights and belongings. Providers should also refuse law enforcement access to patients who are incapacitated, unable to consent, or otherwise unstable.

When it is appropriate for police to speak with patients who are victims of violence, it is essential that officers have training in trauma-informed investigation techniques. This should be an area where the work of police and HVIPs complement one another: ensuring proper training in, and use of, trauma-informed best practices promotes both better health outcomes and more effective investigations.

Sample Policy

The University of Utah Hospitals and the Salt Lake City Police Department created guidance for law enforcement access to and interaction with patients. The protocols for victims receiving emergency treatment include provisions for hospital personnel to be informed of the presence and purpose of a responding officer.[24] In addition, when an officer would like to interact with a patient who is not currently in their custody, they are required to contact the hospital's Customer Service Office and complete a patient access form, as well as providing any other necessary legal documentation.

Access to Legally-Protected Personal Health Information

In some cases, law enforcement officials will seek personal health information (PHI) that is protected by federal law and generally may not be disclosed without patient consent. For patients who are victims of violence, this could include their medical status, as well their mental health status and background. Protecting such information from improper disclosure is both legally required and further supports HVIPs' need to protect patient privacy and establish trust. Under the privacy protections outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), healthcare providers are permitted to release PHI to law enforcement only in narrow, specific circumstances — for example, in order to prevent a serious or imminent threat, report child abuse, or report gunshot or stab wounds in accord with state reporting requirements.[25]

The complexities of treating trauma victims adjacent to an active law enforcement investigation can easily encroach on these federally-protected patient rights. Emergency healthcare workers are not legal experts and are preoccupied with making rapid life-or-death decisions. They may accidentally disclose more information to law enforcement than they should, or law enforcement may draw inferences from unconscious cues or off-hand comments. According to one survey of hospital personnel, only 51% of providers said they ask police officers to leave the room when conducting a patient history or physical exam, and 42% indicated they had directly provided information about patient care plans to officers.[26] Research from a 2021 Working Group on Policing and Patient Rights found that law enforcement officials "can and do use passing comments made by medical providers as evidence in legal proceedings."[27] Such statements could trigger anything from interrogations to deportation proceedings.

Hospitals without adequate administrative policies for HIPAA compliance, and that fail to curtail improper PHI disclosure to law enforcement, could face various federal enforcement mechanisms, including corrective action by the Office for Civil Rights, financial penalties, and even criminal convictions. State attorneys general also have the authority to bring civil actions against HIPAA-covered entities on behalf of state residents to obtain damages or enjoin further violations.[28]

Access to Property and Collection of Evidence

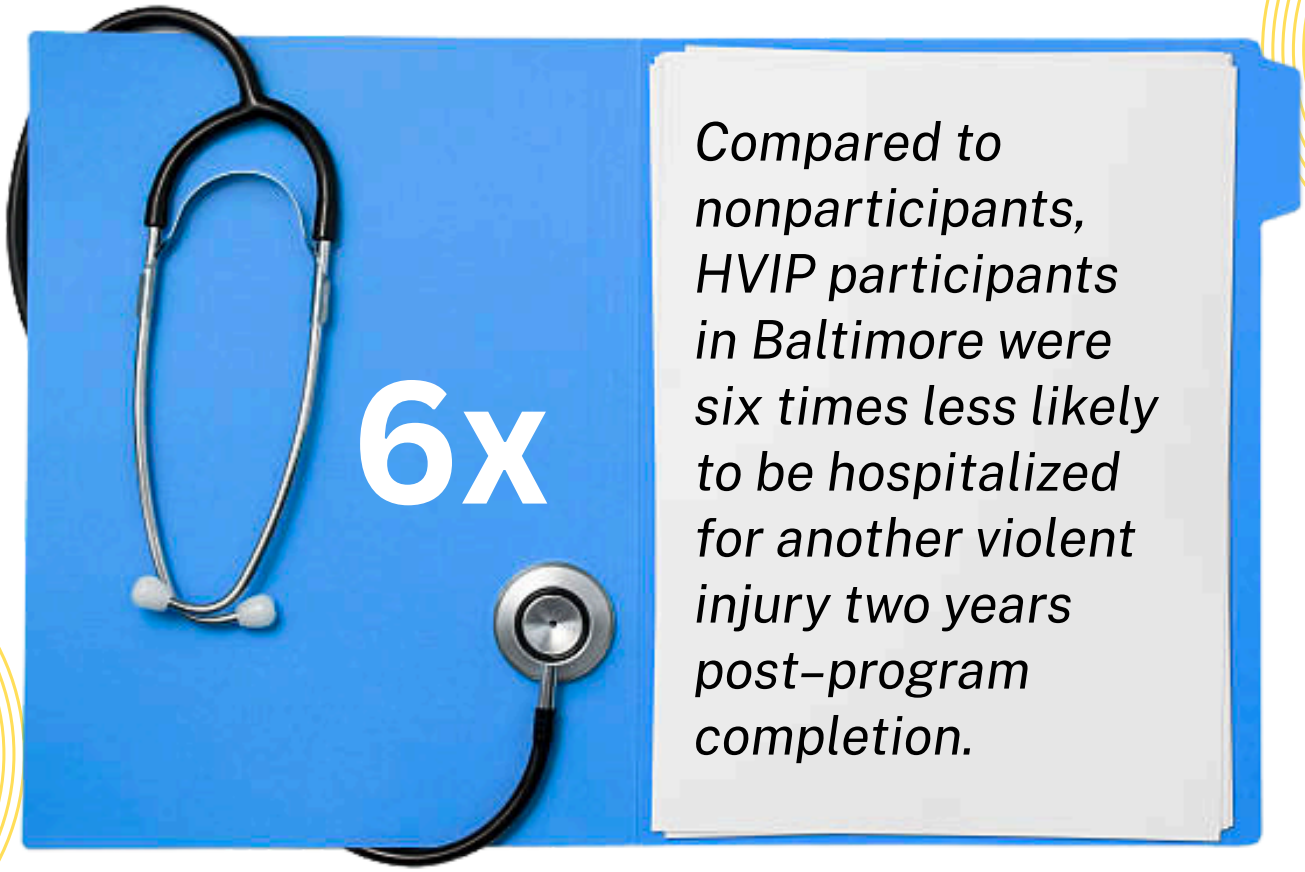
Law enforcement officers may also exceed the bounds of appropriate and effective policing — and thereby undermine the healthcare priorities of HVIPs — when they seize non-evidentiary personal property. In particular, when hospitals do not closely safeguard the collection of property, law enforcement may have easy access to patients' cell phones, car keys, clothing, or cash.

This is problematic both as a matter of patient/victims' rights and program efficacy. First, such easy access to property opens the door to police unlawfully confiscating personal belongings that are not relevant to their

investigation. For example, a 2021 federal lawsuit filed against the Baltimore Police Department (BPD) alleged in part that police violated the constitutional rights of crime victims by taking and destroying non-evidentiary property, including cell phones, clothes, cash, and even car keys. District Judge Stephanie Gallagher allowed the claim to proceed, saying that the plaintiffs had made a plausible showing that police engaged in a "practice or custom of at least arguably unconstitutional searches and seizures that are condoned by BPD."[29]

Second, even legally taken property could lead to problematic law enforcement tactics, such as forcing people to the police station to collect their property where they may be subject to interrogation and/or detention. Seizing belongings from hospitalized patients also undermines the HVIP itself. Removing a person's property further destabilizes a trauma victim at a critical moment, risks their full participation in the HVIP, and potentially prevents the HVIP from achieving its goals.

- Law enforcement may inspect or confiscate an emergency room patient's belongings that are left in "plain view" of officers in the ED or that patients have arguably abandoned after leaving the hospital.[30] Hospitals can avoid this practice by turning over to hospital security any personal belongings that are not in the patient's immediate control.



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RECOMMENDATIONS FOR PROSECUTORS

To be effective, HVIPs must be empowered to operate with best practices in public health and safety. This necessarily requires hospitals and HVIP staff to coordinate with law enforcement and set appropriate restrictions on law enforcement activity. Absent safeguards, police contact with trauma patients may not only violate civil rights, it can reduce the efficacy of HVIPs and compromise public safety, thus undermining the very goal that effective law enforcement seeks to achieve. Prosecutors have a role in increasing the success of HVIPs and ensuring that police investigations respect and are consistent with the role of HVIPs in promoting public safety.

1. **Advocacy and Collaboration**: Prosecutors have a powerful voice to explain and support measures that will most effectively reduce community violence.

A. Program Funding & Implementation:

As shown by DA José Garza's efforts in Austin, Texas, prosecutors can lobby and coordinate with the municipal government for resources to implement public-health-based violence reduction strategies, and can work with hospitals and community members to develop programs following best practices.[31] Prosecutors and other stakeholders are encouraged to connect with the Health Alliance for Violence Intervention (HAVI), which can assist with launching new programs, as well as provide resources and training.[32]

B. Trauma-informed Training:

Trauma-informed care is a cornerstone of the HVIP model. Law enforcement should understand how trauma affects perception and recall, and integrate trauma-informed practices, especially when interviewing survivors of violence. Many organizations offer technical assistance and training, such as the SAMHSA GAINS Center,[33] the National Center for Homeless Education,[34] American Institutes for Research,[35] and the Institute for Health and Recovery.[36] Prosecutors can work directly with these organizations to ensure that both police and prosecutors are following trauma-informed best practices.

C. Hospital and Law Enforcement Partnership:

Prosecutors can cultivate relationships with hospital and police leadership to develop protocols that comply with HIPAA, protect victims' constitutional and civil rights, and give hospital staff and law enforcement clear guidance. In jurisdictions with an HVIP, prosecutors can also connect law enforcement to the HVIP to ensure they understand the critical role these programs play in reducing community violence, thereby increasing law enforcement buy-in. This should include encouraging HVIP staff and local police departments to each designate a point of contact and to establish regular and open communication between them.

i. **Non-Interference**: In order to maintain a successful partnership, neither law enforcement nor the HVIP should interfere with one another's work.[37] Both parties should work together with hospital staff and schedule regular meetings between all stakeholders. Doing so will allow for the investigative needs of law enforcement to be met, while ensuring the HVIP is able to adequately provide services and the hospital is able to prevent any issues pertaining to victim rights.

D. Community Liaisons:

Many HVIPs include staff or volunteers from the patients' community to act as patient advocates and assist with police interactions. If there is no HVIP or if the HVIP does not include a community liaison, prosecutorial offices should make the case for including this service in emergency departments.

E. Heightened Protections for Youth:

Prosecutors can seek additional protections for minors, such as having a lawyer and guardian present during any interactions with law enforcement.[38] For example, in 2021, California established a non-waivable right for minors to consult with legal counsel prior to a custodial interrogation.[39] And, Illinois law requires that children under the age of 15 charged with homicides must be represented by counsel during the entirety of any interrogation.[40]

2. Prosecutorial Discretion and Accountability: In the inevitable gaps where hospital policies do not adequately protect victims, prosecutors can use their own resources and charging discretion to reduce harm, protect the integrity of criminal investigations and prosecutions, and promote overall public safety.

A. **Set Higher Standards for Police Questioning**: As discussed above, constitutional limits on police investigations are inadequate because they fail to account for the unique vulnerabilities of ED patients and the needs of HVIPs. But elected prosecutors can set higher standards. For example, DA policy can presume that EDs are "custodial" settings and require police to inform patients of their rights (including their right to remain silent) before any questioning.[41] DAs can also assume that any patient statements to police are involuntary unless police first confirm with an attending physician that the patient is stable, competent, and fully coherent.[42]

B. **Set Higher Standards to Protect Patient Property**: DAs can also play a role in protecting patient property by advising police on what items would be admissible and have evidentiary value, and creating strong written policies in this area. For example, DAs could determine that patients retain a privacy interest in all property, including clothing that they wear into the hospital, and that "plain view" is an insufficient basis to search or seize property. Instead, DA policy can require police to obtain a warrant or cite an exigency, such as the immediate spoilation of evidence or a public safety threat, to search or seize patient property (DAs can also advise police officers to treat the exigency narrowly, and to obtain a warrant whenever possible). When police do seize property, DAs should encourage police to document the chain of custody and to return property immediately when it no longer serves the purpose that justified its seizure.

C. **Educate Staff**: All prosecutors and law enforcement should be aware of victims' civil rights in healthcare settings, including privacy rights guaranteed by federal legislation like HIPAA and DA policy protecting patient privacy. Similarly, law enforcement, hospital staff, and HVIP staff should all receive training on hospital policies and practices, as well as relevant state and federal laws.

D. **Employ Prosecutorial Discretion**: Prosecutors should carefully review information stemming from an arrest made in an ED. Reviews should include a thorough examination to determine if the law enforcement interaction complied with DA and hospital policies regarding patient rights, as well as HIPAA.

E. **Treat Victims like Victims**: Prosecutors should include HVIP patients in their victim services, including access to victim compensation funds when appropriate, and access to these services should never depend on cooperation with law enforcement. Even in cases that result in carceral outcomes, positive interactions with the DA's office can build trust and mitigate future harm. This may include staffing social workers at the DA's office to support the continuation of care.

F. **Decrease Incentives for Abuse**: Prosecutors can create powerful incentives that affect police conduct. Through their charging decisions, policies guiding what evidence (including witness statements) they will use, and their refusal to work with certain officers who have a record of misconduct, prosecutors can promote ethical police investigations that are consistent with patient rights.

G. **Maintain Open Communication**: Prosecutors should maintain open communication with hospital leadership so that problems can be addressed in a timely and cooperative manner.

H. **Elevate HIPAA Non-Compliance to State AGs**: If hospital leadership is not receptive to ensuring compliance with legal and ethical standards, prosecutors can consider referring issues to the appropriate legal actors with enforcement authority.

CONCLUSION

Prosecutors can play an important role in promoting the effective functioning of HVIPs and thereby contribute to reducing retaliatory cycles of violence. The expansion of Hospital-based Violence Intervention Programs has elevated the need to regulate police activity in emergency departments in order to safeguard the medical care and services aimed at reducing interpersonal and community violence. Patients often have limited constitutional protections in these environments, and courts tend to favor the ability of police to investigate. At the same time, medical laws and ethics are designed to protect individual privacy and autonomy. Where considerations in these settings are complicated, ambiguous, and often contradictory, hospital policies and decisions often control the outcomes of police interactions with hospitalized patients. Elected prosecutors can coordinate with stakeholders and advise on the policies that are most effective to protect the integrity of criminal prosecutions and support the health and safety of community members.

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ENDNOTES

1. The terms “district attorney,” “DA,” or “elected prosecutor” are used generally to refer to any chief local prosecutor, including State’s Attorneys, Prosecuting Attorneys, and Attorneys General with local jurisdiction.
2. *See* Ji Seon Song, “Policing the Emergency Room,” *Harvard Law Review* 134, no. 8 (2021): 2690-2702, https://harvardlawreview.org/wp-content/uploads/2021/06/134-Harv.-L.-Rev.-2646.pdf (explaining that “[t]hose who are most vulnerable to bias and discrimination by institutional actors, including police and medical practitioners, are acutely vulnerable to and subject to the *combined* actions of medical professionals and police.”).
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5. Ashley Sears, “Shot seven times, doctors helped him survive…but something else helped him thrive,” *Fox 6 Now Milwaukee*, May 1, 2014, https://www.fox6now.com/news/shot-seven-times-doctors-helped-him-survive-but-something-else-helped-him-thrive.
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7. Ashley Luthern, “After shooting wounds heal, emotional scars cling,” *Milwaukee Journal-Sentinel*, Sept. 24, 2013, https://archive.jsonline.com/news/crime/nonfatal-milwaukee-shootings-this-year-are-highest-since-2006-b99102536z1-225099602.html.
8. Children’s Hospital Association, “This Program.”
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13. *See* Healing Justice Alliance, “Keys to Collaboration between Hospital-based Violence Intervention and Cure Violence programs,” June 2018, https://ovsjg.dc.gov/sites/default/files/dc/sites/ovsjg/service_content/attachments/Brief_Two_HJA_V6.pdf.
14. Giffords Law Center to Prevent Gun Violence, “Healing Communities in Crisis: Lifesaving Solutions to the Urban Gun Violence Epidemic,” 2019, https://giffords.org/wp-content/uploads/2019/01/Healing-Communities-in-Crisis.pdf.
15. Marla Becker et al., “Caught in the Crossfire: the effects of a peer-based intervention program for violently injured youth,” *Journal of Adolescent Health* 34, no. 3 (2004): 177-183, https://www.jahonline.org/article/S1054-139X(03)00278-7/fulltext.
16. *Ibid*.
17. Randi Smith et al., “Hospital-based violence intervention: risk reduction resources that are essential for success,” *Journal of Trauma and Acute Care Surgery* 74, no.4 (2013): 976-82, https://pubmed.ncbi.nlm.nih.gov/23511134/.
18. Giffords, “Healing Communities.”
19. Hospitals and EDs are also now implicated in immigration enforcement. The Department of Homeland Security (DHS) in January abandoned longstanding policy that generally protected healthcare facilities from immigration enforcement, instead deferring to individual agent “discretion.” Department of Homeland Security, “Statement from a DHS Spokesperson on Directives Expanding Law Enforcement and Ending the Abuse of Humanitarian Parole,” Jan. 21, 2025, https://www.dhs.gov/news/2025/01/21/statement-dhs-spokesperson-directives-expanding-law-enforcement-and-ending-abuse. As part of a broader immigration crackdown, this change has increased Immigration and Customs Enforcement (ICE) presence in hospitals, interfering with patient care and undermining already fragile trust with especially vulnerable populations. Ana B. Ibarra and Kristen

Hwang, "ICE is suddenly showing up in California hospitals. Workers want more guidance on what to do," *Cal Matters*, Aug. 26, 2025, https://calmatters.org/health/2025/08/immigration-hospitals-workers-fear/; Larry Buhl, "ICE agents camp out at Glendale hospital for 6 days waiting to re-apprehend patient," *Los Angeles Public Press*, July 9, 2025, https://lapublicpress.org/2025/07/ice-agents-glendale-hospital-waiting-to-arrest-a-patient/.

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21. Sara Jacoby et al., "When Health Care And Law Enforcement Intersect In Trauma Care, What Rules Apply?," *Health Affairs*, October 1, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180926.69826/full/.

22. *See generally*, Song, "Policing the Emergency Room."

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