

Commentary in response to 'characterising the risk of homicide in a population-based cohort' (O'Neill *et al*, 2019)

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We are social epidemiologists and community advocates focused on addressing social determinants of health inequities. While we appreciate O'Neill *et al*'s effort to link multiple provincial-level administrative data sets to examine homicide victimisation by immigration status in Ontario, Canada, we have concerns about the framing and interpretation of findings and their potential impact on immigrants and refugees.¹

FRAMING AND APPROACH

While O'Neill *et al*'s data and sample size are strengths, the attention to the context of being an immigrant to Canada, theoretical framework and motivation for examining immigrants in relation to homicide victimisation are not fully developed. O'Neill *et al* do not acknowledge having done any community engagement which is critical and ethical² given the long history of exclusion, exploitation, racism and discrimination, and the current global climate of increasing criminalisation of migrants. Meaningful community engagement offers

important context; helps shape the research purpose, questions, approach, interpretation and recommendations; and can reduce the potential for harm.

Though criminalisation of migration under security pretexts is an infringement of international law,³ and contradicts evidence that immigration is related to a *reduction* in crime,⁴ many high-income countries, including Canada, are framing harmful immigration policy (eg, restricting entry, detaining immigrants) as an urgent need to protect against threats of safety and security,^{4,5} disproportionately targeting racialised and Muslim immigrants and refugees. Within this policy context, along with political rhetoric to generate support for it, hate crimes are at record highs in Canada, with approximately 85% of these crimes motivated by racism and ethnic or religious discrimination.⁶

Not only does this paper fail to consider this context, the statements that immigrant communities are 'predisposed to violence' without evidence to support this claim; the conflation of perpetrating and dying by homicide, by alternating between the use of 'homicide' and 'homicide victimisation'; and the suggestion that 'cultural views on gender' increase risk of violence and homicide victimisation against immigrant women, are particularly harmful.

RESULTS AND INTERPRETATION

The authors' emphasis on the increased risk of homicide victimisation of female and male refugees compared to long-term residents is misleading given that these results are not statistically significant. The authors argue that the findings are important regardless of significance, because of large effect sizes. But for many researchers, effect sizes of 1.31 and 1.23, respectively, would be considered small to medium and would lead to a much more cautious interpretation.

The authors' interpretation that non-refugee immigrants have a lower risk of homicide victimisation because Canada's

immigration policies select for highly educated and healthy immigrants reflects problems with the theory informing this research, since homicide victimisation is not within the control of an individual. Social epidemiology was founded on the need to theorise political, economic and cultural context over and above individual characteristics.⁷ A concerning omission is that there is no mention of the potential for hate crimes⁶ to be *at least* partially responsible for homicide victimisation among refugees and immigrants. Additionally, in the text, it is left unclear how a refugee's history of 'violence, trauma and torture' and 'depression and psychosocial illness' are linked to homicide *victimisation*. Such unsupported statements omit essential consideration that Canadian neighbourhoods are heterogeneous combinations of refugees, non-refugees and long-term residents and that violence occurs within a social context which includes racism, xenophobia and Islamophobia.⁸

With the study's low counts of homicide victimisations among refugees (31 among females and 89 among males over 20 years), 90% of all homicide victimisations in the same time period occurring among long-term residents (table 1 of paper), and no clear data pointing to specific factors to intervene upon, we argue that this *potential* in excess homicide victimisation does not warrant targeted homicide prevention strategies, as the authors suggest. Broader prevention strategies targeting the entire population (eg, a national ban on handguns and assault weapons,^{9,10} implementing Canada's Anti-Racism Strategy⁸) may be more beneficial in reducing homicide victimisation.

POTENTIAL IMPACT

We are concerned that the paper's framing, approach and interpretation could negatively impact immigrant and refugee communities targeted by significant racism, anti-immigrant sentiment and Islamophobia at policy, practice, community and individual levels.^{6,11} Community engagement from the start, and comprehensive multi-level, multistage social determinants of immigrant health framework,¹¹ could have prevented misinterpretations of the findings and this potential for harm. It could have also shifted the approach from a deficit- to an asset-based one that recognises the leadership and impacts of women who founded groups such as Mothers for Peace¹² and Mending a Crack in the Sky.¹³ These groups combat the stigmatisation of mothers and families that have lost children to violence; support mothers and families

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experiencing ongoing trauma due to violence; and advocate for policy and programme change to reduce poverty, violence and homicide for all people in Canada, a more inclusive public health approach.

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