# Fighting Antisemitism and Keeping Guns out of the Hands of Terrorists and Criminals Amendment Bill 2026

**Submission No:** 318

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**A submission to the**

**Justice, Integrity and Community Safety Committee**

**on the**

# Fighting Antisemitism and Keeping Guns out of the Hands of Terrorists and Criminals Amendment Bill 2026

# Contents

## Introduction and focus of this submission

I am pleased to make this submission regarding the Fighting Antisemitism and Keeping Guns out of the Hands of Terrorists and Criminals Amendment Bill 2026 (the Bill). While recognising that the Bill seeks to reduce firearm violence through a regime of enhanced penalties, stricter controls over firearm possession, and increased requirements in areas such as 'safe storage', this submission highlights that preventing violence is a complex task. Society cannot legislate its way out of violence, and genuine violence prevention requires evidence-based measures that take into account the factors driving violence.

This submission is divided into four sections:

1. Statistical overview – lethal firearm violence
2. Relationships between legal firearm ownership and firearm misuse
3. Predictors and correlates of firearm violence
4. Promising practices

Given the short timeframe allowed, this submission is necessarily brief. I would be pleased to provide more detail on any of the points raised.

Acknowledging that the Bill focuses on the policy objective of reducing interpersonal violence, this submission does not discuss suicide. However, I am able to provide detailed information about suicide prevention, should the Committee request this.

### Relevant expertise and professional background

I work at the intersection of psychology, criminology, and public policy and have broad experience in legislative/policy evaluation across these fields. I have an extensive professional background in the study of violence and its prevention, and specialise in research into homicide, suicide, and domestic and family violence. I have produced over 100 scholarly journal articles, book chapters, reports and presentations on these topics, and my research has been widely published in both academic and mainstream media outlets.

I am an internationally recognised expert in the study of firearm violence and its prevention, firearm policy, and gun control. My scholarship on these topics has been extensively cited, including by the World Health Organisation and numerous government and non-government organisations in Australia and internationally.

I am currently the Executive Director of Analysis, Policy and Strategy with the Violence Prevention Institute Australia. I have also worked as a Principal Research Fellow in the School of Applied Psychology at Griffith University, focussing primarily on violence risk assessment tools and practices. I was the Inaugural Director of the Griffith University Homicide Research Unit, Deputy Director of the Griffith University Violence Research and Prevention Program, and a Senior Research Fellow with the Australian Institute of Suicide Research and Prevention. I have been an Honorary Research Fellow with the Department of Economics, University of Otago (New Zealand) and an Honorary Associate Professor with the TC Beirne School of Law, University of Queensland. I serve on the Editorial Board of the highly ranked international peer-reviewed journal Trauma, Violence, & Abuse.

In addition to these roles, I have served in voluntary leadership positions in various professional and community organisations, including as Chair of the Board of Directors of the Queensland Homicide Victims' Support Group from 2019-2022. I am the current President of the Queensland Branch of the Australian and New Zealand Association of Psychiatry, Psychology and Law (ANZAPPL). I have also

served on several (unremunerated) advisory panels, including the Queensland Police Minister's Weapons Advisory Panel under both LNP and Labor Governments from 2012-2024.

**Disclaimer**

The opinions expressed in this submission are mine alone, and do not represent the views of any organisation.

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## Section 1: Statistical overview – lethal firearm violence

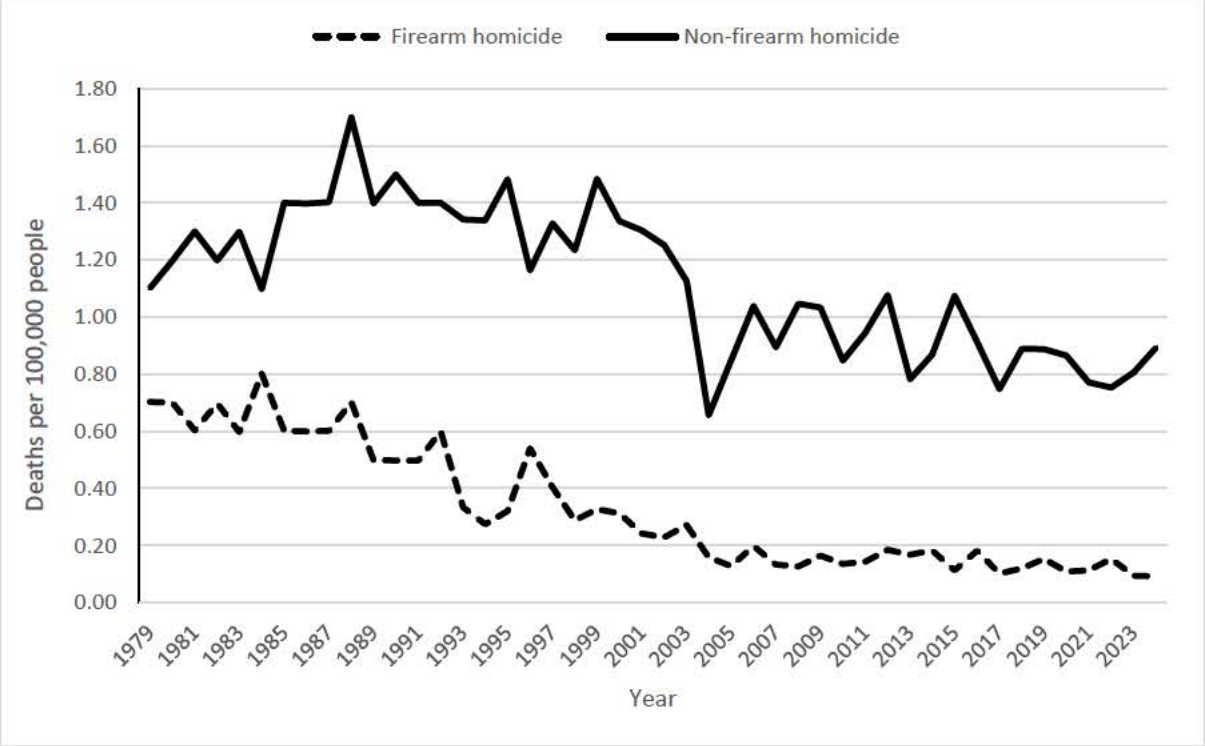
This section provides a snapshot of firearm-related homicide nationally, and by states and territories. To provide broader context, non-firearm mortality statistics are also shown.

Long-term trends over time are shown where possible (noting that reliable data is not always available to enable this), to indicate whether firearm misuse is increasing or decreasing. Statistics for 2023 and 2024 are preliminary only, and subject to revision in line with standard Australian Bureau of Statistics (ABS) procedures and delays between deaths occurring and Coronial determinations being finalised.

### National trends

Figure 1 shows national firearm and non-firearm homicide rates. Firearm homicide rates declined noticeably through the 1980s and 1990s, and have continued to decline slightly since the mid-2000s. Non-firearm homicide rates have fluctuated over time, although have also declined over time and remained relatively stable (with a slight decline) since the mid-2000s.

Figure 1: Homicide rates – whole of Australia




Source: ABS, Causes of Death, multiple years.

### Homicide methods

In 2023–24, 82 per cent of homicide incidents (n=216) involved the use of a weapon. Knives and other sharp instruments were used in one-third of all incidents (34%, n=88). Knives have been the most frequently used weapon type every year since the early 1990s, and were the primary weapon in 35 per cent (n=3,317) of all homicide incidents since 1989–90.

Fifteen per cent (n=38) of homicide incidents in 2023–24 involved the use of hands and/or feet. Hands and feet were the primary weapon in 21 per cent (n=2,004) of incidents since 1989–90; however, the proportion of incidents where hands and feet were used has decreased over the last three decades. In 2023–24, hands and feet were the primary weapon in 19 per cent (n=33) of homicide incidents where the primary victim was male compared with six per cent (n=5) of incidents where the primary victim was female.

Firearms comprised 17 per cent (n=1,589) of weapons used in homicide incidents since 1989–90. In 2023–24, 12 per cent (n=31, see Table 10) of incidents involved a firearm. A firearm was slightly more likely to be used in incidents where the primary victim was male (13%, n=23) compared with incidents where the primary victim was female (9%, n=8).[1]

Australian Institute of Criminology (AIC) data from the National Homicide Monitoring Program (NHMP) annual report for 2023-24, reproduced below in Table 1, shows that the distribution of firearm homicides, and homicides in general, follows the population distribution. States with more people tend to have more homicides overall, including more firearm homicides.

Table 1: Homicide method by jurisdiction, 2023-24

| | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Total |
|---|---|---|---|---|---|---|---|---|---|
| Firearm | 9 | 9 | 5 | 5 | 3 | 0 | 0 | 0 | 31 |
| Knife/other sharp instrument | 24 | 22 | 19 | 11 | 7 | 0 | 3 | 2 | 88 |
| Blunt instrument | 1 | 2 | 2 | 3 | 3 | 0 | 0 | 2 | 13 |
| Hands and feet | 14 | 6 | 8 | 4 | 2 | 3 | 0 | 1 | 38 |
| Fire | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 |
| Drugs | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Poison | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Vehicle | 2 | 4 | 3 | 1 | 0 | 0 | 0 | 0 | 10 |
| Other | 2 | 0 | 2 | 1 | 0 | 0 | 1 | 0 | 6 |
| Multiple weapons | 2 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 6 |
| Weapon not stated | 6 | 3 | 5 | 2 | 2 | 0 | 0 | 1 | 19 |
| *Weapon used* | *62* | *50* | *46* | *27* | *17* | *4* | *4* | *6* | *216* |
| Weapon not used | 4 | 0 | 1 | 4 | 0 | 0 | 0 | 0 | 9 |
| Not stated/unknown | 11 | 4 | 0 | 18 | 1 | 3 | 0 | 0 | 37 |
| **Total** | **77** | **54** | **47** | **49** | **18** | **7** | **4** | **6** | **262** |

Source: AIC NHMP 2023–24 [computer file]

## Type of firearm

Table 2 shows assault deaths (i.e., homicides) by firearm type, at the national level, over the past 10 years. The number of deaths involving other and unspecified firearms has increased in recent years. The reasons for this are not clear.

[1] Miles, H., & Bricknell, S. (2025). *Homicide in Australia 2023–24: Statistical Report 52*. Australian Institute of Criminology: Canberra.

Table 2: Assault deaths - firearm type

| Year | Handgun discharge | Rifle, shotgun and larger firearm discharge | Other and unspecified firearm discharge |
|---|---|---|---|
| 2015 | 8 | 17 | 2 |
| 2016 | 12 | 26 | 6 |
| 2017 | 4 | 18 | 3 |
| 2018 | 6 | 18 | 6 |
| 2019 | 13 | 24 | 2 |
| 2020 | 6 | 15 | 7 |
| 2021 | 4 | 14 | 13 |
| 2022 | 5 | 14 | 20 |
| 2023 | 1 | 11 | 13 |
| 2024 | 7 | 8 | 10 |

Source: ABS, Causes of Death, 2024.

## State and territory trends

Disaggregated statistics for states and territories are not consistently available pre-2000s. Figures below show data from 2001 onwards.[2]

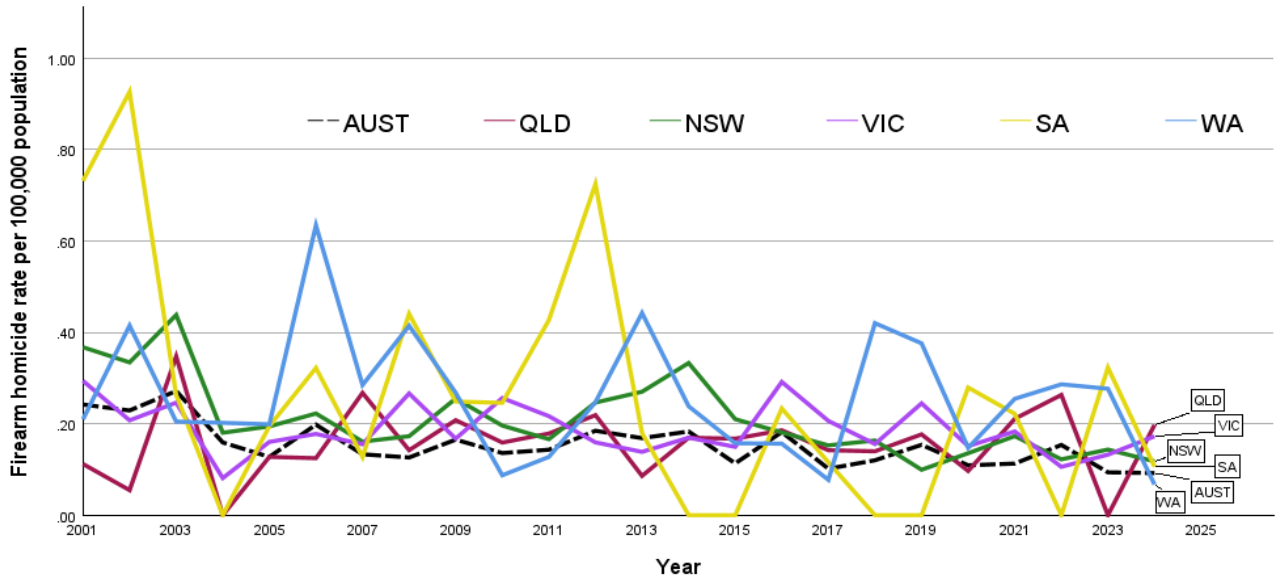
Figure 2 shows rates of firearm homicide (A) and non-firearm homicide (B) for Australian jurisdictions. Firearm homicide rates for Tasmania, the Northern Territory, and the Australian Capital Territory are not shown due to extremely small sample sizes (typically fewer than five cases per year and with many years recording zero firearm homicides). Non-firearm homicide rates are also not shown for those jurisdictions due to small sample sizes.

Queensland has had long-term firearm and non-firearm homicide rates that fluctuate around the national average. Note that the small number of homicides per year mean that rates can appear to vary substantially from year to year, even though overall numbers remain low.

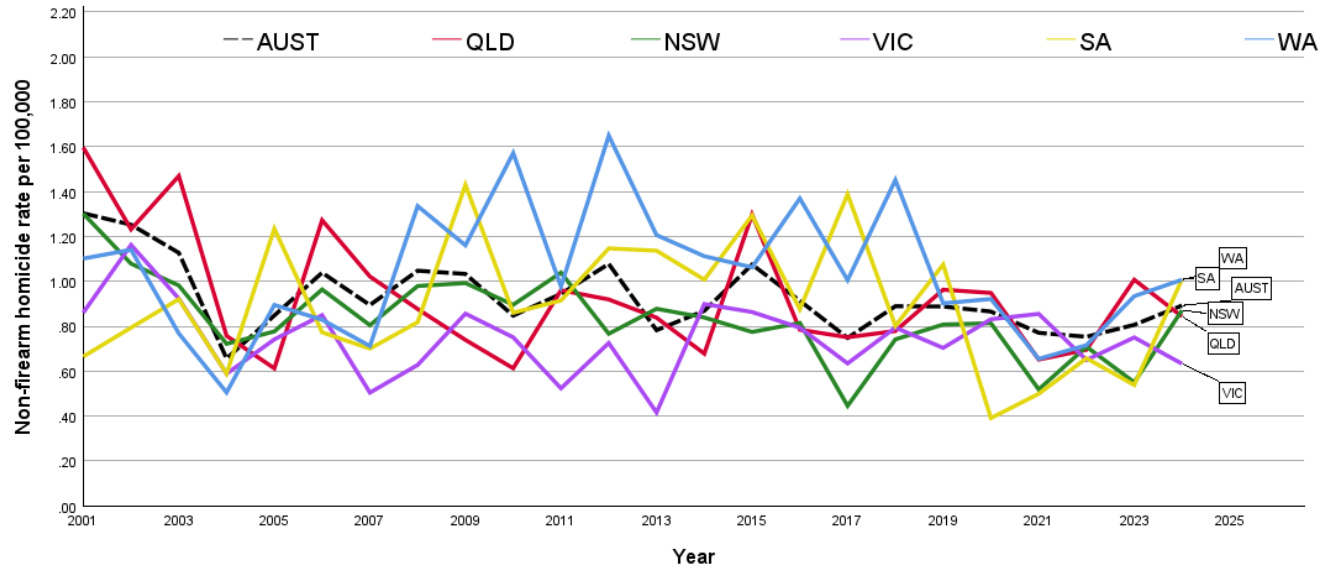
[2] ABS Causes of Death data for assault with a firearm, given the very small cell sizes, is presented by male, female, and total persons, with cell numbers randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals. In some instances, this means that the total persons figures given by the ABS are less than the total figures for males plus females. In these instances, the figure presented throughout this report is the higher of the two. That is, if total persons equals 7 but males plus females equals 8, the figure used is 8. If the total persons figure equals 8, but males plus females equals 7, the figure used is 8. Caution should be applied, however overall trends over time are unlikely to be affected.

Figure 2: Firearm and non-firearm homicide rates by jurisdiction

(A)




(B)




Source: ABS, Causes of Death, multiple years.

## Queensland – firearm and total homicide numbers

Table 3 shows the number of firearm and total homicides in Queensland.

Table 3: Queensland firearm and total homicide numbers

| Year | Firearm homicide number | Total homicide number | Firearm homicide % |
|---|---|---|---|
| 2001 | 4 | 61 | 6.6 |
| 2002 | 2 | 47 | 4.3 |
| 2003 | 13 | 68 | 19.1 |
| 2004 | 0 | 29 | 0.0 |
| 2005 | 5 | 29 | 17.2 |
| 2006 | 5 | 56 | 8.9 |
| 2007 | 11 | 53 | 20.8 |
| 2008 | 6 | 43 | 14.0 |
| 2009 | 9 | 41 | 22.0 |
| 2010 | 7 | 34 | 20.6 |
| 2011 | 8 | 51 | 15.7 |
| 2012 | 10 | 52 | 19.2 |
| 2013 | 4 | 43 | 9.3 |
| 2014 | 8 | 40 | 20.0 |
| 2015 | 8 | 70 | 11.4 |
| 2016 | 9 | 47 | 19.1 |
| 2017 | 7 | 44 | 15.9 |
| 2018 | 7 | 46 | 15.2 |
| 2019 | 9 | 58 | 15.5 |
| 2020 | 5 | 54 | 9.3 |
| 2021 | 11 | 45 | 24.4 |
| 2022 | 14 | 51 | 27.5 |
| 2023 | 0 | 55 | 0.0 |
| 2024 | 11 | 58 | 19.0 |

Source: ABS, Causes of Death, multiple years.

## Firearm use in domestic and family violence related homicides

Since 2014, the Australian Bureau of Statistics has been gathering data about victim-offender relationship in various crimes, along with weapon use. Table 4 shows firearm use in domestic and family violence (DFV) related homicides in various jurisdictions (not all are given in ABS data), from 2014 to 2024.

Figures should be viewed with caution, as data collection and reporting may not be consistent over time and reported figures may be an undercount. With that noted, Queensland appears to have had very few firearm-related DFV homicides over the past decade.

Table 4: Domestic and family violence related homicides[3]

| | QLD | | NSW | | VIC | | SA | | WA | |
|---|---|---|---|---|---|---|---|---|---|---|
| Year | Total DFV deaths | Firearm DFV deaths | Total DFV deaths | Firearm DFV deaths | Total DFV deaths | Firearm DFV deaths | Total DFV deaths | Firearm DFV deaths | Total DFV deaths | Firearm DFV deaths |
| 2014 | 46 | 4 | 48 | 9 | 37 | 3 | 14 | 0 | 11 | 0 |
| 2015 | 35 | 0 | 32 | 10 | 42 | 0 | 13 | 0 | 17 | 0 |
| 2016 | 37 | 3 | 43 | 4 | 40 | 3 | 16 | 3 | 37 | 0 |
| 2017 | 27 | 3 | 28 | 3 | 35 | 4 | 22 | 0 | 13 | 0 |
| 2018 | 20 | 0 | 37 | 4 | 33 | 0 | 12 | 0 | 38 | 6 |
| 2019 | 20 | 0 | 38 | 3 | 36 | 0 | 14 | 3 | 12 | 0 |
| 2020 | 28 | 0 | 38 | 3 | 35 | 3 | 12 | 0 | 28 | 3 |
| 2021 | 8 | 0 | 26 | 3 | 32 | 3 | 14 | 0 | 12 | 0 |
| 2022 | 29 | 0 | 29 | 0 | 28 | 0 | 15 | 0 | 18 | 0 |
| 2023 | 41 | 0 | 44 | 8 | 31 | 0 | 12 | 6 | 18 | 0 |
| 2024 | 43 | 0 | 47 | 0 | 37 | 0 | 11 | 0 | 22 | 0 |

Source: ABS, Recorded Crime – Victims, multiple years.

## Legal status of firearms used in suicide and homicide

There is no up to date information available about licensing and registration status of homicide offenders and firearms used in homicides. Information that has previously been published as part of the AIC NHMP consistently indicated that the majority of firearms used to commit homicide were unregistered and the perpetrators unlicenced.

Information about the legal status of firearms used in homicide (i.e., whether registered) and the licence status of perpetrators (whether they did or did not hold a current, valid firearms licence) is no longer routinely published by the AIC. Recent anecdotal information about firearm misuse, in the form of statements made by police to the media, is consistent with past observations however cannot be taken as definitive.

## Licence revocations – Queensland

Information about the number of licence applications refused, or issued licences suspended or cancelled per year in Queensland is not available. However, information released to the Queensland Parliament in various years provides partial data (Tables 5 to 8). When information is available about reasons for revocation is given, it suggests that most licences are revoked due to domestic violence or mental health concerns. While caution should be applied, particularly given the dated nature of the information, this suggests that 'fit and proper person' legislation is applied on an ongoing basis.

[3] Victims of selected offences have been determined to be DFV related where the relationship of offender to victim, as stored on police recording systems, falls within a specified family or domestic relationship, or where an DFV flag has been recorded, following a police investigation. Homicide and related offences includes murder, attempted murder and manslaughter. Excludes driving causing death. There are differences in the way that relationship of offender to victim is recorded across the states and territories. Relationship of offender to victim data not published for Western Australia. Queensland data may be understated. Includes victims for whom the selected characteristics were not specified.

Table 5: Reasons for concealable firearm licence cancellation during 2009-2010

| | Number of revocations |
|---|---|
| Domestic violence | 19 |
| Weapons offence | 2 |
| Drug offence | 2 |
| Court disqualified | 1 |
| Mental health | 7 |
| Violence offence | 1 |
| Condition breach | 1 |
| Public interest (may include persons sentenced to a term of imprisonment) | 5 |

Source: Parliament of Queensland 2010 QoN 2405.

Table 6: Reasons for all licence type revocations – 2006-2010

| | Calendar year | | | | |
|---|---|---|---|---|---|
| | 2006 | 2007 | 2008 | 2009 | 2010 |
| Weapon offence | 19 | 16 | 17 | 16 | 19 |
| Violence or threatening violence (not including due to issuing of DVO) | 57 | 31 | 34 | 31 | 16 |
| Total revocations | 525 | 452 | 296 | 272 | 250 |

Source: Parliament of Queensland 2010 QoN 1923.

Table 7: Reasons for all licence type suspensions/revocations – 2010 and 2011

| | 2010 | | 2011 | |
|---|---|---|---|---|
| | Suspensions | Revocations | Suspensions | Revocations |
| Domestic violence | Not available | 128 | Not available | 170 |
| Mental health | 143 | 60 | 112 | 94 |
| Drugs | 19 | 11 | 45 | 17 |
| Violence | 40 | 22 | 39 | 20 |
| Weapons | 9 | 17 | 42 | 16 |
| Public interest | 9 | 44 | 21 | 56 |
| Total | 220 | 282 | 259 | 373 |

Source: Parliament of Queensland 2012 QoN 618.

Table 8: Reasons for all licence type suspensions/revocations – 2012-2016

| Year | Suspension cases | Revocation cases | Total |
|---|---|---|---|
| 2012 | 416 | 286 | 702 |
| 2013 | 416 | 359 | 775 |
| 2014 | 500 | 420 | 920 |
| 2015 | 563 | 545 | 1108 |
| 2016 | 562 | 556 | 1118 |

Source: Parliament of Queensland 2017 QoN 148.

Parliament of Queensland 2019 QoN 808 indicated that between 2017 and 2019 there was a total of 2863 suspension/revocation cases. While it appears that suspensions/cancellations rose from 2012 to 2019, this does not necessarily indicate an increasing 'problem' in the form of, for example, more violence or mental health concerns among licence holders. Rather, it may reflect changing laws,

changing policies, changes in how laws/policies are interpreted and applied, or other administrative matters.

## Characteristics of firearm homicide perpetrators

There has been relatively little research into the characteristics of Australian firearm homicide offenders – for example, their backgrounds, socioeconomic circumstances, and the like. However, a small amount of evidence shows that the use of firearms to perpetrate homicide often involves younger (aged under 30) males in urban areas.[4] This aligns with the general profile of homicide offenders and homicide incidents in Australia, regardless of method.[5]

Homicide offenders are typically male. In 2023–24[6] 87 per cent (n=242) of all Australian homicide offenders were male and 13 per cent (n=36) were female. Homicide victims are also generally male. n 2023–24, there were 179 male (65%) and 98 female victims (35%) of homicide.

Homicide offenders (regardless of method used) tend to differ from the general population on a range of characteristics. For instance, homicide offenders are more likely than the general population to have a criminal history. The most recent data from the NHMP indicates that, where information was available, 57 per cent (n=138) of all male offenders and 53 per cent (n=19) of all female homicide offenders had a criminal history. Male domestic homicide offenders (62%, n=45) were more likely to have a criminal history compared with male stranger homicide offenders (57%, n=21) and male acquaintance homicide offenders (49%, n=32)

Data within the Australian Homicide Project, which is based on Australia-wide interviews with over 300 convicted homicide offenders suggests that relative to other methods, males who use firearms (the female sample was too low to enable analysis) are broadly similar to non-firearm homicide offenders on self-reported characteristics such as demographics, socioeconomics (e.g., unemployment, education level), alcohol and drug problems, past criminal history (including contact with the criminal justice system in the year prior to the homicide), threats of suicide/suicidal behaviours in the 12 months prior to the offence, and psychiatric diagnoses. However, self-reports may not be accurate, and should be viewed with caution. In addition, the sample size of firearm homicide offenders was relatively small (n=44) and may not be representative of firearm homicide offenders overall.

Nevertheless, the data suggests that rather than being a distinctive ‘type’ of offender, Australian firearm homicide offenders tend to resemble homicide offenders overall. This is consistent with a selection of international studies.

[4] Negin, J., Bell, J., Ivancic, L., Alpers, P., & Nassar, N. (2021). Gun violence in Australia, 2002-2016: a cohort study. *The Medical Journal of Australia*, *215*(9), 414–420.
[5] E.g., Miles, H., & Bricknell, S. (2025). *Homicide in Australia 2023–24: Statistical Report 52*. Australian Institute of Criminology: Canberra.
[6] Miles, H., & Bricknell, S. (2025). *Homicide in Australia 2023–24: Statistical Report 52*. Australian Institute of Criminology: Canberra.

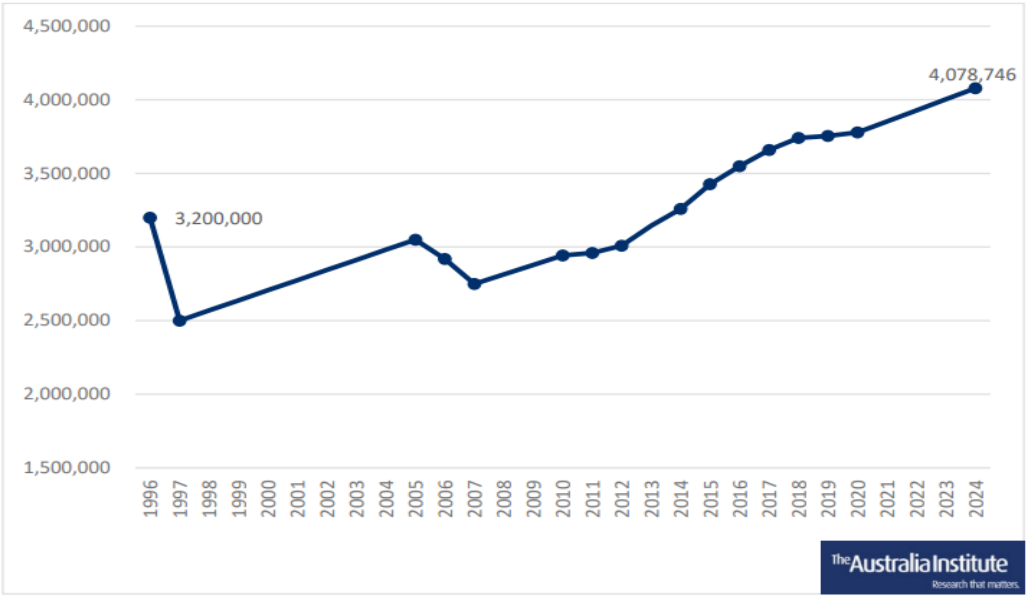
## Section 2: Legal firearm ownership and firearm violence

The apparent growth in legal firearm ownership has received recent attention. For example, it is often stated that there are now more guns in Australia than there were before Port Arthur. This has driven calls to impose numerical limits on the number of firearms a licensed individual may possess. The Bill does not include any caps on gun numbers. It is appropriate to consider whether this measure should be included and whether it would be likely to reduce firearm violence.

Although reliable pre-1996 statistics are not available, piecemeal data from that time (for example, based on self-reported survey data and limited police statistics) suggests there were roughly three million firearms owned before 1996. That number now exceeds four million, according to estimates made by the Australia Institute and based on state and territory registry information. Numbers should be viewed with caution however it is apparent that there has been a relatively steady upwards trend over time (Figure 3).

In addition to the increase in registered firearms, firearm licence numbers have been steadily increasing. Again, pre-1996 figures are not available and not all states release historic or current information. However, in New South Wales for instance, there were 180,663 licences in 2001, rising to just under 260,000 in 2025. In Queensland, there were around 150,000 licences in 2010, rising to approximately 210,000 licenced individuals at the time of writing.

Figure 3: Estimated number of registered firearms in Australia




Source: The Australia Institute, Australian gun control.

Recent national debate has drawn attention to the number of legally owned firearms in Australia, and it has been suggested that fewer firearms in the community will lead to increased community safety. This reflects the assumption that ‘more guns equals more gun misuse, and less guns equals less gun misuse’. That assumption was frequently articulated in Australia during the 1980s and 1990s (for example, within the 1990 National Committee on Violence report ‘Violence: Directions for Australia’). It formed the basis for many elements of the 1996 National Firearms Agreement (NFA), following the Port Arthur massacre.

Internationally, some studies have found positive correlations between levels of firearms ownership and firearm misuse (more guns, more gun misuse), others have found little or no evidence of a relationship, and still others have suggested an inverse relationship between firearms ownership and gun crime (more guns, less gun misuse). However, these studies are generally from the United States and should not be extrapolated to the Australian context.

In the 1980s and 1990s, based on the data that was available in Australia at the time, it was reasonable to assume that there was a positive relationship whereby as firearm ownership increased, so too did firearm misuse. However, we now have the benefit of close to 30 years of post-NFA data to evaluate whether this assumption is correct.

Australian data shows that as legal firearm ownership has *increased* in Australia, relevant indicators of firearm misuse have *decreased*.[7] This does not imply that one causes the other. It simply suggests that there is little, if any, relationship between levels of legal firearm ownership in Australia, and firearm misuse. In other words, the increased number of legally owned firearms in Australia does not appear to relate to an increased occurrence of firearm violence.

There is no available evidence to suggest that the number of firearms an individual legally owns relates to any risk that individual may pose of firearm misuse. It is clear from the evidence that is now available that the assumption that the number of legally held firearms relates to the level of firearm misuse, has not been borne out.

**Implication: There is likely to be little, if any, public safety benefit to be gained from imposing numerical limits on lawful possession.**

**Mass shootings**

It is often suggested that prohibiting certain types of firearms in response to the 1996 Port Arthur massacre has prevented (or greatly reduced) mass shootings. This, in turn, has driven recent calls to place further prohibitions on certain types of firearms. The Bill does not do this. It is therefore appropriate to consider whether there is a relationship between firearm type and mass shooting events.

Analysis of past mass shooting events indicates considerable variation in terms of the type of firearm/s used (ranging from single shot .22 rifles through to semi-automatic firearms), and whether the firearms were legally owned. Typically, one or two firearms were used. Based on existing evidence, it is reasonable to say that any type of firearm can be used to commit a mass shooting and that perpetrators may or may not hold a licence.

Mass shootings (defined as incidents where four or more people are killed, not including the perpetrator) have always been extremely rare events in Australia - as is mass murder more generally. Their rarity means that it is very challenging to conduct rigorous statistical analysis. Existing attempts to do so suffer from a range of additional limitations; chiefly, they fail to consider long-term data *prior* to 1996 and instead look at only a relatively short period of pre-1996 data (such as from 1979 onwards). They also fail to consider the 'clustering' of mass shootings around a specific period of years, and instead take broad averages.

When longer-term pre-1996 data is considered, it becomes apparent that most mass shootings – nine out of 13 – were clustered within a short period of time. They occurred between 1987 and 1996. Australia's well known public place mass shootings (Hoddle Street, Queen Street, Strathfield Plaza, Port Arthur) all occurred in that period. From 1964 to 1986 (a 22 year period), there were three mass shootings. In the 28 year post-Port Arthur period 1997-2025, there have been four mass shootings

[7] Although not discussed in this submission, this is also true of firearm suicide.

(Lockhart (2014), Osmington (2018), Darwin (2019), Bondi (2025)). Two of these have been public place events.

The data suggests that the years between 1987-1996 were an anomaly. Given the widespread and relatively permissive nature of gun ownership prior to that time, it is unclear why mass shootings were not common during the 1960s and 1970s. It is also unclear why there was a sudden cluster of mass shooting events in the mid-1980s to mid-1990s – in other words, we do not know what 'started' them. Without this knowledge, although it is simple to say that banning certain firearm types 'stopped' mass shootings, this is an unsupported conclusion.

## Illegal gun ownership in Australia

By its very nature, the number of illegally held firearms in Australia is unknown. Estimates range from around 260,000 (Australian Criminal Intelligence Commission estimates) up to around 6 million (based on historic import, sales, and police data, combined with 1996 buyback data). It is not unreasonable to suggest that the truth is likely to rest somewhere between those two estimates, however there is no way of accurately knowing the true size of the illicit firearms pool.

There are multiple sources of illegal firearms in Australia. These include firearms that were not handed in as part of the buyback scheme in 1996, theft from legal sources (such as owners or dealers), illegal manufacture (including 3D printing) and illegal import. Information about sources of firearms used in crimes is not routinely released, however past publications suggest that theft from legal owners represents a relatively small percentage of firearms recovered against crimes.[8]

## Non-lethal firearm violence and other issues

As already shown above, firearm homicide has declined over the past decades. Additional indicators of firearm misuse have also shown downwards trends.

*Armed robbery with a firearm - Australia*

Table 9 shows national armed robbery numbers by weapon type. Table 10 shows weapon use in armed robbery as a percentage of total.

[8] See for example Chapter 3 of the final report of the Senate Inquiry 'The ability of Australian law enforcement authorities to eliminate gun-related violence in the community', tabled in 2015.

Table 9: Armed robbery – weapon numbers[9]

| Year | Firearm | Other weapon (total) | Knife | Syringe | Bottle/ glass | Bat/bar/ club | Other | Weapon n.f.d. |
|---|---|---|---|---|---|---|---|---|
| 2010 | 1035 | 4142 | 2687 | 138 | 179 | 407 | 729 | 523 |
| 2011 | 987 | 4392 | 2952 | 147 | 144 | 277 | 871 | 598 |
| 2012 | 1097 | 4441 | 2946 | 134 | 122 | 372 | 863 | 696 |
| 2013 | 903 | 4106 | 2633 | 126 | 81 | 282 | 984 | 624 |
| 2014 | 795 | 3333 | 2317 | 75 | 75 | 274 | 176 | 729 |
| 2015 | 601 | 2968 | 1989 | 62 | 64 | 255 | 364 | 1090 |
| 2016 | 646 | 3239 | 2075 | 61 | 62 | 326 | 469 | 1107 |
| 2017 | 579 | 3206 | 2096 | 61 | 61 | 306 | 415 | 978 |
| 2018 | 619 | 3304 | 2137 | 59 | 52 | 316 | 426 | 997 |
| 2019 | 670 | 3903 | 2650 | 39 | 61 | 334 | 485 | 1223 |
| 2020 | 441 | 3368 | 2292 | 30 | 39 | 281 | 435 | 942 |
| 2021 | 528 | 3253 | 2089 | 42 | 52 | 203 | 596 | 606 |
| 2022 | 476 | 3594 | 2233 | 24 | 76 | 218 | 704 | 639 |
| 2023 | 537 | 4130 | 2573 | 23 | 76 | 202 | 827 | 878 |

Source: ABS, Recorded Crime – Victims, 2024.

Table 10: Armed robbery – weapon proportions (%)[10]

| Year | Firearm | Other weapon (total) | Knife | Syringe | Bottle/ glass | Bat/bar/ club | Other | Weapon n.f.d. |
|---|---|---|---|---|---|---|---|---|
| 2010 | 7.1 | 28.3 | 18.4 | 0.9 | 1.2 | 2.8 | 5 | 3.6 |
| 2011 | 7.2 | 32.2 | 21.6 | 1.1 | 1.1 | 2 | 6.4 | 4.4 |
| 2012 | 8.3 | 33.7 | 22.4 | 1 | 0.9 | 2.8 | 6.6 | 5.3 |
| 2013 | 7.7 | 35.1 | 22.5 | 1.1 | 0.7 | 2.4 | 8.4 | 5.3 |
| 2014 | 8 | 33.7 | 23.4 | 0.8 | 0.8 | 2.8 | 1.8 | 7.4 |
| 2015 | 6.7 | 33.1 | 22.2 | 0.7 | 0.7 | 2.8 | 4.1 | 12.2 |
| 2016 | 6.9 | 34.4 | 22 | 0.6 | 0.7 | 3.5 | 5 | 11.8 |
| 2017 | 6 | 33.4 | 21.9 | 0.6 | 0.6 | 3.2 | 4.3 | 10.2 |
| 2018 | 6.1 | 32.6 | 21.1 | 0.6 | 0.5 | 3.1 | 4.2 | 9.8 |
| 2019 | 5.7 | 33.1 | 22.5 | 0.3 | 0.5 | 2.8 | 4.1 | 10.4 |
| 2020 | 4.7 | 35.8 | 24.4 | 0.3 | 0.4 | 3 | 4.6 | 10 |
| 2021 | 5.8 | 35.6 | 22.9 | 0.5 | 0.6 | 2.2 | 6.5 | 6.6 |
| 2022 | 5 | 37.5 | 23.3 | 0.3 | 0.8 | 2.3 | 7.3 | 6.7 |
| 2023 | 4.8 | 36.7 | 22.9 | 0.2 | 0.7 | 1.8 | 7.3 | 7.8 |

Source: ABS, Recorded Crime – Victims, 2024.

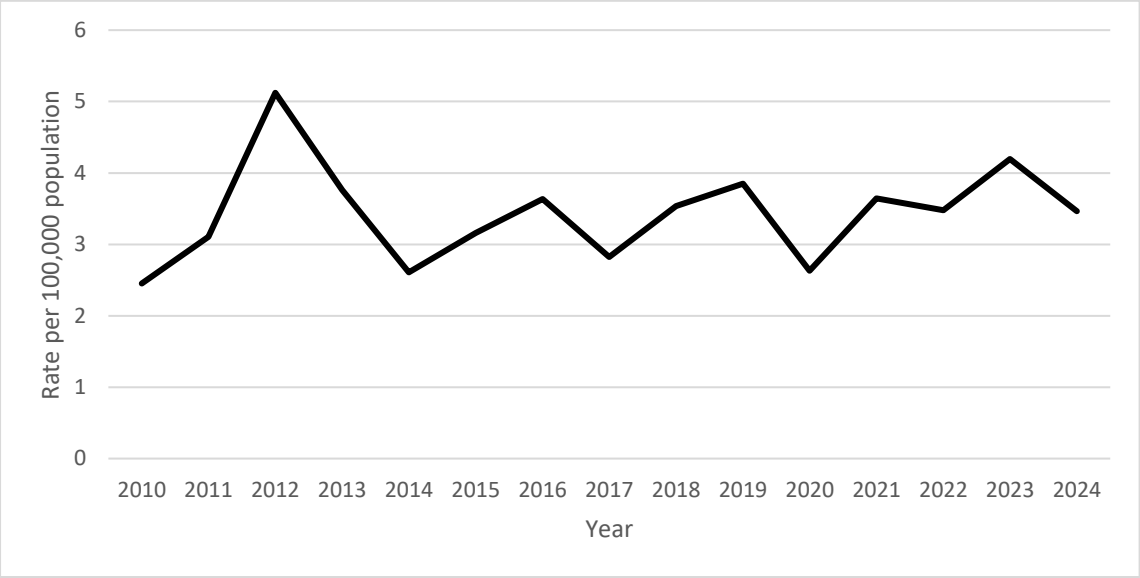
[9] Data prior to 2019 may not be comparable due to South Australia system changes; Weapon used data for Queensland overstated prior to 2020; 2023 data for Northern Territory and Tasmania revised; n.f.d indicates not further disclosed

[10] As for note 9.

*Armed robbery with a firearm – Queensland*

Figure 4 shows rates of armed robbery with a firearm in Queensland, over time. Rates have been relatively stable.

Figure 4: Armed robbery with a firearm - Queensland




Source: ABS, Victims of Crime, multiple years.

*Firearm theft*

Firearm theft figures are not routinely publicly released and the available statistics should be viewed with caution. However, estimates provided by the Australia Institute (Figure 5) suggest that firearm theft has followed an irregular pattern over time, characterised by an increase until around 2015-16, then decline.

Figure 5: Firearm theft in Australia

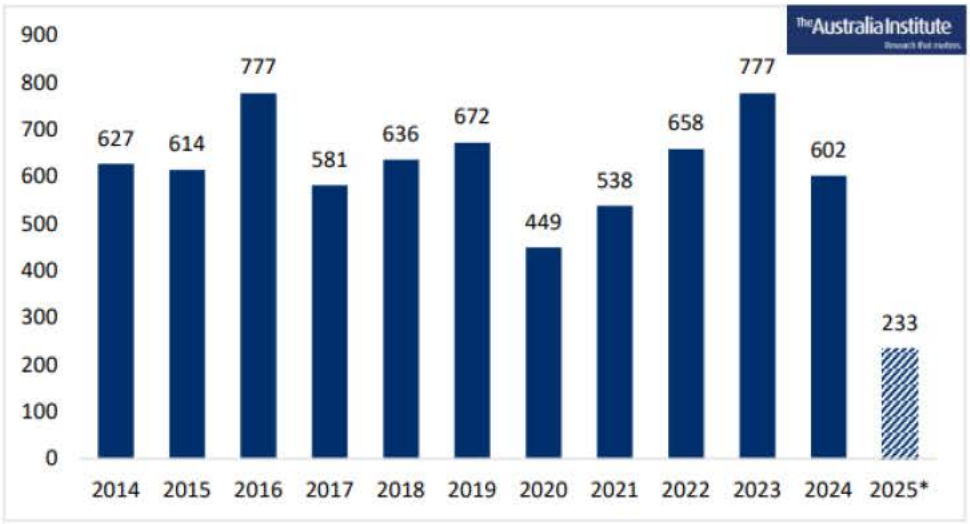

Source: See Appendix
Note: Totals for 2009-10, 2010-11 and 2011-12 do not include South Australia, and totals for 2019-2025 do not include the Northern Territory.
* 2024 excludes three quarters in Western Australia where the number of firearms stolen was not reported.
† 2004-2012 figures use financial years, and 2018 to 2024 figures use calendar years. From 2012 to 2017, the type of year used varies by jurisdiction (details in the Appendix)

Source: The Australia Institute, Firearm theft in Australia.

There are discrepancies between the data provided by the Australia Institute, and other information sources. For example, the Australia Institute cites 636 stolen firearms in Queensland for 2018, whereas Queensland Police Service data released under Right to Information states that 611 firearms were stolen in that year. As such, while it appears reasonable to conclude that firearm theft has been declining since around the 2015/2016 period, it is not clear exactly what figures are applicable.

Queensland figures are shown below (Figure 6). Some years are estimates only and should be viewed with great caution. However, it appears that firearm theft in Queensland has been relatively stable over the past decade, despite increases in legal ownership.

Figure 6: Firearm theft in Queensland



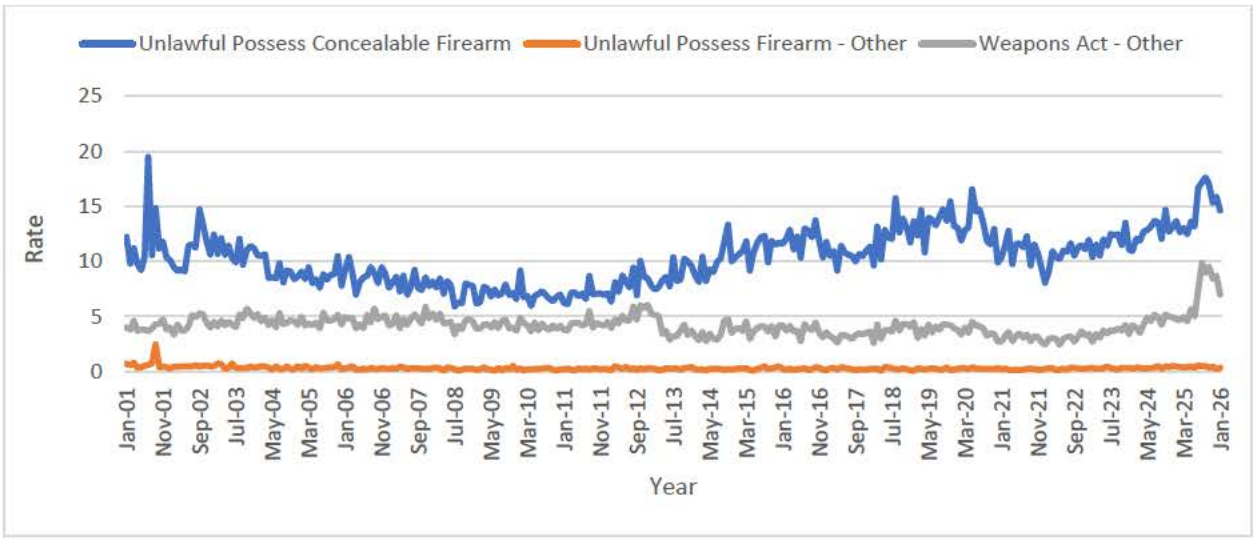

Source: Queensland Police Statistical Services; Ryan (2018) "Gun theft at its lowest in four years", https://statements.qld.gov.au/statements/83807
*Note: 2025 data is only for the period from January to May.

Source: Australia Institute, Firearm theft in Australia.

*Weapons Act offences*

Figure 7 shows various Weapons Act offences. There has been growth in unlawful possession of concealable firearm offences over time. This may reflect an increase in enforcement efforts (better detection of unlawful possession), a real increase in unlawful possession, or both. It is noteworthy that unlawful possession of a concealable firearm offences have increased, while indicators of firearm misuse (such as homicide, robbery, and theft) have not.

Figure 7: Weapons Act offences




Source: Queensland Police Service, Queensland Crime Statistics.

## Section 3: Predictors and correlates of firearm violence

**Is mental illness associated with violence?**

In response to the Wieambilla shootings, the State Coroner recommended that the Queensland Government review the feasibility of introducing mandatory mental health assessments for all firearm licence holders (similar to the model recently introduced in Western Australia). The Bill does not do this. It is therefore appropriate to consider whether mental illness is associated with violence, and relationships between mental illness and firearm violence in particular. It is also appropriate to consider what types of indicators may be most useful in assessing an individual's likelihood of committing violence (whether with a firearm or some other method).

There is a pervasive public perception (including among specific groups such as police[11]) that mental illness is associated with interpersonal violence. This is a misperception. The overwhelming majority of people with mental illness do not engage in violence.[12] If they do, it is more likely to be towards themselves than others. In addition, people with mental illness are more likely to be victims of violence than perpetrators.[13]

Large epidemiologic studies of community-representative samples report that mental illnesses only moderately increase the relative risk of any violence. Importantly, even though a person with mental illness may have a modestly higher likelihood of committing violence *relative* to a person without mental illness, the *absolute* risk remains low – in other words, the vast majority of people with diagnosable serious psychiatric disorders do not commit violence.[14]

Misperceptions about violence and mental illness also extend to misunderstandings and unrealistic expectations about what mental health professionals can and cannot do. It is unreasonable to expect mental health professionals to be able to predict future violence in general – let alone homicide, which is virtually impossible to predict. Attempts to predict future violence are highly inaccurate. For instance, a study of psychiatrists at a major urban psychiatric facility found that around 30 per cent of the time highly experienced practitioners were unable to correctly predict patients who would become violent to others on the basis of clinical judgment. The only reliable predictors of violence were a history of violence and a current threat to commit violence.[15]

More recent research supports the finding that threats to commit violence are a better predictor of imminent risk than specific psychiatric disorders. However, violence in the more distant future is not as easily predicted. There appears to be little long-term predictive utility of simply having a mental illness. Accumulated research suggests that the best long-term predictor of future violence is a history of violence, not mental illness.

In extremely rare instances, people with serious mental illness do commit acts of extreme violence. While victims of homicide by a person with mental illness are generally people they know (such as family members), homicides involving strangers tend to garner substantial attention. These are exceptionally rare events; for example, there were 18 cases of stranger homicide by patients with a psychotic illness in New South Wales between 1991 and 2005. The rate of stranger homicides committed by people diagnosed as having either schizophrenia or psychosis based on pooled studies

[11] Morabito, M., & Socia, K.M. (2015). Is dangerousness a myth? Injuries and police encounters with people with mental illnesses. *Criminology and Public Policy*, 14, 253-276; Watson, A. C., Corrigan, P. W., & Ottati, V. (2004). Police officers' attitudes toward and decisions about persons with mental illness. *Psychiatric Services*, 55(1), 49–53.
[12] Rueve, M. E., & Welton, R. S. (2008). Violence and mental illness. *Psychiatry*, 5(5), 34–48.
[13] Choe, J.Y., Teplin, L.A., & Abram, K.M. (2008). Perpetration of violence, violent victimization, and severe mental illness: balancing public health concerns. *Psychiatric Services*, 59(2), 153–64.
[14] Swanson, J. W., McGinty, E. E., Fazel, S., & Mays, V. M. (2015). Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Annals of Epidemiology*, 25(5), 366–376
[15] Convit, A., Jaeger, J., Lin, S. P., & Volavka, J. (1989). Predictions of assaultive behaviour in psychiatric inpatients: Is it possible? In D. A. Brizer & M. Crowner (Eds.), *Current approaches to the prediction of violence* (pp. 35– 62). American Psychiatric Press: Washington, DC.

from a range of countries including Australia, has been calculated at around one per 14.3 million people per year.[16]

Despite their rarity, homicides committed by people with mental illness (particularly, stranger homicides) often result in sensationalised media reports. These contribute to misunderstandings about mental illness and violence and overestimation of the association. This can exaggerate the risk of violence by people with mental illness and lead to 'blame' being placed on mental illness and/or the mental health system or mental health workers. Perceptions that the mentally ill are dangerous can also stigmatise mental illness, and people living with mental illness.[17]

Knowledge about relationships between mental illness and violence has progressed greatly in recent years. Some studies, especially throughout the 1990s and early 2000s, suggested a significant association between mental illness and interpersonal violence, typically finding that the risk of violence was higher among individuals with diagnosable psychosis, bipolar disorder, or major depression relative to those without. However, a growing number of studies show that associations between mental illness and violence typically reduce greatly, or disappear entirely, when factors such as substance misuse and past criminal behaviour/violence are taken into account.

## The role of substance use, past behaviours, and life circumstances

The literature on risk factors for violence indicates that certain characteristics of an individual, including prior violence and criminal involvement, are much more statistically predictive of involvement in future violence than the presence of a mental illness. The power of mental illness as a predictor diminishes greatly when these characteristics are taken into account.[18]

Substance misuse is an important contributor to violence, with or without the presence of mental illness. For example, in the Unites States, where most research has been conducted, the National Epidemiological Survey on Alcohol and Related Conditions (NESARC), involving 34,000 subjects living in the community, found that the incidence of violence was higher for persons with a severe mental illness but only for those with co-occurring substance abuse or dependence. The highest risk occurred for dual diagnosed individuals with a history of past violence.[19] The NESARC study also showed that severe mental illness was not on its own associated with an enhanced risk of committing severe violence, such as by misusing a firearm.

New South Wales data shows that between 1993 and 2016, a total of 2159 homicide offenders were dealt with by the NSW courts, including 169 (7.8%) who were found not guilty due to mental illness. Nearly all of those (88.7%) had a schizophrenia-related psychosis. However, there were high rates of psychiatric comorbidity including substance use disorder (60.7%) and a history of a prior head injury (41.1%). Most (83.4%) had previous contact with mental health services, but only half of these had received treatment with antipsychotic medication.[20]

Australian data shows that in 2023-24 the majority of homicide offenders had a criminal history. When disaggregated by sex, more male homicide offenders (57%) had a criminal history, relative to female

[16] Nielssen, O., Bourget, D., Laajasalo, T., Liem, M., Labelle, A., Häkkänen-Nyholm, H., Koenraadt, F., & Large, M. M. (2011). Homicide of strangers by people with a psychotic illness. *Schizophrenia Bulletin*, 37(3), 572–579.
[17] Pescosolido, B. A., Manago, B., & Monahan, J. (2019). Evolving Public Views On The Likelihood Of Violence From People With Mental Illness: Stigma And Its Consequences. *Health Affairs*, 38(10), 1735–1743.
[18] E.g., Skeem, J. L., Winter, E., Kennealy, P. J., Louden, J. E., & Tatar, J. R. (2014). Offenders with mental illness have criminogenic needs, too: toward recidivism reduction. *Law and Human Behavior*, 38(3), 212–224.
[19] Price, M., & Norris, D. (2010). Firearms laws: A primer for psychiatrists. *Harvard Review of Psychiatry*, 18(4), 326–335.
[20] Nielssen, O., Lyons, G., Oldfield, K., Johnson, A., Dean, K., & Large, M. (2022). Rates of homicide and homicide associated with severe mental illness in NSW between 1993 and 2016. *The Australian and New Zealand Journal of Psychiatry*, 56(7), 836–843.

homicide offenders (53%).[21] [22] Where information was available, male domestic homicide offenders (62%, n=45) were more likely to have a criminal history compared with male stranger homicide offenders (57%, n=21) and male acquaintance homicide offenders (49%, n=32).

Early Australian studies suggest that less than five per cent of homicide offenders had mental illness.[23] The most recent available data shows that in 2020-2021, around 13% of Australian homicide offenders (n= 26) were known to have a mental health condition at the time of the homicide. Most offenders (n=24) had a condition other than depression, but further information was not given.[24] For example, substance use disorder is a recognised mental illness, which may account for some of those individuals[25]. Homicides by people with mental illness were not disaggregated by weapons type so there is no way of knowing whether any of those offenders used a firearm (and, if so, whether they held a licence).[26]

Other Australian studies show that a high proportion of homicide offenders have alcohol/drug problems prior to the offence.[27] Contextual (e.g., homelessness) and historical (e.g., past violence) factors also increase the risk of violence among the mentally ill (just as they do among people without mental illness).[28] Violent crimes attributed to mental illness are often associated with socioeconomic factors like unemployment, history of trauma, lack of access to care, food insecurity, and insecure housing.[29] Australian research has found that stranger homicides during psychotic illness were more likely to be committed by homeless people, people with a history of conduct disorder, and with adult antisocial behaviour. Also, studies of violent crime and bipolar disorder show similar rates of violence among siblings who do, and do not, have bipolar disorder.[30]

Most violent incidents involving individuals with a mental illness involve either a family member or a close acquaintance and are usually characterised by a history of conflict and violent encounters. Examination of crimes involving individuals with mental illness indicates that less than 20 per cent are directly preceded by exacerbated symptoms of the illness.[31] It is rare that the presence of a mental illness 'explains' violence. Mental illness is one factor in a person's life that is sometimes relevant to violence, but it is very rarely the only factor, or a causal factor.

For example, analysis from 66 domestic homicide reviews (DHRs) in England and Wales where the victim and perpetrator were related, such as parent and adult child (intimate partner homicides were excluded) showed over half (n=35, 53.0%) of perpetrators were reported to have diagnosed mental health problems, most frequently psychotic disorders (37.9%) and mood disorders such as

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[21] Bricknell, S. (2023). *Homicide in Australia 2020-21*. Statistical report 42, Australian Institute of Criminology: Canberra.
[22] The most recent NHMP report, released in 2025, states that availability of coronial and court documents used to cross-reference data provided by state and territory police has "resulted in larger amounts of missing data on the mental health and disability status of homicide offenders... Consequently, these data are not published in this report." (p.4)
[23] Mouzos, J. (1999). *Mental Disorder & Homicide in Australia*. Trends and Issues in Crime and Criminal Justice No. 133, Australian Institute of Criminology: Canberra.
[24] Bricknell, S. (2023). *Homicide in Australia 2020-21*. Statistical report 42, Australian Institute of Criminology: Canberra.
[25] Ogilvie, J.M., Tzoumakis, S., Thompson, C., Allard, T., Dennison, S., Kisely, S., & Stewart, A. (2023). Psychiatric illness and the risk of reoffending: recurrent event analysis for an Australian birth cohort. *BMC Psychiatry*, 23, 355.
[26] Bricknell, S. (2023). *Homicide in Australia 2020-21*. Statistical report 42, Australian Institute of Criminology: Canberra.
[27] Eriksson, L., Bryant, S., McPhedran, S., Mazerolle, P., & Wortley, R. (2021). Alcohol and drug problems among Australian homicide offenders. *Addiction*, 116(3), 618–631.
[28] Berg, M. T., Krajewski, A., Lu, Y. F., & Rogers, E. M. (2025). Violence, Gun Violence, and Mental Illness in a National Sample of Incarcerated Adults. *Justice Quarterly*, 1–26. Advance online publication, 13 October 2025.
[29] Krebs, A., & Mackavey, C. (2023). Mass shootings, firearm injuries, and mental health. *Archives of Psychiatric Nursing*, 47, 16–20.
[30] Fazel, S., Lichtenstein, P., Grann, M., Goodwin, G. M., & Långström, N. (2010). Bipolar disorder and violent crime: new evidence from population-based longitudinal studies and systematic review. *Archives of General Psychiatry*, 67(9), 931–938.
[31] Peterson, J. K., Skeem, J., Kennealy, P., Bray, B., & Zvonkovic, A. (2014). How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness?. Law and Human Behavior, 38(5), 439–449.

depression (25.8%). A more common risk factor was alcohol misuse (62.1%, n=41; 38 were men) and substance misuse (60.6%, n=40; 39 men, 1 transwoman). Nearly half of perpetrators (48.5%; n=32) were described as misusing both alcohol and substances. Additionally, perpetrators were reported to lead a chaotic lifestyle; including sleeping rough and having a history of offending behaviour. Nearly all perpetrators with mental health difficulties received support for mental health (88.5%; n=46) and physical health (86.5%; n=45).

Around seven out of ten (71.2%) perpetrators had a criminal justice history.[32] Almost half of perpetrators (n=32, 48.5%) had a history of criminal offences related to domestic violence assaults, frequently of an intimate partner. Of this group, 25 (78.1%) also had alcohol misuse problems and 24 (75.0%) had substance misuse problems. Almost one-third (n=21, 31.8%) of perpetrators were involved with probation services. Most had intersecting mental health and substance misuse issues and were involved with other agencies such as mental health services or children's social care.[33]

Severe mental illness alone has not been found to be a valid or reliable predictor of future violence.[34] Violence (with or without the presence of mental illness) is extremely difficult to predict, however indicators such as substance use, past aggressive behaviour, past behavioural regulation problems, and past contact with the justice system are more reliably associated with future violence than mental illness.[35] Mental illness may interact with those factors, such as by lowering substance-induced inhibitions toward violence, but on its own has extremely limited predictive validity. Mental illnesses progress, deteriorate, stabilise, or get better with time and circumstance; they are a condition, not an indicator of a person's 'dangerousness' or propensity to engage in violence.[36]

**Implication: When factors such as problematic substance use or past violence are identified, mental health assessment can be appropriate. However, mental health assessment in the absence of other risks is unlikely to yield useful information about propensity for violence.**

**Different types of mental illness have different associations with violence**

The type of mental illness matters for violence risk. For example, studies suggest that common mood disorders such as depression and anxiety are unlikely to be associated with violence. Although studies of violent offenders and incarcerated persons find high levels of mood disorders, those conditions generally co-occur with numerous other risk factors for violence (and the mood disorders may emerge *after* violent behaviour occurs).

Some severe mental illnesses have been statistically associated with an increased risk of violence (though again, these correlations tend to diminish when substance misuse and past behaviour is taken into account). A recent systematic review indicated elevated risk of violence among people with schizophrenia spectrum disorders compared with community controls,[37] and people with psychosis

[32] Bracewell, K., Jones, C., Haines-Delmont, A., Craig, E., Duxbury, J., & Chantler, K. (2021) Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide. *Journal of Gender-Based Violence*, 6(3), 535–550.
[33] Bracewell, K., Jones, C., Haines-Delmont, A., Craig, E., Duxbury, J., & Chantler, K. (2021) Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide. *Journal of Gender-Based Violence*, 6(3), 535–550.
[34] Chappell D. (2014). Firearms regulation, violence and the mentally ill: a contemporary Antipodean appraisal. *International Journal of Law and Psychiatry*, *37*(4), 399–408.
[35] Whiting, D., Lichtenstein, P., & Fazel, S. (2021). Violence and mental disorders: a structured review of associations by individual diagnoses, risk factors, and risk assessment. *Lancet Psychiatry*, 8, 150-161.
[36] Rozel, J. S., & Mulvey, E. P. (2017). The Link Between Mental Illness and Firearm Violence: Implications for Social Policy and Clinical Practice. *Annual Review of Clinical Psychology*, 13, 445–469.
[37] Whiting, D., Gulati, G., Geddes, J. R., & Fazel, S. (2022). Association of Schizophrenia Spectrum Disorders and Violence Perpetration in Adults and Adolescents From 15 Countries: A Systematic Review and Meta-analysis. *JAMA Psychiatry*, 79(2), 120–132.

accounted for 10 per cent of all criminal convictions in New South Wales between 2001 and 2015 – an over-representation of that group.[38] Even so, serious mental illnesses generally show associations with violence that are several times weaker than those seen in more behaviourally based diagnoses, such as substance abuse or antisocial personality disorder.

There is some evidence - including from Australia - that individuals experiencing untreated first-episode psychosis could be at elevated risk for involvement in violence even when other factors are taken into account.[39] Psychosis is a mental condition in which the main feature is the presence of a delusional belief. Psychotic illnesses include schizophrenia, severe mood disorders accompanied by delusional beliefs, and other conditions that present with false beliefs, including psychosis arising from medical illnesses affecting the brain, and drug induced states. Some studies have found that among homicide offenders with psychosis, the most common reason given for lethal assault is the delusional belief that the victim was about to attack the offender.[40]

Delusional beliefs are often secondary to hallucinations (such as hearing voices) and often occur in the presence of severe disturbances in the capacity for logical thinking. Other symptoms include misinterpretation of everyday events, impaired emotional regulation, loss of volition and impairment in other areas of intellectual function. Psychotic illnesses often cause severe social disability.[41]

Symptoms such as paranoid delusions and command hallucinations rather than diagnoses per se, are more likely to be associated with violence by people with mental illness.[42] When symptoms reach a certain stage, people with psychosis very frequently come to the attention of emergency services. However, the symptoms often observed during the period between the beginning of a change and the emergence of obvious symptoms of psychosis include anxiety, irritability, depression, illogical thinking and irrational suspiciousness. Typically, the people who first notice behavioural changes in those with psychosis are family members (or others who are close to the individual, such as friends).

In the Wieambilla shootings, for example, it emerged that family members had raised concerns with police. However, family members may be unsure of what they are seeing or how to get help for their loved one, and often make multiple unsuccessful attempts to obtain support. This can be due to not knowing what to do or who to contact, or not being able to access already over-stretched support services. In some instances, the only available service is police, who are not mental health specialists.

**Implication: The people best placed to recognise early behavioural changes that may signal elevated likelihood of violence occurring (whether with firearms or more generally) are those who are closest to the individual. There may be a role for enhanced community education and support around what to do and who to contact for help, along with expanded support services for the seriously mentally ill.**

[38] Chowdhury, N. Z., Albalawi, O., Wand, H., Allnutt, S., Adily, A., Kariminia, A., Sara, G., Schofield, P. W., O'Driscoll, C., Greenberg, D. M., & Butler, T. (2020). Psychosis and Criminal Offending: A Population-Based Data-Linkage Study. *Criminal Justice and Behavior*, 48(2), 157-174.
[39] Large M.M., & Nielssen, O. (2011). Violence in first-episode psychosis: a systematic review and meta-analysis. *Schizophrenia Research*, 125(2–3), 209–20; Winsper, C., Singh, S. P., Marwaha, S., Amos, T., Lester, H., Everard, L., Jones, P., Fowler, D., Marshall, M., Lewis, S., Sharma, V., Freemantle, N., & Birchwood, M. (2013). Pathways to violent behavior during first-episode psychosis: a report from the UK National EDEN Study. *JAMA Psychiatry*, 70(12), 1287–1293.
[40] Large, M., & Nielssen, O. (2007). Treating the first episode of schizophrenia earlier will save lives. *Schizophrenia Research*, 92(1-3), 276–277.
[41] Nielssen, O., Large, M., Ryan, C., & Hayes, R. (2007). Legal implications of the increased risk of homicide and serious violence in the first episode of psychotic illness. *Criminal Law Journal*, 31, 287-294.
[42] Lurigio, A.J., & Harris, A.J. (2009). Mental Illness, Violence, and Risk Assessment: An Evidence-Based Review, *Victims and Offenders*, 4(4), 341-347.

Past contact with the mental health system is often found among mentally ill people who have committed serious violence. In New Zealand, for example, a study of 11 criminal incidents involving mental illness (six incidents of homicide, of which two were of multiple victims and one of murder-suicide; two of rape, two of armed incidents of known patients who were shot by the police and one of the release of a dangerous patient with subsequent threats and arson) found that the primary diagnosis was schizophrenia in six cases, bipolar affective disorder in two, and major depressive disorder, substance dependence and personality disorder in one case each. Six patients had a secondary diagnosis of substance dependence. At the time of the incidents, all were in contact with mental health services.[43]

In the UK, it has been found that 14 per cent of homicide perpetrators had a mental illness at the time of their offence. Eight per cent of all people committing homicides had had contact with mental health services in the year prior. Of these, 71 per cent had lost contact with mental health services. The majority had personality disorder or substance abuse disorder. Around a quarter (23%) of those with a mental illness were non-compliant with medication. Other research has found that while serious violent events are typically not predictable, many are characterised by major flaws in service delivery to people with severe mental illness, such as clinical practice errors and resource, training, policy and coordination failures.[44]

**Implication: Although serious violent offending by mentally ill offenders is rare, among offenders who do commit violence many have had past contact with the mental health system. High quality service delivery and continuity of care is vital.**

**Personality disorders and violence**

There is some evidence that certain personality disorders – particularly antisocial personality disorder (ASPD) – are associated with greater propensity for violent behaviour including homicide. It is important to understand that personality disorders are not a mental illness. Mental illness is typically viewed as 'acute' or episodic, with symptoms that come and go and that are amenable to treatment. In contrast, personality disorders refer to conditions seen as chronic and pervasive. Personality disorders may be characterised by challenging behaviours such as emotional dysregulation, hostility and aggression, non-compliance with medical/psychiatric directions, impulsivity, and risk-taking behaviours.

ASPD is an adult diagnosis characterised by a persistent pattern of disregard for and violation of others' rights, often beginning in childhood or early adolescence. Individuals often manipulate others for personal gain, lack empathy, and seldom feel remorse for their actions. They typically struggle to develop stable interpersonal relationships and may experience significant impairments in social and occupational functioning throughout their lifetime. They frequently engage in deceitful behaviour and criminal acts, including interpersonal violence (also encompassing domestic and family violence). The estimated prevalence of ASPD in the general population is around two to three per cent, but with dramatically higher prevalence among incarcerated individuals.

There is a known association between ASPD and violent crime, in part because a pattern of impulsive behaviour and criminal conduct is part of the definition of the condition. Diagnostic criteria include the presence of a pervasive pattern of disregard for and violation of the rights of others. Clinical features include failure to conform to social norms concerning lawful behaviours, such as performing acts that

[43] Simpson, A. I., Allnutt, S., & Chaplow, D. (2001). Inquiries into homicides and serious violence perpetrated by psychiatric patients in New Zealand: need for consistency of method and result analysis. *The Australian and New Zealand Journal of Psychiatry*, 35(3), 364–369.
[44] Simpson, A. I., Allnutt, S., & Chaplow, D. (2001). Inquiries into homicides and serious violence perpetrated by psychiatric patients in New Zealand: need for consistency of method and result analysis. *The Australian and New Zealand Journal of Psychiatry*, 35(3), 364–369.

are grounds for arrest; deceitfulness, repeated lying, use of aliases, or conning others for pleasure or personal profit; irritability and aggressiveness, often with physical fights or assaults; and reckless disregard for the safety of self or others. The key feature is a pattern of behaviour that persists over time – not isolated incidents.

Studies show an association between personality disorders and homicide; for example, a Swedish case linkage study found that almost 30 per cent of homicide offenders had been diagnosed with personality disorder prior to the homicide[45] and a study from the United States found that 24 per cent of homicide offenders met the criteria for the diagnosis of at least one personality disorder.[46] A study from England and Wales found that the prevalence of personality disorder in homicide perpetrators was 56.3 per cent. Severe personality disorder was present in 62 per cent (n = 338) of all those with a personality disorder and was significantly associated with homicides of strangers and previous violence.[47]

Research also suggests that personality disorders in homicide offenders are associated with a history of any conviction for violence and previous offence of possession of a weapon.[48]

**Implication: Overall, mental illness is unlikely to be a useful or accurate predictor of whether a person is likely to engage in future violence towards others. Rather than focussing on psychiatric diagnoses as a potential indicator of propensity for violence, there is greater value in examining patterns of past behaviour. Behavioural indicators, such as past violence and problematic substance use, are likely to provide more reliable information.**

There is some evidence that borderline personality disorder (BPD) may be associated with violence. However, once again, correlations tend to reduce when factors such as substance misuse and past behaviour are controlled for.

## Is mental illness associated with firearm violence?

Although mental illness, overall, is generally not associated with elevated risk of lethal interpersonal violence when other factors are controlled for (such as substance misuse), it is necessary to consider whether mental illness is associated with the use of specific weapons such as firearms. Some studies suggest that people with mental illness are less likely to use a firearm to commit homicide than people who do not have mental illness.[49]

There has been very little Australian research on this topic. In New South Wales, for example, it has been found that although older homicide offenders were more likely to have a psychotic illness than homicide offenders overall, the proportion of firearm homicides among that group was around the same as other age groups (and the overall proportion of firearm homicides was similar to studies from

[45] Fazel, S., & Grann, M. (2004). Psychiatric morbidity among homicide offenders: a Swedish population study. *The American Journal of Psychiatry*, 161(11), 2129–2131.
[46] Martone, C. A., Mulvey, E. P., Yang, S., Nemoianu, A., Shugarman, R., & Soliman, L. (2013). Psychiatric characteristics of homicide defendants. *The American Journal of Psychiatry*, 170(9), 994–1002..
[47] Swinson, N., Webb, R., & Shaw, J. (2021). The prevalence of severe personality disorder in perpetrators of homicide. *Personality and Mental Health*, 15(1), 49–57.
[48] Swinson, N., Webb, R., & Shaw, J. (2021). The prevalence of severe personality disorder in perpetrators of homicide. *Personality and Mental Health*, 15(1), 49–57.
[49] Matejkowski, J., Fairfax-Columbo, J., Cullen, S.W., Marcus, S.C., & Solomon, P.L. (2014). Exploring the potential of stricter gun restrictions for people with serious mental illness to reduce homicide in the United States. *The Journal of Forensic Psychiatry & Psychology*, 25(3), 362-369; Schwab-Reese, L.M., & Peek-Asa, C. (2019). Factors contributing to homicide-suicide: differences between firearm and non-firearm deaths. *Journal of Behavioral Medicine*, 42, 681-690.

Finland and the UK).[50] Studies from Australia suggest that relative to overall percentages of firearm homicide (around 12% of all homicide incidents, based on the most recent available data) a similar, or potentially lower, percentage of homicides by people with psychosis involve firearms; 12 out of 124 offenders with first episode psychosis (10%) used a firearm relative to four out of 148 with past treated psychosis (3%).[51]

Studies exploring linkages between mental illness and gun violence are limited due to the infrequency of serious violent acts - particularly homicides and multiple victim incidents. Although studies have compared the proportion of mentally ill individuals who commit violent versus nonviolent crime, they have generally not made comparisons by weapon use. Most studies do not disaggregate by weapon type or severity.

Studies exploring gun violence by people with mental illness are limited, due to the rarity of this type of violence (even in the United States). One US study has shown that gun violence by people with severe mental illness occurs in two per cent or less of patients in the year after discharge from inpatient settings; rates may be lower among less acute patients.[52] Others have found lower prevalence of mental illness among perpetrators of firearm homicides than non-firearm homicides.[53] This suggests limited overlap between mental illness, firearms, and violence and implies that even if all of those individuals could be identified and stopped from engaging in gun violence, the impact on overall levels of gun violence would not be substantial. At a population level, it seems that being mentally ill does little to identify a useful group for targeted firearm violence prevention policy.[54]

Mass shootings receive particular attention but the empirical literature on mental illness and mass shootings is limited due to extremely low base rates. It is almost entirely informed by case studies of perpetrators. The limited research on mental illness among mass shooters is mixed. Some case studies have found that a majority (60%) of mass shooters had either been diagnosed with or demonstrated serious mental illness.[55]

However, a study of psychosis in a database of mass shootings determined that psychosis was not a motivating factor in most (69.8%) incidents nor did it differentiate the types and number of firearms mass shooters used.[56] Some scholars[57] state that mass shooters generally do not display serious mental illness such as psychosis. Others find higher rates of mental health problems (10 vs. 2%) and suicidal thoughts (30 vs. 6%) among mass homicide offenders compared to single homicide offenders.[58]

Criminologists have shown that violent acts committed with and without firearms have very similar motives, occur in similar social contexts, and are similar in a range of other characteristics.[59] For

[50] Reutens, S., Nielssen, O., & Large, M. (2015). Homicides by older offenders in New South Wales between 1993 and 2010. *Australasian Psychiatry*, 23(5), 493–495.
[51] Nielssen, O. B., Yee, N. L., Millard, M. M., & Large, M. M. (2011). Comparison of first-episode and previously treated persons with psychosis found NGMI for a violent offense. *Psychiatric Services*, 62(7), 759–764.
[52] Steadman, H. J., Monahan, J., Pinals, D. A., Vesselinov, R., & Robbins, P. C. (2015). Gun violence and victimization of strangers by persons with a mental illness: Data from the MacArthur Violence Risk Assessment Study. *Psychiatric Services*, 66(11), 1238–1241.
[53] Shawon, R. A., Adhia, A., DeCou, C., & Rowhani-Rahbar, A. (2021). Characteristics and patterns of older adult homicides in the United States. *Injury Epidemiology*, 8(1), 5.
[54] Rozel, J. S., & Mulvey, E. P. (2017). The Link Between Mental Illness and Firearm Violence: Implications for Social Policy and Clinical Practice. *Annual Review of Clinical Psychology*, 13, 445–469.
[55] Rocque, M., & Duwe, G. (2018). Rampage shootings: An historical, empirical, and theoretical overview. *Current Opinion in Psychology*, 19, 28–33.
[56] Peterson, J. K., Densley, J. A., Knapp, K., Higgins, S., & Jensen, A. (2022). Psychosis and mass shootings: A systematic examination using publicly available data. *Psychology, Public Policy, and Law*, 28(2), 280–291.
[57] Fox, J. A., & Fridel, E. E. (2016). The tenuous connections involving mass shootings, mental illness, and gun laws. *Violence and Gender*, 3(1), 14–19.
[58] Fowler, K. A., Leavitt, R. A., Betz, C. J., Yuan, K., & Dahlberg, L. L. (2021). Examining differences between mass, multiple, and single-victim homicides to inform prevention: Findings from the National Violent Death Reporting System. *Injury Epidemiology*, 8(1), 49.
[59] E.g., Cook, P. J., & Goss, K. A. (2020). *The gun debate: What everyone needs to know?* Oxford University Press.

example, Berg et al[60] studied incarcerated offenders, and found that more than half (53.9%) of the respondents had ever been diagnosed with mental disorders. Approximately 36 per cent reported being diagnosed with depression, 33 per cent with anxiety disorder, 30 per cent with bipolar disorders, 10 per cent with schizophrenia, 23 per cent with PTSD, and 12 per cent with personality disorder. Around 24 per cent of respondents reported being hospitalised for their mental health, with eight per cent being hospitalised for their mental health in the year before their arrest. About 28 per cent of respondents reported having substance use disorder with at least one mental disorder.

Respondents incarcerated for violent offences had greater mental health burden than those incarcerated for property offences but were not more likely to be diagnosed with personality disorder than property crime offenders. Compared to property offenders, violent offenders were also more likely to have been hospitalised for mental health conditions in their lifetime and in the 12 months leading up to their incarcerating arrest. Among violent offences, however, differences in the prevalence of mental illness across individuals incarcerated for firearm and non-firearm violence were not statistically significant except anxiety disorder. Firearm violence offenders were 30 per cent less likely to be diagnosed with anxiety disorder than non-firearm violence offenders.

Respondents incarcerated for firearm violence had similar prevalence of diagnoses and hospitalisations than those incarcerated for violent offenses without firearms. Respondents incarcerated for multiple-victim violent offenses that involved firearms did not have greater mental health burden than those incarcerated for single-victim crimes that involved firearms. Additionally, the prevalence of mental illness did not vary by whether a firearm was used during either violent incidents or homicides. None of the mental illness variables distinguished individuals who committed firearm homicides from those who committed homicides with other weapons. When viewed together, the results suggest that gun violence was not attributable to mental illness (in that particular incarcerated sample).

Interpersonal conflict and criminal activity tend to drive most firearm homicides. Illicit substance use is associated with firearm violence in particular, especially when also associated with involvement in illegal drug sales.[61] However, mental illness tends to be raised in high-profile incidents, creating a false perception that people with mental illness are at a substantial risk of committing firearm violence. What is counted as a mental illness, and the extent to which an individual's actions are attributable to mental illness, are complex issues.

For example, while most researchers agree that people with symptoms of serious mental illness are overrepresented in the small pool of mass public shooters, multiple researchers have concluded that most perpetrators do not have such symptoms or diagnoses.[62] In addition, the presence of a mental illness does not rule out other motivators for violence that are common in non-mentally ill samples – such as revenge or other grievance.[63]

Because of violence within a small segment of the mentally ill and some media portrayals of the mentally ill, it is assumed by the public that mental health professionals should be able to identify those patients who have a propensity for acting violently in the future.[64] Policy requiring mandatory mental health assessment for firearm owners may therefore reflect exaggerated public perceptions of the danger associated with mental illnesses.[65]

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[60] Berg, M. T., Krajewski, A., Lu, Y. F., & Rogers, E. M. (2025). Violence, Gun Violence, and Mental Illness in a National Sample of Incarcerated Adults. *Justice Quarterly*, 1–26. Advance online publication, 13 October 2025.
[61] McGinty, E.E., Choksy, S., & Wintemute G.J. (2016). The relationship between controlled substances and violence. *Epidemiologic Reviews*, 38(1), 5–31.
[62] Lankford, A., & Cowan, R. G. (2020). Has the role of mental health problems in mass shootings been significantly underestimated? *Journal of Threat Assessment and Management*, 7(3-4), 135–156.
[63] Soliman, L., Baines-Waiz, O., Rozel, J. S., Blankenship, K., & Rachal, J. (2024). A Moving Target: Firearm Deaths, Mental Health, and the Role of Physicians. *Current Psychiatry Reports*, 26(12), 859–865.
[64] Trestman, R.L., Volkmar, F., & Gold, L.H. (2016). Accessing mental health care. In L.H. Gold & R.I. Simon (Eds.), *Gun Violence and Mental Illness*. American Psychiatric Publishing: New York, NY, pp 185–217.
[65] Appelbaum, P. S., & Swanson, J. W. (2010). Law & psychiatry: Gun laws and mental illness: how sensible are the current restrictions? *Psychiatric Services*, 61(7), 652–654.

A further assumption is that by reporting those who are perceived as possibly violent in the future to the appropriate authorities and providing the patients with adequate treatment, it is possible to significantly reduce future events of firearm violence. The evidence for this is highly tenuous. Again, this reflects unrealistic and unsupported beliefs that mental health professionals can determine which patients with a mental health problem are likely to be involved in firearm violence in the future.[66]

**Implication: Mental health professionals cannot be expected to predict future firearm violence.**

Research into firearm violence in the United States increasingly indicates that gun violence perpetrated by the mentally ill is rare, and is often associated with non-psychiatric risk factors. For example, Baumann[67] compared patients who had been admitted for mental health treatment, with a matched community sample, finding no indication that firearm access among the patient sample was associated with an increase in odds of violence. Factors such as drug use and race were associated with increased odds of violence perpetration, holding constant patient status. Importantly, patient status was not a significant, independent predictor of violence perpetration, even in the context of firearm access.

Background checks must be based on empirical criteria rather than perception. Research does not support that mental health background checks will be effective in preventing violent crimes. By promoting views to the contrary, especially when this is not empirically grounded, society is both creating and supporting the stigmatising belief that that mental illness is dangerous, unpredictable, and to be feared. Similarly, what is often promoted is a misleading view of mental health as the cause of large-scale tragedies.[68]

Much of the limited research on gun violence and mental illness has focused on violence among individuals with severe mental illnesses or rates of mental illness among individuals arrested for violent crimes.[69] To conclude a link between mental illness and violence based on this body of research is subject to selection bias, and the population examined is not representative of individuals with mental illness in the general population. Overall, research suggests that restricting firearm access on the basis of a pattern of dangerous/risky behaviours (e.g., substance abuse, domestic or other violence) may reduce gun violence,[70] whereas restricting gun ownership based on mental illness is largely ineffective.[71]

In contrast to a risk based approach that assesses specific populations (such as those who have engaged in certain behaviours), mental health assessment of an entire population of individuals (e.g., all firearm owners) is unlikely to provide useful information about violence, over and above more behaviourally based assessments (such as past contact with the criminal justice system).

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[66] Price, J. H., & Khubchandani, J. (2016). Firearm Violence by the Mentally Ill: Mental Health Professionals' Perceptions and Practices. *Violence and Gender*, 3(2), 92-99.
[67] Baumann, M. L., & Teasdale, B. (2018). Severe mental illness and firearm access: Is violence really the danger? *International Journal of Law and Psychiatry*, 56, 44–49.
[68] Kangas, J. L., & Calvert, J. D. (2014). Ethical issues in mental health background checks for firearm ownership. *Professional Psychology: Research and Practice*, 45(1), 76–83.
[69] Lu, Y., & Temple, J. R. (2019). Dangerous weapons or dangerous people? The temporal associations between gun violence and mental health. *Preventive Medicine*, 121, 1–6.
[70] Swanson, J.W., Sampson, N.A., Petukhnova, M.V., Zaslavsky, A.M., Appelbaum, P.S., Swartz, M.S., & Kessler, R.C. (2015). Guns, Impulsive Angry Behavior, and Mental Disorders: Results from the National Comorbidity Survey Replication (NCS-R). *Behavioral Sciences and the Law*, 33, 199-212; Tessler, R. A., Haviland, M. J., Bowen, A., Bowen, D., Rivara, F. P., & Rowhani-Rahbar, A. (2022). Association of state-level intoxicated driving laws with firearm homicide and suicide. *Injury Prevention*, 28(1), 32–37.
[71] Swanson, J. W., McGinty, E. E., Fazel, S., & Mays, V. M. (2015). Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Annals of Epidemiology*, 25(5), 366–376; Vars, F.E. Meadows, B., & Edwards, G. (2022). Slipping through the cracks? The impact of reporting mental health records to the national firearm background check system. *Journal of Economic Behavior and Organization*, 195, 52-74.

**Implication: Like violence in general, involvement in firearm violence is more likely to be associated with factors such as problematic substance use, past violence, and other criminal behaviours, than mental illness. Background checks for a person's suitability to possess firearms should take a pattern-based behavioural approach that focuses on those factors.**

## The role of the therapeutic relationship and disclosure

Little is written about practices of Australian doctors in managing firearm access for perceived at-risk patients. In an early survey of 243 psychiatrists and general practitioners in Queensland, 93 per cent of respondents believed that mental health practitioners had a role in reporting people they considered at risk of firearm violence.[72] However, practitioners may have conflicting roles as both clinicians and evaluators of licence suitability. The latter may affect the objectivity of their decision making and – crucially - rapport with the client/patient.

Policies that seek to mitigate gun violence risk by focusing on the narrow intersection between mental illness and firearm misuse may disrupt essential and effective elements of the therapeutic relationship.[73] For example, there is some evidence, from the US and Australia, that linking mental health assessment with firearm removal may lead to reticence to seek help and reduced disclosure of symptoms such as thoughts of suicide/violence/ homicide, thoughts of self-harm/suicide attempts, depression, hopelessness and paranoid thoughts.[74]

Any ability of mental health assessment to detect potentially relevant indicators such as substance misuse also depends crucially on patient disclosure. Patient disclosure is likely to be affected by concerns such as not wanting to be found unfit to possess a firearm, privacy considerations, and worries about stigma, discrimination, or other negative consequences (such as removal of firearms in cases of existing possession).[75] Patients may be reticent to disclose mental illness, other circumstances, and homicidal or suicidal thoughts knowing it may affect their chances of obtaining or keeping a firearm.

For some, firearm ownership and use are integral and enduring aspects of their life, closely bound to their identity, occupation and self-esteem. Losing a firearm licence may be especially distressing.[76] For example, research conducted in the Riverina region (New South Wales) indicated that it was

[72] Kingswell, W. J., Reddan, J. G., & Stedman, T. J. (1998). What do doctors know, think and do about firearms?. *The Medical Journal of Australia*, 168(3), 143–144.
[73] Appelbaum, P.S. (2013). Public safety, mental disorders, and guns. *JAMA Psychiatry*, 70(6),565–66; Metzl, J. M., & MacLeish, K. T. (2015). Mental illness, mass shootings, and the politics of American firearms. *American Journal of Public Health*, 105(2), 240–249.
[74] Bryant, L., Garnham, B., & Posselt, M. (2022). Tailoring Suicide Prevention Strategies for Men in Farming Occupations. University of South Australia: South Australia; Charder, N., Liberatos, P., Trobiano, M., Dornbush, R. L., Way, B. B., & Lerman, A. (2021). The Influence of New York's SAFE Act on Individuals Seeking Mental Health Treatment. *The Psychiatric Quarterly*, 92(2), 473–487.
[75] E.g., Burns, V. F., Walsh, C. A., & Smith, J. (2021). A Qualitative Exploration of Addiction Disclosure and Stigma among Faculty Members in a Canadian University Context. *International Journal of Environmental Research and Public Health*, 18(14), 7274; Earnshaw, V. A. (2020). Stigma and substance use disorders: A clinical, research, and advocacy agenda. *American Psychologist*, 75(9), 1300–1311; Pearce, L. A., Homayra, F., Dale, L. M., Moallef, S., Barker, B., Norton, A., Hayashi, K., & Nosyk, B. (2020). Non-disclosure of drug use in outpatient health care settings: Findings from a prospective cohort study in Vancouver, Canada. *The International Journal on Drug Policy*, 84, 102873; Wilson, H. (2020). How stigmatising language affects people in Australia who use tobacco, alcohol and other drugs. *Australian Journal of General Practice*, 49(3), 155–158.
[76] Wand, A. P., Peisah, C., Strukovski, J. A., & Brodaty, H. (2014). Firearms, mental illness, dementia and the clinician. *The Medical Journal of Australia*, 201(11), 674–678.

difficult to engage men in farming in mental health services, in part because of the potential relinquishment of firearms and protracted process of having them reinstated.[77]

**Implication: Mandatory mental health assessment may have unintended negative consequences, including harming the therapeutic relationship and reducing the likelihood of relevant disclosures.**

It is acknowledged that there would be very significant resource implications associated with mandatory mental health assessment and that these would be expected to place significant strain on an already overburdened mental health system and its workers. However, these considerations are not discussed in this submission.

[77] Bryant, L., Garnham, B., & Posselt, M. (2022). *Tailoring Suicide Prevention Strategies for Men in Farming Occupations*. University of South Australia: South Australia.

## Section 4: Promising practices

**Promising practices for addressing firearm violence**

It is acknowledged that firearm buybacks have been raised in recent policy debate, and that Queensland has chosen not to participate in the recently announced federal firearms buyback. Within federal debate, gun buybacks have been said to enhance community safety by removing firearms from the community. As shown above, there is no support for the premise that levels of legal firearms ownership in Australia are associated with levels of firearm misuse, which undermines this premise.

Beyond this, evidence indicates that firearm buyback schemes are not an effective (or cost effective) violence prevention measure. Australian and international studies suggest that the people who respond to buyback programs and firearm amnesties are characteristically 'low risk': they are not the ones likely to be involved in violence. Australian studies claiming that the 1996 buyback program impacted on firearm-related deaths (the majority of which are suicides) typically fail to take into account other factors such as changes to licensing processes and related measures (for example, waiting periods, safe storage, etc) introduced at the same time as the buyback program.

Most research into firearm violence prevention has been conducted in countries other than Australia. Although caution should always be applied when extrapolating findings from different countries, that work nevertheless provides useful insights. Briefly, measures that have been found to be successful in reducing firearm violence include:

- 'Problem oriented policing' (such as focussing on crime 'hotspots')
- Concerted efforts to seize firearms from criminals, target illicit gun traffickers, and prosecute gun crimes
- Enhanced case management and tailored probation/parole strategies for firearm violence offenders
- Intensive rehabilitation programs that address underlying individual factors associated with violence
- Community-based interventions that are multi-faceted and developed in close collaboration with communities (and, ideally, are community led).

Successful responses to firearm violence are proportional, place-based, and take socioeconomic and cultural context into consideration. What is appropriate and effective in one location may not work in another location, and involving individual communities in violence prevention efforts is crucial.

**Implication: Addressing firearm violence – and violence more generally – requires comprehensive measures that are evidence-based and address contributors to violence, as well as focus on individuals with a high propensity for violence and communities at elevated risk.**

**Best practice approaches to managing firearms in a mental health context**

Internationally, the best-practice approach to managing firearms and mental health[78] includes:

- Educating mental health and other relevant professionals about how to ask clients/patients (and their next of kin/carers, etc) about firearm access in instances where a risk has emerged or where a clinician has reasonable belief that a risk of harm to self or others exists;
- Training clinicians how to do this without creating stigma or barriers to disclosure, how to recognise and manage personal biases (such as a dislike of firearms), and how to recognise personal, professional, or cultural importance around firearm ownership;
- Ensuring that laws protect professionals from prosecution or other professional consequences in instances where they believe breaching confidentiality is necessary and appropriate;
- Educating the community so that family members or other associates of an individual displaying concerning behaviour know how to report that to an appropriate authority (for example, providing simple information about what to do if a person has or may have access to firearms – whether legal or illegal - and may be at risk of harming themselves or others).

[78] McGinty, E. E., Webster, D. W., & Barry, C. L. (2014). Gun policy and serious mental illness: priorities for future research and policy. *Psychiatric Services*, 65(1), 50–58; Price, J. H., & Khubchandani, J. (2016). Firearm Violence by the Mentally Ill: Mental Health Professionals' Perceptions and Practices. *Violence and Gender*, *3*(2), 92-99; Rozel, J. S., & Mulvey, E. P. (2017). The Link Between Mental Illness and Firearm Violence: Implications for Social Policy and Clinical Practice. *Annual Review of Clinical Psychology*, 13, 445–469.