
DEVELOPING A COMMUNITY ALCOHOL SUPPORT PACKAGE: AN EXPLORATORY STUDY WITH A PUNJABI SIKH COMMUNITY

FINAL REPORT

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**Sarah Galvani and Gary Manders
with Sarah Wadd and Shaheen Chaudhry**



Tilda Goldberg Centre
for social work
and social care



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- ⌘ Dr Harish Mehra; Chair – Asian Rationalist Society
- ⌘ Karen Geddes; Constituency Inspector, Perry Barr, West Midlands Police
- ⌘ Handsworth Health and Wellbeing Group
- ⌘ Handsworth Association of Schools

An explanatory note: Sikhism, Gurdwara and the Guru Granth Sahib

The Gurdwara or temple is a place of worship for Sikhs; it is the Sikh house of God. It means the gateway through which the Guru can be reached. A Gurdwara is not just a public place of worship, it can be anywhere the "Guru Granth Sahib is installed and treated with due respect", including a room in a house. The Guru Granth Sahib is both a scripture but also a living document – it is considered the "supreme spiritual authority" and also the Head of Sikhism.

Gurdwara vary according to a number of factors including what they offer the community, where they are located and the people within the committees that drive them.

"Three main functions are carried out in all public Gurdwaras. One is Kirtan which is the singing of hymns from the Guru Granth Sahib, another is Katha which is reading of the Guru

Granth Sahib and explanations. The third main function which is carried out at every Gurdwara is the Langar, free community kitchen for all visitors of all religions. Along with these main functions Gurdwaras around the world also serve the Sikh community in many other ways including, libraries of Sikh literature, schools to teach children Gurmukhi and the Sikh scriptures and charitable work in the community on behalf of Sikhs.”

Information taken from <http://www.sikhs.org/gurdwara.htm> (2011)

Project Advisory Group

A Project Advisory Group (PAG) was established as a consultancy group and as a critical friend to the project. The group met twice physically at the start and towards the end of the project. Individuals were also contacted for specific advice at different stages of the project. Our thanks go to the PAG for its support.

- | | |
|--|---|
| 1. Ms Annette Fleming (Chair)
<i>Chief Executive – Aquarius</i> | 8. Angela Kattri
<i>Practitioner, Asian Communities – Aquarius</i> |
| 2. Sarah Galvani
<i>Principal Investigator, Tilda Goldberg Centre for Social Work and Social Care, University of Bedfordshire</i> | 9. Mr Sachdev Virdee
<i>General secretary – Asian Rationalist Society (GP)</i> |
| 3. Ben Howells
<i>Tier 2 Outreach Manager – Aquarius</i> | 10. Dr Panth Grewal
<i>Consultant Psychiatrist working closely with Nishkam Centre</i> |
| 4. Shaheen Chaudhry
<i>BME Communities Development Worker – Aquarius</i> | 11. Harbans Ubhi
<i>Vice Chair of UK Asian Women's Centre; Managing Director-Forever Living Products</i> |
| 5. Tarsem Singh Cooner
<i>Lecturer in Social Work, University of Birmingham</i> | 12. Tonia Clark
<i>Handsworth Resident; Finance and Resources Manager, Aquarius</i> |
| 6. Max Vaughan
<i>Alcohol Co-ordination and Commissioning Manager, Birmingham DAAT</i> | 13. Gary Manders
<i>CASP Project Researcher</i> |
| 7. Iqbal Singh Sandhu
<i>Aquarius service user representative</i> | |

We would like to thank the PAG for their involvement in this project and for the contacts and suggestions they provided throughout the course of the research.

Executive Summary

Background

This project was borne out of a timely combination of policy and practice concerns. Practice based evidence suggests a rapid increase in the number of Punjabi Sikh men presenting to hospital with alcohol-related liver disease and other alcohol-related harms. Aquarius Action Projects sought evidence to help it to better understand the needs of a particular Punjabi Sikh community in East Handsworth and Lozells in Birmingham and how this could be translated into future alcohol service provision. At the same time Government policy in England has sought to emphasise the role of the community and family in supporting people to sustain long term changes in their problematic alcohol and other drug using behaviour. This research project sought to combine both the practice-level concerns and the emerging policy framework. It sought to determine the feasibility of developing a community alcohol support package (CASP), which identified the support needs of communities and families, within a Punjabi Sikh Community in Birmingham.

Methodology

Objective and aims

The objective of this research was to explore the feasibility of developing a Community Alcohol Support Package (CASP). Through a review of existing evidence and ethnographic research, the research aims were:

Evidence review

1. To identify the range and scope of existing community alcohol provision.
2. To explore the evidence of its effectiveness in reducing or addressing problematic alcohol use.
3. To identify gaps in the evidence base in relation to community alcohol services or support.

Ethnographic research

1. Establish the views of service providers, commissioners and other relevant administrative bodies about the alcohol support needs within the local community.
2. Establish the views of residents of the community about their support needs in relation to alcohol services and support.
3. Identify the 'environmental' opportunities and challenges within the community for developing a CASP.
4. Map the alcohol support services available in the selected community.

In sum, the research sought to marry the views of the community about its alcohol-related needs with what the research evidence says 'works' in relation to community based interventions. This would, in theory, provide a good grounding for the development of future Aquarius' services.

Sample, data collection and analysis

The existing evidence was collected through comprehensive literature reviews and a thematic approach to synthesising the literature was adopted. The empirical research sought the involvement of residents of the community, community service providers and service users. Data collection involved observation, focus groups, individual interviews and a self-completion survey. The surveys were analysed using a statistical software package, SPSS. Statistical analysis involved primarily descriptive statistics on all variables and bi-variate analysis where possible. The Mann Whitney U test (Mann and Whitney 1947 cited by Field 2009) was applied to explore any significant differences within the data.

The qualitative data from all interviews and focus groups were transcribed and uploaded into a qualitative software computer-based package, NVivo. Analysis in Nvivo follows a form of thematic analysis where data are coded in detail (level 1), grouped into categories (level 2) and synthesised within thematic domains (level 3).

Process and observation notes have been re read, summarised and are presented in a descriptive fashion highlighting in particular any transferable lessons from the research process to the service development process.

Findings: summaries

⌘ Summary – process issues

Reflections on the process of research, and not just the findings and implications, are key to ethnographic research. What an ethnographic study offers is consideration of the context and the social, cultural and political environment in which it takes place. The processes and learning that results is treated as data that is as rich and important as the more ‘traditional’ forms of data collection. The processes described here include important barriers, opportunities and learning points which offer transferable lessons for the development of future alcohol services within the Ward. Key amongst these is an understanding and acceptance of the hierarchies, power dynamics and political nuances between individuals and organisations in the community. This can only be learned over time and through developing relationships with individuals within the community who offer small bits of information in the course of discussion. Piecing together the ‘information jigsaw’ is the task of the researcher or practice development team. However, this also has an impact on timeframes for the work and needs to be considered in commissioning arrangements. It means allowing more time than usual for negotiating access to the community and key influential individuals given the suspicion of white services ‘parachuting in’ and the sensitivity of the subject matter. In addition, the issue of confidentiality, shame and stigma are huge barriers to both research and to practice development and service use/access. While this is not an unusual concern among people with alcohol or other drug problems, it is keenly felt in a close knit, minority community that has a religious prohibition of alcohol.

⌘ Summary – survey data

The anonymous survey data from 89 respondents revealed high levels of perceived knowledge about alcohol’s impact on health and behaviour. In particular, respondents identified the issues of arguments, conflict and violence at home as having a close relationship with alcohol consumption, alongside liver and kidney and financial problems.

With the exception of financial problems, these were the themes that emerged strongly from the qualitative work (see findings sections below). The negative impact of drinking on friends and family was highlighted although they were not identified as primary sources of alcohol information. The internet and GP were identified most as information sources which have potential implications for future service development. Ignorance of the impact of alcohol on their health and wellbeing scored highly in the question about barriers to help seeking, closely followed by shame of others finding out. Given these findings it is unsurprising that the respondents identified education and awareness for children and young people as the main type of support service needed. This was followed in almost equal measure by education and awareness for adults, support for children and for family members of people with alcohol problems and individual counselling. Finally, the role of religion in providing support attracted mixed responses. More than two thirds felt it was important in helping people to overcome alcohol problems and just under two thirds felt it should offer advice to people with alcohol problems.

⌘ **Summary – service users**

The findings from the eight service user interviews led to key themes that remained dominant throughout the analysis of all the qualitative data:

1. The norm of drinking within the Punjabi culture – this was reinforced closer to home by observed drinking of fathers.
2. The tension between culture and religion, the confusion this caused and the resulting mixed messages it gave to younger people. The service users also raised notions of ‘proper’ or ‘strict’ Sikhism (those who were baptised) versus behaviour expected of those who were not.
3. Issues of shame and stigma at both an individual, family and community level were clear and, while other negative impacts of drinking were identified, it was the loss of status within the family and community that people feared.
4. Domestic violence - the inclusion of domestic violence in vignette 1 led to some interesting responses with some people thinking it should be handled within the community while others adopted a more ‘westernised’ approach of calling the police and prioritising safety issues.
5. Gender differences in drinking are stark and the changes in younger women’s drinking to a more ‘westernised’ approach were noted. However, this was not the case for older women.
6. Generation differences in drinking - there was no agreement on whether or not there were generation differences with some participants feeling young people were better educated about alcohol and its harms while others felt they drank more than older people.
7. The role of religion and the Gurdwara in supporting people who had changed their drinking behaviour was positively highlighted by several service users as was the need to avoid it if you had been drinking.
8. Service provision - the service users offered a range of suggestions for the qualities of future services as well as the location and promotion of services. No one suggested family interventions. The role of the Gurdwara in service provision split views with some suggesting it should and could have a far greater role while others felt it should not.

9. Barriers to help seeking were identified with awareness of services, language barriers, shame and stigma, and trust issues cited.

⌘ **Summary – young people**

There were 22 young people aged 10-14 years old who took part in school-based focus groups. Generally, there was a good knowledge of alcohol's impact on health, particularly its negative impact on the liver and heart and on mental and emotional health. As might be expected some people knew more than others with several showing a high degree of ignorance. Shame and embarrassment was raised as a cost of drinking alongside other costs to the individual and the family. Drinking as a coping mechanism for stress, rejection or other difficulties in people's lives was cited as the main reason for drinking with very few people mentioning positive reasons for drinking. Within this younger age group the gender differences around drinking were viewed as being unfair (and also within wider gender specific roles) although there was a clear understanding of the expectations on girls to behave differently. As with other groups the discussion about generation differences in alcohol consumption split views. It also raised the question about alcohol and responsibility and that older people were, and had to, take more responsibility for their drinking because of its impact on others. This included what parents taught their children about drinking through their own example. There was a very clear message that the Gurdwaras should help people with their drinking by offering teaching and support. Two young people felt people were judged by Sikhism in spite of the fact that some of those who were seen to judge others drink themselves. Finally, they made a range of suggestions in relation to future service provision with some creative and innovative responses including alcohol patches and alcohol credit cards.

⌘ **Summary – women's group**

Fourteen women took part in a focus group that was held in Punjabi language. They were largely a group of middle aged to older women. Discussion was focussed largely around vignette 1 and focussed very quickly on the topic of domestic violence and abuse and the need for the woman to do something ranging from calling the police and leaving him to 'backing away' at home. The fact that women "suffer in silence" as a result of their upbringing was also mentioned. The women described a change in drinking culture over the years (although readily acknowledged the drinking history of Punjabi farmers) with young women's drinking as something particularly new. They had a similar debate as others about whether or not there were generation differences in alcohol consumption between younger or older people. As with other groups they equated knowledge about alcohol and limits of alcohol with behaviour change. Finally, they felt that services and information were available if needed.

⌘ **Summary – service providers**

Nineteen service providers were interviewed at some length. They came from a range of professional backgrounds. The majority perceived alcohol consumption as increasing among the Punjabi Sikh Community and noted that alcohol-related harm had increased too, particularly hospital admissions. Many also identified the tensions between the religious prohibition of alcohol in Sikhism and the drinking culture of Punjabi tradition. Again reference was made to two cultures within Sikhism – one that drinks and one that does not - and this was cited as a barrier to awareness raising and offering support, as it leads to

denial of any problems. For this reason, several participants noted that changing the nature of alcohol use in the community would take time and perhaps even a generation. One generation change that was noted here and elsewhere was the increase in younger Punjabi Sikh women's drinking or at least the visibility of such drinking. Gender was also an issue raised in terms of needing to support women as parents and partners of family members with substance problems or recognising their role in trying to seek support for their loved one for their drinking and violent behaviour often via the GP. Generation differences were not noted as fervently by the service providers as other groups. The concern was raised that older people's drinking may be missed and that younger people's drinking was increasing.

Existing service provision was identified as having a range of problems from a lack of awareness of where services are to language barriers and attitude problems within the community, such as, asking for help is a weakness. Importantly one service provider reflected on the lack of understanding among specialist substance use services of the "collective belonging" that led to intense feelings of shame and dishonour if a Punjabi Sikh is identified as having an alcohol problem. The importance of future services having some understanding of shame, stigma and the consequent importance of trust and confidentiality in service provision was raised within discussion of future service provision. However, one of the main themes for future alcohol service provision was the need to embed future service provision within a health and well being framework and possibly a holistic service that addressed a range of health and social care needs, not just alcohol. Awareness raising and education was suggested by many participants as a future service requirement, particularly through Sikh TV channels and radio emphasising the 'free' and 'confidential' nature of the service provided. Suggestions for service types were varied but the need for support for families was highlighted. Who will deliver future services was considered – GPs and other health and social care professionals (once trained) were identified as was the need to mainstream substance use interventions. Importantly one service provider highlighted the tension between the relative 'safety' of white service providers vs. a practitioner or clinician from within the community with cultural understanding and language skills but around whom there would be fears of gossip within the community. Accompanying this tension was a similar one around location of services – there was general agreement that services need to be locally situated but not be obvious alcohol services.

The involvement of Gurdwaras in providing support generated a lot of discussion. Many participants found a clear resistance from Gurdwaras, or influential individuals within them, to engaging with alcohol issues. Conversely, it was clear that some Gurdwaras were already providing some support, albeit not in a formal way, e.g. through providing food in the Langar Hall for those who were not too drunk, visiting affected families at home, talking to people when sober, or displaying information on local alcohol services. A list of suggestions about what Gurdwaras could offer ranged from active intervention to signposting and partnership working however it was clear that the power dynamics of the various Gurdwara would need to be negotiated carefully and innovative leaders sought to drive any Gurdwara-based or Gurdwara-associated alcohol work. Beyond the Gurdwara, participants identified a range of past and present partnerships around alcohol support and clearly identified the need for future partnership working to ensure alcohol support was embedded in the community. Finally, future service provision, partnership working and community support of alcohol services will take place within a broader social and political context of austerity,

recession and public service cuts. These challenges were raised by several Service providers and may yet determine what new or innovative services are possible or viable.

⌘ **Summary – Aquarius work to date**

Aquarius has previously developed a specialist service for Asian people that did not have the success anticipated. There is currently very limited service from Aquarius within the community but opportunities have arisen for greater partnership working. The barriers and opportunities could be considered in determining the options for developing a programme of regular and frequent work within the community.

Recommendations

Recommendation 1

Develop an Aquarius CASP based on a community development model. Bear in mind the process outlined in the CASP process model 1 (see page 93) and build in plenty of time to ensure the right people are involved from the outset.

The following recommendations are made with an awareness that a genuine community development approach would involve the community development team deciding what services would be developed and how. These recommendations may or may not be part of those discussions. However, we offer them as a starting point for discussion based on our analysis of the findings of this research.

Recommendation 2

Within the CASP, develop two clear service plans to meet the needs of two groups of potential service users: i) a discrete alcohol/substance use service that is more likely to meet the needs of the middle and older age groups in particular, who may be wary of mainstream services; ii) develop a more open Aquarius alcohol support service within the community that offers educational resources, training, awareness raising, brief interventions, and more medium term interventions that may suit the needs of the younger Punjabi Sikh community in particular. It is likely that current models of intervention will suit this younger group.

Recommendation 3

Ensure that future services are located within the community, physically. The discrete service would, as the name suggests, not carry an alcohol service label and it should be located somewhere detached from the main thoroughfares in the community.

Recommendation 4

Ensure that the CASP service plans address the current gaps in service provision. In particular these appear to be:

- An education and awareness raising programme, or campaign, targeting all age ranges – in particular the use of internet or computer-based programmes as well as Punjabi language media.
- Interventions for family members in their own right – in particular a service that works with women and children affected by both problematic substance use and domestic abuse.

- A prevention and early intervention service – particularly for younger people just beginning their drinking careers.
- Individual interventions that are framed within a broader health and well being context.

Recommendation 5

Underpin any interventions with methods and approaches that have been adapted, or designed anew, to meet the needs of the community. These will need to consider the appropriateness, or lack thereof, of psychosocial ‘talking therapies’ for middle to older age Punjabi Sikh service users.

Recommendation 6

Consider staffing requirements in terms of characteristics and skills. Appointing ‘health and well being professionals’, who offer a holistic service and are experienced and highly skilled, may require appointing people to more senior grades.

Recommendation 7

Ensure that all Aquarius screening and initial contact/assessment routinely asks about religious affiliation.

Recommendation 8

Given the reliance on primary care as the first port of call for many people with alcohol problems, a rolling training programme and brief online training resource could be developed for GPs along with resources for patients in Punjabi and English.

Conclusion

This two-part research project set out to explore the possibility of developing a Community Alcohol Support Package (CASP) within a selected community in Birmingham. The Punjabi Sikh community became the focus of the study due to increasing concerns about presentations to hospital by men with alcohol-related harm indicating a history of heavy drinking.

Part 1 comprised reviews of existing evidence to accompany the empirical ethnographic research (part 2) and to highlight effective interventions that may be considered in a CASP for the Punjabi Sikh Community. No studies of effectiveness were found for alcohol interventions with people of Asian origin and this is clearly a gap in the evidence base.

The process of conducting the ethnographic element of the study and the learning gleaned from it has been as important as the findings of the study. What is highly apparent is that a high degree of commitment, patience, and time, will be needed to engage with the community on this sensitive issue. It is also clear that future service provision has to be developed with community members as equal players.

In total 152 people took part in data collection and the range of people was diverse in terms of age, degree of knowledge about substance use and services, and experience of living and working within the community of East Handsworth and Lozells. This diversity was reflected in the responses of participants whose views often represented different polar extremes. It

is not time well spent to attempt to unify such views and homogenise a heterogeneous community but it is time well spent to consider how to respond in practice to the views and needs expressed.

To that end, the development of a package of alcohol support should include a toolkit of services to suit different people, places and approaches. As one participant stated, “each new generation presents a different set of issues”. Any approach must therefore be flexible and dynamic. The important factor in responding to the community’s needs is to ensure, for the sake of sustainability, that future services are community led and relate clearly to the policy and practice agendas of community partner organisations. It will not be a quick or easy task. There are cultural histories and religious sensitivities to consider at each step of the way.

While we await better statistical evidence of need and better evidence of effective interventions, we need to trust in our practitioners and our community members that something needs to be done. The final word rests with a member of the Punjabi Sikh community who states:

The figures as you know are showing that we have got a problem, but we have to be brave and say we have, rather than brushing it under the carpet and saying this isn’t a problem. We have got to say that we have got to look at it. We are human beings and the quality of human beings is to speak the truth... . At least when you tell the truth something can be done about it.

Section 1: Background

This project was borne out of a timely combination of policy and practice concerns. First, the project's commissioner, Aquarius Action Projects, was aware of ongoing concerns about the apparently increasing number of Sikh men presenting to its Birmingham-based hospital service with alcohol-related health problems. The concern was that this was a group of people whose needs were not being fully addressed by existing service provision and Aquarius wanted evidence from which to consider future service development. Second, in 2010 the Government published its national drug strategy for England and identified 'families and communities' as needing to support people in their recovery journey from alcohol or other drug problems.

By enabling local communities to support more individuals to become free of their dependence and contribute to society, we will build a bigger and better society for all.

(Theresa May MP, Home Secretary)

While discussions of the Coalition Government's 'Big Society' have waned, there is still a renewed emphasis in the drug strategy on the role of families and communities in supporting their loved ones achieve longer term 'recovery' from alcohol and drug problems. Whether they are equipped to offer that support and whether they have been provided with information on how best to do that are questions that appear not to have been asked.

This project sought to combine both the practice-level concerns and the emerging policy framework. It sought to determine the feasibility of developing a community alcohol support package (CASP), which identified the support needs of communities and families, within a Punjabi Sikh Community in Birmingham.

Alcohol use among the Punjabi Sikh community

The extent of alcohol and other drug use among the Punjabi Sikh community is not known. There is no reliable prevalence data based on religious or cultural identity. What exists is some information about Asian alcohol consumption and this is sometimes broken down further into other broad categories including, for example, British Indian or Indian. The National Alcohol Treatment Monitoring System (NATMS) (DH/NTA 2013) reports that only 1% of people in alcohol treatment in the year 2011-2012 identified as "Indian".

Aquarius' in-house data show a far better picture for the geographical area of the study. In the year June 2011-2012, 16% of Aquarius service users from the selected area of the study (see below for further information) were 'Asian or Asian British – Indian'. However there was an almost equal number of non-attenders in the same ethnic category at 17% (Howells, personal communication, April 2012). Figures for attendance of other Asian groups were far lower.

Regionally there is also recognition that Black and Minority Ethnic (BME) groups may not be well served by current service provision. One of the actions identified in the current Birmingham Alcohol Strategy (BDAAT 2012: 35) is to "[e]nsure that treatment services are

culturally sensitive to the needs of the range of BME groups in Birmingham". This follows a Joint Alcohol and Drugs Needs Assessment in 2011 that also concluded that "[w]ork needs to focus on those areas where numbers in treatment do not reflect the ethnic populations" (BDAAT 2011: 7). BDAAT also commissioned a study by a local service provider to identify the service needs of BME communities in Birmingham (ACP-Kikit 2012). The final report does not provide any breakdown of the needs according to religious, cultural or ethnic identity nor a breakdown of the religious, cultural or ethnic identity of participants. The authors concluded that specialist BME services were the preference of the majority of the participants however as the research was partially conducted within their own specialist BME service, the findings are not reliable.

Community and family focus in service provision and development

Since the publication of the national 2010 strategy, an array of alcohol and drug policy documents and reports has emerged. Each recognises the impact of problematic alcohol and other drug use on families and communities and their involvement in supporting people's journey from problematic to unproblematic substance use. However, the use of 'community' varies between them – often meaning criminal justice and licensing sanctions. Among them were *The Government's Alcohol Strategy 2012* as well as an independent alcohol strategy, *Health First: an independent alcohol strategy for the UK 2013*. The Government's strategy again highlights the role of communities in taking action at a local level to minimise and curb alcohol related harm although prioritises alcohol licensing and sales, anti social behaviour and criminal justice sanctions. Similarly, while families are mentioned, their role is somewhat diminished in comparison to the drug strategy two years earlier. The independent alcohol strategy, however, calls for far "greater investment" in "specialist community-based alcohol services to meet current and future alcohol treatment needs" as well as repeatedly identifying the harm caused to families and children through problematic alcohol use (University of Stirling/Alcohol Health Alliance UK/British Liver Trust 2013: 8).

Further reports include *A fresh approach to drugs: the final report of the UK Drugs Policy Commission (UKDPC) 2012* and the National Treatment Agency's plan for its transition into Public Health England, entitled *Building recovery in communities: the transition to the new public health system* (DH 2012). In its final report before its demise, the UKDPC summarises drug policy and the evidence base and calls for a fresh approach to drug policy, one that is not so caught up in political concerns. Of communities, the UKDPC states:

To support recovery, a wide range of treatment, mutual aid and supportive local community approaches is required. Opportunities for action include promoting recovery through balanced treatment systems, which take account of the varied and individual nature of recovery, recognise diverse needs, and are underpinned by a competent workforce. The role of local communities including employers, faith groups and generic services should be enhanced, particularly if stigma among these groups is reduced.

(UKDPC 2012: 19)

Further, it identifies support for families as an essential element of future drug policy:

People with drug problems are more likely to achieve recovery if they have a supported and supportive family. The involvement of adult family members of people with drug problems can promote recovery for their drug-using relative, but they also need support in their own right. This needs to be reflected in local area planning processes and service development alongside the need to support children of drug-misusing parents.

(UKDPC 2012: 19)

However, while these strategies and evidence summaries differ in focus, they agree on the need for local level action and/or responsibility for affecting change in the community. The NTA (2012: 4) calls for “an 'Asset Based Community Development' approach so partnerships can assess the recovery networks of their own communities and take them into account through the JSNA [Joint Strategic Needs Assessment]”.

These publications are set within a policy context that is moving government control for alcohol and drug policy and service provision from a central to a local and regional level of governance. The extent to which local alcohol and drug service commissioning will identify the support needs of families and communities in their own right is yet to be determined.

However, in the Birmingham Alcohol Strategy 2012-2016 one of its summary points states:

Local areas will need to develop their own preventative and intervention priorities based on an assessment of need at a sub-population level. This could include the adoption of a Community Alcohol Partnership in specific areas in the city.

(BDAAT 2012:14)

There is also clear commitment to a shift towards a ‘think family’ approach (p.7) and to family focussed interventions (p.26) as well as a commitment to identify carers of people with alcohol problems and provide “support pathways” (p.27).

Thus, at a regional level, there is an existing strategic framework for the development of community focussed alcohol work that addresses family support needs. The trick is to determine what the ‘community alcohol partnership’ might look like based on evidence and consultation with people in those “specific areas”. Further, it needs to determine how the community is likely to feel about such partnerships and whether genuine partnership and engagement of the community can be achieved.

While the exploration of a community alcohol partnership was not the focus of this research, its exploration of the feasibility of a CASP with both community members and service providers highlights many relevant issues relating to alcohol and related service provision. Importantly too it identifies process issues that any consultation and partnership development needs to take into account.

Before moving to the research methodology and findings, we will first provide an overview of the Punjabi Sikh community identified for the study.

Section 2: Sample community

The definitions of ‘community’ are wide ranging and contested. For the purposes of this project we adopt two particular meanings, i) a group of people who share a particular culture or way of life, ii) a defined geographical location.

The choice of which particular community to focus on was an operational one. The research was commissioned by Aquarius with a view to informing its service development and therefore the decision about which community rested with Aquarius.

After discussion with Aquarius Chief Executive, Annette Fleming and Outreach Services Manager, Ben Howells, the decision was taken to focus on the Sikh community as a group of people that were thought to be slipping through the net of services. Anecdotal and practice-based evidence suggests that front line staff, particularly those in hospital-based services, are seeing increasing numbers of Sikh men (and/or those from a Punjabi culture) entering health services as a result of their substance use – usually alcohol. In particular, one hospital-based team was encountering Sikh men with alcohol-related liver disease, a late stage in the terms of alcohol-related harm.

Local data show that East Handsworth and Lozells (EH&L) is the ward with the most alcohol-related hospital admissions out of the 40 Birmingham wards (Sheldon/BDAAT 2012). In addition, local analysis of Primary Care Trust data suggests that more than 40% of people in East Handsworth and Lozells live in areas deemed high risk in terms of problematic alcohol use, with almost 56% living in areas deemed medium risk of problematic alcohol use. Both East Handsworth & Lozells and the neighbouring ward of Handsworth Wood (HW) house high proportions of British Indians, many of who are Sikh and/or Punjabi. It is also an area where Aquarius does not currently have any services. Thus the decision was to focus on the Punjabi Sikh community in East Handsworth and Lozells. In practice the bordering ward of Handsworth Wood was also included in some aspects of the ethnographic research, particularly where agencies or individual participants were located on the border of the two wards.

East Handsworth and Lozells Ward profile

East Handsworth and Lozells sits within the constituency of Perry Barr and is approximately two kilometres to the north of Birmingham City Centre.

According to the 2011 census data, over half the population of EH&L (60.7%) report “Asian” or “Asian British” ethnicity and there is a younger age profile than the City’s average (source: BCC, undated). Almost half the ward’s population were born overseas (44.9%) and 19.3 % of households do not have English as their main language (19.3%) (source: BCC, undated).

Half the population of HW are “Asian” or “Asian British” (51.5%) with an age profile that is similar to the City’s average. Only 14.5% of households do not have English as their main language and 39% were born overseas (source:



BCC, undated).

In terms of religious identity, the majority of Sikhs (72%) in Birmingham live in eight wards of the City including EH&L (6.7%) and HW (25.6%). According to the 2011 census, 3% of Birmingham's population said they were Sikh. This compares to the average figure for England at 0.8% (BCC undated). 92% of Sikhs in Birmingham are of Indian origin with over half the Sikh population born in the UK (BCC 2003). The age profile for Sikhs in Birmingham is also a great deal younger than the average for England and Wales. At the last census (2001) 60% of Sikhs were under 34 yrs old compared to just 21.6% in the general population in that age group¹ (BCC 2003).

In 2009 a community consultation reported a number of positive aspects of living in the Lozells and Handsworth wards included the diversity of the population, the friendliness of the people and the ease of access to local facilities (Middleton et al. 2009). The parks, community gardens and the public transport links were also identified by community members as positive features of the area. The report's authors also identified falling crime rates, a "vibrant cultural scene" in relation to music and the arts, and improving levels of educational achievement by secondary school pupils. That said the area, and the EH&L ward in particular, still face some challenges:

⌘ **Deprivation**

EH&L and HW are two of the four wards within the Perry Barr Constituency. According to the Index of Deprivation (Birmingham City Council (BCC) 2011) Birmingham has 10 wards falling within the 10% most deprived SOAs in England. EH&L is one of them. It is also the 5th most deprived ward in Birmingham. Handsworth Wood is ranked 24 (of 40 wards) in terms of the multiple deprivation indices.

⌘ **Unemployment and worklessness**

Birmingham has fourth highest claimant rate in the UK of people claiming unemployment benefit and the highest claimant proportion. L&EH has the second highest claimant rate at 28.3% following Aston at 30.3%. HW by contrast had only a 12.3% claimant rate (source: BCC May 2012a).

Birmingham has second highest worklessness rate of all English cities – Liverpool being first – with 18.7% of the working age population workless. In L&EH ward the worklessness rate is 26.1% and in HW 16.4%. Above 25% is seen as high. Worklessness rates in all 40 wards of Birmingham have increased in the quarter ending March 2012 (source: BCC March 2012b).

There are clearly established links between deprivation, poverty and alcohol and other drug problems which suggest that people within the ward are at risk of problematic substance use.

⌘ **Alcohol profile**

¹ More recent data from the 2011 census is not yet available.

Local Alcohol Profiles for England (LAPE) data

Both wards sit within Heart of Birmingham (HoB) Primary Care Trust (PCT). The LAPE for HoB shows that the PCT's profile for many of the areas measured are significantly worse than the regional average. For example, it is worse than the regional average in relation to alcohol specific mortality in men and women, alcohol related hospital admissions, chronic liver disease among men, alcohol-related crime and violent crime, alcohol-attributable hospital admissions for men and women, alcohol-attributable mortality for men (NWPHO 2011).

Interestingly, it was better than both the regional and England averages for alcohol specific hospital admissions for under 18s and for binge drinking.

Several requests were made to the Licensing Board for information however we were directed to their website which only provides lists of licenses granted in the ward and no demographic information on the licensees.

⌘ Criminal justice data

Arrests for alcohol-related offending² in the Handsworth and Lozells areas where ethnicity is categorised as Asian have stayed fairly consistent at around the 240 mark for the last five years. There is no discernible pattern by month of the year to the arrests. The majority of people arrested were of Indian origin and from the "Handsworth" area of Birmingham (source: personal communication, WMP 2012). In terms of alcohol involved crime, EH&L is ranked 12/40 wards with HW ranked near the bottom at no. 36 (personal communication, Sheldon/BDAAT 2012).

⌘ Health data

The last available ward development plan (2003) included the need "to promote and improve health" among its seven key challenges. Overcoming the barriers to people accessing health services and involving the community to do so is part of the identified approach to achieve this goal. Further, it reports that levels of diabetes are high. The negative physical and mental health impact of alcohol can be serious and there are established links between diabetes and excessive alcohol use. Addressing alcohol in an appropriate way in the community stands to support improved health and well being.

Data that ranks the wards by the numbers of people in alcohol treatment per population shows that HW is ranked 19/40 and EH&L is ranked 27/40 (personal communication, Sheldon 2012). Care should be taken in interpreting these data as they could be interpreted both positively and negatively. For example, from a positive viewpoint you could conclude that demand for treatment is not particularly high in those wards because there are fewer people with alcohol problems. Alternately, the negative view is that people with alcohol problems are not accessing treatment or finding it suitable, accessible or available to them. Thus reference to other data is required.

Looking at the rankings of alcohol specific hospital admissions by ward shows a very different picture. EH&L is ranked first, meaning it had the highest number of alcohol specific

² In this case it includes the following offences: drink-driving, drunk in charge of a child, drunk and disorderly.

hospital admissions in 2010-11. HW is not a great deal better with a ranking of 9 (personal communication, Sheldon/BDAAT 2012).

Similarly local analysis of PCT data suggests that more than 40% of people in EH&L live in areas deemed high risk in terms of problematic alcohol use, with almost 56% living in areas deemed medium risk of problematic alcohol use. HW figures are lower with 4.5% living in high risk areas and over 40% living in medium risk areas. More than half the population of HW (53%) were deemed as living in low risk areas, compared to only 1.8% of people in EH&L (personal communication, Sheldon/BDAAT 2012).

In spite of repeated requests, no data were available from City hospital.

Summary

The demographic profile of East Handsworth and Lozells suggests an area of some deprivation with a number of challenging health and social care issues both directly alcohol-related, e.g. hospital admissions, and unrelated to alcohol, e.g. unemployment rates. Local data also suggest that it is a community that is at risk of problematic alcohol use which lends weight to Aquarius' choice to focus on this community for this exploratory study and suggests the need for locally accessible service provision.

Section 3: Methodology

Aims and Objectives

The objective of this research was to explore the feasibility of developing a Community Alcohol Support Package (CASP)³. In order to achieve this, a two strand approach was adopted:

1. A review of the existing research evidence relating to community-based interventions for alcohol problems.
2. Ethnographic research in one selected area of Birmingham.

The specific aims of each strand are as follows:

Evidence review

4. To identify the range and scope of existing community alcohol provision.
5. To explore the evidence of its effectiveness in reducing or addressing problematic alcohol use.
6. To identify gaps in the evidence base in relation to community alcohol services or support.

Ethnographic research

5. Establish the views of service providers, commissioners and other relevant administrative bodies about the alcohol support needs within the local community.
6. Establish the views of residents of the community about their support needs in relation to alcohol services and support.
7. Identify the 'environmental' opportunities and challenges within the community for developing a CASP.
8. Map the alcohol support services available in the selected community.

In sum, the research sought to marry the views of the community about its alcohol-related needs with what the research evidence says 'works' in relation to community based interventions. This would, in theory, provide a good grounding for the development of future Aquarius' services.

Sample population and recruitment

The sample population and setting for the ethnographic research was pre defined as a result of operational decisions about which community and group of people to focus on for this exploratory study. As Hammersley and Atkinson (2007: 28) state:

Sometimes the setting itself comes first – an opportunity arises to investigate an interesting situation or group of people; and foreshadowed problems spring from the nature of that setting.

³ Interventions that are based within a particular community or neighbourhood and support various members of the community rather than interventions or initiatives focussing on one group of people or individuals.

However, within our sample population we sought to include a range of people across age, gender and professions. We did not seek a representative sample given the small scale and exploratory nature of this project but we did seek to garner the views of as wide a range of residents and members of the community as possible.

In sum, the following groups of residents and community members were targeted:

- ⌘ Professional groups (n=15), including GPs, housing providers, employment agencies, community policy officers, social care providers, alcohol service providers and commissioners.
- ⌘ Community service providers (n=16), including pharmacists, wedding venue managers, off licence holders and pub landlords.
- ⌘ Punjabi Sikh alcohol service users or those who identify as drinking heavily and who are not currently in touch with specialist services (n=10).
- ⌘ Residents including children and young people (n=10), older people (n=10), men and women in the community (n=40; 20 of each), (total n=60).

In order to establish the best recruitment strategy, and to encompass aim four of the research, a mapping exercise was conducted to determine the range of services in the area. A database was created that listed, among others, housing providers, youth centres, GP surgeries, schools, religious institutions, libraries, social care and so on. Further the Project Advisory Group suggested additional sources for recruitment including advertising and wedding venues. Additional contacts recommended by others interested in the project were also followed up including health and local government representatives. Finally, organisations that were logged as a result of our observational street work were also recorded.

The result was an extremely large database and decisions needed to be made about recruitment strategy. This was done in a phased approach starting with a number of agencies and individuals whom we identified through discussions locally as having a potentially key influence or location within the community. Others we identified through our initial observation/street work. It was an iterative process and as we progressed other contacts and links were suggested to us. The findings sections of this report present a profile of our final sample of respondents and participants for each element of the data collection process.

Data collection methods

A number of research methods were used to meet the aims and objectives of the two strands of this project. The following section provides a brief description of each one.

⌘ Evidence reviews

What counts as a community-based alcohol intervention is open to debate. For the purposes of this project six foci were chosen with an emphasis on determining effective alcohol interventions:

- i) Interventions for the Punjabi Sikh community

- ii) Family interventions
- iii) Interventions focussing on awareness, education and prevention
- iv) Interventions described as 'community' alcohol interventions.
- v) Mutual aid interventions
- vi) After care interventions.

Given the additional time and effort required to recruit our community sample, it was agreed with Aquarius to focus on the first four.

The evidence reviews were comprehensive reviews rather than full systematic reviews which are both costly and time consuming. To this end literature searches were conducted of key databases in health and social care in addition to the grey literature and Cochrane Collaboration databases. Key search terms and the databases searched are detailed in the respective reviews (Galvani 2013a, Galvani, 2013b, Manders and Galvani 2013a, Manders and Galvani 2013b). Date parameters ensured a focus on most recent literature/evidence with older sources accessed where they appeared key to the focus of the review. A number of the reviews drew on existing literature reviews, particularly where they were relatively recent systematic reviews. Inclusion and exclusion criteria were set for each search to keep the number of hits manageable and appropriately focussed prior to full text reading.

Ethnographic research

Within ethnographic research it is important that context is fully considered and that the research methods are responsive to it rather than rigid and pre defined. Given the range of people we were contacting we required a number of methods and data collection tools. These are outlined briefly below.

Overt observation

The first two days of the fieldwork for the project were spent observing the ward of East Handsworth and Lozells. This entailed walking every street in the ward, recording observations including, for example, the relative wealth of the area, agencies and services, places where people congregated and, where appropriate, talking to people about the project. Where possible (subject to ethical constraints), and with permission, information on the project and a link to the self-completion survey (see below) was left with individuals and community-based agencies. However, this observation work continued throughout the project as the research team were present within the community to conduct interviews, seek new contacts and encourage survey completion. Written observation notes were kept by the research team.

Self-completion survey

A brief self-completion survey (appendix 1) was constructed using specialist online survey software Qualtrics. The survey was available to complete online and it was also available in paper form. The survey contained brief, anonymous, demographic information followed by 15 questions, primarily multiple choice or scaled questions on people's perceived knowledge about the impact of alcohol on someone's health and behaviour, the reasons people drink alcohol, their awareness of services and how they would seek help for a friend with a drink problem, their views of the type and location of alcohol support services needed locally, and the role of religion in supporting people with alcohol problems. A final

question asked if people would be willing to speak to us further and, if so, to leave a name and contact number. Online surveys were able to be submitted electronically, paper based copies were placed by respondents into an envelope or collection box.

Focus groups

Focus groups were used with two groups of participants during the research. First, a focus group was held with a group of women attending a women's centre. Second, focus groups were held with three groups of young people. Focus groups allow for a supportive structure for participants particularly where there is a focus on potentially sensitive topics. They also allow for participants to respond to each other and thus debate about a topic is stimulated. Finally, for research purposes, they are both cost and time effective.

For both groups, a vignette was used to start discussion (see appendix 2). Vignettes are written or pictorial scenarios that usually present a story involving people in a particular context and situation. They are helpful to start discussion particular around potentially sensitive issues and are usually used alongside a series of questions about how people would respond or interpret the actions of the people within the vignette. For our study we used a number of different vignettes that would speak more clearly to the various perspectives of the people we were speaking to. Questions were tailored to the nature of the vignette and essentially sought their views on 'what would you do' or 'what would you advise' in this particular situation, in order to garner people's individual views and experience as much as possible.

The vignette discussion was followed by a semi-structured interview schedule asking about their perceived differences between generations' drinking, the role of religion in supporting people with alcohol problems, barriers and opportunities to help seeking, knowledge of local services and where they think alcohol services should be located. Similar questions were used for both focus groups although the language was changed to be age appropriate for the young people's group.

In addition, for the young people, an ice-breaker exercise was used at the start of the focus group. Each person was given post it notes and asked to write on them the impact of alcohol on people's health and behaviour and put them on the wall. They were also encouraged to write any questions they wanted answering on the 'post it' notes and stick them on the wall too for our research team to try to answer at the end.

Semi-structured interviews

In addition to the focus groups, semi-structured interviews were used with individual participants (see appendix 3) including the service user interviews and interviews with the professionals and community services providers⁴ (appendix 4). Semi-structured interviews, compared to structured interviews, allow for a greater degree of flexibility in the administration of the interview schedule. They allow for people to speak freely without being constrained by a particular order of question as well as enable the researcher to clarify questions or respond to questions posed by the participant. They also allow for flexibility in how the interview begins and who begins it.

⁴ Not all participants provided services directly, however for brevity we use 'service providers' from this point to refer to other professionals as well as those involved in direct service delivery.

With permission from participants, the focus groups and individual interviews were tape recorded. Where permission was not given, researchers took hand written notes. Both forms of recording were transcribed as soon as possible after the interview/focus groups in order to allow for maximum recall of both content and context.

Process notes

Ethnographic research enables the process of the research to be considered as part of the data. The process provides important context to the research process and reflects a journey that is influenced by the exploratory nature of the research. It also records the necessary responses to opportunities and barriers that arise or changes in direction that present themselves as the research progresses. The process of this project's work and the learning gleaned from it are as equally important to record and document as the findings and outcomes. The process issues will provide a helpful insight into the potential challenges and opportunities of developing Aquarius' services within the chosen community and are also presented in this report.

Data analysis

⌘ Evidence reviews

A thematic approach to synthesising the literature was adopted. The depth and breadth of the themes varied according to the review in question, for example, the review of alcohol interventions within the Punjabi Sikh/Asian community was based on limited evidence or literature and therefore a number of emergent themes are presented but they are not supported by a depth of evidence. In contrast, the review of family interventions resulted in a huge amount of literature thus the literature was categorised into particular types of interventions with fewer themes emerging within each category, however the results have greater depth as they are based on large numbers of detailed studies.

⌘ Surveys

The surveys were analysed using a statistical software package, SPSS. Statistical analysis involved primarily descriptive statistics on all variables and bi-variate analysis where possible. The Mann Whitney U test (Mann and Whitney 1947 cited by Field 2009) was applied to explore any significant differences within the data.

⌘ Qualitative Data

The qualitative data from all interviews and focus groups were transcribed and uploaded into a qualitative software computer-based package, NVivo. Analysis in Nvivo follows a form of thematic analysis where data are coded in detail (level 1), grouped into categories (level 2) and synthesised within thematic domains (level 3). The process is loosely based on the processes that underpin grounded theory analysis with the qualities of having constant comparison between the data as it is read and analysed. However, unlike grounded theory, the analysis for our data does not intend to generate theory, rather its purpose is to draw out similarities and differences in the data. These data are then presented in a narrative form within the findings sections of the report.

Process and observation notes have been re read, summarised and are presented in a descriptive fashion highlighting in particular any transferable lessons from the research process to the service development process.

Limitations

It was evident from the beginning of this exploratory study that we were only ever going to be able to scratch the surface of this topic given its sensitivity for many people within the Punjabi Sikh community. However it was apparent as time passed that the longer we persevered, the more we became known, and the more people were prepared to talk to us. However, given the time and resource limitations, the data collection period had to be limited. Our findings are based therefore on relatively small numbers of respondents and participants. It was clear that a much larger project is possible and that may of course produce different results, for example, allowing further statistical analysis to show differences between groups, for example, age or gender.

Ethical considerations

The research was approved by two ethics committees at the University of Bedfordshire. The first was at Institute level (Institute of Applied Social Research), the second at University level. Further approval was required from the Institute committee once the research was underway due to the later inclusion of an anonymous survey tool to the research data collection methods.

Information about the research and what would be done with the data collected was clarified on a combined information and consent sheet provided to each participant. We designed a range of consent sheets bearing in mind the age and roles of those from whom we were seeking consent; for example there were separate forms for young people, parental consent, service providers, and other adult participants. Additionally consent had to be geared toward the method of data collection, for example, the front page of the online survey comprised a combined information sheet and consent form that needed to read and completed before respondents could continue with the survey. The forms were read and signed by all participants or it was read to participants as appropriate. These were securely stored away from any raw data.

Verbal consent was provided by a number of community based agencies who gave permission for our research team to speak to people within their premises or organisation. This was recorded and logged in researchers' notes.

Section 4: Findings - Process issues

A key part of ethnographic research is documenting and reflecting on the process of the research, the relationships within it, the lessons learned, and how these contribute to the outcomes of the project. It enables the context and environment within which the research takes place to be central in the process rather than ignored as if they had no bearing on the research process.

Learning to engage

The research process raised a number of key questions that were answered, in part, by doing the research. For example, how do you engage a community you are not a part of, do not speak their language, or share their religious beliefs or cultural background? This question is clearly as relevant to an organisation considering new service provision as it is to a new research project within the community concerned. Our reflections found the following were requirements to even begin to have conversations about alcohol needs and service provision:

- Humility in seeking permission to undertake the research
- Be honest and up front about the nature of the research
- Find time to build trust with people; this takes patience. We had to be prepared to go through a number of people and repeat basic information about the research and repeat introductions about who we were and what we were doing.
- Ensure your attitude is one that accepts they are the experts in their lives and you are willing to learn. This also allows you to question from a different perspective and interrogate their understanding and views.
- Be tenacious and persevere in the face of setbacks. People often did not show up for appointments or they were cancelled. Some interviews took several attempts to meet before they actually happened. Our researcher recalls a couple of examples:

I turned up on one occasion and the person was exceedingly busy with lots of other people and it was difficult to undertake the interview. I offered to come back at a more convenient time and on both occasions I had to be prepared to wait and not be impatient about scheduled appointments, or him being busy and made myself comfortable with a cup of chai in the Langar Hall but at a discrete distance so as to be seen but not in the way. It was hard to work out if people were being polite and did not want to be rude but were trying to gently put you off, or to say no. You had to work out when it was best to cut your losses and say I have made the effort but I am not getting anywhere.

I spoke to a youth organisation on the telephone and was told to send an email with the research information and did this on two separate occasions but the person did not respond but was extremely polite on each occasion. At this point I felt this was a closed door. On another occasion I left messages on an answerphone and sent an email and waited for over a month before getting a response, which came out of the blue.

- Seek out potential gatekeepers – the community has a number of people with influence and power who, once identified, are key people to target.
- Consider gender issues – our male researcher was accepted by other males but we needed our female team member in order to access the women's groups.
- Have a team member who speaks the language as this opens doors that otherwise would not be open. At very least, learn a few words in the language. It shows respect and opens up conversation. As our researcher said:

Learning a few words, phrases of Punjabi was also important to gaining some credibility, to show I was open to learning and not just coming in to impose my values, beliefs, ideas. Willingness to learn about the Sikh faith was also very important. It broke down barriers - like the use of the word Giani for the religious officiant in the Gurdwara.

- ⌘ Be aware of customs and respect religious practice – for example, carry a headscarf to cover your head when entering a Gurdwara (men and women).

Hierarchy, power and politics

It became apparent from an early stage that there were key people in the community, often attached to a Gurdwara who held considerable power and influence in their own organisations with ripples into the wider community. It was also apparent that there was a clear hierarchy in some Gurdwaras (but not all) and it took time to learn the nuances of this. The Gurdwaras always referred us to the Committee members but they were hard to get hold of. There is a clear chain of authority in Gurdwaras and it needs to be carefully identified, by building relationships on the ground and mapping these to see who to approach. We only started to scratch the surface of building relationships and further work needs to be undertaken particularly with the Gurdwara committees and/or Trustees.

Status was important to some of the key people in the community and this needed to be understood in order to gain access to their organisation and individuals within it. Respecting this perspective involved, for example, the Principle Investigator emailing and asking for access when there was no response to the researchers' contacts. On another occasion the PI attended a 'lively' meeting to explain and defend the research and potential future service development. Here and elsewhere it was made very clear that "parachuting" in services from outside without genuine partnership working would not be acceptable within the community.

Related to this is the importance of image within the community and how people are perceived. For example, it is important for people to be perceived as hospitable and generous. Outward displays of wealth were about stating how well people were doing, which is reflected in being generous towards guests, often with alcohol and food.

It also became clear that there were spiritual differences between organisations, often Gurdwaras, and that particular Gurdwaras were known for particular attitudes to, or beliefs about, people who have alcohol problems. Some were renowned for being more tolerant and empathic than others. However, such differences were not confined to Gurdwaras – we

became increasingly aware that there were differences in spiritual beliefs or simply the personalities of key organisations' personnel that resulted in people not being able to share the same meeting, for example. Understanding and learning about such relationships has vital implications for service development and may explain some of the challenges of partnership and multi-agency working within the community.

Finally, through the fieldwork we learned that in spite of principles of equality within Sikhism there is still a strong caste system which historically underpins the differences between Gurdwaras (see 'Service Provider' chapter). Different castes affiliate to certain Gurdwaras and the implications of this for effective partnership working with more than one Gurdwara round the 'service development table' may need to be considered.

Resistance to discussing alcohol

One of the challenges of this research was to discuss alcohol with people of the Sikh religion. Repeatedly we were told 'real Sikhs' do not drink alcohol. Yet we were also aware that Punjabi culture often involved heavy drinking. This tension is not, of course, confined to Punjabi Sikhs. It is also a tension that is found in other cultures and religions. However this tension meant that discussing alcohol was highly sensitive and often met with a denial of any issues at all. This had to be handled carefully, subtly pointing out the evidence to the contrary and acknowledging the sensitivity of the subject matter.

People's attitudes toward alcohol use also impacted the level of engagement. There were people who recognised it as a problem but were not necessarily prepared to do anything more than acknowledge it and who did not wish to become further involved. Others provided tokenistic access only. For many the view was that such issues were dealt with by and in the community and imposition from outside was to be avoided.

Relationships with gatekeepers

Gatekeepers are those with "the power to grant or withhold access to people or situations for the purposes of the research" (Burgess, 1984:48). Accessing individuals or members of organisations often required trusting a gatekeeper to communicate and make arrangements on our behalf. This required compromise and we did not always get what we wanted. As our researcher found, persistence and patience paid off in many cases:

I think the fact that we showed up every day in the same places and our faces and name began to be known, established some credibility. We acquired some familiarity with the different Gurdwaras. Each of these operates differently. Learning how the different Gurdwaras operate enables you to begin to obtain access, through approaching the right people.

Another example included a local Sikh police officer who the researcher met and accompanied into the community. He was well known by local people and introduced our researcher to people and places that led to further interviews and contacts. The researcher was seen as being a 'safe person' to talk to because of the association. Importantly the back

story to this contact was that initial contacts with the police at both regional and community level resulted in little to no awareness or concern about Punjabi Sikh alcohol use from a criminal justice perspective. A last minute offer to put us in touch with a Sikh officer, when followed up, resulted in a very helpful meeting and further contacts.

Confidentiality, shame and stigma

Given the sensitivity of the topic and the hard work needed for even preliminary engagement, confidentiality was a very important component of the research. Shame was a significant factor that prevented people from seeking help. This will of course transfer to future service development. Our research became aware that there were 'communities within the community' which often prevented people from discussing their views or experiences openly for fear of others finding out or gossiping about them. For this reason individual interviews were most productive and this is likely to be transferable to alcohol service provision.

Gendered roles

Sikhism is clear about the importance of equality both in terms of class and gender. Its Gurus rejected the caste system and took steps to minimise inequality on the basis of caste; for example, women all take the surname 'Kaur' and men 'Singh' to avoid people's caste being deduced from their names (RealSikhism 2013). Within Sikhism women's subjugation is also denounced; women should be treated as equals with the first Guru, Guru Nanak Dev Ji, denouncing the inferiority of women and pointing out that without women there would be no one at all (RealSikhism 2013). However, the principle is not always evident in practice. There are culturally traditional roles which need to be understood, for example, the male dominated structure of Gurdwara committees. The experience of the research team was that they also tended to be predominantly older males. This will need to be considered in terms of making contact regarding service development.

Requests for access to women's groups within some of the key organisations we contacted were overlooked. Women are perceived, however, to hold the power in the household and within the family. Our research also noted generation differences in attitudes and tolerance of traditional relationships and expectations. These differences are explored further within the main findings of the project.

Summary

Reflections on the process of research and not just the findings and implications are key to ethnographic research. What an ethnographic study offers is consideration of the context and the social, cultural and political environment in which it took place. The processes and learning that results is treated as data that is as rich and important as the more 'traditional' forms of data collection. The processes described here include important barriers, opportunities and learning points that offer transferable lessons for the development of future alcohol services within the Ward. Key amongst these is an understanding and acceptance of the hierarchies, power dynamics and political nuances between individuals and organisations in the community. This can only be learned over time and through developing relationships with individuals within the community who offer small bits of information in the course of discussion. Piecing together the 'information jigsaw' is the task

of the researcher or practice development team. However, this also has an impact on timeframes for the work and needs to be considered in commissioning arrangements. It means allowing more time than usual for negotiating access to the community and key influential individuals given the suspicion of white services 'parachuting in' and the sensitivity of the subject matter. In addition, the issue of confidentiality, shame and stigma are huge barriers to both research and to practice development and service use/access. While this is not an unusual concern among people with alcohol or other drug problems, it is keenly felt in a close knit, minority community that has a religious prohibition of alcohol.

Section 5: Findings - Survey and mapping data

The self-completion survey was developed in response to suggestions from the Project Advisory Group that an anonymous questionnaire may gain more responses because of its anonymity. It was also a helpful medium for community consultation at a number of scheduled health and well being events in and around EH&L towards the start of the project. These included health promotion events held at the Nishkam Centre on Soho Road and a large Sikh Mental Health and Wellbeing event held in September 2012. The latter attracted an audience beyond the targeted geographical ward of EH&L, however given the questions were not specifically geared to the ward, it was felt appropriate to retain all responses. The questionnaire was also used at the men's and women's fitness sessions held within the within the Nishkam Centre and some were used with members of the public who the research team encountered during their visits to various Gurdwara or during their travels around EH&L.

In total 89 responses were received and the demographics of the sample are presented below. More men than women responded, there was a higher response rate among the two mid-range age groups. As might be expected the majority of respondents were Sikh with an equal split between Handsworth and Handsworth Wood (H&HW) and other cities (OC):

Table 1: Demographics of survey respondents

		n (%)
Gender	Male	52 (58%)
(n=89)	Female	37 (42%)
Age (years)	≤24	15 (17%)
(n=89)	25-44	35 (39%)
	45-64	29 (33%)
	≥65	10 (11%)
Religion	Sikh	72 (81%)
(n=89)	Muslim	1 (1%)
	Hindu	11 (12%)
	Christian	4 (5%)
	Atheist	1 (1%)
Area of residence	H&HW	27 (31%)
(n=87)	OB (other Birmingham)	14 (16%)
	OC (other Cities)	25 (29%)
	S&D (Sandwell and Dudley)	21 (24%)

The summative responses to the survey are detailed below. These primarily form the same order and pattern as the questions themselves.

Knowledge and perceptions of alcohol-related problems

Respondents were asked “on a scale of 1-10, how much would you say you know about alcohol and its impact on your health?” (1 = I know nothing and 10 = I am an expert). Perceived knowledge of the impact of alcohol on health was generally high, the mean score was 8 (range 2-10, SD = 2.1). A quarter of respondents (n=25, 28%) perceived themselves to be an expert on the impact of alcohol on health. This may be explained by the fact that a many questionnaires were completed by people attending health events. The data may, as such, present a positively skewed picture.

Respondents were also asked “on a scale of 1-10 how much would you say you know about alcohol and its impact on people’s behaviour?” (1 = I know nothing and 10 = I am an expert). Perceived knowledge of the impact of alcohol on people’s behaviour was also relatively high; the mean score was 8 (range 3-10, SD 1.7) and 25% (n= 22) perceived themselves to be an expert on the impact of alcohol on people’s behaviour.

Respondents were asked which of a number of health and social problems they thought were related to drinking too much alcohol; they were allowed to select more than one option. Responses were:-

Table 2: Which health and social problems are related to drinking alcohol?

	%
Arguments and conflicts at home	87
Liver and kidney problems	84
Violence and threats of violence at home	80
Financial problems	80
Loss of employment	71
Mental health problems	63
Getting into trouble at school or college/university course	57
Not eating properly	54
Poor sleep	53
Heart and lung problems	43
Smoking	25
Other	11

The association with arguments, conflict and violence were high along with liver and kidney problems. Interestingly only 25% felt smoking was related to drinking alcohol when there is a substantial amount of evidence of a close association between alcohol and smoking. This could however reflect Sikhism’s teachings that smoking is also prohibited, along with alcohol and other drug use. Further explanations for this are seen in the findings from the women’s group (below). Respondents were given the opportunity to provide any other issues which they thought were related to drinking too much alcohol. Responses included “fights, rape”, “trouble with the police”, “poor self image” and “using other drugs”.

When asked “on a scale of 1-10 how much shame do you think people with alcohol problems feel”, the mean score was 6 (range 1-10, SD 2.82). However, the range of responses spanned all options from very shameful to no shame.

Given the gender differences in drinking within Punjabi culture (Galvani 2013a) the data were explored to determine whether there were any significant differences between male and female responses. No significant differences were found between males and females with respect to self-perceived knowledge of alcohol and impact on health (Mann Whitney U = 761, $p = 0.087$, 2-tailed) and perception of how much shame people with alcohol problems feel (Mann Whitney U = 771, $p = 0.141$, 2-tailed). However, females scored lower than males for self-perceived knowledge of the impact of alcohol on people's behaviour (mean score 7.4 versus 8.4) and this difference is statistically significant (Mann Whitney U = 683, $p = 0.017$, 2-tailed). This may reflect the lower levels of drinking among females; without the drinking experience they may be less confident about its impact on behaviour. However, further research with a larger sample size would need to confirm this finding.

Respondents were asked what they thought were the main reasons people drank alcohol (they were allowed to select up to three options). Responses were:

Table 3 – The main reasons people drank alcohol?

	%
To escape or forget their problems	81
Peer pressure/other people do it	74
Like the buzz it gives them	62
To fit in with their peers	57
To give them more confidence or courage	44
To be a good host when people visit/when hosting a party	34
Like the taste	33
To rebel against parents' religious or cultural rules	29
To help them sleep	28
To give them an excuse for behaving badly	25
Other	7

The fact that 'being a good host' is quite far down the list of reasons given is interesting in light of the findings from both the literature review (Galvani 2013a) and the qualitative data that found a very deeply culturally engrained of alcohol consumption relating to being a good host at home or at a wedding in particular. A free text box allowed respondents to suggest other reasons people might drink. These included "bereavement, loss of job", "medical problems" and "nowadays there is no tea/coffee for visitors, it is spirits".

Knowledge of, and attitudes towards, alcohol interventions

Respondents were asked "if you knew someone in your family or friendship groups that had an alcohol problem, would you.... (please tick one option)". Most respondents said they would talk to the person about getting help although the survey did not determine who this help might be from:-

Table 4 – What would you do if a friend had a problem with alcohol?

	%
Try to talk to them about getting help	60
Other	25
Ask someone else for their advice on what to do	10
Pretend nothing is wrong and carry on as normal	1
Stay away from them	5

Other reasons given included “get him/her interested in meditation” and “send them to alcohol services/hospitals/mental health”.

Respondents were asked “if your friend or family member said they wanted some help with their alcohol problem, would you know who to suggest”. 27% answered ‘no’ to this question, the remaining 73% answered ‘yes’. On first appearances this response is very positive however we then asked a follow up question in terms of who would they suggest; far fewer people responded. Responses included an alcohol service (n=19), GP/doctor (n = 17), Alcoholics Anonymous (n = 8), internet (n = 2) and elders of the community (n = 1).

Respondents were asked “do you think other people are affected when someone has an alcohol problem”. Only 1/89 answered ‘no’ to this question. Respondents who answered ‘yes’ were asked to specify who they thought was affected. All those who gave an answer said family and/or friends. Some also thought that “people at work” (3), “society/nation, community” (2) and “pedestrians from drink drivers” (1) would be affected.

Respondents were asked “if you wanted to know more about alcohol, health and wellbeing, where would you most likely go to for information”. Given the concerns about privacy it is perhaps unsurprising that many chose the internet or the GP. Very few stated friends, family or religious leader:

Table 5: Where would you most likely go for information?

	%
Internet	19
GP	15
Alcohol service	7
Friend	2
Family member	1
Religious leader	1

Over half the respondents (55%) said ‘other’ and went on to give a combination of categories suggesting that they would not rely on one source of information alone. Most of these categories included both the GP and the Internet with some also including alcohol services and family members. Ten responses also included ‘religious leader’.

When asked whether they knew of any services in the area they live that support people with alcohol problems, 34% of respondents said yes and 66% no. Those who answered yes to this question were asked to name the service. Services named include AA (n=7), Aquarius

(n=9), Addaction (n=1) and South London Maudsley (n=1). It is perhaps not surprising that so few were able to name services if they had not had occasion to seek them out.

When asked “what do you think are the main reasons that might stop people seeking help if they were worried about their own drinking (tick up to two boxes)” most responses related to ignorance or shame. Fewer respondents felt it was about a lack of locally available services. Again this may be skewed by the fact that the questionnaires were largely completed in health events or activities.

Table 6: What might stop people from seeking help?

	(%)
Don't realise the effect it is having on their health or wellbeing	60
Shame/afraid other people in their family or neighbourhood might find out	57
Thinking they can change their drinking on their own	52
Don't know where to go or who to ask	42
No services locally that meet their needs	10
Other	9

A further question explored the type of support services respondents felt were needed in the area where they lived. Respondents were allowed to tick as many categories as they wished. Education and awareness for people of all ages received most responses with less than half feeling the need for self-help groups.

Table 7: Type of support services needed locally?

	(%)
Education and awareness for children and young people	80
Education and awareness for adults and older people	65
Support for children of parents who have alcohol problems	62
Support for family members of people with alcohol problems	62
Individual counselling services	60
Self-help groups	44

A free text box allowed respondents to list other services which they thought were needed. Responses included “meditation” (1), “police in cases of domestic violence” (1) and “services for specific groups i.e. Asian men, young people, women only, alcohol specific issue support groups” (1).

Females were more likely than males to know who to suggest if a family friend or family member said they wanted some help with their alcohol problem (79% vs. 69%) and to know of services in the area that support people with alcohol problems (43% vs. 27%) but these difference were not significant ($p = 0.34$ and $p = 0.1$ respectively).

Religious support for people with alcohol problems

Respondents were asked “is religion important in helping someone overcome alcohol problems. 69% of respondents answered yes and 32% answered no. Those who thought that religion was important in helping someone overcome alcohol problems gave a variety

of reasons for this including “attending a place of worship can help and mixing with people without alcohol problems can help”, “faith gives support, reassurance and also deviations (sic) and distractions”, “gives someone reason to stop”.

Reasons given by respondents who didn’t think that religion was important included “if people want to continue drinking, they will, no matter how much they are educated with religion”, “think they would need proper help” and “religious people are too judgemental and moralistic”.

Females were more likely to believe that religion is important in helping someone overcome alcohol problems (73% vs. 65%) but, again, this difference was not significant ($p = 0.45$). It is quite likely that the lack of significance is due to small sample size.

Respondents were also asked “what should the role of religion be, if any, in supporting someone to deal with their alcohol problem (please tick all that apply)”. Nearly two thirds felt the role was to offer advice with smaller numbers of respondents seeing a role for religion in support, prayer and as a coping mechanism.

Table 8: What should be the role of religion in supporting people with alcohol problems?

	%
Offer advice	63
Support of faith community	47
Coping mechanism	39
Prayer	38
Not important	10
Other	9

Respondents who answered ‘other’ to this question were asked to elaborate. Text drew on the specific institution of the Sikh Gurdwara, one appearing critical - “should be important in one’s recovery but Gurdwaras not interested” - and, in contrast, one response finding the Gurdwara helpful - “people from the Gurdwara put me in the right direction”.

Future research should target a greater sample size to allow for further analysis by religion and age.

Mapping data

One of the aims of the empirical research was to map the existing alcohol services within the community. Apart from Aquarius’ presence at Rookery Road fire station on one half day each week, alcohol support comprised AA meetings, and a range of services run from Birmingham and Solihull Mental Health Foundation Trust, located in Orsborn House, Handsworth, including Central and West Addiction HUB and a Blood Borne Virus Team. A service user group, DATUS, was also located in Handsworth as was Zephyr, a Turning Point project offering a structured day programme for people “recovering” from alcohol and drug problems. Housing provider Midland Heart also operate a Homeless Service Centre in the area and the A-Team alcohol team offer interventions through GP surgeries in two practices

in Handsworth including individual counselling and relapse prevent. What is not known is the extent to which their service user group includes Punjabi Sikh people.

Summary

The anonymous survey data revealed perceived high levels of knowledge about alcohol's impact on health and behaviour. In particular respondents identified the issues of arguments, conflict and violence at home as having a close relationship with alcohol consumption, alongside liver and kidney and financial problems. With the exception of financial problems, these were the themes that emerged strongly from the qualitative work (see findings sections below). The negative impact of drinking on friends and family was highlighted although they were not identified as primary sources of alcohol information. The internet and GP were most identified as information sources which again has potential implications for future service development. Ignorance over the impact of alcohol on their health and wellbeing scored highly in the question about barriers to help seeking, closely followed by shame of others finding out. Given these findings it is unsurprising that the respondents identified education and awareness for children and young people as the main type of support service needed followed in almost equal measures by education and awareness for adults, support for children and for family members of people with alcohol problems and individual counselling. Finally, the role of religion in providing support attracted mixed responses. More than two thirds felt it was important in helping people to overcome alcohol problems and just under two thirds felt it should offer advice to people with alcohol problems.

Section 6: Findings - Qualitative

Service users

Eight service users agreed to be interviewed as part of this research. Three were known to Aquarius, the other five were recruited through our presence within the community or contacts from other people. Many more Punjabi Sikh service users were identified and approached but did not want to take part. Two service users lived out of the EH&L area. The majority of participants were male and were within the 17-64 years age bracket.

Table 9: Demographic profile of service user participants

Age (yrs)	Under 16: n=0	17-24: n=1	25-34: n=1	35-44: n=1	45-54: n=2	55-64: N=3	65 and over: n=0
Gender	Male: n=7				Female: n=1		
Ethnicity	Punjabi: n=7				Missing data: n=1		
Religion	Sikh: n=8						
Postcode	B11: n=1		B44: n=1		B21: n=4		WV14: n=2

Despite being a small number of service users, a huge amount of data emerged from the interviews. Through data analysis (see section 3 above) eleven themes emerged and these are presented in brief below.

⌘ Drinking norms

The service users were very clear about the norm of drinking within the Punjabi culture. One service user described how 'generosity' is a key part of providing hospitality and everything is done in excess. Also they described how proud Punjabi's were as people and how they were raised to be "bold and courageous, develop pride". Some also referred to the fact that as a British Indian or an Indian in England there was a double drinking culture as the English also have a reputation for drinking. Not only was drinking a norm but, for many, drinking quantities was the norm, particularly spirits.

Among the service users who were currently not drinking, they described tremendous peer pressure on them from family members and friends to start again or at least have a drink. This was particularly so at parties or at weddings or other celebrations. Weddings were repeatedly raised in all our interviews with people in this Punjabi Sikh community as heavy drinking occasions and people usually had examples to give of their own or others' behaviour relating to wedding drinking.

Several service users described weddings that had been meat and alcohol free highlighting how "proper Sikhs" do not drink even at weddings and parties. However, it is clear that

alcohol and meat-free⁵ weddings pose a threat to the status of the host. In his support of such weddings one service user states:

People can tend to charge you more because there is no animal fat in it. I would not say it is not any cheaper per head. Alright you might not have the alcohol but you're still going to bring all the soft drinks in.

One service user remembers his father criticising a friend because they were not offered alcohol:

...if you don't offer guests alcohol they think you are bad mannered. I remember my dad saying once that how rude the family were because they didn't get the bottle out so my mum had to argue with him and explain that they had become strict Sikhs.

A number of service users pointed out the mixed messages that were passed to the younger generation about their religion and drinking.

...if you bring kids up very strictly in the Sikh religion and then you attend a wedding with them and they see 500 guest all drinking and eating meat – the kids get confused thinking if they can all do it then it can't be “wrong”.

These confusing messages to young people and their connection with learned drinking behaviour within families (parents, siblings) and peer groups was a common topic for discussion. Vignette 2 in particular raised the issue of fathers' drinking influencing their children's behaviour and some also reflected on similar experiences with their own fathers:

...when I was drinking it was because I used to see my dad drink. I thought it was the norm.

Another described seeing her father drinking every night and seeming happy afterwards so she tried it and found it made her forget 'what was going on' for a couple of hours. Others simply described the normality of drinking as part of their social and family scene. One service user reflected on a tendency to link alcohol with all social activities and being seemingly unable to meet friends without it.

As well as drinking because it was the norm and learned behaviour a number of other reasons for drinking emerged. One person felt it was about the difficulty people had finding work, another that it helped him relax and sleep and another to “deal with the pressures of life”. For one person he started drinking again when he had marital problems and for another because he had the 'urge' to drink suggesting possible dependency issues.

⌘ Negative impact of drinking

Service users were clearly aware of the dangers of drinking. They gave examples including the death of family members, usually their fathers, as well as friends. Others reported a

⁵ Sikhism also prohibits eating meat.

range of losses including the breakdown of marital relationships, their home, their health, financial losses, losses relating to their business and also their children. The loss of family status and being judged by others, including family and community members, was seen as both shameful and stigmatising. However, for one service user the judgements were also met with advice and attempts at support:

People do feel judged. Many people used to say to me, you are drinking too much and I used to say to them, what do you know about me, because I can handle it, because at the time I thought that I could handle it, but it overtook me and when it overtook me, I knew people were judging me. At the same time they were trying to advise me for my own sake, but I was not taking that advice. I was not listening to them.

Shame remained a dominant theme for the service user group. The shame and stigma is both individual and communal. It is the latter, particularly in the wider context of being part of a minority ethnic group, which makes the sensitivities about gossip especially pronounced. One service user gave the example of saying when he went into detox his family said he was on a college course which he said was only a “white lie” as he was learning about alcohol and receiving an education.

A few service users said that shame was not experienced by drinkers on the grounds that if they felt ashamed they would not do it.

Other negative aspects of drinking were the impact it has on their health (death, liver damage, lung problems, stomach problems, breathing problems, hangovers), their relationships /children (relationship breakdown, criticism or fear from children, wife and child returning to India, bad example to the kids) and their behaviour (behaving like an idiot, fighting and aggression).

⌘ Domestic violence

The inclusion of domestic violence in vignette 1 raised some interesting responses. One service user reported that such incidents are sorted out in the community. If a man is violent or abusive to his wife, the wife’s family and close friends will retaliate by way of seeking ‘justice’. Others said they would advise the wife to call the police and advise her to put her safety and that of the children first although one of these suggested she call one of the elders in the community first as he was “sure someone would be on standby in case something happened”. This sense of problems being dealt with within the family first, and if not the community as second choice, resonates throughout the findings and will be considered further in the discussion chapter.

⌘ Gender differences in drinking

Drinking by younger Punjabi Sikh women was perceived to be increasing alongside increasing levels of westernisation in particular. Their levels of drinking were raised by a number of participants in this study as “a big problem”. One service user explained her view of the challenge younger women faced:

I find the Sikh women are living two lives and they feel torn, good Sikh girls at home and different when they go out, they are westernised. I find the younger generations say they are lost and this is sad. The religion is confusing as well as the cultural beliefs as the young generations are brought up with Western culture. This also happened with me and my sister, at home we were Sikh girls and as soon as we stepped out we became Western girls.

This concern was raised across the various community groups as a challenge given the extent to which women's drinking is frowned upon, in addition to the religious prohibition. One service user reported that men's attitudes had not changed in terms of the acceptance and non-acceptance of women's drinking but that younger women have changed their attitudes and will not tolerate some of the discrimination. Older women's drinking was not seen as an issue.

Further references to gender differences related to women in their role as wives, care takers, mothers. Service users identified the embarrassment they would have if their husband or son had a drink problem and their possible attempts to hide it from the community. They were also referenced in terms of not knowing where to go to seek help for their loved ones.

⌘ **Generation differences in drinking**

There were differences of opinion about whether or not there were generation differences in drinking behaviour. Some felt young people were better educated about alcohol, "more aware of the harms of drinking" and more open to learning and changing their ways, others that younger people drank more than older generations with a wider range of drinks to choose from, and two felt younger people used illicit drugs more than.

Some felt the older generation were more responsible with their drinking than young people whose motivation for drinking was different, e.g. courage, being part of a group.

The elders take their time with alcohol and that compared to the youngsters and they enjoy it and the drink is to be enjoyed whereas the youngsters is get it down you, get it down you.

Some service users pointed out that the older generation did not fight and become aggressive after drinking. However the inconsistency of some elders who drink and go to temple was again highlighted.

In the Sikh community, especially the old generation they still drink and go to temples/Gurdwaras but they are in denial. Either they are just being ignorant or not wanting help or they just don't want to stop drinking.

One service user felt it was the responsibility of elders to educate the younger generation about what is acceptable and what is not. The issue of generation differences didn't stop at drinking but expanded into more general discussions about differences between older and

younger generations in terms of discipline, work ethic, attitudes to elders and parents, and material expectations.

⌘ Religion, culture and alcohol

The challenge throughout this project and for those living within the Punjabi Sikh community is to understand what are often contradictory messages regarding alcohol within cultural-religious boundaries.

One service user stated “The culture and religion are separate. Culture is completely separate to religion, like Punjabi culture is drinking, dancing, partying, flamboyantness.” Another stated “it was the culture to drink back in India from the beginning and they have brought it over here and have continued to drink”. While Sikhism prohibits alcohol, baptised Sikhs in particular are not expected to drink. The following quote illustrates well some of the tensions:

If you go to a party you will see a lot of Mr Singh’s sitting at one table, they’re the ones who have been baptised and there is another table with Mr Singh’s who haven’t reached that baptised stage yet, and you’ll see another table with the youngsters. So everybody has their little group in the wide range that is the community. So [drinking alcohol] is accepted and it isn’t accepted. That is the distinction between culture and religion but if you ask them they are all Sikhs. There [are] your cultural boundaries and your religious boundaries. The people who are baptised will say no they [the non baptised] are not proper Sikhs. Even though they are Sikhs they are following the culture but they are drinking. When you have been baptised you don’t go back to your old ways, but people do tend to break it and then they will go away. You see, we have been taught, as we have been growing up, if you are going down that road and you want to be baptised you don’t look back again. You are not supposed to look back. If you look back you will go back to your old ways and you will break your religion and break your baptism. It’s a sacred thing when you have been baptised.

Another service user felt that it was acceptable for non-baptised Sikhs to drink but only within certain limits. One person felt that he could balance being both a “proper Sikh” and a “normal person, a Punjabi person drinking” stating that he lived “the two sides”.

A number of service users highlighted the sacred nature of baptism. Drinking, and problematic drinking, by baptised Sikhs would clearly add to the shame and stigma felt by themselves and would be received critically within the community. Thus, future service provision may want to establish, as part of assessment or intervention, whether people are baptised or not and whether this is a factor that can help or hinder changes in their drinking behaviour.

Religion also was identified by the role it could play in replacing people’s substance use and supporting the individual. One service user described the “best vibe” he had was from his prayers rather than from the substances he had previously taken. Others described the

'sewa' as providing an important outlet, either as part of a court imposed statutory community order, or as a way to keep occupied and give something back. Another described it as giving him an identity that he hadn't previously found while one person said it provided him with food "but nothing else". Teaching and learning about their religion and the opportunity for self reflection as a consequence was also seen to be a crutch for people in newly found sobriety although one person stated that the language used in the Gurdwara was a barrier for him although he had taken steps to address it:

I cannot read or understand fluent Punjabi myself. That is the main problem a lot of people have. When they go to the temple, they don't learn nothing, they don't understand. The Sikh scriptures themselves are written in a language over 500 years ago, so they are more like Persian, because that was the language at the time when they were written. Even those who can speak fluent, even my elder generation who can, they don't even understand the Sikh scripture. It is not even Punjabi it is Gurmukhi (script of Sikh scriptures). The main problem is understanding but there [are] many websites out there now which have got translations and have translated it into English. So that is how I have begun to understand myself.

Some service users found that advice from people within the Gurdwara had been helpful with one person describing how the Giani sat down and listened to him and gave him advice. There was however general agreement that people under the influence of alcohol should not enter the Gurdwara.

...as a Sikh you don't go to the temple, me personally I wouldn't go to a temple smelling of alcohol. Once you have drank you shouldn't go near a temple, unless, you'd have to wait to sober up before you could go in there. Get rid of the alcohol smell before you approach somebody if you have got a problem. You don't go and say your prayers when you are drunk because it's disrespectful. If you did want to say your prayers you can always go home and pray. You can sit on a park bench and say your prayers. There is nothing stopping you doing that as well.

⌘ Service provision

A range of suggestions were given for future service provision. These were further categorised into four groups; i) the qualities/characteristics of services, ii) location, iii) promotion of services, iv) other considerations:

The qualities or characteristics of the services should be:

- Confidential and discrete
- Friendly and welcoming service
- Approachable and respectful staff
- Inconspicuous
- Staff who speak the same language as the community
- Staff from the same cultural background
- Educational – units, liver damage
- Phone line/help line – 24hr

- Holistic service (helps engagement/retention)
- Separate services for family members and drinker.

Location of the services:

- Community centres – ‘surgery’ once a week in all of those attached to the Gurdwaras
- Library based service once a week
- Within GP surgeries
- Service in Handsworth
- Temples and Gurdwaras
- Universities
- Medical centre
- Within homelessness services
- Easy access – on bus routes, easy parking
- Nothing that is central and close to shopping or market where people will be seen going in and out.

Promotion of services

- Better marketing and promotion needed – including in Punjabi as well as English
- Advertising through Punjabi media – Radio XL; Asian network; notices in the Park, Council buildings
- Gurdwaras – need training and then to talk about it more
- Sangat TV – presenting facts and evidence not just issues
- Open days at temples
- Door to door work in the community
- Leaflets and contact details to temples
- Educate the Gianis – training for them.
- Images/pictures of damage alcohol can cause.
- CDs/DVDs in different languages about services, harm to health and family.
- Promotion through facebook and social media.

Other considerations

- Positive role models
- Run seminars about healthy lifestyles with alcohol in there too
- Get the Gianis ‘on side’ and get involved with the groups at the Gurdwara/ community centre – get at least one supportive Gurdwara
- ‘Talking therapy is not really good, as not in specific languages, and Asians don’t understand this therapy, they only relate to medical models’
- White counsellors (independent and confidential) vs. Punjabi Sikh counsellor (may get back to the community)
- Building relationships with the Chairs of the Temples/Gurdwaras
- Partnership between alcohol service, probation and Gurdwaras.

Help within the family

As with many cultures, the family is central to the lives and culture of the Punjabi Sikh community. Quite explicit within the service user interviews (and others) was the

preference to sort out problems, including alcohol, within the family first. As alluded to on page 41, there appears to be a hierarchy of help seeking emerging:

Level 1: sorting it out within the family

Level 2: involving other supportive members in the immediate community

Level 3: seeking external help.

Only when the first two levels have failed will additional help be sought and this appears to be primarily from health, in particular, GPs/primary care. The issues around family involvement and support followed the presentation of the vignette:

The best way to sort things out is to work through the family, tell the mum, tell the dad, look he is doing this. It is normally families that sort things out internally. We don't really go out to seek advice from anybody else. If we have problems in our community, we tend to sort them out amongst ourselves. If there is a dispute say between me and somebody else. There will be an elder who knows us both, who will sit us down and try and talk it out. We don't really like go to the Police or certain agencies or help from anybody else, because there is no need to and we can sort it out ourselves, it is better that way. That is the way people tend to sort things out.

In response to vignette 1, one service user suggested the wife told her husband he was not able to drink at home or to ban alcohol in the house. However, this may not always work. As one service user recalled, reflecting on his own family experience, "My mother would tell him [his father] not to drink and he would say I'm going to drink and you cannot stop me." Another felt that relatives may appear to help but "behind your back they will be laughing at you". One service user suggested the wife in the vignette talk to an elder "who can approach the family and talk to the family, that is how they keep it in house". Similarly, in vignette 2 with the young person, the first port of call was the parents to talk to him about it although as one service user pointed out, it would depend on the parents. Elders more broadly are often referred to particularly in terms of their responsibility to teach the younger generation what is acceptable and what is not although for one service user his "wake-up call" was the other way round; his daughter intervened and told him to 'sort himself out' or leave.

Here and elsewhere wives appear to be given the responsibility for asking for help but, as one person noted, there may be a reticence about asking for help: "in today's society they have got to come out of their shell and say you need help. If we can get to the Gurdwaras [we can] ask the ladies would your husband be willing to come for help". One service user's family got together and investigated alcohol services – the sister and cousin made an appointment for the service user to attend.

Family alcohol interventions

Family alcohol interventions from outside agencies were not suggested by any service user. This could be because they were not aware that such approaches were available however one service user suggests another possible explanation:

Family intervention is a hard thing to do in Sikh/Punjabi culture because 9 times out of 10 the Sikh husband will not want his wife there, and to know the whole truth. They will not tell you the truth anyhow. You know what they are drinking. Say for arguments sake they have been drinking two bottles of vodka a day, they will say I am drinking half a bottle of vodka and a couple of beers. But you have been told before by his wife he has been drinking much more. He is going to be in denial. He will not want his wife there for the simple reason that his wife will tell the truth. The wife will say he is drinking so much and he will say shurruup, shurruup [shut up] and that will start bringing tension between the two as well. It is an awkward situation.

Given the association between domestic abuse and substance use, recognition of this potential tension is an important one. The same service user suggests the following approach:

There needs to be separate help for the drinker and the partner. The support for the partner would be, yes your husband has got a problem. We can help him but he has got to help himself first.

One of the reviews for this project sought to identify the evidence based family interventions, both for the drinker and family members in their own right (Manders and Galvani (2013a). However, clearly there needs to be consideration given to whole family interventions given the concerns raised here and the apparently high level of domestic abuse.

The role of Gurdwara in service provision

Service users had conflicting views about the role of the Gurdwara in supporting people where there were alcohol problems. There were four main positions:

- i. Gurdwaras should have nothing to do with alcohol interventions
- ii. Gurdwaras can support people once they have addressed their alcohol problem; as a way of reengaging them with their spirituality and encouraging their employment/ activities, e.g. through sewa
- iii. Gurdwaras should be actively involved in education and awareness and signposting to specialist services, e.g. talking to people about alcohol; Giani's should be trained and prepared to educate people; they should have leaflets and information available
- iv. Gurdwaras should actively seek to engage people with alcohol problems offering advice and listening.

Two service users felt that religion did not have a role and should not have a role to play in alcohol service provision, one because of the mixed messages it gives which she felt were not "healthy". Others felt the Gurdwaras played a role "but only when you're not drinking" – as a way to help people to continue their abstinence for example, by encouraging 'sewa', volunteer activities to keep people occupied and giving something back to their faith and community.

Some service users felt the Gurdwara should be more welcoming and engaged with people with alcohol problems:

I think it should be the Gurdwaras' duty to set up services for people with alcohol issues.

Gurdwaras could help people. If people in Gurdwaras approached people and talked to them, people would pour their heart out about their situation because people just want someone to listen to them and hear them tell their story. They want somebody who has the time and they can be helped by approaching them. If someone receives help, they will be willing to help others. Guru said we should be willing to care. We shouldn't see people as a problem, they need to go into the community to see what is going on.

Others found the Gurdwara helped their reengagement with their religion and what was important to them in their lives. One person in particular felt that once one temple was successfully 'on board' with a role in alcohol education and support, the others would follow suit. He suggested it would be a "slow burn" but that it would "catch on". Offering 'langar' or food as an incentive to attend a seminar or lecture was also suggested. The idea of the Gurdwara or attached community centre hosting lectures, seminars, 'surgeries' was a popular one.

⌘ Barriers to help seeking

A wide range of barriers to help seeking were provided from the emotional to the practical to barriers of motivation or lack thereof. Some people said that help was available but some people just didn't want help and wanted to continue drinking. At the other end of the spectrum some service users felt that people did not know what was out there, where to go or how to access it, or what an intervention or 'treatment' might entail. On the practical side language was given as a barrier for some people who needed a Punjabi or Hindi speaker as was literature in those languages.

In terms of emotional issues one person commented that seeking help was tied up with masculine identity which prevented men from coming forward for help sooner:

Some people might think that it is not right for a man, especially in the Asian community that I am supposed to be the main food provider and the main man in the house, to seek help.

Other commonly cited barriers included shame and stigma, embarrassment, concerns about confidentiality and issues of trust in the individual counsellor or service. This included a view that this would stop a mother from seeking help for a son as she might be blamed for not raising him correctly.

Summary: Service Users

The findings from the service user interviews led to key themes that remained dominant throughout the analysis of all the qualitative data:

1. The norm of drinking within the Punjabi culture – this was reinforced closer to home by observed drinking of fathers.
2. The tension between culture and religion, the confusion this caused and the resulting mixed messages it gave to younger people. The service users also raised notions of ‘proper’ or ‘strict’ Sikhism (those who were baptised) vs. behaviour expected of those who were not.
3. Issues of shame and stigma at both an individual, family and community level were clear and, while other negative impacts of drinking were identified, it was the loss of status within the family and community that people feared.
4. Domestic violence - the inclusion of domestic violence in the vignette led to some interesting responses with some people thinking it should be handled within the community while others adopted a more ‘westernised’ approach of calling the police and prioritising safety issues.
5. Gender differences in drinking are stark and the changes in younger women’s drinking to a more ‘westernised’ approach were noted. However, this was not the case for older women.
6. Generation differences in drinking - there was no agreement on whether or not there were generation differences with some participants feeling young people were better educated about alcohol and its harms while others felt they drank more than older people.
7. The role of religion and the Gurdwara in supporting people who had changed their drinking behaviour was positively highlighted by several service users as was the need to avoid it if you had been drinking.
8. Service provision - the service users offered a range of suggestions for the qualities of future services as well as the location and promotion of services. No one suggested family interventions. The role of the Gurdwara in service provision split views with some suggesting it should and could have a far greater role while others felt it should not.
9. Barriers to help seeking were identified with awareness of services, language barriers, shame and stigma, and trust issues cited.

Young People

Three focus groups were held with young people at a school within East Handsworth and Lozells. In total there were 22 young people who took part. The breakdown of their ages, gender, ethnicity, religion and postcode is below (see table X).

Table 10: Demographic profile of young people participants

Ages	11 yrs: n=10	12 yrs: n=4	13 yrs: n=3	14 yrs: n=4	15: n=0	Missing data: n=1	
Gender	Male: n=10			Female: n=12			
Ethnicity	Asian: Indian: n=17		White: English/Welsh/ Scottish/Northern Irish/British: n=2		Black : Caribbean: 1 Other Black/ African/ Caribbean background: n=1		Mixed: White and Black Caribbean: n=1
Religion	Sikh: n=14	Sikh/Hindu: n=2		Christian: n=3	Atheist: n=1		Agnostic: n=2
Postcode	B20: n=13		B21: n=5		B42: n=1		B43: n=3

As the school had warned us, they found it hard to recruit willing participants from the 'older' end of the age spectrum – in particular 15-16 year olds – and therefore the views and experiences of this group are missing from these findings.

There were a similar number of male and female participants; most students were of Asian – Indian descent; most were of Sikh religion; and most from the B20 postcode area of Birmingham.

Two focus groups were single sex (1 x male and 1 x female) and one was mixed sex due to lower numbers in the last two groups. The original intention of separating out the groups by gender was to enable more open discussion of gender differences and role expectancies given our learning to that point. On analysis, there appears to be little to no differences in terms of responses to the vignette 2 and the follow up questions, therefore the findings are presented together below.

⌘ Alcohol's impact on health and behaviour

The young people seemed particularly aware of the potential harm of alcohol on the body. More than half of them mentioned the negative impact of alcohol on the liver suggesting some effective, possibly recent, education. Several mentioned the impact on the heart and made more general comments about the negative impact of alcohol on the body in their responses to the vignette in particular.

- ⌘ It's not good for them to be drinking- it can affect the liver.
- ⌘ Alcohol affects your health and body e.g. liver, heart etc.
- ⌘ If you are young and drink too much, you are most likely to get addicted.
If you are older you might have a heart attack. When you are about 30-40. The younger you are to start to drink the more it affects your body.

- ⌘ I have learnt that drinking can really hurt you, so don't.

They were also aware of the impact of alcohol on mental health and emotions ranging from anger to 'not being able to think properly'.

- ⌘ Alcohol changes people's moods and they stink as well.
- ⌘ People have different emotions which in reality show that person is drunk.
- ⌘ Alcohol can affect your liver and you cannot really think properly.
- ⌘ It makes them angry and affects their liver.

Only one young person mentioned that alcohol can 'make you happy'.

There were, however, some young people who showed quite a degree of ignorance about alcohol.

- ⌘ Is alcohol like vodka?
- ⌘ Some people just like have occasional drinks but then they get hooked.
- ⌘ What are the differences between alcohol and wine?
- ⌘ Instead of drinking alcohol just drink champagne – it's almost the same thing.

Also of concern was the emergence of a set of beliefs that alcohol is responsible for bad behaviour; that alcohol could 'make you' do things you would not do otherwise do.

- ⌘ You can get into a fight and not know what you are doing.
- ⌘ Drinking makes you do stupid things
- ⌘ Alcohol makes you feel different and if you drink too much you sometimes cannot control yourself.
- ⌘ It can make people do stuff they don't know about and people die from too much drinking.

Clearly their learning appears to have been effective in terms of the impact on health but seemingly less so in relation to its impact on behaviour or, for some, what alcohol is.

⌘ **Costs of drinking**

The young people also seemed aware of the potential costs and losses of drinking. One person mentioned financial costs and that people drink at home before going out to save money but many cited costs to individual's families and lives. The young people highlighted the potential of getting into trouble from drinking with individuals commenting on people 'ending up in prison', getting into trouble at school, or damaging job prospects as a result of drinking.

The issue of shame that Saacha in vignette 2 would bring on the family as well as his religion was also raised.

If he goes into a Gurdwara it could affect his religion because people might say, he is Sikh but look at what he is doing. It might bring embarrassment onto the family. It could bring shame.

It would be like harder for somebody who is in a strict religion to like go to an AA meeting or something. It is harder because of shame. If someone from their community sees them there they will be like, oh they were at an alcoholics place.

The issue of shame and stigma within the family and community is raised regularly within all groups of participants and is clearly one that needs to be considered at all stages of service development and provision.

⌘ **Reasons for drinking**

There was a great deal of discussion around reasons for drinking in response to the vignette. Peer pressure was given as a main reason for Saacha's drinking with suggestions that his parents should stop him from hanging out with his drinking friends but others that say he may lose his friends because of his drinking behaviour. Other reasons tended to focus on drinking alcohol as a response to negative experiences in people's lives; examples include, drinking because nobody cares, because there are problems at home, feeling unloved, drinking to cope, to fit in, to calm down, in response to stress/depression/death or a 'bad patch', if there's nothing to do, if someone is rejected by their religion, or if they are being judged or pushed around by others.

- ⌘ He is probably depressed, because it doesn't mention the mum in the scenario and the mum could have left because of the dad.
- ⌘ It depends what part of their life they are going through. If they are going through a really bad patch in their life. Some people turn to drinking and they start having a problem and could go that way.
- ⌘ People drink when they are stressed and having bad influences and they need help.
- ⌘ He might be going to the place of worship to get rid of his sins and bad stuff. They have banished him from there and so he doesn't have anything to do, so he is just going to drink.

There were fewer 'positive' reasons given including that drinking was part of normal growing up behaviour, to get more attention at school, to have a good time, to rebel against parents, to feel 'manly', 'to let go' while on holiday, and drinking being acceptable on special occasions or celebrations.

⌘ **Gender differences**

The discussion about gender differences in drinking, in light of the vignette used also raised wider debate about gender divisions and roles. There were those that felt the gender division was not fair in the context of the vignette with Saacha and his sister being treated so separately. As one of the boys said:

Maybe the girl doesn't get enough attention because normally the boys get more attention. So the girl thinks I might as well drink because nobody cares about me. I can waste my life basically.

The sister will get in more trouble, because she is a girl and she is meant to be setting a good example.

In Indian communities girls are supposed to be kind, polite, well behaved but she doesn't want to behave like that she wants to be different.

Some young people were aware of body differences between girls and boys affecting the impact had on them. Some spoke knowledgeably while others described it in more basic terms:

Government guidelines 3-4 units a day for a man and 2-3 for females and 2 days not drinking. It's less for females because it hits the females more. Body differences.

They are stronger [males]. They can cope with alcohol better because they are stronger.

Females are weaker.

Traditional roles of girls including care taking, looking after the home, being 'lady-like' and 'being shy' were also raised in the context of drinking contravening such expectations while some of the young people described that as being 'unfair'.

⌘ Generation differences

There was a range of sometimes conflicting views about generation differences in various aspects of drinking. Becoming an adult or reaching an age when you were able to take responsibility for your own drinking was seen as distinct from young people's drinking.

It is okay for adults to drink but they have to take responsibility for themselves. Like you are allowed to drink at a certain age and you are allowed to smoke, buy cigarettes and alcohol at a certain age. It is their responsibility to take care of their actions and they know they shouldn't do this and this, drink and drive.

As with other debates within this research and also within the literature there was no clear agreement about whether this younger generation was 'worse' than previous generations as the following exchange from the girls only focus group illustrates:

- The older one's get more out of control.
- No the younger's go more out of control because like the older' are more like mature.
- They know how to handle it.
- Not some people.

- The youngers drink more because they want to experience it.
- Some people think they are cool.
- The older people as well.
- When older people drink it affects other people around them.
- They want to calm down/ chill with their friends, that is their excuse.
- They have got more excuses to drink.
- It is worse when olders drink because they do weird stuff like they go on the streets and start shouting and stuff.
- Youngers and olders do the same.

Some felt that older generations were more disciplined, knew their limits, drank less, got drunk more easily, and were aware of their body not being able to cope with heavy drinking. They also felt they were aware of their responsibilities and felt more shame about their drinking. However not everyone agreed; others felt younger people had an advantage as they were more educated about alcohol.

Older people know what they are doing, young people kinda don't know what they are doing. Younger people drink because they think it is cool. They are trying to show off.

We are young and know not to drink because we know it can affect our health. Older people in their days when they went to school they didn't really teach them about that stuff.

⌘ **Parent's role**

The vignette raised a great deal of discussion around drinking due to learned behaviour from family members. Many of the young people were critical of 'dad', and sister, in the scenario as setting bad examples and Saacha growing up thinking that drinking was what he should do:

I think maybe he thinks it is okay to drink because he has seen, when he was growing up, he has seen his dad drinking from a young age and he probably thinks that he has a right to. He is not setting a good example.

The dad should stop drinking and it might influence his son to not drink as much.

Well, it's his dad's fault because he didn't influence him right, not teaching him the right thing to do.

- He has probably seen his sister drink and that is probably why he thinks it is okay to drink.
- He has seen her drink, so he copied her.
- He maybe started because he got some from his dad. He's copying his dad, got hold of one his drinks.

It's like it is okay for him to drink but not his children. Like children shouldn't drink and he doesn't want his son to do it, and his daughter is hiding it from him and she is like

an adult so she is hiding it just in case her father goes, “Oh you are disgrace to the faith”.

The young people agreed that, in the vignette, it was the father’s role to set the example and stop drinking in order to support Saacha’s drinking. They felt there should be help from close family members with a range of views about who to talk to including his mother and advice from his sister.

However, a discussion ensued in the girls’ focus group about families being difficult to talk to particularly if they were very religious:

- It doesn’t matter if you are religious or not, it is the same thing.
- It is harder to talk to your parents who are religious.
- You are the same even if you are religious, you are still the same person even though you are religious.
- But your parents will be stricter if they are religious.
- It’s the same thing, they are still your parents even if they are religious. They are the same parents and they still care about you.

Further discussion included personal knowledge of parents who bought alcohol for their children “like on birthdays and stuff” and examples of stories they had heard whereby parents had children removed or were in trouble because of their drinking.

⌘ Religion and drinking

Further to the discussion about religious parents and conversations about drinking, the young people made a number of observations about the role of religion in supporting people with alcohol problems. Most related to religion offering support to people through talking to them and offering advice:

The people in the faith communities could ask the people who are drinking because they have a problem, they could ask them how they feel about it. Like what they could do and why they turned to drinking and help them sort out the problem.

The Gurdwara could help him because Sikhism isn’t a religion it is a teaching and it could like teach him.

The Gurdwara could help him religiously and mentally - teaching.

He could be helped religiously. He could have gone to the Gurdwara for help.

Other comments suggest that Saacha in the vignette would be judged by, and rejected by, the Gurdwara and his religion for drinking and that his behaviour was ultimately disrespectful.

They have probably been put down by their culture saying no we won't help you, because you are drinking we don't want to help you. I am not helping you because you have drank and disrespected the culture with your alcohol use.

In the Sikh religion they don't allow you to drink at all. The people who go to the Gurdwara and in India they don't go out they just help and don't drink at all. It's disrespect if you drink.

Two young people succinctly summarised the dilemma and the tensions within Sikhism (and indeed other religions) relating to how to respond to people with alcohol problems:

I think there would be people who would want to help them but there would be others like [who] don't want to help because they did drink and they basically disobeyed the rule set by their religion. I think they would feel judged.

If a person that drinks judges you, that is not fair because they drink as well. Say if you are a Sikh person who drinks and another Sikh person judges you and drinks as well, that is not fair.

In Sikhism smoking is also forbidden and one young person said that their experience was that people who smoke do not get stopped from entering the Gurdwara only those who drink. A few young people offered religious shame and embarrassment as reasons why people who were drinking would not seek help. Others simply said they didn't seek help because they didn't want it or thought they would be judged if they did.

⌘ **Strategies for changing drinking behaviour**

There was a range of strategies for changing drinking behaviour from advising a friend in that situation to "know their limits" and to slowly cut down his alcohol use, to advising him to stop/get some help/find a job, go to boxing club or hang out with different friends. The majority however said that telling their friend (or Saacha in the vignette) to stop was the way to help:

I'd tell him to take a break and if he feels better after it he will stop. He would have time to think about it, because he won't be drunk all the time.

I would say stop it and then leave it up to him because you cannot force him, say stop it and let him stop it, if he wants to.

If I told him to stop and I saw him drinking I would knock the glass or can out of his hand. If he was like drinking at school I would like tell someone.

I'd tell him to quit, because if he keeps on doing it he is going to go straight off the path and probably end up smoking and all that, it's bad and it could lead to things getting much worse.

Various helping agencies were identified including Teachers, the GP, Drinkline, Childline, and

Talk to Frank.

⌘ Future service provision

The young people had a great deal to say about future service provision and raising awareness of existing services. Some young people made suggestions for services or policies that already exist, e.g. drop in centre, peer education, putting taxes up, providing 'interactive' services for young people, a law for alcohol outlets to check people's age, but as one young person pointed out "We don't know [about services] and haven't been told because we don't have drinking problems".

Responses included the need for more advertising through helplines, TV and posters on billboards, information in GPs, an alcohol information pack, as well advertising what type of services are available.

There was general consensus that the Gurdwara should have helped Saacha in the vignette although one person pointed out that "it was kinda disrespectful to show up drunk at a place of worship". Another person suggested the "faith community should give people tips about not drinking".

Some innovative responses included having 'alcohol patches' like they do with cigarettes and having an alcohol 'credit card' "with only a certain amount to pay for alcohol and if you don't have enough money you cannot have alcohol and an alcohol 'spray' to stop people from drinking. So if you get a job then they will top you up then". Others included getting rid of the strong alcoholic drinks and 'keeping the alcopops', the Government stopping alcohol sales, a card that is stamped when people go for help with a free gift once the card is full, showing people the negative effects of being drunk, supervisors in pubs to stop people getting drunk.

Suggestions for the location of services included the community centre attached to the school, services near pubs, parks, and one in each area of Birmingham.

Summary: Young People

There were 22 young people aged 10-14 years old who took part in school-based focus groups. Generally, there was a good knowledge of alcohol's impact on health, particularly its negative impact on the liver and heart and on mental and emotional health. As might be expected some people knew more than others with several showing a high degree of ignorance. Shame and embarrassment was raised as a cost of drinking alongside other costs to the individual and the family. Drinking as a coping mechanism to stress, rejection or other difficulties in people's lives was cited as the main reason for drinking with very few mentioning positive reasons for drinking. Within this younger age group the gender differences around drinking were viewed as being unfair (and also within wider gender specific roles) although there was a clear understanding of the expectations on girls to behave differently. As with other groups the discussion about generation differences in alcohol consumption split views. It also raised the question about alcohol and responsibility and that older people were, and had to, take more responsibility for their drinking because of its impact on others. This included what parents taught their children about drinking through their own example. There was a very clear message that the Gurdwara should help

people with their drinking, offering teaching and supporting people as well as a couple of insightful young people who felt people were judged by Sikhism in spite of some of those people drinking themselves. Finally they made a range of suggestions in relation to future service provision with some creative and innovative responses including alcohol 'patches' – akin to nicotine patches - and alcohol credit cards.

Women's group

A focus group was held in an existing service that provided women only groups. It was a general women's group and not targeting any particular group of women, for example, those affected by a partner's alcohol use or domestic violence. There were 14 women in the group. The language for the group was Punjabi and vignette 1 (see appendix 2) was read out to the women and discussion followed. Similarly subsequent questions were asked in Punjabi. The discussion lasted 1.5 hours and two additional women who were present decided not to take part. Written notes were taken as the women did not wish to be digitally recorded.

The demographic profile of the women in this group is below:

Table 11: Demographic profile of women's group participants

Ages	Under 45: n=0	45-54: n=4	55-64: n=4	65-74: n=6
Gender	Female: n=14			
Ethnicity	Indian Punjabi: n=9	Indian: n=1	Pakistani Punjabi: n=2	Pakistani: n=1 Bangladeshi: n=1
Religion	Sikh: n=5	Muslim: n=5		Hindu: n=4
Postcode	B66: n=1	B18: n=1	B44: n=1	B21: n=6 B20: n=5

The vignette resulted in a number of themes some stemming directly from the question posed at the end of the vignette "What are your thoughts on reading this scenario? What advice would you give her?".

⌘ Taking action to help herself and her children

The women focussed very quickly on the domestic violence and harm to the family related to the husband's drinking. There were a range of responses but there were clear messages about the woman needing to do something. In other words, while they reflected on people who were afraid to speak up or tried to keep the violence and abuse hidden, the main message from this group of women was that the wife in the scenario had to take some form of action. Advice ranged from seeking formal intervention via the law and 'government' and/or 'leaving him' to the woman 'backing away' from him in order to make him think about his behaviour and its impact on her and the children:

She should take some action, she needs to back away from him to make him realise that my wife and children are withdrawing from me because of my drinking, this will make him think about his wife and children and about his life and either get his drinking in control or stop. (Woman 2)

My advice, if she is willing to take it, I will say to her seek help from the Government, separate from him and if the children are young, take them

with you and they will have a better life, if you stay with him, the boys will also turn out to be like him “alcoholics”. (Woman 3)

However there was also recognition that many women will hide or deny domestic violence. One woman said that women needed strength to take action, another that women will “make excuses for him” and “pretend there is nothing wrong”. Another highlighted how for generations they had been raised not to “split up” the family and therefore tolerated a great deal including the financial consequences as well as the physical and mental health consequences of drinking.

Sikh women do not complain much, they will suffer in silence to keep the peace within the family and community. They don’t like involvement from others, whether its friends or agencies. (Woman 6)

⌘ Drinking culture past and present

There was a range of views about the drinking culture within the Punjabi tradition, reflecting history and present day drinking and the change in women’s drinking. The following exchange was between six women in the group:

1. The Punjabi drink because of their culture, that I am a Punjabi, it’s fashionable to drink, it’s a trend
2. I once heard on the news that most alcohol is drunk in the Punjab in India than anywhere else in the world
3. I think it is drank every where
4. In the olden days, the guys used to work in the fields as farmers and they used to drink after work, after a hard day’s work, they used to drink one or two glasses, have dinner and go to bed, but their kids have started to drink more, just too much
5. Even the women are drinking these days, they never used to drink
6. They keep their husband company and they drink together to socialise. They are copying the English women.

A further woman added:

Even the Pakistani drink these days and this was never heard of before. If you go to my area, all the Pakistani lads have cans in their hands, this was unheard of before, but their community will deny that there is a problem.

While a cultural history of drinking was acknowledged there is a sense that drinking is increasing, particularly among new groups of drinkers, e.g. women and Pakistani’s. There is a sense that what is happening now is worse than it used to be rather than just a change.

While this research focuses on drinking, smoking has emerged as a behaviour that is also forbidden in Sikhism. Within the women’s group, one woman asked for this to be explained:

1. Tell me about one thing, in the Sikh religion, you frown more on people who smoke than drink, why is that?

2. The reason for this is that back home, the Guru's horse would not go on the path where there was tobacco growing, so even the horse recognised this drug and for this reason, smoking is looked down on more.
3. Some Punjabis say that smoking is forbidden and not drinking.
4. Smoking causes lung damage.

This awareness of the impact of smoking on health is attributed to the 10th Guru, Gobind Singh. According to Dhillon (2011):

...the reason is that smoking is recorded as being forbidden by all the Sikh writers who were contemporaries of the 10th Guru. According to these writers Guru Gobind Singh was once riding with his Sikhs when he suddenly stopped his horse and after dismounting proceeded to rip out a wild tobacco plant. The Sikhs asked why the Guru had ripped the plant out and the Guru replied that the Sikhs should avoid alcohol as it destroys a generation but tobacco destroys several generations. The Guru then forbade his Sikhs to ever use tobacco.

⌘ **Generation differences in drinking**

Here and elsewhere in the research we encountered conflicting views about whether or not there were differences in drinking between generations. The following exchange between four women illustrates this nicely:

Woman 1: A lot of difference between the old and young generations.

Woman 2: 100% difference, the more educated ones don't drink, they gamble.

Woman 3: The older men used to drink less.

Woman 4: I disagree I think they used to drink more.

Woman 3: The ones that drink heavily, do it any way whether they are from the old or young, but the ones that are educated, whether old or young, drink in moderation, and they say it's good for the health. You can compare this to the British, the ones that drink in limits, they say it does not cause any harm. Obviously the ones that drink too much have liver damage.

Woman 4: The younger generations are more educated so they know their limits.

There is an interesting equation that some of the women make that education about alcohol leads to drinking within limits or drinking in moderation. Some of this relates to what young people learn in school but one woman also felt it was the responsibility of elders to teach young people about alcohol.

A wider discussion about young people learning drinking behaviour within the family also ensued:

Woman 3 - It's learned behaviour from the fathers when the lads drink and if they have not been told by their elders that its "wrong" then how will they learn.

Woman 4 - My husband drinks but my boys "thank God" do not drink; they have seen their dad drinking and have not followed him. I am very lucky that my sons have not gone the same way.

Woman 5 - Sometimes the boys see the Dad and do not want to be like him so they turn the other way, but this is not often. The kids understand the dangers, they are more educated and choose not to be like their fathers.

This sense that education is important in avoiding alcohol-related harm is repeated elsewhere in these findings and is supported by the survey's results that the majority of participants believed that education and awareness about alcohol is the most important service needed locally. Unfortunately evidence shows that knowledge of alcohol and units does not necessarily equate to changes in consumption.

There were further discussions around generation differences more broadly including the different expectations between younger generations' relationships but also a shift in the location of their drinking and entertainment:

Woman 8 - The young generations do not demand anything like the above from their wives, and the young wives are also not prepared to cook for them at all hours of the night. I cannot imagine them making so many chapaties!

Woman 9 - This is because the young Sikh men do not bring friends home like the older ones used to, they rather go out and enjoy themselves, not at home.

⌘ **Recalling drinking behaviour**

Some of the women were able to recall examples of their own friends' and families' substance use. One woman spoke of her husband's drinking and resulting liver problems and his attempts to hide them from the GP, another of her husband's smoking and another of her brother's untimely death through drinking. Other women recalled similar stories:

This woman's husband came home at 2am with his friends after they had all been drinking and he asked her to make food for them all. Obviously there was not much food due to his drinking, even not much food for the young kids. Anyway he demanded but there was no flour for the chapatis, although she had put the chapati pan on the cooker to warm up. When she told him there's no flour, he picked up the pan and was going to hit her with it, luckily she ran out and he followed her. She was shouting for help and a white woman saw this happening and dial 999. The police got involved, they were then separated, she started receiving benefits, and the kids grew up well without DV etc. (Woman 7)

Woman 8 - Once there was a wedding and the bride's father had a few drinks and he was not allowed in for the Religious Ceremony. (Woman 8)

Woman 9 - Very good, he should have known better and should have waited for the party afterwards to drink.

The latter quote perfectly illustrates what has been highlighted elsewhere about the Punjabi culture versus Sikh religion dichotomy. It was not appropriate to drink prior to entering religious premises but there was an acceptance of drinking in relation to the wedding party.

There was also discussion about the man's ability to remember what he is saying and doing after drinking. One woman felt that he could remember and gave a story to illustrate, another felt that it was possible that a man couldn't remember what he did, citing an incident of child sexual abuse before she came to England where her husband was a police officer. She thought it was possible evidence that the man confused his wife and his daughters when drunk.

⌘ Role of religion

The women felt that religion could help but only if the people who needed it attended the "Temples, Gurdwaras and Mosques" in the first place. One woman suggested they had a role in "reaching out" to them, another that there had been a shift within a local Gurdwara from accepting people who had been drinking into the Langar Hall to them not being allowed at all.

⌘ Seeking help

There was general agreement among the women that there was help available if people chose to take it but that it was the individual's choice to do so. However women also felt that people were often unwilling to help themselves and may not know what treatment was available.

Woman 1 - The barriers are that they don't understand the treatment available to them. My neighbour is a sick man, he needs help, but he is not willing to help himself

Woman 2 - One barrier could be that they have gone beyond help and feel 'what's the point?', might as well continue

One woman felt it was about having the right motivation to change, for example, when it's affecting their relationships and family or their health. GPs were discussed as a potential source of help, but their limitations were acknowledged too. Several women in particular felt that the GP could not do anything unless the husband was willing to accept help. The women also cited a number of places including GP surgeries and pharmacies where information was available on alcohol if people wanted to access it.

Not a great deal was said about services only that there should be some. Two women felt attendance should be compulsory for drinkers, with one suggesting a new law that they must seek help. A further woman suggested community centre as a good location for services.

Summary: Women's Group

Fourteen women took part in a focus group that was held in Punjabi. They were largely a group of middle aged to older women. Discussion was focussed largely around the vignette and focussed very quickly on the topic of domestic violence and abuse and the need for the woman to do something ranging from calling the police and leaving him to 'backing away' at home. The fact that women "suffer in silence" as a result of their upbringing was also mentioned. The women described a change in drinking culture over the years although readily acknowledged the drinking history of Punjabi farmers and young women's drinking as something new. They had a similar debate about whether or not there were generation differences in alcohol consumption between younger or older people. As with other groups they equated knowledge about alcohol and limits of alcohol with behaviour change. Finally they felt that services and information were available if needed.

Service providers

Individual interviews were held with a total of 19 service providers⁶. The intent was to garner the views and experiences of a cross section of people who provided a range of front line services within the community. These involved people who managed and commissioned services as well as those who delivered them. No detailed profile information will be provided for this sample, as care must be taken not to provide identifying information. However, the following is a broad summary of their roles:

- ⌘ Five participants worked in specialist substance use services of some kind, including one person as part of a peer led service
- ⌘ Five participants were involved in Gurdwaras or related services
- ⌘ Three participants were providing, or had previously provided, supported housing in the EH&L ward
- ⌘ Two participants were from a criminal justice background
- ⌘ One was a publican/landlord
- ⌘ Two provided social and counselling services
- ⌘ One worked in a hospital service that serviced the local population.

Thirteen of the 19 participants were from a Punjabi Sikh background. All were incredibly helpful participants and the interviews resulted in an enormous amount of data. The findings presented here therefore focus only on the themes most closely tied to the aims of the research relating to the alcohol support needs of the community and the environmental challenges and opportunities to developing a community alcohol support package (CASP).

⌘ Statistics, figures and trends in alcohol problems

While data on alcohol consumption by, and alcohol problems within, the Punjabi Sikh community were not available for this research, all our specialist substance use participants and several other participants made reference to perceived increases of alcohol consumption and alcohol-related problems with the community. Alongside 'new Europeans' within the EH&L community, British Indians or British Sikhs were identified as those drinking problematically. The following quote illustrates the view shared by many of the service providers:

The British Indian/Sikh community are not presenting til very late with health problems – we are seeing longer term health harms in that community, stemming from a spirit drinking culture. There have been many years of ignoring the problem and drinking hard spirits.

Even the pub landlord was aware of the high rates of hospital admission as was one of the service providers related to the Gurdwara:

⁶ Far greater numbers were contacted including all GPs in the ward who received letters asking for participation. No GP responses were received; other individuals declined to participate; others agreed but were not subsequently available.

It is a lot higher for Punjabi Asian males in terms of hospital admissions related to alcohol than anything else. I know quite a lot of people who have passed away through the drink. So I usually tell them if you want to kill yourself don't do it here, anywhere else. (Publican)

We have only got to say to these people there is a problem and the figures are there, medical figures are there to prove it. Sikhs are the biggest piss artists at the moment! Figures are proving it when it comes to liver cirrhosis and when they end up in hospitals and that. The problems are there and they are young Sikhs. (Gurdwara-related service provider)

Several participants felt there were relatively small numbers of Punjabi Sikh problem drinkers compared to other groups although not minimising the significant problems the small group had. However, they also found that they struggled to engage them in specialist services as one specialist provider noted:

There is a higher presentation of Asian admissions to the Gastro ward and other wards, high representations of Asians, especially Punjabi. Through SPOC (single point of contact) we receive on average 120 referrals every quarter. 70% Self referrals, 20% are from the Hospital. From the 120, I would say 30 or even 40% are Asian clients and out of the 20% hospital, I would say 50% to 60% are Asian. That's why we need to be more creative in trying to engage them.

One participant said the difficulty was that while the largest group of problematic drinkers, the white British drinkers, were reflected in the treatment figures, minority groups including the British Indian community in those wards were not. Others reflected on the 'keep it within the community' approach to resolving drinking problems and how that would reduce their visibility to services.

⌘ **Drinking culture vs. religious beliefs**

As with other participants the service providers were aware of the tensions between Punjabi culture and the Sikh religion in relation to alcohol. One participant explained it well:

Coming from a religious/faith perspective you have to keep a clear mind. Therefore anything intoxicating is taboo. Most people growing up in Sikh/Punjabi culture are aware of this as they have more contact with religion within the community. However, on the cultural side, drinking alcohol is part of the culture; eulogised in pop songs, celebrations, e.g. weddings are not complete without alcohol – if you don't provide alcohol at weddings you'd be seen as a poor host. There is a tension between the culture and the religion/faith. Spiritually, you shouldn't drink; culturally, it is widely acceptable.

The norm of drinking alcohol emerged from these interviews quite strongly; from the pub landlord who stressed the embedded nature of drinking within the culture to the criminal justice person who described it as:

...there is a culture within Sikh[ism] that drinks and another culture within Sikh[ism] that don't, that is the norm - we are not supposed to be drinking. ... Truth is they know it is wrong but they don't want to be reminded constantly.

In terms of engaging people in debate about alcohol and alcohol awareness raising, one substance specialist found that Sikh beliefs were often used to hide their drinking and to deny any problems:

The religion and the culture do not go together they are two separate entities. Really much so and really separated and that. This is what I struggle with in terms of raising awareness about alcohol - is that people will jump back to their religion when you mention it.

However, there was also a sense that religion could offer a lot of support both in terms of offering somewhere to go for help or as part of a decision to stop or change their substance use. One person stated that it also provided a network for people who have begun to change their substance use and want a network that the person can 'link back in to'. One member spoke about religion as helping keep people away from the drink provided they engaged with the religion.

A specialist substance service provider raised concerns that because of the blurring of cultural-religious boundaries Sikhs were becoming stereotyped:

This is all based on culture and not religion. ... Even religious events like Vasaki, celebration of the harvest and New Year, in the evenings the bottles of alcohol are opened to celebrate. The Sikh drink to have a good time and be part of something e.g. at weddings they feel they have to drink "am going to drink, am going to dance and am going to have a good time" The Sikhs are now getting stereotyped like the Irish used to.

Others were critical of Sikhism resulting in people judging others, including those drinking alcohol, suggesting there was an element of hypocrisy in their teachings and behaviour:

There is a prohibition that they don't have a caste system but they do; there is a prohibition that we shouldn't treat women as inferior but we do; same with disabled people, for example, we do. In practice we don't actually follow any of their instructions at all.

⌘ Changing the nature of alcohol use in the community

In the discussions about cultural norms, some service providers also reflected on the need to change the culture of drinking within the community. One respondent felt it would be the children who would change things in years to come. Indeed, another substance specialist pointed out that a consultation with a young British Muslim group found that they would feed the harm reduction messages up to older members in their community. One counselling service provider stated that when children saw the hypocrisy of their parents

and the religion's teachings set against the reality of cultural practice, they would decide on their own values and rules. In contrast several service providers pointed out that young Punjabi Sikh people were more often poly drug users and how Punjabi music was full of references to alcohol.

Several of the participants highlighted the fact that any change would necessarily take time:

... the issue we are talking about [is] changing the whole culture and way of society not just in the temple but within the community as well. It cannot be done within 12 months. If a service already exists why isn't it already happening? ... To change a culture and a belief takes time.

... to change a tradition it takes years and years. It can take 20- 30 years sometimes to change a tradition, you have to change people's thinking because thinking is linked to tradition.

This is an important consideration for service to consider. However, sensitive and collaborative a partnership may be, the culture of heavy drinking is unlikely to change in the near future. In the meantime, a number of initiatives were presented as options to educate or protect the community including: a "good role model" to support the next generation in making healthy choices, promotion of moderate drinking as banning alcohol would not be acceptable; encouraging people to accept that they can have enjoyment without alcohol.

⌘ Ethnic differences in drinking patterns

The discussion about religion, culture and particular groups of people drinking also involved a wider discussion about ethnic differences and similarities in relation to alcohol use. White British people were the predominant group identified in relation to alcohol problems but the new European communities, particularly the Polish community (both generally and within EH&L) were also identified as heavy drinkers. One service provider said he believed there was no difference in the drinking patterns of Sikh people compared with White British, another that all communities were the same but some were better than others at hiding it, while others pointed out the heavy spirit drinking culture among Punjabis, and the gendered nature of drinking compared to other new immigrant communities, for example, "Somalis and new immigrant Africans". West Indians, African/African-Caribbean were also identified as presenting to some Gurdwaras under the influence of alcohol. One of the explanations for the heavy spirit drinking culture was offered by a Punjabi Sikh participant from a health background who pointed out that historically Punjabi farmers did not drink very much but they would drink 'home brew' which was very strong. By comparison, the whisky available in the UK was not perceived as strong.

One of the challenges in identifying differences in patterns and harm is the lack of visibility of alcohol problems. One health service provider described it as two groups; first, a small group of Punjabi Sikh street drinkers "accessing services repeatedly" in a revolving door fashion, second, a larger group of more affluent drinkers who present to services less but whose drinking create "larger ripples to family and community".

⌘ Gender differences

Two main themes emerged in relation to gender differences. The first relates to a perception that Punjabi Sikh women's drinking is increasing. The second relates to the woman's role in someone else's drinking behaviour.

More than half the service providers made reference to women's drinking. Some commented on the perceived increase in primarily young Punjabi Sikh women's drinking. There is no data to say whether or not it has increased or whether, as one participant said, it is more visible now. Previously public drinking by women would have been "culturally inappropriate".

Three service providers linked the perceived increase in women's drinking with the growing "equality issue". This is interesting given the teaching in Sikhism is that men and women are equal – a concept that was strongly refuted as not the reality by several of the service provider participants. Two participants were clearly surprised by women's drinking with one describing how shocked he was at a young woman's spirit drinking at a party while another observed a young woman falling over with intoxication. One service provider stated that "Equality should only be looked for if it is good for you". By way of a contrast, older women's drinking is not perceived as being an issue although one substance specialist said it is more likely to be happening behind closed doors.

The second sub theme relates to women's roles as wives, mothers, care takers. The women's service provider stated existing services were not supporting women as parents of children with substance problems nor as partners of people with substance problems. Far from being equal, she observed that women have a "very weak" role in Asian culture. This was confirmed by another participant who stated that women are always blamed in Asian culture whether it is for his drinking or his violence and abuse towards her. Other participants reported the women suffered in silence with a drinking and often violent husband. Some services tried to signpost women to the right agencies, and the GP was a common place to suggest. Women reportedly attended the GP with their drinking husband or would go alone to seek help. The women's service provider also reported that women would go to the GP with physical symptoms when in fact it was emotional and mental wellbeing that was the issue. The woman often did not have the support of extended family and tended to "suffer in silence".

One respondent admitted that his Gurdwara was really unable to offer women support:

If a wife has a husband who is drinking and asks for help we can provide free food in the Langar and she can talk to the women in the Gurdwara, but there is nothing else we can do - no support. If Domestic Violence - advise her not to separate but stay and support him. There are no counselling services at the Gurdwara. If a couple seeks help we can talk to them, and help them. There is no support if women come on their own, no support- not able to do anything for them.

Domestic violence was raised by seven participants as having a relationship with alcohol. Participants reported a regular correlation between the two although, as with alcohol,

domestic violence was reportedly kept hidden because of the shame and because, as one person stated, “they will get labelled”.

⌘ **Generation differences**

As with previous groups of participants the service providers presented a mixed picture in relation to perceived differences in drinking by generation. Overall fewer participants stated that older generations’ drinking was worse but there was an acknowledgement by a few participants that heavy alcohol use among older people may be missed.

At the same time, some of the substance use specialists and the publican felt the younger people’s drinking was getting worse:

The young ones seem to drink more than the older generation. Some of young ones, I know their parents, and their parents don’t really drink. Then you get the older generation who come in who have one or two pints followed by a couple of whiskeys and then go, but they don’t live far and live locally and don’t drive or anything. That is the norm for most of the older generation. It is mostly parties where you see the drinking with the Sikh/ Punjabi culture.

Lads getting together in pubs and bars, the youth Asians are drinking more. May be due to more disposable income, or it’s macho to do it and also Asian females are drinking more.

Two participants felt the younger generation of Punjabi Sikhs are now drinking at the same rate as any other community, including the White British population that makes up the majority of people with alcohol problems.

Drug use and dealing among young people was mentioned by five participants who felt that the ‘new generation’, that is, below 30 years of age, were drug users including Class A drugs and also legal highs.

⌘ **Existing service provision**

Awareness of existing services was mixed including Aquarius, Sifa, Turning Point, Swanswell, AA and the Health Exchange. Clearly those in specialist roles knew the field while others were not aware of any local services.

Referrals

Most of the service providers outwith specialist alcohol and other drug services referred people on to specialist services of one kind or another. In relation to alcohol services Aquarius and Sifa were mentioned as the main agencies for alcohol referrals. Others simply said they referred people on for help without specifying to which service. Of particular interest is one respondent who has two different roles, one in his professional life and another relating to a particular Gurdwara. He noted that he had made plenty of referrals in his professional life but not in his religious role – because of the fear of shame leaking out to the community. Many service providers spoke about signposting people on with only the substance specialists, unsurprisingly, directly engaging with the person’s substance problem.

In addition to the voluntary services identified, one of the criminal justice participants was keen to point out the *drug rehabilitation requirements* and the *alcohol treatment requirements* that were available through the courts and pointed out that little is done about those who did not comply with the order. The role and context of the service or organisation people worked for understandably determined the level of referrals they made.

Problems with current services and barriers to service provision

A number of problems with, and barriers to, service provision were identified by this service provider group. These included:

- Lack of knowledge within the Asian community about where to go for alcohol support – particularly any services within the local community.
- Individuals' ignorance that their physical problems may be linked to their alcohol use and difficulties discussing it and therefore engaging them in a useful way.
- Lack of trust of services stemming from poor experiences of formal institutions in their country of origin and wider racism and marginalisation experiences within the UK.
- Ignorance, and fear, of what alcohol services do and what counsellors may or may not ask them or expect of them, e.g. expectation that "a Punjabi Sikh counsellor [will] impose abstinence on them".
- Attitude that asking for help is a weakness.
- People not accepting they have an alcohol problem.
- Lack of understanding of cultural diversity among alcohol services and the complexity of this across different generations.
- Lack of fit between needs of Punjabi Sikh clients and service provider criteria and approach. This was raised by several service providers in terms of ensuring models and approaches fit with local community beliefs and service needs, e.g. group work for older male Punjabi Sikhs, and also in terms of lack of specific services, e.g. detox when someone requires immediate attention. One respondent stated they had previously invited Aquarius to talk to people but that "it didn't fall into our way of helping people, they had to do this and that before helping them".
- Lack of understanding among services of the importance of "collective belonging" and community stigma and shame. Ignorance of how the community works.

Culturally there is a sense of shame and honour - [I] don't want to name and shame myself, name and shame my family, name and shame my close associates family and friends or where I belong or where I come from - because it is very embarrassing for them.

- Language barriers – this was raised in two key ways; first, was the need for Punjabi speakers in services and for literature and information in the Punjabi; second, was the need for Giani's in the Gurdwara to speak English in order to be able to talk about alcohol (and other issues) with the congregation.
- Location of services – services that people had to travel to were seen as a barrier. However, geographical accessibility also had to be balanced with shame on themselves and on their family of being seen attending a local service.

- Services not knowing what each other offers – focus solely on own targets preventing cooperation.
- Services not being delivered by people in the community and being time limited resulting in services not being embedded in the community.
- Not wanting Asian alcohol workers for fear of word getting back to the family and community.

Clearly these identified problems can be discussed in the context of plans for future service provision.

⌘ **Future service provision**

It's one of those things because the community originated from a really tight knit background when people were first migrating over here everyone knew everyone. So elements of that still exist but are quite diluted quite a lot now. It's about a trust issue and that is the biggest thing. Trying to understand a community and the stigma that is still within it - not just alcohol and drugs but across any service - is a hard job. The services have a hard job trying to understand the communities they serve.

Nine categories emerged from the data analysis relating to future service provision. Each will be summarised below:

Approach of future services

A large number of suggestions were made in terms of the approach that could or should be adopted by future services. These range from suggestions about specific methods of working, for example Motivational Interviewing and Brief Interventions, to broader principles and considerations for service delivery, for example, promoting a service based on the benefits it will bring to the family, individual and society of changing drinking habits. Other suggestions included the need for a supportive, empathic and non-judgemental environment.

The issue of embedding future services within a health and well being framework was a very clear message that was raised repeatedly with one respondent stating the service needed to be “camouflaged” with an approach adopting a “symptom point of view”, that is, asking people about “any sleeping problems” or conflict at home. Another suggestion was to take a more ‘public health’ approach and embed alcohol support within wider package of other health and social care issues, including exercising, “eating junk”, and smoking. This sense of a more holistic approach to alcohol support and one that involves “...family, friends, GP, Gurdwara, and offers voluntary work...” was suggested by several participants.

A clear thread was the need for a spectrum of interventions given that different generations of Punjabi Sikhs would have different needs requiring different services, as well as different levels of drinking. Clearly one size would not fit all. One person also felt that service user involvement had to be increased along with “more specific Asian groups” although was aware that there was a lack of a role model in the Asian community at present. The need for

a high profile or celebrity 'champion' from the community was also suggested by two people to help with opening the topic up for wider discussion.

One service provider highlighted the need to target the whole community with systematic screening in order to make a difference and be able to evidence reach and impact. This respondent also felt that brief interventions should be mainstreamed with drivers for interventions written into contracts and commissioning arrangements and supported by informed supervision and management.

Building rapport and trust within the community: cultural understanding

A very clear message from both service provider groups and other participants was the need to ensure that services were relevant to the community and not simply 'white' services 'parachuted' in to the community. This meant listening and learning and being prepared to think and practice alcohol support differently in order to gain the trust of the community and overcome the huge hurdles of suspicion, shame and stigma that surround this issue. As one respondent stated:

The service should be a high quality service irrespective of if you speak English or not ...people know Aquarius is doing this research and it's specialised for the Sikh community; people are going to say they care. They will learn a lot more than maybe another organisation out there... . For instance you have used Punjabi words and I have never had anyone mention 'Giani' to me and you have mentioned key things like 'sewa' and that builds up a bit of rapport. If you build up that rapport, you build up the trust. I could say come and speak to Gary [the researcher] because he at least has an understanding.

Hand in hand with issues of trust and rapport was the need to stress the confidential and "discrete" nature of any future service. This understanding of cultural needs in order to build trust and engage people in services was raised by some service providers in relation to their own work and agency. The importance of building that trust was key to people being open to discuss their problems with them. Some of these Ward-based agencies were willing to form working partnerships with Aquarius with one suggesting that their "neutral" agency could be a good place to start as it was "non-clinical".

One participant identified the need to find the message that works within that community and go with that message rather than imposing pre formed organisational messages on the community. The potential messages are somewhat complicated by the cultural versus religious tension but one cross cutting theme from the findings has been the need to embed alcohol services within a health and well being context and this will be discussed further below.

Embedding alcohol within a health and well being context

Throughout this research the potential negative impact of alcohol on someone's health has been one of the clearest messages received. From the school pupils to the service providers there is an awareness of too much alcohol being bad for your health. Health services have

been repeatedly identified as either a potential conduit to specialist alcohol services or as a host for their work:

Having services based in fairly discrete places like primary care and in GPs surgeries. It is not having alcohol treatment centres any more that people don't want to go to and you put people off. You need to make them quite discrete and anonymous.

GPs and other health service providers appear to hold a high status within the Punjabi Sikh community, however service providers views of their effectiveness in relation to alcohol knowledge, advice and referrals were very mixed. On the one hand GP surgeries have been identified as where people are most likely to go for help and an appropriate place for information and advice on alcohol; on the other they have been criticised for a lack of knowledge, poor engagement with this subject, not asking people about their alcohol consumption and giving erroneous advice.

Consultants within hospital settings were also identified as holding status within the community. However, as one participant pointed out, whether the status and trust placed in medical professionals holds true for later generations of Punjabi Sikhs is not known. Further even within this setting, one participant found people did not wish to discuss alcohol's relationship to their health problem even though it was critical at times.

The advice and experience of most of the service providers was to embed alcohol service provision within a health and well being framework and within a broader public health context that took a holistic approach to an individual's health. This has implications for what the service is called, for example, avoiding calling it an 'alcohol service' with 'alcohol workers'.

We send a health worker in not an alcohol worker to do healthy lifestyle work - whatever you want to call it. That person would have a range of skills around looking at a range of issues, would know how to refer that person if that person required it. There is some mileage there. As long as we see alcohol as a stand alone issue it is going to scare people off. If you start to give it that context and start looking at alcohol in context then you are going to be much more successful.

The existing Health Exchange service, in a community building adjacent to a Gurdwara, was cited as an example of a service that addressed alcohol in a broader health setting and context.

Funding and commissioning issues

In the current climate of cuts to the public sector, several participants raised questions about funding issues. One provided an example of having an alcohol and health worker post funded by Big Lottery funding which stopped and they are attempting to get further funding from Birmingham City Council. The intention is for the person to be somebody from the community who would "go around all the Gurdwaras".

One participant highlighted the priority of funding services that meet the needs identified in the City's alcohol needs assessment exercise although future capacity to do this assessment has been limited due to staff cuts. However, the extent to which the needs of hidden populations or marginalised groups are identified in such exercises is not known, particularly if there is limited statistical data combined with public denial of any alcohol problems and/or these are hidden by the family and community networks.

Where to target funding in terms of drinking population was also an issue for one participant who highlighted how money can be better spent on "catching people earlier in their drinking career" through brief interventions, including in mainstream services, rather than those who have been drinking heavily for a long time. Such comments suggest an 'either/or' funding approach resulting from limited resources.

Against the backdrop of a 'recovery' agenda dominating substance use commissioning and service provision, one participant noted the move towards commissioning holistic services that supported healthy lifestyles all round and how alcohol services may struggle to adapt.

Awareness raising and education

The results from the anonymous surveys (see section 5) highlighted a view that both younger and older people needed more education and awareness about alcohol. This also emerged from the qualitative interviews with service providers flagging up either the need to do more alcohol awareness or giving examples of what they were currently attempting to do.

Awareness raising through local Sikh TV channels and radio channels was a frequently suggested medium for awareness raising, with one person in particular emphasising regular use rather than just a 'one off'. Several participants from the community also said there should be information in their "Punjabi paper" on alcohol and its impact. Some services had already used these media or were planning to use them to convey messages about health issues more broadly. These media seem popular within the community and worthy of further consideration in planning future services provision at a range of levels.

Four participants highlighted ignorance about units and measures of alcohol among the Punjabi Sikh community and the need to provide information in Punjabi about units as well as English. Another stated how safer drinking messages were also needed.

Knowing measures and limits is an issue in the Indian community. Where bottles of spirits are put on the table at weddings and birthdays and people will just fill up because there is no level on the glass and just top it up all the way.

Another pointed out how "gradations of drinking are not understood within the community" and someone had a drink problem or did not. One service provider made reference to the supporting statistical data on "Indian" ethnicities and drinking problems suggesting a "targeted campaign" is needed that is tied in to people's beliefs irrespective of affiliation to particular "temples" or castes. The suggestion was to ensure an "iconic temple" was engaged to lead the campaign and then others would follow.

In terms of literature, one participant stated that “two words should be on all language specific literature – “free” and “confidential” “. She said that often mentioning alcohol ‘shut people down’ in terms of conversation and therefore official literature can provide another source of information. Another participant pointed out the mixed messages people receive about alcohol and harm and the need to get clear messages across to particular communities. Some people suggested places for advertising and information including the Book keepers/betting shops, Gurdwaras, health events, GP surgeries and schools.

Type of services

A small number of suggestions were proposed in terms of the types of services needed. These ranged from prevention and education services, e.g. membership of sports centres for young unemployed people and service users speaking to young people in school, to further resources for outreach and home visiting services as well as evening services for people to access outside work hours. Mutual aid services delivered by people within the community were also suggested as a way of services reaching out to people where their problematic alcohol use is known. Another suggestion was to develop online information and treatment services which may appeal particularly to the younger generations who are more IT literate. Two participants raised the fact that there needed to be services for Asian men as they had no groups or services to refer them to. Finally the need for aftercare and follow up support was mentioned by one substance use service provider.

As with other groups of participants the needs of families of people with alcohol problems were acknowledged by the service providers. Three issues were raised:

1. the impact of problematic drinking on the family – particularly concerns over safeguarding for children and adults.
2. the role of the family in supporting someone who has an alcohol problem – including the need to “make it attractive” for families to engage in alcohol support.
3. the need to support family members in their own right – particularly women.

One participant suggested a day centre was needed for “alcoholics and their families” and several spoke about providing the family with knowledge about alcohol and local support services to help them understand. One service was primarily geared towards supporting family members, primarily women, who experienced mental distress and who were living with a family member’s alcohol and other drug use. This service provider who spoke of other services not understanding the women’s needs. Other health oriented services provided no intervention for families while the substance specialist services, including the service user led service, had family interventions within their remit. One criminal justice participant spoke of no formal family intervention approaches but gave examples of how the service was adopting an “ongoing practice” of building links with the family.

Who should deliver services

Three key issues were raised by a small number of participants in relation to service delivery:

1. Training of health and social care professionals in brief interventions – in particular GPs were identified as a group in need of training on alcohol issues in order to give appropriate advice. The effectiveness of training alone, however, was questioned by one participant whose audit of brief interventions training found the use of it was minimal in practice.
2. White services/service providers versus community led services – the tensions between Punjabi Sikh people preferring someone with cultural understanding, language skills, knowledge and sensitivity but also feeling it may be safer in terms of gossip and shame if they had a white practitioner rather than someone with their community. As one participant remarked:

How do you get past someone wanting to see someone of their own culture but who won't judge them because of the spiritual aspect of their drinking. In the latter respect white doctors are seen as safer in terms of confidentiality.

3. The need to mainstream substance use interventions – although one participant in particular felt there was an attitudinal barrier from many front line staff to asking about alcohol use.

Location of services

A number of service providers felt the location of a future service was important and that a local service within the community of Handsworth was required. Some participants felt it should be within the community but not "in people's faces" due to confidentiality and privacy reasons. Suggested locations included community centres and community fora and events – places where people get together. This need for a balance between a locally situated service that was culturally sensitive but not one that was obvious to everyone was a clear message. Two participants mentioned the need for the service to have a number of access points to the service.

Involvement of Gurdwaras

The final theme that emerged from the analysis of this service provision data related to the extent of involvement of Gurdwaras in providing alcohol support. The responses reflected a range of views.

- Resistance to engage with alcohol issues

Gurdwaras provide open access to the community and this means that anyone is free to enter and to take food in the Langar Hall. Some participants were clear that intoxicated people should respect the temple or Gurdwara and not attend when intoxicated. One participant gave an example of needing to escort intoxicated people off the premises as the women and children had been scared by intoxicated people fighting. Other examples were given of people with substance problems using "rude language", stealing from the collection box and stealing items from the stage in the prayer hall. One respondent said that women who had a husband who was drinking could ask for help and advice from other women in the Gurdwara but "there is nothing else we can do – no support". The same respondent stated "if they come drunk we tell them to go back home". One person also explained how people in the community donate to the Gurdwara for the services it provides and in that

way the “congregation own it” and do not want drink or drug affected people in a place where they bring their families and children.

One participant spoke of his knowledge of people who had spent “lots of time in deep delicate negotiation” with Gurdwaras resulting in no change although he reflected that there may be Gurdwaras where it has worked well which he was not aware of. In over a decade of experience however, he said “no one seems to have been able to crack it”. Of course it is not known whether such previous initiatives have sought genuine partnership from the outset, at the right level, and adopted a community led model or whether they have tried ‘delicately’ to negotiate delivering their own style of services with the wrong people.

- What Gurdwaras are currently offering

Some participants reported that their local Gurdwara had made some attempts. One participant said the Gurdwara committee had put posters up in the temple but the next committee that was elected took them down. Several participants reported their Gurdwaras as raising the issue of alcohol and drug use from the stage after prayers, particularly when they had leaflets about services or discussing it in general terms. Some spoke of it in terms of the need to abstain from substance use while others spoke of understanding the negative impact it could have on people’s health, family relationships and responsibilities they had. One participant said a President of their Gurdwara had visited community members to discuss their drug or alcohol use following visits from a parent or spouse.

It is worth noting however that drunkenness rather than lighter alcohol consumption appeared to be the line which, once crossed, resulted in the rejection of people within the Gurdwara. Several participants who were quite involved with Gurdwaras pointed out that food was available to all provided they were not drunk; another stated that people were allowed to enter the prayer hall providing they were able to not fall over when they bowed. Others pointed out the Gurdwara’s hosting of health events to which alcohol services had been invited and some said they referred people to organisations like Aquarius.

- Future role of Gurdwara

Whether or not the Gurdwara should provide services and the reasons for doing or not doing so were debated. The visibility of an alcohol service within the Gurdwara, given its centrality within the community, was seen by some participants to be off putting because of the fear of shame and gossip:

I think a lot of people would be put off with an alcohol service in a Gurdwara, because if they went to Gurdwara and people would see you there and know what you do. If it was something separate I am sure a lot more people would go.

One participant pointed out that the same could be true of an “average Church of England” congregation.

However, there was plenty of support for the Gurdwara doing something. Several participants pointed to differences between Gurdwaras’ attitudes to people using alcohol or

other drugs and the need for people to “find a Gurdwara that accepts them”. One respondent from the community said they had to be “brave” and acknowledged there was an alcohol problem within the community that needed to be addressed.

There were a number of suggestions for Gurdwaras’ involvement as follows:

- Education and awareness raising about alcohol and related harms, both within the Gurdwara and also inviting Aquarius to speak on the stage about its services.
 - Developing an alcohol campaign across all Gurdwaras to ensure maximum exposure and ensure people cannot avoid hearing the message by going to a different Gurdwara. This could be led by an “iconic temple” in order to influence others.
 - Establishing a paid health worker within the Gurdwara (whose remit included alcohol support).
 - Promoting existing services emphasising discretion and confidentiality.
 - Host Aquarius service “at a weekend” for example.
 - Provide or host family interventions.
 - Training for Giani’s and other volunteers in the Gurdwara.
 - Gurdwaras to work in partnership with the police to promote any new health service.
 - Hand out information on locally available alcohol and drug support services.
- Issues to consider when engaging with the Gurdwara

An early learning point and one which was repeatedly emphasised in different ways throughout the project was the power dynamics inherent within and between Gurdwaras. This was mentioned as a potential help and a hindrance to developing alcohol support services. The power of the “upper echelons of religious communities”, and particular influential individuals, was mentioned in relation to stifling those staff and volunteers within the Gurdwara that would be supportive of alcohol initiatives. They were also mentioned as potential drivers for change if and when such initiatives were led from the top.

The differences between Gurdwaras on a general level and relating to alcohol support were also noted:

There is a lot of racism within Sikhism and in the Indian community as well with castes and that is a big thing. Historically the differences in Gurdwaras are to do with differences in caste.

Some Gurdwaras are very supportive and all are welcome; ‘lets sort this mess out, if we can be part of it, we are happy to’ but others will be ‘this is a very embarrassing subject to touch on and we don’t want to be part of it. Why should we name and shame our people’. For others, if there is nothing in it for them they would not get involved but if there was something in it for them they would be interested. The first question they would ask, is there funding involved.

Funding was mentioned as a driver for Gurdwaras to take on additional services but also in relation to Giani's wanting payment for "extra duties" - implying that talking about alcohol with people may be deemed outside their remit.

In addition, several participants mentioned the older, male, demographic of those running the Gurdwara and also of those attending with young people not attending. Therefore interventions based within a Gurdwara or related to it may reach only particular sections of the community.

⌘ **Role of the community in alcohol support**

Given the challenges already raised about the acknowledgement of alcohol-related harm within the Punjabi Sikh community, it is unsurprising that some participants identified a community resistance to responding to alcohol. The issue of blame, gossiping, and concerns over "back chatting", once again underpinned discussion about responses to alcohol within the community. Further there was a fear that gossip would affect the children and the family's reputation. Because of this, two people felt that service should not be provided within the Punjabi Sikh community.

Several health participants said the community had simply 'not faced up' to the harm alcohol was inflicting within it, with one pointing out that it wasn't just alcohol that was avoided as a topic but also other issues such as cancer awareness. One provider stated that the community's attitude was 'they have chosen to drink so they need to deal with it' and that approaches to alcohol-related harm therefore had to come from a health perspective and be embedded in health provision in the community.

One respondent was passionate about the community needing to 'help itself' on this issue, not just 'ask for money from other people to resolve it. First, however, work was need to engage the community and promote the work, "we need to work with the Sikh people, tell them this is the problem and these are the people who are trying to help you and signpost them in the right direction there." Another agreed suggesting that feeding information into the community through events was a first step.

A number of participants gave examples of their current responses to alcohol problems, from the pub landlord who had "an arrangement" with a local taxi company to get people home when inebriated to the service provider who worked towards ensuring that people affected by a loved one's alcohol use were not isolated through gossip and "pin pointing" of others. Other examples included tolerating groups of drinkers within services providing they were not drinking and referring on to the GP.

⌘ **Partnership working**

There was a good level of partnership working already taking place within the community, some past and present relating to alcohol but also to other health and social care provision. Some spoke of working with Aquarius in the past but the implication was this was not a regular or frequent occurrence, more one off events or visits to agencies. There was a general acceptance that partnership working was key to service delivery and that no service could work in isolation. Some spoke of working 'hand in hand' to signpost people to services, others about active partnership practice.

Some people said particular partnerships were challenging – particularly getting referrals from GPs or working with other statutory agencies. Partnerships with the Gurdwara did not emerge as a strong theme from the service provider interviews although one person felt that it was an obvious starting point:

... why wouldn't you approach the temple itself - that is where people are going in and kinda just talk to them and say, these are the services on offer in a quiet way and let everyone know they are there and do that repeatedly and there will be resources available.

One of the criminal justice participants said it was mutually beneficial for the police to know if any initiative was set up in the Gurdwara or community centre as they can give information in the course of their work. Others also raised ideas about how their work could support alcohol initiatives with young people and their parents.

⌘ **Policy framework and impact on service development**

This research was taking place in a context of impending changes to central and local government structures. A number of service providers spoke about the challenges this posed. The Localism Act 2012 placed greater accountability for a range of health and social care services including needs analysis, commissioning and service provision, to local government and away from central government control. At the same time, the country is in an economic recession and the outlook in the next few years remains economically depressed and gloomy. The implications for alcohol service provision are difficult to predict. First, the chances of efforts by the government to prevent future alcohol problems through taxation seem unlikely. Given the Government gets a large tax revenue from alcohol sales, losing this revenue is not likely to be attractive to them in the current financial climate; the Coalition Government has recently announced a 'U' turn on minimum pricing proposals. One of our participants made reference to the easy availability of alcohol through shops that are open 24hrs a day, "if it was so concerning for the council about people's health they wouldn't be giving every Tom, Dick or Harry a licence to run the places." Second, it is unknown how the Government cuts in public spending are going to be played out at a local level. People with alcohol and other drug problems tend not to be the highest on the list of deserving causes and may well lose out in the increased competition for funds.

Both the revenue issue and the move to localism are likely to have an impact on service development and partnership working. One service provider we spoke to was unsure whether their organisation would be continued once their existing funding ran out within the next few months despite achieving above their targets. Another identified the gap in debt service provision left by the closure of another service. Another said that complex care meetings were already a "nightmare" to get people to attend. In this context, planning ahead for partnership work is likely to be difficult. Further, only the health oriented services had any targets relating to alcohol or other drugs and these offered some help in supporting their work; the remainder did not because their focus was on other issues primarily.

One service provider said central government needed to offer some definitive requirements for alcohol or other drug services. The implication is that without them there will be a mix of

standards and service provision with the potential for it to become a postcode lottery. The local DAAT, for example, are now down to “about 10” staff members from 45. Further, he reported that it has only 1/6th of the funding that drug services receive for alcohol services even though the alcohol problem is “six times” that of the drug problem.

Summary: Service Providers

Nineteen service providers were interviewed at some length. They came from a range of professional backgrounds. All perceived alcohol consumption as increasing among the Punjabi Sikh Community and noted that alcohol-related harm had increased too, particularly hospital admissions. Many also identified the tensions between the religious prohibition of alcohol in Sikhism and the drinking culture of Punjabi tradition. Again reference was made to two cultures within Sikhism – one that drinks and one that does not - and this was cited as a barrier to awareness raising and offering support, as it leads to denial of any problems. For this reason, several participants noted that changing the nature of alcohol use in the community would take time and perhaps even a generation. One generation change that was noted here and elsewhere was the increase in younger Punjabi Sikh women’s drinking or at least the visibility of such drinking. Gender was also an issue raised in terms of needing to support women as parents and partners of family members with substance problems or recognising their role in trying to seek support for their loved one for their drinking and violent behaviour often via the GP. Generation differences were not noted as fervently by the service providers as other groups. The concern was raised however that older people’s drinking may be missed and that younger people’s drinking was increasing.

Existing service provision was identified as having a range of problems from a lack of awareness of where services are to language barriers and attitude problems within the community, such as, asking for help is a weakness. Importantly one service provider reflected on the lack of understanding among specialist substance use services of the “collective belonging” that led to intense feelings of shame and dishonour if a Punjabi Sikh is identified as having an alcohol problem. The importance of future services having some understanding of shame, stigma and the consequent importance of trust and confidentiality in service provision was raised within discussion of future service provision. However, one of the main themes for future alcohol service provision was the need to embed future service provision within a health and well being framework and possibly a holistic service that addressed a range of health and social care needs, not just alcohol. Awareness raising and education was suggested by many participants as a future service requirement, particularly through Sikh TV channels and radio emphasising the ‘free’ and ‘confidential’ nature of the service provided. Suggestions for service types were varied but the need for support for families was highlighted. Who will deliver future services was considered – GPs and other health and social care professionals (once trained) were identified as was the need to mainstream substance use interventions. Importantly one service provider highlighted the tension between the relative ‘safety’ of white service providers versus a practitioner or clinician from within the community with cultural understanding and language skills but around whom there would be fears of gossip within the community. Accompanying this tension was a similar one around location of services – there was general agreement that services need to be locally situated but not be an obvious alcohol service.

The involvement of Gurdwara in providing support generated a lot of discussion. Many participants found a clear resistance from Gurdwaras, or influential individuals within them, to engaging with alcohol issues. Conversely, it was clear that some Gurdwaras were already providing some support, albeit not in a formal way, e.g. through providing food in the Langar Hall for those who were not too drunk, visiting affected families at home, talking to people when sober, or displaying information on local alcohol services. A list of suggestions about what Gurdwaras could offer ranged from active intervention to signposting and partnership working however it was clear that the power dynamics of the various Gurdwara would need to be negotiated carefully and innovative leaders sought to drive any Gurdwara-based or Gurdwara-associated alcohol work. Beyond the Gurdwara, participants identified a range of past and present partnerships around alcohol support and clearly identified the need for future partnership working to ensure alcohol support was embedded in the community. Finally, future service provision, partnership working and community support of alcohol services will take place within a broader social and political context of austerity, recession and public service cuts. These challenges were raised by several Service providers and may yet determine what new or innovative services are possible or viable.

Section 7: Discussion

The key objective of this research was to explore the feasibility of developing a community alcohol support package (CASP) within a community identified by the commissioner of the research, Aquarius Action Projects (Aquarius).

For Aquarius, one of the groups about which it had particular concerns was the Punjabi Sikh community – men in particular – who were increasingly presenting to Aquarius’ hospital-based services with alcohol-related health problems. It was anticipated from the outset that this would be a challenging community with which to engage due to the religious prohibition of alcohol in Sikhism, the norms of heavy drinking within Punjabi male culture, and the very real challenge of being a predominantly white research team investigating such a sensitive subject within a minority ethnic community. Further, we were obviously time and resource limited given the exploratory nature of this research.

For some or all of these reasons these findings have a number of limitations. First, they are based on a limited number of respondents and participants. Therefore the views and experiences of individuals and groups reflected in this project are not generalisable to a wider population of Punjabi Sikh people. In spite of this, our findings echo, and add depth and breadth to, the small amount of research on this topic previously. Second, we were only able to access particular participants in the time available despite our best efforts. For example, repeated attempts were made to access GPs in the Ward, without success. GPs had been identified by many participants as a key referral and advisory source for people with alcohol problems. However, one person who was interviewed in a different capacity was also a GP and we were able to interview a number of other health professionals and service providers. Third, we had also hoped to access older Punjabi Sikh children but only the younger age group decided to take part in the focus groups. This should be an area for future research particularly as young people begin to make the transition into adulthood and begin to make choices about their alcohol consumption. Finally, many unsuccessful attempts were made by various means to contact a whole host of additional service providers or key informants.

Grasping the nettle

What this project highlighted was the potential complexity of addressing problematic alcohol use within the Punjabi Sikh community. The tension between a heavy drinking male culture and the prohibition of intoxicating substances within Sikhism remains a nettle that has not yet been grasped within (or outwith) the community. There was also concern about the need to avoid stereotyping the Punjabi Sikh community while at the same tackling a recognised health and social problem. In this research, discussion of the topic was met with polarised responses, from complete denial of alcohol use to a ready acceptance of a heavy drinking culture that needs to be addressed.

Yet, the role of religious beliefs in influencing individuals’ behaviour is not always a direct one. As one participant pointed out, “Religion is more a conscious part of their lives even if they are not religious themselves”; there are such strong links between the individual, family, the local community and Sikhism that it influences people’s sense of self and shame when living with problematic drinking. It was apparent from the data collected that people

had to negotiate this tension as part of their daily lives; for some this was about the extent of their religious adherence and whether or not they were baptised or 'proper' Sikhs. For another they simply viewed it as two types of Sikhism which they chose to move between. For many, however, it appeared hard to reconcile and thus difficult to discuss. Achieving belief-behaviour congruence, where individuals' stated beliefs do not always match up with their behaviour, is not a new issue, nor one confined to the Punjabi Sikh community. For decades scholars have noted how this tension impacts on how, and whether, the issue is socially recognised and the extent to which shifts in attitudes or behaviour result (Rokeach and Rothman, 1965). Future alcohol service provision will need to consider how to raise and discuss this duality in a way that is both supportive and culturally sensitive.

The shame and stigma associated with problematic alcohol and other drug use is keenly felt by Punjabi Sikh people and was a strong theme emerging across all the data. More than three decades ago, Moscovici and Paicheler (1978) offered the concept of the 'assertive distinctiveness' of minority groups who wanted to present a positive image and stress their individuality, and who downplayed more problematic issues - like heavy drinking - in order to maintain the positive presentation of the group (Goffman, [1959] 1990). There is a clear need for service providers to get behind these issues and to get to the actual nature of the problem in hand.

Those with knowledge of problematic substance use will know that the vast majority of people, regardless of religious beliefs or cultural identity, feel ashamed and embarrassed about problematic drinking or other drug use. So what is different about the shame and stigma experienced by this particular group of people? This research suggests that the answer is found in the multiple layers and levels of shame and stigma. It is not only individual shame but also shame and stigma within (and upon) the family and community. For many Punjabi Sikhs the community is highly important to their individual and cultural identity; it is a familiar and safe place for a member of a minority ethnic community that lives in a western, white dominated society. There are shared understandings and beliefs that usually do not stretch past the bounds of the community and beyond which they are expected to adapt to the rules and customs of the majority group. Indeed the community provides a personal identity, as the following quote shows:

Whenever we go back to India for example we are seen as foreigners, they don't see us as being Punjabis in general. They see us as very affluent in this country and we don't need to work and that. This is a stereotype. If you are suffering racism and there is no sense of belonging, you are really in this flux of identity and your identity is who you are with, the community that is around you. (Specialist Service Provider)

As the community is so central to providing personal and cultural identity, it is easy to see how, within a relatively small community, judgement and gossiping about someone's alcohol use can lead to isolation for both the individual and the family.

Similarly the role of the family is hugely important within the Punjabi Sikh community. As identified on page 48, family is the first level of support when problems occur. The family, its reputation and achievements, and those of its children, are a matter of pride and, for

some, an indicator of status within the community. It is clear from these findings that wives and children were also keenly aware of the losses and impact a father's drinking can bring. Further, a child's problematic substance use, or even public displays of drinking by young women, can bring shame upon the family. Wives in particular were engaged with seeking help on their husband's behalf. Thus, future service provision needs to include the support it can offer family members in their own right and the appropriate location for this support. Partnership with existing services as well as integrated into any new developments is likely to be the key. Adapting existing models, for example, Orford et al.'s (2007) '5 step model' offers a structured way forward and could be used within group or individual settings including existing women's groups, youth groups and work with individuals in newly developed health and well being services. Further, training key people within various community settings to support people's use of the 5 step self-help manual (translated into Punjabi too) could provide leadership from within the community.

What did not emerge from the findings was any appetite for whole family approaches – this reflects the findings in the review of existing literature on alcohol interventions for the Punjabi Sikh Community (Galvani 2013a). However caution is needed interpreting this finding as whole family approaches were not asked about directly and only one person volunteered that this would not work because a 'husband' would not want his 'wife' to know the extent of his drinking, nor would he talk about it in front of the children. Three factors suggest that this is an approach worth exploring further; i) the importance of family to Punjabi Sikh people, ii) the evidence that exists around the benefits of family support in helping people to change problematic drinking behaviour, and iii) the apparently successful use of family and couple's work in other minority ethnic alcohol services (see Manders and Galvani 2013a, Menzies Banton et al. 2006). This suggests that whole family interventions should not be completely discounted. It may be more appropriate to offer family interventions further into a treatment or intervention journey and once trusting relationships have been established. However, this is an area that needs further discussion with community members and partner organisations.

Community development and partnership practice

“It's about taking the lid off it really, in an intelligent way.”
(Specialist Service Provider)

A number of key messages emerged from this data about the importance of genuine partnership practice in the development of future service provision and also provision that is community led. The importance of such practice was to address the need for cultural competence and sensitivity in delivering services as well as practical issues of locating future services in easily accessible places within the community. However, there are likely to be tensions to address given the resistance to discussing alcohol among many sections of the community, and the fear of gossip and shame within the community if services are delivered by local people. These will need to be explored openly with partner agencies at the start of future work.

A number of service providers, service users, and members within the community, were able to talk openly about the need to address alcohol harm and supported the need for

better education and service provision locally. Indeed several service providers invited Aquarius to work with them, within their organisations. These offer a good place to start and are leads that should be followed up. Others were not, or were only minimally, receptive to the research and its implications for service development. Among these were some people who could be influential in the community and whose support would deliver a clear message. Consideration needs to be given to strategies to engage these people, including their recruitment as possible leaders of community alcohol initiatives or a programme of work relating to alcohol support. It is important to note that previous studies have recommended that the community is 'involved' in service provision (Menzies Banton et al. 2006). This creates an impression that (predominantly white) services will invite community members to take part in discussing the implementation of what are, in effect, pre existing approaches and models of service. The findings of this study suggests an approach where services and approaches are developed with the community from the start, rather than using community members as a sounding board for the appropriateness of existing service provision and approaches.

Sharma (2004:1-2) outlines five approaches to community work as follows:

Community mobilisation refers to getting community members to participate in an activity planned by an agency whose mission is to improve the status of the community in health or other matters. *Community organisation* is when community members get organized to identify needs, set objectives and develop plans for community improvement in health or other matters. *Community participation* entails involvement of the community members in planning with an agency whose mission is to improve the status of the community in health or other matters. *Community development* is the organization and stimulation of local initiative and leadership in a community to encourage change in health or other matters. *Community empowerment* is the social action process whereby individuals gain mastery over their lives in the context of changing their social and political environment.

This research suggests that community development and community participation are the models best suited to future service development. A number of previous attempts to engage the community have been made and some service providers expressed frustration at the lack of success in partnerships with Gurdwaras. Further analysis of what has been attempted previously, what approach has been adopted and who was involved, may help to inform future partnership practice. There were somewhat mixed views from all groups about whether or not Gurdwaras should be more actively engaged with alcohol support although there appeared to be general agreement about its role in offering spiritual and practical support to people who are stopping or have stopped their drinking. It is worth considering whether future discussions about alcohol service provision with Gurdwaras may begin at this point. Discussions with Gurdwaras' committees could focus on developing a consistent support package post alcohol intervention. This may be acceptable and also provide an opportunity to build relationships in which to ground future discussions about different types of involvement and support. There is evidence of successful partnerships with Gurdwaras including Coe and Boardman's (2008) 'health and lifestyle' programme

which was developed with the community and grew from a concern about levels of diabetes.

However, people with alcohol problems are not a homogenous group and it is likely that a multi-pronged approach will be required if an effective community alcohol support package is to become embedded within the community, not just partnerships with single organisations or Gurdwaras.

Factors to address within service provision

Clearly one size of service provision will not fit all and the differences in the community's alcohol support needs are important to highlight from the outset. As might be expected the knowledge levels of the community about alcohol ranged from ignorance to expert and all stages in between. Alcohol service provision needs to address age and gender specific needs, domestic violence and abuse, issues of confidentiality and trust, preferences for different models of intervention and all within a culturally aware and culturally sensitive framework. What a relatively small community allows is the opportunity to tailor a package of alcohol support to meet a range of needs.

The survey of community members identified alcohol education and awareness for both adults and young people at the top of their list for future alcohol services. Many of the qualitative research participants reinforced this perception that people were ignorant about alcohol and the impact it could have, or is having, on them. It seems clear that a programme of alcohol education and awareness is seen as desirable even though the evidence for education and prevention initiatives is limited and primarily aimed at younger people (Manders and Galvani 2013b). There were consistent views that the media and the internet should be used to advertise and educate including Sikh radio and TV channels and newspapers, although Europe wide data of mass media campaigns found no effect on reduction in use or intention to use (EMCDDA 2013). Similar suggestions emerged about the use of advertising, in Punjabi as well as English, about Aquarius services. For some this openness about alcohol services, what they do and where they are located may be helpful, for others a more discrete service will be required.

This research demonstrated some clear differences between generations and genders in Punjabi Sikh drinking culture in terms of expectations about alcohol consumption and the environment in which that happens. These differences will require different service responses. The generation debate tended to centre around whether or not older Punjabi Sikhs' drinking was worse, and more hidden, than younger people's drinking. There was some concern among service providers in particular that older people's drinking was being missed, particularly given the reportedly older demographic of Punjabi Sikh men presenting to hospital-based services. Ongoing analysis of older people's drinking across a range of ethnic groups in the UK shows that, compared with younger age groups, older people are generally less knowledgeable about alcohol, are increasingly presenting to hospital with alcohol-related harm and are more likely to die from alcohol-related harm (Wadd et al. 2013). Wadd et al.'s (2013) analysis also shows that older people generally do better in treatment than younger people. The challenge is to ensure older Punjabi Sikh people's drinking is identified and addressed as well as that of younger people. It is likely that younger generations born in the UK and whose use of alcohol and other substances fits

more closely with western peers may find existing services appropriate. This appears not to be the case with the older age group. With an ageing demographic in the UK, it will be important to carefully consider appropriate interventions for older people within the Punjabi Sikh community and how to engage this potentially hidden group.

Perceptions that the younger generation drink less than older generations have some support in the existing literature (Cochrane and Bal 1990, Forshaw 2010, Hurcombe et al. 2010). Debate by participants in the research suggested this was to do with young people receiving more alcohol education. However, knowledge of alcohol does not equate to behaviour change as education and prevention studies have shown (see Manders and Galvani 2013b). Further, western influences appear to have some impact on younger Punjabi Sikh drinking patterns and lifestyle and it is clear that the younger generation are developing a bi-cultural competence in alcohol (and other) behaviour. As one Punjabi Sikh participant pointed out in relation to her own youth, young people are likely to switch between their Western and Punjabi Sikh identities whilst negotiating the alcohol rules that separate the two.

The process of doing this research demonstrated the importance of the researcher's gender in terms of accessing participants. The qualitative data collected reinforced the very clear divide between expectations and learned behaviour about drinking between the sexes. Young Punjabi Sikh women's drinking was seen to be increasing as was their openness about drinking in public – both of which were identified as new concerns from community members. It is difficult to determine the extent to which young women's drinking is a “big problem” and who it may be problematic for. It is possible that Punjabi Sikh young women are just starting to drink or are breaking with tradition by being seen drinking alcohol in public. It may be seen as problem because of the cultural expectation that young women do not drink and certainly not in public. In other words, their drinking may not be extensive or problematic in terms of causing problems to health, finances, crime, and so on; it may be that *any* drinking by women, particularly in a public setting, will be considered to be problematic when placed in the context of honourable women needing to be abstinent (or be seen to be abstinent) from alcohol. However, population data more widely demonstrates that young women's drinking is similar to young men's drinking although their drug use is significantly lower than boys' drug use (Fuller et al. 2011). Future services for the Punjabi Sikh community therefore need to consider gender sensitive support and to understand, and respond to, family concerns about young women's drinking bearing in mind the historical and gendered context of women's drinking in this community.

Conflict, domestic violence and abuse, repeatedly emerged from both the survey data and the qualitative data as related to problematic alcohol use. There were a number of stories and examples given to illustrate the overlap. The relationship between the two issues is well evidenced and its impact on the victims is traumatic and often lifelong (see Galvani 2010 for review of the literature). Victims often feel embarrassed, blameworthy, ashamed and unable to ask for help. As with alcohol problems, the issues of shame and stigma are intense, particularly in cultures, including Punjabi Sikh culture, which discourages divorce and separation and promotes lifelong family cohesiveness and honour. What is known about problematic alcohol use and domestic violence is that drinking can increase both the frequency and severity of the violence and abuse by someone who is prone to violent and

abusive behaviours (Fals-Stewart 2003, Graham et al. 2004). While some studies indicate stopping or reducing alcohol use may reduce the frequency and intensity of the domestic violence, it does not stop it and, if the service user relapses, the violence and abuse returns to equal or higher levels (O'Farrell et al. 2004). Manders and Galvani (2013a) provide an example of one London-based agency serving a large south Asian population that has sought to address carefully both these issues within a culturally sensitive but safe way. Future alcohol service provision within the Punjabi Sikh community would do well to adopt a similar model with implications for staff training, development and support.

Finding any existing statistical data on people's religious affiliation for this study was a challenge. Most data that was publicly, or privately, accessible recorded broad ethnic group but not religious affiliation. This suggests that asking about religion is not a routine part of screening or assessment processes. Indeed religion was only added to the National Census for the first time in 2001 as "an optional question" (Mathur et al. 2013). This lack of data on religion is a tremendous oversight, not just for monitoring and recording purposes but it also implies an attitude that religion is either unimportant or people feel it is intrusive to ask. Given its importance to many members of the Punjabi Sikh community, service provision needs to incorporate questions about religious affiliation. It needs to enable discussions about religious beliefs (where appropriate) or, at very least, be open to discussion about people's faith and provide an informed response. Research has found that a strong religious affiliation is predictive of lower levels or non use of substances (Bradby and Williams 2006, Hurcombe et al. 2010). Manders (2013) in his study of the beliefs and values of young offenders and their attitudes to offending refers to this as having "moral conversations" with people that allowed for an honest and open discussion of tensions around, for example, behaviour and religious beliefs. In this way, he states, it overcomes "simplistic binary thinking". Not discussing religious beliefs is missing out on a potential source of support and motivation (Furness and Gilligan 2010; Holloway and Moss 2010).

Section 8: CASP models for process and practice

Two models have emerged from the process and findings of this exploratory research. The first CASP model reflects our learning of the process of engaging with the Punjabi Sikh community in East Handsworth and Lozells. It illustrates the stages of the research process and draws from these an application for a process of service development.

⌘ Model 1 – A CASP process model

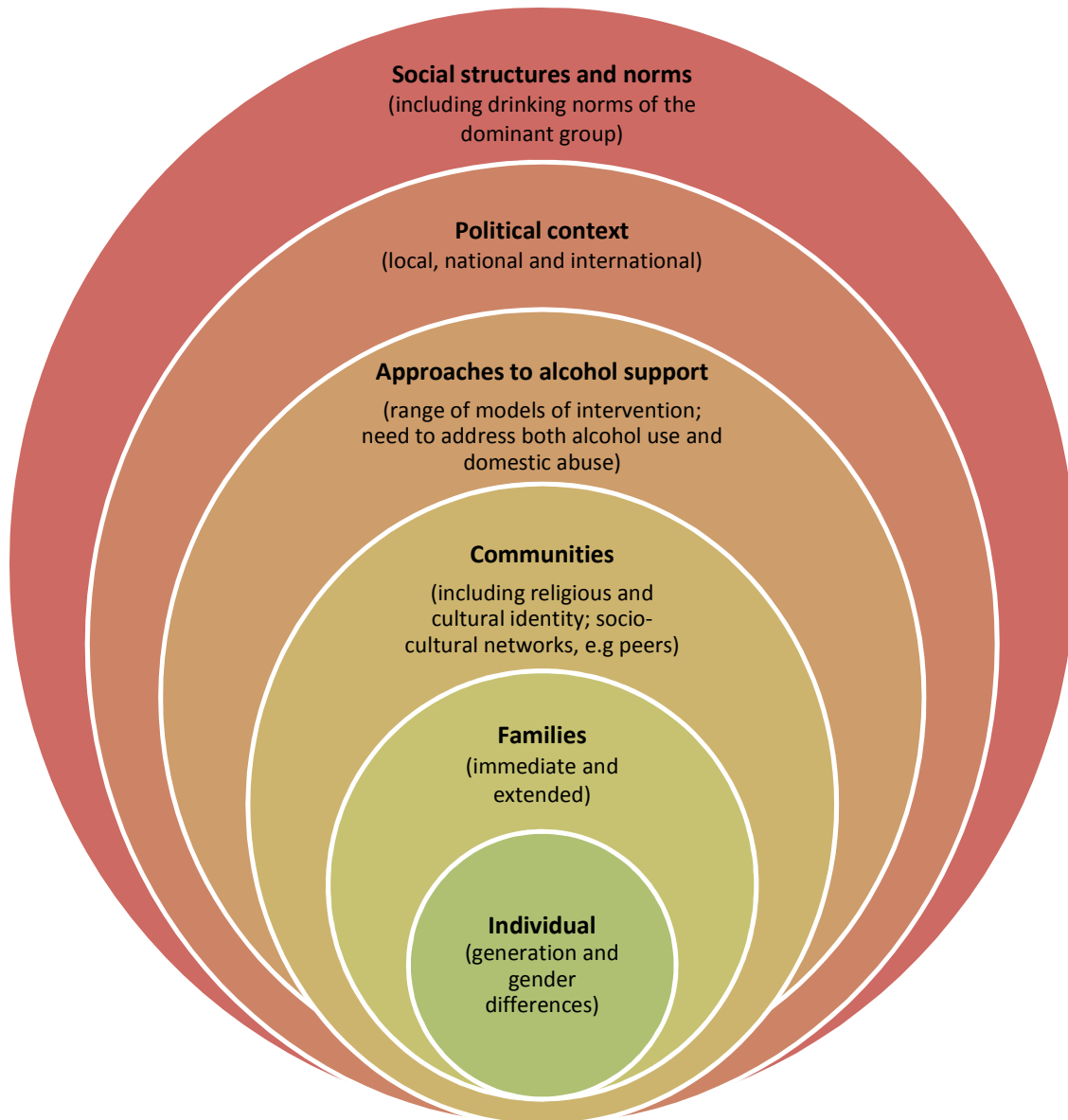


The CASP process model does not include a time frame; each stage will vary according to many individual and intra-individual factors. It emphasises the need for a good knowledge of the community and a willingness to listen to, and to learn about its culture, hierarchy, language, organisations and people. Its goal is to engage and develop sustainable relationships with a range of people from which to develop future services in partnership with the community.

A second CASP model (see model 2 below) focussing on future service development has also been developed. This research suggests a number of key features that need to be considered in practice and these have been placed within a nested model:

1. There needs to be recognition of the hierarchy of help seeking outlined on page 46 - Family support and help is the first layer, seeking support within the community, including religious support, is the second, with the final layer being support from agencies or individuals external to the community. Future service provision will need to determine what it can offer at each level of help seeking.
2. The heterogeneity of the Punjabi Sikh community – while the culture and religion may unify people and provide an identity, the heterogeneity is particularly accentuated by generation and gender differences and western influence. As one service provider stated “each generation presents quite a different set of issues” which will need to be considered in service provision. Thus a range of services will be needed.
3. Approaches to alcohol support – future service provision needs to take account of the preference for a discrete alcohol service within a health and well being framework. Such provision should contain a toolkit of approaches to, and models for, service delivery and not rely on existing models only.
4. The political context – both at a local level, including inter-agency differences and philosophical perspectives, as well as a national level, where national policy impacts local implementation as well as the resources that are available for it. Services need to establish, and negotiate, the terrain of local politics around alcohol support and service provision. For this community, the international level is also significant with political and socio-cultural events and concerns about the Punjab having an impact on individuals’ lives in the UK.
5. The social structures and norms – particularly the dominant discourse around alcohol use as part of the ‘wet’ drinking culture in the UK. Both Punjabi male drinking culture and White British culture have heavy drinking as part of their drinking culture. Changing drinking culture will need some attention to prevent future booms in problematic alcohol use.

⌘ **Model 2 – A CASP service development model**



Section 9: Aquarius work to date

(based on information provided by Aquarius BME Development Worker, Shaheen Chaudhry)

The findings of this study and implications for service development should also be set within the context of Aquarius current and past work with this community. The following summarises the most recent attempts at community engagement and is information drawn primarily from three staff members, two current and one previous member of staff who are, or were, involved in the service delivery.

Sahaita

This was a specialist alcohol service for South Asian communities set within the centre of Birmingham (Essex Street). It was set up to deliver a culturally sensitive alcohol service to people from South Asian communities. It began in 1999 and closed in 2003. According to its manager the project offered family approaches as well as individual counselling, and gender specific counsellors.

What worked – what didn't

- Language skills – the range of languages spoken among the team worked well in ensuring there were no language barriers for service users.
- Location - There is disagreement about the appropriateness of the location of the service – one member of staff felt the service was in the wrong place being outside the community and would have been better located on the Stratford or Soho Road, another that the location was good precisely because it was not in the community and people were less likely to be concerned about others seeing them going in and out.
- Intervention – Aquarius extended its existing models of practice to Sahaita however it has been suggested that 'talking therapies' are not necessarily the most appropriate for the community. More direct methods, e.g. medication and detox and direct advice may have been a better way to work.
- Development work – there was limited time for setting up the service and one member of staff felt the development work (which this study and associated evidence reviews has identified as being so vital) was given insufficient time. One person felt that the result was that the service did not fully engage the communities targeted, particularly as home visits were restricted.
- Outreach/promotional work – this sits separately from development work in that it is about service delivery and promotion. One member of staff felt this was done well using radio shows and Asian network TV channels. However, they also stated that more could have been done to raise awareness and increase referrals.
- Lack of referrals – The service closed as a result of a lack of referrals and the decision was taken to integrate the specialist counsellors into mainstream Aquarius services. Clearly the reasons for the lack of referrals are important to assess and may reflect the need for greater development time and engagement with community services and organisations.
- Health Screening – this was a more successful part of the project. Funding was received from the Sikh Council and Sahaita was invited to speak about alcohol

awareness at Gurdwaras at the same time health checks for BP and diabetes and weight control were carried out. Twelve sessions were conducted in total.

Current practice

- Aquarius has one Asian Communities Counsellor (ACC) who works for half a day each week based at the Handsworth Fire Station. However, this is now coming to an end. It is hoped the work will continue in another location.
- The ACC continues to make home visits which, in her experience, work well with the Sikh Punjabi community. She says they will engage with you if you visit them at home. She said the previous generations preferred to be seen in Health Care Settings but the current generations want to be seen in a confidential setting and not necessarily by an Asian Counsellor.
- Aquarius also has a BME Communities Development Worker who is working on developing links with BME communities
- The BME community development worker has been involved in a series of initiatives:
 - To date she has attended three Health and Wellbeing days at Nishkam Centre.
 - Conducted alcohol awareness training to service users.
 - Recruited two women graduate volunteers from the Punjabi Sikh community to be alcohol 'champions' within that community.
 - There have been over 12 BME specific events attended by BME development worker, two funded by Aquarius and run with partners in the Somali community and also in the Asian Rationalist Society.

⌘ Opportunities

- Further development work with the Nishkam Centre Association (NCA) attached to the large Gurdwara on Soho Road. Preliminary discussions suggest they are happy to host Aquarius for 1-1 work but Aquarius would need to pay for the room.
- The NCA is building a new health centre on Soho Road including GPs, pharmacy – this provides a potential opportunity for Aquarius partnership and links at a senior level would need to be made quickly.
- The Mashriq Centre in EH&L provides the opportunity for alcohol work within the Centre with men and women. It is also viewed as a good place to locate women either as family members/carers or as drinkers and provide intervention. The Centre Manager is keen for 1-1 alcohol support sessions to be held there but is their funding is currently under threat and their future is uncertain.
- The Health Exchange is interested in joint work with Aquarius. It has BME workers on staff and a presence at many local events that Aquarius also attend.
- Current practice by the ACC includes a larger number of home visits and this works well with this community.
- The importance of development work should not be underestimated and appropriate time and attention should be given to it.
- Further alcohol awareness training to GPs has been identified by staff as potentially beneficial to future referrals and care pathways.
- A number of other individuals have expressed an interest in Aquarius working in partnership with them and these details will be passed on to maintain confidentiality.

⌘ Barriers

Four main barriers have become apparent through the existing or recent work with the Punjabi Sikh community and this exploratory study.

1. There is a lack of awareness of services that are available, for example, the street drinkers interviewed for this project were not aware of Aquarius presence at the fire station in Handsworth.
2. There is only one Asian Communities Counsellor in Aquarius who is passed all Asian clients by her colleagues. Given the preference for home visits, this can involve a lot of travel which limits the amount of people who can be seen in a day.
3. People on the front line of organisations in the community are very helpful but decisions are often made through the committee. Aquarius senior management would need to establish an agreement about partnership work.
4. Current work with the community has demonstrated that there is an awareness of alcohol problem within the Punjabi Sikh community but that people are unwilling to take the lead.

Summary

Aquarius has previously developed a specialist service for Asian people that did not have the success anticipated. There is currently very limited service from Aquarius within the community but opportunities have arisen for greater partnership working. The barriers and opportunities could be considered in determining the options for developing a programme of regular and frequent work within the community.

Section 10: Recommendations

This section pulls together the implications of this exploratory project for the development of an Aquarius CASP. It is clear from the process and findings of this research that there are divergent views about the Punjabi Sikh community's needs in East Handsworth and Lozells and its path for future alcohol service provision. As the CASP model 2 (above) points out, this is not a homogenous community (although we have referred to it as such for brevity within this report), and a Community Alcohol Support Package would need to comprise a range of needs and services. It is evident that there is a need for alcohol interventions targeting different groups and using different approaches. There are also people within the community who recognise the problem and would like to take further collaborative working with Aquarius in order to reduce alcohol-related harm within the community. There are others where the doors to partnership are only slightly open, if at all, and these can be nurtured and developed.

The recommendations set out below present an ideal. We are aware that both internal and external considerations will influence the extent to which they can be realised, particularly uncertainty about future funding of alcohol service provision.

Recommendation 1

Develop an Aquarius CASP based on a community development model. Bear in mind the process outlined in the CASP process model 1 and build in plenty of time to ensure the right people are involved from the outset.

The following recommendations are made with an awareness that a genuine community development approach would involve the community development team deciding what services would be developed and how. These recommendations may or may not be part of those discussions! However, we offer them as a starting point for discussion based on our analysis of the findings of this research.

Recommendation 2

Within the CASP, develop two clear service plans to meet the needs of two groups of potential service users: i) a discrete alcohol/substance use service that is more likely to meet the needs of the middle and older age groups in particular, who may be wary of mainstream services; ii) develop a more open Aquarius alcohol support service within the community that offers educational resources, training, awareness raising, brief interventions, and more medium term interventions that may suit the needs of the younger Punjabi Sikh community in particular. It is likely that current models of intervention will suit this younger group.

Recommendation 3

Ensure that future services are located within the community, physically. The discrete service would, as the name suggests, not carry an alcohol service label and it should be located somewhere detached from the main thoroughfares in the community. Alternately it could be based within existing community services but still retain a confidential and "camouflaged" service in order to counter fears of gossip and stigma and to maximise accessibility.

Recommendation 4

Ensure that the CASP service plans address the current gaps in service provision. In particular these appear to be:

- An education and awareness raising programme, or campaign, targeting all age ranges – in particular the use of internet or computer-based programmes as well as Punjabi language media. The Gurdwaras may support an awareness campaign of this kind. Access to hidden populations may be possible through other existing community groups and activities. School and community based education programmes for secondary school pupils should be continued with a view to the most evidence based approaches.
- Interventions for family members in their own right – in particular a service that works with women and children affected by both problematic substance use and domestic abuse. Partnership with community services, for example, the Mashriq Centre, could be one option.
- A prevention and early intervention service – particularly for younger people just beginning their drinking careers. Supporting resources in Punjabi and English would be helpful.
- Individual interventions that are framed within a broader health and well being context. Existing health and well being services may be appropriate. New developments within the community may also provide an ideal opportunity to introduce a new service and approach, for example, the Nishkam Centre Association is planning a new health centre.

Recommendation 5

Underpin any interventions with methods and approaches that have been adapted, or designed anew, to meet the needs of the community. These will need to consider the appropriateness, or lack thereof, of psychosocial ‘talking therapies’ for middle to older age Punjabi Sikh service users. A more directive approach may need to be considered even if this initially appears incongruent with the principles underpinning Aquarius current practice. In addition, adequate time for home visiting should be built into this role. (This is not to suggest dispensing with current practice, simply that additional tools may be required.)

Recommendation 6

Consider staffing requirements in terms of characteristics and skills. Appointing ‘health and well being professionals’, who offer a holistic service and are experienced and highly skilled, may require appointing people to more senior grades. Such professionals may need to offer skills such as speaking Punjabi, cultural competence, religious competence, domestic abuse expertise, a persistent and patient manner and skilled in a range of interventions and approaches. (Existing Aquarius staff, who may already be known as alcohol specialists within the community, would probably not be appropriate for such roles within the discrete service.)

Recommendation 7

Ensure that all Aquarius screening and initial contact/assessment routinely asks about religious affiliation.

Recommendation 8

Given the reliance on primary care as the first port of call for many people with alcohol problems, a rolling training programme and brief online training resource could be developed for GPs along with resources for patients in Punjabi and English. This could also be offered to Giani's or other key people within the Gurdwaras in the wards of EH&L and HW.

Conclusion

This two-part research project set out to explore the possibility of developing a Community Alcohol Support Package (CASP) within a selected community in Birmingham. The Punjabi Sikh community became the focus of the study due to increasing concerns about presentations to hospital by men with alcohol-related harm indicating a history of heavy drinking.

Part 1 comprised reviews of existing evidence to accompany the empirical ethnographic research (part 2) and to highlight effective interventions that may be considered in a CASP for the Punjabi Sikh Community. No studies of effectiveness were found for alcohol interventions with people of Asian origin and this is clearly a gap in the evidence base. The effectiveness of community approaches was also limited and often included prevention initiatives, policy changes, policing, and licensing reviews. While these may be part of a future initiative, the CASP should focus on education, prevention and intervention for community members at individual, family and community levels.

The process of conducting the ethnographic element of the study, and the learning gleaned from it, has been as important as the findings of the study. It spoke very clearly to one of our aims which sought to establish the environmental opportunities and challenges to developing a CASP. What is highly apparent is that a high degree of commitment, patience, and time, will be needed to engage with the community on this sensitive issue. It is also clear that future service provision has to be developed with community members as equal players.

In total 152 people took part in data collection and the range of people was diverse in terms of age, degree of knowledge about substance use and services, and experience of living and working within the community of East Handsworth and Lozells. This diversity was reflected in the responses of participants whose views often represented different polar extremes. It is not time well spent to attempt to unify such views and homogenise a heterogeneous community but it is time well spent to consider how to respond in practice to the views and needs expressed.

To that end, the development of a package of alcohol support should include a toolkit of services to suit different people, places and approaches. As one participant stated, “each new generation presents a different set of issues”. Any approach must therefore be flexible and dynamic. The important factor in responding to the community’s needs is to ensure, for the sake of sustainability, that future services are community led and relate clearly to the policy and practice agendas of community partner organisations. It will not be a quick or easy task. There are cultural histories and religious sensitivities to consider at each step of the way.

While we await better statistical evidence of need and better evidence of effective interventions, we need to trust in our practitioners and our community members that something needs to be done. The final word rests with an influential member of the Punjabi Sikh community who states:

The figures as you know are showing that we have got a problem, but we have to be brave and say we have, rather than brushing it under the carpet and saying this isn't a problem. We have got to say that we have got to look at it. We are human beings and the quality of human beings is to speak the truth... . At least when you tell the truth something can be done about it.

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Appendices

Appendix 1 – Anonymous survey

Alcohol, Health and Well-Being Survey

Thank you for taking part in this survey. This first page provides brief information on the survey, a confidentiality statement and an informed consent agreement. Please read them carefully before progressing with the survey.

About the project

- This research seeks your views on alcohol, health and well being. We want to find out what your views are about the impact of alcohol on people's health and what services you think are needed to support people who have health or well-being problems that might be related to their alcohol use. The survey will only take you about 10 minutes to complete.

Confidentiality/anonymity

- The survey is anonymous. We do not ask for your name. We ask for some general information on your age and gender for example, but only for the purpose of knowing the profile of all our respondents.
- **The data you provide is held on a secure server by the survey provider and is encrypted** as it is downloaded to the University of Bedfordshire server. Only the research team will have access to the data which will be destroyed no more than 12 months after the completion of the project and its related outputs.
- We may use your one of your responses as a quote in our research report and outputs but these are anonymous so no identifiable information will be included.
- For people who provide their contact details at the end of the survey, these will be treated with the utmost confidentiality. This will only be broken if anything you tell us suggests you are at risk of harm or that you have, or were intending to, harm other people.

Right to withdraw

- You can stop filling out the survey at any time. You can withdraw your responses by ticking a box at the end of the survey and your data/survey responses will be deleted from the dataset.

Who can I contact if I have questions?

- If you have any further questions about the research please feel free to contact the Principal Investigator, Dr Sarah Galvani on 07884 007222 or sarah.galvani@beds.ac.uk.
- If you are unhappy with any element of the research process you are also entitled to contact an independent person at the University of Bedfordshire. The contact is Angus Duncan at angus.duncan@beds.ac.uk or 01582 743473.

If you are happy to proceed please give your consent in the box below:

☐

I understand that by ticking this box I am giving my consent to take part in this research.

Date

Background information

1. **Age** (please circle): under 16 17-24 25-34 35-44 45- 54
 55-64 65- 74 75 +

2. **Sex** (please circle): Male Female

3. **Ethnicity:** Please tick one option that best describes your ethnic group or background:

Asian / Asian British	
Indian	
Punjabi	
Pakistani	
Bangladeshi	
Chinese	
Any other Asian background, please describe	
Black / African / Caribbean / Black British	
African	
Caribbean	
Any other Black / African / Caribbean background, please describe	
White	
English / Welsh / Scottish / Northern Irish / British	

Irish	
Gypsy or Irish Traveller	
Any other White background, please describe	
Mixed / Multiple ethnic groups	
White and Black Caribbean	
White and Black African	
White and Asian	
Any other Mixed / Multiple ethnic background, please describe	
Other ethnic group	
Arab	
Any other ethnic group, please describe	

4. **Religion** (please tick one):

<input type="checkbox"/>	Sikh
<input type="checkbox"/>	Hindu
<input type="checkbox"/>	Muslim
<input type="checkbox"/>	Christian
<input type="checkbox"/>	Agnostic
<input type="checkbox"/>	Atheist

	Other – please state
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5. Name of **ward/area where you live** or **postcode**: e.g. Handsworth, Lozells or B21

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Survey questions

1. On a scale of 1-10 how much would you say you know about alcohol and its impact on your health (1 = 'I know nothing' and 10 = 'I am an expert') *(Please circle your answer)*

1 2 3 4 5 6 7 8 9 10

2. On a scale of 1-10 how much would you say you know about alcohol and its impact on people's behaviour (1 = 'I know nothing' and 10 = 'I am an expert') *(Please circle your answer)*

1 2 3 4 5 6 7 8 9 10

3. Which of the following do you think are related to drinking too much alcohol *(tick all that apply)*:

	Poor sleep
--	------------

	Not eating properly
--	---------------------

	Heart and lung problems
--	-------------------------

	Liver and kidney problems
--	---------------------------

	Mental health problems
--	------------------------

	Smoking
--	---------

	Arguments and conflict at home
--	--------------------------------

	Violence and threats of violence at home
--	--

	Financial problems
--	--------------------

	Loss of employment
--	--------------------

	Getting into trouble with school/university or your job
--	---

	Other – please state
--	----------------------

4. On a scale of 1-10 how much shame do think people with alcohol problems feel? (1 = 'no shame' and 10 = 'extremely shameful') *(Please circle your answer)*

1 2 3 4 5 6 7 8 9 10

5. What do you think are the main reasons people drink alcohol (*please tick between one and three boxes*)?

<input type="checkbox"/>	Like the taste
<input type="checkbox"/>	Peer pressure/other people do it
<input type="checkbox"/>	Like the buzz it gives them
<input type="checkbox"/>	To fit in with their peers
<input type="checkbox"/>	To escape or forget their problems
<input type="checkbox"/>	To help them sleep
<input type="checkbox"/>	To give them more confidence or courage
<input type="checkbox"/>	To be a good host when people visit/when hosting a party
<input type="checkbox"/>	To rebel against parents', religious or cultural rules
<input type="checkbox"/>	To give them an excuse for behaving badly
<input type="checkbox"/>	Other – please state

6. If you knew someone in your family or friendship groups that had an alcohol problem would you ...: (*please tick one option*)

<input type="checkbox"/>	Try to talk to them about getting help
<input type="checkbox"/>	Pretend nothing is wrong and carry on as normal
<input type="checkbox"/>	Stay away from them
<input type="checkbox"/>	Ask someone else for their advice on what to do
<input type="checkbox"/>	Other – please state

7. If your friend or family member said they wanted some help with their alcohol problem would you know who to suggest? (*please circle your answer*)

NO

YES

If yes, who would that be (please enter below)?

8. Do you think other people are affected when someone has an alcohol problem? *(please circle your answer)*

NO

YES

If yes, who do you think they are (please enter below)?

9. If you wanted to know more about alcohol, health and wellbeing, where would you be most likely to go for information? *(please tick one box)*

<input type="checkbox"/>	Work colleague
<input type="checkbox"/>	GP
<input type="checkbox"/>	Internet
<input type="checkbox"/>	Family member
<input type="checkbox"/>	Alcohol service
<input type="checkbox"/>	Friend
<input type="checkbox"/>	Religious leader
<input type="checkbox"/>	Other – please state

10. Do you know any services in the area where you live that support people with alcohol problems? *(please circle your answer)*

NO

YES

If yes, which service/s do you know about (please enter below)?

11. What do you think are the main reasons that might stop people seeking help if they were worried about their own drinking *(please tick up to two boxes)*?

<input type="checkbox"/>	Thinking they can change their drinking on their own
<input type="checkbox"/>	Shame/afraid other people in their family or neighbourhood might find out
<input type="checkbox"/>	Don't know where to go or who to ask
<input type="checkbox"/>	Don't realise the effects it is having on their health or wellbeing
<input type="checkbox"/>	No services locally that meet their needs

	Other – please state

12. What type of support services do you think are needed in the area where you live? *(please tick all that apply)*

	Education and awareness for <i>children and young people</i>
	Education and awareness for <i>adults and older people</i>
	Support for family members of people with alcohol problems
	Self-help groups
	Individual counselling services
	Support for children of parents who have alcohol problems
	Other – please state

13. Where do you think any alcohol support services should be based *(please tick all that apply)*:

	Place of worship
	Community centre that runs other groups and classes
	Health centre/GP
	Specialist community alcohol services
	Library
	Other – please state

14. Is religion important in helping someone overcome alcohol problems? *(Please circle your answer)*

NO

YES

Please say briefly why you have answered yes or no
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15. What should be the role of religion, if any, in supporting someone deal with their alcohol problems? *(Please tick all that apply)*

<input type="checkbox"/>	Not important
<input type="checkbox"/>	Seek support of faith community
<input type="checkbox"/>	Prayer
<input type="checkbox"/>	As a coping mechanism
<input type="checkbox"/>	To offer advice
<input type="checkbox"/>	Other – please state

Thank you for taking part in this survey! Your views and experiences are important to us in seeking to support people in the best possible way.

17. If we wanted to speak to you further about your views, would you be willing to talk to us? *(please circle as appropriate)*

NO

YES

If yes, please leave your name and contact number below:

Name
Contact number or email

NB. This information will be kept confidential and only the research team will have access to it.

Thank you again. We appreciate your time. Please place this questionnaire in the box provided.

Don't forget if you want a friendly service which can provide advice on alcohol issues for you,
a friend or family member contact
Shaheen Chaudhry at Aquarius on 07837 889520

If you have changed your mind and want to withdraw from the survey, please tick the box below. Otherwise leave it blank.

☐

Appendix 2 – Vignettes used in focus groups and individual interviews

Vignette 1

A friend raises some concerns with you about her husband's drinking. They are married with two children and he is a successful business man. He has started drinking at business lunches when entertaining clients. His drinking seems to be increasing and he is regularly drinking at home and has recently become more aggressive in his behaviour when under the influence. From what she tells you it seems he may have been violent and abusive to her on a number of occasions, and this behaviour has been witnessed by the children. She is beginning to get frightened particularly when he's having a business lunch meeting and is likely to be drinking. The children are starting to be wary of him too. She tells you he has also been admitted to hospital on several occasions for health problems but now she thinks it may be related to alcohol.

Question for women's focus group

What are your thoughts on reading this scenario? What advice would you give her?

Variation for service user interviews

A friend raises some concerns with you about his drinking. He is married with two children and is a successful business man. He has started drinking at business lunches when entertaining clients. His drinking seems to be increasing and he is regularly drinking at home and has recently become more aggressive in his behaviour when under the influence. You have some concerns that he may have been violent and abusive to his wife on a number of occasions, and that these have been witnessed by the children. He has also been admitted to hospital on several occasions.

What are your thoughts on reading this scenario? What advice would you give to him? What advice would you give his wife?

Vignette 2

Saacha is a fifteen year old of Punjabi descent who likes drinking with his friends; "it's normal", just something he and his friends do, it's a sociable thing "like everyone is out drinking all the time". He hides his drinking from his family because drinking is frowned upon in his faith community. He goes to a lot of parties and spends more time out than at home. The group of friends he hangs out with ask people to go into the shops for them to buy alcohol. He doesn't always get drunk, but lately there have been a few occasions when he has not managed to get home on time because he's been drinking and he is beginning to push the boundaries at home. He also turned up at the Gurdwara smelling of alcohol and was asked not to go in again under the influence. His older sister also drinks but has avoided getting into trouble and her family don't know. He has threatened to tell his parents about her drinking if she doesn't pick him up from time to time when he's been out with his mates. Saacha's father also drinks but is furious with his son for having been arrested recently for drunk and disorderly behaviour in the community park. He was called out to the police station late one evening to pick Saacha up. He had every intention

of not allowing his son to come back home but he had calmed down after remembering drinking in his own youth.

Questions for young people

What do you think of Saacha's behaviour? If Saacha was your friend and was getting into trouble with his drinking, what would you advise him to do? What do you think his parents should do? What differences are there between how people might view Saacha's drinking and his sister's or father's drinking?

Questions for service user participants and women's focus group

How would you deal with this situation if you were Saacha's father or mother?

Appendix 3 – Focus group questions

Women's group/Service user questions

1. What, if any, differences do you see between younger and older generations and their attitudes towards alcohol?
2. Many religions, including Sikhism, prohibit alcohol use, yet many people within these religions still drink alcohol. How do you think alcohol services can best reach out to people of Sikh faith or Punjabi culture to offer them support with their drinking?
3. In your experience, what role does religion play in supporting (or otherwise) people with alcohol problems?
4. Many people with alcohol and other drug problems feel ashamed of their drinking. Are there pressures that you feel may be different for people of other faiths/backgrounds as someone with a Sikh/Punjabi background?
5. What do you think are the main reasons that might stop people seeking help if they were worried about their own drinking?
6. What do you think are some of the opportunities and barriers people of Sikh faith or Punjabi culture face when needing support for alcohol problems or accessing services?
7. Do you know any services in the area where you live that support people with alcohol problems? If so, which ones?
8. What type of alcohol support services do you think are needed in the area where you live?
9. Where do you think any alcohol support services should be based?

Young people's questions

6. What, if any, differences do you see between younger and older people and their attitudes towards alcohol?
7. Many religions say alcohol use is wrong, yet many people who follow these religions still drink alcohol. This can make it difficult for people to ask for help when they need it. How do you think alcohol services can best reach out to people who have such religious beliefs to offer them support with their drinking?
8. What do you think might be some of the difficulties people face when needing support for alcohol problems or accessing services?
9. Do you know any services in the area where you live that support people with alcohol problems? If so, which ones?
10. In your experience, what role does religion play in supporting people with alcohol problems?
11. Many people with alcohol and other drug problems feel ashamed of their drinking. Are there pressures that you feel may be different for people of particular faiths/backgrounds?
12. What do you think are the main reasons that might stop people seeking help if they were worried about their own drinking?
13. What type of alcohol support services do you think are needed in the area where you live?
14. Where do you think any alcohol support services should be based?

Appendix 4 – Service provider interview questions

Your service and alcohol

1. Does your service knowingly encounter people with alcohol and other drug problems? If so, how often?
2. How does it currently respond to a) substance specific needs, b) the person's wider health and social care needs?
3. What are some of the challenges you face with working with people with alcohol problems?
4. What are the types of co-existing problems you experience as being associated with alcohol problems among your service user/client/customer group?
5. What alcohol services are you aware of?
6. How often do you refer people to them?
7. Does your agency have any strategic targets relating to:
 - a) alcohol or other drug use
 - b) health improvement
 - c) supporting families with complex problems
8. If so, what are they?

Alcohol and the local community

1. What is your view of the needs of the local community in relation to alcohol support?
2. Do you notice any particular group or groups of people among those with alcohol problems?
3. We are particularly interested in alcohol use by the Punjabi Sikh community – have you any experiences or views about people drinking within this community?
4. What are the gaps in alcohol service provision locally in your experience?
5. Are you aware of any barriers locally for people in terms of seeking help for alcohol problems?
6. What do you feel is the best way to encourage local people to seek help for alcohol problems?
7. Is there anyone else you think we should talk to about alcohol problems and needs locally?