



Wolverhampton Joint Strategic Needs Assessment

Alcohol in the Punjabi-Sikh Community

Drugs & Alcohol Needs Assessment – Supplementary Chapter

July 2024



Contents

Executive Summary	3
Punjabi-Sikh community in Wolverhampton	3
Alcohol in the Punjabi-Sikh community	3
Limitations and knowledge gaps.....	6
Recommendations	7
1. Punjabi-Sikh community	9
1.1. History of Punjabi-Sikh culture.....	9
1.2. Punjabi-Sikhs in the UK	9
1.3. Punjabi-Sikh community in Wolverhampton	10
2. Alcohol in the Punjabi-Sikh community	13
2.1. Attitudes and perceptions of alcohol use	13
2.2. Patterns of alcohol consumption	13
2.3. Gender/sex differences	19
2.4. Generational differences.....	19
2.5. Alcohol-related harm	19
2.6. Support and treatment	22
3. Limitations and knowledge gaps	26
4. Recommendations	27
Strategic	27
For Public Health and the City of Wolverhampton Council	27
For Alcohol Treatment Services and Lived Experience Recovery Organisations.....	28
For Primary Care, Maternity, and Emergency Services.....	28
For Research (national and/or local).....	28
Appendix 1 – Findings from 2010 M·E·L Research report	29
References	33

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Executive Summary

Punjabi-Sikhs represent a community of people within the British population with ethnic ancestry in Punjab and religious heritage from Sikhism. The historical intersection between ethnicity, religion, and language is likely to have contributed to the creation of a unique Punjabi-Sikh cultural identity, which shapes the community's relationship with alcohol. Present day Punjabi-Sikhs communities in the UK include first-generation migrants who settled in the UK over the last 80 years, as well as their direct relatives who were born and/or raised here.

Punjabi-Sikh community in Wolverhampton

Wolverhampton is home to one of the biggest Punjabi-Sikh communities in the UK, where they account for around one in eight residents, making them one of the city's largest minority groups.

Ethnicity

- Punjabi, as an ethnic group, is not routinely captured in the England and Wales Census.
- Over one in five people (21.2%) identify themselves as Asian, three quarters of which are ethnically Indian (15.9%).
- In the absence of reliable data on Punjabi ethnicity, religious affiliation is likely to be a better indicator for estimating the size of the city's Punjabi-Sikh population.

Religion

- One in eight Wolverhamptonians (12.0%) identify themselves as Sikh, well above the national average for England (0.9%).
- Wolverhampton is the local authority in England and Wales with the largest proportion of Sikhs in its population, as well as the third largest Sikh community in absolute terms (31,769), behind Sandwell (39,252) and Birmingham (33,126).
- Sikhs also represent the city's second largest faith group behind Christianity (43.8%).
- Wolverhampton's Sikh population is evenly divided by gender (12.4% of males, 11.7% of females) and is generally younger than the overall city population.
- A big proportion of the community lives in the south of the city, with one in six Sikhs (16%) living in Blakenhall, where they represent 41% of the ward's population; nonetheless, the community is widely spread across the city.

Alcohol in the Punjabi-Sikh community

Despite being prohibited in Sikhism, alcohol consumption is relatively ubiquitous in Punjabi-Sikh culture. Most people, particularly males, feel pressured to drink at social events, especially at weddings and parties, where they are encouraged to consume large quantities of alcohol. Given the UK's heavy drinking culture, some British Punjabi-Sikhs even describe a 'double drinking culture'.

Patterns of alcohol consumption

Asian populations are generally reported to drink less and have lower rates of alcohol dependence than the general UK population and/or their White counterparts. However, these generalisations are likely to mask or misrepresent some patterns of alcohol consumption specific to Punjabi-Sikh communities:

- Three in five British Sikhs (61%) consume alcohol, including two in three males (64%) and more than half of females (56%).¹ This translates into around 10,300 Sikh males and 8,800 Sikh females in Wolverhampton.
- One in seven Sikhs (15% of males, 13% of females) consumes alcohol 2-3 times per week, whilst one in nine (11%) drinks 4+ times per week.¹ This corresponds to around 2,400 Sikh males and 2,000 Sikh females in Wolverhampton drinking 2-3 times per week, and to around 1,700 males and females drinking 4+ times a week.
- One in eight male Sikhs (12%) and 7% of female Sikhs drinks 10+ units per week,¹ which translates into around 1,900 Sikh males and 1,100 females in Wolverhampton.
- Comparing the reported prevalence of drinking, frequent drinking, and heavy drinking with people of Indian ethnicity, the rates are similar for males but slightly higher in Sikh females.²
- Drinking patterns are otherwise very different from those of other Asian ethnic groups. Compared to people of Chinese ethnicity, Sikhs report lower prevalence of drinking but higher prevalence of frequent drinking, whereas they are equally likely to drink heavily. In contrast, Sikhs are significantly more likely to drink, drink frequently, and drink heavily than those of Bangladeshi and Pakistani ethnicities.²
- However, the prevalence of drinking, frequent drinking, and heavy drinking is still lower in British Sikhs than in the White British population.²
- There is limited good-quality data to allow for a direct comparison with other religious groups. Muslims are the least likely group to drink, with over 90% of abstention rates, whereas Hindus report similar or lower drinking prevalences. Sikh men also have rates of heavy drinking closer to those of Christians than those of other South Asian religions.³
- According to the City Lifestyle Survey, the prevalences of drinking, frequent drinking, and heavy drinking in Wolverhampton are considerably lower than those reported by national surveys.⁴ However, this data source has several limitations which are likely to affect the validity of the findings.
- One in six (16%) Sikh males and one in eight (12%) Sikh females binge drinks at least weekly, which translates into around 2,600 males and 1,900 females in Wolverhampton.¹
- One in eight Sikhs drinkers (13% of males, 12% of females) is unable to stop drinking either daily or weekly, whereas the vast majority (67% of males, 73% of females) has never been in that position.¹
- Half of British Sikhs (54%) have a family member or friend with a drinking problem, over two-thirds of which are relatives; 95% of relatives are males and over 80% are aged 35-64.¹

Gender/sex differences

- Alcohol consumption in the Punjabi-Sikh community has traditionally been associated with men, with gender roles and attitudes meaning that drinking alcohol has generally been seen as less acceptable for Punjabi-Sikh women.⁵
- However, a longstanding focus on men may be hiding a shift in gender attitudes, with similar rates of frequent and problem drinking reported in males and females.¹

Generational differences

- Generational differences in health behaviours in ethnic minorities can be partly explained by changes in socio-economic status^{3,6} and a weakening of ethnic identities in second generations,⁶ and are likely to be underpinned by each generation's distinct acculturation strategies.⁷
- There is no clear consensus on the direction and size of the generational difference in alcohol consumption for the UK's Punjabi-Sikh community.

Alcohol-related harms

Health harms

- Asian and in particular Sikh males are overrepresented as patients with alcoholic liver disease (ALD) compared to other ethnic groups and the general population,³ and have a higher risk of ALD-related hospitalisation and/or death.^{8,9}
- Asian males in Wolverhampton are overrepresented in alcohol-specific deaths (31.3% of deaths vs. 21.7% of the city's population).¹⁰
- Asian males are also overrepresented in alcohol-specific emergency admissions at The Royal Wolverhampton NHS Trust (19.6% of admissions vs. 11.7% of its catchment population).¹⁰
- Given that the vast majority of the city's Asian population is either from Indian ethnicities or Sikh, it is possible to assume that this represents an excess in alcohol-related health harms in Wolverhampton's Punjabi-Sikh male population.

Social harms

- Two in five Sikhs have experienced direct impacts from problem drinking by an immediate relative, including emotional and mental health issues, damaged family relationships, separation or divorce, domestic abuse, and neglect of children.¹ This corresponds to around 6,900 Sikh males and 6,600 Sikh females in Wolverhampton.
- Two thirds (62%) of Punjabi-Sikh women and girls have experienced domestic abuse and one third (32%) reports having experienced sexual abuse.¹¹ This translated into around 9,700 and 5,100 females, respectively, in Wolverhampton. Given the well-established relationship between problem drinking and domestic violence and abuse,^{12,13} it is very likely that problem drinking contributes at least partially to this.

Support and treatment

- Two-thirds (67%) of Sikhs with problem drinking say they had not been made aware that they required help to stop drinking, with the remaining third having been alerted by a combination of friends, family, themselves ('self-realisation'), and medical professionals.¹
- Of those who manage to quit drinking, 43% stop by themselves ('Cold Turkey'), with only a minority seeking professional support.

Engagement with treatment services

- Ethnic minorities in the UK have historically been underrepresented in alcohol treatment services.³ However, this generalisation may hide or mask patterns specific to Punjabi-Sikhs, different local realities, or even more recent trends.

- Indian males in Wolverhampton are overrepresented in treatment services for “alcohol only” (23.0% of service users vs. 16.3% of the city’s population), whilst Indian females have almost doubled their representation in the last 3 years (5.5% in 2021/22 vs. 9.6% in 2023/24).¹⁴
- The patterns are similar for those identifying as Sikh, although the figures are likely to be an underestimate due to an underreporting of service users’ religion.¹⁴

Barriers and facilitators

- There are multiple barriers to Punjabi-Sikhs accessing support related to alcohol use, of which stigma is the most common one, often underpinning other barriers. Other barriers are described in the table below.

Type of barrier	Ethnic minorities ¹⁵	Punjabi-Sikhs ¹⁶
Attitudes	<ul style="list-style-type: none"> • Shame and stigma in admitting to alcohol-related problems. • Cultural attitudes towards help-seeking (viewed as a character weakness). 	<ul style="list-style-type: none"> • Stigma. • Religion. • Over-reliance on a medical model of treatment and disregard for therapy. • Cultural implications of being simultaneously a member of the Punjabi-Sikh and the addiction communities. • Gender and generational differences.
Knowledge	<ul style="list-style-type: none"> • Poor understanding of the harms of alcohol use. • Lack of knowledge of services available. 	<ul style="list-style-type: none"> • Lack of understanding of addiction.
Practical	<ul style="list-style-type: none"> • Language difficulties. 	<ul style="list-style-type: none"> • Lack of culturally specific services.
Political		<ul style="list-style-type: none"> • Lack of government commitment to alcohol support for ethnic minority communities.

- However, multiple facilitators can be used to help reduce these barriers, including providing culturally specific and competent services, incorporating users’ religious/spiritual strategies into the therapeutic process, providing time to build relationships and develop trust, providing confidential and private services, and having identifiable, positive role models with lived experience within the community.

Limitations and knowledge gaps

- The lack of data specific to the Punjabi-Sikh population, both nationally and at a local level, means that many of the findings have relied on imperfect data (e.g. biased or unrepresentative) and/or required extrapolations from data relating to Asian, Indian, and/or Sikh populations. For example, this makes it difficult to estimate the exact level of alcohol-related harm in Wolverhampton’s Punjabi-Sikh population.
- And when accounting for the community’s numerous cultural barriers to engaging with services, it is possible that the apparent overrepresentation of males in alcohol treatment services is masking a higher unmet need in this population than the data suggests, so this needs to be further explored.

- A longstanding focus on males, though justifiable, may be hiding a change in gender attitudes towards alcohol, whereas younger generations' continuing integration into the British culture is likely to be changing their drinking behaviours. Both issues need to be better understood as they will have significant implications for future practice.
- Finally, given Wolverhampton's high prevalence of alcohol-related harm, any meaningful city-wide strategy to address this should acknowledge and account for its diverse demographics.

Recommendations

The following section highlights the recommendations made based on the findings and knowledge gaps identified.

Strategic

- **Set up a steering group under the city's Drug and Alcohol Strategic Partnership** with partner organisations and community representatives **to address the high level of alcohol-related health harm in its Punjabi-Sikh population**, for example by developing a local action plan. Potential priority areas for intervention could include:
 - Raising awareness of the harms of alcohol consumption.
 - Improving the early identification of problem drinking and alcohol-related harm.
 - Increasing opportunities to signpost people with problem drinking to sources of help.
 - Reducing barriers to engaging with statutory services and other sources of support.
 - Identifying and implementing preferred methods of support.

For Public Health and the City of Wolverhampton Council

- Coordinate the Drug and Alcohol Strategic Partnership steering group.
- **Collect good-quality quantitative data to better understand the drinking behaviours of the Punjabi-Sikh community in Wolverhampton**, for example through a local representative survey. This would allow for:
 - A better understanding of whether there are significant differences in the patterns of alcohol consumption of the local community compared with national surveys.
 - The monitoring of the gender differences in alcohol consumption, particularly focussing on the growing levels of consumption in females.
 - A clearer understanding of generational differences in alcohol consumption.
- **Work with the community**, including community and voluntary sector organisations, community centres, Gurdwaras and faith leaders, and educational establishments **to raise awareness of the harms associated with alcohol consumption through a life-course approach**, for example by developing inclusive peer led campaigns, providing health education to families, and empowering local health champions.
- **Work with partners to ensure that health promotion programmes** such as Make Every Contact Count (MECC) and health literacy **are culturally appropriate**.

- **Explore and address the intersections between alcohol and social harms** such as domestic abuse, sexual violence, and crime.
- **Work with the wider public health system to address the wider (social and commercial) determinants of alcohol consumption**, for example by regulating the local advertising and supply of alcohol products.

For Alcohol Treatment Services and Lived Experience Recovery Organisations

- Appoint representatives to join the Drug and Alcohol Strategic Partnership steering group.
- **Improve the provision of community and culturally specific support (i.e. that considers language, religion, and ethnic group)**, for example through employing community-specific support workers (e.g. Punjabi-speaking), providing community-specific group sessions (e.g. Sikh-based groups), and providing translated resources.
- **Provide culturally appropriate training to staff on addressing alcohol use in this population** to improve the rates of engagement with services and completion of treatment.
- **Organise outreach interventions in community-relevant venues to screen for problem drinking and alcohol-related harm**, for example using health checks, AUDIT-C screening tools, and FibroScans.

For Primary Care, Maternity, and Emergency Services

- Appoint representatives to join the Drug and Alcohol Strategic Partnership steering group.
- **Provide culturally appropriate training to clinical staff on alcohol use in this population** to raise awareness, increase the uptake of opportunist screening and brief interventions, and improve referral rates to treatment services.

For Research (national and/or local)

- **Collect quantitative data on the drinking behaviours of the Punjabi-Sikh population at regular intervals**, for example through annual representative surveys. This would establish data trends over time and allow for:
 - A better understanding of the evolving nature of this population's patterns of alcohol consumption.
 - The monitoring of the gender differences in alcohol consumption, particularly focussing on the growing levels of consumption in females.
 - A clearer understanding of generational differences in alcohol consumption.
- **Conduct qualitative research to explore the changes in gender and generational attitudes towards alcohol** in the Punjabi-Sikh population, for example through interviews and/or focus groups.

1. Punjabi-Sikh community

Punjabi-Sikhs represent a community of people within the British population with ethnic ancestry in Punjab and religious heritage from Sikhism. The historical intersection between ethnicity, religion, and language is likely to have contributed to the creation of a unique Punjabi-Sikh cultural identity.^{7,17}

1.1. History of Punjabi-Sikh culture

Historically, the Punjab was a multi-cultural, multi-faith region in South Asia, comprising areas of modern-day India and Pakistan. Until 1947, Punjab was administered as part of the British Raj and its population included a mixture of Sikhs, Muslims, and Hindus. However, upon the partition of India, these populations were displaced primarily along religious lines,^{17,18} with Punjabi-Sikhs today living primarily in India, where they make up 58% of the population of the state of Punjab.¹⁹

Sikhism is a religion founded by Guru Nanak in the Punjab region in the 16th century.²⁰ The Gurdwaras (Sikh temples) are places of congregational worship and religious celebrations and play a central role in Sikh communities. A significant aspect of Sikh practice is Langar, a community kitchen attached to every Gurdwara where volunteers prepare and serve free meals to all visitors.²⁰ Langar embodies the Sikh principles of equality, selfless service, and community support.



Figure 1 – Saragarhi Monument in Wednesfield, Wolverhampton.²¹

For centuries there has been a strong relationship between Punjabi culture and Sikhism, with the lines between two often getting blurred,²² leading to people frequently thinking of Punjabi-Sikh culture when discussing Punjabi populations or communities.⁷

1.2. Punjabi-Sikhs in the UK

1.2.1. History

Ever since the British occupation of Punjab, there have been multiple waves of Punjabi-Sikh migration to the UK. Migration started in small numbers during the colonial period, especially as the Punjab became a main area for recruitment into the British Indian Army and the Indian Imperial Police. After independence, Punjabi-Sikhs joined thousands of Commonwealth citizens who were invited to move to the UK to work in low-skilled jobs in industries such as foundries and textiles that were in high demand in the aftermath of the Second World War.²⁰

This migratory wave consisted primarily of male workers, who established themselves in the UK before bringing their families. In the 1960s and 1970s, many Punjabi-Sikhs who had settled in East Africa (Kenya, Uganda) in the post-colonial period were forced to leave due to political instability, with many choosing to relocate in the UK (known as ‘twice migrants’).²³ The majority of today’s Punjabi-Sikhs communities have origins in these diasporas, either as first-generation migrants who settled in the UK, or as direct relatives born and/or raised here.

1.2.2. Population

There is no official data on the exact size of the UK’s Punjabi-Sikh population, the vast majority of which lives in the West Midlands and in London.²⁴

Ethnicity

Punjabi, as an ethnic group, is not routinely captured by the Office for National Statistics for the England and Wales Census. In the latest Census, Punjabi-Sikhs were only able to identify themselves first as ‘Asian, Asian British or Asian Welsh’ (henceforth Asian) on the high-level ethnic group and as either ‘Indian or British Indian’ (henceforth Indian) or ‘Any other Asian background’ on the low-level ethnic group.²⁵ Those opting for the latter were then able to write their ethnicity in a write-in box (e.g. Punjabi, Sikh).²⁶ Some Punjabi-Sikhs, particularly those born from inter-ethnic relationships, may also have identified themselves as belonging to ‘Mixed or Multiple ethnic groups’ (henceforth Mixed), such as ‘White and Asian’ and ‘Other Mixed or Multiple ethnic groups’ (henceforth Other Mixed).

According to the 2021 Census, 5.5 million people identified themselves as Asian, which represents one in ten English residents (9.6% of the English population). Of these, 1.8 million identified as Indian (3.3%), with only 8,153 and 22,814 identifying themselves as ethnically Punjabi and Sikh, respectively. A further half a million identified themselves as White and Asian (474,190, 0.8%), with equal numbers identifying as Other Mixed (242,350, 0.8%).²⁷

Religion

In the absence of reliable data on Punjabi ethnicity, religious affiliation is likely to be a better indicator for estimating the size of this population. This is reinforced by the fact that British Sikhs mainly identify as Sikh from a religious (rather than ethnic) perspective,²⁴ and that most Sikhs also identify as Punjabi or Punjabi-Sikh.⁷ However, this may exclude those who, despite sharing a Sikh cultural and religious background, identified themselves as not having a religion. According to the latest Census, 524,140 people identified themselves as Sikh, which represents 0.9% of the English population.²⁸

1.3. Punjabi-Sikh community in Wolverhampton

Ethnicity

According to ethnicity data from the latest Census, over one in five people in Wolverhampton identify themselves as Asian (21.2% of the city’s population), three quarters of which are ethnically Indian (15.9%). Other Asian ethnic groups include Pakistani (2.5%), Chinese (0.3%), Bangladeshi (0.2%), and Other Asian (2.2%).^{27,29,30} As described above, the latter group will include some people who identified themselves as ethnically Punjabi or Sikh, whilst those from Mixed ethnic groups are also likely to include a few Punjabi-Sikhs. A breakdown of the 2021 Census data on ethnicity for Wolverhampton is available in table 1.

Ethnicity	Overall		Male		Female	
	Number	% population	Number	% population	Number	% population
Asian	55,900	21.2%	28,116	21.7%	27,784	20.7%
- Indian	42,052	15.9%	21,129	16.3%	20,923	15.6%
- Pakistani	6,676	2.5%	3,364	2.6%	3,312	2.5%
- Chinese	802	0.3%	386	0.3%	416	0.3%
- Bangladeshi	530	0.2%	254	0.2%	276	0.2%
- Other Asian ^a	5,840	2.2%	2,983	2.3%	2,857	2.1%
Mixed	14,063	5.3%	6,842	5.3%	7,221	5.4%
- White and Asian	2,573	1.0%	1,298	1.0%	1,275	1.0%
- White and Black ^b	9,433	3.6%	4,609	3.6%	4,824	3.6%
- Other Mixed	2,057	0.8%	935	0.7%	1,122	0.8%
White	159,708	60.6%	77,818	60.1%	81,890	61.0%
Black	24,636	9.3%	11,824	9.1%	12,812	9.5%
Other	9,417	3.6%	4,951	3.8%	4,466	3.3%

Table 1 – Ethnicity breakdown of the Wolverhampton population, by gender (^aincludes those identifying as ethnically Punjabi or Sikh; ^bincludes 'White and Black African' and 'White and Black Caribbean') [Census 2021].²⁷

Religion

One in eight Wulfrunians (12.0%) identify themselves as Sikh, well above the national average for England (0.9%). Wolverhampton is the local authority in England and Wales with the largest proportion of Sikhs in its population, as well as the third largest Sikh community in absolute terms (31,769), behind Sandwell (39,252) and Birmingham (33,126). Sikhs also represent the city's second largest faith group behind Christianity (43.8%), with Islam (5.5%) and Hinduism (3.7%) much less prevalent (figure 2).²⁸⁻³⁰

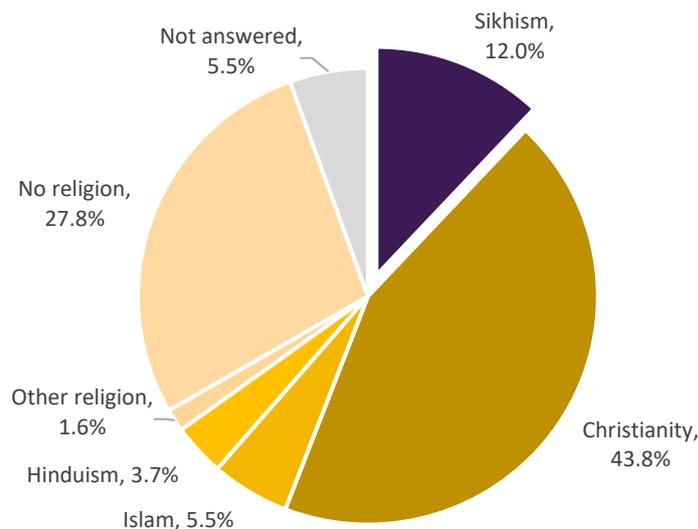


Figure 2 – Prevalence of different religions in Wolverhampton (Census 2021 via WVInsight).²⁸⁻³⁰

When combining the city's two biggest Indian religious groups - Sikhs and Hindus -, the total approximates to the size of its Indian population (15.7% vs. 15.9%), which means that Sikhism is likely to be a reliable demographic proxy for the city's Punjabi-Sikh community. And **with one in eight residents being Punjabi-Sikh, this community represents one of the city's largest minority groups.**

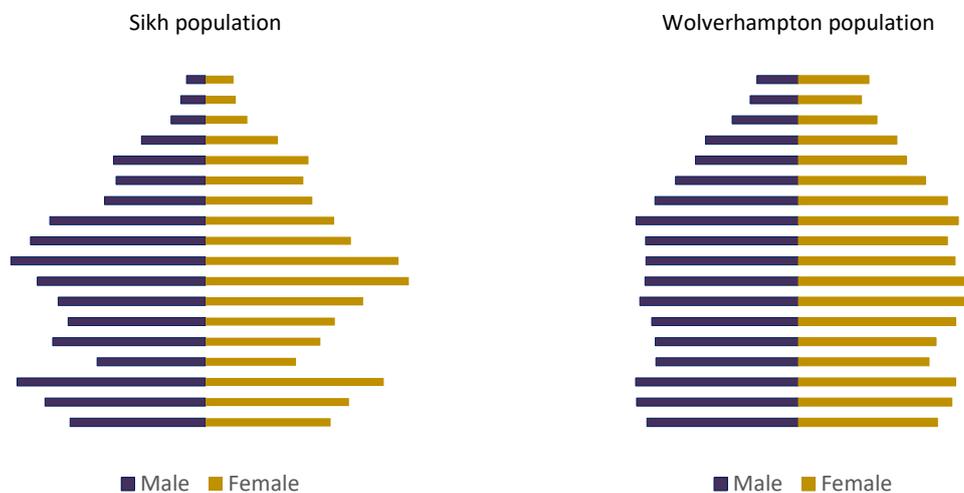


Figure 3 – Population pyramids for Wolverhampton's Sikh (left) and overall (right) populations, by gender (Census 2021 via WVInsight).²⁸⁻³⁰

Wolverhampton's Sikh population is evenly divided by gender, representing 12.4% of males (16,111 residents) and 11.7% of females (15,658 residents), and is generally younger than the overall city population (figure 3). A big proportion of the community lives in the south of the city, with one in six Sikhs (16%) living in Blakenhall, where they represent 41% of the ward's population (figure 4). Other wards with large Sikh communities include Ettingshall North (8.8% of Sikhs, 19% of the ward's population), Penn (7.5% of Sikhs, 19% of the ward's population), and Ettingshall South & Spring Vale (7% of Sikhs, 17% of the ward's population). Nonetheless, the community is widely spread across the city, with even the ward with the lowest proportion of Sikh residents (Bushbury North, 3%) being well above the national average.

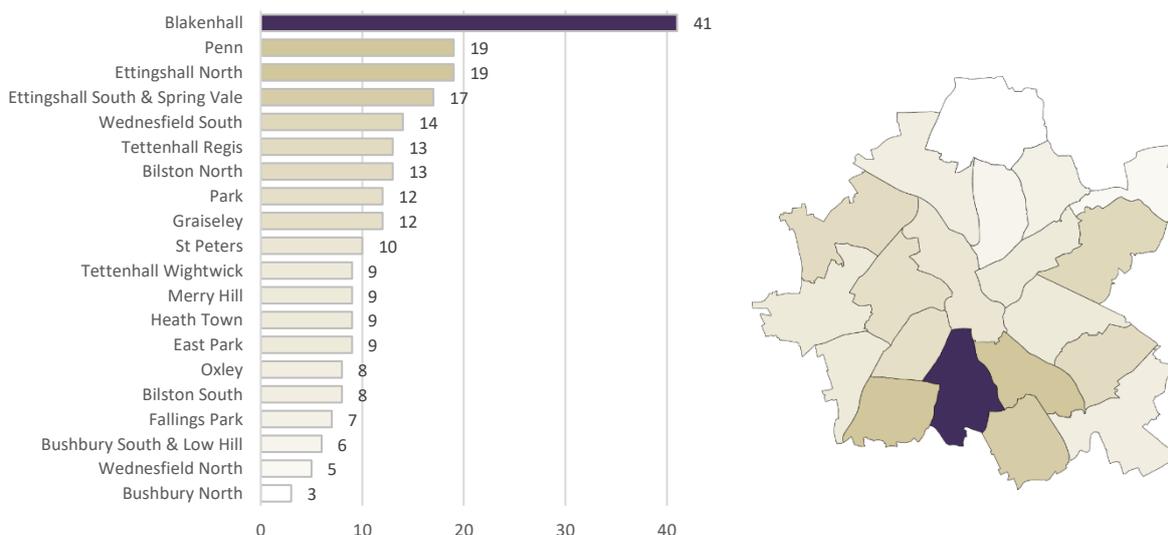


Figure 4 – Distribution of Wolverhampton's Sikh population by ward, as a proportion (%) of each ward's population (darker colours representing a higher proportion) [Census 2021 via WVInsight].^{28,29}

2. Alcohol in the Punjabi-Sikh community

2.1. Attitudes and perceptions of alcohol use

2.1.1. *Alcohol in the Punjabi-Sikh culture*

Despite being prohibited in Sikhism, alcohol consumption is relatively ubiquitous in Punjabi-Sikh culture.^{1,31} Sikhism has a long tradition of discouraging the use of intoxicants, with some Shabads (hymns) from the Guru Granth Sahib specifically discouraging alcohol consumption. In 1931, the Rehat Maryada (the Sikh Code of Conduct) formalised the proscription of alcohol and other intoxicants in Sikhism,¹ with baptised Sikhs expected not to drink.³¹ As a result, individual religious beliefs influence consumption behaviour amongst Punjabi-Sikhs, with women identifying as strong adherents the least likely to drink.³² However, in Sikhism, those who are not baptised are still considered members of the Sikh community so long as they believe in the Gurus.⁷ This, combined with the rise of a distinct Punjabi-Sikh cultural identity, means that many people who identify as Sikh or Punjabi-Sikh are not necessarily baptised, practice its faith, or follow its teachings.

In fact, despite the religious injunction, there has long been a strong culture of heavy alcohol use in Punjab.¹ Drinking is relatively common amongst Punjabi-Sikhs, especially at weddings and parties, where people are encouraged to consume large quantities of alcohol.³¹ Recent qualitative studies described that British Punjabi-Sikh men consider drinking large quantities of alcohol as part of their culture,^{7,33} with one survey reporting that half of Sikhs feels pressured to drink at social events.³⁴ As such, it is possible to establish that Punjabi-Sikh culture has a particular relationship with alcohol beyond what is preconised by Sikhism, with some British Punjabi-Sikhs even describing a 'double drinking culture', given the UK's heavy drinking culture.³¹

2.1.2. *Alcohol in the Punjabi-Sikh community in Wolverhampton*

In 2010, the Wolverhampton Primary Care Trust (PCT) commissioned M·E·L Research to conduct an exploratory study on the perceptions of alcohol use in the Asian communities of Wolverhampton. A combination of qualitative (semi-structured interviews, 'chattabout' sessions, case studies) and quantitative (outreach surveys) methods was used, with sub-group analysis conducted for Sikh, Hindu, and Muslim religious communities.³⁵ Despite being 14 years old, it remains the most comprehensive piece of research on alcohol in the Asian communities of Wolverhampton.

The M·E·L Research report found that alcohol played an important role in the lives of the Sikh community, with its culture seen as one of excess. Many reported heavy drinking as 'normal', with weddings and celebrations identified as key locations where alcohol was consumed in excess. It also singled out religion as the main factor influencing people's perceptions on alcohol within this community. The main findings of this report which are relevant to the Punjabi-Sikh community are summarised in appendix 1 (page 29).

2.2. Patterns of alcohol consumption

Whereas a few studies specifically explore drinking patterns in Sikh and/or Punjabi-Sikh communities, most of the existing literature and data sources only report broader ethnic groups (e.g., Asian, Indian), whereas religion data is often not routinely collected. Asian and South Asian populations are generally reported to have higher rates of abstinence; drink less frequently, smaller amounts, and less heavily; and have lower rates of alcohol dependence than the general UK population and/or their White counterparts.^{2,3,36} However, given Punjabi-Sikhs' unique cultural identity and relationship with alcohol, these generalisations are likely to mask or misrepresent some patterns of alcohol consumption specific to Punjabi-Sikh communities.

2.2.1. Prevalence of alcohol use

National data

A 2022 joint study by the Sikh Recovery Network (SRN) and the British Sikh Report (BSR) provides perhaps the best source of data on alcohol consumption for the UK's Punjabi-Sikh population.¹ It surveyed a representative sample of British Sikhs (1,095 respondents, 55% male) using a combination of online and in-person questionnaires and found that **three in five Sikhs (61%) currently consume alcohol**, including two in three males (64%) and more than half of females (56%). These findings are broadly in line with those from a 2018 study jointly conducted by the BBC and BMG Research into the drinking habits of British Sikhs (1,049 responses), which reported that 61% of them drank at least occasionally.³⁴ The findings of both surveys are summarised in table 2.

Contrasting these findings with data for other Asian groups allows us to directly compare the drinking habits of Punjabi-Sikhs with those from other Asian communities. An additional analysis of Health Survey for England (HSE) 2011-19 data conducted by NHS England in 2022 provides us with the best source of information relating to alcohol consumption by ethnicity (table 2).² Overall, the prevalence of alcohol consumption in Sikh males is comparable to that of ethnically Indian men (63%), whereas it is slightly higher in Sikh females than in ethnically Indian women (36%). However, the prevalence is very different from that of other Asian ethnicities, with both male and female Sikhs drinking less than those who are Chinese but significantly more than Bangladeshis and Pakistanis. It is also worth noting that the prevalence of alcohol consumption for all Asian groups is well below that of the White British population.

Data source	No. responses	Group (ethnic/religious)	% of respective group consuming alcohol		
			Overall	Male/men	Female/women
National data (Sikh)					
SRN/BSR study (2022) ¹	1,095	Sikh	61%	64%	56%
BBC/BMG study (2018) ³⁴	1,049	Sikh	61%	72%	49%
National data (other ethnic groups)					
HSE (2011-19) ²	1,919	Indian ^a	50%	63%	36%
	353	Chinese ^a	73%	77%	70%
	512	Bangladeshi ^a	10%	13%	8%
	1,273	Pakistani ^a	6%	9%	2%
	60,342	White British ^a	88%	91%	86%
Wolverhampton data					
City Lifestyle Survey (2022-23) ⁴	372	Sikh	34%	40%	28%
	709	Indian	32%	40%	27%

Table 2 – Prevalence of alcohol consumption, by ethnic and/or religious group and gender (^aage-standardised data).

There is limited good-quality data on the drinking patterns of Hindu and Muslim religious groups in the UK to allow for a direct comparison with Punjabi-Sikh communities. A literature review on ethnicity and alcohol published by the Joseph Rowntree Foundation (JRF) in 2010 identified that Muslims were the least likely group to drink, with some studies reporting over 90% of abstinence rates.³ This is in line with the HSE data for Pakistani ethnic groups (predominantly Muslim). The picture is less clear for Hindus, with studies reporting similar or lower drinking prevalence compared to Sikhs.

Wolverhampton data

There is no recent survey or study exploring the patterns of alcohol in the Punjabi-Sikh population of Wolverhampton. The best recent data source available is the City Lifestyle Survey, conducted by the City of Wolverhampton Council Public Health team between October 2022 and February 2023.⁴ The City Lifestyle Survey collected 6,021 valid responses, with 372 respondents identifying as Sikh (religion) and 709 identifying as Indian (ethnicity). The results for the alcohol-related questions were overall very similar between the two groups, which is unsurprising given that Punjabi-Sikhs represent three quarters of the city's Indian population. According to the City Lifestyle Survey, the prevalence of alcohol consumption for both those identifying as Sikh and ethnically Indian was well below those reported by national data sources (table 2), with only one in three respondents (32-34%) saying they drink alcohol, compared with one in two Indians (50%) and two in three Sikhs (62%) nationally. Despite male respondents reporting a higher prevalence of drinking than female ones (40% vs. 27-28%), these figures are well below those reported nationally for both Indian ethnic groups (63% vs. 36%) and Sikhs (64-72% vs. 49-56%).

However, there are several limitations with this dataset which may affect the validity of these findings. Despite collecting 6,021 valid responses, only 6% of respondents identified as Sikh and only 12% identified as ethnically Indian – both well below the proportion of the Wolverhampton population they represent (12% and 16%, respectively). Coupled with the disproportionate number of female respondents, who represented 57% of Sikh and 60% of Indian participants, this raises a significant risk of selection bias, with those who took part unlikely to be representative of the city's Punjabi-Sikh community. There is also a possible social acceptability bias affecting the interpretation of results, as participants underreport behaviours which can be seen as socially sanctioned. This is more likely to happen in the City Lifestyle Survey than in the two national surveys – whereas the SRN/BSR and BBC/BMG studies focused solely on the drinking behaviours of British Sikhs (i.e., respondents knew exactly what they were being asked about and had no incentive for underreporting their consumption), the City Lifestyle Survey was a broad questionnaire on the lifestyle habits of the general population, with only a few alcohol-related questions. Additionally, there is a risk of an information bias arising from the fact that participants were given the possibility of skipping some questions, with only around one third of Sikh and Indian respondents answering follow-up questions exploring their drinking habits in more detail. Finally, given the relatively small number of respondents for each ethnic/religious group (particularly for follow-up questions), the results should be interpreted with caution.

2.2.2. Frequent alcohol use

National data

According to the SRN/BSR report, out of those that consume alcohol, one in four (24%) drinks 2-3 times per week and one in five (17% of males, 20% of females) drinks 4+ times per week. Extrapolating these results to the entire Sikh population (i.e., drinkers and non-drinkers), this equates to **15% of Sikh males and 13% of Sikh females consuming alcohol 2-3 times per week** and **11% drinking 4+ times per week**. The BBC/BMG survey also reported on the frequency of alcohol use, although the lack of detail on its methodology does not allow for a direct comparison of the results (possible answers included 'occasionally', 'sometimes', and 'very often'). It found that 13% of British Sikhs drank 'very often' (definition not provided), including 16% of males and 9% of females. The findings of both surveys are summarised in table 3.

Frequency of alcohol consumption is harder to compare with the HES ethnicity data due to difference in the metrics used by the different data sources (table 3). Nonetheless, it is possible to understand that frequent consumption in Sikh males follows a similar pattern to that of ethnically Indian men (16% drink 3+ times per week), whereas Sikh females are more likely to drink frequently than ethnically

Indian women (only 3% drink 3+ times per week). As was the case for overall drinking prevalence, frequent alcohol use is less common in all Asian ethnic groups compared to the White British population.

Data source	No. responses	Group (ethnic/religious)	Frequency	% of respective group (% of respondents in their group who drink alcohol)		
				Overall	Male/men	Female/women
National data (Sikh)						
SRN/BSR study (2022) ¹	1,095	Sikh	2-3 times/week	-	15% (24%)	13% (24%)
			4+ times/week	-	11% (17%)	11% (20%)
BBC/BMG study (2018) ³⁴	1,049	Sikh	Very often ^a	13%	16%	9%
National data (other ethnic groups)						
HSE (2011-19) ²	1,919	Indian ^b		10%	16%	3%
	353	Chinese ^b		9%	10%	8%
	512	Bangladeshi ^b	3+ times/week	5%	6%	3%
	1,273	Pakistani ^b		2%	3%	1%
	60,342	White British ^b		28%	34%	22%
Wolverhampton data						
City Lifestyle Survey (2022-23) ⁴	372 (125 answered this question)	Sikh	2-3 times/week	8% (22%)	12% (30%)	3% (12%)
			4+ times/week	3% (10%)	5% (13%)	2% (7%)
	709 (226 answered this question)	Indian	2-3 times/week	8% (24%)	12% (30%)	5% (19%)
			4+ times/week	3% (9%)	6% (14%)	1% (4%)

Table 3 - Frequency of alcohol consumption, by ethnic and/or religious group and gender (^aother options included 'occasionally' and 'sometimes'; ^bage-standardised data).

Wolverhampton data

Comparing the City Lifestyle Survey data for Sikh respondents with the results from the SRN/BSR study (both used the same metrics), the prevalence of frequent drinking is lower in Wolverhampton than what is reported nationally (table 3). As described above (page 15), there are several limitations with this dataset – small numbers, risk of multiple biases – which may affect the validity of these findings.

2.2.3. Problem drinking

Problem alcohol use, or problem drinking, refers to an intake which exceeds low risk drinking guidelines (up to 14 units a day, ideally spread evenly over 3 or more days).¹² It can also be described as heavy or excessive drinking. Problem drinking includes increased risk drinking, binge drinking, and alcohol use disorder (AUD).

Increasing risk drinking – also known as hazardous drinking – refers to an established pattern of drinking which increases the risk of damage or harm to health.^{12,36} It is defined as drinking more than 14 units of alcohol a week but less than 35 units for women and 50 units for men.¹² Binge drinking refers to the consumption of high amounts of alcohol – 8 units for males, 6 units for females – on a single occasion.³⁷ Alcohol use disorders (AUD) is an umbrella term which includes higher-risk drinking and alcohol dependence. Higher-risk drinking – also known as harmful drinking – relates to an established pattern which is already causing health harms, whereas alcohol dependence refers to higher-risk use with physical signs of addiction.^{12,36}

National data

The 2010 JRF literature review found high rates of heavy drinking in British Sikh men – closer to those of Christians than of other South Asian religions.³ The SRN/BSR study found that, out of those who drink, one in six males (18%) and one in eight females (12%) drinks 10+ units per week. Extrapolating these findings to the entire Sikh population (i.e., drinkers and non-drinkers), it found that **12% of Sikh males and 7% of Sikh females drink 10+ units per week**. The full findings of the study are summarised in table 4 (the BBC/BMG survey did not report on consumption levels). Once again, differences in the metrics used prevent a direct comparison of these findings with those from the HSE ethnicity data (table 4). Nonetheless, levels of heavy consumption in Sikh males seem to mimic those of ethnically Indian men (11% drink over 14 units per day), whereas Sikh females appear less likely to drink heavily compared to ethnically Indian women (only 2% drink over 14 units per day). The prevalence of heavy drinking is also significantly lower in all Asian groups than in the White British population.

Data source	No. responses	Group (ethnic/religious)	No. units per day	% of respective group (% of respondents in their group who drink alcohol)		
				Overall	Male/men	Female/women
National data (Sikh)						
SRN/BSR study (2022) ¹	1,095	Sikh	10+	-	12% (18%)	7% (12%)
National data (other ethnic groups)						
HSE (2011-19) ²	1,896	Indian ^a		7%	11%	2%
	349	Chinese ^a		9%	12%	7%
	513	Bangladeshi ^a	>14	5%	6%	4%
	1,270	Pakistani ^a		1%	1%	1%
	59,329	White British ^a		27%	36%	18%
Wolverhampton data						
City Lifestyle Survey (2022-23) ⁴	372 (125 answered this question)	Sikh		2% (5%)	3% (7%)	1% (3%)
	709 (219 answered this question)	Indian	10+	2% (5%)	3% (9%)	1% (3%)

Table 4 – Amount of daily alcohol consumption, by ethnic and/or religious group and gender (^aage-standardised data).

Data source	No. responses	Group (ethnic/religious)	Frequency of binge drinking	% of respective group (% of those in their group who drink alcohol)		
				Overall	Male/men	Female/women
National data						
SRN/BSR study (2022) ¹	1,095	Sikh	Weekly	-	10% (16%)	7% (12%)
			Daily (or almost daily)	-	6% (9%)	5% (9%)
Wolverhampton data						
City Lifestyle Survey (2022-23) ⁴	372 (125 answered this question)	Sikh	Weekly	3% (9%)	5% (15%)	1% (3%)
			Daily	1% (2%)	1% (2%)	<1% (2%)
	709 (219 answered this question)	Indian	Weekly	2% (6%)	3% (11%)	1% (3%)
			Daily	<1% (2%)	1% (2%)	<1% (1%)

Table 5 - Frequency of binge drinking, i.e. consuming, in a single occasion, at least 6 (females) or 8 units (males), by gender.

The SRN/BSR study also explored the prevalence of binge drinking in British Sikhs and found that one in four (25%) males and one in five (21%) females who drank did so on a weekly or daily (or almost daily) basis (table 5). Extrapolating these findings to the entire Sikh population (i.e., drinkers and non-drinkers), it found that **one in six (16%) Sikh males and one in eight (12%) Sikh females binge drank at least weekly**.

It also reported that **one in eight Sikhs drinkers (13% of males, 12% of females) was unable to stop drinking either daily or weekly**, whereas the vast majority (67% of males, 73% of females) had never been in that position (figure 5). However, no equivalent data is available to directly compare these figures with the general population and/or other ethnic or religious groups.

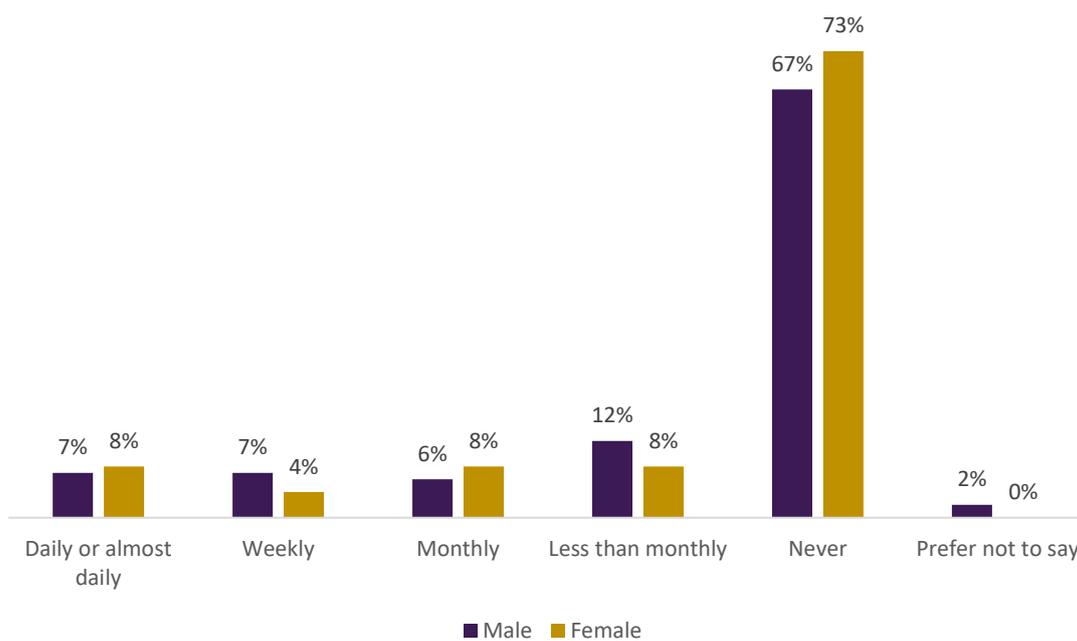


Figure 5 – How often were participants unable to stop drinking once they started, in the last year, by gender (base – respondents who admitted to consuming alcohol) [SRN/BSR study, 2022].¹

An older study from 2004 also identified that one in five British Sikh men had multiple signs that indicated that their drinking was of concern (e.g., excessive weekly intake, engagement in risky activities), a much higher proportion than any other South Asian religion.³²

The SRN/BSR study also found that **half of British Sikhs (54%) have a family member or friend with a drinking problem**, over two-thirds of which are relatives. This means that around one in three (37%) of British Sikhs reports having a relative with a drinking problem, of which 95% are males and over 80% are aged between 35 and 64. This is slightly higher than the numbers reported by the BBC/BMG survey, which found that one in four (27%) British Sikhs has a (predominantly male) relative with a drinking problem.

Wolverhampton data

As with other previous data points, the prevalence of problem drinking reported in the City Lifestyle Survey is well below that which reported by the SRN/BSR survey (tables 4 and 5). However, as described above (page 15), there are several limitations with this dataset – small numbers, risk of multiple biases – which may affect the validity of these findings. As for alcohol use disorders, there is no available data on its prevalence in the Punjabi-Sikh community in Wolverhampton.

2.3. Gender/sex differences

Alcohol consumption in the Punjabi-Sikh community has traditionally been associated with men. Similar to the trends in other communities, men have typically drunk more than women, with gender roles and attitudes meaning that drinking alcohol has generally been seen as less acceptable for Punjabi-Sikh women.⁵ A recent qualitative study by D. Bagri reported that British Punjabi-Sikh men tend to drink large amounts of alcohol to “help fulfil a cultural identity that is heavily influenced by ideals of hegemonic masculinity”.⁷

However, a longstanding focus on the drinking patterns of Punjabi-Sikh men may be hiding a shift in gender attitudes. The 2010 JRF literature review reported an increase in drinking and drinking frequency among Sikh girls,³ whereas the SRN/BSR study found similar rates of frequent and problem drinking in males and females.¹ Despite the absence of literature exploring the attitudes of Punjabi-Sikh women in more detail, Bagri reported that British Punjabi-Sikh women could increasingly be turning to alcohol as a coping mechanism, reflecting a growing acceptability of drinking in their community.⁷

2.4. Generational differences

Generational differences in health behaviours in ethnic minorities, including on alcohol consumption, can be partly explained by factors such as changes in socio-economic status (SES)^{3,6} and a weakening of ethnic identities in second generations.⁶ According to Bagri,⁷ some of these changes are likely to be underpinned by distinct acculturation strategies: whereas first generations acculturated primarily through ‘separation’³⁸ from the host culture (i.e., holding on to their original culture), second generations seem to favour ‘integration’,³⁸ having adopted the habits and values of British culture. Given the high prevalence of drinking in both Punjabi-Sikh and British cultures, this is likely to lead to smaller behavioural changes compared to other minority groups.

In fact, there is no clear consensus on the direction and size of the generational difference in alcohol consumption for the UK’s Punjabi-Sikh community. Whereas the 2010 JRF literature review found that, compared to their parents’ generation, second-generation male Sikhs were less likely to drink and drink heavily,³ two other observational studies reported opposing results for second-generation Indians. A 2008 study analysing data from the Health Survey for England reported that second-generation Indians were more than twice as likely to drink frequently than first generations (not adjusted for deprivation or SES),³⁹ whereas a 2019 study analysing data from the Household Longitudinal Survey reported higher frequency of drinking in second generations, even when adjusting for SES.⁶

2.5. Alcohol-related harm

Alcohol-related harm includes all harmful outcomes arising due to alcohol use. It exists on a spectrum and includes health and social consequences, immediate and long-term, both to the self and to others.³⁶

2.5.1. Health harms

Short-term health harms resulting from problem drinking include illness and death from immediate events such as accidents, injuries, and alcohol poisoning. Long-term impacts include illness and death resulting from chronic diseases such as cancer, alcoholic liver disease (ALD), and cardiovascular disease.¹² Alcohol-specific deaths are those which arise as direct consequence of problem drinking, whereas alcohol-related deaths include deaths from any cause that can be (directly or indirectly) attributed to alcohol.⁴⁰

National data

There is no national routinely collected data on alcohol-related health harms broken down by either ethnicity or religion. As such, the data presented here is taken from a literature review of academic papers.

The 2010 JRF literature review reported that South Asian men, and in particular **Sikh men, were overrepresented as patients due ALD** when compared to other ethnic groups and the general population, and that they tend to be younger at diagnosis than their White counterparts.³ An older observational study examining mortality from liver disease in the West Midlands (not included in the literature review) also described an almost **four times higher risk of death due to ALD in Asian men** (of which 80% were thought to be Sikh) than in their White peers (SMRⁱ of 3.79, 95% CIⁱⁱ 3.21 to 4.26).⁸

These findings are reinforced by those of a more recent linkage study exploring ethnic differences in alcohol-related hospital admissions and mortality in Scotland. The 2016 study identified that, when adjusting for age, country of birth, and deprivation, **men of Indian ethnicity had a 75% higher risk of ALD-related first hospitalisation or death** than their White counterparts (95% CI 7.3% to 187%).⁹ In contrast, men of Pakistani ethnicity had a 35% lower risk (95% CI 0.4% to 58%).

A 2015 cross-sectional study examining geographical variations in alcohol-related hospital admissions by ethnicity identified that people of Indian ethnicity had higher rates of hospitalisation in the Midlands (128 per 100,000) compared to any other English region (29 per 100,000 in the South of England, 48 per 100,000 in the North of England, 99 per 100,000 in London).⁴² Despite the figures not being adjusted for confounders, such as deprivation, this pattern differs from most other ethnic groups, from whom rates in the North of England are generally higher than in the Midlands.

Wolverhampton data – mortality

Despite the lack of data specific to the Punjabi-Sikh community, linkage data on alcohol-specific deaths for the city's Asian population is available. This dataset was obtained by matching death registration data held by the NHS Midlands and Lancashire Commissioning Support Unit (CSU) to the Secondary Uses Service (SUS) database to establish ethnicity.¹⁰ The proportion of alcohol-specific deaths for people of Asian ethnicities (23.8%) is overall slightly higher than its share of the city's population (21.2%), with Asian males in particular significantly overrepresented (31.3% vs. 21.7%). The full findings are displayed in table 6.

Ethnicity	Overall		Male		Female	
	% of alcohol-specific deaths ^a	% population	% of alcohol-specific deaths ^b	% population	% of alcohol-specific deaths ^c	% population
Asian	23.8%	21.2%	31.3%	21.7%	8.6%	20.7%
Mixed	0%	5.3%	0%	5.3%	0%	5.4%
White	73.0%	60.6%	64.4%	60.1%	90.1%	61.0%
Black	2.0%	9.3%	2.5%	9.1%	1.2%	9.5%
Others	1.2%	3.6%	1.8%	3.8%	0%	3.3%

Table 6 – Distribution of alcohol-specific deaths in Wolverhampton by ethnicity and by gender (^a86.2% ethnicity matched; ^b83.6% ethnicity matched; ^c92% ethnicity matched) [death registration data linked to SUS database for ethnicity].¹⁰

ⁱ *Standardised Mortality Ratio (SMR)* – method dividing the total number of observed deaths in a population to the total number of expected deaths in a population.⁴¹

ⁱⁱ *95% Confidence Interval (95% CI)* – interval within which the true value is expected to be, with 95% certainty.

Given that the vast majority of the city’s Asian population is either from Indian ethnicities or Sikh, it is possible to assume that **Punjabi-Sikh males are overrepresented in alcohol-specific deaths in Wolverhampton**, which may indicate an excess in alcohol-related health harm in this population. However, it is important to acknowledge two limitations with this data set. The first is that this analysis relies on a relatively small number of alcohol-specific deaths, so results should be interpreted with caution. The second limitation arises from the fact that not all the reported deaths were matched by ethnicity (86.2% matched overall, 83.6% of males, 92% of females). A bias could have been introduced if, for example, one or more ethnic groups were disproportionately accounted for in unmatched deaths. However, there is no way to verify or refute this.

Wolverhampton data – hospital admissions

Local data on emergency admissions due to alcohol is also available. According to data from The Royal Wolverhampton NHS Trust (RWT) obtained from the SUS database,¹⁰ between April 2020 and March 2023 15.5% of emergency admissions due to alcohol-specific causes were from people of Asian ethnicities (table 7). Analysing the figures by gender, one in five male admissions (19.6%) are from Asian males, whereas only one in twenty female admissions (5.0%) are from Asian females. However, given that the Trust’s catchment area extends beyond Wolverhampton, particularly into South Staffordshire, (figure 6), these figures need to be compared with the Trust’s catchment population.

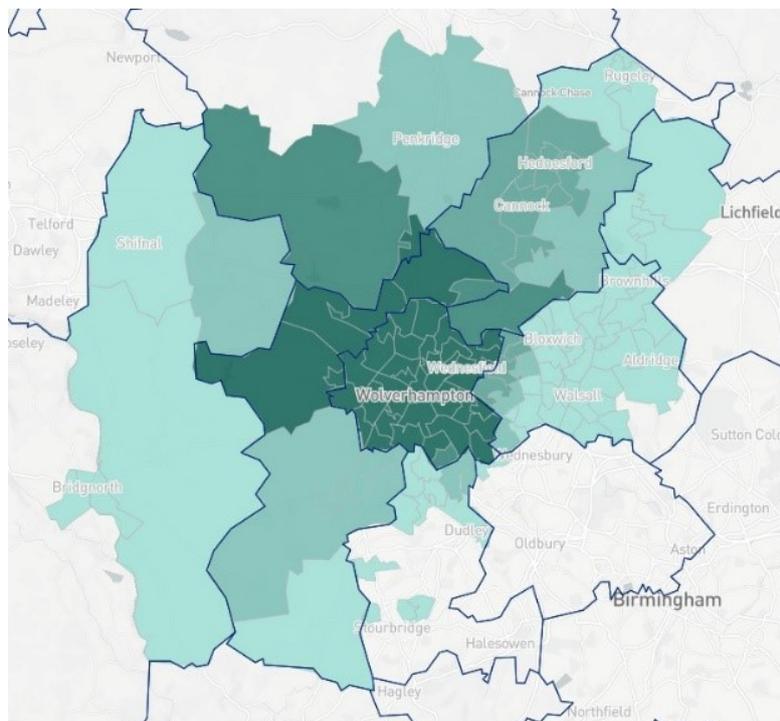


Figure 6 – Proportion of patients attending The Royal Wolverhampton Trust by MSOAⁱⁱⁱ (darker colours representing a higher proportion, proportions below 5% not shown).⁴³

Considering that 11.7% of the RWT catchment population is of Asian ethnicities,⁴³ it is possible to establish that **Asian males are overrepresented in alcohol-specific emergency admissions**, which may also indicate an excess in alcohol-related health harm in the Wolverhampton’s Punjabi-Sikh population. This is reinforced by the fact that South Staffordshire has very small Asian population (2.8%),²⁷ making it likely that most of the Trust’s catchment population from Asian ethnicities lives in Wolverhampton.

ⁱⁱⁱ Middle Layer Super Output Area

Ethnicity	% of alcohol-specific emergency admissions			% of RWT catchment population ⁴³
	Overall	Male	Female	
Asian	15.5%	19.6%	5.0%	11.7%
Mixed	1.4%	1.4%	1.4%	2.6%
White	79.9%	75.6%	90.6%	81.1%
Black	1.7%	1.6%	2.1%	3.7%
Others	1.5%	1.7%	1.0%	1.0%

Table 7 – Distribution of emergency admissions due to alcohol-specific causes at The Royal Wolverhampton NHS Trust (RWT) between 2020 and 2023 by ethnicity and by gender (SUS database via NHS Midlands and Lancashire CSU)¹⁰

2.5.2. Social harms

The most direct social consequences of problem drinking are the impacts it has on families. The SRN/BSR study reported that **two in five Sikhs (43% of males, 42% of females) had experienced direct impacts from problem drinking by an immediate relative**, including emotional and mental health issues, damaged family relationships, separation or divorce, domestic abuse, and neglect of children. Despite not exploring the role of alcohol as a driving factor, a 2022 survey by the Sikh Women’s Aid charity reported that **two thirds (62%) of Sikh women and girls had experienced domestic abuse**, with a third (32%) of respondents describing having experienced sexual abuse.¹¹ Given the well-established relationship between problem drinking and domestic violence and abuse,^{12,13} it is very likely that problem drinking contributes at least partially to this.

2.6. Support and treatment

2.6.1. Management of alcohol consumption

To understand their recovery journey, the SRN/BSR study asked additional questions to respondents who admitted to problematic alcohol use.¹ **Two-thirds (67%) of Sikhs with problem drinking said they had not been made aware that they required help to stop drinking**, with the remaining third having been alerted by a combination of friends, family, themselves (‘self-realisation’), and medical professionals.

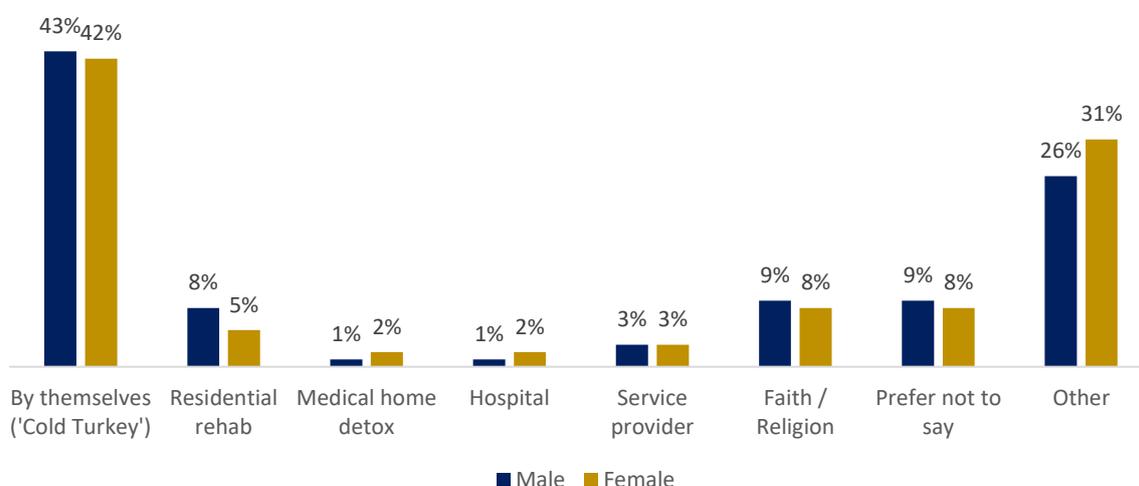


Figure 7 – How did participants stop their alcohol consumption, by gender (base - respondents who admitted to problematic consumption and had managed to stop drinking) [SRN/BSR study, 2022].¹

Of those respondents who had managed to quit drinking, **43% had stopped by themselves ('Cold Turkey')**, with only a minority seeking professional support (figure 7); one in five (16% of males, 23% of females) had relapsed whilst in recovery; one in three (33%) reported not having the right level of support in recovery (although 25% preferred not say); and only one in seven (11% of males, 17% of females) used a recovery model to help their recovery (of which Alcoholics Anonymous meetings were the most popular, used by one-fifth).

2.6.2. Engagement with treatment services

The 2010 JRF literature identified that ethnic minorities in the UK have historically been underrepresented in alcohol treatment services.³ However, this generalisation may hide or mask patterns specific to Punjabi-Sikhs, different local realities, or even more recent trends.

Wolverhampton data

Data from the local drugs and alcohol treatment service provider – Recovery Near You (RNY) – is available through the National Drug Treatment Monitoring System (NDTMS).¹⁴ A breakdown by ethnicity and religion of those in treatment for “alcohol only” in Wolverhampton between April 2023 and March 2024 is available in table 8.

According to NDTMS data, 18.8% of those in treatment in 2023/24 identified themselves as ethnically Indian, above their share of the city’s population (15.9%). Indian males, in particular, are overrepresented in treatment services (23.0% vs. 16.3%), whilst Indian females appear to be underrepresented (9.6% vs. 15.6%). However, over the last 3 years (2021/22 to 2023/24), the representation of Indian females in local treatment services for alcohol has almost doubled since 2021/22, whilst it has barely changed for males (figure 8).

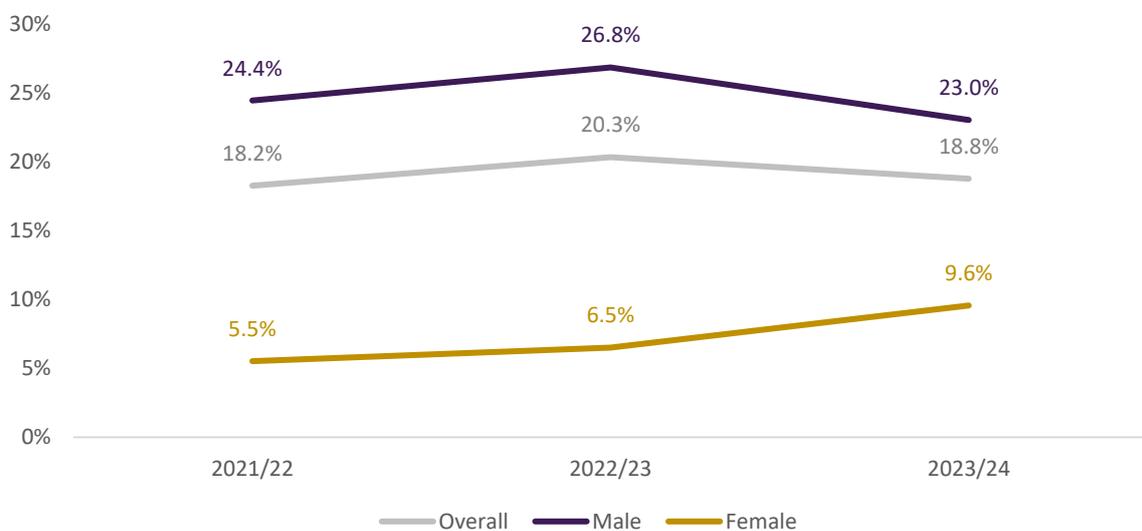


Figure 8 – Proportion of people of Indian ethnicity in treatment for “alcohol only” between 2021/22 and 2023/24, by gender (RNY via NDTMS).¹⁴

Although a direct comparison is difficult to establish, these figures mirror gender differences in alcohol-related harm identified above for the city’s Asian population, potentially indicating an engagement with services by Punjabi-Sikhs proportional to the level of harm in their community.

When examining this data by religion, 12.3% of those in treatment identified themselves as Sikh, in line with their share of Wolverhampton’s population (12.0%). Similarly to ethnicity, Sikh males are overrepresented in treatment services (15.9% vs. 12.4%), whilst Sikh females are underrepresented (4.5% vs. 11.7%). As seen in figure 9, there has been little significant change in Sikh representation in services over the last 3 years.

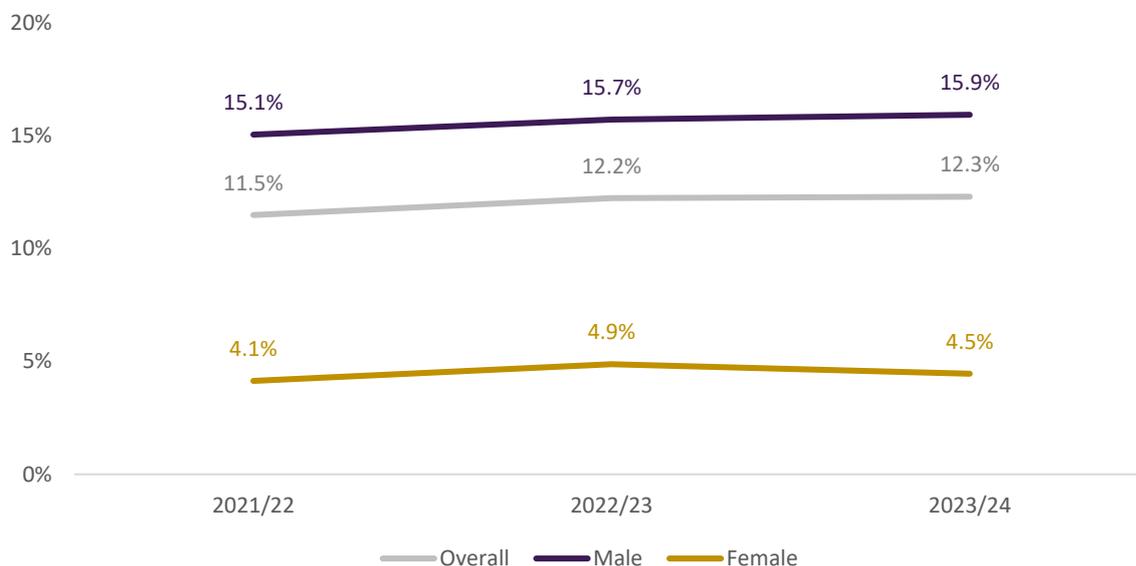


Figure 9 - Proportion of people identifying as Sikh in treatment for “alcohol only” between 2021/22 and 2023/24, by gender (RNY via NDTMS).¹⁴

However, the total for the two main Indian religious groups – Sikhs and Hindus – is slightly below the proportion of people in treatment from Indian ethnicities (15.3% vs. 18.8%), whilst the proportion of those in treatment without religion is well above the city average (58.9% vs. 33.3%). This indicates that service users are likely to underreport their religion compared to the Census, which may translate into an underestimation of the true engagement of Sikhs with services. As such, ethnicity data is probably a better indicator of the Punjabi-Sikh community’s engagement with services.

	Overall		Male		Female	
	% of people in treatment for “alcohol only”	% population	% of people in treatment for “alcohol only”	% population	% of people in treatment for “alcohol only”	% population
Ethnicity						
Indian	18.8%	15.9%	23.0%	16.3%	9.6%	15.6%
White British	66.1%	54.7%	59.9%	54.3%	79.6%	55.1%
Religion						
Sikh	12.3%	12.0%	15.9%	12.4%	4.5%	11.7%
Hindu	3.0%	3.7%	3.5%	3.7%	1.9%	3.8%
No religion ^a	58.9%	33.3%	53.4%	35.5%	70.7%	31.2%

Table 8 – Proportion of people engaging with the drugs and alcohol treatment service for “alcohol only” in Wolverhampton by ethnicity and religion, and gender (^aincluding religion unknown or not disclosed) [RNY via NDTMS, 2023-24].¹⁴

However, there is a consistent discrepancy between the total number of people reported as being in treatment for alcohol only and the total number with reported ethnicity and religion, with only around three quarters of services users having data for ethnicity and religion (601 vs. 444 in 2021/22, 546 vs. 384 in 2022/23, and 685 vs. 496 in 2023/24). As with alcohol-specific deaths data, a bias could have been introduced if, for example, one or more ethnic or religious groups were disproportionately accounted for in those without reported ethnicity or religion.

2.6.3. Barriers

Two recent literature reviews identified key barriers to accessing support related to alcohol use. One, published by Alcohol Change UK in 2019, summarised the main barriers common to different ethnic minority groups,¹⁵ whereas the other, published earlier this year, explored barriers specifically amongst the British Punjabi-Sikh community.¹⁶ The latter identified **stigma** as the **most commonly cited barrier** in literature, **often underpinning other barriers**. The main findings from both studies are summarised in table 9.

The 2010 M·E·L Research also explored potential barriers to accessing help. It found that the person themselves not admitting to having a problem with alcohol was seen as the key barrier amongst Sikhs. Despite this not being seen as specific to the Asian community, social stigma was seen as exacerbating the problem. Other barriers identified included lack of awareness about organisations providing treatment and advice, and the counselling model of treatment (seen as a potentially poor fit for Asian communities). Other relevant findings are summarised in appendix 1 (page 29).

	Ethnic minorities ¹⁵	Punjabi-Sikhs ¹⁶
Attitudes	<ul style="list-style-type: none"> Shame and stigma within communities in admitting to alcohol-related problems. Cultural attitudes towards help-seeking that view this as a character weakness. 	<ul style="list-style-type: none"> Stigma. Religion. Over-reliance on a medical model of treatment. Disregard for therapy. Cultural implications of being simultaneously a member of the Punjabi-Sikh and the addiction communities. Gender differences. Generational differences.
Knowledge	<ul style="list-style-type: none"> Poor understanding of the harms of alcohol use. Lack of knowledge of services available. 	<ul style="list-style-type: none"> Lack of understanding of addiction.
Practical	<ul style="list-style-type: none"> Language difficulties. 	<ul style="list-style-type: none"> Lack of culturally specific services.
Political		<ul style="list-style-type: none"> Lack of government commitment to alcohol support for ethnic minority communities.

Table 9 – Barriers to ethnic minority and Punjabi-Sikh communities accessing alcohol services and support.

2.6.4. Facilitators

The 2024 literature review also explored some of the ways to help the Punjabi-Sikh community accessing the necessary support.¹⁶ These are summarised below:

Community & culture

- Providing culturally specific services – involving community members to ensure the relevance and sustainability of services.
- Providing culturally competent services – i.e. employing staff from a similar cultural background and fluent in the same language, but also taking account of the staff sex and age.
- Providing cultural awareness training to therapists.

Religion

- Incorporating users' religious/spiritual strategies into the therapeutic process.
- Involving the Gurdwaras – unclear role, with potential resistance from Gurdwaras (or influential individuals within them) contrasting with the fact that some already provide informal support (e.g. displaying information of local alcohol services):

“Power dynamics of the various Gurdwaras need to be negotiated carefully, building relationships with the chairs of the Gurdwaras and seeking out innovative leaders to drive any Gurdwara associated alcohol work.”

Stigma

- Providing time to build relationships with community and develop trust.
- Emphasising confidentiality of services.
- Providing services in private locations – where people aren't seen entering or leaving by members of their own community.
- Providing services that are flexible and able to respond to changing community needs.

Promotion of services

- Advertising support services in community language and broadcasters (e.g. Asian radio).
- Organising open days at the Gurdwaras.
- Door-to-door work in the community.
- Promotion through social media.
- Having identifiable, positive role models with lived experience within the community.

3. Limitations and knowledge gaps

As discussed throughout the document, a major limitation from this needs assessment is the lack of data specific to the Punjabi-Sikh population, both nationally and at a local level. As such, many of the findings have relied on imperfect data (e.g. biased or unrepresentative) and/or required extrapolations from data relating to Asian, Indian, and/or Sikh populations. For example, this makes it difficult to estimate the exact level of alcohol-related harm in Wolverhampton's Punjabi-Sikh population.

Another uncertainty concerns the level of unmet need in this population. When accounting for the community's numerous cultural barriers to engaging with services, it is possible that the apparent overrepresentation of men in alcohol treatment services is masking a higher unmet need in this population than the data suggests, so this needs to be further explored.

Additionally, a longstanding focus on males – justifiable, given their disproportionate levels of alcohol consumption and harm – may be hiding a change in gender attitudes towards alcohol, whereas younger generations, driven by their continuing integration into the British culture (among other factors), are also probably shifting their patterns of alcohol consumption. Both issues need to be better understood as they will have significant implications for future practice.

Finally, given Wolverhampton's high prevalence of alcohol-related harm (24.3 alcohol-specific deaths per 100,000 population in 2020-22, the fourth highest rate in the country⁴⁰), any meaningful city-wide strategy to address this should acknowledge and account for its diverse demographics.

4. Recommendations

The following section highlights the recommendations made based on the findings and knowledge gaps identified.

Strategic

- **Set up a steering group under the city's Drug and Alcohol Strategic Partnership** with partner organisations and community representatives **to address the high level of alcohol-related health harm in its Punjabi-Sikh population**, for example by developing a local action plan. Potential priority areas for intervention could include:
 - Raising awareness of the harms of alcohol consumption.
 - Improving the early identification of problem drinking and alcohol-related harm.
 - Increasing opportunities to signpost people with problem drinking to sources of help.
 - Reducing barriers to engaging with statutory services and other sources of support.
 - Identifying and implementing preferred methods of support.

For Public Health and the City of Wolverhampton Council

- Coordinate the Drug and Alcohol Strategic Partnership steering group.
- **Collect good-quality quantitative data to better understand the drinking behaviours of the Punjabi-Sikh community in Wolverhampton**, for example through a local representative survey. This would allow for:
 - A better understanding of whether there are significant differences in the patterns of alcohol consumption of the local community compared with national surveys.
 - The monitoring of the gender differences in alcohol consumption, particularly focussing on the growing levels of consumption in females.
 - A clearer understanding of generational differences in alcohol consumption.
- **Work with the community**, including community and voluntary sector organisations, community centres, Gurdwaras and faith leaders, and schools **to raise awareness of the harms associated with alcohol consumption through a life-course approach**, for example by developing a target campaign, providing health education to families, and empowering local health champions.
- **Work with partners to ensure that health promotion programmes** such as Make Every Contact Count (MECC) and health literacy **are culturally appropriate**.
- **Explore and address the intersections between alcohol and social harms** such as domestic abuse, sexual violence, and crime.
- **Work with the wider public health system to address the wider (social and commercial) determinants of alcohol consumption**, for example by regulating the local advertising and supply of alcohol products.

For Alcohol Treatment Services and Lived Experience Recovery Organisations

- Appoint representatives to join the Drug and Alcohol Strategic Partnership steering group.
- **Improve the provision of community and culturally specific support (i.e. that considers language, religion, and ethnic group)**, for example through employing community-specific support workers (e.g. Punjabi-speaking), providing community-specific group sessions (e.g. Sikh-based groups), and providing translated resources.
- **Provide culturally appropriate training to staff on addressing alcohol use in this population** to improve the rates of engagement with services and completion of treatment.
- **Organise outreach interventions in community-relevant venues to screen for problem drinking and alcohol-related harm**, for example using health checks, AUDIT-C screening tools, and FibroScans.

For Primary Care, Maternity, and Emergency Services

- Appoint representatives to join the Drug and Alcohol Strategic Partnership steering group.
- **Provide culturally appropriate training to clinical staff on alcohol use in this population** to raise awareness, increase the uptake of opportunist screening and brief interventions, and improve referral rates to treatment services.

For Research (national and/or local)

- **Collect quantitative data on the drinking behaviours of the Punjabi-Sikh population at regular intervals**, for example through annual representative surveys. This would establish data trends over time and allow for:
 - A better understanding of the evolving nature of this population's patterns of alcohol consumption.
 - The monitoring of the gender differences in alcohol consumption, particularly focussing on the growing levels of consumption in females.
 - A clearer understanding of generational differences in alcohol consumption.
- **Conduct qualitative research to explore the changes in gender and generational attitudes towards alcohol** in the Punjabi-Sikh population, for example through interviews and/or focus groups.

Appendix 1 – Findings from 2010 M·E·L Research report

The main findings of the 2010 M·E·L Research report which are relevant to the Punjabi-Sikh community are summarised below. Unless stated otherwise, the findings relate to all Asian communities (Sikh, Hindu, and Muslim).

Perceptions of alcohol use

- Alcohol was identified as playing a part in the lives of all the main Asian religious communities in Wolverhampton, particularly the Sikh and Hindu communities.
- Sikh and Hindu weddings and celebrations emerged as key locations where excessive alcohol was consumed. The perceived excessive culture particularly of Sikh communities was seen as one which made it very difficult for someone to stop drinking.
- Religion was identified as the key variable impacting most peoples' perceptions on alcohol.
- Just under half of Sikhs (47%) thought that most people in their community drank alcohol.

Gender differences

- Two thirds of respondents (61%) thought there were differences in drinking between men and women, consistent across all three religions.
- Women were thought to drink less and men more, with women also more likely to keep their drinking hidden.

Generational differences

- Just under half of respondents (48%) thought there were differences in drinking between younger and older people, with some thinking older people drank more linked to the stress of life and some thinking younger people drank more.
- Older Sikh men were seen as the heaviest drinkers and their drinks of choice were often large quantities of spirits and beers.
- Younger Asian people were more likely to drink alcohol in the same venues as their White counterparts and to have adopted more westernised behaviours.
- Young people who drank at university were thought able to maintain two identities and keep their drinking more hidden from their family – one life at home, one life at university.

Alcohol-related harms

- Over half of survey respondents (55%) thought their community was not well informed about the way alcohol can affect health.
- The main health problems reported by respondents associated with alcohol were liver (83%) and kidney problems (53%).
- The most reported social problems were violence (60%) and family problems/breakdown (47%). Amongst Sikh respondents, the most common responses were family breakdown/problems (52%), domestic violence (41%), and drink driving (34%).

Safe drinking

- Normal drinking was seen as a more useful construct than sensible drinking, as it accounted for what is normal for different religions (such as abstinence or heavy drinking).
- Religion prohibiting drinking (32%) was seen as the key factor thought to help people drink sensibly, followed by shame being brought on the family (25%).
- One in four respondents (25%) also stated that there was nothing to help people drink sensibly.
- Female respondents were more likely to say that bringing shame on the family helped people in the community to drink sensibly (31% female compared to 21% male).

Safe drinking messages

- Just over one quarter of respondents (28%) thought that people in their community had heard about the recommended limits to drinking that health services say is sensible.
- Just 18% thought that members of their community accessed written information about drinking sensibly.
- However, just 14% thought there were things that prevented access to written information, including information not being in the required language, not being easy to understand and preferring to speak to somebody rather than read information.
- Despite this, written information sources still emerged as the best ways for people to access information (posters and leaflets), followed by Asian radio stations, community events and Asian television channels.
- The best people to provide messages about sensible drinking overall were thought to be the GP and NHS (28%), family members (24%) and religious figures (17%), with Sikh respondents more likely to favour messages from family members.
- Despite religion being seen a prohibiting factor in drinking alcohol, religious figures rank highly as those well placed to give messages about sensible drinking.
- Similarly, whereas there was an element of keeping drinking behaviour from the family, family members were seen as well placed to provide sensible drinking message.
- Respondents highlighted that sensible drinking messages should cover the damage to health that alcohol can cause (33%), the negative impact of drinking (such as behavioural problems, relationship issues, 28%), and advice on stopping drinking or reducing the amount consumed (24%).
- It was also found that advice and support should be non-judgmental and kept in the mainstream, although the gender and ethnicity of workers needed particular consideration and tailoring.

Problem drinking

Excess drinking

- The key factor perceived to encourage people in the community to drink a lot was drinking at functions and family celebrations (68%), followed by peer pressure from friends (29%).
- The top three reasons leading to people drinking a lot were general stress of life (42%), pressure from within the family (33%), and because close friends drink (26%). Sikh respondents were more likely to cite pressure from within the family (more than other religious groups) and the general stress of life (over 40%) as important factors.
- The proportion of respondents citing pressure from within the family increased with age; worries about money and unemployment were most common amongst those aged 45-64 years; pressure from university/college was most likely to be cited by those aged under 18.
- Poverty, unemployment, and family problems emerged as perceived causes of drinking too much, along with a lack of community provision and things for Asian communities to do.

Hidden drinking

- Two thirds of respondents (69%) thought that some people in their community hid the fact that they drank alcohol from others. Sikh respondents were the most likely to agree (71%).
- Around nine out of ten of respondents (87%) thought there were some groups who were most likely to hide their drinking. Sikh respondents were the most likely to agree (90%).
- The qualitative data highlighted women as the sub-group most likely to be hidden drinkers, whereas the survey highlighted younger women (61%) and younger men (66%). Sikh

respondents identified older and younger women as the most likely to keep their drinking hidden.

- The main perceived reasons for keeping drinking hidden were to hide it from the family (32%) and to maintain reputation and/or hide from shame (30%). Sikh respondents were most likely to think people keep their drinking hidden to maintain reputation and/or hide from shame (34%).

Community response

- There were mixed findings about the community response to someone with an alcohol problem.
- A compulsion to ‘keep it in the family’ to avoid stigma and shame was identified as having to be balanced against perceptions that the community would want to help a person with an alcohol problem.
- One in five survey respondents (23%) thought the community would ignore it if someone was drinking too much, yet one in five also thought that someone would talk to the person (21%) or talk to the family (20%). Sikh respondents were most likely to think that someone would talk to the family.

Help and support

Seeking help

- Friends (21%) and parents (21%) emerged as the main people those in the community were thought to listen to about drinking too much. One in five respondents (20%) also reported that members of the community wouldn’t listen to anyone, with Sikhs the most likely to think so.
- Just one in ten respondents thought that people in the community were likely to seek help for their drinking.
- One third (34%) of survey respondents think the key barrier to getting help would be the person themselves not admitting they have a problem with alcohol. Even though this wasn’t seen as specific to the Asian community, factors such as social stigma were seen as exacerbating the problem.
- The qualitative data indicated that people from all Asian backgrounds would be hesitant to get treatment for alcohol problems and, if they did, this would be several years after their problems began to manifest themselves. Some Sikh men were found to eventually seek treatment, although this happened primarily amongst older men (aged 50+), who could already be experiencing severe health problems as a result of their longstanding problem drinking.
- The qualitative data also indicated that it was often women who sought help on behalf of their husbands/partners, so this was seen as a valuable route of access to be tapped into.

Awareness of existing support

- There was a lack of knowledge about organisations providing treatment and advice. Two fifths of survey respondents (42%) couldn’t name any such organisations. However, just under one third of respondents (29%) thought there were no barriers to use of services for those drinking too much.
- Two thirds of respondents (68%) thought that people in the community would be unlikely to know about the help available for drinking too much.

Providing support

- Four in ten survey respondents (39%) thought that talking to people and/or providing support/advice would help people drink less. One third (31%) thought that providing education and raising awareness was key.
- GPs emerged as a trusted source of information and advice regarding health-related matters, even though Asian people would not necessarily speak to them about alcohol being the underlying cause of health problems. Concerns about confidentiality and seeing the GP within social circles in everyday life were also raised.
- The general approach of the service emerged as the critical success factors for any service for people with alcohol problems. The key requirements were that the service should be patient, understanding and professional (32%), be confidential and private (27%), and educate and raise awareness (26%).
- The counselling model of treatment was identified as a potentially poor fit when working within Asian communities. Expectations about treatment needed to be made culturally competent and treatment should be holistic, tackling the underlying problems behind excessive alcohol consumption.
- The qualitative data also indicated that both awareness raising and provision of treatment services needed to be rooted within the community, where trust and a rapport was already present, rather than delivered from outside.

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