Abstract

Community beliefs related to intentional injury inflicted by others were examined in a population-based telephone survey (n= 1030) in Queensland, Australia. Young adults 18-24 years were nominated as the most likely to be intentionally injured. 89.1% of respondents nominating this group believed that the injury incidents occur in alcohol environments. Though respondents from this age group also identified 18-24 yo as most likely to be intentionally injured, this was at a significantly lower level than did parents or 25-64 yo respondents. Responsibility for preventing injuries was placed on proprietors of licensed premises, schools and parents/family of the victim for alcohol, school and home environments respectively. Beliefs were aligned with prevalence data on intentional injury demonstrating a high level of awareness in the community about likely victims and situations where intentional injuries occur. Interventions could target families of young adults to capitalize on high levels of awareness about young adult vulnerability.

Key words: community attitudes; injury prevention; intentional injury; risk perception.

Introduction

World Health Organization projections show that by the year 2020, intentional injuries (violence and self-inflicted injuries) and unintentional injuries (especially road traffic crashes) will be in the top 15 causes of loss of disability-adjusted life years (DALYs) worldwide.^{1,2} A 2006 update of these projections predicts falling rates of death from intentional injury in middle and lower income countries, but increases in the violence-related mortality rate over the next 20 years in higher income countries such as Australia³. Within Australia, assault is the fourth leading specific injury cause of hospital admission (being exceeded by falls, transportation injury and self-harm causes) and accounts for approximately 6% of all injuries but 42% of intentional injury⁴. The overall social and economic costs of assault-related injury were estimated at AU\$1.6 billion in 2001⁵.

The Australian Bureau of Statistics estimated in 2004-05 that 2 million incidents of assault (including incidents not reported to the police) occurred in Australia, based on responses to a self-report survey. Approximately 400,000 of the survey respondents indicated that they had experienced more than one assault⁶. During the same period, official hospital data indicated that over 20,000 separations occurred as a result of an assault.⁷ Figures are somewhat higher for the year 2008-09 with 28,759 hospitalisations coded as due to assault (ICD-10-AM) as shown in Table 1.⁸ Table 2 shows the breakdown of assault-related hospital separations by place of occurrence. Hospitalised victims were overwhelmingly likely to be male (ratio of 3:1 male to female). In addition, rates of assault-related injury were highest for both males and females in the ages 15-44 years, peaking at 20-24 years for males and 25-34 years for females.⁸ For males, this pattern is similar to that of the United States, where homicide also peaks in adolescence/young adulthood and is the second leading cause of death for ages 10-

24 years.⁹ Alcohol also appears to play a key role in assault-related injury in Australia with one major study (cited in [26]) estimating that 47% of all perpetrators of assault and 43% of all victims were intoxicated prior to the assault.

Table 1 about here

Table 2 about here

In the state of Queensland, assault-related injury is the fifth leading injury cause of death (self-harm, transport crashes, falls, and accidental poisoning rank 1-4 respectively) accounting for 2% of injury deaths, which equated to 23 deaths in 2006.^{4,7} Queensland's rates of assault-related deaths and hospitalisations are the second highest in Australia. In the period 2008-09, assault resulted in more than 6,500 hospital separations in Queensland.⁸ Recent analyses of data relating to emergency department (ED) presentations in Queensland for January 1999 to June 2010 reveal that there were more than 8800 cases where assault was the code used for intent.¹⁰ Of these, 12% were identified as assault by intimate partner and 38% were identified as alcohol related (Ruth Barker, Director, Queensland Injury Surveillance Unit, personal communication, February, 2011). Overall 65% were male, 21% were aged 21-25 years and 16.5% 26-30 years. These figures are underestimates as not all hospitals participate in the data collection for the QISU database. The true level of assault-related injury presentations to the ED is likely to be five times greater (Ruth Barker, Director, Queensland Injury Surveillance Unit, personal communication, February, 2011). Thus the number of presentations to hospitals in Queensland for injury from assault (ED and separations) is likely to be more than 7,000 cases per annum, with the majority of these involving young men and/or alcohol. This age pattern is similar at the national level with

around 85% of hospitalisations due to assault in 2006 being to people aged under 45 years. As the median age at death due to assault was 35.7 years,⁸ the impact on years of potential life lost (YPLLs) is significant, rendering intentional injury a public health issue of considerable concern.

The number of assault-related injury deaths in Australia has decreased dramatically over the last 10 years, from 300 in 1997 to 155 in 2006.¹¹ This may be due to a number of factors such as improvements in emergency procedures resulting in better recovery times, improvement in treatment, and changes in the way that data on such incidents collected or coded. For instance, it is unclear how much the enactment of the Australian National Firearms Agreement in 1996, which imposes strict controls on who may own firearms and the type of firearm as well as requiring licensing for owners, affected trends in homicide.¹² As with the figures for Queensland, it is likely that the official figures underestimate the true number of assaults as they do not include incidents that are traditionally less likely to be reported such as domestic incidents, particularly intimate partner-related violence, that do not result in a hospitalisation or police intervention. Nevertheless, assault and its consequences are preventable and controllable therefore a further decline in the number of assault-related injuries is both possible and desirable.^{9, 13-15}

While focussing on, and intervening with, assailants may lead to reductions in injury from assault, a focus on intervening with the potential targets of assault, particularly young adults, is also worthwhile given that injuries due to assault are likely to be largely a result of the combination of facilitating circumstances rather than premeditated. Applying the Health Belief Model would suggest that higher levels of perceived risk of both intentional and unintentional injury are associated with the uptake of injury prevention initiatives to reduce

the injury risk.¹⁶ However, where individuals do not perceive a need or risk to themselves, there is unlikely to be any change in behavior. For example, parents who do not perceive a risk to their children from motor vehicle crashes have been shown to be unlikely to take up suggestions to reduce the risk or to change their practices in restraining their children: there is no perceived need to do so.¹⁷ Thus it would seem that to reduce the rate of assault-related injury one of the key factors affecting the likelihood of people adopting safer practices is their beliefs in relation to the risk of sustaining the injury, that is, their beliefs about whether assault related injury is something that affects them or people like them. Currently our knowledge in relation to people's beliefs about assault and who is most vulnerable to it, or their perceptions in relation to their own susceptibility to assault is underdeveloped.

Previous research has investigated peoples' beliefs and perceptions in relation to bushfire safety, drowning prevention, and falls prevention in older people, yet no study has been conducted specifically on people's beliefs in relation to intentional injury (assault-related injury) and its prevention for Australia.^{4,18-21} As part of a larger survey examining injury prevention more generally, the current study aimed to assess peoples' beliefs about which age group(s) are most at risk of being injured deliberately, the situation(s) or location(s) where deliberate injury most commonly occurs and perceptions about the responsibility for preventing such injury. An additional focus of this study was on how well public perceptions regarding intentional injury parallel patterns in official data. Such a comparison provides one indicator of the likely community receptivity to interventions aimed at reducing the risk of intentional injury and is helpful in informing appropriate prevention efforts. It is also useful in establishing a baseline measure of how aware specific groups in the community are of both their own age group and others' relative risk of intentional injury.

Methods

Setting

Queensland is a tropical and sub-tropical state in Australia with a population of around 4 million people. The state has a large land area (1.7 million km²) and a resulting geographically widely-dispersed population, though Brisbane, the capital city, is home to half the state's residents. In the 2006 census of population most of Queensland's population reported that English was the sole language spoken at home (86%), while 8% reported this as a language other than English.²² Around 75% of residents indicated that they had been born in Australia, with a further 10% who were born elsewhere indicating countries of origin culturally very similar to Australia (i.e. NZ, UK, Canada, US).²²

Table 3 about here

Recruitment of sample

A pool of potential participants was generated utilising random digit telephone dialing and was stratified according to both residential location (urban, regional, remote) and age group (18-24, 25-64, 65+ years, parents on behalf of children under 18 years). A final sample of 1,030 respondents was obtained distributed as shown in Table 3. Location was categorised using the Accessibility/Remoteness Index Australia, ARIA classification²³. All Queensland postcodes were assigned to one of three categories: urban (ARIA 'highly accessible'), regional (ARIA 'accessible' or 'moderately accessible') or remote (ARIA 'remote' or 'very remote'). Quotas for interviews were set on a combined age group and location basis.

Response rate

The random digit dialling technique generated 10,404 calls where a householder answered. Of these, 2,573 were ineligible because the applicable quota was full, 2,371 requested a different interview time but were subsequently unable to be contacted (5 call back attempts), 131 were aged under 18 years old, 213 were unable to respond (deaf/drunken/senile/language difficulties) and 3,718 refused to participate. A very conservative approach would suggest a response rate of 12% (the final number of respondents, N = 1032, divided by the total number of calls minus calls to ineligible but willing householders, 8587). Least conservatively, the response rate is 21%. Full details of the various outcomes of calls can be found in the Appendices to the main report of the study.⁴

The questionnaire and procedure

A brief (10-15 minutes) survey was administered using computer assisted telephone interviewing (CATI). Survey items were based on critical injury issues for specific age groups identified both from the literature and from interviews held with ten key Australian injury experts prior to the survey design. Item development was guided by previous injury surveys where possible²⁴, and supplemented by items purpose-designed by the researchers, including those on intentional injury by another person as reported here. The final survey comprised 17 core questions administered to all respondents plus specific modules that were administered based on the respondent's age group (with parents responding on behalf of children aged under 18 years) (see Table 4 for core item content). This paper reports results from those core questions relating to beliefs about intentional injuries. .

Intentional injury questions

There were three core questions relating to beliefs about intentional injury. Participants were asked firstly which age group they believed was most often injured by another person

deliberately (age groups were read to the participant), then asked to identify the situation or location in which people of that age group most often suffered this injury (single free responses were elicited) and the people or organizations most responsible for preventing such injuries (up to three free responses were recorded). For the last item, interviewers were provided with a set of guidelines to group the free responses into categories (see Appendix A) for later analysis. Other core questions examined more general beliefs about preventability of injury in four key environments (home, work, on the road, in or on the water) as shown in Table 4. A more detailed description of the overall survey, sampling strategy and item content can be found in the final report⁴.

The survey was administered by a social and marketing research company. Ethics approval for the study was provided by the HREC at Queensland University of Technology (Approval number: 0800000489).

Table 4 about here

Analysis

Descriptive analyses using SPSS were conducted to summarize demographic characteristics of the sample and the responses to individual items relating to preventability of injury in four key locations (in the home, on the road, at work, in or on the water) and to intentional injury²⁵. In order to ensure that responses were representative of the Queensland population (for age and residential location), post-stratification weights were applied to responses. Weights were calculated based on the population data for age distribution among survey locations using Australian Bureau of Statistics figures for the 2006 census (see Table 2). In

order to check for whether there was any influence of demographic differences on attitudes and beliefs in relation to preventability of injury, analysis of variance testing was carried out. No significant differences on the basis of respondent sex, age group (as above), residential location (as above), household income, and highest education were found. While country of birth was collected as a demographic in this survey, few respondents indicated a country of birth other than Australia or New Zealand and thus this variable could not be used in more detailed analyses. This was not unexpected due to the small proportions of residents from other countries of birth in the overall Queensland population as mentioned earlier.

Results

Table 3 illustrates the demographic characteristics of the respondents.

Intentional injury was perceived as most likely among young adults 18-24 years (59%), followed by adolescents aged 10-17 (18.7%), children aged 5-9 years (8.2%) and babies or young children aged < 5 years (4.6%) as shown in Table 5. Less than 2% of respondents selected other age categories and around 8% gave other non-age based responses. However, responses to this question differed according to age group of the respondent. Specifically, though more than half of the young adult respondents (54.5%) nominated the 18-24 year age as most at risk of intentional injury, Chi square tests revealed that they were significantly less likely than parents (59.6%) or people aged 25-65 (62.1%) to nominate the 18-24 year age as most vulnerable to intentional injury, $\chi^2 (df = 12) = 21.44, p < .05$.

Table 5 about here

For the age category they nominated, respondents were then asked to specify situations or locations in which they believed these deliberate injuries take place (free responses). Among the respondents who nominated young adults (18-24 years) as most at risk, the majority (89.1%) identified situations involving alcohol (e.g. drinking at licensed premises and hotels) as those where these injuries occur (see Table 6). Similarly, 40.6% respondents who had nominated adolescents (10-17 years) and 43.0% who had nominated children (5-9 years) as the age group most likely to be injured deliberately considered that the school environment was the most likely situation for this to occur. Respondents who nominated babies and young children as the most at risk of deliberate injury identified the home environment as the most likely situation (66.0 %).

When analyzed for situation type (regardless of age group of respondent or age group nominated) alcohol environments were still the situation respondents perceived as those most likely for assault to occur (61.5% overall) (see Table 6, though note the somewhat smaller n in this analysis). At school (12% overall) and in the home (8.6% overall) were much less likely to be identified and there was a wide variety of other situations or locations that were identified as well (17.9%) including “at work, “when catching public transport at night” and “anywhere.”

Table 6 about here

Finally respondents were asked ‘who should be responsible for preventing these injuries?’ A maximum of three responses was recorded from each respondent. The top five first-mentioned responses in descending order were: the aggressor, 16.4%; proprietors of licensed premises, 15.0%; parents/family of the aggressor, 11.0%; parents/family of the victim, 10.7%

and the victims, 9.8%. As shown in Figure 1, responses to this question were consistent with those situations or locations respondents had identified as where they believed people are intentionally injured. Notably, in alcohol-related environments the patterns of perceived responsibility appear different from the other two, with a substantial proportion of respondents identifying aggressors and/or victims as well as proprietors as responsible, possibly reflecting the more mature ages of the perceived victims in this compared to the other two environments.

Figure 1 about here

Discussion

Almost 60% of survey respondents of all ages nominated young adults (aged 18-24) as the age group most likely to be deliberately injured by another person. Moreover, an association between alcohol and intentional injury was a clearly identifiable theme in these responses, with 61.5% indicating a situation involving alcohol as most likely for assault-related injury. Both of these results exceed the actual incidence (see Tables 2 and 5 for figures) of injuries with these characteristics but suggest a high level of awareness among respondents in this study of the vulnerability of young adult men and the involvement of alcohol in assault-related injury. This is encouraging. However, it appears that public awareness is not as great when it comes to the vulnerability of slightly older people (25-35 years) who are also relatively vulnerable to assault. For women, this is likely to be risk of assault from intimate partners as well as from sexual assault, issues that were apparently not well identified by this sample. It may be that the way the questions were put to respondents affected their responses here and this represents a limitation of the study. However, it is noteworthy that young

people themselves (aged 18-24 years) were significantly less likely to identify their own age group as vulnerable to intentional injury. Though over 50% did nominate their own age group, almost 40% did not, suggesting a substantial lack of awareness. This lower level of awareness or acknowledgment may help explain why some individuals in this age group do not appear to take sufficient action to prevent intentional injury to themselves. The situation in which such injuries appear to be most likely, that is, those involving alcohol (such as licensed premises), probably exacerbates this by increasing the possibility of impaired judgment amongst young people when they are most at risk. Moreover, consumption of alcohol outside the home brings with it other safety issues for young people, such as transport home from venues. Although we have no measure in this survey of the respondents' own behavior in relation to riskier intentional injury activities, such as consuming alcohol in licensed venues, it is likely that a much higher proportion than 50% of the young adults would be doing this at least occasionally, given that alcohol consumption patterns for 18-25 year olds in Australia suggest that 25-33% drink at risky levels.³⁰ Thus it is also likely that many are unwittingly exposing themselves to risk of intentional injury.

Both protection from assault and safe transport are amenable to planning or to use of overall behavior routines. Indeed there has recently been a government funded mass social marketing campaign that has targeted young people's safety behavior in Australia especially in relation to risky but occasional alcohol consumption (binge drinking) and spiking of drinks with illicit drugs (see "Don't turn a night out into a nightmare" campaign). The results from our study may in part be indicative of success from this campaign. Alternatively, it may be that the high level of media attention/sensationalisation in Australia given to alcohol-related assaults that occur around licensed venues has placed this issue well within the public consciousness. We cannot draw definitive conclusions about this from our research.

However, even though awareness appears high, many young people are apparently not getting the message. This may be due in part to practical barriers to changing some behaviors that might be considered as less important by young adults themselves (eg planning for safe travel/safe levels of alcohol consumption in advance) compared to other behaviors with opposing goals (such as becoming intoxicated or presenting an image of being a hard-drinking ‘lad’ or ‘ladette’). It may be that campaigns to alter young people’s beliefs about their susceptibility to assault may have to address factors other than physical safety, such as self efficacy or response efficacy.^{28,29}

Encouraging more collective social responsibility in other forms may also be useful. Anecdotally we know that young people, particularly young women, have come to regard drink spiking as a serious threat and that many protect themselves against this by arranging that a trusted person ‘looks after’ drinks when necessary. Interventions to minimize assault in alcohol environments might similarly encourage young people, both men and women, to have plans for assisting one another using a ‘buddy’ system or friendship group. It is also important that interventions include those aimed at broader society as well as those aimed at groups already perceived as bearing some of the responsibility for preventing assaults (eg proprietors of premises where young people consume alcohol). Another possibility for intervention might be to attempt to capitalize on parental awareness of their teen or young adult children’s vulnerability, by, for example, encouraging parents to actively explore young people’s safety planning with them.

Schools and homes were also identified as locations for intentional injury, albeit to a much lesser extent and to quite different age groups, suggesting that generally home and school environments are not perceived as high risk for intentional injury. This is consistent with

injury figures. Official data in Australia 2008-09 suggests hospitalization due to assault injury in the home represents around 1 in every 6 cases of injury (15%).⁸ However, a large proportion of assault-related hospitalizations (58%) were coded as ‘unspecified place/not reported’ thus making it difficult to know the true proportions of assaults in the home environment. In addition, it is likely that data for some groups or causes may be underreported to a greater extent due to the reluctance to report some kinds of assault, for instance, those committed by one family member against another. So too, the actual cause of an injury occurring at home may be deliberately misreported to hospital staff where family members are involved. We have no way of gauging the extent to which this is the case. For children, analysis of data relating to Emergency Department presentations for assault in Queensland during 1999 to 2007 suggest that home is the most common location, with around one third coded as occurring at home (32%), followed by public locations (24%) and school (17%), though for very young children (under 5 years) 61% of these injuries occurred at home.¹⁰ However, unspecified location accounted for 18% of the presentations which may mean the actual occurrence at home is higher.

Respondents generally identified those organizations, groups or people responsible for the environment in which the injuries occur to be the most responsible for prevention. They highlighted the responsibility of schools in relation to intentional injury to children 5-17 years and parents/family of the victim for intentional injury to young children < 5 years in the home. There appeared to be a greater burden of responsibility placed on aggressors and victims when it came to perceptions of responsibility for alcohol-related injury. For intentional injury in alcohol environments, proprietors of licensed premises were identified as holding the most responsibility, followed by the aggressor and then the victim. This suggests that there may be public support for greater use of interventions that emphasize responsible

service of alcohol. Identification of the victim as at least partially responsible for reducing intentional injury in alcohol associated environments may indicate receptivity to interventions that attempt to raise the awareness among members of the most vulnerable age groups (18-34 year old men) of their greater vulnerability and strategies that might be used to reduce their risk. In this respect, families of young men might also be targeted in interventions to equip parents with ways that they may be able to assist young men to reduce their risk of deliberate injury.

This study has some important limitations. The first of these is self-report or social desirability bias. The results have to be viewed with this in mind. The second bias is that typically associated with telephone surveys, where households without a home telephone may differ in some important way from those with one. So too, the use of land lines may bias the results here, as mobile phone use as the primary telephone contact is on the rise in Australia (though the Australian Bureau of Statistics estimates it to represent fewer than 10% of all homes, G. Pollard, personal communication, 2009). Our reported response rate is between 12 and 21% and this is relatively low by medical research standards, though in keeping with response rates of social research surveys. Moreover, there is little detail available in relation to the characteristics of people who declined to participate. The survey asked only about country of birth and not ethnicity and hence the results cannot be used to determine the role of ethnicity in any of the issues explored. It may be that particular safety issues are more influenced by factors associated with different ethnicities and these have not been captured in the findings here. These points need to be borne in mind when considering the applicability of the findings. A further limitation derives from the wording of the questions themselves. It is probable that some forms of response were restricted by the way that questions were put to respondents. For instance, when asked to nominate the age group most likely to be involved

in intentional injury, respondents were given a restricted choice, and though some did respond with answers that were not one of the choices, respondents were inclined to choose one of the age categories offered to them. Similarly, we did not give respondents the option of ranking their identified people/groups responsible for preventing injuries. We asked only for the first three and used our own criterion of first mentions to decide which ones were most important. This may not truly reflect public views. .

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APPENDIX A

Question 2 - Free responses list:

1. In their homes
2. At school
3. At work
4. In public playgrounds or shopping areas
5. When drinking alcohol in alcohol environments or socialising in alcohol environments
(e.g. drinking at pubs, clubs, parties)
6. Sports/sporting events
7. While traveling in the dark (morning or night)
8. Anywhere/Everywhere
9. Other (Specify)
10. Don't know
11. Refused

Question 3 - Free responses list:

1. victim/person being injured or hurt
2. aggressor/person who is doing the injuring or hurting
3. Parents/families/relatives of the victim/person being injured
4. parents/ families/ relatives of the aggressor
5. Neighbourhoods/communities
6. Proprietors of licensed premises/Bouncers / security guards/ licensed venues/people
holding the parties
7. People running the sporting events
8. Council/local government

9. Police
10. State Government/social services
11. Schools
12. Everyone [*go to next section – do not ask for other mentions*]
13. Nobody [*go to next section – do not ask for other mentions*]
14. Other specify
15. No others (*only display for 2nd and third mention*)
16. Don't know [*go to next section – do not ask for other mentions*]
17. Refused [*go to next section – do not ask for other mentions*]
18. other 2
19. other 3
20. Federal government
21. Friends / peers of the victim / person being injured
22. Friends / peers of the aggressor

Table 1: Assault-related hospitalization, Australia 2008-09, by age group of victim⁷

Assault-related hospitalization by age group (2008-09)								
Age (years)	0-4 % (n)	5-14 % (n)	15-24 % (n)	25-34 % (n)	35-44 % (n)	45-64 % (n)	65 + % (n)	total
	1.3 (376)	2.1 (591)	32.9 (9432)	27.3 (7855)	20.2 (5822)	14.0 (4024)	2.2 (639)	100 (28,759)

Table 2: Assault-related hospitalization, Australia 2008-09, by place of occurrence⁷

Place of occurrence	Home environment	School or education environment	Trade and service area	Other specified (eg health service area)	Other unspecified	Total
Assault related hospitalizations % (n)	15.1 (4352)	0.8 (240)	10.2 (2946)	15.4 (4416)	58.4 (16,805)	100 (28,759)

Table 3. Demographic characteristics of the sample

Demographic characteristic	n (%)	Weighted n (%)
Gender		
Male	439 (42.6)	430 (41.8)
Female	591 (57.4)	599 (58.2)
Age group		
18-24	249 (24.2)	129 (12.5)
25-64	253 (24.6)	342 (33.2)
65 and over	253 (24.6)	168 (16.3)
Parent (proxy for under 18s)	275 (26.7)	391 (38.0)
Highest education		
Primary school	77 (7.5)	
Completed year 10 or 12	486 (47.2)	
Technical college or University	454 (44.1)	
Other	13 (1.3)	
Household income (AUD)		
< 35,000	255 (24.8)	209 (20.3)
35,000-64,999	197 (19.1)	210 (20.4)
65,000-89,999	153 (14.9)	178 (17.3)
90,000-120,000	127 (12.3)	141 (13.7)
> 120,000	141 (13.7)	154 (15.0)
prefer not to answer	157 (15.2)	137 (13.3)

Table 4: Content areas of the 17 core survey questions

Content	Number of items related to the content
Whether respondent or someone in the immediate family had been injured in a way that permanently affected the respondent's lifestyle, work or leisure activities	1 item
Beliefs about preventability of injury in four key environments (home, work, on the road, in or on the water)	4 items
Belief that respondent could personally make a difference to their own safety in each of the four key environments (home, work, on the road, in or on the water)	4 items
Beliefs about which age group is most likely to be deliberately injured by another person	1 item
Beliefs about where (situation) deliberate injury by another person is most likely to occur	1 item
Beliefs about who is most responsible for preventing deliberate injury (to the age group nominated)	1 item
Beliefs about who should supervise young children in and around domestic swimming pools	1 item
Presence and checking of smoke detection devices in the home	2 items
Whether hot water temperature in bathroom when at it hottest is capable of scalding a child	1 item
Whether anyone in the household has received first aid training in the previous 3 years	1 item

Table 5: Proportion nominating each age group as most likely to be intentionally injured by another person (by age group of respondent)

Age group of respondent	Proportion nominating each age group as most likely to be intentionally injured by another person					
	Age group nominated (selected from response options read out)					
	Babies or young children 0-4 years % (n)	Children aged 5-9 yrs % (n)	Adolescents 10-17 years % (n)	Young adults 18-24 years % (n)	Other % (n)	Totals % of respondent age gp (n)
Parents of children <18 yrs	5.0 (19)	9.2 (35)	19.9 (76)	59.6 (227)	6.3 (24)	100 (381)
Young adults (18-24 yrs)	5.3 (7)	8.3 (11)	24.2 (32)	54.5 (72)	7.6 (10)	100 (132)
Adults 25-64 years	2.8 (10)	7.7 (27)	16.2 (57)	62.1 (218)	11.1 (39)	100 (351)
Older adults 65 years or more	6.0 (10)	7.1 (12)	16.7 (28)	54.8 (92)	15.5 (26)	100 (168)
Totals % of whole sample, (n)	4.5 (46)	8.2 (85)	18.7 (193)	59 (609)	9.6 (99)	100 (1032)

Table 6: Perceptions of who is most likely to be assaulted and where: Proportions of respondents identifying each location type as most likely for intentional injury (by age group nominated as most likely to be injured)

Age group nominated as most likely to be injured intentionally	Babies or young children 0-4 years % (n)	Children aged 5-9 yrs % (n)	Adolescents 10-17 years % (n)	Young adults 18-24 years % (n)	Other age group % (n)	Totals % (n)
Environment identified for intentional injury						
When drinking alcohol or socializing in alcohol environments	0 (0)	0 (0)	23.5 (45)	89.1 (540)	31.6 (18)	61.5 (603)
Home environment	66 (31)	31.7 (25)	5.2 (10)	0.5 (3)	26.3 (15)	8.6 (84)
School environment	6.4 (3)	43.0 (34)	40.6 (78)	0.5 (3)	0 (0)	12 (118)
Other (eg at work, anywhere)	27.6 (13)	25.3 (20)	30.7 (59)	9.9 (60)	42.1 (24)	17.9 (176)
Totals	100 (47)	100 (79)	100 (192)	100 (606)	100 (57)	100 (981)

Figure 2 Type of organisation, group or person identified as responsible for preventing intentional injury in alcohol-related, school and home situations/locations (as a proportion of the respondents identifying that situation in the earlier question, first mentions only).

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