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Participatory Governmentality:
Social Network Transitions in Malaysia's Mental Healthcare

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Abstract

With the growing use of networking communication technologies and social media networks in Malaysian and Asian Pacific societies, prospects for public health governance and health communications have been shifting. Based on Manuel Castells' conceptual framework of the 'network society', this dissertation conducts a structural analysis of Malaysia's mental health governance. This research serves as a case study to respond to a broader objective to understand the evolution of national governmental practices and rationality in a transitioning Malaysian society. These (1) micro and (2) macro objectives form the primary research framework for the dissertation. Nine mental health initiatives by governmental, entrepreneurial, and civil societal leaderships in contemporary Malaysian society have been purposively sampled for a qualitative content analysis. These nine sets of data mainly come from organisational websites, official institutional documents, social networking platforms, and public media commentaries. Having studied the participatory network transitions, affordances, and practices in Malaysia's new mental healthcare landscape, this dissertation critically discusses the emerging issues and challenges in this domain of societal governance, and proposes a new conceptual model of 'participatory governmentality' for emergent network societies. Here, the findings reveal that, in response to the gradual decline in the hegemony of traditional institutions, emergent affordances in Malaysia's network society are being harnessed for (1) rebuilding a trusted, transparent system of collaborative governance, and (2) fostering participatory networks and public diplomacy for improving the quality of life (QOL) of the nation's citizenries. Hence, it is suggested that ordinary citizens, societal and governmental leaderships, and researchers further investigate into how mobile communications can provide the means for improving or reforming self-care routines, for transparent participation of citizenries in governmental decision-making processes, and for building cross-sectoral solutions and public diplomatic practices in Malaysia.

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List of Abbreviations

Abbreviations	Meaning
ASEAN	Association of Southeast Asian Nations
IUS	Internet Users Survey
MCMC	Malaysian Communications and Multimedia Commission
MENTARI	Pusat Kesihatan Mental Masyarakat / Community Mental Health Centre
mHealth	mobile health
MOH	Ministry of Health
MPSS	Majlis Pembangunan Sosial Sarawak
NGO	non-governmental organisation
NHMS	National Health and Morbidity Survey
NIH	National Institutes of Health
NSRM	National Suicide Registry Malaysia
QOL	quality of life
WHO	World Health Organization

CHAPTER ONE

Introduction

Mental Healthcare in Network Societies

Broadly speaking, in contemporary Southeast Asia, citizens have been taking the initiative to intervene in the major processes of societal governance.¹ Participatory citizenries are not only a historically significant challenge to traditional governmental institutions. They are also a particularly difficult phenomenon for scholarly analyses, fundamentally because of their constantly evolving and fluctuating characteristics.

In the particular governmental domain of mental healthcare, scholars in Southeast Asian and Asian Pacific health communications in the information age continue to struggle, if at all, to systematically account for the large-scale and multidirectional rise of participatory health practices. Today, focus continues to be placed upon the integration and subsuming of emergent networking technologies under traditional statist mechanisms of healthcare. Moreover, studies into the structures and practices of Malaysia's mental healthcare domain still have not produced a comprehensive breakdown of the changing landscape of mental healthcare in Malaysia's emergent network society, in light of the gradually weakening symbolic dominance of the national institutions of health and the increasing decentralisation of political power in the country.

According to the statistics published in the most recent Internet Users Survey (IUS) by the Malaysian Communications and Multimedia Commission (MCMC) (2020), Malaysia has been edging towards the direction of a society of digital communication networks. An 88.7% of Malaysians are Internet users; 98.7% of these

¹ See Joanne Lim's (2021a; 2021b) new analyses of more than 750 survey responses from Malaysia, Indonesia, Thailand, the Philippines, and Vietnam, about the relationships between the state and society, and the respondents' perspectives on the systems of governance from these Southeast Asian settings.

Malaysians access the Internet easily through their smartphones. As digital media literacy continues to improve in the country, 72.4% of Malaysian Internet users understand the content, and 63% of them ensure the validity of the content, before dissemination in the communication networks. Moreover, the top five activities conducted online among Malaysians are: (1) text communications; (2) social media consumption; (3) video consumption; (4) voice/video communications; and (5) information search. The implications of these emerging trends in Internet usage and new communicative practices on Malaysia's mental healthcare and societal governance mechanisms deserve a comprehensive series of structural analyses.

Indeed, the emergence of new communication technologies and the changing landscape of communicative practices among the Malaysian publics constitute this dissertation's primary point of departure. In an increasingly networked/networking Malaysian society, it is reasonable to propose that mental healthcare and societal governance practices have evolved beyond the sole responsibility of traditional (bio)political authorities. To be more precise, it is hypothesised that mental health and public health could no longer be unilaterally subsumed under a statist hierarchy that proceeds from the sovereign nation-state, to national legislation, to governmental ministries, to national health institutions, and finally, to the healthcare practitioners.

A number of examples can serve to illustrate the increasingly disruptive and decentralised societal order in contemporary Malaysia. In the political domain, it has become an understatement to assert that traditional political institutions have been unable to neglect the structural influences of social movements, public participation, and "networked publics" in the information age (e.g. Weiss 2012; Abidin 2021). In Malaysia's mental healthcare, social media platforms, such as Facebook and Instagram, have been providing new protocols for the expression and development of ordinary citizens and students' voices and perspectives in mental health (e.g. reachout.to.you 2021; greenribbongroup.my 2021; beh.indthemask 2021). Students and prosumers in Malaysia, who may not have the professional license for medical and/or pedagogical practices (yet), can exercise their interventional agency in health communications on their personal or group networks through referencing and/or collaborating with the works of relevant experts. Additionally, the use of mobile networking tools, such as instant messaging applications, has opened up the option for the technical interactions

and communications between healthcare practitioners and patients to be conducted from different geographical locations, and with respect to personal preferences in treatment methods, pace, and schedules. These examples and possibilities amount to a transitional phenomenon that requires thorough investigation.

Overall, in the ongoing search for the structural determinants of and solutions for mental ill-health, mental illnesses, and suicide in Malaysia, public networks seem to be challenging statist institutions in formulating and addressing the emergent problematics. A systematic explanation of this new structural impasse in power relationships in the intertwined domain of mental healthcare and societal governance is the main concern of this study. For a one-year period, a modest approach to such an endeavour is to analyse and compare the recent initiatives and organisational practices of political, economic, and civil societal communities in the increasingly important domain of mental healthcare. Furthermore, because the disrupted relations of power and spatial-temporal order in the organisational practices of mental healthcare are attributed to the widespread public adoption of networking communication technologies, this comparative study will trace the various communication platforms of these selected initiatives: for instance, social media, institutional documents, official websites, and mobile applications.

This conceptual framework to be adopted for this structural investigation stems from Manuel Castells' long-term sociological analyses of global network societies, since the 1990s, until the present. Key references are *Communication Power* (Castells 2013) and *The Rise of the Network Society* (Castells 2010a). More particularly, Castells' analytic categories of (1) statist structuration and network restructuration, (2) public diplomacy and collaborative governance, and (3) the spatial-temporal implications of digital communication networks will be central to this series of analyses. This dissertation will undertake the task of incorporating and comparing Castells' perspective on network societies when investigating the processual structure(s) of Malaysia's mental healthcare practices. Moreover, this Castellsian perspective on mental healthcare in Malaysia's emergent network society will directly contribute to understanding and assessing the ongoing development and evolution of governmental rationality and governmental (re-)forms in the country.

Research Questions

This study asks the following two research questions about mental healthcare and public governance in contemporary Malaysia.

First. In Malaysia's network societal transitions, how do local biopolitical leaderships govern, organise, or approach mental healthcare and public health? The operational definition of 'local biopolitical leaderships' for this study is 'governmental, entrepreneurial, and civil societal initiatives for mental health'. Accordingly, the sampling strategy will primarily cater for this operational definition. The nine (9) initiatives to be gathered and analysed indeed originate from governmental, business, and civil societal organisations in contemporary Malaysian society.

Second. In an emergent societal structure, how do new organisational approaches to Malaysia's mental healthcare and public policymaking provide a systemic challenge to Michel Foucault's (1978; 2003: 239-264; 2008) two classical categories of 'statist biopolitics' and 'liberal governmentality'? Here, Foucault's two problematics will serve as a historical foundation on which the dissertation explores, understands, and assesses the most recent development or evolution of the practices in Malaysia's mental health communications and governmental rationality. More precisely, Foucault's analyses of Western European psychiatric institutions under the post-Enlightenment liberal nation-state will become a canonical standard, against which the Malaysian mental health system, its liberal statist constitution by the British colonial administration, and its recent social network transitions, are systematically compared and contrasted.

It is planned and envisioned that, after addressing these two research questions, this dissertation will be able to become a knowledge basis for future diplomatic practices in healthcare and governmental policymaking, and for long-term research on public healthcare practices and participatory governance in emergent network societies.

Arguments and Chapters

This dissertation asserts these following three central arguments. First, Malaysia's mental healthcare is experiencing (1) a series of social network transitions and (2) the temporary co-existence of statist and networking practices. Second, the liberal governmentality that centres upon hierarchies, institutions, and legislative structures for the management of production in society no longer holds in Malaysia today, due to two fundamental reasons. First, the nation-state's symbolic rule has been increasingly challenged by alternative visions. Second, the traditional desire for (market / individual / civic) 'freedom' is being challenged by the growing focus on society's Quality of Life (QOL) in the path towards global regeneration, public diplomacy, and a sustainable world order (cf. Castells 2008; Lim 2021b). Third, as a Castellsian contribution to the research on new societal governance in Southeast Asia (cf. Lim 2021a, 2021b), this dissertation proposes that the governmental rationality of contemporary Malaysia has been and continues to be caught in the historical-structural impasse between (1) statist hierarchies and (2) participatory networks.

The analyses are organised in the following manner. Sub-chapter 1.1. is the literature review. Here, the nascent interdisciplinary research background from which this study emerges is explained. Subsequently, in sub-chapter 1.2., a complete overview of the research design, comprising (1) the conceptual framework, (2) the sampling strategy, and (3) and the coding frame for the qualitative content analysis, is provided. Chapter Two breaks down the liberal statist form of mental healthcare that has been the inherited and dominant form since the late Malayan colonial period (circa, second half of the nineteenth century): from institutional hierarchies, to instrumental subjects. Chapter Three traces the emergence of the 'participatory network' form in contemporary Malaysia's mental healthcare, situated within the rise of the network society: from personalised mental health communications, to diplomatic solutions and other participatory affordances. Chapter Four follows from Chapter Three to propose a series of five emergent participatory practices in Malaysia's mental healthcare: mobile information access; mobile patient-practitioner communications; transnational approaches of mHealth businesses; health publics and voice equality; and stakeholders' networks for public health.

Having studied the social network transitions in Malaysian mental healthcare, Chapter Five (1) properly responds to the two research questions, (2) discusses the

emerging issues and challenges in contemporary public healthcare and governance, and (3) proposes a new conceptual model of ‘participatory governmentality’ for emergent network societies. Here, in response to the decline in the necessity of liberal governmentality, it is suggested that there are emergent affordances in Malaysia’s network society for (1) rebuilding a trusted, transparent system of collaborative governance, and (2) fostering participatory networks for improving the QOL of the nation’s citizenries. Finally, a number of suggestions for more thorough investigations are offered to three different groups of readers (namely, individuals; societal and governmental leaderships; and researchers) in the concluding chapter.

1.1. LITERATURE REVIEW

This sub-chapter provides a review of key communications research on health and societal governance. There are three sections in this literature review. The first section provides the background to the research on the changing landscapes of health practices and societal governance in the Asia Pacific, Southeast Asia, and Malaysia. The second section highlights and challenges how communications researchers have thus far only studied the role of new communication technologies in providing affordances for traditional health systems and communications. It will be suggested here that, following Castells’ framework of the network society, researchers could study how the intervention of new communication technologies in the governance of health and society has more fundamentally allowed for the design of more ‘diplomatic’ approaches to societal governance, involving country-level and multi-sectoral stakeholders and even citizenries in making national decisions together. Accordingly, the third section proposes a new pathway for research on the emergent processes in contemporary Malaysia’s health and societal governance.

Popularised Biopolitical Practices and the Ongoing Development of Health Prosumers in Asian Network Societies

A communications approach to analysing and evaluating the structural and processual dimensions of national health systems and health governance has been receiving growing attention in the past two decades (cf. World Health Organization 2005; Katz, Rice, and Acord 2005; Dutta and Elers 2020). Broadly speaking, key areas of concerns in this research area include health communications, national health systems and governance, public health policymaking, and with increasing relevance in the contemporary global context, public participation for public health. One of the increasingly common argument in this vast literature contends that health should no longer be viewed as the theoretical and policymaking concerns of health experts, national institutions of health and knowledge, and the nation-state. One of the most ‘authoritative’ sources who have reinforced this argument of democratisation is the World Health Organization (WHO) (2005: 32) in its *Promoting Mental Health*: “work with an array of public and private sectors, not just the health sector.” Presumably, institutions of health and governance in various democratic contexts would have been facing new challenges following the disintegration of traditional, top-down, and one-to-many ‘mass’ communication processes (Bennett and Livingston 2020: 25-27).

In the Asia Pacific, the seminal anthology that Liew (2016) has edited—*Liberalizing, Feminizing, and Popularizing Health Communications in Asia*—provides strong ground for subsequent research into health governance and communications in non-Western and Southeast Asian contexts. In this collection, key case studies have pointed out how, in a number of Asian nations, peoples are actively negotiating with what Foucault has classically categorised as ‘biopolitics’.

To recapitulate, biopolitics refers to a large-scale political activity of modern societies concerned with the surveillance, objectification, management, optimisation, and utility of the biological processes of populations. This political activity aims to regulate and sustain the biological, mental, behavioural, sexual, and reproductive health processes of a social system (cf. Foucault 1978: 136-141; 2003: 239-264). In line, I agree that taking Foucault’s pioneering analyses of ‘biopolitics’ as the canonical reference can help place ongoing research into concrete historical and ‘transitional’ perspectives. In fact, Liew’s (2016: 2-3) anthology actually questions Foucault’s (1988 [1961]) early analyses of the “medicalization” of modern European societies. More than that, it effectively demonstrates how contemporary Asian scholars have been

overcoming the inherited “Eurocentric paradigm” in researching health communications (Liew 2016: 2-3).

In this fresh perspective, important publications on the Chinese, Indonesian, Singaporean, and Malaysian health governance landscapes have emerged (e.g. Ferzacca 2016; Lim and Gan 2016; Farquhar 2016; Dutta and Elers 2020). These publications provide timely insights into how the changes and/or evolution of societal structures have engendered changes and evolution in health systems and health practices, from the individual level to the societal level, within Asian (network) societies. Of particular relevance is the work of Lim and Gan (2016: 115-127) on the gradually shifting decision-making processes among Malaysian women fighting against breast cancer. This study sheds light on the emergent dilemmas among (older generation) Malaysians (39-73 years old, as defined by Lim and Gan) in adapting to the use of new media and Internet-enabled information systems for becoming ‘informed patients’ and for making independent health decisions. It also reveals the different types of relationship between Malaysians and their health experts beyond simple reliance. This study is an insightful role model for communications research into the evolving health landscape in Malaysian society.

Since Malaysians are gradually becoming active prosumers of health information and are no longer passive receivers of ‘education’, advice, and treatment, their proactive health behaviours are already challenging Foucault’s classical proposition of a disciplinarian society’s expert-led biopolitical practices. Specifically, the new challenge that the category of Malaysian prosumers may pose for this study is the rise of a vast variety of new and unfamiliar methods and tools for work in nationwide health communications and governance. Because prosumers consume, disseminate, and produce health information and contents based on their own preferences and objectives, the relatively ‘familiar’ route of healthcare—from the doctor to the patient, from the state to the population—has been disturbed/disrupted by the polymorphous activities and relations among mobile health prosumers in Malaysia. Thus, the proliferation of networking communication technologies and the growing independence of active prosumers suggests the need for large-scale re-evaluation of the authorities and processes of health and societal governance. Here, the main question pertains to the particular ways in which networking communication technologies are providing

affordances for a new approach to public engagement and diplomacy for addressing nationwide health and societal challenges. In transitional terms, the state's biopolitical management of the population, and the usually unidirectional power of the medical expert over his/her patients at least in the domain of public health communications, might experience important qualitative changes.

Affordances of Communication Networks for Redesigning Public Health Governance and Nationwide Health Diplomacy

In the beginning of the century, the influence of a range of mobile communication technologies has caught the attention of scholars studying comparative health systems. The organisational influence of mobile phones, the Internet, and self-service health kiosks in different national health systems has led to important early publications, such as the work of Katz, Rice, and Acord (2005: 183-214).

Although they have not accounted for the influence of even more innovative mobile devices (e.g. smartphones, smart bands) and networking platforms (e.g. social media) in today's global network societies, a lesson from Katz, Rice, and Acord (2005: 186) continues to be highly influential for this research domain: namely, what they have called the 'Syntopian' perspective on the integration of emergent technologies in national health systems. Rejecting dystopian and utopian perspectives, the Syntopian approach traces "how people, groups, organizations, and societies adopt, use, and reinvent [...] technologies to make meanings for themselves in relation to others" (*Ibid.*). This means that, instead of being (1) overly dismissive, (2) overly reactionary and critical, and (3) overly celebratory towards new communication technologies in health, a Syntopian analysis of the new formal and technological features in this domain would allocate greater attention to how they are harnessed for new healthcare solutions in specific national and societal contexts. This Syntopian perspective, in fact, has implicitly guided a large number of research publications on the integration of mobile technologies into health systems globally and in Southeast Asia (e.g. World Health Organization 2019b, 2020, 2021; La Sala *et. al.* 2021; Ganasegeran, Renganathan, Rashid, and Al-Dubai 2017; Rahim *et. al.* 2019; Ayub *et. al.* 2017; Kemp *et. al.* 2020).

Here, I would challenge that the long-adopted Syntopian perspective has only managed to reiterate the idea that networking communication technologies are tools that, if used well, can provide helpful affordances for upgrading health systems. I would suggest that the Syntopian perspective on new technologies should be complemented with, if not replaced by, Manuel Castells' (2008; 2011; 2013: 19-38) framework of new societal 'forms' for the structural analyses of Malaysia's mental health governance (to be further discussed in the following sub-chapter on Research Design).

The Castellsian perspective would recommend that researchers do not view networking communication technologies as merely 'tools' to be subsumed under health systems or societal contexts. Intrinsic to these networking technologies, there is actually a new 'organisational form' for the fundamental re-designing of health governance and communications: namely, shifting away from central governmental institutions, and moving towards public governmental networks. Instead of looking at communication networks and networking communication technologies as optional tools to be adopted or relinquished in differing settings, the new form and practice of 'networking' will have to become the core concern in the structural analyses of health governance.

Indeed, if networking communication technologies are merely viewed as tools, one may easily overlook that these technologies (e.g. mobile devices, instant messaging applications, social media platforms) have provided the means for disrupting Southeast Asian landscapes of health communications and societal governance. In the age of digital communication networks, or in fact, in *network societies*, mental health governance should not be studied as detachable from the (new) forms and processes of societal governance where it resides. For example, while it remains highly important to document the various improvements in traditional health systems through the use of new communication technologies (Ganasegeran, Renganathan, Rashid, and Al-Dubai 2017; Rahim *et. al.* 2019; Ayub *et. al.* 2017; Tursunbayeva *et. al.* 2017), La Sala *et. al.*'s (2021) study from Australia demonstrates the transformative role of Instagram in building participatory forms of public engagement for suicide prevention and mental healthcare. In fact, a passage by La Sala *et. al.* (2021: 16) can help underscore a changing societal structure beneath contemporary health governance: "Whilst the Australian government, at both state and federal level, is attempting to address [the reluctance among young people at risk of suicide to seek professional help] by

providing additional resources for mental health services, there is still an urgent need for community-based interventions that can reach large numbers of young people quickly and provide them with much-needed skills and information.”

Comparing the above two examples, *the delicate and important difference* lies in whether one recognises and demonstrates the conceptual argument that the use of networking technologies and communication networks bears the potential to engender a corresponding change in the organisational form and processes of health and societal governance. Without this Castellsian framework, it would be difficult to capture how networking communication technologies are actually providing the structural affordances for organisational transitions in societal governmental processes.

Particularly, in a ‘networking Malaysia’, stakeholders’ perspectives on national challenges continue to grow in presence and importance. In terms of mental healthcare and suicide prevention, advocacy groups and civil societal actors have been active in contributing their recommendations and perspectives to country-level decision-making processes on social networking platforms (e.g. Majlis Pembangunan Sosial Sarawak 2021). In terms of societal governance, there is, in October 2021, a new online survey², disseminated by the MCMC to citizens and stakeholders to gather perspectives and ideas on the potential implementation of a national mobile application (‘MyDIGITAL’) towards achieving mobile government (mGovernment), including in the area of healthcare services. In order to help ordinary citizens to make sense of, and actively seize the opportunities to participate in, these initiatives for the (co-)governance of society, this study aims to produce (and become) a useful knowledge basis.

Reorganisation for Structural Analyses in Malaysia

In the information age, health and governance are facing the gradual divergence between (1) traditional governmental practices and (2) participatory and networking practices. It is from this emergent context of health and governance, especially locally, that this study stems. In recognition of recent publications on networked and ‘below-

² This national study is titled ‘Survey on the Proposed Concept of National Mobile Application 2021’ (MCMC 2021).

the-radar' political participation in contemporary Malaysian and Southeast Asian societies (cf. Lim 2017, 2021a, 2021b; Abidin 2021), it is proposed that macro-level structural analyses can be conducted on public mental health diplomacy and collaborative practices in Malaysia's transitioning contexts. Accordingly, to categorise and understand the current issues and challenges in the decentralisation processes as well as participatory and social network transitions in Malaysia's contemporary mental health governance is the primary task of this study.

Here, it is the aim of this dissertation to systematically explain the profound relationship between (1) the structural implications of new communication technologies and (2) the changes and evolution in the structures of biopolitical practices, diplomatic governance, and network societies. An investigation into the new landscape of mental health (co-)governance in a structurally transitioning Malaysian society will require a thorough clarification about how a range of new communication technologies have been impacting on the practices of mental healthcare and societal governance.

Particularly, this study focusses on how Malaysia's multi-sectoral leaderships in the form of national government stakeholders, business communities, and civil societal actors have been adapting to and capitalising on the transitioning landscape of mental healthcare in the epoch of digital communication networks. Towards the end of the dissertation, this study aims to be able to point Malaysia's policymakers, researchers, and other stakeholders concerned by mental healthcare and societal governance towards a number of key structural issues and impasses in their transitioning society.

1.2. RESEARCH DESIGN

This sub-chapter aims to introduce (1) the conceptual framework and (2) sampling procedures of this dissertation. Accordingly, there are two sections to fulfil these tasks. The first section contains three subsections. Subsection 1.1. first provides the basic definitions of these three categories: biopolitics, governmentality, and societal governance. Subsection 1.2. situates these three defined categories within what Castells calls 'network societies' of the contemporary global context. Subsection 1.3., then, formally introduces the main conceptual framework of this dissertation: i.e. forms of

societal governance and their ongoing contestations. To put the conceptual framework in a condensed manner, it proposes that, *in the ongoing global transitions from traditional industrial societies into contemporary network societies, the historically dominant statist approach to societal governance (i.e. the use of institutions, centralised systems, hierarchies, and nation-states) has been fundamentally challenged and weakened by the emergence of participatory communication networks*. This conceptual framework of formal contestations in a network society will guide and inform the structural analysis of contemporary Malaysia's biopolitical practices and governmentality: i.e. mental health governance, initiatives, and communications. The second section introduces the nine (9) sampled initiatives for this study. This introduction includes the rationale, the relevance, as well as the limitation of sampling these nine sources. Moreover, how the use of these nine sets of data has obtained a formal ethical approval by the research ethics committee of the candidate's university will also be clarified.

Conceptual Framework

Societal governance, governmentality, and biopolitics

From the analytic perspective of Manuel Castells, this dissertation views mental healthcare' as a series of processes of organisation, production, and delivery within the broader developmental structure of a given society. Akin to other domains of human activity in society, processes of mental healthcare proceed within particular societal structures. In the simplest terms, the choice of a societal structure governs how material resources, human resources, labour processes, delivery of services, and organisational ideas are organised and developed within a particular sphere, domain, or industry of human activity. Accordingly, competition in the choice of such a societal structure within a particular domain immediately amounts to an instability in the societal governance of that domain. Therefore, even within the supposedly apolitical domain of mental healthcare, the broadest theme of 'societal governance', societal structures, and societal processes actually constitutes the most fundamental concern for the functioning and the future of this healthcare domain.

In Castells' sociological analysis of new societies, societal structures, and (urban) societal processes, the issue of societal governance has been predominant from the beginning. Moreover, it is a general agreement among Castellsian scholars that Castells has documented a major transition in the dominant form of (global) societal governance over the past five decades: from the hierarchical and centralised; to the diplomatic and decentralised (cf. Castells 2000, 2008, 2013: 47-53; Stalder 2006: 104-140). Nonetheless, one of the most overlooked aspects in Castells' analysis is the importance and influence of the classical works from the French philosophical historian, Michel Foucault, on the function of power in societal governance. From the start of the first volume of Castells' *Information Age* trilogy, titled *The Rise of the Network Society*, Castells (2010a: 13-21) has already foregrounded Foucault before his own communications-based conceptualisation of emergent network societies. Here, for instance, Castells (2010a: 15) argues: "Power is founded upon the state and its institutionalized monopoly of violence, although what Foucault labels the microphysics of power, embodied in institutions and organizations, diffuses throughout the entire society." In *Communication Power*, Castells (2013: 33-36), again building upon Foucault's foundational analyses, argues that "disciplinary" Enlightenment societies (i.e. liberalism, industrialism, developmentalism, biopolitics) have transitioned into global network societies (i.e. informationalism, public diplomacy, communication networks).

Under the theme of societal governance, this dissertation will first of all recognise that, Foucault's two classical categories of (1) biopolitics and (2) governmentality could not be overleaped by a Castellsian analysis of the processes of structuration and production of mental healthcare in contemporary Malaysia's network society. In concrete terms, the line of analyses in this dissertation is highly concerned with the different scales of the key structural concerns in contemporary mental healthcare. While there are concerns of a smaller scale such as individuals, schedules, and personal access to information, there are also gradually broader dimensions such as inter-personal relationships, hierarchies, and organisational structures. Therefore, societal governance, governmentality, and biopolitics will constitute the largest historical and societal categories, under which this Castellsian analysis of the micro-processes of mental healthcare proceeds.

Governmentality and biopolitics have their respective definitions and analytic concerns. To define and delineate these two terms will be the current task. Biopolitics is a large-scale political activity whose institutionalisation in post-Enlightenment Europe was first developed through European colonialism in other regions of the world (e.g. Southeast Asia; cf. Stoler 1995: 55-94; Foucault 2003: 239-264); colonial masters experimented with the biological management of populations in the colonies, and these new biopolitical techniques were carried back to the metropolises for domestic use. This political activity is concerned with how a full range of life processes of a population can be monitored, adjusted, and governed: e.g. biological development of every citizen, mental health, hygiene, family and disciplines, sex and reproduction, women's and children's sexuality, and demographics and mortality.

Governmentality is a general name for the act of rationalising governance within a given historical moment of a given society, meaning that there can be different types of governmentality—i.e. different forms of governmental rationalisation—in different societal contexts. Foucault's (2008: 51-73) analysis of post-Enlightenment European societies, for example, points to a 'liberal statist governmentality'. Proponents of this liberal governmentality were concerned with the question: how can freedom be enhanced with minimal governmental intervention? Here, emergent was an overarching social contract that promises and produces individual freedom, provided only that this be under the omnipresent and silent supervision of a sovereign state (cf. Lemke 2013: 35-52; Wallerstein 2013: 7-34; Jessen and von Eggers 2019: 53-72).

Overall, the definitions can be synthesised as follows: (1) *the “analytics of biopolitics” and critiques of biopolitical processes in a society are concerned with rethinking how to “live differently” as a societal collective* (Lemke 2010: 434); and (2) *the analytics of governmentality and critiques of governmentality are concerned with rethinking how to govern differently as a societal collective*. For this study, it is posited that biopolitical processes are directly influenced by governmental rational processes in a network society. The close and evolving relationship between biopolitical processes and governmental rationality, *between citizens' QOL and the making of national consensus*, in an emergent network society (i.e. Malaysia), forms the main research concern and guideline.

Accordingly, a hypothesis can be formulated in response to the research question of the dissertation. In line with new structural elements in an emergent network society, biopolitical processes and governmental rationalisation of this transitioning society will very likely also be structurally affected. In contemporary Asian societies, practical questions and solutions in public health governance, national legislation on health and suicide, health systems, and national and public health communications are the key areas where biopolitical and governance structures are reproduced, negotiated, and contested, arguably with increasing diversification and decentralisation of inputs, perspectives, and participation in the information age (cf. Liew 2010: 1-11). In the present case, the biopolitical processes and governmental frameworks in contemporary Malaysian society will be particularly exemplified by the organisational, production, and communication structure(s) of the local mental healthcare domain. Accordingly, the next subsection will elaborate upon the potential evolution of and structural modification in biopolitical activity and governmentality in an emergent network society.

Biopolitics and governmentality in Malaysia's network society

Before proceeding to the new challenges to and new configurations of biopolitics and governmentality within an emergent network society, the definition of this Castellsian category—i.e. ‘network society’—needs to be put into place. To be straightforward, this dissertation follows the construction given by Castells (2013: 4) in this crucial passage from the opening chapter of *Communication Power*:

“the network society, the social structure that characterizes society in the early twenty-first century, a social structure constructed around (but not determined by) digital networks of communication. I contend that the process of formation and exercise of power relationships is decisively transformed in the new organizational and technological context derived from the rise of global digital networks of communication as the fundamental symbol-processing system of our time.”

In the above passage, Castells first recognises a new social structure. Second, this new social structure relies on, and thus, is characterised by, digital communication networks. Third, and consequently, one can understand that a network society is a social structure,

whose internal power relationships and production processes fundamentally depend on (1) particular technological entities (i.e. digital communication technologies), and (2) a particular organisational form (i.e. networks and the practice of networking). The network society, then, is a society where networking, communicative, and participatory practices precede the crystallisation of hierarchies and structures. Two implications immediately follow the emergence of the network society. First, traditional trust in the systemic work of institutions and hierarchies in society has been replaced with large networks of intense contestations between differing perspectives, worldviews, groups, and identities throughout an entire social field. Second, and nevertheless, due to the inevitable breakdown of traditional structures, an authentic version of ‘democratic participation’ and the restructuration of the inherited societal framework can become a new objective for societies to work towards. With respect to the current investigation into Malaysia’s mental healthcare, the rise of the network society means that power relationships, production processes, and organisational practices could no longer be unquestioningly considered as restricted to the traditional hierarchy as manifested in an intergovernmental or statist ‘health system’.

Having situated the analysis within the Castellsian frame, (1) biopolitical activity and (2) governmental rationality would seem to concern not only a sovereign nation-state or a central governmental institution of health. Instead, these two problematics and their evolving mechanisms have become also the concern of a wider and decentralised assemblage of active participants, such as ordinary citizens, academics, direct stakeholders, and non-governmental and civil societal organisations (NGOs, CSOs), in a particular network society. Indeed, a framework that recognises diplomacy, networking, and participatory practices in emergent network societies would be a more adequate approach to understanding the processes of mental healthcare and health governance in contemporary Malaysian society. In practical terms, this framework will contribute to a more comprehensive account of the mental health governance landscape in Malaysia, pointing to one that does not dismiss and does not overlook the immanent self-assertion of a large collection of non-governmental organisations and advocacy networks who have been gathering greater socio-political attention to a range of important issues in public mental health and suicide prevention: the I-Life Suicide Prevention Association (Penang), Green Ribbon (“a small team of

four women”; see @greenribbongroup.my [2021] on Instagram), LAMAN MINDA, the Malaysian Youth Mental Health Initiative (MINDAKAMI), the Malaysian Mental Health Association, the Mental Illness Awareness and Support Association (MIASA), to name only several.

This is the conceptual context from which the research questions of this study emerged. First, during Malaysia’s network transitions, how do political, entrepreneurial, and civil societal leaderships approach mental health governance? Second, during these transitions, how do Foucault’s classical categories of biopolitics and governmentality compare to contemporary Malaysia’s mental healthcare? Indeed, in the current study of Malaysia’s mental health governance, it ought to be recognised that the Malaysian historical and societal conditions in which biopolitics and governmentality are currently practised and analysed can be fundamentally different from four decades ago in Europe, when Foucault published his analyses. Here, this dissertation will draw from Manuel Castells’ *Information Age* trilogy and *Communication Power* for a structural analysis of Malaysia’s mental healthcare to provide a challenge to, and indeed, a necessary reprogramming and remodelling of biopolitics and governmentality, for *the present situations*. Essentially, one should take in account the rise, proliferation, and structural influences of (1) new communication technologies, (2) new networking practices, and therefore, (3) new forms of governance in Malaysian society and their adoption in the increasingly participatory landscape of mental healthcare in the recent two decades.

Forms in contestation: statism, networks

Throughout this chapter, one of Castells’ important propositions has been alluded to, that, at the global level, there is an ongoing historical contestation between two forms of societal governance and production. This controversial idea remains a ‘proposition’ because it remains incomplete, debatable, and tested with research materials from different parts of the world (cf. Stalder 2006: 104-140; Castells 2010b: 303-366). The two forms in contestation are (1) statism and (2) participatory networks. The key is that each of these two forms structure production processes in two distinct ways, because each of them produces a respective mechanism of (1) time and (2) space.

By the first term, ‘statism’, Castells means the form of the sovereign nation-state. A nation-state, for Castells, is a persistently and consistently centralising entity

of power management, whose hierarchical authority is characterised by a sovereign geographical boundary and the cultural force of a national identity. In the information age, national boundaries and statist authority have encountered a fundamental crisis, because the decentralisation of information, self-identification, and decision-making capacities means that power relationships have come into disruption and reconfiguration beyond the easy control of central state power. In short, the solidity of the historical relationship between statist authority and the national identity is experiencing a “systemic erosion” (Castells 2010b: 331).

By the second term, ‘networks’, Castells means horizontal connections of independent and interdependent nodes beyond central institutional management. These ‘nodes’, additionally, can be individuals or groups, and they are connected via independent protocols and interests that are decided and modified by the networks themselves. Therefore, individuals are connected into networks by common protocols, fundamental choice, and mutualistic interests, without the invisible, universal, and abstract guidance of any of the overarching familial, communal, national, or religious imaginations. Accordingly, networking communication technologies would here denote the emergent media platforms that allow for the new form of horizontal connections for work and life, which intrinsically bypasses statist institutions.³ In practical terms, mobile devices, social media, websites, mobile applications, smartphones, and artificial intelligence (AI) have come into transformative use for new processes of healthcare and societal governance (cf. Lim 2021a, 2021b; Katz, Rice, and Acord 2005: 183-214).

Here, with regard to mental healthcare in Malaysia’s information age and network society, the historical contestation between these two forms of societal governance awaits in-depth investigation. For a long time, the local conceptualisation about mental healthcare has been perennially dominated by the form of the state. Until today, statist or ‘national’ mental healthcare remains the dominant approach to the delivery of services, public (mental) health communications, and policymaking for mental health. Key examples come from major local policy publications that necessarily pay a majority of analytic attention to centralised resources, mechanisms, and processes,

³ For further detail into the characteristics of each of these two forms, Castells’ (2000) early essay, ‘Contours of the Network Society’, provides lucid, concise, and authoritative differentiation and characterisation.

as well as specific policy recommendations on how to improve them (e.g. Haque 2005; Lim 2018; Chua and Mogan 2021): treatment costs, quality of services, travelling distance, and shortage of psychiatric and clinical human resources, to name several key prevailing issues. The Castellsian framework, however, would recognise and propose that statist mental healthcare (alongside its long range of traditional concerns) is no longer the only (or, necessary) approach to mental healthcare, because networks, networking practices, and new spatial-temporal configurations are emerging for a new form of mental healthcare.

Indeed, the fundamental structural contestation between statism and networks ultimately resides in the societal configuration and management of time and space. Here, it is the study's proposition that the evolving categories of time and space will directly structure / re-structure how mental healthcare is managed and produced. In a network society, as Castells (2013: 33-36) proposes, physical spaces of traditional institutions become media communication networks, while "disciplinarian" routines of work and life are increasingly replaced with flexible personal schedules, individualised career pathways, and negotiable appointments. Time is becoming "timeless," while space has become "flows" of information (*Ibid.*). Overall, the dissolution of routines and hierarchies into fluid, flexible, and adaptable structures in the categories of time and space is directly analogical of the fundamental structure of the network society: a "social arrhythmia" (Castells 2010a: 475).

Within this line of arguments, the thesis statement of this dissertation can be more accurately formulated. In response to the first research question, political, economic, and civil societal leaderships in Malaysia are approaching mental healthcare in increasingly diplomatic and less restrictive manners. Despite the strong persistence of the statist approach, mental healthcare and mental health communications in an emergent network society in Malaysia would be experiencing a series of network structural transitions. This statement proposes that the changing landscape of mental healthcare in Malaysia is witnessing less hierarchical and more participatory mechanisms of healthcare production, health communications, societal governance, and processual planning. In response to Foucault's classical categories, secondly, a networking form of biopolitical co-productivity and a QOL-based participatory governmentality are structurally contesting with the traditional edifice of statist

disciplinarian biopolitics and hierarchy-based liberal governmentality in a transitioning Malaysian society. In consequence, this dissertation can serve as a minor Malaysian contribution to a new line of investigation in the literature on Southeast Asian societal governance, *Digital Sociocracy*, as designed by Lim (2021b): “The focus of a digitally regenerative intervention is on the use of digitally-obtained information, feedback, comments, and even complaints to improve society’s well-being in a way that builds the capacity of a decentralized ecosystem needed for future growth.”

Purposive Sampling and Qualitative Content Analysis

In response to the research questions, this dissertation collects materials from nine (9) Malaysian mental health initiatives. These nine initiatives are evenly distributed into three categories of leadership in Malaysian society: (1) the governmental, (2) the entrepreneurial, and (3) the civil societal. The nine initiatives are selected, sampled, and analysed based on their perceived importance in Malaysian society. Key indicators of their importance include their (1) institutional influence, (2) website popularity, and (3) social media metrics. The main aspects of these nine datasets to be assessed and discussed in this study are the various detailed ways in which mobile, digital, and networking communication technologies may support, affect, and/or alter the organisational and production processes of these mental health initiatives. Following are the nine Malaysian mental health initiatives as sampled for this dissertation:

1. Governmental:

1. *ASEAN Mental Health Systems* (ASEAN 2016)
2. *National Health and Morbidity Survey* (NHMS) 2019 (National Institutes of Health 2019)
3. MENTARIs (Instagram, Facebook) (Mental Health Innovation Network 2021)

2. Entrepreneurial:

1. Naluri (2021a)

2. PlusVibes (2021a)
3. The Help Talk (2021a)

3. Civil societal:

1. *Bridging Barriers: A Report on Improving Access to Mental Healthcare in Malaysia*, Penang Institute (Kuala Lumpur) (Lim 2018)
2. 'Looking Beyond Anti-Stigma Campaigns When It Comes to Mental Health', *New Naratif* (Sim 2019)
3. 'R U Ok??? Mental Health and Comedy in a Pandemic' (Projek Dialog 2020a)

Certainly, the limitation of this study's observational datasets is the lack of certainty in data representativeness. To be specific, two levels in the representativeness of these nine initiatives need to be detailed. First, periodically, these nine initiatives were introduced from at least 2016. They emerged in the nationwide context of digital and mobile transitions. Thus, these nine initiatives (1) fulfil the research objectives and answer the research questions; and they (2) provide understudied insights for an in-depth content analysis and critical discussion. Second, however, the nine initiatives bear different degrees of representativeness for their respective categories of leadership in Malaysian society. For instance, for the three governmental initiatives, they have a fairly strong representativeness for the category of 'the governmental', because they are the official documents that formally report to the nationwide citizenry the exact ways in which state health authorities and institutions work and behave. For the remaining two categories of observational data, it is the limitation of this study to not be able to ascertain the precise degree(s) to which they represent their respective categories of societal leadership. In other words, while it can be quite sure that the governmental datasets provide representative insights into Malaysia's state healthcare agencies and processes, the entrepreneurial and civil societal datasets cannot represent the full range of approaches, methods, and digital tools that might have been utilised by non-selected enterprises and organisations in these non-state categories of societal leadership. Yet, although there could have been many more initiatives, tools, and methods in the entrepreneurial and civil societal sectors, the selected initiatives could still provide in-

depth qualitative insights that are required for this inductive, exploratory study, and for building the theoretical grounds for future deductive, experimental studies that would aim to test specific hypotheses and theories about contemporary health governance.

These materials have been given a Level-A ethical approval by the research ethics committee of the Faculty of Arts and Social Sciences (FASS), the University of Nottingham Malaysia. The Level-A ethical approval was requested because the user information and user-generated contents on the sensitive theme of ‘mental health’ (e.g. comments, questions, and other forms of personal expression) on the social networking platforms under examination necessarily pose the risk of being exploited, studied, and gathered by researchers without prior conscious awareness, knowledge, and consent of the users themselves. The approval is given on the condition that only the non-participant information, such as a website’s user interface and technological or structural affordances, or quantitative social media metrics, will be included in the dissertation’s analyses, in a way that does not compromise security.

The construction of the coding frame for the qualitative content analysis in this study is directly informed and structured by the joint theoretical framework of Manuel Castells and Michel Foucault (as expounded in detail in the previous sub-chapter; see pp.13-20 of this dissertation) (see ‘Building a Coding Frame’, Schreier 2014: 174-178). In this coding frame, the three main categories in health governance are predetermined and predefined (see Table 1.2.1., p.24). Under these three categories, the findings are subsequently identified as their subcategories or supportive categories, because it is not possible to predict the precise elements of the statist healthcare in Malaysia, or how the health infrastructural transitions are happening, as well as their particular motivations and effects among the nine initiatives (e.g. the state may have starkly different motivations to use digital technologies for healthcare compared to those of the civil society groups or business communities). In other words, all the new sub-categories and their supportive materials identified are entirely original, and depend on what the selected datasets may reveal. It is in this way that the various empirical elements, motivations, methods, implications, drawbacks, and benefits of incorporating digital communication technologies in Malaysia’s mental health communications and governance can be coded and interpreted for a more general and critical discussion.

CATEGORIES	DESCRIPTIONS
(1) statist healthcare	Mental healthcare processes, provisions, and legal apparatuses of the nation-state; top-down or vertical; traditional; largely using hierarchies, tables, and institutions
(2) networked healthcare	Mental healthcare processes that are horizontally produced and managed; more personalised; using mobile networks and interpersonal connections; usually involving digital communication technologies
(3) transitional processes in healthcare	Elements, challenges, processes, and structural changes that are involved in moving from statist healthcare to networked healthcare

Table 1.2.1. The coding frame for the qualitative content analysis in this dissertation, comprising the three main categories and their descriptions

CHAPTER TWO

Conventional National Mental Healthcare

Introduction

As a first step to the line of analyses, this chapter will explain and illustrate the function of the statist form in Malaysia's mental healthcare. Here, in this introduction, a historical account of the formation of the statist form in mental healthcare will be provided. Then, in the subsequent sections of this chapter, the key subcategories in contemporary Malaysia's statist mental healthcare system will be explained and demonstrated with recent examples.

The statist form in Malaysia's mental healthcare emerged from an important and long process of (1) European social transformations and (2) a colonial implantation in early twentieth century Malaya. To understand how a European (e.g. French, English) asylum institution became implanted in a Southeast Asian setting, one can directly compare (1) Foucault's (1988 [1961]: 241-278) organisational structural analysis of European asylums and the psychiatric personnel in a chapter of his first and seminal book, *Madness and Civilization: A History of Insanity in the Age of Reason*, 'The Birth of the Asylum', and (2) the historiography of colonial Malayan asylums and Malaysian mental health programs (cf. Haque 2005). Such a developmental comparison between these two 'sides' of the world becomes necessary, when, for instance, a 2018 report on improving access to mental healthcare from the Penang Institute in Kuala Lumpur asserts the following binary construction:

"In general, culture-bound supernatural beliefs about health and mental illness tend to be stronger among rural communities. On the other hand, recent studies have shown that the more urbanized populations in cities appear to have a more Westernized understanding of mental illness and mental health literacy, perhaps due to greater exposure and education" (emphasis entirely in original; Lim 2018: 111).

Here, one can observe that the statist institutionalisation of mental healthcare is considered to be a “*Westernized*” method. Nevertheless, to obtain a more concrete account of the emergence of this so-called Westernised method in the Southeast Asian region, the tracing must be done from early Western modernity *itself*, while moving towards the late colonial period in Malaya.

The transition of ‘mental healthcare’ from early European modernity, to the Southeast Asian and Malayan settings, to contemporary Malaysian society, shall be understood, in periodical terms, through four evolutionary steps. First, from the late sixteenth (16th) century to the eighteenth (18th) century, the European societal treatment of the insane and mentally ill transformed from a regime of punishment, discrimination, and ostracism, towards a more humane, moralistic, and parental approach of personal education, the cultivation of self-esteem, and the general social process of inculcating the ethical virtue of self-sufficiency and self-responsibility: i.e. independence in the care of the self. This methodological turn served the preservation of the solidity of a societal moral structure. Second, this moralistic approach to mental healthcare had instigated the formation of the modern professional asylum and the emergence of the ‘humane’ expert (cf. Foucault 1988 [1961]: 260-273). Third, from the late eighteenth (18th) century to the late nineteenth (19th) century, the British colonial administration in Malaya undertook the implantation and humanisation of the asylum institution in their management of the mentally ill in this colony. One can observe the entire process of implanting and humanising colonial Malayan asylums in the following passage:

“Four decades after the British settled in Penang, which constituted a part of the Straits Settlements, a “lunatic system” was set up in the 1830s and the British regime established asylums in three of the Federated Malay States during the late 18th century. In 1887, Dr Gilmore Ellis took charge of the New Singapore asylum, which replaced the original one built in 1862. Ellis is recorded as a psychiatrist who brought in therapeutic care and not just incarceration for the mentally ill patients—he abolished straitjackets, introduced vocational training (rope making, weaving, etc.), and improved methods of record keeping” (Haque 2005: 187).

Fourth and finally, after (1) Malaya's achievement of national independence, (2) the formation and economic modernisation of the Malaysian nation-state in sixty years, and (3) the broader processes of the regionalisation (i.e. Association for Southeast Asian Nations [ASEAN]) and the internationalisation of mental health governance (e.g. World Health Organisation 2019a), the modern national mental health system in contemporary Malaysia has become consolidated multi-dimensionally (e.g. hospitals and clinics; clinical and medical labour forces; institutional resources; national mental health communications), in constant relation and response to the regional and international counterparts and guidelines (cf. ASEAN 2016).

In other words, the statist form has undergone a series of internal transformations, in the Western, colonial Southeast Asian, Malaysian, as well as contemporary international settings. Throughout these transformations, the care of the mentally ill moved away from the repressive and punitive approaches (i.e. repressive state apparatuses), and liberalised towards the administrative, hierarchical, positivist, and scientifically rational approaches (i.e. official authority of knowledge; morality and humanity; and positive behavioural re-integration). That is the historical basis to the structural analysis of this chapter. Subsequently, the statist form in contemporary Malaysia's mental healthcare is examined in five essential subcategories: (1) central catalogue of resources and knowledges; (2) institutional hierarchy; (3) top-down delegation of tasks and services; (4) instrumental subjectivities; and (5) national mental health communications.

2.1. Central Catalogue of Resources and Knowledges

First, there has been a propensity to tabulating and distributing central and large-scale catalogues of resources and knowledges in statist mental healthcare. The use of catalogues is key to the statist function because they inform central planning and execution for the development or modification in various levels of societal governance. This tendency is therefore logical because the statist distribution of mental health services is predicated upon a fundamental need for population-level solutions, for large-

scale policymaking, and for the preservation and surveillance of a national societal order.

Here, the key is an imposition of a statist form on mental healthcare since the birth of the asylum, and since the emergence of the liberal nation-state globally. In this statist form, historical foresight is the basis, because a central healthcare system, just as a typical nation-state, assumes “control over space and time” (Castells 2010b: 303) in “preserving an old asylum structure of non-reciprocal observation” (Foucault 1988 [1961]: 250-251). This means that a central health system exists to enforce a particular historical vision (i.e. time) as well as a particular and limited range of health behaviours (i.e. space) among a mental health workforce and the general population (or the various scales and realms of its control) for an undisturbed development of the nation. Due to a rational administrative need to know and manage every physical item and all equipment, every individual expert and every medical worker, and every institutional contribution to a more general health system and to the management of public health, the Malaysian state, and Malaysian society as a whole, have been attuned to the use of central catalogues of human, physical, financial, and institutional resources and knowledges.

To illustrate the use of central catalogues of mental health resources in the Malaysian national mental health system, the section draws examples from (1) the ASEAN (2016) report on mental health systems in Southeast Asia, and (2) the Penang Institute’s report on improving access to mental health resources in the Malaysian mental health system (Lim 2018). From the onset, one can observe that these two reports—one of a regional intergovernmental superpower, and another of a Malaysian non-governmental organisation—are essentially major catalogues that contain micro catalogues within themselves. The organisation of contents in each of these reports itself deserves analytic attention. The ASEAN (2016) report comprehensively documents the entire health and mental health systems in Malaysia by way of hierarchies: general health system, mental health system (i.e. vision and mission, national policy, framework, governance, legislation, resources, financing), community mental health program, non-governmental organisations, training (i.e. guidelines and modules), and finally, information systems. Next, because the Penang Institute report (Lim 2018) aims to substantiate a policy recommendation on improving and easing public access to mental healthcare, it essentially communicates with the national mental health personnel

through key categories in a traditional public health system: epidemiology and healthcare demand, mental health workforce (mainly: psychiatrists and clinical psychologists), public discrimination and stigmatisation, and expenditure (mainly: consultation, medication, and transportation).

From the ASEAN report, screen capture 1.1.1. below demonstrates a tabulation of the distribution of mental health human resources in various (health and non-health) institutions in contemporary Malaysian society. This 2016 catalogue shows that there were three hundred and nineteen (319) psychiatrists in Malaysia, of which one hundred and sixty-three (163) were working under the Ministry of Health (MOH) Malaysia. As observed, in the mental healthcare division under the MOH, there were, at that time, more than one hundred and sixty psychiatrists, more than three hundred medical officers, twelve clinical psychologists, more than one thousand two hundred staff nurses, and more than six hundred assistant medical officers. This tabulation can effectively inform national policymakers and national budgetary decision-makers upon which particular level(s) of the medical institutional hierarchy, or which particular institution(s), would require adjustment, reinforcement, or enhancement of healthcare labour power.

Table 5.4: Distribution of Psychiatrists providing Psychiatric Services

Facilities	Number of Psychiatrists
Ministry of Health	163
Universities	77
Private unit	19
Ministry of Defence	4
Private Sector	56
TOTAL	319

Table 5.5: Human Resources providing mental health care in Ministry of Health facilities

Human Resources	Total
Psychiatrists	163
Medical Officers	314
Clinical Psychologists	12
Staff Nurses	1220
Assistant Medical Officers (Medical Assistant)	697
Counsellors	188
Occupational Therapists	146
Social Workers	40

Screen capture 2.1.1. National distribution of mental health human resources

Source: ASEAN (2016: 69)

Second, there is national data in mental healthcare and on the prevalence of various mental illnesses. More particularly, databases can be found in the National Health and Morbidity Survey (NHMS) administered across Malaysia every five years. Furthermore, under Malaysia's MOH, there are (1) the Health Informatics Information System, (2) data regularly aggregated on the total number of cases and the number of new cases of mental disorder at the primary care level, (3) the Schizophrenia Registry, and (4) the previously operating National Suicide Registry (NSRM).⁴ The existence and operation of these various layers of national mental health data are documented in a particular subsection ('Information Systems') in the Malaysian chapter in *ASEAN Mental Health Systems* (ASEAN 2016: 79).

Third, the Penang Institute report contains a table (see screen capture 1.1.2. below) comparing the number of psychiatrists located in public hospitals from every state in Malaysia against the number of outpatient visits to public hospitals in every state in Malaysia (Lim 2018: 56). This comparison allows for the tabulation of the psychiatrist-cases ratio in every state in Malaysia. The main purpose of this tabulation is to inform decision-makers, stakeholders, and policymakers in public mental health and public health in general (whether governmental, parliamentary, or non-governmental) about the severity of the lack of human resources (i.e. here, psychiatrists) in the Malaysian mental health system. In fact, this table is only one of the twenty (20) catalogues in this report.

⁴ Since its observed and reported cessation in 2009, various stakeholders in Malaysian society have been advocating the re-establishment of the NSRM, and public access to national data on suicide cases (e.g. *The Star* 2019; *Malaysiakini* 2021).

Table 4: State Breakdown of the Number of Psychiatrists based in Public Hospitals, and Corresponding Numbers of Psychiatric Outpatient Clinic Visits for the year 2013

State	Number of psychiatrists in public hospitals	Total Outpatient Visits	Number of Patient Cases per Psychiatrist
Perlis	2	8,026	4,013
Kedah	9	39,509	4,390
Pulau Pinang	8	28,404	3,551
Perak	12	87,489	7,291
Selangor	26	45,381	1,745
WP Putrajaya	3	3,026	1,009
WP Kuala Lumpur	54	68,297	1,265
Negeri Sembilan	6	21,688	3,615
Melaka	7	20,169	2,881
Johor	15	47,084	3,139
Pahang	9	44,563	4,951
Terengganu	7	61,484	8,783
Kelantan	15	28,579	1,905
Sarawak	5	28,643	5,729
Sabah	6	16,071	2,679
WP Labuan	0	614	N/A
Total	184	501,492	N/A

Source: National Healthcare Establishment and Workforce Statistics (NHEWS) report, 2013; author's own calculations

Screen capture 2.1.2. Number of patient cases per psychiatrist in public hospitals

Source: Lim (2018: 56)

In summary, this section has provided two sets of examples to demonstrate the use of central catalogues in the statist mental health system in Malaysia. First, reports communicating with statist health policymakers organise their contents and arguments as major catalogues containing micro catalogues. Second, catalogues and databases have been deployed at various levels of decision-making in the national mental health system. These levels include various types of health and non-health institutions, various types of mental health workers, and health equipment under the purview of Malaysia's MOH. The purpose in using catalogues, databases, tables, and large-scale statistics is to help devise solutions that apply to national demographics. As the National Institutes of Health (2019: 1) explains, these statistics help “estimate the occurrence of particular health conditions” and “monitor trends in the population's health over time.” These examples also reinforce Castells' theoretical argument that the statist form has been the most effective and relentless method of population management in the recent history of global organisational systems: “to focus resources, to keep the unity of the project in accomplishing their tasks” (Castells 2000: 153).

2.2. Institutional Hierarchy

Second, the Malaysian mental health system is composed of multiple administrative hierarchies. These hierarchies are dispersed into (1) the delivery of services, (2) mental health legislation and governance, and (3) systemic planning and infrastructural development. At the core of the statist form of mental healthcare, there is a modern administrative rationality. This means that every decision, every behaviour, or every level of activities is structured by an institutional functional cause. Because institutional functionalism does not allow for difference or deviation, each violation of and every margin of error in the hierarchy will be countered with pre-determined correction and punishment. Overall, *the sole purpose of an institutional hierarchy is to ensure absolute compliance with the effective execution of already programmed tasks in every rank of the hierarchy for the overall interests of a particular organisation.*

Here, a disciplinary “silence” of institutional domination that Foucault (1988 [1961]) and Castells (2013) have previously observed is relevant. This silence, however, is not an external repression of alternative voices. Instead, it is the hegemonic effect of a stable balance of power relationships in particular institutions. If a hierarchical system of labour functions optimally, destabilisation and differences are not possible. This means that, in order to preserve the optimal functioning of this hierarchical system, dialogues and interpersonal communications as the basis of creativity and inventiveness must be eliminated (Foucault 1988 [1961]: ix-xii; Castells 2013: 10-19). In the case of mental healthcare, this would mean that the delivery of services, mental health legislation and governance, and systemic planning and infrastructural development are strictly guided by a particular *functional* hierarchy. In the case of Malaysia, this structure is first of all ‘national governmental’. What the mental health institution (whether a hospital, a clinic, a centre, or a nursing home), the psychiatric and clinical personnel, the pharmacist, and the patient can (or cannot) do are pre-determined by a functional-moral structure. This structure, finally, is not a ‘natural’ event, but the result of stable power relationships in the institutional functional hierarchy.

1. Delivery of services. In terms of the delivery of services, the Malaysian mental health system provides three levels of mental healthcare. These three levels are (1)

hospitals, (2) clinics and family medicine specialists (i.e. primary care), and (3) community-based care (i.e. Assertive Community Treatment [ACT]). In terms of human resources, the hierarchy begins from the Ministry of Health and the Director-General of Health, followed by the National Mental Health Promotion Advisory Council, psychiatric hospitals (i.e. public, private), primary care (i.e. governmental health clinics), and followed by individual psychiatrists, clinical psychologists, psychotherapists, occupational therapists, councillors, and pharmacists. The practices of the subordinate level must strictly comply with the practices of the superior level(s). These practices are performed in such concrete institutions as hospitals, clinics, centres, and nursing homes. Patients are, finally, receivers of support, treatment, and consultations at the bottom of a long and enormous hierarchy.

2. Legislation and governance. The delivery of mental health services and mental health promotion are governed by a vertical series of legislative frameworks. The 1952 Mental Disorder Ordinance has been replaced by the Mental Health Act passed 2001, which came into effect in 2010 as Mental Health Regulations (ASEAN 2016: 68). Private psychiatric hospitals must comply with the Private Healthcare Facilities and Services Act 1998. These legislative frameworks cover the entire process of the delivery of services: appointment of hospitals, psychiatric nursing homes, community mental health centres, and government staff, and visitors, licensing of psychiatric personnel, the administration of the electroconvulsive therapy (ECT), admission of patients, apprehension of mentally disordered individuals, punishment for the ill-treatment of mentally disordered individuals, discharge of patients, transfer of patients, and the management of the belongings of mentally disordered individuals, among other matters (see World Health Organisation 2010). As the essence of modern administrative rationality, the liberal rule of law is central to the functioning of institutional hierarchies, including those in Malaysia's statist mental healthcare.

3. Systemic planning and development. Finally, the following passage from Sim's (2019) interview article for the *New Naratif* demonstrates the ordinary Malaysian citizen's relationship with the hierarchy of the national mental health system. To retain the voice of the passage, and for the analytic purpose, it is quoted in full:

“Though the forthcoming 2020 national census promises to be more inclusive and sensitive to determinants of well-being, it's unclear how mental health will actually

factor into national priorities. In the recently announced Budget 2020, significant allocations were made for social welfare. But while spending on healthcare has been increased from RM28.7 billion in 2019 to RM30.6 billion the following year, mental healthcare was not specifically mentioned” (Sim 2019).

Here, an attitude of uncertainty is projected. This uncertainty pertains to the budgetary and infrastructural development of the nation’s mental healthcare system. In fact, this nationally identified passage speaks from a citizen’s helplessness in the face of uncertainty, passivity, and non-participation. The ordinary citizen’s passive waiting for the national mental health system to clarify and elaborate upon the budgetary allocation for the development of this system is the necessary result of systemic hierarchies. To further contextualise, this passage comes after paragraphs that argue for “collaboration between policymakers and other stakeholders” (Sim 2019). This means that, apparently, there has been increasing awareness in Malaysia about (1) the tight domination of governmental authorities in mental healthcare policymaking and (2) the growing need for the horizontal networking of stakeholders and people for collaborative planning.

In brief, the healthcare hierarchy has been identified and examined, while its authoritarian effects have been illustrated. Moreover, this hierarchical method has also been challenged by the Malaysian publics for a more diplomatic, participatory, and collaborative alternative.

2.3. Unidirectional Delegation

Third, unidirectional delegation of duties and provision of services are key to the function of the statist form in mental healthcare. The main purpose of this unidirectional, top-down passage of instructions is to curtail arbitrariness and unpredictability in a health system. This form of labour is rendered possible and sustained by the use of institutional hierarchies, explicated in the previous section. In the case of mental healthcare in Malaysia, this will mean that the delegation of duties, passage of instructions, and provision of services all begin from the Ministry of Health Malaysia, and terminate at the conjuncture between the instrumental institutional expert and the

passively receiving patient. To put the statist mechanism into perspective, it would differ from a public “diplomatic” method where, instead of hierarchical discipline, productive interactions between ideas and between people rebuild a dynamic foundation for a “sustainable order” (Castells 2008: 91).

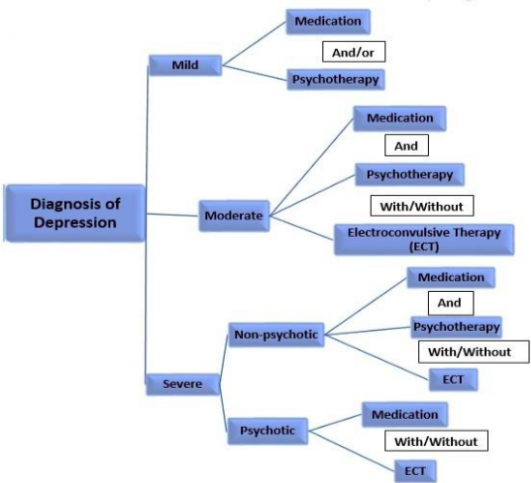
The following excerpts from two prominent examples demonstrate the silent instrumentality that Foucault has observed from the statist form of mental healthcare. Regarding top-down delegation of work, Foucault (1988 [1961]: xii) argues as follows: *“a kind of silent transparency which reveals—as mute institution, act without commentary, immediate knowledge—a great motionless structure”* (emphasis entirely in original). Here, following the order of institutional hierarchies, the unidirectional passage of authority ensures a transparency, though one that is not based on consensus, but silent and precise execution of orders. In every step of the way, the statist system assumes that it would already have prepared a complete blueprint of immediate answers for every individual decision-making and every behaviour. Accordingly, every decision made and action taken must be able to respond to the deep-lying value system of an institution.

The first example comes from the Malaysian chapter *ASEAN Mental Health Systems* (ASEAN 2016: 67). Following is a short passage from the chapter: “The Mental Health Framework was developed in 2001 and is a reference as the blueprint for planning, implementation and evaluation of mental health services in Malaysia” (ASEAN 2016: 67). This passage comes from the Malaysian mental health system (i.e. from the Ministry of Health Malaysia), and asserts the unilateral foundation for the development and future of Malaysia’s mental healthcare. Certainly, the passage does not exclude the possibility of modification and change; it at least recognises the need for periodical and standard ‘evaluation’ of local mental health services. Nevertheless, while the passage was published in 2016, the same framework devised from 2001 (i.e. fifteen years prior) remains intact as the principle reference for all activities in mental healthcare: from planning to evaluation. The fifteen-year perseverance of a guideline demonstrates the considerably small extent to which the system will evolve or be modified. In particular, the five main areas of concern in this framework are (1) promotion and prevention, (2) easy access, (3) early detection, (4) management of

severe patients, and (5) rehabilitation (*Ibid.*). For each of these five areas, there is already a solidified blueprint for planning, implementation, and evaluation.

The second example is a screen capture from the Penang Institute’s report on improving access to mental healthcare in Malaysia (see screen capture 1.3.1.) (i.e. Figure 37 from Lim 2018: 122). Here, an MOH-approved clinical practice guideline for the treatment and management of major depressive disorders is figured. Three different levels of the severity of the depressive disorders are assigned three different treatment pathways. Nonetheless, the more pertinent observation from this example is that the individual professional decision of the health expert is always already structured by a series of higher ranks in the hierarchy: from the delegation of instructions come from the MOH; to the clinical practice guideline; to the mental health institution; to the individual authority of knowledge; and finally, to the patient.

Figure 37: Algorithm for treatment of mild, moderate and severe cases of depression.



Source: adapted from the MOH Clinical Practice Guidelines for Management of Major Depressive Disorder (MOH/P/PAK/124.07 (GU))

Screen capture 2.3.1. Three severity levels of depression and their respective treatment pathways according to the MOH
Source: Lim (2018: 122)

From the systemic processes of planning, implementation, and evaluation, to the clinical processes of diagnosis, consultation, and treatment, the entire pathway of public mental healthcare in Malaysia is a top-down unidirectional mechanism. Ultimately, this is the process of work in the statist form. Change or modification upon evaluation

processes, if ever needed, would require a long process of hierarchical delegation. Every rank in the hierarchy will have to anticipate the explicit and specific order of change from the rank that is directly superior to itself, and this procedure proceeds step by step, and rank by rank, towards the bottom of the hierarchy. The lower the rank, the less decision-making influence it will possess and exert; the higher the rank, the more absolute and central a decision becomes. Every decision, every point of contact, every action, and every conclusion must comply with the delegated order from the superior ranks. This also implies that statist mental healthcare necessarily prioritises foremost the disciplinary integration of diverse components into a *clean* order of administrative rationality, all before the recognition and resolution of biopsychosocial problems in their unique complexities.

2.4. Instrumental Subjects

Under institutional hierarchies and in unidirectional processes of work, there are instrumental subjects executing the normative functions in the statist form. The term ‘instrumental’ comes from Castells’ analysis. In his analysis, he calls ‘instrumental’ any individuals committed to the value and production systems of an institution. Here, it is not only meant that instrumental subjects simply ‘serve’ or ‘work for’ an institution. Rather, instrumental subjects are individuals who fulfil functions within an organisation to preserve and strengthen the existing relations of power and a dominant value system, as well as a domain-specific language that firmly sustains these existing relations (Castells 2010b: 358; 2013: 14-19). In the case of mental healthcare, instrumental subjects perform delegated tasks, based upon centrally managed frameworks and guidelines, in order to preserve the essential mechanism of a national mental health system, but also an ethical structure. For instance, the former Secretary-General of ASEAN has maintained the deep-lying intergovernmental objective undergirding all Southeast Asian mental health systems: “The ASEAN Socio-Cultural Community Blueprint 2025 promotes a healthy, caring, sustainable and productive community that practices healthy lifestyle resilient to health threats and has universal access to health care” (ASEAN 2016: ix).

The reason that individuals can become instrumental subjects is that, inevitably, there is a deeply entrenched value system behind the function of every subject within an institutional hierarchy. Castells (2013: 155-165) argues that every individual is always already “framed” by a particular value system or particular value systems through interpersonal and/or institutional communications. A frame is a particular way of thought that structures an individual’s or a group’s decision-making and behaviour: “framing means activating specific neural networks” (Castells 2013: 142). Without a frame, decision-making proceeds in a social vacuum. A social vacuum is a realm devoid of explanatory schemes, agendas, and collective references. In fact, the argument that every individual is always framed in a particular way, or in several compatible ways, holds true, even in a societal condition where an individual is free to choose the particular frame(s) he or she prefers to be subjected to; because frames are an inevitable component of social relations and societal governance.

Accordingly, because a statist system of mental healthcare cannot allow for the heresy of alternative, strange, and foreign frames, it must already have produced and sustained a particular frame for the thinking, decision-making, and behaviour of the individuals *working inside it*. These individuals are then instrumental subjects who must consistently stay self-disciplined within the frame of the statist-nationalist mental healthcare. This explains why, in a parallel pathway of conceptualisation precedent to Castells, Foucault (1988 [1961]: 257) observes that asylums are “a religious domain without religion, a domain of pure morality, of ethical uniformity.” Because instrumental subjects of different ranks self-discipline under a particular systemic hierarchy, under a particular routine of labour, and under particular frames of thought which cannot be disrupted, little nonconformity—strictly speaking—can be allowed to emerge, let alone circulate.

The following is a narrative example (Sim 2019) to demonstrate the existence of ethically uniform and ruthless instrumental subjects in Malaysia’s statist mental healthcare. It is a story revealed by a patient, named Armie. Over three years of seeking treatment, Armie has encountered various forms of discrimination from multiple psychiatrists of five different hospitals for her non-heteronormative gender self-identification. She revealed that it has been difficult to meet a psychiatrist who was not dismissive and judgmental towards her, from both public and private hospitals in

Malaysia. Here, the word ‘judgmental’ is actually used in the article, though one must carefully acknowledge that ‘judgmental’ is not only a moral category, but also a feature in power relationships. The judgmental attitude of psychiatrists towards what they deem to be ‘exceptional’ cases (e.g. non-heteronormativity) is a direct result of their roles as instrumental subjects under a particular framing in a particular power balance.

Here, the harshness with which Armie has been treated in various psychiatric institutions in Malaysia speaks of the ethical ruthlessness of instrumental subjects. If a group of psychiatrists are harsh in their judgmental corrective practices, it is because the institutional framing that conditions and structures them into instrumental subjects is profoundly entrenched. While Castells (2013: 155-192) has extensively theorised the fundamental influence of frames on individuals’ behaviours, I add that, *not every individual is aware of the behavioural effects of the particular frame that has structured him or her, whether it be from families, communities, groups, institutions, or nations. This unawareness, or unwillingness to be aware, is the cause for the necessary ruthlessness of instrumental subjects.* Accordingly, being ‘judgmental’ shows only the public psychiatrists’ basic commitment to national development. Sim (2019) adds, “Armie’s experience highlights an uncomfortable problem in mental healthcare in Malaysia today: even when one reaches out for help, the help you receive might be inadequate.” In this case, the word, ‘inadequate’, means that instrumental subjects in the mental health system would not arbitrarily allow for a nonconformity to disturb the national ethical power structure.

From regional development (i.e. ASEAN), to healthcare institutional functions, the instrumental subjects repetitively reproduce the power relationships in the long hierarchies, and actively normalise heretic framings from non-central, non-official sources. Therein lies the drawback when mental healthcare practices are unilaterally, centrally planned and executed by well-disciplined instrumental subjects.

2.5. National Mental Health Communications

Finally, one of the most important subcategories of statist mental healthcare is the practice of national mental health communications. To put this subcategory into

perspective, one needs to recall the field of health communications as situated in the literature review of this dissertation. Here, an early and significant document has been produced by the WHO (2005), titled *Promoting Mental Health: Concepts, Emerging Evidence, Practice*. Here, mental health communications are one of the subcategories of health communications, which in turn constitute part of health-centred population governance (i.e. a “biopolitical” regime; cf. Foucault 1978: 139-145; 2008: 317-324). Accordingly, national mental health communications are one of the subcategories of national health communications, which in turn constitute part of a national health system, and finally, part of the structure of the liberal nation-state (cf. Foucault 2008: 51-73).

However, national mental health communications are, historically speaking, an increasingly contested category of practice. To be more precise, national mental health communications are becoming increasingly problematic and interesting, especially when one recognises the recent global transformations in mobile communication technologies and non-hierarchical organisational practices. Due to an ongoing network decentralisation at the global level, the categories of the nation-state, national health systems, and national mental health communications, which highly depend on the traditional one-to-many mode of communications, are “in defiance of historical logic” (Castells 2010: 355). To illustrate emergent non-hierarchical practices in global mental health promotion, the WHO’s report on mental health communications offers these recommendations: “work with an array of public and private sectors, not just the health sector; [...] strive to increase people’s control over their own mental health; avoid over-dependence on “expert-driven” approaches” (World Health Organization 2005: 32).

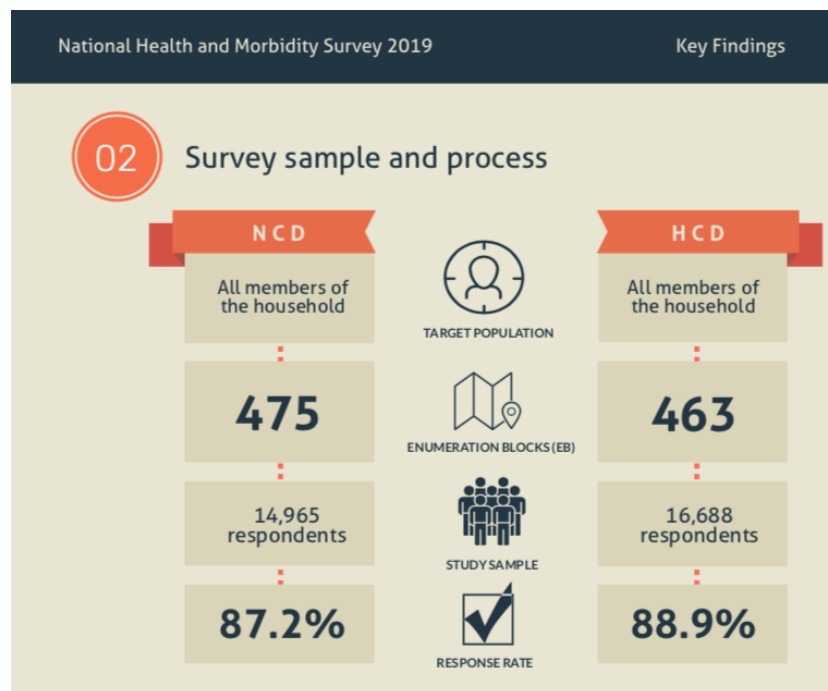
In light of these new bottom-up tendencies, it would seem that the existence of national mental health communications illustrates the obstinate persistence of the nation-state and the well-bordered ‘national sovereignty’ within global networks. In a context where two societal governmental frameworks (i.e. traditional statism versus emergent networks) seem to co-exist, national mental health communications become one of the terrains where the nation-state can strive to preserve its authority. Indeed, national mental health communications are one of the terrains where the Malaysian nation-state continues to firmly establish its authority presence.

Accordingly, the analyses from the previous four sections of this chapter cannot be detached from national mental health communications. Without a general statist mechanism comprising (1) central catalogues, (2) a hierarchical regime, (3) top-down delegation of authority, and (4) nationally or centrally identified instrumental subjects, the practices of national mental health communications would not be possible. The three examples below will demonstrate how these statist components structure and produce national mental health communications.

The first example comes from the *ASEAN Mental Health Systems* report (ASEAN 2016: 63-79). In the Malaysian chapter, there is a particular section about programs for ‘mental health promotion’ in Malaysia since the early 2000s. In this country, mental health promotion has been conducted through a series of nationwide initiatives: (1) Healthy Lifestyle Campaign; (2) celebration of World Mental Health Day; (3) Promotion of Healthy Family Campaign; and (4) ‘Handling Stress Effectively’ initiative with the theme: ‘Be Healthy for Life’. These activities, moreover, “including health education, interpersonal communication, multisectoral collaboration and networking as well as training, were carried out at the national, state and district levels” (ASEAN 2016: 70). In the first analysis, this very passage exposes a persistent structural paradox in contemporary mental healthcare: while internal activities were executed based on a decentralised / networked method, these local activities were still to maintain a central national structure. This is explained by Castells (2010: 303-366) as an awkward “geometry” of contemporary statist management: the process of legitimization of central interests and domination can only prevail through the decentralisation and delegation of central authority to local constituencies and communities. Therefore, although there are such horizontal networking activities as “interpersonal communication” (see section 3.3. of Chapter Three), these activities still cannot be separated from a centralising force of the nation-state.

The second example of the Ministry of Health’s network of MENTARIs (‘Community Mental Health Centres’) is extracted from the Mental Health Innovation Network (2021). Again, the adoption of the network form in this context is an exemplification of the paradoxical geometry of contemporary statism. First, the source has unambiguously stated that MENTARIs were conceived and executed as a result of Malaysia’s Mental Health Regulations 2010. Second, MENTARIs are directly

supervised and managed by the Malaysian government’s Ministry of Health. And yet, in this context, the centralisation of authority is accomplished through the decentralising “outreach” and subsequent “re-integration” of individuals and diverse voices back into the statist bio-political structure of a healthy and productive national population, a national health system, and national development and progress (*Ibid.*).



Screen capture 2.5.1. Survey sampling and process for the NHMS 2019

Source: NIH (2019: 2)

The third example of national mental health communications is extracted from an infographic report of a recent NHMS (National Institute of Health 2019: 2) (see screen capture 1.5.1. above). The screen capture demonstrates the entire (decentralisation and recentralisation) process of the survey. This survey is conducted by two clusters: (1) non-communicable diseases (NCD); (2) healthcare demand (HCD). Both clusters of the survey were conducted throughout all states and federal territories in the Malaysian nation-state. In every survey, all members of a household were administered the full-structured questionnaire. Each cluster of the survey was conducted in more than four hundred and fifty ‘enumeration blocks’ (EB). Here, an EB refers to “a land area which is artificially created and consists of specific boundaries” and that consists of “approximately 500 to 600 persons” (cf. ‘Glossary A-Z’, from Department

of Statistics Malaysia 2021). In total, the survey consolidated thirty-one thousand six hundred and fifty-three (31,653) respondents throughout Malaysia. In fact, face-to-face interviews were also conducted by the approval of the Medical Research and Ethics Committee (MREC) of the Ministry of Health, although it is not clear how many interviews have been conducted. From these procedures, one can observe a statist communicative practice. Individuals from diverse geographical sites provide real-time and personal physical and mental health information to a ‘decentralising-recentralising’ health authority. A heterogeneous mass of health information is subsequently conveyed to and gathered by this health authority for the production of a population-representative statistical report. Overall, the statistical information in this NHMS infographic report is a statist integration of diverse individual health conditions, literacies, and demands in a series of health communicative practices. Yet, the NHMS is unique in comparison with the previous two examples, for it shows how national mental health communications can be accomplished not only from the top to the bottom (i.e. one-to-many), but also from the diverse masses to the top (i.e. many-to-one).

In Malaysia, centralised processes of mental health communications should be more accurately referred to as ‘national-local mental health communications’. This is because the Malaysian nation-state provides mental health services and communicates mental health information in a cycle of decentralisation and recentralisation. However, a more significant lesson is that national mental health communications are intact even in an emergent network society. National mental health communications require (1) a clear delegation of authority to the local constituencies and instrumental subjects, (2) a clear commitment to the preservation of a national hierarchy of mental health practices, and (3) the conservation and consistent renewal of the central catalogue of knowledges in the nation-state’s long-term supervision over the population’s mental health.

2.6. Liberal Statist Healthcare and Its Policy Drawbacks

Hitherto, it shall be clear that this chapter has been preoccupied with the liberal-statist ‘art of government’ in contemporary societies. Here, the statist form is not reducible to any particular institution. Instead, it is a method of thought, practice, and self-critique

that gradually emerged in Western Europe (i.e. Germany, England, France) in the seventeenth century, and that has been conducive for the centripetal and organisational objectives and activities of modern (whether political, health, or economic) institutions (cf. Foucault 2008: xiii-xvii, 1-25, 51-73).

To more firmly understand this liberal statist method, one should survey the trend that Foucault (2008: 67) has captured from post-Enlightenment European population management:

“What basically must a government do? It must give way to everything due to natural mechanisms in both behavior and production. It must give way to these mechanisms and make no other intervention, to start with at least, than that of supervision.

Government, initially limited to the function of supervision, is only to intervene when it sees that something is not happening according to the general mechanics of behavior, exchange, and economic life.”

In this passage, the liberal statist form of governance is astutely synthesised. Liberal governmentality is concerned with improving the answers to the governmental question of how a society can maximise individual freedom by the least amount of interference or intervention. The solution has been ‘supervision’. This overarching supervision is possible, however, only if there is a set of universal laws, because individuals with freedom can interfere with the freedom of others, causing disorder to a desirable balance of power and freedom. The liberal statist method is, then, constantly concerned with optimising and enhancing a desired liberal societal structure that (1) does not ever need to intervene into individuals’ freedom of socioeconomic productivity, and (2) consistently protects and enhances such individual freedom, but, (3) on the strict condition that the threat of non-conformity, societal destabilisation, and insubordination to a hegemonic balance of power would not ever take place.

Liberal governmentality is therefore, as Foucault (2008: 63) has taught us, an “immediate” self-contradictory practice of rationalising governance. This is because *it essentially looks for a productive freedom that nevertheless needs to be allowed by an artificial, abstract, and universal rule of law*. In practical terms, this means that individuals must willingly give up *some of their own freedom* to an abstract ‘social contract’, reified in the form of an actual government (elected or otherwise), which will

then institutionally guarantee that citizens will retain this original freedom, on the condition that they do not challenge the social contract. Hence, liberal statist institutions are, inherently, predicated upon a ‘consented inequality’ in the relationships of power in a society. *The liberal desire for the institutional guarantee for individual productive freedom explains why modern institutions that produce goods, services, and values are paradoxically dependent upon hierarchies and the rule of law.*

Here, Castells would agree with Foucault’s analysis of the relational power in statist institutions. Institutions are not inherently ‘powerful’, because they are only the temporary structuration of a particular habituated balance of power relationships in the form of a social contract. In other words, institutions express the *domination* of a social contract. In light of Foucault’s analysis of liberal governmentality and the social contract, Castells (2013: 15) further explains: “there are concentrated expressions of power relationships in certain social forms that condition and frame the practice of power in society at large by enforcing domination. Power is relational, domination is institutional.” For the case of this dissertation, the *liberal statist form* thus conditions and frames the series of practices in the Malaysian national mental health system.

This statist form from the British colonial asylum system (extending from the European psychiatric institution) was first established in Malaya in the nineteenth century and had been structurally liberalised and modernised in the early twentieth century (cf. Haque 2005: 186-188; Chong, Mohamad, and Er 2013: 1-2). The liberal institution for mental healthcare inherited from the British colonial administration was the basis of the mental health system in place in contemporary Malaysia: e.g. the elimination of punishment and repressive reconstitution of individuals; the use of hospitals, beds, catalogues, and documentation; the humane treatment by psychiatrists and doctors; the institutionalisation and standardisation of psychiatric practices through national legislation.

The liberal governmentality in Malaysia’s mental healthcare ensures a silent, consistent, and non-interventionist optimisation of internal activities: (1) hierarchies, (2) catalogues, (3) unidirectional delegation, (4) instrumentalism, and (5) nationally and communally framed health communications; as analysed throughout this chapter. This form of practice works as an overarching ‘panoptic’ supervision over the optimal functioning of developmental activities throughout the institutions. Insofar as

hierarchies, delegation, and instrumental subjects function ‘normally’, the *liberal statist form* ensures that an invisible authority retains mute supervision. In Malaysia, liberal statist governmentality works as an abstract national necessity, under which the MOH, the Mental Health Regulation 2010, the National Institutes of Health (NIH), the National Health and Morbidity Survey (NHMS), the Malaysian mental health system, the nationwide network of MENTARIs, and government-employed psychiatrists and clinical psychologists receive their respective areas and degrees of productive and corrective authority in a static and unidirectional passage of delegation.

In practical and policymaking terms, what does this series of analyses into the liberal statist form of mental healthcare propose? As observed from the Malaysian case studies discussed in this chapter, statist centralisation means that (1) *participatory and diplomatic initiatives* (e.g. civil society’s call to revive the NSRM), (2) *alternative policy recommendations* (e.g. citizens’ call to clarify the specific budget allocated for mental healthcare), and (3) *different frames for mental health* (e.g. the case of Armie) among the increasingly proactive national publics continue to be quite often excluded, or seemingly ignored, by the formal mechanisms of public healthcare and policymaking agencies of the federal government. These interrelated situations pose the question of how various concerned segments and stakeholders in Malaysian society can collectively and collaboratively address the emergent tasks to make mental healthcare and national health policymaking more widely accessible, diplomatic, and adaptable. This question is directly tackled by the main concerns of the subsequent two chapters, where new participatory affordances as well as practices for mental healthcare in a network society are to be studied.

Indeed, because the new participatory features in Malaysia’s mental healthcare will need to be addressed in the next two chapters, only later in Chapter Five will I examine and discuss in further detail the structural and societal implications of the persistence of liberal statist governmentality and statist mental healthcare in Malaysia’s network society. Chapter Three, next, will first elucidate a series of *participatory network transitions* from liberal statist mental healthcare in Malaysia. A formal shift from the statist categories examined in this chapter would be immediately observed.

CHAPTER THREE

The Rise of Participatory Networks and Its Implications on Mental Healthcare Processes

Introduction

Following the five subcategories in how the statist form functions in Malaysia's mental healthcare, this chapter traces how this domain is experiencing a series of participatory network transitions. Here, it is contended that the statist form is gradually giving way to the networking form and participatory networks.

First of all, it would be key to define 'networking'. Essentially, the networking form can be understood only in comparison with the statist form, and in recognition of the enormous difficulty in which the statist form struggles to survive (whether in mental healthcare or other domains of societal governance) in global network societies. Not only is the strength of the statist form inextricably connected to the maturation of the 'networking' form and participatory network transitions. Both forms of societal organisation are also in intense contention globally (cf. Castells 2010b: 303-366).

Castells' starting point towards analysing the rise of the network society is the rise of a new mode of communication in societies that are transitioning from industry-based to information-based production. This new mode of communication is *wireless mass self-communication*, which replaces the traditional 'mass communications' model, including such features as the mass media and professional journalism, bureaucratic processes of mass production and circulation, and mass audiences that prevailed during the 'mass media' period of the newspaper, the radio, and the television (Castells 2010a: 355-406). By wireless 'mass self-communication', Castells does not mean that an entire society of self-sufficient individuals communicate with 'themselves' in their own personal private spaces. Instead, self-communication means that individuals themselves decides for themselves individually (1) what to produce, (2) what to consume, and (3) what to circulate. The rise of mass self-communication, furthermore, is enabled by the

rapid adoption of networking communication technologies: for instance, widely accessible electromagnetic Internet connectivity, portable personal computers, mobile phones, smartphones, social media platforms, and today, continual innovation of smart devices (e.g. tablets, wearables).

More specifically, the growing adoption of self-communication processes and networking communication technologies would lead to participatory transitions in mental healthcare due to the reconfiguration of 'time' and 'space' in contemporary Malaysia. Here, following Castells (2010a; 2013), these two components of time and space and their reconfigurations must be categorically differentiated. In traditional industrial society, time is disciplinary and repetitive, while space symbolises boundaries and limitations. This configuration of time and space means that instrumental subjects work inside concrete institutional places under a specific temporal regime (i.e. the regular 'working hours'). The necessity of this disciplinary regime comes from a more profound objective: the progress of an institution requires the absolute compliance of all with a standard spatial-temporal structure. In emergent network societies, the unitary conception of time and space would be reshaped. Here, time is individualised and diversified, and space is composed of nodes and networks. Individuals have detached from institutional disciplinary time, and from the need for concrete spaces for co-productive work. Rather, new ways to manage of time and space are emerging. First, personal management of schedules (i.e. time) is becoming common and necessary, for individuals themselves manage their own development. Second, personal customisation of networks (i.e. space) is becoming common and necessary, for individuals themselves manage their own communication networks. Time is personally structured, while space has become mobile networks. Accordingly, what Foucault has called the 'disciplinary' techniques of institutions (Castells 2013: 35) have come to be individually self-imposed by individuals in relation to their specific objectives for themselves *regardless* of institutional and national routines.

Therefore, as mobile and smart communication technologies are being harnessed by self-conscious social actors within a society, a chain of transitions from the smaller units of each social condition to the broader levels would take place. Participatory network transitions in the smallest units of the various domains of societal governance on a broad scale result in a broader transformation from the industrial

society into the network society. Accordingly, the ‘networking form’, and the participatory network transitions that it causes, can be defined by the increasingly dominant ‘horizontal’ and ‘participatory’ approach to co-production processes and power balances amidst the optimal maturation of emergent network societies.

Certainly, Malaysian mental healthcare still exists as a concrete domain of production. However, this domain has been adapting to (1) the contemporary diversification of schedules, (2) the new mobile reality of information flows, and (3) the ongoing dissolution of the institutional space-time complex. As the examples in this chapter will demonstrate, there are now emerging options for various stakeholders in mental healthcare, including patients and practitioners, to conduct consultations flexibly in chosen time via mobile asynchronous communications. In short, self-selective and horizontal participatory processes in mental healthcare have become possible because personal communication networks, inter-personal relationships, and work arrangements have been profoundly reshaped by “timeless time” and “the space of flows” (Castells 2010a: 448-459, 475-499).

Finally, the spatial-temporal reconfiguration in contemporary network societies would fundamentally challenge what Foucault has derived from the mental health institutions of pre-industrial and industrial European societies (from the sixteenth century to the nineteenth century). Here, he has claimed that, “*in the serene world of mental illness, modern man no longer communicates with the madman*” (*emphasis entirely in original*; Foucault 1988 [1961]: x-xi). In the mental healthcare of contemporary Malaysia, it seems more suitable to propose that experts, help-seekers, and mental health advocacy groups actively communicate and collaborate to produce solutions and ideas on their communication networks and social media platforms. In other words, the ‘serene world’ of health institutions seems to be making way for participatory, horizontal, and active health communications.

In practical terms, to become able to understand and appraise these possible structural changes and new affordances, they should be traced from smaller units such as personal health communications and the management of interpersonal relationships, and gradually towards the aggregate dimensions, such as flexible meetings, diplomatic communications, and participatory arrangements of work. This pathway grounds the argument of the chapter. Moreover, in order to systematically manage the complexity

of the transitional processes, this dissertation has decided to separate the analysis of (1) the emergence of *the participatory networks and affordances*, and (2) the emergence of *participatory practices*, in Malaysia's mental healthcare, into two different chapters. For this chapter, the concern would be the use of the networking form and the participatory opportunities that it provides for the nation's mental healthcare practices. Tracing the advent of the networking form is conducted via three subsections: (1) personalised mental health communications; (2) managing inter-personal relationships; and (3) adaptable plans, diplomatic solutions, and participatory affordances for nationwide mental healthcare practices.

3.1. Personalised Mental Health Communications

In the smallest unit of mental healthcare, individual behaviour has become detached from the structuration of the centralised health system, and become 'personalised' through the processes of self-selected communication, self-identification, and self-decided mental healthcare preferences. To clarify, personalisation of the individual is not a 'natural' phenomenon; individuality or subjectivity cannot be equated with personalisation. In traditional industrial forms of work arrangement, individuality is deeply structured by a specific set of human relations. In emergent network societies, how an individual intends for himself or herself, or his or her lifestyles, to be structured or framed is becoming relatively choice-based, personal, and multidirectional. This personalisation in contemporary mental healthcare must be situated within broader transitions in the dominant communication processes in a network society: from the mass media, to the mobile self-communication networks.

To understand the capacity for personalisation in Malaysia's mental healthcare both among patients / clients and among service providers, the following passage provides the conceptual foundation:

“when communication breaks down, when it does not exist any longer, even in the form of conflictual communication (as would be the case in social struggles or political opposition), social groups and individuals become alienated from each other, and see

the other as a stranger, eventually as a threat. In this process, social fragmentation spreads, as identities become more specific and increasingly difficult to share” (Castells 2010a: 3).

Here, by the ‘breakdown of communication’, Castells captures the trend that communication processes are increasingly decentralised and individualised in the age of mobile social networks. Emergent are self-communication and ever more “specific” processes, powered by personally owned wireless communication technologies and communication networks, which are characterised by personal choice in the selection and rejection of media and messages. For Castells, then, two major trends in global communication processes can be observed. First, powerful segments of societies gradually lose their ‘monopoly’ of the basic patterns and substances of communications.⁵ Second, self-communication processes on the other hand continue to disrupt traditional orders of signification and identification.

In this expanding “condition of structural schizophrenia” (Castells 2010a: 3), Malaysia’s mental healthcare also experiences a shift at the micro level of communications between individuals. Because individuals no longer rely on centralised, instrumental, and top-down healthcare, a new form of mental health initiatives that resonates with the personalisation of individual behaviour has been on the rise in Malaysia. The following two passages are inserted in full to demonstrate the emergence of the personalised Self in the nation’s mental healthcare:

“Don’t pressure yourself trying to follow the same steps as others. Remember that you have your own path to success and there is no recipe that works for everyone. We all have a different exam paper in life, so take care of yourself first, everything else comes second” (PlusVibes 2021).

⁵ A question that could not be addressed by this dissertation is the extent to which Castells’ argument about the ‘breakdown of communications’ could be defended in a time when social media algorithms are structuring contents for user consumption and when social media companies are controlling personal big data for algorithmic and governmental purposes (e.g. *Malay Mail* 2016). However, it could be conceptually agreed that, despite the data control and trained algorithms in social media networks, contemporary communication processes, sustained by personal mobile devices, are evolving towards self-selection, personalisation, and diversification of information consumption. Moreover, big data is *user-generated*, suggesting the ground for the exercise of critical consciousness in a networking society.

“Convenient, customised and confidential care is centered around each Naluri member, whether at home or at work” (Naluri 2021).

The opening message by the PlusVibes founder to its website visitors targets the specific demographic of Malaysians in the personalisation processes. Four textual instances could demonstrate the Castellsian argument about the breakdown of traditional identification and the rise of personalisation in mental healthcare. First, the PlusVibes founder presupposes that “yourself” can be categorically separated from “others.” Second, she argues that every individual has a specific “recipe” for his or her own existence. Third, she argues that every individual has a specific “exam paper” in his or her own existence, meaning each person will have his or her own set of life problems. Fourth, she argues that the atomic individual must take care of himself or herself first, before “everything else” in existence. Here, PlusVibes is describing a particular experience in contemporary Malaysia, and demonstrating its understanding of the personalised Self, in order to advertise itself.

Similarly, Naluri’s passage speaks to this new trend in mental healthcare. Its services are designed to cater for every need of every individual client, from any geographical and occupational backgrounds. Here, the presupposition is that every individual is leading a completely different lifestyle in comparison with others.

Other than the clients, The Help Talk is also personalising its recruitment of professional healthcare service providers:

“The mental health professionals on this platform are not employees of The Help Talk, and we do not professionally oversee them. We rigorously screen each mental health professional to ensure that they possess the qualifications, experience, and registration/licensing that is required for them to practice before being on this platform. They are bound by their respective professions’ code of ethics, legislation, and professional body” (The Help Talk 2021b).

Here, one learns that every mental health practitioner who provides services to the The Help Talk’s clients is, apparently, different from another. Each of them possesses a unique qualification background, depth of experience, licensing source, and code of

ethics. What binds these individually unique professionals together is the mHealth application of The Help Talk, as well as its array of protocols (e.g. “screening”, “professionalism”). Mental health practitioners providing services for The Help Talk clients temporarily assemble on this platform to gain commissions for themselves; seemingly without any constitutional, national, governmental, institutional, communal, and legal necessities.

Increasingly, mental healthcare has observably transitioned from a centralised hierarchical system of instrumental functions into decentralised networks of irreducible individuals in connection, communication, and collaboration with each other. *The individual—as a self, projecting a specific set of ideas, background knowledge, personality traits, and life difficulties—becomes a new figure in Malaysia’s mental healthcare.* Detached from the signification order of the nation-state, traditional national and familial significations would thus no longer suffice to define who he or she is. Self-communication processes have indeed significantly enhanced the capacity of the individual in the reiterative process of self-identification. The personalisation of individual behaviour, the practice of self-identification, and the destabilisation of historical-communal sensibility in an emergent network society of self-communication processes suggests that the mental health domain would be also experiencing similar processes of network restructuration.

3.2. Managing Inter-Personal Relationships and Networks

Following the personalisation in mental healthcare, what follows is how individuals collaborate to build mental health initiatives. In the transition from the centralised form to the decentralised form of mental health practices, a new form of collectivism gradually bypasses the instrumental reductionism of its traditional counterpart. This structural transition is the domain’s adaptation to the shift away from traditional and top-down mass communications, and into relatively volatile networked self-communication processes (as the dominant mode of communication) in network societies. In this ‘networked mental healthcare’, the self-decided addition of individuals into interpersonal communication networks is leading to a new generation of *workplace*

relations. This form of workplace relations would be characterised by the management and adaptation of interpersonal relationships, replacing top-down delegation of tasks common to institutions.

Importantly, the previous section has alluded to a new risky situation, where the breakdown of the traditional mode of communications would lead to diversification and conflicting of approaches to information transfer, consumption, and identification among people. These processes of decentralisation would open the room for the increase in especially ideational conflicts among fragmented individuals, due to the increasing differences in ‘self-designs’ and information management in a network society. However, in the self-communicative processes of coproduction, interpersonal power relations (i.e. conflicts) among individuals would not conducive for productivity. Hence, following the expansion of self-communication processes and the gradual change to an ‘inter-personal’ form of power relationships, one expects to learn about the rise of ‘inter-personal respectfulness’ even *within* a common workplace. Here, ‘respectfulness’ is not a romanticised category of transcendental ‘human goodwill’ or an apolitical ‘moral code of conduct’. Rather, inter-personal respectfulness is a response to the irresolvable and growing *differences* among individuals in networked workplaces. If everyone is ‘different’ and ‘unique’, *all shall be respected* in the processes of communication. This constant and consistent *equalisation of power* emerges as the inevitable ‘social contract’ in the co-productive and co-managing processes of networked mental healthcare. In other words, relationships and networks are strategic processes that will require careful handling and management.

Accordingly, upon the emergence of personalised communication processes in mental healthcare, workplace relations have also adapted to the structural influences of this new form. Because the smallest unit of contemporary mental health is not an institutional instrumental position but a concrete ‘self-deciding’ individual, productive processes have also become less institutional, and become more inter-personal. Insofar as individual behaviour is personalised, ‘inter-personal’ relationships and networks will be part of the necessary consequences. This delicate shift is influenced by the *personal experience* in the new productive processes of Malaysia’s mental health governance.

In operational terms, individual stakeholders *choose* to ‘come together’ to co-produce mental health initiatives and co-design ecosystems. Ordinary citizens, non-

governmental stakeholders, researchers, practitioners, and government officials can proactively network to coproduce ideas and programs for Malaysians in need of mental health support. In fact, they can as easily *choose* to terminate their participation in these health networks. In light of these possibilities, five Malaysian cases can illustrate the growing need for mental health initiatives to carefully handle, gate-keep, and manage inter-personal networks.

First, the *New Naratif* data argues that “there needs to be collaboration between policymakers and other stakeholders” (Sim 2019) for the nation’s mental health policymaking, decision-making, and system-building. While it would be most ‘common’ to expect Malaysian parliamentarians, relevant leaderships from the Ministry of Health (MOH) Malaysia, and officials from the ASEAN Mental Health Task Force (AMT) to undertake this (re)invention of health ecosystems in Malaysian society, the *New Naratif* proposes the horizontal ‘reprogramming’ (i.e. sharing) of public health responsibilities and decision-making powers. In the new paradigm changing from institutions to networks, new inter-personal relationships will have to be built, managed, and sustained. This is because, not only the traditional national authorities, but also civil societal actors, individuals diagnosed with mental illnesses, mental health business leaders, and concerned citizens would enter the expanding decision-making networks. While this collection of stakeholders would be able to co-construct interpersonal networks for producing a mentally healthy society, the new challenge would be how these new networks could be managed and sustained for productive use.

Second, The Help Talk also adopts an inter-personal approach to managing their network of recruited counsellors and clinical psychologists. The following passage is cited for illustration and close reading:

“Help Malaysians in need by being on The Help Talk. You will be able to consult clients and do what you do best – caring, understanding, guiding them to new ways of thinking, and teaching skills to manage the challenges that they face in their lives. Don’t worry about the rest – we do them for you.” / “The Help Talk can be your main source of income, or as a supplement to your current work. You decide the amount of clients that you do therapy with here at The Help Talk. Most of the operations here are asynchronous, which means that you are able to log in daily at your most

convenient times of the day. You do not need to worry about anything else, other than to perform the work that you love” (The Help Talk 2021c).

From the above passage, a friendly approach to expanding and strengthening an existing communication network of counsellors and clinical psychologists of diverse professional backgrounds can be observed. Two key elements from the passage could be highlighted. First, the collaboration is completely based on negotiation, consensus, and an individual case-by-case basis. Every potential collaborator (whether a counsellor or a clinical psychologist) as well as the principle platform provider (The Help Talk) are in control of what they individually want (e.g. desired salaries, suitable schedules) and what they individually do (e.g. the amount and type of labour). This first subcategory is strongly demonstrated by the use of “asynchronous” collaboration, instead of normative ‘working hours’ (e.g. 8AM-6PM), because everyone has his or her ‘own’ schedule(s). Second, TheHelpTalk is apparently networking collaborators from a wide variety of institutional or professional backgrounds. This is illustrated by the negotiable setting of (1) income types, (2) number of clients, and (3) daily schedules.



Figure 3.2.1. Poster: ‘R U Ok??? Mental Health & Comedy in a Pandemic’

Source: Projek Dialog (2020a)

Third, the list of five speakers for Projek Dialog’s mental health forum come from five completely different occupational backgrounds (see screen capture 2.2.1.). From this ‘R U Ok???’ forum poster, the clue is the professional background stated under each of the five individuals’ names. These five occupations are: (1) clinical psychologist; (2) doctor-turned-comedian; (3) yoga instructor cum student; (4) filmmaker cum content creator; and (5) civil societal stakeholder. Similar to The Help Talk, Projek Dialog serves as a common platform (e.g. Instagram, crowdcast.io) to gather a variety of professionals for a common objective. Logistically speaking, the assemblage of these individuals would presumably not be possible without a *consensus* on the time, date, hosting platform, discussion points, and theme of this activity.

Following are the fourth and fifth examples from Naluri and PlusVibes:

“We don’t charge by expensive consultation sessions. Instead, we give you unlimited and on-demand personal coaching services (optional: at a fraction of the price) through our app platform, giving you a myriad of resources and support networks that will help you increase the success rate of your intended lifestyle change by up to 3x” (Naluri 2021b).

“Whether it is individuals or organisations, it’s a topic we shy away from as we are afraid of the negative perception associated with it. But this platform, which is anchored in motivation and support, breaks down the barriers a little and gets users to access the help they need”—‘PlusVibes’ (Gopinath 2020).

The Naluri passage emphasises an abundance of resources and professional support, but which would only be deployed “on-demand.” This means that healthcare services are provided without forceful ‘expert’ imposition on, and with informed interests and consensus from, the customers.

The PlusVibes founder’s speech provides insights into how she approaches the breakdown of negative ideas on mental illnesses. Emphasis is put on “break[ing] down the barriers a little.” This phrase hints that health education at the level of individuals (i.e. ‘users’) cannot be conducted through forceful means. Instead, an incremental approach to progress and change is proposed. This example suggests that *public* mental health communications and education (i.e. in comparison to traditional nationwide

health promotion) are becoming interpersonal, intimate, and sensitive to every individual's cognitive, intellectual, and developmental backgrounds.

In summary, it is reiterated that the task to manage of interpersonal networks and the equalisation of perspectives in Malaysia's mental healthcare is growing in importance. The transition from the traditional form of centralised institutional power relations towards a new and risky form of inter-personal power relations means that individuals are adapting to a new way of 'working together'. This new form is possible and necessary as a result of mass self-communication processes. Because the dominant form of communication as the basis of a societal structure is becoming increasingly personal in Malaysia today, one would continue to see diversified, personalised, and 'respectful' mental healthcare processes. On the larger scale, the practice of interpersonal respectfulness in co-productive processes is actually paving the way for the expansion of 'public diplomacy' and participatory approaches in mental healthcare; this is the concern of the next and final section of this chapter.

3.3. Adaptable Plans, Diplomatic Solutions, and Participatory Affordances for Nationwide Mental Healthcare

Following the previous sections, it is learned that a new form of mental healthcare in this emergent network society builds on large-scale and highly respectful connections among mental health stakeholders. This section proceeds to the broadest level of the analysis, and will try to demonstrate that communications-based co-production of mental healthcare increasingly depends on public diplomacy and participation.

Public diplomacy differs from the hierarchical outlook in traditional healthcare processes in two ways. First, the delivery of services transitions from mass-based to individual-based processes due to the growing significance of personalised needs. Second, the delivery of services is becoming less hierarchically performed, and more horizontally and communicatively co-produced. In network societies, as Castells (2008: 85) astutely argues, "Because people have come to distrust the logic of instrumental politics, the method of direct action on direct outputs finds increasing support." In other words, because collaboration and consensus can be rapidly forged via instantaneous and

needs-based communications, contemporary mental health initiatives are more direct, more productive, and more effective in addressing real-life individual concerns than their institutional predecessors.

Consequently, one could expect to observe a stronger urgency and assertiveness in reaching out to and calling for individuals, consumers, and clients among mental health initiatives in Malaysia today. While being proactive and assertive, it is equally important to notice that these initiatives could not be imposing their services, as they would recognise the importance and priority of ‘power balance’ between initiatives and individuals. Because initiatives are co-produced by individuals and stakeholders, and because these initiatives also require quick and large-scale support from participants, networked mental healthcare stipulates the construction and maintenance of close rapport and healthy relationships in diplomatic processes of work.

The three following passages are cited in full to demonstrate the extent to which mental healthcare is experiencing a new proactive, collaborative, and diplomatic form:

“MENTARI is a new approach initiated by the Ministry of Health Malaysia (MOH) to improve outreach and re-integration of people with mental health problems” /

“MENTARIs work closely with other MOH service components and attempt to build more linkages with other governmental / non-governmental agencies and the public” (Mental Health Innovation Network 2021).

“Be connected online to a qualified counselor or psychologist today” (The Help Talk 2021a).

“Our multi-disciplinary teams of Dietitians, Doctors, Fitness Coaches, Executive Coaches, and Pharmacists speak your language in more ways than one. Just like you, they understand local lifestyle constraints and challenges, thereby giving them the upper hand in customising a plan that isn’t just catered for the masses” (Naluri 2021b).

First, though still under the supervision of the MOH, the MENTARI network is called a “new approach” by this ministry. Indeed, MENTARIs can be considered as new, insofar as the MOH takes the initiative to reach out to other stakeholders and share the public health responsibility and decision-making powers. Not only does it relate to

other components of the MOH; it actively seeks collaboration with non-governmental and citizen stakeholders. Here, it would seem that the MOH is adapting to a form of production akin to ‘networking’, as the traditional form of hierarchical instrumentality is being replaced by collaboration and diplomacy. In less romanticised terms, in order to maintain their relevance and applicability amidst networking transitions, even national governmental agencies (and their nationwide initiatives and plans) have to actively seek to build new ‘working relationships’ with non-governmental stakeholders and citizens/netizens. The nation-state would continue to lose its legitimacy and require maintenance of that, because in this emergent network society, consistent and honest communications have become the primary means to ensure continuing relevance.

Second, The Help Talk is more direct than the MENTARI network. In promoting the initiative, The Help Talk uses the imperative syntactic form: “be connected online [...] today.” Here, this imperative form seems less to be an invitation than an urgent call for attention and connection. Without connection and collaboration with clients, The Help Talk could not build and expand its business networks.

Third, the case of Naluri best illustrates proactive diplomacy and negotiation for mental healthcare. The passage speaks to an anonymous, intimate ‘you’: an individual with a particular language preference, a particular lifestyle, and a particular set of life challenges. Moreover, Naluri emphasises that its networks of health professionals are highly equipped to work closely with this ‘you’. By underscoring that its approach is not mass-based, but rather individually and respectfully customised, new working relationships could begin to be built.

Recognising the rise of diplomatic networks and participatory initiatives in producing mental healthcare services and plans, it would now be necessary to formally synthesise the participatory affordances provided by networking communications technologies and the organisational form of networks. Accordingly, the participatory affordances of mobile communication networks for Malaysia’s mental healthcare include, but are not limited to, the following four.

1. ***Accessibility***. Mobile networks improve the accessibility of healthcare services, mental health communications, and collaborative treatment planning especially for ordinary citizens.

2. ***Adaptability***. Mental healthcare and health governance practices are becoming more adaptable to changes in schedules and circumstances in the age of asynchronous, instantaneous, and mobile communications.
3. ***Negotiability***. Plans for mental healthcare, whether at the national, private, or personal levels, are becoming less ‘imposing’ and hierarchical, and becoming more negotiable, diplomatic, and sensitive to differing cases.
4. ***The power of connecting and switching resources among networks of mental health stakeholders***. The various stakeholders in Malaysia’s mental healthcare are now able to enhance their channels of diplomatic health communications via mobile communication technologies and the practice of networking. In fact, intellectual, logistical, and material resources can be shared and/or exchanged among governmental and non-governmental stakeholders for various *common* purposes.

To conclude, this chapter has traced a series of participatory transitions, from the smallest to the largest units, in Malaysia’s mental healthcare processes. By following the changes from the smallest unit of the individual, to the largest unit of nationwide public diplomacy, these transitions have been systematically captured and illustrated with a number of Malaysian case studies.

Interestingly, the (momentary) co-existence of two forms of spatial-temporal work arrangements in mental healthcare has been observed. While primary care services, hospitals, and governmental institutions of health still exist and remain reliant on work routines and the space of places, new ways of delivering and restructuring mental healthcare via mobile communication networks are concurrently expanding in Malaysia. Thus, alongside national health institutions, mental healthcare is gradually becoming more interactive, intimate, and sensitive to needs. Furthermore, a list of participatory affordances has been compiled.

Nevertheless, the rise of communication networks and participatory affordances does not spell the end of the analysis, because the broader applications of networking

in the various subdomains of mental healthcare remain to be dissected. These broad influences and applications will be studied in subsequent pages.

CHAPTER FOUR

Emergent Participatory Practices in Malaysia's Digital and Mobile Healthcare

Introduction

Chapter Three covered a series of transitions towards participatory networks in Malaysia's mental health governance. Nevertheless, the concrete practices that follow these transitions remain to be studied. Accordingly, this chapter aims to account for a number of emergent features in participatory mental health governance, and substantiate these said features with real examples. Because the networking form has introduced transient and needs-based communication networks in mental health, the basic practices of (1) information access, (2) distribution of resources, (3) health communications and promotion, (4) regional health governance, and (5) national and/or public health policymaking are witnessing new approaches.

In the first analysis, the large-scale emergence of participatory practices in Malaysia's mental healthcare is possible, because the networking form has profoundly disrupted and restructured the production and management of (1) *time* and (2) *space* among increasingly differentiated Malaysians. In this emergent network society, space and time are less universally and centrally managed, and that their developments have become instantaneous and fragmented. These spatial-temporal transitions replace (1) institutional places with individuals and their self-selected communication networks, and replace (2) national development, universal working hours, and quotidian work-life routines with personalised schedules and self-defined well-being. Mobile networks and personal schedules provide the participatory affordances for Malaysians to reconsider traditional missions of communities, institutions, societies, and nations, whether as individuals, or as newly formed publics.

Indeed, the networking form has been supporting a new generation of mobile and participatory health practices. Notable and common examples include, for instance,

personalised information access and health-related expressions on social media platforms; the use of mobile health (mHealth) apps via clicking one's smartphone from literally 'anytime, anywhere'; or the flexible settings of treatment and consultation sessions via personal healthcare contacts on cross-platform instant messaging apps. After the dissolution of spatial and temporal constraints, new mental health practices continue to be forged, circulated, and evolve in the personal communication networks of Malaysians.

From the available data, this chapter is able to identify five (5) new categories of mental healthcare practices in an increasingly networking Malaysia. This list could not claim to be exhaustive, due to a limitation in the sampling size. Future research endeavours adopting the dissertation's conceptual framework may encounter additional categories and subcategories, depending on the types and sizes of the data sampled from the transitioning nation. The five categories are:

1. Mobile information access;
2. Mobile patient-practitioner communications;
3. Mobile transnational networks (i.e. evolving from the practice of intergovernmental regionalism, such as ASEAN);
4. Networks for health deliberation and voice equality; and
5. Networking stakeholders for mental health governance.

4.1. Mobile Information Access

The first area of an ongoing mobile restructuring is public access to mental health information. The traditional vertical model where patients consult and pay for health advice from healthcare institutions is being gradually replaced by instantaneous and ubiquitous access via the digital device. This access is also often free of charge, provided one is an Internet user in a networking society. In categorical terms, the public consumption and dissemination of health information stems from a number of supportive conditions: (1) the availability of the digital infrastructure; and (3) the basic

prerogative to use and share health information from and to anywhere. These supportive conditions are supposed to be available in network societies, nevertheless.

Mobile restructuring of public access to mental health resources follows the spatial-temporal reconfiguration in a network society (Castells 2010a: 440-448; 2010c: 2741-2744). Traditionally, utility of public health facilities, expertise, and information can be costly, in terms of both money and time. The costs usually owe to the travelling, architectural, and administrative processes that are entailed in the institutionalisation of health expertise, knowledge, and authority, and in the consumer's use of public or private health resources. In a network society, the practice of 'space' as a category of societal governance dissolves and reshapes, from the institutional and the architectural, to the productive flows of communication networks.

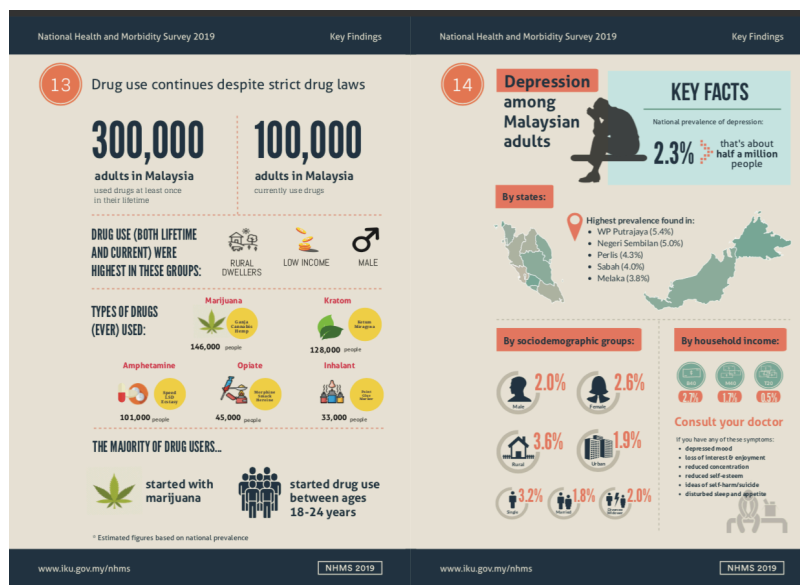
In this context, consumption of mental health information and health communications operates on the basis of networks. Three Malaysian examples can illustrate this category of networked health practices: (1) the NHMS reports and infographic booklets available through a click on the website of the Institute of Public Health (see Screen Capture 3.1.1. and Screen Capture 3.1.2.); the free-of-charge PlusVibes mobile mental health application (*KOSMO!* 2020); and the public free-of-charge forum organised by Projek Dialog on the relationship between mental health and comedy during the coronavirus pandemic (see Screen Capture 3.1.3.).

The NHMS infographic booklet by the NIH (2019) synthesises and visualises the mental health information (e.g. drug use, depression, mental health of children, functional difficulties) in a non-technical language to support understanding and self-decided healthcare choices among Malaysian publics. All the editions of the NHMS are available and can be accessed on the website of the Institute of Public Health via smart or electronic devices.

The PlusVibes application contains chatting platforms, motivational videos, informative reading, and meditation guidance in relation to "family, finances, physical health, leadership, self-love" (PlusVibes 2021a), which are perhaps the most common concerns that would connect and generate interactions among citizens of this 'modernising' nation. PlusVibes founder, Madiha Fuad, has also stressed that this mHealth application has been designed to be highly user-friendly, choice-based, and can benefit even those who are "less adept" at ICTs (*KOSMO!* 2020).

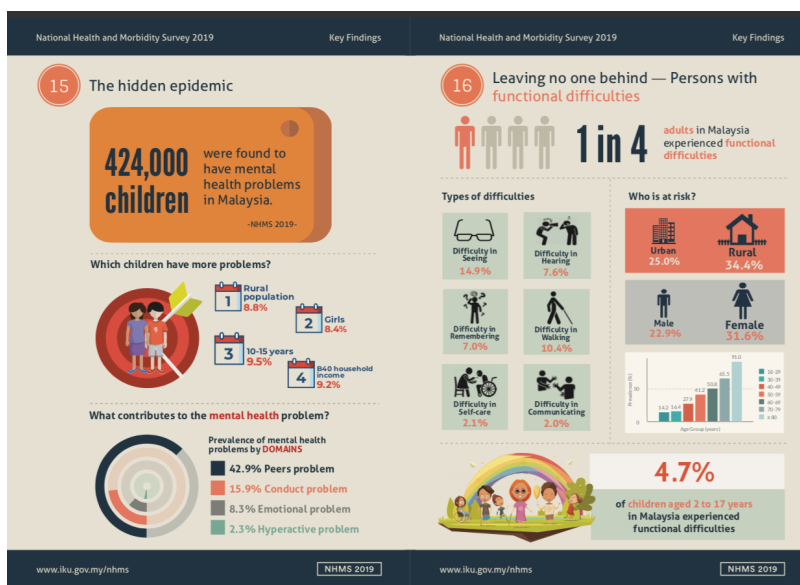
The public forum by Projek Dialog, titled ‘R U Ok??? Mental Health & Comedy in a Pandemic’, is consistently interactive. The event has generated dialogue not only between the invited speakers and the moderator on screen, but also between the organiser, the speakers, and the audience in the comments. Nearly two hours of direct exchanges on mental health, self-care routines, and the Freudian and existentialist approaches to the human psyche and comedy among a clinical psychologist, a doctor-turned-comedian, a filmmaker, a yoga instructor, and a virtual crowd took place, without anyone travelling and spending on any form of transportation to a central institutional venue. The recorded forum has been reformatted into a free-to-access YouTube video for those who did not (manage to) attend live.

Although these three initiatives by three quiet different organisations differ by design and content, they bear at least four structural commonalities. They are publicly available for free. They can be accessed from anywhere with a network connectivity through a click on a smartphone, other smart gadgets, or the personal computer. Access to these resources depends on personal choice and need. Access to these three initiatives is not limited by the traditional categories of geographical distance, personal schedules, socioeconomic backgrounds, organisational settings, and institutional power differentials. As observed, mobile communication processes allow movement and reconfiguration of public health informational access even amidst traditional state management of physical space and movement (e.g. the movement control order [MCO] during the coronavirus pandemic). These three Malaysian mental health initiatives have demonstrated the spatial-temporal reconfiguration in public access to mental health resources, information, support, and communications.



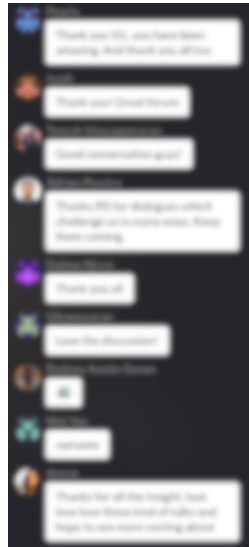
Screen capture 4.1.1. Depression among Malaysian adults

Source: National Institutes of Health (2019: 13-14)



Screen capture 4.1.2. The hidden epidemic

Source: National Institutes of Health (2019: 13-14)



Screen capture 4.1.3. The comment / chat function of a live forum⁶

Source: Projek Dialog (2021a)

Finally, new approaches to informational access should not mean that formal knowledge produced within scientific institutions is obsolete or can be easily displaced by individual filtering preferences. Instead, it would be more accurate to view that the Malaysian layperson's consultation with the experts on health concerns is more likely to come with greater health literacy and intelligence. People could / should independently study mental health information for themselves. However, in this new landscape of public access to mental health information, new questions especially about how networked health information access would destabilise and disrupt national health information systems should be formulated. Yet, reassurance is provided by the fact that, at least from the available data in this section, decentralised and central sources of mental health information, whether imparted or discussed, continue to be based upon rigorous (natural / social) scientific research procedures.

⁶ The content in Screen Capture 3.1.3. has been intentionally reduced to invisibility in strict compliance with the conditions that have been set for the ethical approval for the use of the sampled data by the research ethics committee of the Faculty of Arts and Social Sciences (FASS), the University of Nottingham Malaysia. In particular, it has been agreed between the candidate and the ethics committee that user expressions of any kind on the theme of mental health in the data will not be published for the protection of the safety and privacy of the users themselves.

4.2. Mobile Patient-Practitioner Communications

Moving towards non-hierarchical management of patients, the relationship between the patient and the healthcare practitioner is being reconfigured. This reconfiguration is taking place in two main ways. Firstly, the multimedia-aided streamlining of the traditional processes of scheduling, appointment, and patient-expert communications is becoming common. Second, the use of mobile data collection techniques to track the patients' behavioural patterns for improving their physical and mental health continues to expand, with the informed consent of the patients. Not only are mobile communications helping replace the time-consuming and energy-consuming processes of scheduling, travelling, and face-to-face meetings. They have also supported the development of new approaches, such as mobile behavioural management.

There is a commonality among these two ways of improvement: namely, they provide instantaneity, transparency, and accountability in treatment processes. In concrete terms, these point to three advantages. First, patient-expert communications are fully recorded for future reference. Second, behavioural management and improvement are traceable, scalable, and calculable, both for the health of the patients and for the business strategies of the service providers. Third, professional feedback and expert advice are directly justifiable with behavioural scientific evidence.

Moreover, 'seamlessness' has become a most frequently used term. The Help Talk (2021a) proposes that they "aim to provide a seamless experience that is affordable, convenient, and confidential for clients." Naluri (2021a) also proposes that its team "seamlessly links with connected devices to track and monitor your progress." Seamlessness denotes the breakdown and disappearance of spatial boundaries, which would be an intrinsic quality of mobile health communications. In practical terms, procedural seamlessness is emerging as the 'guiding principle' for mobile and participatory treatment processes today.

The 'seamless' mobile patient-practitioner communications are composed of, at least, the following three components (see Diagram 3.2.1.): (1) asynchronous communications or instant messaging; (2) mobile behavioural management; and (3) mobile self-management.

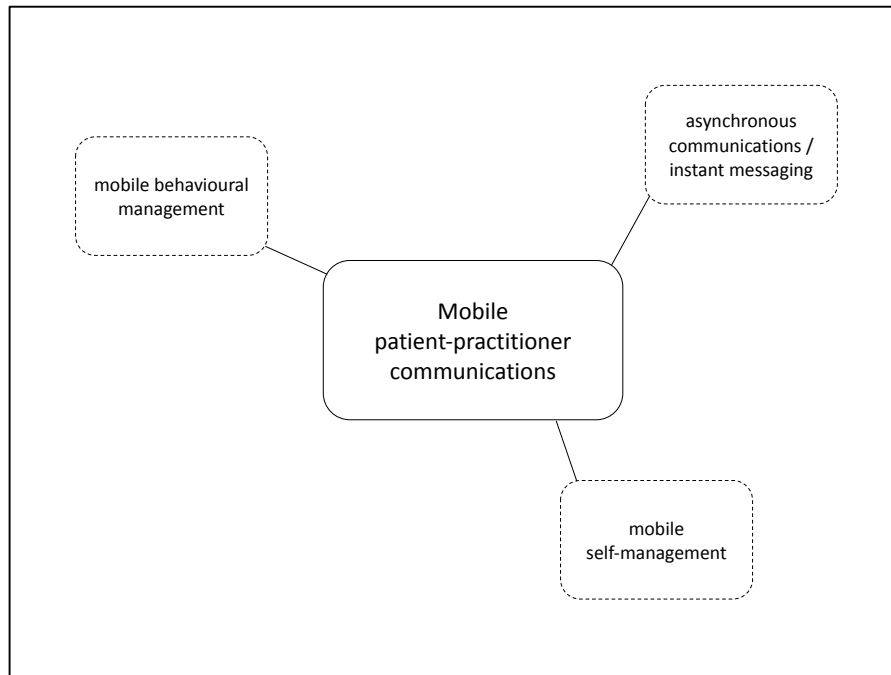


Diagram 4.2.1. The three components of mobile patient-practitioner communications

Asynchronous communications. Instant messaging practices mean that the traditional practices of schedules, appointments, and institutional settings are increasingly replaced by choice-based, context-based, needs-based, instantaneous, and asynchronous communication processes. Asynchronous communications take place according to highly contextualised necessities. The three mobile health applications under examination—i.e. The Help Talk, Naluri, and PlusVibes—provide this type of communications for the patients and their allocated health practitioners.

Mobile behavioural management. The monitoring of behavioural change is informed by systematically self-recorded data of individual behavioural patterns. This big-data management technique is already common in the global industry of ‘digital therapeutics’. The accumulation of data about the patient’s food intake, frequency of activity, and patterns of thinking is done by the patients for their practitioners by following the instructions on the stipulated mHealth application (see Naluri 2021a). In other words, the monitoring and adjustment of a patient’s behaviour is done through the mHealth application.

Mobile self-management. Mobile self-surveillance and self-management can be achieved in at least four ways, exemplified by Naluri’s (2021a) approach. These four ways are (1) the use of daily reminders; (2) the documentation of food intake via a photo

food journalling platform; (3) the documentation of thinking patterns via a digital thought journal for cross-sectional analyses and comparisons of thought and behavioural patterns; and (4) the long-term tracing of weight loss or gain via a provided Bluetooth-connected weighing scale. These mobile tools in an mHealth application are provide the means for patients to manage themselves in compliance with their practitioners' specific health intervention strategies.

4.3. Transnational Ambitions of Malaysia's mHealth Businesses

The logic of mobile networking and the use of mobile applications as connective tools have significantly empowered Malaysia's private sector in their ambitions to expand and regionalise their health and mental health initiatives. This proliferation of and growing preference for the 'networking' logic could be attributed to (1) the weakening of the traditional boundaries of the nation-state and (2) the continual growth of globalised urban citizenries in Malaysia. While these business initiatives do not necessarily explicitly 'challenge' systems of national health governance, and while Malaysia's 'national mental health system' remains intact, mobile transnational healthcare networks, particularly of the private sector, continue to expand.

In recent years, there have been an increasing number of health regionalisation endeavours by intergovernmental agencies. In the past three years alone, there have been three WHO (2019b, 2020, 2021) publications (*Recommendations on Digital Interventions for Health System Strengthening*; *Digital Implementation Investment Guide* (DIIG); and *Global Strategy on Digital Health 2020-2025*) that advocate for the integration of digital interventions into national, regional, and international health governance. In fact, these documents explicitly mention that their target readers are: "decision-makers in ministries of health and public health practitioners, to aid them to develop a better understanding of which digital health interventions have an evidence base to address health system needs" (WHO 2019b: 8). The explicit target readers are, indeed, the ministries of health of nation-states: the legally authoritative source of health governance. This overt mentioning of target readers reinforces the divide between (1)

centralised health governance and (2) health business initiatives centred upon returns on investment (ROI).

Indeed, despite the WHO's vehement initiatives, the economic potential of mobile communication technologies has been seemingly successfully harnessed by private mental health investment endeavours that transcend hierarchically organised systems of national health governance. Among the sampled Malaysian cases, an increasingly common ambition is to achieve expansion across the Southeast Asian region (e.g. Malaysia, Singapore, Indonesia, and others) in the near future. Public statements from Naluri and PlusVibes can demonstrate the regional and transnational ambitions of Malaysia's private health businesses. Here, two extracts are fully inserted to illustrate each speaker's line of argumentation:

“As we shift more from communicable diseases to non-communicable diseases, Southeast Asia is caught between building healthcare systems that need to cater for both. Unfortunately, most chronic disease care is still provided within costly hospital settings. We need more out-of-hospital care, and centered around the individual, in a cost-effective, scalable, and accessible way” (Naluri 2021c).

““The plan is to go regional,” [Madiha Fuad] says. “It’s a mobile app, so you can access it from anywhere. We want to first target countries with high-pressure work environments, and we will be partnering local NGOs. That’s where the bulk of the funds that we get from our investors at that point will be channelled towards — creating more languages for the platform, and funding on-site teams to generate content. Right now, the focus is building a solid base and getting more people to use it so we can refine and perfect the user experience.”” / “Similarly, from a regional and global perspective, there are not many platforms that bring users and content together like PlusVibes does, the exception being a website in Singapore. “But we are an app, and that’s important because it means we are accessible anytime, anywhere,” she points out”—‘PlusVibes’ (Gopinath 2020).

Naluri speaks of the emergence of a new health landscape today, for which a new approach to healthcare must be devised and implemented. Mental health, for instance, can be considered as a non-communicable disease, because it is not transmissible from one individual to another. Thus, as Naluri proceeds, while

centralised health systems (e.g. hospitals, primary care services, clinics, community medical centres, health ministries) are meant to contain, curtail, and prevent the disastrous outbreak of communicable diseases (e.g. epidemics, pandemics), the rise of non-communicable diseases (i.e. mental illnesses) among individuals in informational societies means that hospitalisation must make way for the use of alternative treatment methods of personalisation and customisation throughout Southeast Asia in order to maximise the number of clients, and correspondingly, of ROI.

PlusVibes founder, Madiha Fuad, speaks of her ambition “to go regional” to support individuals in high-pressure Southeast Asian economies. Its expansion strategy is to work with NGOs from these regional contexts. Its logistical power comes from the fact that PlusVibes, as a mobile application, enjoys asynchronous and instantaneous communications with collaborators, consumers, and healthcare professionals beyond geographical and sovereign boundaries.

Indeed, transnational healthcare businesses co-exist with regionalised health governance in the age of mobile communications and networks. While centralised efforts to devise new governmental frameworks for regional or global health governance continue to emerge, such as those recommendations and strategies in the WHO publications, transnational mental healthcare investments—exemplified by such Malaysian private initiatives as Naluri and PlusVibes—have also been growing in size and ambition. Nevertheless, it should be kept in mind that these business ambitions for transnational expansion also point to new avenues for multi-stakeholder, public-private collaboration, in the context of improving the nation’s mental health governance.

4.4. Networks for Health Deliberation and Voice Equality

Fourth, Malaysians are witnessing the emergence of networked health publics in the digital public sphere. Networked health publics differ from traditional health communications by at least three characteristics.

1. ***Participatory media affordances.*** First, networked health publics enjoy a new set of participatory features on available networking platforms, including

mobile and web apps. In traditional practices, information usually comes from institutionalised authorities of power/knowledge via top-down, one-to-many communications of the mass media. Moreover, discussion on public health issues would more often involve patient-expert interactions within concrete institutional spaces. The rise of networked health publics means that at least two participatory possibilities have emerged. First, the transfers and management of mental health information have shifted into one-click mobile public access, co-production, and self-selected circulation. Second, networked health publics engage in open health deliberation. Even though they are often deemed less than 'real', networked health publics show their co-productivity and societal impacts via key social media metrics: for instance, numbers of followers, likes, comments, shares, and website traffic statistics.

2. ***Transparent and horizontal consensus-building.*** Second, networked health publics undertake transparent and horizontal consensus-building and check-and-balance processes within their social networks. In comparison with traditional healthcare processes, ordinary netizens, including increasingly diverse young Malaysians, are able to directly participate in public events of deliberation on mental health issues, in such a way that all interactions and agreements made on a particular networking platform are recorded for future public reference. One example would be the use of voting on questions, comments, and polls to signal popularity, relevance, and preferences.
3. ***Voice equality.*** Third, through the new media affordances, networked health participants can contribute their concerns to the virtual public discussion, often with the security option to use anonymity and pseudonyms. Ordinary citizens, media prosumers, and non-expert audiences who are concerned by the theme of mental health have begun to participate in co-designing approaches, solutions, and initiatives for Malaysia's mental healthcare. Audiences, patients, experts, civil societal organisers, and institutions together contribute questions, examples, and ideas for improving the nation's mental healthcare within transient communication networks.

The first and second characteristics of networked health publics can be illustrated by the following four Malaysian examples:

1. MENTARI and MyHEALTH (under Malaysia's MOH) (see from screen capture 3.4.1 to screen capture 3.4.5);
2. Naluri (see screen capture 3.4.6);
3. Projek Dialog; and
4. PlusVibes (see screen capture 3.4.7.).

MENTERI and MyHEALTH under Malaysia's MOH are active in building national digital health publics. Screen capture 3.4.1. shows a MENTARI infographic from infosihat.gov.my (MOH 2021), where all twenty-five MENTARI stations across East Malaysia and Peninsular Malaysia, alongside all the social media accounts of the MOH's MyHEALTH application, have been organised in an easy-to-read manner. Screen capture 3.4.2. shows the Instagram account of MyHEALTH (2021a), where sixty-nine thousand (69,000) followers form a national MyHEALTH public. Screen capture 3.4.3. illustrates a national MyHEALTH (2021b) public on Facebook, of more than two hundred and sixty thousand (260,000) followers. Screen capture 3.4.4. is the cover page of an all mental health edition (October 2020) of an e-magazine by the MOH (2020), titled *MyHEALTH FOR LIFE*. The publication of this e-magazine assumes a reading public increasingly interested and aware of mental health concerns. Screen capture 3.4.5. records the web analytics of the MyHEALTH official website. In April 2021, more than six hundred thousand (600,000) visits to the governmental health website were recorded. The variety of contents, and the different numbers of followers or visitors for the different platforms by the MOH, MENTARI, and MyHEALTH, may suggest that different segments of Malaysia's networked (mental) health publics have different preferences for health information and interactions.

The various platforms of Naluri have also consolidated networked health publics, such as the playlist of testimonials and their viewers on Naluri's YouTube account. Naluri's YouTube page, having uploaded 68 videos, has garnered three hundred and thirty-seven (337) subscribers. The number of views for each of the user testimonials

ranges from ninety to two hundred and forty (90 to 240) views. An informative mental health video by Naluri (2020), ‘Are You Okay? How to Reach Out to Someone You Think is Struggling with their Mental Health’, garnered four hundred and fifty-three (453) views and sixteen (16) likes as of 28 May 2021.

For Projek Dialog’s forum on mental health and comedy during the coronavirus pandemic, seventy-five (75) individuals, four (4) multi-sectoral panellists, and a moderator have registered to take part. Fourteen (14) questions have been posed by the crowd. Twenty-six (26) from the crowd have voted in a live poll “Do you think memes about mental health are helpful or do more harm than good?” started by the forum organiser.

PlusVibes (see Screen Capture 3.4.7.) has garnered almost three thousand followers on Instagram. Here, PlusVibes has harnessed all the features. These include Instagram stories, profile highlights, and posts. A number of posts are meant to promote the PlusVibes mHealth application. There are a large number of infographics that provide condensed guidelines for self-care. In October 2020, PlusVibes shared a poster about its Zoom-hosted series of six live sessions, ‘Mindful Talks’, where parenting, entrepreneur perseverance, heart health, financial crisis, mental health response to Covid-19, and mental resilience would be deliberated. This poster garnered 251 likes and 8 comments.



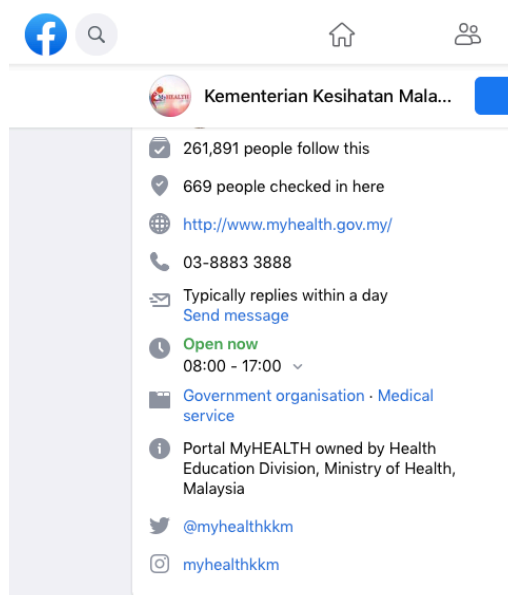
NEGERI	NOMBOR TELEFON	NEGERI	NOMBOR TELEFON
PERLIS		MELAKA	
MENTARI Kangar	+604-9738382	MENTARI Alor Gajah	+606-2892301
KEDAH		PAHANG	
MENTARI Pendang	+604-7596412 ext 114	MENTARI Balok	+609-5834523
MENTARI Kuipang	+604-4761729 / 30	MENTARI Bendera Baru Mentakab	+609-2772521
PULAU PINANG		KELANTAN	
MENTARI Butterworth	+604-3221908	MENTARI Ketereh	+609-7885055
PERAK		TERENGGANU	
MENTARI Simen	+605-5439467 ext 128	MENTARI Wakaf Tapai	+609-6801376
MENTARI Batu Gajah	+605-3463333 ext 248	MENTARI Hospital Sultanah Nur Zahirah (HSNZ)	+609-6212121 ext 2966
MENTARI Selama	+605-8394233 ext 335		
SELANGOR		JOHOR	
MENTARI Selayang	+603-61270946	MENTARI Pekan Nenas	+607-6991926
MENTARI Hospital Tuanku Ampuan Rahimah (HTAR)	+603-33757000 ext 1302 / 03-33701046 ext 107 or 104	MENTARI Masai	+607-2518758
MENTARI Sungai Buloh	+603-61402364		
WP PUTRAJAYA		SABAH	
MENTARI Putrajaya	+603-88811232	MENTARI Kota Kinabalu	+6088-240 984 ext 227 / 234
NEGERI SEMBILAN		SARAWAK	
MENTARI Kuala Pilah	+606-4812158	MENTARI Petra Jaya	+6082-241753 / 082-238228 ext 242
		MENTARI Jalan Oya	+6084-323555 ext 119
		MENTARI Bintulu	+6086-859000 ext 4107, 4105
		MENTARI Miri	011-1056782

Screen capture 4.4.1. Nationwide MENTARI infographic

Source: Ministry of Health Malaysia (2021)



Screen capture 4.4.2. Basic statistics of MyHEALTH's Instagram account



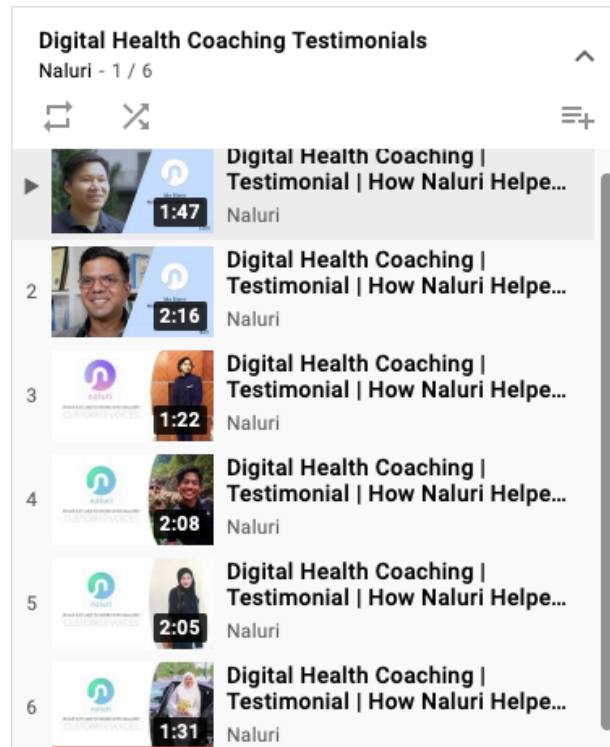
Screen capture 4.4.3. Basic information on MyHEALTH's Facebook profile



Screen capture 4.4.4. *MyHEALTH FOR LIFE*, October 2020 edition on mental health
Source: Ministry of Health Malaysia (2020)

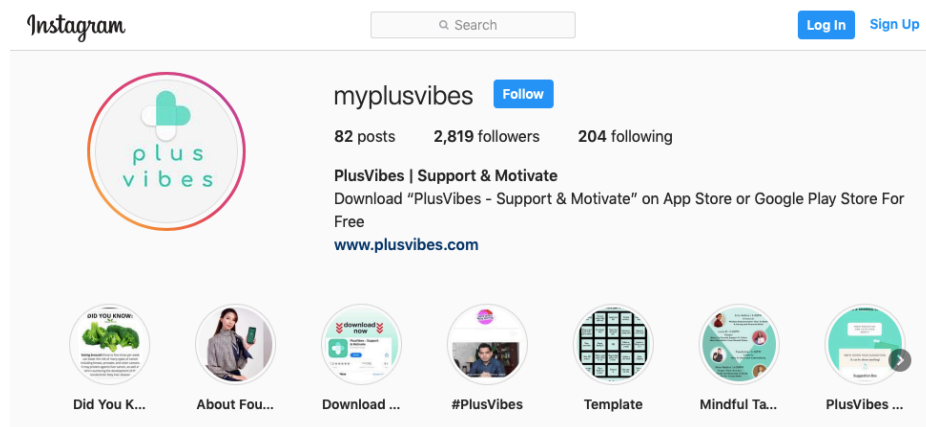


Screen capture 4.4.5. Web traffic statistics of myhealth.gov.my.
Source: These web analytics are produced through *Similarweb*.



Screen capture 4.4.6. Naluri’s YouTube playlist on ‘Digital Health Coaching Testimonials’

Source: Naluri (2020)



Screen capture 4.4.7. Basic statistics of PlusVibes’ Instagram account

In addition to increasing participation, social network functions have allowed the equality of voices and perspectives among digital health publics. Micro-level public participation and the equality of voices in the public sphere have become possible due to the technical affordances of a large variety of networking communication

technologies. These include social media, livestreaming, online video, and instant and private messaging platforms.

In centralised health institutions, participatory engagement and voice equality in mental healthcare would be less encouraged. This is usually because central institutions of health are not state-funded and legalised as a platform for participatory and compassionate co-management of public health issues. Rather, health institutions reify the power imbalances from the scientific expertise revered in the nation: a ‘power/knowledge’ in mental health (see Chapter Two of this dissertation). Thus, patients are more often only to be diagnosed, treated, and reintegrated into society under the strict guidance of institutionalised health authorities.

On the other hand, the most advanced features in social media and livestreaming platforms have allowed public participatory engagement. The range of new media affordances, including questions and answers (‘Q&A’), polls and votes, the comment section, and instant messaging platforms, allow ordinary citizens to rebuild ways to communicate with each other and with health experts over long distances as transient health publics.

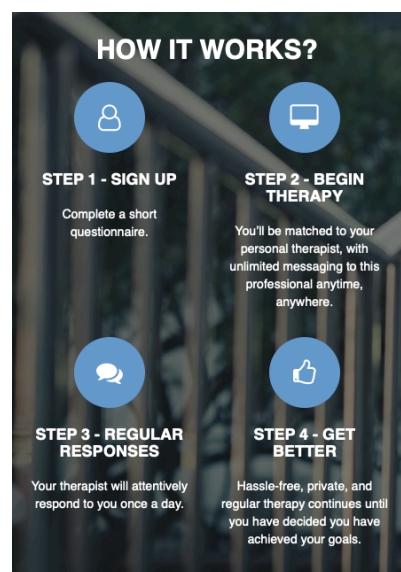
The following three examples can demonstrate how voice equality has been promoted and practised in Malaysia’s mental healthcare.

1. The Help Talk mHealth application (see screen capture 3.4.8.),
2. The Naluri mHealth application, and
3. Projek Dialog’s crowdcast.io forum, ‘R U Ok??? Mental Health and Comedy in a Pandemic’ (see screen capture 3.4.9.).

While these three programs have adopted different approaches to streamlining engagement between the stakeholders in Malaysia’s mental healthcare, they illustrate that networked mental health initiatives increasingly recognise the voice and participation of diverse Malaysians. The increasing appreciation for participatory voices may not be because their clients are always more important. It is logistically possible because networking service providers are much better equipped than their hierarchical predecessors to accommodate and manage large volumes of differing demands and perspectives.

On Naluri's (2021b) official website, a particular column, titled 'Transform your health with Naluri' states that, "conveniently available in the palm of your hands and personalised around your needs, preferences and schedules, transforming your health has never been easier. So why wait? Start your life-changing journey today." As an initiative in the regionally emergent industry of digital therapeutics, Naluri here assumes that an individual, especially the "palm" of his or her hands, is a node in a vast network of networks. The implicated item is the mobile or smartphone. The smartphone, where the Naluri mHealth application resides, allows the user to assert his or her unique demands to specify the services he or she wants to receive.

On The Help Talk's (2021a; see screen capture 3.4.8.) website, four steps are delineated for the user to receive 'regular responses'. The second step states, "unlimited messaging to this professional anytime, anywhere." Here, although the therapist will only "attentively respond to you once a day," the user would be able to convey his or her needs as detailed as he or she wants. Not only does this help address the unique needs that may often be overlooked during highly scheduled, time-constrained face-to-face consultation sessions. Unlimited instant messaging and asynchronous communications allow the user and the therapist to fully articulate their demands and responses, building strong ground for long-term constructive feedback loops between them.



Screen capture 4.4.8. The Help Talk's four-step instructions for users

Source: The Help Talk (2021a)

The case of Projek Dialog (2020a; 2020b) illustrates the proactive assertion of voices among a virtual audience during a mental health forum on the live broadcasting platform, Crowdcast (see from Screen Capture 3.4.9.).



Screen capture 4.4.9. The voting function during a live forum

Source: Projek Dialog (2020a)

From the above illustration, the audience was simultaneously listening and posing questions to the invited speakers. Here, the number of ‘VOTES’ on the left side of the user interface indicates the popularity each question gains. The ‘VOTES’ also reflect the degrees to which these audience comments are important to or resonate with the virtual audience. For example, there were 5 votes in support of a particular question at minute 98:10. In response, the moderator might have decided to interact with this publicly supported question, and prepared for a line of discussion and enquiry among the multi-sectoral panellists and audience members.

These new health publics harness the participatory affordances from (1) mobile *as well as* digital communication platforms. Key digital initiatives by the MOH Malaysia, Naluri, Projek Dialog, and PlusVibes, as well as the new health publics that they have garnered from these virtual public spheres, illustrate the high degree of

productivity and interactivity in Malaysia's transitioning mental health landscape. Moreover, these Malaysian cases demonstrate the emergent ways in which nationwide public deliberation on mental health issues can be collaboratively (re)designed.

4.5. Networking Stakeholders for Malaysia's Mental Health

Governance

Political, economic, and civil societal sectors in Malaysia's emergent network society have been working together for a number of mental health and suicide prevention initiatives. While a majority of these multisectoral activities remain to contribute to improving components of the national mental health system, there has also been a gradual growth of collaborative non-institutional initiatives. Key instances of these activities tend to be about redistributing and exchanging financial and intellectual resources for improving an array of components in Malaysia's mental healthcare.

Several agencies of the Malaysian government have worked with civil societal associations and local communities in mental health and suicide prevention to strengthen "24/7" (i.e. all day, all week) direct mobile support amidst mental health or suicidal emergencies. This series of collaborations includes (1) a 24/7 free-of-charge helpline initiative from August 2019 by the Malaysian Communications and Multimedia Commission (MCMC) and Befrienders KL, (2) a provision for 24/7 support via Talian Kasih 15999 by the Ministry of Women, Family, and Community Development, and (3) in April 2019, then Deputy Minister of Education Teo Nie Ching shared an idea to step up counselling support (in terms of human resources and therapy methodology) in national schools for both teachers and students (Nuradzimmah 2019; Sim 2019). In September 2021, the Sarawak Social Development Council (MPSS) under the state's Ministry of Welfare, Community Wellbeing, Women, Family and Childhood Development (KWKPK), in collaboration with the Criminal Investigation Department (CID) of the Sarawak Contingent Police Headquarters and a number of leading non-governmental stakeholders in psychiatry, advocacy, and communications

research, has launched a guidebook for the police's media statements or press releases on suicide incidences for the objective of safe media reporting.⁷

Furthermore, there has been a strong aspiration for multisectoral collaboration for strengthening the MENTARI national initiative on early diagnosis, clinical treatment, and assertive community treatment (ACT). In response to the public sentiment on the need to shift from treatment-based initiatives to prevention-based ones, the nationwide MENTARI networks (with MENTARI Selayang in Kuala Lumpur as the coordinating centre) have been taking up the “challenges” in adapting information technologies to the development of “preventive and recovery-based” human and research resources (Mental Health Innovation Network 2021). As the Mental Health Innovation Network (2021) adds, the task of designing this “clinical IT-based nationwide system” requires help from ‘other’ stakeholders: “There is a lot that we need to learn and challenges are aplenty—but we are definitely giving it our best shot and is looking forward to sharing this journey with others.” In fact, MENTARIs aspire “to build more linkages with other governmental / non-governmental agencies and the public” (*Ibid.*), although it remains an important policy question as to what particular agencies, which particular advocacy groups, and how the public can specifically contribute to developing much-needed nationwide mobile mental health governance mechanisms.

In non-national settings, multisectoral diplomacy and collaborative efforts project a more technologically advanced outlook. Key tools adopted for mental health support in the private sector include mHealth applications and instant messaging applications for long-distance management of behaviour and asynchronous communication. The adoption of mHealth applications means that these private initiatives bypass the traditional barriers of time (e.g. personal schedules) and geographical and institutional spaces (e.g. travelling, transportation) for healthcare practices and patient-expert relations. Two notable examples are PlusVibes and Naluri. PlusVibes (2021a) “integrates local mental health associations, volunteered listeners and campaigners in a platform that promotes self-development and motivation,” while Naluri (2021a) claims to be “pioneering next-generation digital therapeutics for chronic

⁷ To watch the guidebook launch event in full, kindly visit MPSS' (2021) Facebook Live recording via the link provided in the bibliography.

disease management, mental health support and digital health coaching.” In fact, the two initiatives are collaborative by design. Expert contributors have been gathered for these mHealth application development initiatives originate from a wide variety of professions to cater for highly customised, individuated demands. PlusVibes collaborates with qualified listeners and volunteers from local mental health NGOs for tackling six key themes (i.e. financial advice, relationship advice, stress advice, childcare advice, health advice, and general personal problems). The Naluri team of managers and advisors is composed of business leaders, medical doctors, cloud-based technology experts, psychologists, clinical psychologists, psychiatrists, and public health experts.

For the future, how these national and non-national collaborative efforts might develop and intermingle remains unknown. Similar to national initiatives, PlusVibes and Naluri have been fostering the switching of financial and intellectual resources between stakeholders for developing mHealth applications for treatment-based, individuated mental healthcare. On the other hand, the degree to which the nation’s mental health governance has adequately capitalised on the participatory affordances of mobile communication technologies for improving the biopolitical diplomacy in this emergent network society remains to be monitored.

Additionally, an emergent issue would be the seeming shortage of public interactions between national and private actors for mental healthcare. This lack of connection can be attributed to the incomplete adoption of mobile communication platforms as a revenue for the nation’s health diplomatic processes. Indeed, it has been observed that both state health initiatives and private health initiatives have collaborated with civil societal organisations for their respective efforts. But this is accomplished in a separate manner, whereby national institutions and business communities do not seem to have intersected in any of the nodes in Malaysia’s ‘mental health networks’. However, while it remains unclear why there remains an observed non-intersection between state powers and tech-business powers in mental healthcare, civil societal organisations for mental health have demonstrated the strong capacity for linking, communicating, and switching resources among governmental, business, health, and citizen stakeholders. This capacity for public health diplomacy can be further expanded through a more frequent and public use of mobile communication processes. Indeed, *the policy*

emphasis is, and should be, placed on the need to harness mobile communications for improving the diplomatic processes between these three societal leaderships for addressing preventative and structural concerns in the nation's mental health governance.

In summary, multi-sectoral networking and public diplomacy continues to develop in the governmental, non-governmental, and private domains. National health stakeholders have been fostering financial and intellectual collaboration with NGOs. Entrepreneurial initiatives are also working with private health experts, business management leaders, and NGOs to develop their mHealth applications. While diplomatic communications between public and private institutions continue to build up sustainable momentum for the longer term, it seems that Malaysia's civil societal or advocacy groups for mental health and suicide prevention (e.g. LAMAN MINDA, I-Life Suicide Prevention Association [Penang], etc.) are well-equipped, in terms of diplomatic capacity and domain knowledge, to be a consistent powerhouse for horizontal connections across the entire array of country-level stakeholders (i.e. governmental, business, health) for developing the nation's mental health governance.

More importantly, these horizontal connections can capitalise upon the emergent two-way relationship between public health and networking communication technologies. Public health diplomacy should be convened for the development and application of mobile diplomatic mechanisms for Malaysia's mental healthcare. Mobile communication technologies should also (continue to) be harnessed for improving and expanding the nation's public health diplomacy.

CHAPTER FIVE

Discussion: Towards Public Co-Governance

Introduction

Through the past three chapters, this dissertation has attempted to trace the components of a series of participatory network transitions in contemporary Malaysia's mental health governance. Chapter Four, for instance, has tried to showcase, subcategory by subcategory, a series of comparisons between (1) traditional statist practices and (2) emergent participatory practices in this subdomain of health governance. Yet, it should be stressed that, the entire line of analyses must not be construed to be a celebratory perspective on these observed participatory transitions, due to three reasons.

First, in terms of research, this dissertation intends to be historically, theoretically, and socially grounded. This has been achieved by a close examination of the documents, press statements, and organisational practices from Malaysia's interdisciplinary and multi-sectoral mental health 'industry' (i.e. public and private; offline and online; civil societal, governmental, and entrepreneurial). This examination is conducted with constant comparative attention to Foucault's (1988 [1961]) and Castells' (2010a; 2013) qualitative content analyses on the organisational structures of asylums and societies.

Second, in terms of data collection, this dissertation could not precisely pinpoint the exact extent to which these participatory network transitions have propagated, proliferated, and/or popularised in the nation (which seems to remain in a constant struggle between nationalism and globalisation). This drawback is a necessary result of the limited scope of the data sampled. Indeed, a satisfactory answer to this question will require a broader set of samples that take into account the remarkably diverse backgrounds in Malaysia's geographically fragmented demographics. However, it could at least be reiterated that the series of participatory practices in contemporary Malaysia's societal governance, and particularly in the nation's increasingly multipronged mental healthcare, is an emergent phenomenon in continual development.

Third, in terms of concrete societal impact, this dissertation still has not provided an answer to the practical question: (1) whether and (2) how the networking form is ‘more advantageous’ for the national people’s QOL and for democratic societal governance than the statist form. That the operational societal use-value of participatory networks remains an uncertainty stipulates a critical discussion. Accordingly, this chapter aims to offer a number of responses to this contemporary problematic: namely, the practical implications of these participatory network transitions on traditional statist practices and mental health governance in Malaysia’s emergent network society. These responses would constitute part of the discussion that intends to help various groups of readers and stakeholders make sense of the present and future communications-led networking transitions in the multi-dimensional domain of societal governance.

Moreover, while the previous three chapters have provided the analyses to answer the research questions, this chapter will more directly formalise these answers. To recall, this dissertation is guided by the questions of (1) how the political, economic, and civil societal leaderships in Malaysia conduct mental health governance in an emergent “network society” (cf. Castells 2010a; 2010b; 2013), and (2) how the old constructs of ‘biopolitics’ and ‘governmentality’ have been challenged, or can be rebuilt, by these new contexts. Again, it should be highlighted that the answers to these two questions are neither straightforward nor simple, mainly due to the *co-existence* of two major forms of power arrangements in this transitioning society: the hierarchies; the networks.

Indeed, according to the previous chapters, all three domains of leaderships seem to have engaged in statist and networking forms of mental healthcare. In particular, the networking form points to a relatively emergent and evolving practice in Malaysia’s mental healthcare, which requires socio-historical grounding. This grounding will require two steps. First, the networking form of mental health governance will be situated in relation to its traditional statist counterpart. Second, these networking transitions will be put into comparison with Foucault’s categories of (1) biopolitical states and (2) liberal governmentality. Towards the end of this chapter, it is aimed that these key problematics can be shaped into a formal set of guidelines, or a conceptual model, for future research on the emergent biopolitical and governmental forms and practices for the goal of improving people’s QOL in a networking Malaysian society.

Taking into account these necessary tasks, this discussion chapter will be organised into three sections. Section 4.1. will formally conclude the structural transitions within Malaysia's mental healthcare and underscore their societal implications. Thus, this first section will also respond to the research questions of this dissertation. Subsequent sections provide a critical exploration into the affordances, possibilities, and challenges that are opened up by the collection of findings on participatory networks for health (i.e. bio-political) governance. Section 4.2. proceeds from the first section to discuss a number of the practical challenges and affordances for a new generation of biopolitical and governmental processes in Malaysian society. Section 4.3. develops from the challenges and opportunities discussed in 4.2., and proposes a new direction for Malaysia's governmental rationality.

Following the rise of participatory governmental networks of stakeholders in Malaysia, a new governmentality would look past the hierarchical and unidirectional production and management of legal frameworks, social contracts, and individual self-discipline and freedoms. Instead, beyond any legalistic or universal frameworks, a new model of governmentality—tentatively called 'participatory governmentality'—revolves around (1) participatory networks and (2) transparent public diplomacy, providing the ground for multi-sectoral societal leaderships in emergent network societies to regularly rethink and recalibrate how they can collaboratively manage and foster (3) the long-term sustainability and enhancement of the QOL of national citizenries.

5.1. SOCIETAL FORM: From Statism to Networks

In historical terms, participatory network transitions would be possible because of an imminent crisis of the legitimacy of the statist form (i.e. statism) in a society. The global crisis of this form, indeed, has been elucidated in a chapter in the second volume of Castells' (2010b: 303-366) *Information Age* trilogy, *The Power of Identity*, subtitled: 'A Powerless State or a Network State?' This unresolved problematic of 'statism in crisis' is the starting point to the observed organisational transitions in Malaysian society.

5.1.1. Instability and destabilisation of the nation-state

In line with the analysis of ‘networking’ as a technological edifice and an emergent organisational form, Castells’ analysis of the state moves past the narrow perspective on the state as an identifiable, tangible set of ‘institutions’. Instead, the state has been viewed as a particular *approach* to exercising and organising authorities, and producing values, within a particular society, during a particular historical moment. To understand this approach of the state, this dissertation has identified a number of subcategories from the case of Malaysia’s mental healthcare. These include, but are not limited to, (1) the use of hierarchies, (2) top-down delegation of duties, (3) centralised reservoirs of resources, as well as (4) instrumental subjects and their precise functions within a legal-moral order.

Fundamental to this enquiry on the rise of networks in Malaysia, however, is the ongoing, gradual (1) *instability* and (2) *destabilisation* of this approach of the state. These two challenges to the statist form, moreover, are not the same, which Castells has not explicitly clarified (even when he has indirectly proposed) in his analyses.

Instability. By ‘instability’, I mean that the statist form is itself experiencing an unstable self-constitution due to the emergence of a new governmental form. Castells, in fact, has argued that, across many national contexts, the state has been adapting, responding, and reacting to new organisational forms. In Malaysia, there was already an active call in 2016 by the MOH, for example, for a “multisectoral collaboration” to help improve the nation’s mental health system (ASEAN 2016: 67). This observed proactivity from the state in its rebuild and survival in the age of networked communications shows why the state needs to be considered as one of the active actors in a nation’s ‘social networks’ in constantly asserting and preserving its influence in the minds of the national people. It is thus suitable to suggest that the nation-state has begun to experience (as an ‘actor’) an instability in the face of new forms of societal governance.

Destabilisation. By ‘destabilisation’, I mean that non-centralised, peripheral, and multi-pronged individuals and networks actively challenge the nation-state as external ‘pressures’. From the analysis of this dissertation, one highly relevant and illuminating example is a passage from Azran Osman-Rani, co-founder of Naluri (2021): “Extensive experience in building new, innovative and disruptive businesses that challenges [sic] conventional status quo.” Here, an individual statement from an mHealth website poses a direct question on the historical necessity of the status quo.

The instability and destabilisation of the nation-state would signal the beginning of the crisis of statism. Here, one ought to stay cautious towards declaring the ‘end’ of the statist form and the end of the nation-state, because the state does not seem to have given up struggling for survival and continual influence, even in the face of participatory and social network transitions (cf. Castells 2010b: 343-355; Stalder 2006: 104-105). For the Malaysian context, Chapter Two has elucidated the entrenchment of statist mental healthcare, legally and institutionally. The statist form is most certainly not facing the beginning of the end. However, it seems to be, at least, facing a survival crisis. Following the abovementioned examples, it can be observed that the usual correspondence between (1) the constitution of self-identities and (2) the national influence of the nation-state has been increasingly weakened by the symbolic influences of polymorphous sources in the communication networks. These most recent examples of instability, destabilisation, and changing mechanisms of self-identification, however, must be understood as only part of the ongoing processes of a networking restructuration of Malaysian society.

5.1.2. New space, new temporality, and an emergent societal structure

The statist form in Malaysian society is facing a long-term survival crisis because an alternative societal structure is on the rise and has been growing in its applicability for nationwide organisational practices. For this new societal structure to emerge, changes to the two foundations in the constitution of societies, time and space, are key. The causal relations would suggest that, if there were disruptions to (1) the unidirectional historical imagination of ‘national development’ and (2) the hierarchically organised space of institutions, the nation-state, as a necessary result, would not be able to resume “the four processes of domination, legitimation, development, and redistribution” (Castells 2010b: 361). Structural shifts in the practices of mental healthcare would immediately follow these changes in time and space. Indeed, digital communication networks allow for these changes in time and space. Today, networked mental healthcare allow access and health communications from anywhere, at any time, and for all individuals who own mobile communication technologies.

This new paradigm of time and space aims for ‘seamlessness’ in productivity; work can move past bureaucratic processes, and towards consensus-based alternatives. In today’s healthcare where communication becomes less conducted in disciplinarian

institutions, it would be increasingly performed through digital and social networks. The processes of delivering services and health communications become asynchronous, instantaneous, choice-based, and electromagnetic transmissions of symbols. Relatively recurrent examples from the study's data would be the use of mHealth applications and instant messaging tools for a new generation of mental health communications. This new set of healthcare processes does not only change the relations within health institutions; because they bear the capacity to be ubiquitous throughout Malaysia, they could change relations and processes in mental healthcare across wider social fields.

Here, two key categories would be the regular concern. First, the spatial category of flows is becoming dominant. The space of flows describes the productive process of informational transfer and communications from one node to another among networks of collaborators. Second, the temporal category of timelessness and instantaneity is also becoming dominant. Timeless time, in contrast to disciplinary time, renders possible the initiation of events, processes, and communications in sudden, simultaneous, or asynchronous manners, depending on priorities. These changing categories of time and space point towards a more accessible and convenient generation of appointments, schedules, meetings, health information access, public diplomatic conferences, and national policy recommendations for mental health communications and governance in Malaysia (e.g. Mahathir 2021; Majlis Pembangunan Sosial Sarawak 2021).

Together, (1) the proliferation of networks of informational flows and (2) the gradual breakdown of time into episodes of events bring about the crucial moment of structural transitions, which seems to remain incomplete. In operational terms, network societies are where processes of production, consumption, and circulation are (1) moving past hierarchical, unidirectional, and universal processes, and (2) moving towards horizontally organised, multidirectional and polymorphous, and highly individually and contextually conscious alternatives. The expansive growth of a new societal structure, to be temporarily nominalised as participatory networks, is being witnessed.

5.1.3. Networks and their far-reaching societal implications

The ongoing spatial and temporal transitions in Malaysia's mental healthcare towards the networking form of production bear far-reaching societal implications. For instance, a persistent symptom of these transitions is the growing need to adapt to participation,

collaboration, and networks that the nation-state has been coming to terms with. In terms of space, when nodes of individuals (i.e. patients, health experts, tech experts, civil societal organisations) could be connected via the use of mHealth applications (e.g. Naluri, The Help Talk, PlusVibes), the legally-bound instrumental hierarchies and institutional buildings could come to be relinquished. In terms of time, schedules are not centrally fixed before being distributed to an organisation's instrumental subjects in a mechanical manner. Instead, schedules are highly negotiable in accordance with the individual's professional, health, or even emotional needs. The new organisation of production and of work challenges the approach of the nation-state to modify itself in keeping with the maturing epoch of digital and mobile communication networks.

Indeed, the emergence of contingency and adaptability in the processes of production and delivery of mental healthcare means that productive labour (even in a health domain) could move past uniform and repetitive organisational routines. Here, "statism disintegrated in the face of new information technologies, instead of being capable of mastering them" (Castells 2010b: 341). What Foucault (2008: 1-25) has observed as legalistic governmental conduct, where productive freedom of a population is ensured by a universal hierarchical framework, falls apart, when contingently and flexibly built consensus are becoming a new norm. The difference would lie in the transitions from a law for freedom and progress, towards a priority for participation, consensus, and collective well-being, for networks of participants would not be connected without each agreeing that his or her needs can be met via regular communications.

As universally applicable frameworks continue to lose necessity, new standards come to be decided based on contexts, demands, and the negotiable protocols of particular networks.⁸ In fact, due to these foundational principles of horizontal negotiation and decision-making, networked processes and protocols of production can be regularly checked by 'equal partners' in the networks, and ensured to be transparent, effective, and accountable, in comparison to the authoritarian statist counterparts where rooms for

⁸ The protocols of networks, by which members and nodes of these networks behave, can be relatively flexibly reformed based on majority and context-conscious demands and consensus via functions available in the digital and/or mobile communication platforms. The mHealth applications under this dissertation's analysis, such as Naluri and The Help Talk, purport to provide this new decision-making mechanism (see Chapter Four).

arbitrary top-down decisions exist. However, the transitions from the state to the networks are not necessarily as categorically clear as the Castellsian framework suggests.

In Malaysia, how participatory networks are slowly disturbing the operations of the nation-state could be one of the most significant examples of their far-reaching implications. A strong case to demonstrate the increasingly nebulous relations between the networking form and the statist form in contemporary mental healthcare, and more generally, in the nation's biopolitical governance, is the MOH's MENTARI network. For instance, the following passage is insightful and deserves attention:

“There is at least one MENTARI in each state in the country, and they are managed by the Department of Psychiatry and Mental Health in the nearest hospital [...] In 2014 - mainly due to funding from the government - the number had increased to twenty, with MENTARI Selayang (located approximately 13 km north of Kuala Lumpur) acting as the central coordinating centre.”

Here, witnessed is either a concrete convergence of, or irresolvable tension between, the aforesaid two forms, because the MENTARIs behave in the manner of a networking edifice that is nonetheless concurrently under the purview of statist agencies. First, while the Department of Psychiatry and Mental Health exercises direct supervisory authority over every MENTARI station, MENTARIs are networked across and between all states in East and Peninsular Malaysia. Second, while there are more than twenty MENTARIs coordinated across these localities in Malaysia, MENTARI Selayang in the urban capital of the nation retains the “central” source of managerial powers. Here, two instances of the profound paradoxes in how the biopolitical nation-state is conducting its mental healthcare initiative can be observed. The question will need to be asked: Is Malaysia's national mental health system still centralised, or already networking?

The answer would not be either/or. In network societies, central forces usually retain their credibility by distributing decision-making powers to subordinate levels or marginal zones. This frame would suggest that Malaysia's nation-state may not only be destabilised; for it could rather be re-configuring itself into a “network state” (Castells 2010b: 340-361; Stalder 2006: 122-128) in order to survive the growing challenges of an emergent network society or from participatory networks. In my view, these MENTARIs

are demonstrating a new reality, where networking transitions are putting the pressure on Malaysia's federal governmental agencies to adapt or reform.

While Malaysia's traditional biopolitical institutions have been behaving in a manner akin to the form and practice of networking, the extent to which they are becoming an 'equal partner' with other stakeholders and sectors for Malaysia's mental health and societal governance remains a question for further monitoring. However, one could see that, in comparison to what was documented from Europe half a century ago⁹, Malaysia's contemporary biopolitical and governmental processes, including those that involve the nation-state, seem to be less delineable, and are changing categories. During this moment of structural transitions and adaptations, a new set of uncertainties, challenges, and opportunities are bound to emerge.

Alongside the national mental health system, innovative practices of consensus-based participatory networks and networking communication technologies have been adopted in an emergent landscape of 'networked mental healthcare'. The current concern indeed pertains to the wider *implications* of the co-existence of the statist form and the networking form in the recent evolution of biopolitics and governmentality in Malaysian society. While the three sectors of leaderships, including governmental health institutions, seem to be variously responding to participatory network transitions, they may encounter a series of new common challenges in their potentially converging pathways.

5.2. PUBLIC HEALTHCARE: Reprogramming Bio-politics

Due to the increasing adoption of new communication technologies and participatory networks in Malaysia's mental healthcare and societal governance, the governmental behaviour that Foucault (1978: 136-143) first identified, namely the "biopolitics" of the population, would require a communications-based 'reprogramming' in light of new structural challenges in an emergent network society.

⁹ See Foucault's (1988 [1961]: 241-278) qualitative content analysis of the organisational routines of and documents from the post-Enlightenment European psychiatric institution, in 'The Birth of the Asylum', *Madness and Civilization*.

On the one hand, I acknowledge that there are a large number of Foucauldian social scientists who pay close attention to new and powerful (because ever more delicate) forms of the state's biopolitical management of the population in the wake of the rise of, for instance, new interventions on human reproduction at the global level, biomedical nanotechnology, genomic management, consumer neuroscience, and neuro-economics, in the first two decades of the twenty-first century (e.g. Rabinow and Rose 2006: 204-215; Rose and Novas 2007: 439-463; Neidich 2013: 133-144). These Foucauldian social scientists are preoccupied by recording and analysing new patterns or technologies that are adopted by modern nation-states, "whose highest function was perhaps no longer to kill, but to invest life through and through" (Foucault 1978: 139; cf. Foucault 2008: 317-324; Jessen and von Eggers 2019: 55-58).

On the other hand, this section is less preoccupied by a critical questioning of biopolitics, and more concerned with an emergent participatory approach to programming and conducting biopolitical governance in network societies. Here, key variables of life, health, and individual well-being remain invested 'through and through' with societal attention; meaning, this dissertation would not agree with the perspective that just because individual health is central to a nation's capitalist exploitation, health governance and communications should then be eliminated. The most important difference that a 'network society' and social networks can provide to biopolitics, rather, is that a greater quantity and quality of participation, consultation, and contribution from wider segments of the national publics can be involved, and taken into due consideration, for the needs-based improvement of the people's QOL, including that in Malaysia. The *participatory reprogramming of the nation's bio-political processes* is this section's proposition.

Indeed, I would first contend that the nation-state's symbolic control of the biopolitical machinery has been weakening, because other sectors of actors in Malaysia are becoming increasingly able to participate in and contribute to how (1) technological and human resources and (2) discourses of mental healthcare, are produced, distributed, and structured. Ordinary citizens/netizens, business communities, and NGOs in Malaysia have begun to take part in the nation's biopolitical processes, whether for profit maximisation and ROI, well-being, discursive development and equalisation of voices, or the future of public health governance. The proposition to reprogram processes of biopolitics are therefore not a unilateral assertion, but a derivation from the sampled data

for this study. The nation-state, supposed to be the institutionalised ‘voices’ of the national people, would need to be gradually reprogrammed in such a way that it actually behaves in accordance with frequently and regularly gathered public consensuses.

In practice, this participatory network reprogramming, derived from the analyses in Chapter Three and Chapter Four, will begin from the micro levels and progressively expand to the broader (networked) social fields. Particularly, this section will underscore three possible avenues where ordinary Malaysians, and key Malaysian stakeholders, could harness the available range of participatory network affordances to reprogram their own nation’s biopolitical processes.

5.2.1. Learning ‘Quality of Life’ (QOL)

First, stakeholders in Malaysia’s mental healthcare are beginning to prioritise QOL as individuals will inevitably face a set of common challenges in life. Initiatives and statements from PlusVibes, Naluri, and *New Naratif* (Sim 2019) have argued for the importance of helping individuals sustain mental resilience and build a basic independent capacity to face such issues as employment and financial management, managing human relationships and networks, work-life balance, and leading healthier lifestyles. The health, well-being, and growth of a nation would also realistically require the nation’s citizenries to first become self-sufficient and ‘strong enough’ in addressing challenges. Overall, the QOL of every individual should become the new priority, and constant reminder, when it comes to the processes of societal and health governance, complementing or replacing the often-unspoken priorities of national and/or regional economic ‘development’.

5.2.2. De-marginalisation, adaptability, and transparency

Second, stakeholders in Malaysia’s mental healthcare have been trying to take into consideration the immense and different challenges the nation’s citizenries face ‘on the ground’ by using a new range of consultation and advocacy practices. Key initiatives that fit into this category is the public forum by Projek Dialog and the interview article by *New Naratif* (Sim 2019). Three new layers of transparent public diplomacy have been observed from these initiatives. First, stakeholders are already beginning to pay attention to the de-marginalisation of different voices among the Malaysian publics. Second, the adaptability of institutional and governmental processes has become a new necessity in

response to the increasingly diverse contributions from networked publics. Third, because participants in the bio-political decision-making processes are increasing and will continue to increase in number in an emergent network society, the transparency of decision-making processes is important to ensure that none is more or less prioritised, and that priorities can be set only in accordance with the consensuses built among networked publics. These three layers of public diplomacy can be concurrently achieved via such techniques as sharing open links to survey questionnaires, public anonymous voting in live polls, and responsive public conferences on social networks.

5.2.3. Diplomatic processes and training for mental health governance

Third, the new landscape of networked mental healthcare involves active participation of several sectors of individuals and groups. Patients and citizens/netizens should not be considered as the passive ends of mental health communications, passive receivers of mental health information and advice, and passive consumers of mental health services. The great institutional “silence” (Foucault 1988 [1961]: x-xii) should be replaced by (1) diplomatic healthcare practices and (2) a transparently safeguarded equality of voices among experts and non-experts. For instance, while the PlusVibes mHealth application provides customisable mental health and motivational resources free-of-charge, it also looks for funding, feedback, and advice from other stakeholders in mental healthcare (e.g. NGOs, consumers) for improvement in such key areas as user-friendliness, precision of support, and geographical coverage (e.g. Gopinath 2020).

However, it should also be highlighted that the ‘human skills’ of public diplomacy and collaboration are not inborn. People, including young and new stakeholders, may find it difficult to take part in diplomatic processes where many counterparts are involved, due to a number of reasons, such as not having been accustomed to the processes, challenges, and sheer unpredictability of public diplomacy, participation, and human relations (see Jenkins et. al. 2006: 12-18). The situation may turn worse, when such heavy themes as mental health, suicide prevention, and health policies are involved, bringing an additional layer of intimidation, or cause for hesitance, to participants. While such techniques as anonymous voting and responding to survey questionnaires may mitigate these challenges to participation, societal and mental health governance in participatory reprogramming should take into account the need for various forms of media education

and diplomatic training for the nation's citizenries, young or old, in becoming active contributors to a networked nation's decision-making processes.

5.3. SOCIETY: Towards a Participatory Governmentality?

5.3.1. Two drawbacks of liberal governmentality: power, people

From the eighteenth century onwards, European (always male) leaders in economics and politics had been debating, deciding, and reforming the legal framework in which citizens operate in socio-economic processes (Foucault 2008: 1-25). Freedom and progress had been strictly supervised by a universal framework, unilaterally deliberated by a cluster of European male economists and statesmen. 'Liberal governmentality', or the 'liberal art of government' (*Ibid.*), while ensuring and producing the freedom to produce, had been, paradoxically, a largely masculine, unidirectional and unilateral (i.e. top down), and hierarchical rationalisation of governmental practice. This liberal framework to sustain the social contract for civic freedoms in a population, also being practised for Malaysia's mental healthcare and societal governance today, should be fundamentally questioned and reconsidered, because it contains two (2) intrinsic drawbacks.

ONE: *The abuse of legally centralised power.* The first problem of a governmental framework centred upon legally bound hierarchies is the possibility of despotic arbitration. From the onset, the development of liberal governmentality had been dominated by a few highly influential European men, who were economists, philosophers, and statesmen (cf. Foucault 2008: 1-25): Adam Smith, Jean-Jacques Rousseau, Emmanuel Kant, Jeremy Bentham, Robert Walpole, Marquis d'Argenson, the French "Physiocrats," and the "English Utilitarians," for instance. Here, it could be observed that there had been a monopoly over the discourses and practices of the production of societies and societal freedom in the speeches and writings of a cluster of elite figures. Again, this is a monopoly-for-freedom paradox. In the simplest terms, civic freedoms are safeguarded by a number of men on behalf of populations under a clear hierarchy of social statuses.

This arbitrary and despotic background to supposedly 'universal' freedoms is also emblematic of postcolonial Malaysia. The only difference in the Malaysian case is that

the liberal nation-state developed in a more violent, explicitly authoritarian manner, despite the freedoms inherited from the British colonial government. Two notable examples are (1) the Malaysian New Economic Policy from the Tun Abdul Razak administration in the 1970s as implemented by what was called the Second Malaysia Plan; and (2) the manipulation and abuse of media power by the Mahathir administration from the 1980s onwards (cf. Lee 1992: 156-163; Nain 1994: 181-189). Such is the societal structure—that is, liberal statist institutions centrally and arbitrarily exploited by a closed group of political economic elites—where a few generations of Malaysians have been living and ‘developing’.

In fact, Castellsian scholars have mentioned how (successfully) the paradoxical system of liberal governmentality has worked for the economic development of Malaysia and other Southeast Asian and Asian “tigers” (Castells 2010a: 9-14; Stalder 2006: 119-120). Here, the historical combination of the authoritarian nationalist framework and free economic policies (i.e. the paradoxical social contract) has propelled Malaysia to the climax of postcolonial development. Such a combination was decided and managed by a centralised group of decision-makers, consistently led by symbolically influential statesmen and state-cultivated capitalists (cf. Lee 1992: 156-163). Such was the historical effect of the inheritance of British liberal governmentality in postcolonial Malaysia’s development. The problem, in short, is the risk of non-monarchical secular despotism, because decisions are inherently conditioned to be centrally and unilaterally made from the top of liberal institutions and nation-states.

Malaysia’s statist mental healthcare, or the ‘national mental health system’, works in this liberal governmental framework. There is a hierarchy of docile subjects, whose layers of leaderships relay strict decisions, instructions, and disciplines from the top to the bottom in a chain of commands. The hierarchical and unidirectional process that runs from the ASEAN, to the Malaysian government, to the Malaysian Ministry of Health, to the National Institutes of Health, to the national mental health system, and to the hospital and the psychiatric personnel, speaks of a liberal social contract that strictly ensures that individual freedom is exercised in accordance to the solidity and stability of regional and national development, and not necessarily the welfare or QOL of the national people.

TWO: *The exclusion of people*. This second drawback where liberal processes exclude the voices of the non-central could be a necessary consequence of the first

drawback discussed above. However, even when power is not abused and misused, liberal institutions and their formal frameworks for production and governance are designed in such a way that alternative approaches would be strictly curtailed and prohibited, or would be unlikely to make a difference. One crucial example would be the public call for the decriminalisation of suicide by advocacy groups and academics in Malaysia for years (cf. Ng and Panirselvam 2019), towards which national lawmakers have only taken the first parliamentary steps in October 2021 (see BFM 2021).

5.3.2. MODEL: Participatory governmentality for network societies

Responding to the two illustrated drawbacks of liberal governmentality as identified from Malaysia's traditional mental health system, this dissertation proposes a new model for health, mental health, and societal governance: *participatory governmentality* (see Figure 4.3.2.1.). In concrete terms, beyond the hierarchical protection and production of an entire population's freedom and security, what would 'participatory governmentality' alternatively provide? It would no longer allow a nation-state (or a small group of powerful decision-makers) at the top of an invisible hierarchy to shape and provide universal ideas for all members of society. Rather, moving past purportedly universal frameworks, members of society in their diplomatic and participatory networks directly take part in reforming and/or redesigning the societal conditions that influence and structure the variables of their QOL, including health and well-being.

First of all, this model should not be taken as a universal scheme. It only contains a set of three abstract elements that could help shape directions for how to conduct, modify, and improve governmental practices in a network society. Mainly, this model focusses on *how one can manage and improve the condition* for participatory / diplomatic practices for the goal of improving QOL in a network society. Indeed, there are no rules for movements or decisions. Practitioners or stakeholders can alternate and switch directions or targets in their own contexts. Still, whatever or wherever groups move or choose to do next, all these three elements should be considered concurrently:

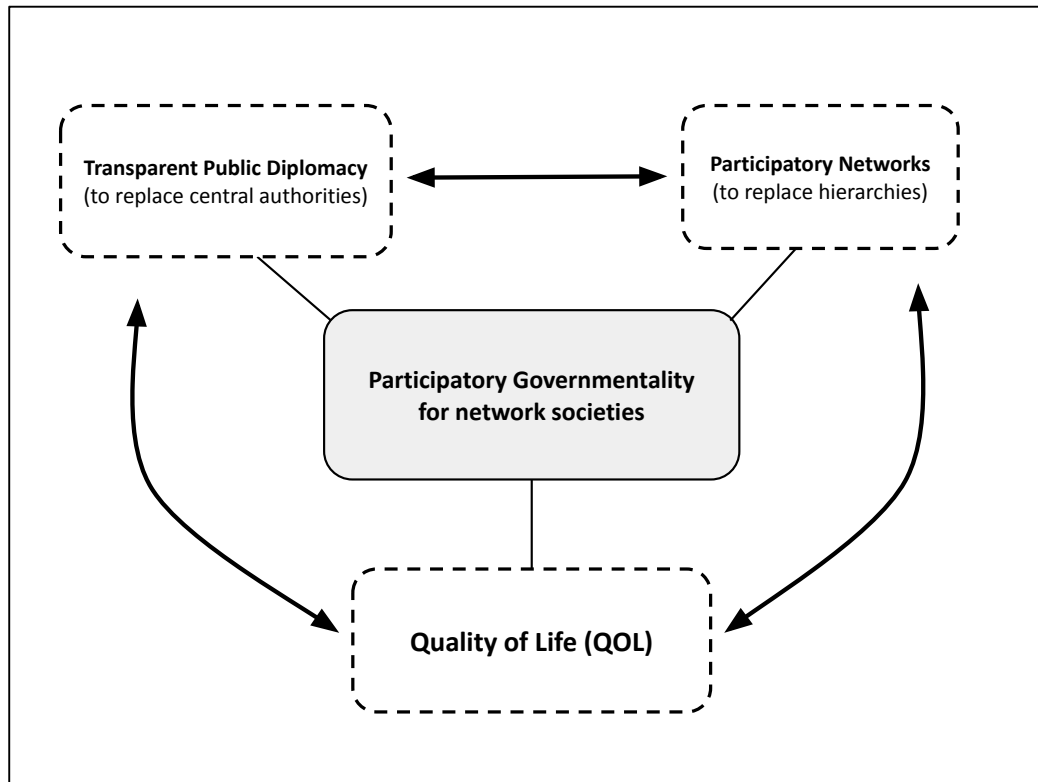


Figure 5.3.2.1. Diagram for the proposed model of Participatory Governmentality

1. ***Participatory networks.*** Participatory networks are intended to replace the use of hierarchies in making decisions and policies for the nation. These are to ensure that the challenges, problems, perspectives, and demands on the ground are no longer neglected by central authorities in the long and ‘silent’ hierarchies of the nation-state.
2. ***Transparent public diplomacy.*** Transparency in public diplomatic activities for national health policymaking, mental healthcare, and societal governance must be strictly ensured in preparation for the increase in the quantity of public inputs in participatory network societies. In a society where hierarchies are replaced by participatory networks, transparency, or traceability, in public deliberation and decision-making processes will be the main check-and-balance mechanism in national societal governance. In even more practical terms, whatever decisions are made or selected for the nation, the processes by which these decisions are made must be able to be publicly traced, explained, and accounted in explicit and unambiguous terms.

3. ***Quality of life (QOL)***. The QOL of the nation's citizenries will act as the 'constant reminder' for participatory networks and processes of public diplomacy. In this way, participatory practices would be fostered mainly to cater for the priority of improving people's QOL, instead of other interests or objectives.

Taken into consideration all these three elements, it should be underscored that the most delicate and important difference between traditional liberal governmentality and this proposed model of participatory governmentality is that the latter consistently involves concerned societal segments / people / citizens / stakeholders into governmental practices and decision-making processes, whether in the domain of mental healthcare, or other biopolitical domains. And the whole purpose of such an involvement of the people's or citizens' active feedback into the procedures of making national policymaking and governmental decisions is to ensure that a general or majority consensus about what is best or what is most suitable to come about their own lives and well-being can be transparently obtained and/or constructed, before any impactful / risky actions are taken or implemented at the various levels of societal governance. That would be the always *disturbing, troublesome, but open-minded foundation* of how the QOL of the nation's citizenries can be constantly kept in mind for structural improvements. In emergent network societies where national signification orders would disintegrate and reshape, a realistic and constantly conscious governmental system for rationalisation, such as 'participatory governmentality', would be integral to implementing a truly representative (i.e. consensus-based) and democratic system of governance.¹⁰

In fact, micro-level examples of participatory governmentality in Malaysia have been documented in Chapter Four. From such initiatives as PlusVibes, Naluri, Projek

¹⁰ It should be highlighted that, as AI-powered systems of participatory governance continue being researched for implementation in Southeast Asian network societies (in order to replace traditional law-making institutions), such as the AI-based *Digital Sociocracy* model newly proposed by Joanne Lim (2021a; 2021b), public diplomacy and participatory networks, in the form of people-meeting-people initiatives (e.g. Centre for Independent Journalism 2021), will continue to be the realistic approach to participatory, collaborative governance. Participatory governmentality caters for this particular techno-societal conjuncture in the long-term transitions towards participatory democratic governance in Malaysia.

Dialog, and The Help Talk, the patients, civil societal actors, ordinary citizens, and experts alike actively participate in and contribute to the mental healthcare processes and communications. Schedules and treatment plans, lines of questioning and analyses, platform organisation and the use of affordances, and nationwide initiatives can be collaboratively organised by technology experts, health experts, NGOs, ordinary citizens, and governmental leaders and ministries, who are, all, only ‘equal’ nodes spread across the ‘mental health networks’ in Malaysia’s vast public sphere.

Ultimately, the two increasingly antagonistic forms of mental healthcare, biopolitical processes, and governmentality examined in this dissertation can be compared to Castells’ following passage on the future of global governance:

“And the choice that we face is either to construct the global political system as an expression of power relationships without cultural mediation or else to develop a global public sphere around the global networks of communication, from which the public debate could inform the emergence of a new form of consensual global governance”
(Castells 2008: 91).

In this passage, Castells concludes about a global societal threshold in the wake of a network restructuration of many societies. This threshold resides between the statist form and the networking form. Most societies and many domains of human activity will encounter such a liminal choice to make. These include the gradually changing domain of mental healthcare, the form of biopolitical governance, and the formal question of governmentality in contemporary Malaysia.

Following Castells’ verdict, this dissertation and its analyses could not argue that network societies and participatory networks have completely effaced and replaced industrial societies and the statist governmental logic. Instead, it would only be argued, and has been substantiated with strong emergent examples, that there have been (1) participatory transitions in mental healthcare in particular, and (2) participatory challenges to biopolitical processes and governmentality in general, in Malaysia. The battleground would finally reside between the statist structuration and the participatory restructuration of the nation’s biopolitical processes.

CONCLUSION

1. Summary of Analyses

Increasingly rapid Internet connectivity, and a growing range of mobile and smart communication technologies, have provided new affordances for self-communication processes in contemporary Malaysia. And these mobile communication processes have ushered in a new set of phenomena, problematics, and democratic possibilities in the biopolitical domain of mental healthcare. Although a number of academic and advocacy publications in the past two decades revolve around inherited mental healthcare concerns, a collection of network innovations, as categorised by this dissertation, suggests that new communication affordances and solutions are worthy of consideration, and indeed, call for a recalibration of governmental frameworks and approaches in the nation.

From a number of initiatives on such mobile platforms as social media, business websites, and online journalistic articles, a growing preference for the participatory or collaborative approach to mental healthcare has been observed and substantiated. The adoption of digital solutions and interventions to tackle public health concerns allows for multi-sectoral collaboration among the key stakeholders in mental health governance—including technology business communities, civil society organisations, and public health authorities of a polity, be they national (e.g. MOH) or regional (e.g. ASEAN)—to take shape. This is despite the fact that they have differed in policy perspectives, such as the case of the possible revitalisation of NSRM for public and civil societal groups to devise targeted solutions for Malaysia's current mental health crisis and for suicide prevention strategies. More particularly, the practice of horizontal networking, co-production, and co-management is reconfiguring and streamlining the key practices in mental health service delivery, mental health support, management of patients and schedules, and open deliberation on public health concerns.

Nevertheless, despite the seemingly positive outlook in the network reconfiguration of the mental health sector, there remains a great difficulty in ensuring and engendering multi-sectoral public diplomacy. In fact, it actually seems that much of the passionate, repetitive ‘call’ for the productive dialogue between different stakeholders, such as the explicit mention of “multi-sectoral collaboration” by the MOH (ASEAN 2016: 67), on the public mental health crisis over the past two decades, remains a prominent idea that awaits wider implementation. Even though networked communication technologies have been put to immensely productive use in various subdomains of mental health by some of the sampled initiatives in Malaysian society, it remains unclear how these disparate initiatives and new solutions can be accepted and implemented on a larger scale in the nation. Together with the new questions for future activities on mental health in the civil societal, private, and public sectors, the feasibility of multi-sectoral public diplomacy in restructuring mental health practices forms part of the unprecedented challenges in this transitioning landscape.

2. Suggestions for Further Exploration

Indeed, future academic research, institutional practices, as well as private and public organisations will have to come to terms with *the challenges of participatory national governance*, brought about by the continual growth of a network society in contemporary Malaysia in this century. New public media platforms, networking communicative tools, and possibilities for multi-sectoral participatory initiatives mean that a broad range of mental health practices would bypass unidirectional processes in institutional hierarchies, and embrace needs-based, proactive, and instantaneous networking practices. Here, not only would state institutions, business communities, and civil society organisations need to look at collaboratively innovating solutions for the large collection of concerns in mental healthcare (e.g. service delivery, public literacy, anti-discrimination, and governance of resources). Because institutional authority has been transitioning into a collection of para-institutional, non-institutional, and multi-sectoral forms of collaborative social planning in Malaysia, (1) the ethical and technical challenges of ‘public diplomacy’, and (2) the important principles of

accountability and transparency during participatory processes, would also need to be imparted to the newer generations of national ‘governmental participants’ and prosumers (cf. Jenkins *et. al.* 2006: 12-18).

Recognising the emerging challenges of mental health governance in a transitioning society, this dissertation offers the following recommendations for individuals, societal and governmental leaderships, and communications researchers.

Individuals

Mobile communications for self-regeneration. Individuals can choose to become well-informed, independent consumers and users of mental health information in relation to key concepts, perspectives, and guidelines in psychological self-care and well-being. To be specific, to become well-informed, independent users and owners of mental health information would mean to become able to analyse, manage, and communicate a wide range of possible perspectives, knowledges, and recommendations on what ‘mental health’ entails, which standards and principles are involved, and how mental health can be self-managed. These perspectives can be psychiatric as much as sociological, psychological, psychoanalytic, philosophical, familial. While individuals becoming independent users of mental health information is part of the recommendations provided by the WHO (2005: 28-32) on promoting mental health, this dissertation adds that mobile communication technologies might help enhance every individual’s capacity to become as independent, self-sufficient, and critically conscious as they want.

Transparent participation in mobile social planning for mental health and other components of QOL. From the few most recent case studies analysed in this dissertation, such as the live broadcast forum of Projek Dialog, and the mobile communications between platform organisers, mental healthcare practitioners, and patients on PlusVibes and The Help Talk for treatment plans and appointment schedules, it is envisioned that mobile participation as an approach to social planning will be expanding to a larger scale in the nation in the years to come. Given the affordances of mobile communication technologies, citizens should begin to explore the possible ways

and areas where their direct and consistent involvement in societal governmental practices and processes can be implemented and safeguarded, beyond such as institutionalised processes as general elections. In concrete terms, the most realistic and common approach to active mobile participation at this stage of the development of Malaysia's network society is the use of social media platforms and any of their innovative functions (e.g. Live broadcast) for direct interactions between and among ordinary citizens and national (biopolitical) decision-makers. Ordinary citizens should pay attention to and/or explore the emerging ways in which large-scale governmental decisions that affect their QOL could directly take into account their supervision and feedback (cf. Lim 2021a, 2021b).

Societal and governmental leaderships

Mobile communications for reforming ecosystems in societal life. Individuals and institutions can harness mobile communication technologies to become better equipped with the necessary understanding to cultivate safe and healthy ecosystems for individual as well as collective life and work. This stipulates that individuals and institutions review, reconsider, and if necessary, reform a whole array of ecological factors that could carry hostility to individuals and communities in the short and long terms. These ecological factors may include the communicative, legal and disciplinary, labour, management, and developmental processes within organisations of different scales: the family, the neighbourhood community, the school, the workplace, the university, and the nation.

Mobile communications for the nation's mental healthcare services. The national mental health system can innovate in the technological and strategic aspects to become aligned with the streamlined, networked options in delivering mental health services to geographically dispersed demographics. This certainly assumes a concurrent effort to continue the improvement of mobile network coverage for especially the remote communities in the country (e.g. *Berita Harian* 2021). By implementing mobile communication processes in the nation's mental healthcare networks, the interaction between the key stakeholders in mental health governance (including patients, nurses,

pharmacists, psychiatrists, counsellors, volunteers, administrators) may also be improved. In fact, to work with stakeholders and harness new communication technologies for improving the networks of mental health stakeholders, practitioners, and healthcare delivery has been the objective of Malaysia's MENTARIs.

Building cross-sectoral solutions. The national mental health system and the local business communities can work together to devise network-based mental healthcare solutions and coverage for national demographics while generating larger revenues. On the one hand, the national system may structurally benefit and innovate from a technological knowledge exchange with tech-companies who, for instance, harness the most advanced digital therapeutic and data-based behavioural management solutions for mental health. On the other hand, business communities—especially mHealth and insurance enterprises—may benefit from extending beyond the niche market of urban consumers, and exploring into a broader national (or nationalised) market of remote, peripheral, and marginalised individuals and communities. Public-private collaborative efforts should be taken into account and covered by the national budget allocation for mental healthcare.

Mobile public diplomacy between state institutions, advocacy groups, mHealth enterprises, and social scientists. The national mental health system, civil society organisations, and social science researchers can devise and organise (online) conferences to deliberate upon key concerns in the technological, socio-political, and access-related determinants of mental health in the country. Conferences as such are to ensure that civil society can hold national policies on mental health accountable, for, in an ideal situation, large-scale policies, programs, and initiatives must be able to respond to the structural determinants of mental health. Key mobile platforms that could support mobile public diplomacy include the prevalent 'Live' broadcast function in various social media platforms, such as Facebook Live, where users from diverse regions in the nation can watch and interact together during these public conferences.

Future communications research directions

Long-term needs assessments to help refine the allocation and quality of mental healthcare services within network societies. Future academic research can pay greater attention to needs assessments across the country to contribute to devising solutions, whether customised or generally applicable ones, for refining the allocation and quality of mental healthcare services. This type of research responds to an ongoing call for the planning and implementation of need-based, evidence-based mental health initiatives in Malaysia (Haque 2005: 193-194; Lim 2018: 17, 143-144; Chua and Mogan 2021: 19-21). Needs assessments to identify key structural determinants should also take into account and make productive use of the new perspectives, affordances, and solutions that are opened up by a network society, such as the use of online or mobile questionnaires at the national level.

Research on the emergent ethical concerns over personal health data. New mobile communication technologies have allowed healthcare processes to incorporate the techniques of health data management of oneself, patients, and interpersonal relationships. This ‘data’, in concrete terms, derives from such components of QOL as: daily workout patterns; daily step count; daily calorie consumption; body weight (i.e. Bluetooth-enabled connection between the mobile device and the ‘smart’ weighing scale); sleep patterns (i.e. light sleep, Rapid Eye Movement [REM] sleep, and deep sleep); blood pressure (i.e. systolic and diastolic); stress levels; to name a few among others. While enabling individual users to take control of their daily health practices and to actively make decisions to improve their overall QOL, such health data as collected and stored in the mobile devices need to be protected to the basic extent that privacy and safety are not infringed. Research on the balance between data-based enhancement of people’s QOL and the safety of individuals can be conducted, as a first step, through analyses of (1) the privacy and usage protocols and/or statements as well as (2) the data-related biopolitical activities by mobile technology corporations and, if any, their national governmental collaborators.

Deeper investigation into Malaysia’s participatory governmental practices for improving the societal conditions that affect the various components of QOL, including mental health and physical health. Future academic research can pay deeper attention to the new mobile and ‘smart’ ways in which governmental (health) institutions, business communities, and civil society organisations can communicate

more closely on key issues in improving and innovating programs for mental health, and more generally, QOL. This research interest stems from a long-term ambition (e.g. Haque 2005: 193-194; Lim 2018: 143-144; Chua and Mogan 2021: 19) for the leaders and actors in the political, economic, and civil societal networks of Malaysian society to work together, and to flexibly exchange intellectual and material resources (i.e. ‘switching’), in order to address a range of potential structural determinants of mental illnesses and low levels of QOL. In fact, the mental health crisis in postmodern computerised societies is likely to intensify in the nearest future. Hence, it is timely and imperative that the stakeholders from these three most resource-rich domains of Malaysian society begin the diplomatic practice of networking and switching for improving and reforming ecosystems of life and work: from the central to the peripheral; from the national to the local. Moreover, it would important to also begin investigating into how the usually ‘powerless’ ordinary citizens of Malaysian society can *directly* take part in societal governance and social planning through the most advanced mobile means in the coming age of artificial intelligence (AI) powered governance, machine learning and training, and big data decision-making algorithms (cf. Lim 2021a, 2021b).

3. Ongoing Societal and Research Challenges

Civil societal, academic, and national approaches to Malaysia’s mental health crisis have been concerned with deep structural problems; there are questions that do not have immediate, straightforward answers (e.g. Lim 2018: 143-145; Sim 2019). How can Malaysia increase and/or improve access to mental healthcare? How can the local mental health workforce be enlarged in size and enhanced in quality? How do professional and expert bodies reduce and eliminate discrimination towards the mentally ill? How can the professions of psychiatry and clinical psychology be more appreciated and less stigmatised among next generations of Malaysian medical science, natural science, and social science students, in comparison with other branches of the health and medical sciences? How can the financial costs of accessing and receiving mental health services—e.g. consultation, counselling sessions, and where necessary,

medication—be reduced and be made more affordable to the general public and especially the less affluent?

These questions point to prevailing structural concerns, namely the financial, labour, cultural, and institutional dimensions of Malaysia's mental healthcare. These are complex, long-term, and profound problems awaiting careful and suitable solutions to be co-produced by the various sectors and stakeholders in a Malaysian society currently experiencing participatory network transitions.

Indeed, following the range of informational, mobile, and participatory transitions, Malaysians have been afforded new solutions for their own mental healthcare processes. These developments are possible due to the global proliferation of (1) the networking logic and (2) mobile self-communication technologies (cf. Castells 2013: 54-136). The emergence and rapid democratisation of one-to-one, one-to-many, bidirectional, and multidimensional modes of communication continue to inaugurate new avenues for the self-decided mass production and circulation of concepts and programs for mental health.

While traditional structural problems remain intact, and awaiting accurate remedies, the rise of new initiatives, solutions, and perspectives in Malaysia's networked public sphere demonstrates powerful signs of a “multilayered and multiscalar” restructuration of mental healthcare (Castells 2013: 14). This network restructuration, more often than not, bypasses the domination of state institutions of health, and is predicated upon the capacity of personal choice, personalisation and customisation, inter-*personal* activities, and diplomatic setting of solutions in the new communication processes among the nation's citizenries. Therefore, despite the prevailing difficulties at the individual and public levels, there is reason to pursue subsequent deepening of research and policy deliberation. Exploring, understanding, and harnessing the productive resources of emergent network societies, one would learn that a large number of traditional barriers and profound issues could already be tackled and/or discussed by citizens and non-governmental groups in the ‘smart’ ways.

Recalibrating prevailing lamentations on the range of long-term problems and challenges, a participatory governmental perspective on mental healthcare, public health, and societal governance pays closer attention to the co-production and co-management of psychosocial resilience and sustainable national development *from the*

ground up. Looking at emergent network societies and the manifold possibility of their futures, the proposed model of ‘participatory governmentality’, replacing statist rationality, can lead to common resilience and consensus at various levels of really sustainable development. This perspective proposes that societal stakeholders, including scholars, continue to examine, capture, and address the remnants of a centralising propensity in societal governance processes. Indeed, scholars could next investigate into not only which and how participatory mechanisms can be implemented (e.g. Karu 2022), but also why it might be structurally premature to implement these participatory mechanisms in the first place, in a Malaysian society caught in the threshold between state apparatuses (that are susceptible to abuse) and collaborative networking practices.

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