BRIEF COMMUNICATION

Alcohol Harm in Malaysia: Always the Right Time to Discuss

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Introduction: Alcohol is a major risk factor for various non-communicable diseases (NCDs) such as cardiovascular related illnesses, liver cirrhosis and cancer. Despite the dangers of alcohol use, there is limited local research available to assist policy and advocacy. This commentary attempts to highlight what is presently available and suggestions to move forward in this field of research and services provision. Methods: A brief report of recent updates is provided for this article. Results and Conclusion: A number of recommendations are provided to assist in deliberating discussions to shape future policies which will improve current available practice and clinical service in the field of alcohol addiction.

Keywords: Alcohol Dependence, Addiction, Prevention

Alcohol is a major risk factor for various non-communicable diseases (NCDs) such as cardiovascular related illnesses, liver cirrhosis and cancer[1]. Alcohol harm is widely seen amongst those who drink heavily over a period of time. Nevertheless, increase use over short periods such as binge drinking can also lead to medical complications such as acute intoxications, veisalgia, headaches, memory loss and blackouts. Acute heavy alcohol use also has serious social repercussions such as motor vehicle accidents, physical fights, domestic violence, sexual assaults and also high-risk behaviours such as unprotected sexual intercourse[1]. The United Nations (UN) in 2011 passed a resolution to tackle risk factors for NCDs which include alcohol use through preventive measures[2]. The resolution was meant to be given priority by all member countries and was only the second time a health issue was discussed. The first was the resolution on HIV/AIDS in 2000. At present 63% of the world populations' death is the outcome of NCDs and this number is expected to only rise further if no action is taken immediately[3]. Malaysia is a member of the UN since independence in 1957.

According to World Health Organization (WHO), Malaysia per capita alcohol consumption rises from 0.8 litres of pure alcohol in the years 2003-2005 to 1.3 litres of pure alcohol in the years 2008-2010[1]. In the latest National Morbidity Health Survey (NMHS) 2011[4], it was reported that 11.6% of those above 13 years old were found to be current alcohol users. Alcohol use was discovered to be highest in those living in

urban areas, amongst Chinese, between ages 20-24 years and surprisingly in those with higher level of income. This was different from other studies which often reported alcohol use to be in those from disadvantaged communities with lower levels of income[5]. A major worry however, was binge drinking where 5.7% of those who did drink alcohol drank in this manner[4]. The binge drinkers studied tended to be older (30-34 years) and were Malays. In Malaysia, Malays are defined to be Muslims[6] and therefore prohibited by law to purchase and consume alcohol of any type. Alcohol dependence on the other hand was found to be small (1.2%)[4]. Apart from the NMHS, there is very limited information on alcohol use in Malaysia from a health perspective and even lesser in non-health areas such as cost to properties, accidents and other areas of interest[7]. In spite of these findings, clinical observation often note that Indians are found to be over-represented in terms of medical stabilization and treatment for alcohol complications such as delirium tremens and withdrawal seizure in both the emergency rooms and also clinics. Maniam, 1994[8] however, did not find this in his study but did concur that a more robust community survey was warranted. Therefore, more studies are needed to investigate current rates to ensure the information captured is accurate.

As a result of the low prevalence of alcohol-related disorders in the national statistics coupled with small numbers of local alcohol prevalence studies, there has been limited regulation towards the alcohol industry[7]. The alcohol industry is still able to advertise in both printed and visual media and host events to promote alcohol use. Although meant strictly for the non-Muslim minority, alcohol use unfortunately is not only confined to the 35% of the population as initially presumed. For the native people in Sabah and Sarawak, a previous study found prevalence of use of the latter to be higher and alcohol dependence was reported to be as high as 30%[9].

In light of the presently available information and the apparent lack of interest in alcohol harm in Malaysia, the authors are compelled to start this discussion. The platform within Malaysian psychiatry was taken as psychiatry is the major discipline involved with the care of those with substance related disorders and mental illnesses including alcohol dependence. The evidence is slowly pointing towards a possible national crisis especially in Sabah and Sarawak which has the highest numbers of alcohol users. Malaysia is also unique in that alcohol use is not confined to industry produced alcohol but also local brew known as ‘tuak’ in Sarawak and ‘lihing’ in Sabah, both of which have alcohol levels which are still not well studied[9]. Clinical experience in dealing with alcohol-related disorders will show that patients who sought help, or were compelled to seek medical interventions for their alcohol problem consumed cheap liquor marketed with brands such as ‘Thai Song’, ‘Club 99’, ‘7 Seal’, ‘Orang Tua’ and several others. These cheap alcoholic beverages can have alcohol contents up to 40%. These beverages were often cheaper and consumed when unable to afford branded beverages.

Similar to the fight against tobacco use in Malaysia, a similar strategy is needed for alcohol misuse and harm[10]. There must be a plan to increase preventive efforts through restricted sales to non-minors, increase in alcohol taxations and limited sales in specific establishments. There is an opportunity to prevent mistakes made in countries such as New Zealand which allowed alcohol to be sold in supermarkets as a food item when it is known that alcohol

in its pure form is a poison and a substance of abuse[11]. However, tighter regulation in the sales of alcohol alone may promote the consumption of locally brewed alcoholic beverages and the smuggling of untaxed alcoholic beverages. Therefore, more stringent enforcement is needed as well. Promotional activities also need to be regulated to stop the indirect and direct advertising to minors. One study had reported that 45% of Malaysian youth had consumed alcohol[12]. The NMHS methodologically recorded alcohol use amongst those 13 years and above in its survey and therefore there was a possibility that some respondents were underage during the reporting.

Unlike the mistakes made in tobacco control in Malaysia, treatments for current problem alcohol users should start early through locally available services. All clinicians in these services also need to be trained and proficient with the knowledge and experience in dealing with alcohol dependents. It is preferable if more primary care practitioners, especially those in government health clinics, apply the interventions suggested in the guideline to manage alcohol problems at primary care level published by the Ministry of Health[13]. The guideline uses Alcohol Use Disorders Identification Test (AUDIT) as a screening tool to detect problematic alcohol drinkers and its intervention is based on Brief Intervention (BI) from the WHO. Severe cases, however, need to be referred to centres with specialist care, especially centres with addiction specialist. Ideally management of problematic alcohol drinkers at the referral centres should not only be confined to the department of psychiatry and mental health, but include other medical specialities to work in a more multidisciplinary approach. To achieve optimal multidisciplinary inputs during medical stabilization, these drinkers need to be treated in a specific multidisciplinary ward for patients with addiction and substance disorders. Medical schools in Malaysia can also assist by ensuring all graduates have minimum competency in alcohol treatment provisions as a requirement to graduate as medical doctors. At present, the authors are not aware of this requirement in the 34 available local medical schools.

In order for these efforts to work, there needs to be national involvement under the purview of the Ministry of Health Malaysia working in collaboration with both national and state level stakeholders such as the Ministry of Education and non-governmental agencies. These stakeholders are needed to increase both research and advocacy in alcohol use. The national policy already available should be made known to all relevant stakeholders to ensure smooth implementation of local policies in the country[1].

Lastly, it is imperative that discussion on alcohol use is limited to alcohol misuse so as to not stigmatise alcohol users who drink within the recommended limits. Nevertheless this discussion needs to start immediately before alcohol misuse increases further as Malaysia urbanizes and moves towards a high-income nation. As our local studies have found, an increase in income is associated with increasing harm in the context of alcohol and therefore every effort must to be made to ensure that Malaysians are protected and assisted should the need arises.

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