Clin Occup Environ Med
3 (2003) 721–732

Clinics in
OCCUPATIONAL *and*
ENVIRONMENTAL
MEDICINE

Government approaches to reducing workplace violence

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Violence increasingly is viewed as a preventable public health problem and not as an inherent aspect of the human condition [1]. Like other types of violence, the potential for violence in the workplace has been recognized to occur whenever workers come into contact with customers, clients, patients, co-workers, and supervisors. Many occupations have involved an inherent risk for criminal violence, such as law enforcement, corrections, taxi service, mental health care, and convenience store service.

Beginning in the 1980s, news reports of multiple homicide incidents in workplaces that usually were not associated with a high risk for workplace homicide or physical assault gave rise to an expanded concern about workplace violence [2]. By the early 1990s, governmental policymakers who were concerned about occupational safety and health explicitly recognized assaults as an important cause of morbidity and mortality in the workplace and that evidence-based strategies were needed to address the problem.

In 1990, the National Institute for Occupational Safety and Health (NIOSH) reported data from its National Traumatic Occupational Fatalities surveillance system, indicating that from 1980 to 1985, homicide was the third leading cause of occupational fatalities in the United States, accounting for 13% of such cases [3]. In 1992, the US Bureau of Labor Statistics fully implemented its Census of Fatal Occupational Injuries (CFOI) surveillance system, receiving data from all 50 states and the District of Columbia. The 1992 CFOI data indicated that "assaults and violent acts" accounted for 20% of all occupational fatalities and were second in frequency only to transportation-related fatalities [4].

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1526-0046/03/$ – see front matter. Published by Elsevier Inc.

Since 1992, workplace homicide consistently has ranked among the leading causes of occupational fatalities in the United States. In 2001, there were 639 workplace homicides in the United States, compared with 2517 workplace deaths related to transportation accidents, 962 caused by "contact with objects and equipment," and 808 resulting from falls [5]. This finding reflects a steady decline from the historical high of 1063 workplace homicides reported in 1993 and coincides with a decline in the total number of violent crimes during the same period [6].

To address the problem of workplace violence as a preventable public health problem, federal, state, and local governmental agencies have adopted policies, legislation, and regulations and have engaged in educational outreach over the past 13 years to eliminate the causes and prevent the occurrence of violence in the workplace. While addressing workplace violence as a preventable public health problem, governments have become aware of the duality that is inherent in workplace violence prevention—workplace violence is an occupational safety and health issue and is a law enforcement issue. This perceptual duality has stymied government efforts to address the prevention of workplace violence, because many people view violent behavior as a matter of criminal law enforcement, regardless of the place where it occurs, and not an area for the application of traditional prevention measures for occupational safety and health.

Types of workplace violence

In 1995, the California Division of the Occupational Safety and Health Administration (Cal/OSHA) developed a three-part classification system, recognizing that workplace violence is not a single problem in terms of prevention but is a set of different problems in which each problem necessitates its own specific approach to prevention. This classification system uses the traditional public health approach of focusing on the hazardous agent (ie, a human agent) and describes three types of workplace violence events based on the relationship between the human hazardous agent (or perpetrator) and the type of workplace at risk [7].

In a Type I event, the perpetrator has no legitimate business relationship with the workplace and usually enters the workplace to commit a criminal act. Retail robbery is the most typical example of this type of event. In a Type II event, the perpetrator is a recipient of a service that is provided by the workplace or the victim. Typical examples are assault by a frustrated customer on a service provider, assault by a patient on a healthcare provider, and assault by a criminal suspect on a law enforcement officer. In a Type III event, the perpetrator (or his or her family member or acquaintance) has some employment relationship to the workplace. Typical examples are assault by a current or former employee on other employees or supervisors and assault on an employee (and often others) by a current or estranged family member, spouse, or lover.

State and local policies, laws, and regulations by type

State and local government approaches to reducing workplace violence can be categorized by type of workplace violence.

Prevention of retail workplace violence: type I

Requirements for late-night retail businesses were among the earliest governmental approaches intended to prevent assaults on workers. Efforts to decrease the assault rates among convenience store (C-store) workers became an early focus of governmental efforts to prevent violence because of the robbery deterrence programs initiated by the C-store industry in the 1980s [8].

Governmental measures to protect C-store workers included administrative regulations adopted in 1990 by the Washington Industrial Safety and Health Services Agency [9] and legislation passed in 1990 and 1992 by the State of Florida [10,11]. Partly in response to franchisee concerns about the risk for late-night retail robbery, Virginia passed legislation in 1990 that prohibited gasoline retail franchisers from requiring franchisees to stay open for more than 16 hours per day or more than 6 days per week [12].

Washington State

The Washington Administrative Code 296-24-10203 applies to retail establishments, except restaurants, hotels, or taverns, that operate between the hours of 11 PM and 6 AM. The Washington State regulation focuses on the training of workers and on the environmental characteristics of the workplace that have been associated with the risk for robbery, such as dim exterior lighting. The regulation requires that employers train their employees in safety, security, and crime-avoidance procedures. The employer must emphasize the importance of maintaining a clear view of the cash register from outside of the store and maintaining only minimal cash levels in the register. Employers developed emergency response procedures in the event of a robbery.

Florida

Florida was the first state to pass extensive legislation relating to the prevention of retail crime. The Florida law is limited to convenience businesses, which were defined as any place of business that is engaged primarily in the retail sale of groceries, or of groceries and gasoline, and open for business at any time between 11 PM and 5 AM. Businesses that solely or primarily are restaurants, have at least five employees on the premises between 11 PM and 5 AM, have at least 10,000 square feet of retail space, or are businesses in which the owner or members of the owner's immediate family work between 11 PM and 5 AM were excluded. The Florida Attorney General was given enforcement responsibility and the power to seek civil penalties of up to $5000 per violation, plus attorneys' fees and costs [13].

Like the Washington requirements, the Florida statutes address employee training and the environmental aspects of robbery and injury prevention. Florida's legislation, however, also provides for approval of employee training curricula and contains more detailed environmental requirements. These requirements include security cameras, drop safes for cash management, height markers at the entrance to stores, and silent alarm systems. If a murder, robbery, or other specified violent crime occurs at a covered business, one of the following measures must be implemented between 11 PM and 5 AM: At least two employees must be on the premises at all times, a secured safety enclosure of transparent polycarbonate must be installed, a security guard or off-duty police officer must be on the premises, or the doors to the establishment must be locked and business must be conducted through an indirect pass-through, trap door, or window. The additional security measure chosen must be in place for at least 24 months after the date of the most recent violent crime that is covered by the legislation, after which time the business may request an exemption from the Office of the Attorney General of the State of Florida. Implementation of crime prevention measures that are included in various state legislation for anti–C-store violence (eg, cash control, visibility and lighting, employee training, elimination of escape routes) have been shown to be associated with a lower risk for robbery [14].

Local government

Taxi barrier ordinances are an example of local government efforts to protect workers in high-risk occupations for workplace violence. Municipalities that have taxi ordinances include Los Angeles; Chicago; New York; Baltimore, Maryland; Boston; Albany, New York; and Oakland, California (C. Rathbone, personal communication, 1999). Taxi barrier ordinances are one of the few types of laws that have been evaluated for their impact on reducing injuries. Stone and Stevens evaluated the impact of the Baltimore, Maryland, ordinance and found that in the 12-month periods before and after the ordinance took effect in 1996, assaults on taxi drivers decreased 56% [15]. These authors also reported that in 1991, a cab operator who worked without a barrier was five times more likely to be assaulted than was a driver protected by a barrier.

Prevention of healthcare workplace violence: type II

Workers in healthcare facilities are at increased risk for workplace violence [16], especially those who work in emergency departments and in facilities that care for psychiatric patients [17]. Nonfatal assaults may be an even greater problem for the healthcare industry than are fatal assaults. In 1999, nonfatal assaults on hospital workers occurred at a rate of 8.3 assaults per 10,000 workers—a rate that is much higher than the rate of two assaults per 10,000 workers for all private sector industries [18]. Even though most assaults on healthcare workers are not be fatal, and some assaults involve no physical injury [19], they inevitably exact a psychic toll in an already stressful work environment [20]. California and Washington have

adopted statutes requiring planning and employee training to prevent assaults on employees in healthcare settings.

California

In February 1993, 10 days after a disgruntled patient shot and critically wounded three physicians at the emergency department of the Los Angeles County–University of Southern California Medical Center [21], a bill was introduced in the California legislature addressing the issue of security in emergency departments. As enacted 9 months later, the legislation included security precautions and requirements for state licensing of general acute care hospitals and acute psychiatric care facilities [22].

The new legislation required licensed general acute care and acute psychiatric hospitals to conduct security and safety assessments within 2 years. Using this assessment, hospitals had to develop a security plan that included measures to protect personnel, patients, and visitors from aggressive or violent behavior [23]. The hospital security and safety assessment must include an examination of trends of aggressive or violent behavior at the facility. The hospitals are required to track incidents of aggressive or violent behavior as part of their quality assessment and improvement program and for the purpose of developing the security plan. For the security plan, the hospitals are required to consider any guidelines or standards on violence in healthcare facilities that have been issued by the Cal/OSHA program or by the federal Occupational Safety and Health Administration (OSHA). As part of the security plan, hospitals must adopt security policies that included personnel training policies designed to protect employees, patients, and visitors from aggressive or violent behavior. Hospitals also are required to report to local law enforcement within 72 hours of any assault or battery, as defined in the California Penal Code, against any on-duty hospital employee that results in injury or involves a firearm or other dangerous weapon.

The California hospital workplace security legislation included special provisions for hospital emergency departments [24]. All hospital employees who regularly are assigned to the emergency department are required to receive initial and continuing security education and training relating to the following topics: (1) general safety measures, (2) personal safety measures, (3) cycle of assault, (4) predicting factors for aggression and violence, (5) obtaining patient history from a patient with violent behavior, (6) characteristics of aggressive and violent patients and victims, (7) verbal and physical maneuvers to diffuse and avoid violent behavior, (8) restraining techniques, and (11) resources available to employees for coping with incidents of violence, including critical incident stress debriefing or employee assistance programs [25]. Medical staff who are not employed by the hospital but who regularly are assigned to the emergency department or other departments identified in the security plan also must receive training.

Along with provisions for planning and training to prevent and respond to violence in hospitals, the California hospital security legislation added consideration of a hospital's ability to provide a secure environment as an element to be considered by the state when a facility applies for Medicaid (Medi-Cal) contracts

[26]. Security measures that could be considered in contract negotiations include procedures and equipment to detect lethal weapons, limitation of access to the emergency department by unauthorized personnel, assignment of full-time security personnel to the emergency department, and use of emergency panic buttons to alert local law enforcement in the event of a threat or incident [27].

To evaluate the impact and effectiveness of the 1993 California legislation pertaining to healthcare facility security, NIOSH contracted with the University of Iowa School of Public Health to survey 150 hospitals in California and compare them with 50 control sites in New Jersey. Comparisons will be made with respect to security measures instituted and the incidence rates of violent events before and after implementation of a hospital security plan. Evaluating the effectiveness of mandated hospital security plans such as California's assist in determining whether similar governmental approaches to workplace violence prevention will be effective in other states.

Washington State

Legislation enacted in Washington State in 1999 mirrors the requirement of the California law with respect to development of a hospital security plan. The Washington statute goes further by including a provision for training of all affected employees, not just those in the emergency department, and includes a detailed requirement for recording violent acts against employees, patients and visitors [28]. In 2000, a similar measure was enacted to apply to the state's two psychiatric hospitals [29]. This statute provided additional details on the physical attributes that must be addressed in the security plan, including access and egress controls, door locks, lighting, and alarm systems. Development of this security plan also requires consideration of the procedures to be taken in response to violent acts and policies and procedures addressing smoking, activity and therapeutic programs, personnel communication between shifts, and patient restraint and seclusion.

Security in healthcare settings is likely to continue to be a focus of concern among legislators as efforts to control costs and a growing population without health insurance place greater stress on healthcare resources, healthcare workers, and patients. In the 2003 to 2004 session of the New York State legislature, a bill was proposed that would require employers to develop and implement programs to "prevent and minimize workplace violence" (New York State Bill S00200 by Spano).

Employee-initiated workplace violence: type III

Violence that is perpetrated by an employee of the workplace is not an area in which federal, state, or local governments have chosen to legislate or adopt specific regulations. An exception to this trend is legislation to prevent the occurrence of Type III incidents that result from domestic violence spilling over into the workplace or from stalking by a former employee or other individual. The law permits potential victims of domestic violence at home to obtain restraining orders

against potential perpetrators. If Type III violence involves an individual who fears assault in the workplace, he or she cannot obtain a restraining order against the perpetrator coming into the workplace, because the potential victim has no legal standing. Victims of domestic violence often are located easily by a perpetrator at their workplaces. In many states, health departments have focused on the issue of domestic violence, chiefly in the home, but also at the workplace.

In California, the Workplace Violence Safety Act of 1994 addresses the issue of domestic violence protections in the workplace [30]. Under the act, an employer whose employee has experienced unlawful violence or a credible threat of violence from any individual has the legal authority to seek a temporary restraining order on behalf of the employee [31].

Of increasing interest to legislators and policymakers in the area of Type III workplace violence is the incidence of verbal aggression in the workplace. Although the incidences of verbal aggression, threat making, and other intangible workplace assaults are unknown, more attention is being focused on verbal workplace violence. So-called "relational violence" or "adult bullying" in the workplace increasingly has been noted in employee surveys of job satisfaction [32]. In 2003, a bill was introduced into the California legislature proposing that it would be unlawful for an employer to subject an employee to an "abusive work environment" (California Assembly Bill 1582 by Koretz). Because Type III incidents more closely are related to supervisor–employee interactions and employee interpersonal relations, an employer's considerate and respectful management of employees increasingly is being stressed by governmental policymakers as a crucial aspect in preventing verbal and physical violence in the workplace.

State OSHA programs

Washington and California enforce occupational safety and health regulations that require employers to implement comprehensive safety management programs. These states have interpreted the regulations to require employers to take steps to prevent assault on employees when such events are recognized or reasonably foreseeable.

In Washington, workplace inspections related to workplace violence primarily address employer compliance with the Washington Administrative Code 296-24-040, which requires an accident prevention program that includes a formal written program [33]. As discussed earlier, late-night retail workplace violence is addressed by a separate regulation.

Cal/OSHA has applied its general safety and health management regulation to workplaces in which the risk for violence to employees is recognized [34]. To aid employers in determining whether their workplace is recognized to be at risk for workplace violence, Cal/OSHA issued a comprehensive set of guidelines in 1995 that detailed employers' responsibilities for prevention of workplace violence against employees [35]. In an analysis of enforcement inspections, in which more than 200 inspections were conducted in 11 industries in California, retail and

healthcare establishments were inspected most frequently because of the occurrence of an assault or because of the receipt of an employee complaint [36].

Federal OSHA

Federal OSHA is empowered to enforce a general duty on employers to take steps to reduce or eliminate recognized workplace hazards that are likely to cause death or serious physical harm to employees [37]. In a 1992 memorandum, OSHA interpreted the general duty clause of the Occupational Safety and Health Act to include (or at least not exclude) the reduction or elimination of criminal acts of violence that are recognized in a particular employment arena as part of the nature of conducting business [38].

From 1993 through 1995, healthcare and retail businesses were most frequently inspected industries, and OSHA issued general duty clause citations to eight private businesses and three federal government establishments [39]. After losing an appeal of a workplace violence citation in the *Megawest* case in 1995, OSHA curtailed use of the general duty clause to address the hazard of workplace assaults [40]. The case was against a company that managed an apartment complex whose employees were exposed to physical assault by the tenants of the complex. In this case, OSHA unsuccessfully argued that a NIOSH Hazard Alert on Workplace Violence [41] supported a general duty clause violation.

Since losing the *Megawest* decision, OSHA has focused its efforts to prevent workplace violence on developing guidance and recommendations for employers in industries that have a recognized risk for workplace assault. In 1996, OSHA released guidelines for healthcare and social service workers [42]. In 1998, OSHA issued recommendations for workplace violence prevention programs in late-night retail establishments [43]. In 2002, OSHA published an informational Fact Sheet for Workplace Violence that endorses, where appropriate, measures such as employee training, video surveillance, extra lighting, alarm systems, drop safes, cash control, and other prevention measures [44].

In 2001, OSHA and NIOSH participated in the Tri-national Conference on Violence as a Workplace Risk under the auspices of the North American Agreement on Labor Cooperation—an occupational safety and health accord under the North American Free Trade Agreement [45]. In 2003, a Federal Interagency Task Force on Workplace Violence Research and Prevention, which included OSHA and NIOSH, was established to ensure collaboration among federal agencies on prevention of all three types of workplace violence in the public and private sectors.

Terrorism as workplace violence

Since the September 11, 2001, terrorist attacks and the 2001 anthrax attacks, governmental efforts have been undertaken to increase protection of all work-

places against terrorism. Interventions that have been designed to protect workplaces and their occupants from terrorist attacks have many similarities to interventions that are aimed at enhancing the security of workplaces.

Terrorism is defined by the US Department of State as "premeditated, politically-motivated violence perpetrated against noncombatant targets by subnational groups or clandestine agents" [46]. Most "noncombatant targets" are workers, and the business workplace should be considered to be at increased risk for terrorist-motivated workplace violence.

Although terrorism is not considered a traditional form of workplace violence, employers should address the threat of terrorism as a part of their overall workplace security program. The pattern of global terrorism indicates that business workplaces are more likely to be targeted for terrorist violence than are military, government, or diplomatic facilities [47]. Perpetrators of terrorist violence against the workplace usually have a political motivation for their actions, but also resemble perpetrators of other types of workplace violence. Traditional prevention measures for workplace violence that are recommended by government [48] and the private sector should be implemented to address the threat of terrorism [49].

In addition to its role in protecting critical infrastructures, such as power and energy systems, transportation systems, and telecommunications systems, the government is expending resources to educate and prepare the American workforce for chemical, biologic, and radiologic (CBR) threats to the workplace. Efforts are aimed at preventing the introduction of airborne CBR agents into an occupied building [50]. Technologies to detect the introduction of a CBR agent or to filter the agent out of the incoming air supply of a building are being developed to protect workplace from a CBR terrorist attack [51].

Significant governmental concern about workplace terrorism involves the introduction of a biologic agent into the workplace. The agents of most concern are smallpox, anthrax, plague, tularemia, and botulism toxin. Each of these agents can produce high fatality rates—ranging from 30% for smallpox to 80% for anthrax—and smallpox and anthrax can be grown easily in large quantities and are resistant to destruction. These attributes make these two agents ideally suited to aerosol dissemination to many workers. Anthrax spores intentionally were distributed through the US postal system in fall 2001. As a result, five deaths occurred, and 22 people developed anthrax (11 dermal cases and 11 inhalational cases) [52]. Of these 22 individuals, 20 (91%) were mail handlers or were exposed to worksites where contaminated mail was processed or received. Mail handling precautions now are seen more commonly in employers' workplace security programs, and employees are trained on how to handle mail as if it were contaminated. Similarly, efforts to prepare the healthcare and emergency responder workforce for a terrorist-initiated smallpox attack have begun [53].

Another area of governmental concern is emergency preparedness and planning. Since September 11, 2001, an emphasis has been placed on existing state and federal regulatory requirements for workplace emergency preparedness and planning. The Department of Homeland Security is working collaboratively

with occupational safety and health agencies on federal and state level to ensure that workplaces are prepared to meet the challenges of CBR terrorism. Of special concern to federal, state, and local governments is the protection of emergency responders who are involved in postincident rescue and recovery work [54]. These workers face unique hazards, including significant respiratory hazards, in preparing for or responding to a terrorist attack at the workplace.

Terrorism is a unique subset of Type I workplace violence and is of growing importance. The probability that any workplace will experience a terrorist event is small, but the events of September 11, 2001, require the acknowledgment of a new risk calculus. Before September 11, the probability of a workplace event that was as horrific and destructive as that of the World Trade Center attacks seemed remote. Now, it is incumbent for employers to be aware that business workplaces are at risk for terrorist violence and that prevention, preparedness, and planning are paramount to ensuring employee safety and business continuity.

Summary

Even though no national legislation or federal regulations that address workplace violence prevention have been enacted or adopted, many state and local governments have developed policies and have enacted laws and regulations that are aimed at decreasing the incidence of workplace violence. Research efforts are underway to evaluate the effectiveness of some of these laws. The results of such studies will help guide future legislation and regulation in the area of prevention of workplace violence. As a result of the September 11 and anthrax attacks in 2001, the problem of terrorist incidents in the workplace, and how best to prevent their occurrence, has received significant attention from the law enforcement and public health communities. With some refinement, strategies that are used to prevent previously well-recognized types of assaults on employees may help to reduce the likelihood and consequences of terrorist attacks that occur in the workplace.

References

[1] Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. World report on violence and health. Geneva, Switzerland: World Health Organization; 2002.

[2] Kraus JF. Homicide while at work: persons, industries and occupations at high risk. Am J Public Health 1987;77:1285–9.

[3] Bell CA, Jenkins EL. Homicide in US workplaces: a strategy for prevention and research: report of a workshop on occupational homicide prevention, held July 23–24, 1990. NIOSH Pub. No. 92-103. Washington, DC: US Department of Health and Human Services; 1992.

[4] Bureau of Labor Statistics. Fatal workplace injuries in 1992: a collection of data and analysis. Report 870. Washington, DC: US Department of Labor; 1994.

[5] Bureau of Labor Statistics. Census of Fatal Occupational Injuries (CFOI). Washington, DC: US Department of Labor; 2001.

[6] Bureau of Justice Statistics. National crime victimization survey: criminal victimization–2001 with trends 1993–2001. NCJ Pub. No. 194610. Washington, DC: Department of Justice, Office of Justice Programs; 2002.

[7] Howard J. State and regulatory approaches to preventing workplace violence. Occup Med 1996; 11:293–301.
[8] Crow WJ, Erickson RJ, Scott L. Set your sights on preventing retail violence. Security Management 1987;31(9):60–4.
[9] Late night retail workers crime protection, Washington Administrative Code 296-24-10203 (1990).
[10] Convenience Store Security Act, Florida Statutes (Crimes) Title 46 §812.1701-812.175 (1990).
[11] Convenience Business Security Act, Florida Statutes (Crimes) Title 46 §812.1701-812.175 (1992).
[12] Virginia Statute §59.1-21.11.
[13] Barish RC. Legislation and regulations addressing workplace violence in the United States and British Columbia. Am J Prev Med 2001;20(2):149–54.
[14] Hendricks SA, Landsittel DP, Amandus HE, Malcan J, Bell J. A matched case-control study of convenience store robbery risk factors. J Occup Environ Med 1999;41(11):995–1004.
[15] Stone JR, Stevens DC. The effectiveness of taxi partitions: the Baltimore case. Knoxville (TN): Southeastern Transportation Center, University of Tennessee; 1999.
[16] Goodman RA, Jenkins EL, Mercy JA. Workplace-related homicide among health care workers in the United States. JAMA 1994;272(21):1686–8.
[17] State of Washington, Department of Labor and Industries. Study of assaults on staff in Washington State psychiatric hospitals: final report. Olympia (WA): State of Washington; 1993.
[18] National Institute for Occupational Safety and Health. Violence: occupational hazards in hospitals. NIOSH Publication No. 2002-101; Washington, DC: US Department of Health and Human Services; 2002.
[19] Carmel H, Hunter M. Compliance with training in managing assaultive behavior injuries from inpatient violence. Hosp Community Psychiatry 1990;41(5):558–60.
[20] Sandy JG. Homeostasis without reserve—the risk of health care system collapse. N Engl J Med 2002;347(24):1971–5.
[21] Hubler S, Mitchel JL. Patient at county shoots 3 doctors, gives up in stand off. Los Angeles Times. February 9, 1993; sect 1:1.
[22] California Statutes of 1993 ch 936; sect 2.
[23] California Health and Safety Code §1257.7(a).
[24] California Health and Safety Code §1257.8.
[25] California Health and Safety Code §1257.8(a)(1)-(11).
[26] California Welfare and Institutions Code §14083.
[27] California Welfare and Institutions Code §14083(a)-(l).
[28] State of Washington Senate Bill 5312 ch 377; sect 3.
[29] State of Washington Substitute House Bill 2899 ch 22; sect 2.
[30] California Statutes of 1994 ch 29; sect 1.
[31] California Code of Civil Procedure §527.8.
[32] Namie G. US hostile workplace survey 2000. Available at: http://www.bullyinginstitute.org/home/twd/bb/res/surv2000.htmldate. Accessed January 24, 2003.
[33] State of Washington, Accident Prevention Program. Washington Administrative Code (WAC), Section 296-56-60009(1). Available at: http://search.leg.wa.gov/pub/textsearch/ViewRoot.asp?Action=Html. Accessed January 11, 2003.
[34] Injury and Illness Prevention Program, California Code of Regulations Title 8 §3203.
[35] California/Occupational Safety and Health Administration. Guidelines for workplace security. San Francisco (CA): Division of Occupational Safety and Health, California Department of Industrial Relations; 1995.
[36] Peek-Asa C, Howard J. Workplace-violence investigations by the California Division of Occupational Safety and Health, 1993–1996. J Occup Environ Med 1999;41(8):647–53.
[37] 29 USC §654(a) (1).
[38] Attwood CL. Criminal violence in the workplace. Washington, DC: US Department of Labor; 1992.
[39] Occupational Safety and Health Administration, US Department of Labor. Integrated Manage-

ment Information System (IMIS). Available at: http://www.OSHA.gov/cgi-bin/e5t/est1. Accessed February 17, 2003.
[40] Occupational Safety and Health Review Commission. Secretary of Labor v Megawest Financial, Inc., OSHRC No. 93-2879 (1995).
[41] National Institute for Occupational Safety and Health. Preventing homicide in the workplace. NIOSH Publication No. 93-109; Washington, DC: US Department of Health and Human Services; 1993.
[42] Occupational Safety and Health Administration. Guidelines for preventing workplace violence for health care and social service workers. OSHA No. 3148; Washington, DC: US Department of Labor; 1996.
[43] Occupational Safety and Health Administration. Recommendations for workplace violence prevention programs in late-night retail establishments. OSHA No. 3153; Washington, DC: US Department of Labor; 1998.
[44] Occupational Safety and Health Administration. Fact sheet: workplace violence. Washington, DC: US Department of Labor; 2002.
[45] Bureau of International Labor Affairs. Proceedings of the Tri-national Conference on Violence as a Workplace Risk. Montreal, Canada, November 29–30, 2001. Available at: http://www.dol.gov/ILAB/media/reports/nao/violenceworkrisk.htm. Accessed January 11, 2003.
[46] 22 USC ch 38, §2656f, subsection (d) (2).
[47] Office of the Coordinator for Counterterrorism. Patterns of global terrorism—2000. Washington, DC: US Department of State; 2001.
[48] California/Occupational Safety and Health Administration Consultation Service. Model injury and illness prevention program for workplace violence. Sacramento (CA): Division of Occupational Safety and Health, California Department of Industrial Relations; 1995.
[49] Epstein SF. Guidelines for addressing the threat of terrorism: guidelines for prevention and response. International Facility Management Association (IFMA); Houston (TX): IFMA Foundation; 2002.
[50] National Institute for Occupational Safety and Health. Guidance for protecting building environments from airborne chemical, biological, or radiological attacks. NIOSH Publication No. 2002-139; Washington, DC: US Department of Health and Human Services; 2002.
[51] National Institute for Occupational Safety and Health. Filtration and air-cleaning systems to protect building environments. NIOSH Publication No. 2003-112. Washington, DC: US Department of Health and Human Services; 2002.
[52] Jernigan DB, Raghunatham PL, Bell BP, Brechner R, Bresnitz EA, et al. Investigation of bioterrorism-related anthrax, United States, 2001: epidemiology findings [serial online]. Emerg Infect Dis 2002. Available at: http://www.cdc.gov/ncidod/EID/vol8no10/02-0157.htm. Accessed January 11, 2003.
[53] Centers for Disease Control and Prevention. Protecting Americans: smallpox vaccination program. Available at: http://www.bt.cdc.gov/agent/smallpox/vaccination/vaccination-program-statement.asp. Accessed December 2002.
[54] Jackson BA, Peterson DJ, Bartis JT, LaTourrette T, Brahmakulam I, et al. Protecting emergency responders: lessons learned from terrorist attacks. Arlington (VA): RAND Science and Technology Policy Institute; 2002.