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The Effects of Acculturation on Harmful Alcohol Use in the Sikh Community and Outlining the Efficacy of a Culturally Integrative Model

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Abstract

Over the past decades, there has been a significant migration of Sikhs, a religious group originating from Punjab, to Western countries, including Canada and England. Concurrently, while Sikhi maintains a prohibition of psychoactive substance use, Sikh immigrants face elevated alcohol abuse rates. Further convoluting this relationship with alcohol, alcohol abuse rates in Sikh communities continue to grow and negatively affect health outcomes despite the increased availability, recognition, and efficacy of current substance abuse models rooted in health promotion. While health promotion encourages individuals to take control of their health, there exist structural determinants that hinder an individual's decision-making capabilities and resultingly, their health outcomes. Thus, this paper aims to centre the lived reality of Sikhs who migrate to Western countries to understand how the structural determinants associated with acculturative pressures contribute to an increasing tendency to use alcohol. This paper bases itself on a literature review that used the findings of previous studies that constructed both quantitative and qualitative data, with the latter drawing on individual responses to evaluate the lived experiences of Sikh immigrants who faced alcohol problems. It was found that two major structural determinants associated with newcomer health are contributing to alcohol problems in migrant Sikh communities, which are work stress and cultural barriers. Newcomer underemployment and migration from a collectivist to an individualistic culture were found to have contributed to the use of alcohol as a coping mechanism. Furthermore, analyzing existing health promotion models, including the transtheoretical model, supported that a lack of cultural competency led to an inefficacy for Sikhs seeking treatment. Finally, the review highlighted a need for a culturally integrative model and adopted various Sikh elements, including selfless service and the *Gurdwara*, the Sikh place of worship, to outline tools for a culturally integrative

health promotion model for substance use problems. Overall, the limited available research related to Sikh-specific alcohol problems highlighted that it requires future research to effectively analyze the efficacy of overcoming cultural barriers through culturally-specific programming.

Introduction

Used across many cultures for centuries, alcohol is a psychoactive substance with properties that can induce dependence (World Health Organization [WHO], 2022). While consuming alcohol on occasion and in small amounts poses minimal risks, excessive consumption has effects on both the physical and mental health of its users (WHO, 2022). Excessive alcohol consumption has been associated with an increased risk for non-communicable diseases, including some cancers and heart disease, and it has adverse impacts on mental health, including an increased risk of mental and behavioural disorders such as alcohol use disorder (AUD) (WHO, 2022). AUD is a condition that describes an inability to control alcohol use despite the health and social consequences it causes, and encompasses terms such as alcohol dependence, addiction, and alcoholism. (Carvalho et al., 2019). Overall, harmful alcohol use is responsible for 5.1% of the global burden of disease and accounts for 10% of all deaths on a global scale for those aged 15 to 49 years (WHO, 2022).

Given the threats alcohol poses to global health, one of the quintessential examples of health promotion is preventing excessive alcohol use. Health promotion, defined by WHO (1986) as the “process of enabling people to increase control over, and to improve, their health,” has been used as a theoretical framework to model interventions and counselling services to support those with alcohol addiction or abuse problems. Due to drinking guidelines and counselling services, some countries have reported stability or a decrease in excessive alcohol

use. For example, in Canada, the prevalence of exceeding the chronic-risk guidelines of alcohol consumption remained stable among males between 2008-2017 (Statistics Canada, 2017).

However, while this statistic exemplifies a commitment to reducing alcohol abuse rates, this reduction is not equally observed across racialized and cultural minorities, along with newcomers, including Sikhs, a religious group originating from South Asia. For instance, while Sikhs comprise just under 1% of Britain's population, in a survey of over 1000 Sikhs living in the UK, 27% of respondents said that they knew someone within their community suffering from an alcohol-related problem (BMG Research, 2018). Furthermore, Singh & Tatla (2006) have outlined the per capita rate of Sikh alcohol abuse as being one of the highest in the world. Additionally, in a study of men of Asian origin who died from alcohol-related liver disease, 80% were thought to come from a Sikh background (Singh & Tatla, 2006). At the same time, Sikh immigration from India to Western countries has grown throughout the years. For instance, in Canada, Sikhs form the 4th largest and fastest-growing religious group (Statistics Canada, 2022). Thus, while a prioritized target of health promotion is reducing excessive alcohol use, the high rates of alcohol consumption and poor health outcomes in the Sikh community, particularly in Western countries, require further exploration. As a Sikh myself, I particularly am interested in understanding the limitations of current health promotion initiatives because this pervasive issue negatively impacts not just the substance users but also their families and extended social groups.

The central question surrounding this paper is: why do Sikh immigrants experience elevated alcohol abuse rates, and how can incorporating Sikh spirituality in substance abuse treatment programs improve alcohol abuse outcomes in the Western-living Sikh community? This paper is divided into three sections. The first section understands the structural barriers embedded in the Sikh immigrant experience to identify why elevated drinking rates exist. The

second part identifies the shortcomings of current health promotion initiatives to understand why they are inaccessible to the Sikh immigrant population. The last section explores a culturally integrative model for overcoming drinking problems and considers the efficacy of incorporating several Sikh theologies and spiritual elements within a treatment program.

Sikh Diaspora

This section provides a background on the Sikh identity and positions the drinking problems Sikh immigrants face by understanding the issues in acculturation in Western countries. From here onwards, the terms “drinking problems” and “alcohol problems” are used to adopt a more inclusive lens and describe Sikhs who exhibit similar symptoms to AUD, such as alcohol abuse, but may not have a formal diagnosis.

Religion and Culture: Positioning Alcohol Use in Sikhi and Punjab

Sikhi is a religion originating from the Indian subcontinent, particularly Punjab (Singh, 2008). Many Sikhs who identify with the religion are also associated with the Punjabi culture, a South Asian group known for its collectivist culture and characterized by high family and community involvement (Singh, 2008). The Sri Guru Granth Sahib (SGGS) is the holy book that Sikhs adhere to and use as guidance in practicing faith (Sandhu, 2022). In Sikh philosophy, it has been written in the SGGS that one is not allowed to consume alcohol, on the basis of intoxication being sinful and inducing a state of misery (Sandhu, 2022). Thus, for a Sikh, any level of alcohol consumption within their host country can be considered unhealthy because it should not be consumed for recreational purposes and presents itself as a threat to purity.

Immigration and Acculturation

Thus, understanding why Sikhs face drinking problems when they move abroad requires exploring how immigration affects their mental health. Berry (1997) proposed a model of

acculturation, where individuals either integrate, assimilate, separate from the host culture, or are marginalized. The worst health outcomes tend to be associated with marginalization, where one faces psychological distress and feel neither connected to their host nor their home culture (Berry, 1997). While the marginalization category could conceivably be used to describe why immigrant Sikhs face alcohol problems, this model of viewing acculturation tends to position integration on the individual level without considering the wider societal context that may affect their ability to integrate. Contrastingly, Ward & Geeraert (2016) state that the more dissimilar or distant one's original culture and their host culture are to one another, the more difficult it can be to integrate within the host country and the greater the acculturative stress can be. This can impact psychological and socio-cultural adaptation (Ward & Geeraert, 2006). The increased acculturative stress can be used to support the healthy immigrant effect (HIE), which posits that immigrants often arrive reporting better health outcomes than Canadians, and they experience a decline in health outcomes with an increased time spent in Canada (Elshahat et al., 2021). Elshahat et al. (2021) describe in their systematic review that there is consistent evidence that the mental health of immigrants declines over an increased duration spent in their host country. This aligns well with the poor health outcomes and mental health impacts of drinking problems within the Sikh community. Because in the immigration experience, the primary variable changing is geographic location, which comes with a new culture, health system, and legislation, the HIE would suggest that there are structural determinants that are increasing acculturative stress. Using this framework, two main factors contributing to Sikh alcohol problems relate to structural determinants associated with newcomer health, which are work stress and cultural changes.

Firstly, Sikh immigrants are facing stress within the work sphere due to systemic factors in accessing well-paying work. For instance, many Sikh immigrants, primarily coming from

India, may have acquired degrees and possess an advanced skillset; however, because their credentials are not accredited by a Western country, these qualifications are disregarded in their host country (Model & Lin, 2002). This can lead to newcomer underemployment, where a worker's skillset is more advanced than is required for the job they are working (Mawani et al., 2022). To adequately support themselves, have a livable wage, and make ends meet, many are forced into working lengthy hours, engaging in low-wage and labour-intensive work, and often taking on multiple jobs (Sandhu, 2009). To cope with the energy demands of working intensely, coupled with the emotional and psychological stress overworking can cause, Sikh immigrants may seek out alcohol as a coping mechanism (Sandhu, 2009). For instance, Cochrane & Bal (1990) found in a community survey amongst Punjabi males, particularly factory workers, that they often described alcohol as a 'fortifying drink,' which would enable them to work harder and longer, as well as deal with the pressures of work. Thus, the 'fortifying' nature of alcohol may be utilized as a justification for Sikhs to cope with job stress.

The second systemic factor contributing to Sikh immigrants facing drinking problems is the cultural change associated with moving to a Western country. When moving from South Asia to a Western country, Sikh immigrants often experience a significant cultural shift, where individuals move from a collectivist culture to an individualist one. Western societies are characterized by a culture that emphasizes independence and self-reliance (Triandis, 2004). Contrarily, collectivist cultures prioritize the needs of others and involve having dependence on each other within their community (Triandis, 2004). Thus, in the face of distress, Sikh immigrants are more likely to seek out group support, which occurs by speaking to family members within an intergenerational home and speaking to a trusted community member (Singh, 2008). However, the individualistic nature of a Western society, where individuals prioritize

independence, can create a community where a Sikh immigrant may not know where to access support in periods of low mental health, leading to isolation (Ahuja et al., 2003). Without community support to cope with distress, a replacement coping mechanism can become alcohol use (Ahuja et al., 2003). Furthermore, Western societies often possess more liberal attitudes towards alcohol consumption, whereas, in traditional Sikh homes, this is largely prohibited (Sandhu, 2009). Resultingly, living in a collectivist culture and within a closely integrated community can behave as a form of social control, where one's identity can become recognizable if one was to consume alcohol (Sandhu, 2009). However, moving towards a Western society breaks down the social control within a closely integrated community by living in a culture that prioritizes independence (Sandhu, 2009). Because one has greater anonymity, they may be able to consume alcohol without their identity being revealed, and the loss of social control reinforces engaging in this behaviour (Sandhu, 2009).

In both cases of work stress and individualist culture, alcohol is not being consumed for recreational purposes. A Sikh, who usually operates with not drinking alcohol, demonstrates in the immigration experience that there exists systemic barriers that heighten acculturative stress, leading to drinking problems. Recognizing that Sikhs are facing alcohol problems due to this stress sets up the question of why current substance abuse models are not benefitting them.

Current Substance Abuse Models

This section will deconstruct two existing health intervention models to understand their shortcomings in addressing Sikh immigrant needs. These include the transtheoretical model and Alcoholics Anonymous.

Transtheoretical Model

The transtheoretical model (TTM) of behaviour change is a health behavioural model that positions the decision-making and intentionality of an individual wanting to modify a health behaviour (Prochaska & Velicer, 1997). The TTM occurs through 6 stages of change, where an individual enters the pre-contemplation stage, and the goal is the final maintenance stage where they have successfully modified a behaviour (Prochaska & Velicer, 1997). In this model, the TTM understands the flow of an individual's ability to engage in health modification behaviours by moving through each stage by adopting strategies and accessing support (Prochaska & Velicer, 1997). The TTM, while useful for modelling health behaviour, presents some foundational issues, both in its establishment and applicability.

Firstly, the model was designed through Western-based psychology and psychotherapy, and as a result, it tends to position addiction problems in individualistic terms by generally ignoring the social context in which change is occurring and other external factors that play a role in one's ability to change (Morjaria-Keval, 2006). For instance, the TTM tends to limit the role of social influence by positing that it primarily plays an important role in reinforcing behaviour change within the action and maintenance stages (Morjaria-Keval, 2006). However, for Sikh individuals coming from a collectivist culture, social influence plays an important role in behaviour modification at all stages (Morjaria-Keval, 2006).

Secondly, the TTM is limited in understanding the nature of change for Sikh immigrants dealing with alcohol problems, particularly when considering the speed at which Sikhs may modify their behaviours through faith reaffirmation. Morjaria-Keval (2006) conducted a qualitative study on Sikh men who dealt with alcohol problems and were on a path to recovery, where some men fell within the action stage of the TTM. The action stage lasts about 6 months before moving onto the maintenance stage (Prochaska & Velicer, 1997). Some of the Sikh men

in this study, despite having modified their behaviour for less than 6 months, demonstrated using strategies that were closely aligned with behaviour changes in the maintenance stage (Morjaria-Keval, 2006). While temporally, these men fell within the action stage, behaviourally, they fell within the maintenance stage, which exhibits a discrepancy in the TTM. These Sikh men demonstrated intensification and adherence to their faith, meaning the action stage tends to rapidly occur (Morjaria-Keval, 2006). This signifies that the TTM cannot account for dramatic and spontaneous change. If the TTM is used as a framework in counselling services, it does not reflect how Sikh immigrants can use the reaffirmation of their faith to experience catalytic changes in eliminating alcohol consumption and overcoming their drinking problems.

The limitations of the TTM demonstrate that the Sikh identity cannot be isolated from their behavioural change. Without a counselling service that positions their religious and spiritual identity, a Western-developed model of change may not draw on a Sikh's strength in being able to catalytically change through reaffirmation of their faith.

Alcoholics Anonymous

Another substance abuse treatment program is Alcoholics Anonymous (AA), which is an AUD recovery organization that supports recovery from substance abuse problems through its twelve-step program (Kelly et al., 2020). AA's primary philosophy is to help individuals who identify as alcoholics overcome alcoholism and maintain sobriety (Kelly et al., 2020). While AA has been an effective tool for many individuals, it presents some limitations for Sikh immigrants dealing with alcohol problems through labelling barriers and mental health stigma.

Firstly, the way Sikhs philosophize perceptions of alcohol problems and recovery is through its framing as a sin that one can be cured of (Morjaria-Keval & Keval, 2015). Contrarily, in Western views, it is pathologized through recognition as AUD, which is defined as a disorder.

For Sikhs, the framing of their sin as a disorder can create labelling barriers to accessing services. For instance, Morjaria-Keval & Keval (2015) analyzed a qualitative study that worked with Sikh men who were on a path to recovery from alcohol problems and sought both mainstream counselling services and spiritual-based recovery. Some of the participants in this study expressed that they felt excluded from mainstream services because they encouraged labelling as an alcoholic, but upon recovery, these participants felt cured of their sins and did not want to be labelled (Morjaria-Keval & Keval, 2015). Thus, there is a mismatch between the Western worldviews that are centred in a program like AA and the ways Sikhs philosophize their alcohol problems. This can prevent them from accessing counselling services due to fear surrounding labelling.

The second limitation of a program like AA is the ability to access these services due to the stigma attached to mental illness. The Punjabi culture, like many other South Asian cultures, has a stigma associated with mental illness, where accessing counselling support can be viewed as a sign of weakness and there exists a fear of community backlash (Singh, 2008). Furthermore, before seeking a healthcare professional's help, individuals will often seek support through other rituals first (Singh, 2008). Thus, Sikh individuals may face internalized stigma in accessing counselling support like AA and may rather seek spiritual support through rituals and prayer.

Culturally Integrative Model

Overall, the immigration experience, coupled with the TTM and AA, all exemplify how from the very cause of drinking problems to the available recovery supports, there exist gaps in Western counselling supports because they do not provide sufficient cultural competency in defining patterns of distress and wellness. While health promotion enables individuals to gain control of their health, the structural barriers within both society and health behavioural models

depict an exclusionary nature, particularly for minorities, including Sikh immigrants. Thus, for health promotion to support Sikh immigrants in Western countries dealing with alcohol problems, they must adopt an anti-racist and equitable approach that centres worldviews beyond the West. Morjaria-Keval & Keval (2015) have identified that a reconnection to one's culture or religion may serve as a means of rehabilitation. As such, this section will look at various Sikh elements that centre Sikh spirituality within a culturally integrative model and consider their efficacy.

A Model of Change for Sikhs: Catalyst, Commitment, Change

First, a culturally integrative model should accurately reflect the behavioural change that Sikhs with alcohol problems portray when reconnecting to their faith. Specifically, this approach would reflect the rapid and intense nature of change that Sikhs adopt through the reaffirmation of their faith, as Morjaria-Keval (2006) found. Morjaria-Keval (2006), through working with Sikh participants who sought both mainstream and spiritual means of recovery and support, developed a model more reflective of the Sikh experiences with alcohol problems. The stages within this proposed model are catalyst, commitment, and maintaining change (Morjaria-Keval, 2006).

The first stage, *catalyst*, was often observed in participants through the occurrence of a significant event or experience (Morjaria-Keval, 2006). This event led to the individual realizing the severity of their alcohol problems, where they understood how the sinfulness of drinking relates to the negative effects on their social and mental well-being (Morjaria-Keval, 2006). This stage behaves as a catalyst because through, critical self-reflection, they exhibited a desire to be rid of their sin by quickly committing to religious practices to modify their behaviour (Morjaria-Keval, 2006). This directly contrasts the TTM, wherein the first stages, pre-contemplation and contemplation, there is a time period where an individual intends to change but does not

necessarily commit yet (Prochaska & Velicer, 1997). Thus, the rapid behavioural change experienced by the Sikh participants makes the catalyst stage of this model more accurate than the TTM. Next, the second stage in this model is *commitment*, which involves both religious adherence and undergoing purification (Morjaria-Keval, 2006). In this stage, individuals were able to find peace through prayer and spiritual meditation, which proved as strategies that reduced their desire for alcohol (Morjaria-Keval, 2006). Finally, the *change* stage of the model is the maintenance of the behaviour change (Morjaria-Keval, 2006). Through the strategies adopted in the commitment stage that maintain religious adherence, individuals could preserve their behavioural changes and abstain from alcohol consumption (Morjaria-Keval, 2006). An overlying theme within this model is the value of social influence, where cultural, spiritual, and religious meanings are reinforced through the surrounding environment. Some of the strategies adopted include involvement in the Sikh place of worship, the Gurdwara, as well as engagement in prayer, meditation, and selfless service (Morjaria-Keval, 2006). Overall, this framework is effective to apply to a culturally integrative model because it demonstrates how a Sikh experiences fundamental change to their worldviews through reaffirmation and commitment to their faith, rather than just modifying their alcohol-drinking behaviour.

Overcoming Labelling Barriers: Moh

Next, to overcome the labelling barrier within substance abuse treatments, Sikhs should be able to understand their alcohol problems in a way that does not induce stigma, fear, or shame. Because alcohol is referred to in the SGGS as a sin, a philosophical underpinning that reflects its sinful nature is *moh*, which translates to unhealthy attachment (Sandhu, 2009). Moh is one of the 5 vices within Sikhi, which describes how attachment to material goods contributes to an egoism that deters one away from living a spiritually and physically healthy lifestyle (Sandhu,

2009). Thus, instead of labelling a Sikh individual's drinking problems as a disorder such as AUD, a culturally integrative treatment program could label it as an imbalance to wellness through feeding into moh.

Finding Purpose through Community Work: Seva

In the immigration experience, movement to an individualist culture operates as one of the major systemic factors contributing to Sikh immigrants seeking alcohol as a coping mechanism because of community loss. Thus, within a culturally integrative model, it would be beneficial to support Sikhs by offering strategies that support community participation and integration into the community. Within Sikh philosophy, there exists 3 pillars of how to be a good practicing Sikh (Singh, 2008). One of these pillars is *Kirat Karni,* which translates to earning an honest living (Singh, 2008). Within this pillar, Sikhs are asked to carry out good deeds and earn livelihoods that are pure and truthful (Singh, 2008). To practice Kirat Karni, Sikhs can engage in *seva*, which is known as selfless service (Sohi et al., 2018). Individuals engaged in seva are said to receive spiritual fulfilment through volunteer work that serves others (Sohi et al., 2018). Seva can take place both at the Gurdwara, through engaging in tasks such as cleaning and serving food, and outside through community-based work and humanitarian aid, including volunteering at food banks, community centres, and hospitals (Sohi et al., 2018). Seva, often occurring in groups, offers the means to participate in a collectivist culture, which involves working in groups and being attentive to the needs of a community. Sohi et al. (2018) state that seva improves social well-being and increases a sense of community, which increases spiritual fulfilment. This spiritual fulfilment has been found to serve as a protective factor against alcohol use (Waisberg & Porter, 1994). Ultimately, through seva, individuals gain spiritual benefits that

provide a sense of community integration, which can buffer against the acculturative stress when living in a Western country that is more individualistic in nature.

Adopting a Settings-Based Approach: The Gurdwara

Because seva can take place in the Gurdwara, this involves considering the use of a settings-based approach in a culturally integrative treatment program. The settings-based design has been discussed by Kumar & Preetha (2012), which involves integrating health promotion within the social activities where people most often engage, including where they live and work. A settings-based approach can address the behaviours, practices, and cultural beliefs that make health determinants more community-specific (Kumar & Preetha, 2012). Thus, adopting interventions at the Gurdwara could facilitate an environment where individuals are invited to engage in seva and be surrounded by their community, which promotes a community-based approach and supports a collectivist culture.

However, within the literature, there exist some opposing views surrounding the efficacy of utilizing the Gurdwara. For instance, Sandhu (2022) conducted semi-structured interviews with Punjabi-Sikh healthcare professionals working across various healthcare sectors to understand their perceptions of a culturally integrative model for alcohol problems in the Sikh community. Each professional was asked about the use of the Gurdwara as an intervention space, and most stated that they believed that this would be ineffective due to potential judgement that other Sikhs at the Gurdwara may exhibit towards those who were suffering (Sandhu, 2022). While stigma is an important consideration when encouraging the use of the Gurdwara as a healing space, there are some limitations to this study. Firstly, not all these professionals had experience working with patients who had dealt with alcohol-related health problems (Sandhu, 2022). Secondly, Sandhu (2022) justifies interviewing Punjabi-Sikh healthcare professionals as

they could provide the best information. However, the meaning of "best information" is questionable because it affirms that the Gurdwara would be an ineffective source of support without considering the lived experience of Sikhs who have dealt with drinking problems.

Contrarily, the view of the Gurdwara being effective in adopting a settings-based approach has been supported by capturing the lived experiences of Sikhs who faced drinking problems, which Morjaria & Orford (2002) found in their qualitative study. In this study, they used semi-structured interviews to evaluate the experiences of South Asian men recovering from alcohol problems (Morjaria & Orford, 2002). For instance, one Punjabi-Sikh participant in this study said, "There was a void in my life which was filled up with drink, going to the temple fills that void" (Morjaria & Orford, 2002, p. 244). This participant describes how being able to reaffirm their faith within the physical space of the Gurdwara served as a way of eliminating this void. Furthermore, this void can be understood as the isolation and lack of community integration that many Sikh individuals experience. Thus, the Gurdwara, both through being involved in seva and being involved with other community members enables one to operate in a space where they can commit to their faith through societal influences, enabling them to engage in behaviour modification (Morjaria-Keval, 2006). Moreover, at the Gurdwara, one is not allowed to show up intoxicated or drink alcohol on the premises (Gill, 2015). As a result, encouraging increased involvement at the Gurdwara could produce a lifestyle that is incompatible with drinking alcohol.

Replacing Alcohol as a Coping Mechanism: Meditation

Finally, meditation, an important spiritual element of Sikhi, could be encouraged as a strategy within a culturally integrative model. Another one of the 3 pillars in Sikhi is *Naam Japo*, which translates to meditation on God's name (Singh, 2008). Previous research has examined the

efficacy of meditation and prayer within alcohol recovery programs, and generally, it has been regarded as useful in reducing symptoms of depression, anxiety, and increasing wellness (Witkiewitz et al., 2016). For instance, a study on Sikh participants in the recovery stage of their alcohol problems found that many participants stated having peace of mind from incorporating meditation into their daily practices, which lessened their need to resort to alcohol (Sandhu, 2009). Generally, in the immigration experience, many Sikhs who face psychosocial stress lack an effective coping mechanism, leading them to use alcohol (Sandhu, 2009). Thus, by encouraging the use of spiritual meditation for everyday practice, a culturally integrative model can help individuals use meditation as a healthier replacement coping mechanism.

Conclusion

While the archetypal example of health promotion is reducing excessive alcohol use due to its negative health impacts, health promotion has yet to completely become anti-racist and understand how structural determinants of health can impact people's ability to make this behavioural change. For many racialized and immigrant communities, including the Sikh community, the structural barriers in society create inaccessibility to health promotion interventions for alcohol problems. For Sikh immigrants, this is tied to acculturative stress in which individuals experience work stress and a shift in cultural systems. Furthermore, understanding the limitations of existing alcohol treatment models, including labelling barriers and stigma, necessitates the use of a culturally integrative approach. For Sikhs, an effective health promotion model for alcohol interventions includes the incorporation of many spiritual elements that accurately reflect the cultural and spiritual views of mental illness, community networks, and finding peace. Overall, an effective health promotion model is one that is culturally safe. When individuals can utilize a strengths-based approach that draws on their

community, identity, and culture, they can find strength within themselves to take control over their health. This increased control starts from within, where the oppressed and marginalized must reclaim poor health outcomes by working themselves into these health-oriented spaces and drawing on cultural strength to create better health outcomes for themselves.

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