Balancing acts: Rationalisation and care in the management of mental health call centre counsellors in South Africa

Masters Research Project

By

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Declaration

By submitting this thesis electronically, I declare that the entirely of the work contained therein is my own, original work, that I am the authorship owner thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: 1 March 2021

Signature:

Abstract

Over the last 30 years, the international rise and proliferation of call centres have had an enormous impact on global work and labour relations. In the literature on the call centre industry, scholars have repeatedly characterised call centre workers as stressed, exploited, and above all, as subject to extraordinary electronic surveillance and control. As call centres moved into the provision of physical and mental healthcare, a number of scholars have noted that "telecare" workers were not only subject to the wider industry's relentless rationalisation but were also particularly vulnerable to mental health issues due to the nature of their work. This study explores these issues at a mental health awareness telecare centre that I have called Mental health Awareness for South Africa [MhASA]. I focus on the ways in which the centre's management, all permanent workers, approached and attempted to accommodate the conflicting goal of rationalised management practices with the need to care for their vulnerable volunteer counsellors. Towards this end, I interviewed six members of MhASA's telecare centre, five of whom were permanent staff members while one was a senior volunteer counsellor.

Keywords: telecare, call centre, HR management, management practices, emotional risk

Abstrak

Oor die afgelope 30 jaar het die toename in internasionale verspreiding van oproepsentrums 'n enorme invloed op die wêreld se werk en arbeidsverhoudinge gehad. In die literatuur oor die inbelsentrum bedryf het geleerdes herhaaldelik die oproepsentrum werkers as uitgestres, uitgebuit en bowenal onderhewig aan buitengewone elektroniese toesig en beheer gekenmerk. Aangesien oproepsentrums oorgaan tot die verskaffing van fisiese en geestelike gesondheidsorg, 'n aantal geleerdes opgemerk het dat werknemers in die "telecare" nie net onderhewig was aan die meedoënlose rasionalisering van die breë bedryf nie, maar dat hulle ook veral kwesbaar was vir geestesgesondheid kwessies weens die aard van hul werk. Hierdie studie ondersoek hierdie kwessies by 'n bewustheid sentrum vir geestesgesondheid wat ek Mental health Awareness for South Africa [MhASA] genoem het. My fokus le op die maniere waarop die sentrum se bestuur, alle permanente werkers, die botsende doel van gerasionaliseerde bestuurspraktyke benader en probeer akkommodeer met die behoefte om hul kwesbare vrywillige beraders te versorg. Hiertoe het ek ses lede van MhASA se "telecare" sentrum ondervra, waarvan vyf permanente personeellede was, en een 'n senior vrywillige berader was.

Sleutelwoorde: telecare, inbelsentrum, geestesgesondheid-bestuur, bestuurspraktyke, emosionele risiko

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Chapter 1: Introduction

1.1 Problem Statement

Over the last 30 years, the international rise and proliferation of call centres have had an enormous impact on global work and labour relations. In the literature on the call centre industry, scholars have repeatedly characterised call centre workers as stressed, exploited, and above all, as subject to extraordinary electronic surveillance and control (Mulholland, 2002; Glucksmann, 2004; Hannif, Burgees & Connell, 2008; Ball & Margulis, 2011; Woodcock, 2016). As Woodcock (2016) noted, call centre work has become "emblematic of the shift towards a post-industrial service economy" in which other industries are increasingly turning towards the call centre industry's model. Of particular concern to a number of authors is that hospitals and other healthcare providers are with increasing frequency outsourcing the provision of a number of their physical and mental healthcare services to call centres (Goodwin, 2007; Ruxwana, Herselmen & Conradie, 2010; Roberts, Mort & Milligan, 2012). As call centres move into the provision of physical and mental healthcare, a number of scholars have noted that "telecare" workers were not only subject to the wider industry's relentless rationalisation, surveillance, and control, but were also particularly vulnerable to mental health issues due to the nature of their work (Stamm, 2012; Roberts *et al.*, 2012; Howe, Meakin & Islam-Barret, 2014; Kitchingman, Wilson, Caputi, Wilson & Woodward, 2018).

This move to "telecare" happened in a context where the global suicide mortality rate has increased by 60% in the last few decades (Schlebush, 2012: 436), which, according to the World Health Organisation's (WHO) predictions, amounted to 1.5 million suicide fatalities in 2020 alone. South Africa has been unable to evade this public health problem nor the move towards telephonic (and online) mental health care for those who contemplate or actively attempt suicide.

The country has experienced an increase in suicide attempts with around 11% of all non-natural deaths being suicide related (Schlebusch, 2012:436). This translates into about one to two successful suicides and twenty attempted suicides per hour in the country.[1] Psychologists have

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[1] Within 2018 alone, suicide rates increased from 10.7 per 100 000 in February to 14 per 100 000 individuals in September (*The Citizen*, 2018; *EyeWitnessNews,* 2018). The reality of these rates is that every hour a suicide is completed, with 23 'successful' suicides and 460 attempted suicides occurring every day.

been careful to point out that non-fatal suicides should not be treated as a positive outcome, but as a worrying trend in suicidal behaviour, which was reported as exceptionally high among all age groups in South Africa (Schlebusch, 2012), with young people between the ages of 15 and 24 being the most affected, as 9% of non-natural deaths for young people were attributed to suicide (*Africa Check*, 2017; *The Post*, 2018). Furthermore, the historical, cultural, and economic complexities of South Africa have resulted in difficulties when constructing national suicide prevention programmes (Netshiombo & Mashamba, 2012; Schlebusch, 2012). While language difficulties and cultural specifics pose barriers to providing adequate counselling (see Swartz, 1998), the rise in suicide-related behaviours and ideations in the country has seen suicide prevention centres desperately trying to fill urgent needs. They offer valuable services to those on the verge of suicidal acts and to those seeking information and/ or advice relating to suicide and mental health. Suicide prevention centres and charities do this work in a context where psychological counselling and therapy are in short supply to a general populace (Ruxwana, Herselmen & Conradie, 2010). As such, a number of them offer suicide prevention services through manned call centres. South Africa has introduced at least 32 healthcare call centre sites since the 1990s, with the majority of the "telecare" call centres being centred around emergency services, medical assistance, and e-healthcare services. Most of these telecare centres spawn from small volunteer-led projects, NPOs or state agencies (Howe, Meakin & Islam-Barrett, 2014), and are mainly focused on rural towns and areas, aiming to create a network of help beyond large towns and centres and to those who do not have access to technological advances (Ruxwana *et al*., 2010: 17-18).

Fundamentally different from commercial call centres that handle customer queries and marketing, suicide prevention call centres form part of a shift in global healthcare provision toward telephonic services as a means to reach more people in need (Ruxwana *et al*., 2010). While literature on call centres in the Global South has grown as significant portions of the labour force is now employed in this section (see Russell, 2008; Batt, Holman & Holtgrewe, 2009; Mulholland, 2002), suicide prevention call centres have received very little attention. What little work has been done on these suicide prevention centres and workers are outdated, and current research remains restricted to suicide as the main issue rather than the people who work on suicide lines to prevent it (see Wray, Colon & Pescosolido, 2011). This is despite the fact that a number of scholars have pointed out that identifying and helping individuals at imminent risk and possibly experiencing

suicide attempts, contributes to those responders themselves becoming individuals at imminent risk (Gould, Lake, Munfakh, Galfalvy, Kleinman, Williams, Glass & McKeon, 2016: 172).

The question that then arises is: How are suicide prevention centre employees protected from the risk of harmful behaviour themselves? The answer to this question lies within the ways that such individuals make sense of their work and in the procedures and policies that guide the management of such centres. It is amongst management that decisions are made regarding the capabilities, risks, and care of the workforce. This study seeks to contribute to the knowledge on the structuring and functioning of management in suicide prevention centres in South Africa. In particular, this study will focus on one of South Africa's most well-known suicide prevention call centres, a centre I have chosen to call Mental health Awareness for South African [MhASA].[2]

1.2 Rationale

I have long been interested in mental wellness and how it intersects with work, and specifically the work of call centres. In Durban, a number of my family members have worked in call centres and have complained about the stressful nature and the constant surveillance of their jobs. Few of them stayed in the job for more than a couple of months, complaining that they suffered from "burnout". I started to read the sociological literature on work and realised that there is a growing interest in service work and care in this literature, with the greatest attention being directed toward the emergence of call centres. What specifically caught my attention was the management of these call centres and the difficulties faced by their Human Resources (HR) departments. Authors such as Glucksmann (2004), Russell (2008) and Batt *et al*. (2009) addressed the HR issues associated with the structure of large workforces, which typically characterise call centres. While Fine (2005) and Stamm (2012) investigated the contradiction that call centres focusing on public health care place on a capitalist system of productivity; that they try to provide intimate care in a work setting originally intended as a form of mass service provision for profit.

Interested in psychology, I also read a number of studies about people who provide care to those who contemplate, try to, or successfully commit suicide. The literature suggested that this

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[2] Throughout, I have anonymised the organisation as a precaution to protect the organisation from any adverse effects caused by the publication of my research.

work traumatised therapists and made them vulnerable to suicidal thoughts themselves (see Rossouw, Smythe & Greener, 2011). This helped me to reframe the work my family members complained about. I then became interested in suicide prevention call centres because of the complex and vulnerable positions that operators in these centres occupied. However, I realised that I could not do direct research on this group because I could potentially contribute to their distress and/or retraumatise them by discussing their work and experiences as operators.

But if I approached this 'problem' from a sociology of work perspective, then I would be able to address both the precarious and sensitive position of call centre operators and how they are 'looked after' by the organisation to ensure job security and positive mental health. The question of how an HR department would manage vulnerable 'suicide call centre workers' seemed an interesting study that did not run the risk of placing vulnerable workers in uncomfortable situations.

1.3 Literature Review

Sociology of Suicide and South Africa

In 1897, Emile Durkheim published his ground-breaking book, *Suicide: A Study in Sociology* (Durkheim, 1951). It explored the social fact of suicide in Danish society and was immediately hailed as the first example of what a sociological monograph should look like (Taylor, 1988: 8). Although foundational to the development of the discipline, the study of suicide in sociology has been inconsistent. In recent years, the call for sociological contributions in this field has been met with weak responses that are seldom incorporated into global suicide and suicide prevention strategies (Wray *et al.*, 2011).

Whilst suicide is not the leading cause of death in South Africa, it is a national public health concern that has drawn some alarm from the Department of Health and scholars in psychiatry and psychology (Schlebusch, 2012; Bantjies & Kagee, 2013). According to Netshiombo and Mashamba (2012), the rise in suicide rates in South Africa could be attributed to the (Durkheimian) anomie that attends the complexities of modern life in the country, which are exerting immense pressure on the individual. Hostile socio-economic and political realities have taken a toll on South

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Africans; high unemployment rates, high HIV/AIDS prevalence and high crime rates have contributed to a significant increase in the national suicide rate. To counter the rising suicide rates in the country, a number of suicide prevention programmes and studies have been implemented (see Schlebusch, 2012; Ramlall, 2012).

Customer service call centres

Toward the end of the 20th century, globalisation, advances in digitization and the introduction of the World Trade Organisation's *General Agreement on Trade in Services*, stimulated an intensification of international trade in the sale and delivery of 'service' as a product across international boundaries. According to Benner (2006) and Batt *et al*. (2009), this deregulation of service work, coupled with market liberalisation, resulted in opportunities for growth in advanced economies, mainly countries in the Global North, yet created a downward pressure on wages and employment levels, especially in occupations that were skilled and semi-skilled. Thus, although service delivery impacted on economic development, this development successfully occurred through an irregular system of rapidly increasing productivity at the expense of a slow wage increase and restricted employee promotions (Benner, 2006).

The call centre sector emerged in response to this transition into the globalisation of service work. From the early 1990s, call centres became the most important single source of customer contact globally. Unlike previous modes of customer service, the call centre was cheap; it required relatively little capital investment, yet boasted rapid, mass employment on a global scale. Companies – usually from America or the United Kingdom – that provide call services and employ operators do so at international levels, with their head offices situated in national capitals while their call centres are increasingly outsourced to emerging economies (Pande, 2005; Benner, 2006; Batt *et al*., 2009). South Africa, being one of these emerging economies, has recognized in these call centres the possible benefits of economic growth through the international market and a solution to its high unemployment rate. The government, in conjunction with local economic development agencies, have thus developed marketing campaigns designed to promote South Africa as an investment destination for European and American call centre businesses (Benner, 2006: 1026).

While call centres boosted employment in regions where factories once employed large numbers of people and in countries struggling with high unemployment, a number of sociologists agree that the introduction of call centres has had complex impacts on employment, and more broadly, on management and on individual development within such centres (Callaghan & Thompson, 2001; Mulholland, 2002; Russell, 2008; Korczynski, 2009). Today, call centre operations are central to a variety of industries that range from financial services to health care, to public administration, communication, and transportation (Glucksmann, 2004:796). Their constant and rapid development has extended call centre operations to the private and public sectors, while demanding "upskilled" capabilities of its employed operators. And whereas first generation call centre workers only handled enquiries, the operator's work has expanded to a level that presupposes all other occupations within the supply chain. In this, the operator has become the mediator between the client/customer and the business, thus, placing the burden of success or failure of provision on the operator alone (Glucksmann, 2004).

Although call centres have resulted in a rapid expansion into a new sector of work and ever-increasing economic growth, they demanded new kinds of management. The combination of a colossal workforce supported by a cost-efficient framework, meant that management needed to regulate the workforce within a context that minimised autonomy and enforced restrictive time management to deliver service provision within the company's production rate (Mulholland, 2002; Korczynski, 2009). This required a new form of the assembly line workforce in which managers sent endless queues of call queries to call operators who were forced into a repetitive and limiting position as calls were 'fired' at them (Callaghan & Thompson, 2001: 20-21). This conscious production line setup allowed management to maximise the pace of production via the power of the call queue. The assembly-line format of call centre operators' work results in increased and uncontrolled levels of work for individual operators with accompanying job stress, low morale, high turnover, and absenteeism- as well as customer dissatisfaction (Hannif *et al*., 2008: 278). In call centre management circles, this has led to managerial challenges such as how one would insert flexibility into an inflexible work structure, how to continuously keep up the production pace, to elicit worker co-operation, discretionary work efforts and emotional labour while minimising worker resistance (Russell, 2008; Batt *et al*., 2009).

Ball *et al.* (2011: 114) refers to the call operator as the 'monitored employee' *par excellence* due to the extreme methods of control that combine the telephone, computer and surveillance systems, the very technologies that make call centre work possible (cf. Woodcock 2016). The emphasis on technical control, call-handling time and awareness monitoring systems results in a sophisticated framework that produces the maximum number of calls through a constant regulation and limitation of operator activities via the use of round-the-clock surveillance (Mulholland, 2002: 287; Ball *et al.*, 2011:115). In the latter regard, call centre operators work within a system that regulates every action during the call process, including instructions on how to create believable 'performances' that could lead to success, a form of regulated emotional labour (Woodcock 2016; cf. Hochschild, 1983: 90).

In the sociology of work, the management of emotional work has long been recognised as a central part of service sector work. According to Hochschild (1983: 7), emotional labour is the service worker's management of feelings to create a publicly observable facial and bodily display which would then evoke a particular emotional state in a customer/client to a profitable end. For example, if a service worker smiled and spoke in a friendly tone, the customer/client will respond in an equally positive manner and might buy more or be more satisfied with the service rendered. In terms of call centre operators, this task is much more difficult. As opposed to face-to-face interactions, call operators rely solely on the use of their voice to provide a successful service, whilst being constantly supervised by a uniquely structured management system. This leads to a seemingly homogenous workforce for the 'client', scripted and directed through prompters and management protocols. Korczynski (2009) elaborates that the operator has to concentrate hard on what is being said whilst jumping from page to page on the 'script', making sure the information being entered is accurate and that the right things were said with a pleasant tone. The operator is unable to personalise their emotional labour, which leads to alienation, which in turn is intensified because the operator cannot physically leave the situation or detect physical emotional cues from the customer (Korczynski 2009). According to Wharton (2009) and Korczynski (2009), call centre workers often experience this lack of autonomy, regulation, constant supervision, and continuous encounters with faceless customers as alienating, stressful and undermining of their sense of self. This leads to high worker burnout.

The intensity of emotional labour, alienation and burnout is drastically increased when call centres are focused on the public health sector; specifically, public health care. Roberts *et al*. (2012: 492) refer to the workers in this field as "telecare" operators, who provide care "from a distance" giving "peace of mind" through information and communication technologies. These services aim to fill the temporal gaps that are usually involved with hands-on care by providing immediate assistance and directing the emergency services/ medical systems to the individual at risk.

In providing "telecare", the literature makes it plain that it is necessary for operators to be both sensitive and calculative when speaking to callers; relying on verbal skills to produce a virtual version of themselves in the presence of the vulnerable 'client' in a risky situation. [3] Scholars working on this aspect of telecare insist that this projection of self infantilizes the client by reassuring, caring, and addressing the problem as if the operator had some authority over the customer's well-being (Roberts *et al.,* 2012: 498). Such care, especially through the limited means of the telephone, is also quite detrimental to- and exhausting for the operator. According to the literature, the operator's empathy is central to successfully help the caller. To convey empathy, the operator needs to show concern and worry but also produce feelings of warmth and genuineness to decrease the client's levels anxiety and to form a trustworthy bond (Paterson, Reniers & Völlm, 2009). This emotional labour heightens the risk that operators themselves would suffer emotional stress. According to Kitchingman *et al*. (2018:16), telephone crisis operators mainly experience psychological distress in terms of vicarious trauma or a re-experiencing of personal trauma. Furthermore, higher levels of trauma caseloads result in operators experiencing higher symptoms of hyper-arousal, avoidance and intrusion of these traumas in their everyday lives. These detrimental effects are further intensified when the operator is not a trained medical professional. According to Howe *et al*., (2014: 13) three out of four staff in this sector are volunteers and the majority of these volunteers are individuals that have experienced mental illness or trauma themselves. Whilst personal experience may motivate many volunteers, it does put them at a greater risk of re-experiencing personal trauma and feeling compassion fatigue (Stamm, 2012: 3).

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[3] Use of the word client for individuals seeking medical care can be contentious, hence the quotations. I use client in the loosest sense, to visualize the relationship between the operator and the individual, not to imply that a vulnerable individual in a risky situation is seeking an exchange of money for a service.

Managing a workforce specialising in telecare is complex. On the one hand, the management staff needs to routinize tasks to ensure organisational effectiveness and efficiency (Wright & Snell, 1998; Kelley, Lune & Murphy, 2005; Haski-Leventhal, 2009), and on the other, they have to incorporate highly sensitive protocols and practices that ensures both customer safety and the safety of the call operator (Stamm, 2012: 3-4). According to Kreutzer and Jäger (2011: 638), organisations often embrace "managerialism" as a strategy to resolve the supposed ills that mark informal organisations. Subscribing to the norms of efficiency, effectiveness, agency and progress, management in such organisations hope to eradicate the messiness, economic precarity and lack of formalisation associated with many non-profit organisations (NPOs) that run telecare centres.[4] Cho, Bonn and Han (2018) and Waikayi, Fearon, Morris and McLaughlin (2012), in their respective studies on volunteer management, discuss managerialism and how its stratification of activities with additional, role-specific training has resulted in a more effective volunteer population. They hold that prior to formalisation, volunteers were able or obligated to take on various tasks, ranging from lower-skilled public activities to higher-skilled administrative work without training, and would eventually experience burnout (Kelley *et al*., 2005). But now, they argue, incoming and current volunteers are trained appropriately, which is attractive to young volunteers and allows them meaningful self-development, job skills and necessary work experience (Waikayi *et al*., 2012).

In terms of managing the vulnerability of their staff and 'clients', Roberts *et al*. (2012) and Stamm (2012), emphasise the importance of a management staff that is attentive and sensitive to their operators' mental health. They assert that management has to be flexible and that calls cannot be limited to a set time as operators need to form a relationship of trust and support with the caller; calls may escalate to crises situations, and protective protocols need to be enacted, either for the operator and/or the caller; and surveillance of operators is prolonged to ensure safety and well-being after shifts. By virtue of the life-and-death help they provide, telecare centre operators have certain commitments and responsibilities that differ fundamentally from other call centre operators. Fine (2005: 258) discusses the implementation of risk management in such centres

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[4] Kelley et al. (2005: 379-380), states that routinization encompasses organizational formalization and division of labour, for example, job titles; indicators of professionalization, such as designated work hours and increased services; and routine participation in said organisation's field, for example, the health sector.

through the introduction of increased accountability procedures for staff that relate to strategies for harm minimisation, the promotion of standardised procedures, how to ration services through targeting and assessment and how to manage risk when clients' lives are involved. Matching appropriate risk management ties risk to the development of organisational forms and logistics.

These suggestions of flexibility, sensitivity and attentiveness, come at a great contradiction to the strategies of managerialism and routinization mentioned previously. Kelley *et al*. (2005) and Kreutzer and Jäger (2011), in their respective studies on volunteer/management relations, argue that while the implementation of management practices result in several advantages, it also perpetuates a certain idea of a workforce that equates effectiveness with efficiency and high productivity. When applied to telecare centre workers, the outcome would see calls queued, constant supervision, as well as prioritisation of "serious" calls over callers with minor issues and limitations on time spent on calls. Such routinisation undermine operators' ability to provide care over the phone. Thus, management staff at telecare centres face the predicament of balancing the effectivity with which the centre delivers care to vulnerable callers with the vulnerabilities of their operators.

1.4 Research Questions

My main research question is, how does MhASA's management navigate a work environment that positions their volunteers in situations of emotional and mental risk?

In order to answer this question, I also ask, how is the centre organised, specifically, does the centre make use of routinization or aspects of routinization in their organisation of their workforce? Given the nature of their work environment and the fact that MhASA's telecare centre is predominantly volunteer-based, how does HR ensure volunteer commitment and retention? What management practice(s) does HR employ at the centre, in relation to their operator workforce? How does HR account for the occupational hazards of working as a volunteer telecare operator?

1.5 MhASA: the organisation and call centre

MhASA is one of South Africa's oldest and most prominent non-profit organisations that deals with mental health. Being a civil society organisation, MhASA is registered under South Africa's Nonprofit Organisations Act of 1997 as a Section 21 Company, with a Section 18A tax exemption under the 1962 Income Tax Act (MhASA website, 2020).[5] As a legally constituted non-profit organisation, the organisation is allowed to receive benefits or allowances from government and donors in exchange for their essential services.

Established in the early 1990s, MhASA aims to create and sustain public awareness of mental health issues, disorders and wellness, provide educational programmes and events on mental health and advocate for the de-stigmatisation of mental health and those diagnosed and/or suffering with mental health related issues. As an organisation, its expertise lie in assisting patients and callers with mental health queries throughout South Africa (MhASA website, 2020).

I chose this organisation because it is considered to be one of South Africa's best not-for-profit providers of mental health services, with their counselling-and-referral call centre being both easily accessible and publicised as highly successful. This call centre operates daily from 8am to 8pm. According to two of my participants, Nora and Amy, in 2019 the centre hosted 22 helplines that comprised of a general line (for all concerns) and twelve 24-hour dedicated lines that were created in collaboration with universities, pharmaceutical companies, insurance or medical aid companies and mental health-related organisations. Some of these helplines dealt with specific issues or scenarios, for example, substance abuse or suicide. Manning these helplines are volunteer telephone counsellors. At the time of this study, MhASA employed at least six permanent staff members at the call centre, and had a rotating staff complement of approximately 140 volunteer counsellors, with 22 counsellors working during each shift: twelve telephonic counsellors and ten

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[5] The 1997 Nonprofit Organisations Act aims to (1) create an enabling environment for NPOs, and (2) set and maintain adequate standards of governance, accountability and transparency (etu.org.za).
The 1963 Companies Act defines a Section 21 company as a "not-for-profit company" or "association incorporated not for gain". Section 21 companies resemble business-oriented (for profit) companies in their legal structure, but do not have a share capital and cannot distribute shares or pay dividends to their members. Instead, they are "limited by guarantee", meaning that if the company fails, its members undertake to pay a stated amount to its creditors (etu.org.za).
The 1962 Income Tax Act says that a taxpayer making a *bona fide* donation in cash or of property in kind to a Section 18A approved organization- is entitled to a deduction from taxable income if the donation is supported by the Section 18A receipt issued by the organization (sars.gov.za).

online counsellors (MhASA, 2020). According to Lucas, one of my participants, the centre received on average between 250 to 350 calls daily, with each (telephonic) counsellor, during each shift, handling about seven calls minimum.[6]

1.6 Methodology

My study was qualitative and was framed as a case study. I made use of semi-structured, in-depth interviews and limited observations at MhASA's headquarters as methods of data collection. The use of a case study research design was due to the study's intended focus on a single "case"; the *permanent staff* of one of the oldest and most successful suicide prevention call centres in South Africa. Initially, my "case" was the Human Resource Department (HRD), however, after conversations with the call centre's operations director, it became clear that the call centre did not have such a department, but rather a small group of permanent staff members who fulfilled the functions of a HRD in conjunction with their other tasks. These permanent staffers oversaw numerous volunteers who worked as call-centre counsellors for the organisation's helplines.

My research design was exploratory in nature, as pre-existing literature on my subject of enquiry was scarce. The data collection method most suitable for this design was semi-structured, in-depth interviews. Semi-structured interviews provide both the interviewer and interviewee a great opportunity for exploration and investigation. The use of well-structured, open-ended questions places the participant in a position to direct the interview yet provides the interviewer with valuable data that is based on personal experience, opinion, and interpretation of the context under study (Harrell & Bradley, 2009: 27).

For this study, I conducted six interviews; five were with permanent staff members – which included two call centre managers, the volunteer co-ordinator, the support groups co-ordinator, and a senior student counsellor – while the sixth was with a senior volunteer counsellor[7]. All interviews were organised in May and early June 2019 by the operations director of the organisation, several months prior to the data collection. After discussing my project with

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[6] This is based on a calculation of three day shifts with twelve counsellors working in each shift, each handling seven calls per shift.
[7] Refer to Chapter 2 for descriptions of these positions.

employees, the director indicated that the five permanent staff members – and one volunteer counsellor – best placed to answer my questions had volunteered to participate in my study. She also organised an interview schedule for November 2019 that was both convenient for all six participants and coincided with the limited time I had available at the call centre.

The actual interviews occurred in the first week of December 2019 over the course of two consecutive days with three interviews scheduled per day. On the first day, I interviewed Michael, Valerie and Amy and on the second day, I interviewed Lavender, Nora and Lucas. The operations director scheduled these interviews and allocated an hour for each interview, with half an hour breaks in between.[8] Five of my interviews ranged from 45 minutes to 70 minutes, with one interview lasting only 30 minutes.

I was able to conduct all six interviews at the call centre, either in the boardroom, or if it was occupied, in the storage room. Not only did this scheduling and set-up allow me to interview my participants in a space and at a time that was most convenient for them – especially since the interviews were scheduled to occur during or immediately after their shift(s) – but it also provided an opportunity for an informal observation of the call centre; the layout of the call centre and the environment wherein the volunteers and permanent staff work and interact. This observation, combined with a tour of the call centre conducted by Lucas, one of my participants, on my first day, before the interviews commenced provided the necessary orientation to the organisation's call centre.

1.7 Analysis

This study made use of thematic analysis. I consolidated, interpreted, and reduced my participants' responses to "themes". These themes emerged from consistent patterns within the data and were deduced from an analysis of both implicit and explicit ideas from my participants' responses (Guest, MacQueen & Namey, 2011:10). This form of analysis allowed me to produce multiple [sub-]themes within a theme and relate this to other themes (Attride-Stirling, 2001). The aim was to produce a holistic, interpretive network of themes.

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[8] Please refer to Appendices for an outline of the interview schedule.

1.8 Ethical Considerations

In the execution of this research, I followed the ethical guidelines of the British Sociological Association (BSA) (2017). As a social researcher, I ensured that the well-being and rights of my participants were protected. Since the call centre operators might be considered at risk or vulnerable because of the stresses of their job (see BSA, 2017: 6), I did not directly liaise with them. Instead, I limited my study to the organisation's permanent staff who managed the operators, with the exception of a senior volunteer counsellor, who, due to their experience and seniority, held a position that involved the care of other volunteer counsellors.

I also sought informed consent from all participants by presenting them with a consent form to sign. The consent form outlined what the research was about, who undertook the research, and how data was to be gathered, used and distributed (BSA, 2017: 5). Participants were also informed that their participation would be wholly voluntary and that they were able to withdraw from the study at any time. Furthermore, and due to the possibility of participants experiencing discomfort and/or stress during the course of the interview, I included a gentle reminder that should they feel the need for counselling, such services were available within the call centre. All participants were made aware that they would remain anonymous and that I would use pseudonyms when the results were published (BSA, 2017: 6). I digitally recorded interviews but asked my participants for permission before I did so. I also ensured confidentiality by not sharing the personal content of interviews with anyone, except with my supervisor when needed or justified as part of the research process.

Furthermore, I ensured anonymity of the organisation throughout my research study by excluding the organisation's name, location, affiliations, as well as commonly known facts and/or characteristics of the organisation. This was to the ensure that the organisation would not be adversely affected by the research (BSA, 2017: 5).

I was the only person who had access to the data, which I stored on a password-protected computer. This data included interview transcriptions, consent forms and the original participant list (BSA, 2017: 7).

My study was approved by the Sociology and Social Anthropology department's Departmental Ethics committee (DESC), and the Human Research Ethics Committee (REC) of Stellenbosch University (Approval number: 10298).

1.9 This thesis

This thesis is composed of four chapters. Following this chapter are my two analysis chapters. The first of which, Chapter 2, will address the ways in which MhASA's call centre has formally structured its workforce, and how certain aspects of this structuring has resulted in the production and reproduction of an organisational culture that undermined some of the negative aspects of routinisation noted in the literature on other call centres. Chapter 3 will investigate the ways in which MhASA has approached the dilemma of implementing routinisation in the provision of the telecare the centre provided while attempting to account for and provide care for their counsellors at risk. Chapter 4 is the conclusion to my thesis. In this chapter, I will provide a summary of my findings, arguments, and related literature.

Chapter 2: The Counsellors

Existing literature on volunteer management in telecare centres discuss how the implementation of routinization – or structures akin to routinization – affects organisational structuring and the management of telecare operators (see Chapter 1). Although very much in line with Weber's concept of the "iron cage" (Woodcock, 2016), my take on routinization was from a much milder approach. In agreement with Kelley, Lune and Murphy (2005) and Waikayi, Fearon, Morris and McLaughlin's (2012) studies, I conceptualised routinization as a means for telecare centres like MhASA's to 'clean up' their organisational structuring to better the effectivity and efficiency of their services. This chapter aims to explore the ways in which Mental health Awareness for South Africa's [MhASA] call centre has routinized, both their volunteer counsellor population and group of permanent staff members as a means to ensure an effective workforce. The chapter also looks at the ways in which this organisational structuring resulted in the production and reproduction of an organisational culture and identity. I plan to do this by providing descriptions of the organisational structures employed in both groups of staff; these include the various roles/positions given to members of either group, work hours (shifts) and their respective methods of training. I will discuss how some of these aspects have mediated the production and reproduction of a shared organisational culture. In this discussion, I will also look at how this organisational culture has minimised some of the negative effects of routinization, such as divisiveness between both groups of staff due to organisational formalisation and the division of labour.

2.1 MhASA's call centre

Located at the organisation's headquarters, MhASA's call centre is relatively small in size, occupying about a third of their single-floor office space of about 150m². The call centre was divided into two spaces. The first (see Figure 1) was an enclosed room fitted with several large desks and computer screens that seated a maximum of ten counsellors (black dots) at the tables marked in pink and a single call centre manager, who sat at the table marked in green.
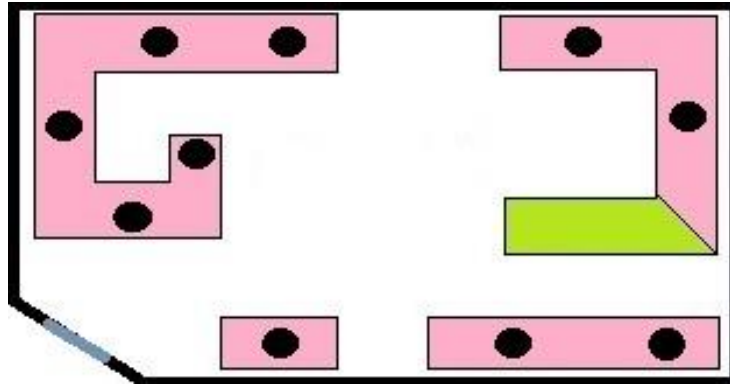
Figure 1. Diagram of the subsidiary call centre (online services) at MhASA's headquarters

Amy, the call centre manager in charge of this room, explained that the counsellors who worked in this room were mainly online-based counsellors, working with the organisation's online platform as well as Facebook and WhatsApp queries, but were also tasked with completing follow-up calls and messages from the 'live' call centre next door. The manager (Amy) sat towards the centre of the room (green table), providing her with a full view of the counsellors. She went on to explain that while she was unable to monitor her counsellors constantly, visually, her positioning made her easily accessible to the counsellors in this room, and allowed her to listen in on the counsellors' and step in when necessary.

To the immediate left of this room, was the second half of the call centre. It was situated within the organisation's larger, open-plan workspace and was partitioned from the rest of the office by an opaque glass wall. Unlike the set-up in the first room, the counsellors in this area had individual cubicles (in pink) of which there were twelve in total, with six in a row, on either side, facing one another (see Figure 2).
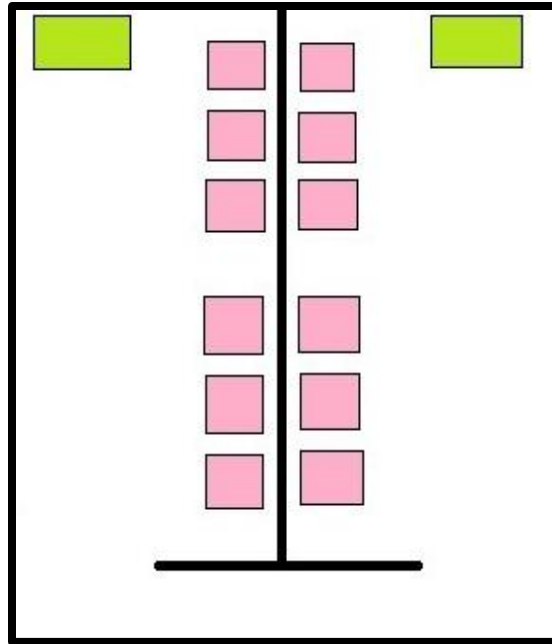
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Figure 2: Diagram of the main call centre (telephonic services) at MhASA's headquarters

The counsellors in this half of the centre attended to all incoming calls and were individually equipped with a computer or laptop, a telephone and a referral guide. At the very back of the room, were two desks (indicated in green), one at each corner, for either two call centre managers or one manager and another permanent staff member. The placement of the call centre manager(s) in this area allowed them to provide constant supervision of all twelve counsellors. Valerie, the other call centre manager, sat at the right-hand side table (during my two day stay at the centre) and spoke of how her seating allowed her to easily look-up and observe her counsellors, and – much like Amy – listen in on them as they worked and step in and assist when necessary. Amy explained that while communication between the two halves of the call centre was limited, the call centre managers did "walk-abouts", strolling from one room to the other, observing their counsellors and attending to counsellors having difficulty resolving their calls.

As noted, the layout of MhASA's call centre – the open plan of each room – provided the permanent staff members, especially the call centre managers, with the opportunity to constantly supervise (and survey) their counsellors, even at times when it seemed less obvious; when the managers were not on their "walk-abouts" or peering over at their counsellors. And while my descriptions of said rooms pointed to supervision as a means to assist their counsellors, it was also partly utilised to ensure effectivity i.e., to ensure that the counsellors were doing their work.

2.2 MhASA's volunteer counsellors

In recent years, MhASA's call centre has seen an exponential increase in the number of prospective volunteer counsellors. In fact, according to the majority of my participants, the period between 2015 to 2019 saw a rapid growth in the size of their applicant group, which has resulted in an equally rapid expansion in the size of the call centre, specifically the number of counsellors on duty per shift. Valerie stated that in 2017, the number of trainees at the call centre was "in the forties" but by the end of 2019, that number had risen to over 100 people per training programme that occurred in that year. Amy measured the growth in the centre by the number of lines it ran; in 2015, the call centre had only four lines, three normal lines and one dedicated line, but by the end of 2019 it had grown to 22 lines, with over half being dedicated helplines.

According to Amy, MhASA's volunteer counsellor population could be separated into three groups; those who joined because of personal experience(s) with mental health, those who studied or are studying in a field that involved mental health and people who had experiences with both. Michael explained that many people joined the call centre because they were either psychology students who wanted practical experience or referrals to further their studies or were already working in the field of psychology. Indeed, MhASA's volunteer counsellor population was dominated by present or past psychology students, while the smallest constituent was made up of people who drew upon their own mental health experiences to counsel others.

Since most of the volunteer counsellors were students, the call centre population was relatively young. However, according to Lavender, the call centre did not allow volunteer counsellors to be under the age of 22. She quickly explained that this was not a form of discrimination, but "protection" for those not mature enough to handle possible "triggering" phone calls. "Age" she said, was "an important factor". There were no age limits on the call centre's older population, and volunteer co-ordinators and other permanent staff members enthusiastically welcomed "elderly" counsellors. As Valerie explained, older counsellors were rare at the call centre, but their skills and experience were highly sought-after.

Despite the increase in older male volunteers, both Valerie and Amy stated that the call centre was still "dominated" by women, who constituted 90% of the counsellor population. Some of my participants suggested that this dramatic gender imbalance was due to "cultural things",

specifically social beliefs that held that men were emotionally less capable than women. To illustrate, Lucas explained that "as a man", he found that a lot of (other) men did not feel comfortable dealing with emotions. Michael added that men "tend to be more practical, they wanna give people advice say", and unfortunately "that's not really very helpful because, whatever it is that you can you muster in your own head to tell somebody to do, they've probably told themselves …, they don't need it to hear it from a stranger". At the call centre, giving callers tangible solutions to their problems was not as helpful as words of encouragement, he insisted. Despite such "cultural" beliefs, my participants noted that there had been an increase in male volunteers who were motivated to help others because of their life experiences with mental health issues. Nora explained that this showed that men were becoming more aware of themselves and "in tune with their emotions than they used to be".

In terms of racial diversity, the centre had a balanced ratio of both black and white counsellors.[9] According to Valerie and Lucas, this was due to a general increase in both black trainees and volunteer counsellors at the call centre. Valerie stated that this was due to a combination of better mental health education and a greater awareness of mental health issues in black communities spawned by MhASA and other organisations like it. The centre also had a small number of coloured and Indian counsellors, but according to Amy and Lucas, the interest from these communities were low. They said that there was no definite reason as to why this was the case.

Types of volunteer counsellors

The phrase 'volunteer counsellor' was an umbrella term that my participants used to refer to the counsellor population in general. However, over the course of the interviews, my participants introduced and discussed several distinctive types of volunteer counsellor positions that existed at the call centre.

All counsellors began working at the call centre as volunteer counsellors. These counsellors responded to calls from the general helpline and thus handled a variety of caller situations.

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[9] In post-apartheid South Africa, the use of these racial categories was not confined to government bureaucracies. My participants still used apartheid-era racial categories to refer to both other people and themselves.

Volunteer counsellors who wanted to work on one of the centre's dedicated helplines would approach the counsellor responsible for it. According to Nora, the volunteer counsellor would then have to observe the current dedicated counsellor, and once the dedicated counsellor concluded that they were ready for the role, they would be formally given the position. Depending on their personal schedules and the capacity of the shift, dedicated counsellors could work day shifts or the night shift. Apart from general volunteer counsellors and dedicated counsellors, the centre also had online counsellors who responded to the centre's three online counselling services; its "contact a counsellor" platform on MhASA's website, its online chatroom, and its WhatsApp counselling platform.

Counsellors who had been with the centre for an extended period of time, or who had dedicated much of their time to the centre, would become senior counsellors. Lucas explained that the centre only promoted people who had put in the time, rather than those who had the highest academic qualifications, because such counsellors would have had the greatest exposure to a variety of calls and how to deal with them. This accumulation of knowledge was what distinguished a senior counsellor from the rest of the counsellor population. However, this also meant that senior counsellors had extra responsibilities. According to Michael, along with being at the call centre for their usual shifts, senior counsellors advised and helped other counsellors with their calls and could take over calls if a counsellor were struggling or refused to handle a caller's "situation". Senior counsellors were also usually given the responsibility of handling the more difficult calls (see Chapter 3). He went on to state that 'senior counsellor' was merely a title to distinguish these counsellors from the other volunteers counsellors on shift at the call centre; they were not permanent staff.

The centre also had reserve or emergency counsellors. Amy explained that these counsellors were unable to book shifts due to work, university or other commitments but formed an emergency group that would "cover" for counsellors who were unable to make their shift for any given day. This emergency work happened with prior notice as dictated by the centre's absenteeism protocol (see Chapter 3).

The call centre had four shifts for volunteer counsellors; three four-hour day shifts (8am-12pm; 12pm-4pm; 4pm-8pm) and one twelve-hour night shift. The day shifts started at 8am. For their shift, counsellors were equipped with a telephone connected to the helpline the counsellor

worked with, a computer to log the callers' details and the call centre's referral guide. Counsellors that booked day shifts worked at MhASA's headquarters while night counsellors worked from home. According to Amy, night counsellors were given a cell-phone connected to the specific helpline that they had chosen to counsel on, an electronic tablet – which was given to them once they became a night counsellor – to record the callers' details, and the call centre's referral guide to assist them with the handling of their calls. Because night shift counsellors worked alone, they kept in constant communication via WhatsApp group chats with fellow night counsellors and the call centre manager responsible for the night shift counsellors.

Turnover

While the call centre's intake of counsellors in recent years had been quite large, many of these counsellors on average stayed between six to eight months. My participants explained that there was no singular reason for the call centre's high turnover rate in volunteers but agreed that leaving was a natural transition. Most of my participants explained that counsellors "moved on" with their lives due to various reasons. Prime amongst these reasons was that many counsellors left in order to continue their studies. The majority of counsellors joined the call centre to get practical experience and/or referrals for their Honours or Masters degrees. Once they had been accepted into their degree of choice, they left the centre. The second most frequent explanation of why counsellors left was that people had lifestyle changes; counsellors either chose to leave because "it's time to move on" and they wanted to do something else, or they could no longer accommodate the call centre work in their lifestyle. In situations where counsellors moved to a different city, but wanted to continue working for the organisation, Amy explained that they would often be able to hold wellness programmes and events that were still tied to the organisation. Of the least common reasons why counsellors left the centre was a realisation that, as Amy said, "[the work] was just too much for them to handle".

Nora vehemently disagreed with her colleagues about the reasons why counsellors left the centre, stating that a significant proportion of counsellors left due to burnout and stress. She explained further,

you deal with it every day … you start feeling depressed because you deal with depression on a daily basis you start feeling burnout symptoms, you start feeling *tired*, you start feeling exhausted because you speak to people that are sad all the time that are exhausted all the time, it just becomes your reality.

Nora's insistence on burnout and stress being the main causes of the centre's turnover rate, echoed a predominant concern in existing literature on telecare centres. MhASA's call centre, much like others mentioned in some of these studies (see Roberts, Mort & Milligan, 2012; Howe, Meakin & Islam-Barret, 2014; and Kitchingman, Wilson, Caputi, Wilson & Woodward, 2018), functioned on a staff of volunteers who continuously placed themselves at risk of exposure to the emotional distress of others. According to both Stamm (2012) and Kitchingman *et al*. (2018), such exposure would eventually result in volunteers experiencing burnout, vicarious traumatization and compassion fatigue,[10] which was essentially what Nora referred to in her explanation. Both authors, in their respective works, go on to state that while this may occur over an extended period of time, it still was the largest contributor to the high turnover rates at telecare centres. Howe *et al*. (2014), adds that such risks were manageable through training, call supervision and staff debriefing (see Chapter 3 for the latter two).

Becoming a volunteer counsellor

In order to become a volunteer counsellor at MhASA's call centre, one needed to go through the organisation's screening process. This process was held twice a year; one in the middle of the year with the training occurring around July, and the other at the end of that same year with the training occurring around February of the next year. However, if there was an unexpected influx of applications, the organisation made provisions for a third screening process to occur.

This screening process entailed a series of suitability "checks". These "checks" ensured that, of the potential volunteer counsellors, only those that best suited the organisation, the role, and the work environment would succeed. Nora summed this up by saying that the screening

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[10] Vicarious traumatization occurs when an individual, like a volunteer counsellor, is exposed to the traumatic events of others.
Compassion fatigue is the negative effect of helping those who experience traumatic stress and suffering. There are two aspects of compassion fatigue: Burnout – feeling overwhelmed and experiencing feelings that their work cannot make a difference, and Secondary trauma – experiencing suffering and trauma in response to helping others (Stamm, 2012).

process was integral to the "quality" of the volunteers that would eventually join the call centre. Additionally, she explained, this process assured a better retention of volunteers, lower turnover due to emotional distress, and a more efficient call centre- and was beneficial for prospective volunteer counsellors.

In the literature on volunteer management in non-governmental organisations [NGOs], scholars have argued that beyond being able to develop useful skills, volunteers also find being able to become a volunteer at a 'hard-to-get-to' organisation rewarding and beneficial; they felt a sense of pride and exclusivity and felt that they were valued for their capabilities (Haski-Leventhal, 2009; Waikayi *et al.*, 2012; and Evetts, 2013). In the case of MhASA, Valerie explained that their call centre was in such high demand among volunteers that only 40% of prospective counsellors became volunteer counsellors. For those who made it, their feelings of accomplishment contributed to volunteers who both strongly identified with the call centre, and who wanted to remain with the organisation in the long term, even if it did not involve the call centre.

MhASA's "checks" on prospective counsellors were largely performed by the volunteer co-ordinator(s) during the course of the organisation's preliminary interviews and their formal (practical) training. According to Nora, the call centre had a three-stage interview process, with each interview constituting an opportunity to "check" prospective volunteers. Prospective volunteers needed to pass each stage of interviewing, before being able to participate in the training. Furthermore, each stage in the interview process had a different set of requirements that prospective volunteers had to meet. These requirements became less rigid as the individual progressed through the interviews and the volunteer co-ordinator attempted to find out more about the applicant, their capabilities, personality, and motivation(s).

The first stage of the interview process was kicked off by an electronic application form that could be found on MhASA's official website. For applicants with access to the internet, this first stage was easily accessible and relatively straightforward; applicants had to fill out their personal information, educational qualifications and their knowledge and experience(s) with mental health and volunteering. Nora explained that when reviewing these forms, the volunteer co-ordinator's concerns centred around the applicants' ability to commit to the responsibilities of a volunteer counsellor. This was determined by paying special attention to specific information such as the applicant's address. Nora explained that if an applicant needed to travel for one or two hours to

get to the call centre, they would be turned down as it "would be difficult for them to travel" and the call centre did not offer travel stipends. Secondly, she would weigh the applicant's reason(s) for wanting to become a counsellor. According to Nora, being charitable was not enough of a reason to want to be a counsellor; "you can give back in all types of ways, [but] this is a very specialised place where we deal with mental health, which is a critical thing". Nora did not want to discourage applicants but wanted them to understand the dedication and "seriousness" necessary to become a counsellor. Lastly, she explained, the volunteer co-ordinator paid particular attention to the applicant's knowledge of and experience with mental health. Lavender and Nora, both long-term employees at the centre who had fulfilled the role of volunteer co-ordinator at some point, agreed that personal experiences with mental health, such as experiencing mental health issues personally or having experienced a family member/friend deal with mental health issues, and/or an educational background in mental health disciplines, was advantageous to prospective counsellors. However, Lavender stressed, applicants who had experienced mental health issues needed to be "stable", they needed to go for therapy or successfully manage their mental health independently.

If an applicant's answers on the form did not meet the centre's basic requirements, they would receive a follow-up email explaining why they were unsuccessful. Once they fulfilled the necessary requirements, applicants could reapply or postpone their volunteer programme participation.

Successful applicants in this first round proceeded to a telephonic interview. During this interview, the volunteer co-ordinator would focus on two aspects: the applicant's commitment to counselling at the call centre and their phone etiquette. Interviewers asked prospective counsellors a series of detailed questions about their ability to commit to being a counsellor at the call centre relating to their current lifestyle, previous engagements, and work and/or studies. This was to gauge whether the applicant would cope with the call centre shift(s) added to their schedules. As Lavender explained,

> we'll also look at things like, what you're currently doing 'are you working at other NGOs? If you're working at other NGOs, why do you also want to at this? Why not invest more time at that NGO?' Uhm, "are you studying? Are you doing a part-time job?' just to kind of look at their commitment realistically, and sometimes they just need you to be like 'can you do this? Do you have the time?'

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Throughout, the volunteer co-ordinator would try to assess the applicant's phone etiquette. According to Nora, the volunteer co-ordinator would "check how you're able to communicate over the phone […] to see if you are comfortable with the phone and if your voice is projected enough". Lavender expanded by saying, "are they easy to understand? Also, how many languages can you speak? Super beneficial, because the more languages that you speak the more different, the more people you can help out with".

After the telephonic interview, applicants who performed well proceeded to the final stage of the interview process, the face-to-face interview. This interview was highly structured and had a test-like format limited to 30 minutes, with the first 15 minutes being allocated to one interviewer and the last 15 minutes allocated to another interviewer. During each segment of the full 30-minute interview, each interviewer asked a different set of questions. After the interview was completed, the interviewers reviewed their segments, and assessed and provided a score for the applicant. If the applicant scored well with both interviewers, they passed the final interview. According to Lavender, the reason for such logistics was to ensure that both interviewers agreed as to whether or not the applicant was suited to be a counsellor, "just to make sure that it remains nice and objective, and there aren't any personal biases…If there is a massive discrepancy between the scores, we'll obviously have a sit-down discussion and try and work out why".

Of my participants who partook in these face-to-face interviews, all implied that there were a set number of questions for this interview, but none of them wanted to commit to listing what these were. However, Amy explained that the interviewers attempted to discuss personal topics that centred around emotional and mental wellbeing. She admitted that it "seems like we pry" but explained that it was for both the safety of the applicant and the callers, "because you don't wanna put anyone that can be triggered by any call or triggered by any situation". The reason for this constant 'checking', Lavender added, was to ensure that interviewees would be able to cope with the work of a counsellor, someone who was "in a comfortable mental health space" and for whom "being in this very stressful environment" did not "trigger" them; these 'checks' were a means of protecting the applicant from future mental and/or emotional distress that would be caused by working as a counsellor.

Once the applicants completed and passed the third and final interview, they were invited to start formal training at the call centre. The 2019 training programme for prospective counsellors

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was split into a theoretical and a practical part.[11] The theoretical training was a two-day workshop that occurred either over one weekend (Saturday and Sunday) or two consecutive Saturdays. Amy stated that either scheduling was chosen according to the incoming group of prospective counsellors' preferences. The prospective counsellors needed to pay R300 for the theoretical training. According to Lavender, this money went towards the catering for the event and the training manual that they handed out. As Michael explained, the theoretical training was a "crash course" on mental health, with professionals such as psychologists and psychiatrists from around the country and counsellors from the organisation, invited to speak on different types of mental illnesses, how they present and typical symptoms. Prospective counsellors also learnt about the experiences of current volunteer counsellors and permanent staffers that worked at the call centre.

After the two-day workshop, prospective counsellors started the practical part of their training programme, which involved twelve, four-hour "listening shifts". These shifts were compulsory and formed the entirety of the in-house, practical training. It also provided the volunteer co-ordinator a last chance to screen prospective counsellors. Depending on their personal schedules, prospective counsellors would "book" their chosen day shift(s) with the volunteer co-ordinator. According to Lavender and Amy, the volunteer co-ordinator and call centre managers suggested that prospective counsellors aim to commit to one shift a week at the minimum, and only commit to more if they were able to accommodate multiple shifts, either every week and/or multiple shifts in a day. As they explained, the one listening shift per week showed commitment, but was also practice for prospective counsellors to include and normalise the shift as a part of their weekly schedule(s).

At the beginning of each shift, the volunteer co-ordinator would give the trainees a worksheet with a list of activities and/or questions that needed to be completed by the end of the shift. According to Amy, these worksheets, sometimes accompanied by handouts with information and/or instructions on how to perform the worksheet activities, were structured as a way for trainees to learn a specific skill per listening shift. This applied to almost all of the listening shifts, with the first shift being an exception as all trainees were required to go around the call centre introducing themselves and asking the volunteer counsellors and permanent staffers for their

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[11] The training programme is constantly evaluated and updated, i.e. the programme described in this chapter may not hold true for current or future training programmes.

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names, what they did, and the roles they fulfilled in the organisation. Amy said that this was to get an idea of who their (possible) fellow counsellors were and how long they had been with the centre.

From the second listening shift onwards, trainees learned – in no particular order – how to: make use of and understand the call centre's logging system, DAISY; access, use and understand the call centre's referral guide as well as source the necessary information on different mental health issues; listen in on a call, answer a call, take a message and send an SMS; manage certain calls, understand the types of calls the centre receives and make use of the appropriate protocols; do breathing techniques; do follow ups on calls and messages, where the follow-ups go; and turn the helplines over to either day mode or night mode.[12]

Most of my participants stated that these activities were completed in combination with trainees listening in on calls taken by volunteer counsellors. Whilst the handouts provided trainees with the instructions on "how to" do these activities, by shadowing volunteer counsellors, they were able to experience practical examples of how to apply the skills they were learning.

Once a trainee concluded their shift, they had a short meeting with the volunteer co-ordinator to discuss the shift, the activities they completed and the difficulties they may have experienced. According to Amy, unless two or more trainees completed the same listening shift, these meetings were one-on-one. This was the case for majority of the after-shift meetings as the one-on-one set-up proved to be most beneficial for the trainees. These meetings were conducted as open-ended conversations, with the volunteer co-ordinator asking the trainees how their shift had gone, how they were managing and if they had any concerns or questions about the worksheet or activities. Amy stated that these meetings were essential as they taught trainees to communicate their concerns with others at the call centre, especially when they later become a volunteer counsellor.

To pass the practical training, trainees were required to do three "formal" (verbal) assessments over the course of the twelve listening shifts.[13] These assessments occurred after the fifth, tenth and twelfth listening shifts and centred around a revision of the work they had done in the listening shifts prior to the assessment. After the fifth listening shift, the volunteer co-ordinator would have

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[12] The call centre had a day/night mode system because night counsellors worked from home. Amy explained that once the day shifts ended at either 5pm or 8pm, the 24-hour helplines were "turned over" to night mode until either 5am or 8am, when the helplines were again "turned over" to day mode.

[13] The word "formal" is used to refer to the standardized nature of these assessments.

trainees recall and discuss the skills and protocols they had learnt from the first to the fifth shift. After the tenth listening shift, the trainee would be similarly assessed on shifts one through to ten, and after the final shift, they would revise everything they have learnt during all twelve listening shifts. Amy explained that during these assessments, the volunteer co-ordinator would take on the role of the listener, paying attention to whether or not trainees had grasped the information and skills they learnt in the previous listening shifts, what they were struggling with, and what needed to be revised, re-explained, or clarified for the trainee to progress. In situations where the trainees were struggling, the volunteer co-ordinator would use the assessment period to help them progress with their training. If a trainee continuously showed signs of struggling with the work at both the fifth and tenth shift assessments, the volunteer co-ordinator would suggest that they make use of the eleventh and twelfth shifts as periods for revision. Trainees who continued to struggle and who showed little progress, would have to rebook and partake in more listening shifts until the volunteer co-ordinator was confident in their capabilities. Nora pointed out that in such situations, the volunteer co-ordinator elongated the training to assist trainees to become "the best version" of themselves as counsellors.

Apart from the formal assessments, the volunteer co-ordinator, call centre managers and counsellors also informally screened prospective counsellors throughout their training. This was done by observing the comments and questions the trainees asked, especially those that were related to the calls. According to both Lucas and Valerie, this was an indicator of whether or not the trainees understood "what we are all about" [Valerie] and if the trainees exhibited characteristics that were appropriate for a counsellor.

Although my participants were reluctant to define an ideal volunteer, when pressed, many identified commitment as a highly prized characteristic in both prospective volunteers and current working counsellors. According to half of my participants, counsellors showed their commitment by consistently showing up for their shifts and attending to their designated duties. Another characteristic that half of my participants looked for in prospective counsellors was people who were passionate about their work. Michael stated that the first aspect he looked for in a prospective counsellor was their "inclination towards the work". A third characteristic that would define a good counsellor according to both Nora and Michael, was empathy. Nora pointed out that counsellors needed to be innately compassionate and nurturing. Lastly, all counsellors needed to

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be non-judgemental and open-minded. Many of my participants asserted that counsellors had to supress their personal biases whilst on shift as it can negatively affect how they handled calls. Michael explained that the need to be non-judgemental was "pushed hard during training"; trainees were taught that it was not their business "to judge anybody on anything" and if they could not adhere to this rule, they must "pass it on" to another counsellor.

Nora also stated that the way in which trainees presented themselves was an important indicator of their "quality" as a counsellor. As she explained, "Are you confident with yourself? Are you still withdrawn?" The centre's staff also commented on the ways that trainees reacted to constructive criticism. The majority of my participants stated that counsellors needed to be open to criticism because their primary responsibility as a counsellor was to help callers to the best of their ability.

If a trainee did not improve or was consistently not doing well over the course of the twelve listening shifts, they would be notified by the volunteer co-ordinator that they were not (yet) suited to the role and responsibilities of a volunteer counsellor. According to Valerie, some trainees left or gave up before they received this feedback because their training exposed them to the "commitment" and "seriousness" required of a counsellor. These trainees realised that they were not suited to counselling or did not enjoy it. However, those that completed the practical training graduated and became part of the volunteer staff at the call centre. These new volunteers were then also able to either finalise their shift schedule and make it their permanent slot or become a reserve counsellor.

2.3 MhASA's management staff

While the call centre's longevity depended on a constant inflow of volunteer counsellors, it needed permanent staff at the managerial level to ensure continuous maintenance, growth and care of the centre's volunteers. The group of individuals that made up the call centre's permanent staff was extremely small in comparison to the volunteer counsellor population. In fact, five of my participants represented just under half of the group. Permanent staff members worked at the call centre five days a week, from Monday to Friday, covering most of the day shifts, from either 8am to 4pm or 9am to 5pm.

The call centre had permanent positions in four of its divisions: managing the volunteer counsellors, media, research and administration. There were two call centre managers at the centre who collectively handled the counsellors, the dedicated helplines, the scheduling of shifts and the counsellor training at the call centre. Both call centre managers also organised meetings, projects, workshops and events outside the call centre. Besides these duties, these managers also acted as liaisons between the organisation, universities and companies that contracted the centre to run their helplines. Apart from call centre managers, the volunteer co-ordinator also worked with the counsellors but handled their recruitment, training and development. The senior student counsellor focused specifically on the dedicated university helplines that the centre ran on behalf of a handful of South African universities. Although it was not explicitly stated, Lucas implied that the counsellor in this position was the unofficial team leader of the call centre's group of student counsellors. The senior student counsellor also did school and corporate talks.

Outside of the management of the call centre, the centre's support groups co-ordinator was supposed to help individuals create and launch support groups that were external to the organisation (and call centre), give constant support and help to current support group leaders, and run support groups for the support group leaders themselves. According to Lavender, the support groups co-ordinator also aided the volunteer co-ordinator with the screening process in 2019.

Furthermore, all permanent staff members that were involved with the call centre (including the support groups co-ordinator), continued to work as counsellors if the situation called for it. Some of my participants even stated that the only difference between themselves and the counsellors were that they held positions with extra responsibilities and duties to perform for the call centre and MhASA. Amy, for instance, expressed that "[her position] doesn't really matter", as she continued to handle calls even after her promotion to a permanent staff member. With this in mind, it was interesting to note that none of the permanent staffers I interviewed mentioned that they were paid for their work at the centre. Moreover, throughout these interviews, many, in their discussions on their relationship with the counsellors made efforts to blur – like Amy – the distinction between themselves and their counsellors.

Nora, Amy, Lavender and Valerie explained that becoming a permanent staff member depended on a position becoming available, because someone had left it or was promoted to another position. To qualify for a permanent position, applicants had to have worked as volunteer

counsellors at the call centre, for about six to twelve months. According to Lavender, individuals outside of MhASA were rarely appointed as permanent staffers because "in order to work here, you really do need to have an understanding of what we do, and how we do it, so I would say in most instances they are people who already work here, already volunteer here". Nora, Amy, Lucas and Valerie had all worked at the call centre as volunteer counsellors and had either worked in various counsellor roles in the call centre (and in other departments of the organisation) or dedicated an extensive amount of time to the call centre. Furthermore, all my participants that were permanent staff members (five), had received their positions through a promotion. For example, Lucas became the senior student counsellor because it was a new role and he was personally asked to lead this division of the centre, while Valerie became a call centre manager because the operations director noticed her commitment and passion for the work and decided that she was the "person they *needed*". Valerie stated that while they were offered the permanent posts, they could also decline the offer and continue to work as a counsellor.

Prospective permanent staffers would then be trained. Amy explained that there would be a "proper hand-over" from the person vacating their position to the new person. She elaborated further by stating that, "[the permanent staffer would] explain everything that happens, like what [they did] on a day to day to day basis and what [they did] on a weekly basis and what [they did] on a monthly basis, and that will be the hand-over". This hand-over period did not have a designated time frame. According to Amy, it was dependent on how quickly the prospective permanent staffer was able to "pick up" the work.

What stood out most for me in terms of MhASA's workplace, was that it kept advancement largely within the organisation. Not only was this sentiment made explicit by Lavender's statement on the suitability of promoting volunteers, but also by my other participants' failure to mention anyone who had been employed from outside the organisation. Instead, their responses pointed toward the benefit of employing counsellors. Unlike outside individuals, counsellors were already extensively familiar with the workspace, the people and the practices and protocols used at the centre. Long-term staff who had been with the call centre (and the organisation) had many social attachments to fellow counsellors and shared a strong organisational identity. In many senses, the call centre was like a community of counsellors who shared values about the dedication and passion needed for their work at the centre. And as a means to maintain this community, these

counsellors turned permanent staffers, placed great focus on the training programme as their main source of reproducing organisational culture. The training programme that I studied in 2019 was in its entirety devised and implemented by Nora. She proudly stated, "When *I* was training [in 2015] there was *no* one that is doing what I'm doing, so the change is *massive*".

Moreover, recognisability and familiarity of permanent staffers were key in the maintenance of a positive and trusting relationship with their counsellors. Counsellors found it easier to speak about their difficulties with their call centre work, because as Amy explained, "[they came to me] because I've been here for the longest time and they know me by face". She added that no counsellor, during her entire time as a call centre manager, had avoided asking her for help as she was always there at the centre. Amy's claim was suggestive of how encompassing the centre's organisational culture was. Permanent staff members, particularly the call centre managers, without a doubt, believed that no counsellor would intentionally hide their distress or difficulties related to the centre because it was "such an open environment" and "everyone talks to each other" [Amy]. Additionally, this showed the lack of divisiveness between both groups, that would have occurred as a result of organisational formalisation and division of labour – aspects of routinization (Kelley *et al*., 2005). Kreutzer and Jäger (2011), in their study on the relationship between volunteers and management staff (in several European NPOs), concluded that the utilisation of managerial instruments like routinization, without the accompaniment of a strong organisational culture usually resulted in tensions between both groups of staff. Volunteers in particular, responded to this lack of personal and professional attachments quite negatively, and by the end of the study many had left, while most of the organisations struggled to attract prospective volunteers.

2.4 Organisational culture and identity

In her article on the professionalisation of volunteer management in Australia, Haski-Leventhal (2009: 4) used the concept of organisational socialisation, which she defined as the process through which volunteers learnt the values, norms and behaviour best desired by the organisation they would eventually join. In a similar vein, Evetts (2013: 780) explained that the socialisation into a profession meant that trainees come to share a professional identity with a sense of common

experiences, understandings and expertise, shared ways of ways of perceiving problems and their solutions, and shared ways of perceiving and interacting with clients.

Looking at MhASA's call centre, evidence of Haski-Leventhal's and Evetts' concepts of professional socialisation was apparent throughout the duration of a volunteer counsellor's stay at the call centre. In my conversations with Lucas and Amy, it became apparent that counsellors – and in some instances, trainees – were able to point out and critique the mistakes made by their fellow counsellors, especially when it involved poor or incorrect counselling. Amy explained that counsellors either spoke to the counsellor in question or reported their conduct to a call centre manager who would then confront said counsellor and help them resolve their mistake. These instances, which were essentially moments of counsellors judging the capabilities of their peers, further socialised counsellors into developing the skills most desired by the centre.

However, the most obvious instances of socialisation occurred during the screening process, particularly, the interviews and the practical portion of the training programme. In terms of the former, all three interviews perpetuated several requirements that were necessary to become a counsellor at MhASA's call centre such as prior experiences with mental health. Given the emphasis placed on this, prospective counsellors learnt that in order to work as a counsellor, having exposure to the mental health issues of other people or experiencing them were important.

In terms of the practical portion of the centre's training, this was the only actual interactions that prospective counsellors had with the centre's staff. Trainees were exposed to their future work environment; this included the types of calls they would receive as a counsellor, the kinds of people they would be working with (both counsellors and their fellow trainees), and the physical space they would be working in. They were able to shadow the current volunteer counsellors at the centre and learn how to counsel. According to Lucas and Valerie, trainees would spend as much time as they could – after fulfilling their activities for that shift – observing counsellors respond to various calls, asking questions about these calls and the various methods they used to counsel, giving their personal takes on how they would counsel as well as receiving feedback, critique and advice from the counsellors they were shadowing. Following this, trainees were also given feedback by the volunteer co-ordinator and call centre managers during the after-shift meetings. These feedback meetings were opportunities for both the permanent staff members and trainees to discuss their shift, what they did correctly, fix what they did incorrectly and receive, once again, advice or

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critique on their behaviour during the shift, for example, whether or not their actions and characteristics were suitable for the role of the counsellor or not and what they could do to change and grow closer to becoming an 'ideal' counsellor.

Throughout this back-and-forth between themselves and the centre, trainees were able to decide if they were a good fit for the norms and behaviours of a counsellor and if they identified with the values and purpose of the call centre. Moreover, this first-hand experience set trainees up for opportunities to build relationships with the permanent staff members, especially the volunteer co-ordinator and call centre managers, and develop friendships with counsellors and their fellow trainees. This meant that beyond the (re-)production of an organisational identity, trainees also developed interpersonal connections, which added to their attachment to the centre and organisation.[14] These experiences ensured that trainees developed an understanding of their role in ways that aligned with the counsellors they were learning from, leading to a shared ethic of what it meant to work as a counsellor at MhASA.

2.5 Conclusion

In this chapter, I explored the various ways in which MhASA's call centre managers routinised the call centre's work and staff relationships. Like many call centres in the literature, the physical layout of this call centre allowed for constant and close surveillance, while the corporate culture encouraged counsellors to listen in on their colleagues' calls to help correct counselling mistakes. Beyond such surveillance, the centre also structured relationships between their volunteer counsellor population and their group of permanent staff members through its training programme, its handover protocols, its use of shifts and its division of labour and role-specification. These formalised labour structures are central to processes of routinization that aim to ensure efficiency in the wider call centre industry (Kelley *et al*., 2005). Against a mechanical framing of routinisation, I also showed in this chapter that some aspects of routinization, namely the centre's training process and feedback sessions, reproduced an organisational culture and identity that valued commitment and loyalty while creating a professional identity for counsellors often still in

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[14] Organisational identity is generally defined as collectively shared beliefs and understanding about fundamental, distinctive and relatively permanent attributes of an organisation, for example, core values, organisational culture and modes of production (Kreutzer & Jäger, 2011).

training to become psychologists. These social values and identities eroded the patterns of worker anomie that the literature described for the wider call centre industry. As such, volunteer counsellors were not arrayed against an extractive and controlling management but framed the centre and its management as an important learning ground that provided a valued service and to which they had individual and social loyalties.

Chapter 3: The Calls

In the previous chapter, I engaged with a central concern in the literature on the management in telecare centres, namely how these centres managed their staff in a context where rationalisation was a watchword (see Chapter 2). As I pointed out in Chapter 1, the implementation of managerialism and routinization in telecare centres often contradicts the demand for management to be accountable for the occupational hazards of the work of telecare operators. As the literature on telecare centres often assert, telecare operators have to be treated with more care precisely because their work puts them at risk of adverse psychological effects (Paterson, Reniers & Völlm, 2009; Stamm, 2012; Roberts, Mort & Milligan, 2012; Kitchingman, Wilson, Caputi, Wilson & Woodward, 2018). This chapter will explore the ways in which Mental health Awareness for South Africa's [MhASA] call centre approached this predicament, especially in their employment of call protocols. In this chapter, I will describe the centre's various protocols, particularly the protocols utilised by the volunteer counsellors when handling calls and the protocols they followed in dealing with traumatic experiences. I will investigate how management implemented these protocols as a means to ensure proper counsellor conduct with callers, but also to provide care in situations of emotional distress or trauma. As a part of this investigation, I will discuss how management has rationalised this care.

3.1 Types of calls and protocols

While the centre made clear distinctions between the calls that came from specific lines, volunteer counsellors and permanent staffers also made use of an informal typification of calls. From the responses of my interviewees, it was evident that this typology closely mirrored the centre's various protocols for handling specific types of calls such as general calls, frequent calls (including prank calls) and difficult calls (including suicide calls). Since almost none of the volunteer counsellors were qualified mental health professionals, the centre developed a set of protocols on how to handle calls correctly.[15] Since 2019, the volunteer co-ordinator and call centre managers

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[15] Most of the mental health professionals associated with MhASA do not work as volunteer counsellors, rather, many of them provide mental health care, such as therapy, for the counsellors, whilst others work with the organisation on mental health talks, the training of the counsellors and workshops.

were responsible for the creation of these protocols. According to Nora, the volunteer co-ordinator, and Amy, a call centre manager, the protocols were meant to help counsellors attend to calls via a standardised and approved system of counselling.

An example of these protocols was the call centre's introductory protocol for all calls, involving several necessary and compulsory steps. This standardised introduction was the call centre's closest example to the call scripts that the literature has identified as key mechanisms used by managers to control and survey telephone operators in call centres (Korczynski, 2009; Wharton, 2009; Roberts *et al*., 2012). When answering calls at MhASA, counsellors needed to retrieve certain information from the caller before they proceeded with the actual counselling. According to Valerie, within the first ten seconds of a call, the counsellor needed to ask the caller for their name and telephone number to ensure that, if the "line drops", the counsellor would be able to call back. Furthermore, counsellors also needed to obtain the address of the caller's location in order to ensure that they could provide adequate referrals and/or contact with public services like public hospitals, clinics, and the police, should a situation turn critical. All this information would be logged onto DAISY. Valerie explained that DAISY was a log system that recorded the details of every caller; this included the caller's name, telephone number, address and their situation/issue.

Once the caller began to talk about their situation, the counsellor was free to counsel according to their own style. Lucas recounted how, during the course of his practical training, different counsellors would attend to calls differently; some would talk, listen and refer the caller to a psychologist or other mental health services, others would listen and "just refer" whilst another group would take their time and try to grasp a deeper understanding of the caller's situation before considering an appropriate way of counselling.

General calls

According to Valerie, Amy and Lavender, the majority of the call centre's day-to-day calls were from people needing information, referrals, or simply to have company. Most of these calls involved people seeking information on or referrals for a variety of mental health services not provided by the centre; or confirmation of resources available to the caller within the area they resided in; or a request for more information. Sometimes these referrals had little to do with mental

health services. Amy, for instance, gave an example of callers asking for referrals for debt counselling. The call centre also received an abundance of calls from people seeking advice on bettering their relationships. According to Amy, some people even called in to say that they were having a good day.

Valerie stated that some of these calls were "easy calls" as the callers just needed "someone to talk to". In such cases, the counsellor "just needed to be that person that the caller can talk to about their situation". Even if the counsellor did not consider these callers' situations to be "serious", they still had to treat it as if it were. The counsellor would listen intently and empathetically to the caller's situation, and depending on what was explained, would either advise the caller on how to resolve the issue, or provide tips and techniques on how to manage their problem, or refer them to a professional for further and more clinically-driven help.

Frequent calls

At the centre, frequent calls referred to multiple calls from a single person. These frequent callers repeatedly called the call centre over the course of either several years, weeks, days or even several times within a day and repeated the same scenario or problem in every call. Frequent callers were identified through DAISY. My interviewees explained that callers who called the centre three times or more were added to their "frequent caller list". This list was not only accessible to the counsellors through DAISY's digital records but was also put on a physical notice board in the call centre where all the counsellors could see it during their shift(s). Thus, either DAISY or the notice board would immediately alert a counsellor if their caller were not only a frequent caller, but also if they frequently called for help or to play pranks.

The centre did not encourage frequent callers because it defined its services in terms of providing help in acute situations. As Lucas stated, the purpose of the centre was to provide immediate help for callers in crisis, not long-term counselling. He went on to explain that because of the centre's lack of resources for long-term counselling, they did not want callers to become dependent on the centre. As such, counsellors often urged callers who phoned repeatedly to seek help from health care professionals. Although the centre discouraged frequent callers, counsellors were not allowed to treat the frequent callers' situations as trivial. According to Valerie, some

callers had serious mental illnesses and/or problems and often contacted the call centre for reassurance. In such situations, the counsellors would provide them with the appropriate counselling and/or services based on a combination of the needs and issues the caller presented during the call and previously stored information from past calls. Valerie remarked that frequent callers were not necessarily asking for intensive counselling, but that "they just need to talk to somebody, all they need is an ear".

The majority of frequent callers tended to be nuisance calls. My participants complained that nuisance or prank calls were a constant occurrence at the call centre. In fact, on my second day of interviews at the call centre, Nora explained that they had received a prank call the previous day, and that such calls happened almost every day. Lucas added that on an average shift, approximately half of all calls received were prank calls.

Many of the prank calls were from individual pranksters who called multiple times, although some of these calls were also made by once-off callers. As my participants explained, prank callers were motivated to shock or harass counsellors. Children were most likely to, as one of my participants said, "get off" on the shock value of their prank calls. They were also more likely to make prank calls and to make them frequently. Children's prank calls were very diverse. They would often call in and proceed to make nonsensical noises such as "bba-bba-bba-bba" or they would continuously scream or laugh or sing a nursery rhyme. According to Michael, there have been multiple instances wherein children would call in with vague scenarios, saying, "I'm sick, I need your help", but would then proceed to ask the counsellor for airtime. Some children or teenagers would also call in with elaborate, imaginative stories that traumatised counsellors before they revealed the call to be a prank. Lavender mentioned an experience with a very serious prank call wherein the caller was adamant that their situation was dire and that they needed immediate physical assistance. The counsellor believed the story and went to extreme lengths to locate and ensure this person's safety, only to eventually find out that the information provided was false. For the counsellors, such traumatic calls were made worse when the caller laughed at very end of the call, as if, Lavender stated, they were "mocking" the counsellor's attempt to help. Lavender said that these calls made her feel as if she had been "taken for a ride" when she had invested in and worried about the caller only to find out that the caller had "wasted your time".

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However, if a counsellor were to grow suspicious of their caller's story, they would have to ask legitimising questions about the caller's age, if anyone else was near the caller, where they were, and how they landed in their situation. Both Amy and Lavender explained that while tedious, asking these questions were necessary to be completely certain of the caller's true intentions. It also helped to assure the counsellor that they had tried to help the caller to the best of their ability, especially when minors called in with supposed traumatic stories. If the caller's responses seemed suspicious, the counsellor could ask the caller to repeat certain answers and/or aspects of their timeline. According to Lucas, this was an easy method of differentiating between prank calls and distressed calls, as pranksters often struggled to recall false telephone numbers for instance.

Apart from the above types of prank calls, the call centre received two further types of prank calls: sexual and abusive calls, with the former occurring more often than the latter. In fact, Amy was the only interviewee to discuss non-sexual, abusive callers; she described a typical call in which the caller either swore at the counsellor or was "upset" at or agitated with the counsellor. She explained that these callers were not upset because the counsellor did not help them but were upset for the sake of "being upset" at the counsellor. Sexually abusive calls were more frequent, and my participants had more substantial descriptions of them. Most, if not all, sexual callers were male and usually targeted female counsellors. According to Lucas, sexual callers would "keep quiet and drop the phone [end the call]", if a male counsellor answered but would continue with their "sexual act" if it was a female counsellor. This "sexual act", Lucas continued, could range from doing sexual or "strange" things, such as making suggestive sounds or noises, to talking in an extremely sexual, "dirty" manner. Amy said that sexual callers tended to be frequent callers and provided a hypothetical example of one such person; a single male caller she said, could contact the call centre up to five or six times a day, either every day, every Tuesday or every Wednesday, for a month. She claimed that "prison calls" could be sexual and/or abusive; prison callers tended to be "super sexual" and/or "super rude". Amy was the only participant to bring up prison callers, even though the centre made use of several "tips" (listed on the noticeboard) such as listening for an echo on the line to determine whether someone was calling from a prison.

To head off frequent prank callers, the call centre managers would warn counsellors in advance that a call about to be patched through to them might be a prank call. They were not allowed to ignore these calls because as Lavender stated with some vehemence, counsellors "can

never assume that a call is a prank call". Some pranksters knew or suspected that the centre had a frequent caller list, and that these lists were not immediately available, which was why they would make multiple calls to the centre within a short period of time. During shifts, when this happened, counsellors would warn each other and the call centre managers as soon as they had a prank caller who had tried this evasion technique. Michael explained that the call centre's open plan structure allowed for counsellors to immediately give each other information on recent frequent pranksters. The next counsellor would then be better prepared for the prankster and could, as Amy suggested, tell them, "you've spoken to another counsellor, they've given you the assistance that you needed, do you need anything more than this?". If the caller then becomes abusive or continues to harass the counsellor, the counsellor can say "okay, I am going to go now" and put the phone down. As Amy firmly stated, the call centre managers accepted this response because counsellors were "*not here to be abused*".

While such preparations were necessary, for both the counsellors' mental health and to keep the call centre's helpline(s) open for callers with more serious situations, prank callers often did not give counsellors the chance to respond and would laugh or scream before ending the call. Because counsellors were not permitted to ignore calls, in these scenarios they would pick up the phone, put it to the side and then hang up, or block the callers' numbers, especially if it was a persistent prank caller.

Michael, Amy and Valerie explained the preponderance of prank calls by pointing out that the helplines were toll-free and that the numbers were included in school Life Orientation textbooks. Radio stations also promoted the call centre's helplines, especially during highly stressful periods such as the matric results period at the end of December and beginning of January. Thus, Amy and Valerie explained that prank callers had "easy access" to the call centre and that certain types of prank calls were "seasonal", with prank calls made by children coming in most frequently during school holidays. While my participants could explain why they received prank calls, and in such numbers, they were nonplussed when I asked why some of these prank calls were so severe and horrific in nature.

Difficult [distressing] calls

Many of my participants pointed out that most people assumed that "difficult calls" were the most common calls received by the centre. Valerie confronted this assumption when discussing her observations of new counsellors coming in for their first official shift, "they are so nervous sometimes to pick up the phone, they're thinking 'I'm gonna get a suicide call' and it's not, I always tell them 'don't expect suicide calls'". This fear, that they would receive traumatic calls relating to suicide, was one that many new counsellors shared, she explained, even though they had handled a variety of calls during their practical training. More seasoned counsellors, however, typified "difficult calls" as those that were difficult for the counsellor to handle because the caller was either uncooperative during the call, because they presented a distressing and/or life-threatening situation that needed immediate remedial, or a combination of the two scenarios. According to Valerie, the combination was the most dangerous situation to the counsellor.

Counsellors typified uncooperative calls as ones where there was a break in communication between the caller and the counsellor. This 'break' could be due to a confused caller, or because they could not hear or comprehend the counsellor, or because they were unwilling or hesitant to accept the counsellor's service. Callers could also become completely unresponsive and stop communication with the counsellor. Valerie stated that the last two scenarios were especially serious when the subject of the call involved distressing and/or life-threatening situations such as cases of robbery, assault and gender-based violence.

Listening to "difficult calls", especially when it came to sexual assault, was often hard for counsellors who became immersed in the callers' situations. By listening to horrible stories of rape or of children being molested or enduring incest, counsellors asserted that they re-experienced the assault with the caller. But they were also, as Amy said, reminded that "this is actually what the world is like" and it is a "scary reality". In this, there was a danger that the volunteer would become so invested in the caller's situation, that they unintentionally abandoned their responsibilities as a counsellor. My participants agreed that sympathising with the caller instead of counselling them, contributed to the problem; they were mental health service providers.

Lucas was the only interviewee who discussed financial calls as an example of a difficult call. For him, calls involving financial constraints and/or unemployment tended to be the hardest, because the callers were already quite despondent having experienced, and possibly still

experiencing such issues. These callers, he explained, mainly called for reassurance, for someone to say that "things are going to be okay". In some instances, reassurance was not enough, and the counsellor had to perform the difficult task of providing substantial but free coping techniques for the caller to apply whilst they continued to search for work. If the caller already attempted such techniques, the counsellor had to try and convince them to make use of more clinically-aligned coping and self-care mechanisms that were time-consuming and may or may not have required the caller to make use of professional health care services.

Counsellors practically handled these distress calls by taking several steps outlined in their protocols, to not only provide assistance during the call but also to prepare the caller for future help once the call was over and the counsellor was no longer able to provide care. In this, the call centre made use of a referral guide that included various public and private health and emergency services with which it had formal relationships. If a caller were in a distressing and/or life-threatening situation, the counsellor could contact the police and/or the hospital for immediate help. In these cases, counsellors would give callers the most appropriate options available to them and give them an idea of what they could expect from public health systems, because long waits and possible victimisation were common in government facilities and police stations. In reference to the latter, Lucas explained that, in his experience, victims of sexual assault were often further "victimised" at the hospital and/or the police station; many were either met with ridicule, blame or reluctance from police officers and/or medical personnel. Knowing this, counsellors had the very difficult task of not only providing adequate and immediate care to the caller, but also of preparing them for the possibility of experiencing discrimination when they sought further help from public services. Such preparation might sound discouraging toward the caller, explained Lucas, but was meant to protect the caller from further "traumatisation" and it was the most that counsellors could do for such callers.

Suicide calls

My participants agreed that suicide calls were generally, as Amy said, "on a different level of difficult". This was because the call centre had both specific training and a specific protocol for suicide calls. Even before they became counsellors, volunteers were taught that suicide calls, although infrequent, should be prioritised because the nature of these calls tended to suggest

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situations in which someone's life, not always the actual caller, was at immediate risk. Counsellors had to do more for these callers, in terms of caring, preparing emergency services, and supporting family members and/or friends. In these calls, Amy explained, counsellors needed to determine whether the caller had suicidal thoughts or had acted on them by taking an overdose of pills for instance. If the former, the counsellor would provide the caller with counselling and refer them to mental health professionals. In the case of an overdose, the counsellor would ask the caller for their address, whether they had family, friends or neighbours who could provide physical assistance to the caller or that the counsellor could notify about the caller's situation. In both scenarios, the counsellor would prepare callers for the arrival of help by asking them to leave a door or window open, to exit their residence, or seek help from a neighbour if they were alone. As Amy stated, the emergency services in South Africa, "will never open [the door]" themselves. Throughout the call, the counsellor had to keep the suicidal person frontmost. As Amy said, *"*it's about […] *making* them know that they're heard, like 'I'm on this phone and I'm with you and we have to find the best options for you'". In order to "never leave the person, or get off the phone with that person*", counsellors would, as Lavender explained, immediately alert or, in centre language "flag", someone else in the call centre when they receive a suicide call. The other counsellors, or call centre manager, would assist the counsellor by calling emergency services, contacting family members, partners and/or friends, and searching for referrals. This allowed the counsellor to focus on the caller.

Amy, Valerie and Lavender pointed out that suicide calls, particularly those involving actively suicidal callers were "the most frightening" for counsellors. but also became "very tricky" to approach. Amy, who taught trainee counsellors this protocol, went on to state that whilst the handling of suicide calls was constructed to be straightforward, in reality it "depends on the call" as these types of scenarios have proven to be difficult in all aspects of handling the call, especially when attempting to retrieve vital information about the caller's personal details and the scenario itself. Valerie recalled such an experience with a suicide call that embodied these difficulties. Over the course of twenty minutes, the caller spoke of feeling suicidal and depressed, which Valerie thought were signs of suicide ideation until, toward the end of the call, the caller casually mentioned that they had already taken "so many pills". She was completely taken aback, because the caller did not start by saying that they had taken pills and displayed no symptoms of an overdose such as a tell-tale slur. This put her and the caller in an extremely stressful and urgent

situation as the caller's life was in imminent danger. From her retelling, it was unclear whether or not the caller received help in time, but she did express feeling helpless. Once the call ended, she asked herself, "have I done enough?". She needed a debriefing to understand that it was not her fault, but also to ensure that her mental health was taken care of after the ordeal.

Valerie's experience was not uncommon. In fact, most of my participants concurred that many counsellors, after handling a distressing call, had to deal with feelings of inadequacy and helplessness. This was due to the fact that counsellors were restricted to providing immediate "care-at-a-distance" (see Roberts *et al.*, 2012) and heavily relied on their 'contacts' to provide the subsequent physical help. These 'contacts' included referral contacts, such as public services, family members and friends. However, from my participants' experiences, it was evident that much like the public criminal and health services, family members and friends were not always keen on assisting the caller and at times hesitated or needed to be convinced of the caller's imminent danger. Amy pointed out that, on occasion, public service officials have also complained of their excessive workload caused by the call centre's cases, and although my participants sympathised with public service workers when serious cases turned out to be pranksters and false alarms, they could not disregard any call that presented as a legitimate distressing situation.

On the other hand, in scenarios where the callers' lives were not threatened, counsellors flagged more experienced counsellors or call centre managers to help them handle the call or to or completely take it over. According to Amy and Valerie, this was quite a common occurrence at the call centre. Nora explained, however, that when counsellors asked someone to take over a call, they would be advised to go for debriefing, as "there is obviously a reason why you cannot handle that call". Michael added that some calls could trigger a counsellor to re-experience personal trauma, rendering them incapable of properly helping the caller.

Debriefing

According to both Amy and Valerie, counsellors would ideally immediately inform the call centre managers of stressful or traumatic calls, something outlined in the centre's protocols. The call centre manager would then ask the counsellor if they were okay and if they needed anything. They would also ask if the counsellor would like to take a break from their shift and maybe make a cup

of tea or sit in the boardroom instead of the call centre area or take a walk. Once the counsellor was able to calm down and had relaxed, they could return to their shift, attend a debriefing session, or if they felt unable to continue, to take a leave of absence.

If a counsellor chose a leave of absence, they needed to follow the absenteeism protocol for staff and ensure that another counsellor would cover for them.[16] Whilst the call centre had grown significantly in size, absent counsellors continued to negatively affect the work environment. As Valerie explained, an unnotified absence meant that other counsellors had to take up a heavier load during busy shifts. This affected morale because other counsellors – as well as the call centre managers – interpreted unnotified absenteeism as both irresponsible and inconsiderate.

The absenteeism protocol demanded that the staffer/counsellor contact one of the call centre managers to tell them that they will take a leave of absence or miss a shift(s). The counsellor would then have to find someone to cover the shift for them. Most people relied on other counsellors they had befriended or would ask a manager for the list of reserve shift counsellors in order to contact someone on that list. Depending on circumstances, the manager would sometimes find a replacement. If a counsellor were unexpectedly absent, especially after a stressful and/or traumatic call or shift, the call centre managers would attempt to contact them directly, or through work WhatsApp groups or via other counsellors. In such instances, the call centre manager would "try and make a plan" by either sharing the absentee's workload amongst the counsellors working during that particular shift, or asking for assistance from counsellors or staffers from the other departments in the call centre, or taking on the absentee's workload themselves.

With all of this in mind, it was evident that although the call centre managers attempted to be as compassionate as possible to the traumatised counsellor; by caring for them after their traumatic experience, suggesting and signing off on their leave of absence and ensuring that their work would be covered by someone else, the onus was still on the traumatised counsellor to initiate any help they would receive. Michael, in his defence of the centre, explained that "if somebody isn't aligned with themselves enough to know that something that happened here has impacted their lives, we not gonna know". Furthermore, much of the managers care toward the counsellors

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[16] This absenteeism protocol applied to all situations in which counsellors took a leave of absence.

was used as a means to assess if they were capable of continuing their work at the centre or needed to be replaced, for the time being.

If, after a traumatic call, the counsellor preferred to not take a leave of absence but to attend a debriefing session, they would have two options. Protocol dictated that the call centre manager could help them schedule an in-house debriefing session with one of the mental health professionals available to MhASA.[17] Second, counsellors could also consult their personal therapist or psychologist outside of the call centre for such sessions but had to inform one of the call centre managers of their appointment(s) to reassure them that they were receiving the necessary help and care. The in-house debriefing sessions were either organised by the call centre manager after a traumatising call or took the form of pre-organised group or individual sessions that occurred once a week. Debriefing sessions were not limited to the struggles that counsellors faced after a difficult call, and counsellors could ask for a session whenever they needed it, for work-related or personal issues, or even just for a general mental health check-up. None of my participants made efforts to state that counsellors were limited to a certain number of debriefing sessions, however, Valerie, in our discussion, pointed out that the centre was not able to sponsor therapy for every counsellor and for those who could afford their own psychologist/therapist would be asked to continue with them instead.

My participants made a clear distinction between debriefing sessions, and "mindfulness" which was used either independently or in conjunction with debriefing.[18] The former focused on the actual debriefing, wherein the volunteer counsellor(s) would have a session(s) with a trained professional in psychology, either a clinical or counselling psychologist. During these sessions, the volunteer counsellor(s) and psychologist would unpack their experience with the call and/or the shift, they would discuss what happened and if the counsellor(s) needed anything; this could range from taking a break from the call centre to receiving mental health care beyond therapy sessions. "Mindfulness" centred around techniques of self-care which all counsellors learnt during their training programme. According to Amy, their resources on mindfulness focused on two

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[17] MhASA has close personal and business relationships with several mental health professionals that also provide their services to the counsellors.

[18] Mindfulness can be defined as moment-to-moment, non-judgmental awareness, that is cultivated through purposefully being non-reactive, non-judgmental, and open-hearted when paying attention to the present moment (Kabat-Zinn, 2015). In practice, it involved the individual (in this case, the counsellor) being mindful of the present, themselves and their actions.

activities: meditation and colouring-in. She went on to explain that many counsellors embraced "mindfulness" as a familiar and convenient technique which they could use whenever and wherever they felt they needed to. This offered a much more flexible and independent way to deal with mental care, she said, than the scheduled sessions did.

Furthermore, my interviewees agreed that while immediate debriefing was ideal, counsellors were sometimes either unaware of how much a call had affected them or were far too distressed to verbalise how they felt. Keeping an eye out for these instances, call centre managers would sometimes ask counsellors to take a leave of absence of at least two or three weeks. Half of my participants admitted that although not part of the debriefing protocol, they – the permanent staffers and senior counsellors – had a responsibility to their counsellors' wellbeing. Michael explained that as permanent staffers, "[they] become very *very* aware of the fact that working here *doesn't* happen in a bubble, if you work here, the work *does* affect you…you don't just leave it behind [after your shift]". The call centre managers would occasionally send the counsellor a message during their leave of absence, to check in on them or to ask when they would be returning to the call centre. Amy stated that by limiting communication, the centre gave the counsellor in question the space to recuperate but also to stay connected to their support system at the call centre without feeling bombarded and/or annoyed by excessive messaging.

The implementation of a debriefing protocol, alongside protocols such as the "how to handle calls" protocols that helped the call centre managers to monitor counsellors, showed that the centre was aware of and made efforts to account for the emotional distress and trauma their counsellors were to experience because of their work. However, many of these efforts ensured that a counsellor's lack of emotional composure or absenteeism did not affect the centre's performance.

3.2 Management practices: The reality of protocol use at MhASA's call centre

After reviewing my participants discussions on their protocols and methods of implementation it became evident that the permanent staff members, particularly the call centre managers, found themselves in a social conundrum. On the one hand, they were a small group of paid permanent staffers tasked with the duty to implement management practices that would ensure that unpaid volunteers worked effectively and that the centre functioned optimally. On the other hand, they

were obliged to account for the vulnerabilities their volunteer counsellors faced on a daily basis as they attended calls from sometimes abusive, threatening, immature and sometimes suicidal callers. This was done via the implementation of protective measures, sometimes within these protocols and at others, by utilising the social dynamics of the centre. In this section of the chapter, I will investigate the ways in which the call centre's permanent staff members approached this predicament, and how they have attempted to accommodate the conflicting goals of both halves of this dilemma.

Management promotes organisational effectiveness

According to much of the existing literature on management in NPOs and telecare centres, with the implementation of managerialism comes several instruments to assure effectivity and efficiency. Kelley, Lune and Murphy (2005), Korczynski (2009), Kreutzer and Jäger (2011), and Roberts *et al*. (2012), in their respective studies list the following as said instruments; formalisation – an aspect of routinisation (see Chapter 1), (constant) supervision, and protocols to regulate operator conduct.

My participants' responses reflected the ways in which MhASA's call centre utilised these instruments. The first being the formalisation of role specification (see Chapter 2). By doing so, the centre ensured that their volunteer counsellor population worked efficiently because each counsellor would only need to perform one kind of task – depending on what type of counsellor they were – during their shift. In terms of constant supervision, during my introduction to MhASA with Lucas I noted how the call centre managers were situated in relation to their counsellors. In both rooms of the call centre (see Chapter 2), the managers sat amongst their counsellors, either within the group or at a slight distance away, and were able to constantly supervise by listening in or eavesdropping on their conversations with the callers (while they counselled), with their fellow counsellors, or even in instances where they voiced a concern or difficulty out loud. The call centre managers could then, easily and quickly swoop in and resolve the problem so that the counsellor could continue to work without issue.

Lastly, the utilisation of protocols for the regulation of counsellor conduct. Although most of my participants attempted to skirt around explicitly stating this, by explaining away their usage

of protocols as solely for the purpose of helping counsellors to handle calls correctly. During our discussions of said protocols, it became apparent that they were essentially a means to control the counsellors behaviour/actions with callers and in the centre. For one, the protocols for handling calls directly affected how counsellors responded to callers. While the centre did not make use of inflexible 'scripts' like traditional call centres, they did make use of suggested phrases/phrasing. This was heavily noticeable in the Prank calls protocol wherein counsellors were either given specific phrases or suggestions on what to say when attempting to deal a prank caller, especially when they needed to cut the call. Moreover, the abundance of pointers on how to identify and handle each type and sub-type of prank call, gave counsellors an idea of what route to take when counselling. Altogether, this ensured that they were able to counsel appropriately and accurately, but also efficiently so as to move on to the next call without wasting time. While many of my participants vehemently denied the use of quotas or time limits for their counsellors, Nora specifically stated – in our discussion on the centre's training programme (see Chapter 2) – that the centre's management paid attention to the amount of time taken to handle a specific type of call. This implied that the centre had a sort of unwritten rule on the timespan a counsellor could take when handling calls, and if they were unable to, as Nora said, "keep time" then they would not make for an effective counsellor.

Additionally, the implementation of the Debriefing protocol and Caller complaint protocol gave the centre opportunities to monitor their counsellors' ability to work, specifically their effectiveness as a counsellor. This was because the end goal of both protocols were to resolve any issues that would hinder counsellors' productivity i.e., ability to work, and as a result affect the efficacy of the centre's services. The Debriefing protocol was used to minimise or even resolve emotional distress a counsellor might have experienced, while the Caller complaint protocol corrected any inappropriate behaviours displayed by a counsellor with a caller.

Caller complaint protocol

According to Valerie, callers sometimes made complaints to call centre managers about counsellors' conduct over the phone. Complainants emailed in their complaints – along with their name and contact details – to either call centre manager whose email addresses were advertised on MhASA's website. Once they reviewed the complaint, the call centre manager would contact the

caller and investigate the substance of their complaint. If the complaint were legitimate, and not a prank or false complaint, which the centre also received, the manager would apologise and promise the caller that "we'll do better". Afterwards, the call centre manager would call in the counsellor the complaint was filed against and ask for their version of what occurred during the call. If the counsellor's story correlated with the caller's complaint, the call centre manager would discuss their mistakes and advise them on how to move forward and become a better counsellor for future callers. However, if the counsellor's story did not coincide with the caller's because, for example, there was a misunderstanding between the counsellor and caller, the call centre manager would disregard the complaint but discuss with the counsellor possible ways of avoiding such situations in future.

While the centre seemed to model the kind of disciplinary surveillance that the literature on call centres have noted (see Ball & Margulis, 2011), MhASA very rarely took disciplinary action against its volunteer counsellors. Out of all my participants, Valerie was the only one to acknowledge and discuss the centre's sole disciplinary protocol. Yet even her description of said protocol was quite general; there were no specificities on how the managerial staff would handle a counsellor's "mistakes" and no mentions of a reprimand or warning were made. This was indicative of the fact that direct disciplinary action at the call centre was practically non-existent. Amy explained that this was because volunteers and permanent staff were less prone to making mistakes because they were driven by "a passion for this work" and an understanding of "what they stood for as counsellors". Thus, while the institutional culture that I described in Chapter 2 often undermined the more negative aspects of routinisation for counsellors, it was also, quite fundamentally a 'soft' disciplinary tool for management in the sense that counsellors were largely compliant with the centre's requirements of them as diligent, conscientious 'workers'.

Regulating counsellor vulnerabilities

A large majority of the literature on management in telecare centres voice a concern about the occupational hazards of working as a volunteer telecare operator, particularly the impact of constantly providing care to others in distress (see Chapter 1). Paterson *et al*. (2009), Stamm (2012) and Kitchingman *et al*. (2018), in their respective studies, conclude that long-term exposure to the distress of others, essentially becomes the distress of the operator and in more cases that none

results in the operator developing mental health issues themselves. These symptoms were worsened when the operator experienced mental health issues or trauma prior to becoming an operator. In order to account for and minimise these effects, Roberts *et al*. (2012) and Stamm (2012), in their separate works, promoted an idea of management that was attentive and sensitive to the vulnerabilities of their operators.

From my discussions with participants, it was apparent that the centre had already implemented measures to accommodate this issue. The most obvious of the two, and discussed throughout this chapter, was the Debriefing protocol. As mentioned, this protocol was put in place to assist counsellors in resolving or minimizing any emotional distress and/or trauma they may have experienced. The second protective measure was the management's endorsement of counsellors' flexible use of the protocols for handling calls. Many of my participants explained that this was due to the fact that, in reality, no call could be as easily typified as the separate protocols implied. Calls were unpredictable due to their heavy reliance on the information callers chose to share, which meant that counsellors had to work with uncertainty and indeterminacy (Roberts, *et al*., 2012: 495). Lavender aptly summarised this sentiment by stating that when answering a call "you just don't know". Thus, by utilising protocols flexibly, counsellors were able to avoid the unnecessary stresses that came with handling unpredictable calls with fixed protocols.

Furthermore, most counsellors, including my participants, have experienced calls where they had to break one protocol in favour of another, because they misinterpreted a caller's situation as being typical of calls associated with one type of protocol before having to switch to a different protocol when they realised they were wrong. Two noted examples of such misinterpretations were Valerie's suicide call experience which she at first interpreted as a more generalised suicide ideation call, and Lavender's prank call experience wherein the caller made serious and believable allegations of abuse that turned out to be false. In both instances, the counsellors had to switch protocols quickly and seamlessly. Because of the seriousness of her caller's situation, Valerie had to abandon the general calls protocol entirely to proceed with the suicide calls protocol in an attempt to save the caller's life. After assisting in an almost completed distressed call protocol, the counsellor Lavender spoke about, had to reconstruct the call's conclusion as the caller revealed themselves to be a prankster.

Due to such experiences, counsellors actively chose to refrain from typifying their calls. During our discussions on the kinds of calls the centre received, my participants were reluctant to categorise calls because, as Amy insisted "each case, each call, each everything is so unique". This showed that although they internalised the call protocols' typifications, volunteers and permanent staff members alike recognised that these protocols were flexible templates rather than scripts.

Management's acceptance of counsellors using call protocols flexibly and their implementation of debriefing protocols could be read as attempts to regulate both counsellors and their vulnerabilities. In terms of the latter, for counsellors to utilise the resources provided by the Debriefing protocol, they needed to speak up about their emotional distress or trauma, making counsellors mostly responsible for their own wellbeing. However, one must remember that most of the permanent staff members, especially the managers, did monitor counsellors that experienced emotional distress or trauma, and continued to check up on them after their debriefing session. The centre's mindfulness training did similar work in 'outsourcing' the responsibility of care to counsellors. In terms of regulating counsellors through the centre's protocols, Valerie and Amy (the call centre managers) allowed the counsellors flexibility in their use of call protocols, but only up to a point. The managers disapproved of actions toward callers that were outside of what was taught as appropriate, even if the counsellor believed it to be helpful, for example, Michael spoke of an experience where he took to the caller's (who was a child) issue as a parent – becoming agitated and distressed when she spoke of suicide – instead of a counsellor attempting to resolve the matter. They explained that this was because counsellors could easily become personally invested in a call or a situation and thus experience vicarious traumatization. Michael went on to explain that when counsellors diverged from protocol, they became "useless" as they were no longer helping the caller, but sympathising with their situation.

With all of this in mind, it was evident that most of my participants understood the centre's protective measures to be exactly that; that by endorsing a limited flexibility and by promoting the need to speak up about your (the counsellors') difficulties, they were fulfilling their responsibility to their counsellors, and not employing another kind of instrument to ensure effectiveness. This was indicative of the strength of the centre's organisational culture and my participants identification with it. Out of all six of my participants, five were permanent staffers that were once volunteer counsellors themselves. This meant that like every other counsellor at the centre, they

were continually socialised into this idea of what a good counsellor was (see Chapter 2), had experienced these risks and utilised these protective measures successfully. Moreover, the call centre functioned on the commitment of their volunteer counsellors, and unlike a paid staff, if dissatisfied by the lack attentiveness of their managers – and other permanent staff members – to the pressures and risks of their work, could leave at any time even without notice (Kreutzer & Jäger, 2011). Thus, the centre needed to maintain, not only a positive relationship with their current volunteer counsellors, but also a good image with the public so as to ensure the attraction of prospective volunteer counsellors.

3.3 Conclusion

In this chapter, I explored the ways in which MhASA's call centre addressed the dilemma of implementing rationalised management practices, while putting in place contingency measures to account for the occupational hazards of working as a volunteer counsellor, particularly the psychological risks involved. I did this by providing descriptions of the centre's various protocols. These included the protocols used by volunteer counsellors on a day-to-day basis to handle calls, and those utilised by the permanent staff members, specifically the call centre managers, to monitor their counsellors' behaviours and wellbeing. From the responses of my participants, it was made clear to me that these protocols were essentially used to help counsellors perform their duties adequately and keep their mental health in good condition. However, upon further investigation, the premise behind these protocols pointed toward maintaining the effectiveness of the call centre via control, monitoring and assessment of the counsellors ability to work. Moreover, it became apparent that my participants, mainly the permanent staff members, endorsement of these protocols, particularly the benefits these provided to counsellors was proof of strength of the centre's organisational culture (see Chapter 2).

Chapter 4: Conclusion

In this thesis, I explored the ways in which Mental health Awareness for South Africa's [MhASA] telecare centre's management staff navigated a work environment that positioned their volunteer counsellors in situations of psychological risk. In doing so, I investigated how this centre's permanent staffers approached the dilemma of implementing rationalised management practices while employing several protective measures to ensure volunteer retention and wellbeing – a central concern in the existing literature on volunteer-based telecare centres. In this chapter, I aim to provide a summary of my study by drawing on my findings and arguments and my reading of the literature.

In Chapter 2, I looked at a common theme in existing literature on volunteer-based organisations and telecare centres; the implementation of routinization and how its processes of rationalisation affects organisation. I explored the ways in which MhASA's telecare centre had routinized both their volunteer counsellor population and group of permanent staff members as a means to ensure an effective and efficient workforce.

As per my findings, it was evident that the centre utilised multiple formalised structures and practices, that were reflective of several aspects of routinization, as a means to ensure organisational effectiveness. In reference to Kelley, Lune and Murphy's (2005) aspects of routinization, I concluded that the centre's volunteer counsellor training programme, handover training for a prospective permanent staff member, use of surveillance and role-specification, were reflective of organisational formalisation and division of labour, while their use of shifts – four structured shifts for the counsellors and one, twelve hour day shift for the permanent staffers – and job titles, such as reserve counsellor and call centre manager, were reflective of professionalisation. Moreover, the implementation of routinization, as with many other call centres (Waikayi, Fearon, Morris & McLaughlin, 2012; Cho, Bonn & Hann, 2018; see Chapter 1), assured an efficient workforce at MhASA's telecare centre.

My findings also pointed to the fact that the centre's screening process – which included the volunteer counsellor training programme that was central to its routinisation goals – produced an organisational culture that socialised counsellors into a professional identity (Haski-Leventhal, 2009; Evetts, 2013). Reflecting on the subsection *Becoming a volunteer counsellor*, prospective

volunteer counsellors, over the course of their interview process and practical training (the twelve listening shifts), were exposed to the various requirements necessary to become a counsellor at the centre, and were able to decide for themselves if they were good fit. Socialisation also provided opportunities for prospective counsellors to form interpersonal relationships with their fellow trainees, the counsellors at the centre and the permanent staff members in charge of their training– the call centre managers and volunteer co-ordinator. Counsellors were further socialised, via the centre's social dynamics, to inhabit a specific type of professional identity as counsellors at MhASA's telecare centre. While this identity – and the social networks that it embedded a new counsellor in – helped to maintain an effective counsellor population, it also dulled some of the effects of routinisation on counsellors.

In Chapter 3, I explored how MhASA's centre tackled a central concern in the existing literature on volunteer-based telecare centres; the conflicting goals of rationalised management practices, and contingencies put in place to alleviate the risks – especially the adverse psychological effects – of working as a volunteer counsellor. I investigated the ways in which this centre's permanent staff members, particularly the call centre managers, approached this predicament.

Towards this end, the centre utilised and relied on various call protocols and protocols for assisting distressed or traumatised counsellors. At a surface level, these protocols, particularly the protocols for handling calls were very similar to the "scripts" (Korczynski, 2009) that played an integral part in the ways in which the call centre managers generally controlled and monitored their volunteer counsellors, while the protocols for assisting counsellors in psychological distress, seemed to outsource mental health care to the individual counsellors.

However, much of my research made it evident that this control and surveillance/monitoring of counsellors were checked by the centre's need to be awake to the fact that every call was different, and mostly importantly, unpredictable (Roberts *et al*., 2012) – and that counsellors needed the freedom to apply the call protocols with flexibility. And while the centre's debriefing protocol placed the onus on counsellors to report their psychological distress or trauma, and its Mindfulness workshops/activities equipped counsellors to handle their stress on their own, the premise – the neoliberal logic (Kreutzer & Jäger, 2011; Woodcock, 2016; see Batt, Holman & Holtgrewe, 2009 and Ball & Margulis, 2011) – of these protocols were again foiled by

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the connections between permanent staffers and volunteer counsellors. Most of the centre's permanent staffers, for example, the managers, were former counsellors and had intimate insight into the pressures and risks their counsellors faced – many staffers also had social ties to the counsellors. They also informally monitored counsellors who left work unexpectedly, or took time off to deal with the effects of a traumatic call or needed a break overall, to make sure that these counsellors were coping and to offer free counselling from MhASA. In the context of this centre, where counsellors offered their labour and services on a voluntary basis, the looming power of management that marked work in traditional call centres with paid operators, were also stayed i.e., the usual heavy handedness of management was minimised to not only maintain their volunteer counsellor population, but also attract future volunteers.

In conclusion, MhASA's telecare centre's approach to management implementation was much more sophisticated and attentive than the literature on traditional call centres and telecare centres implied (see Chapter 1). While routinization – and its aspects of rationalisation, formalisation, surveillance/monitoring and control – was quite apparent, it was not predominant, rather management was navigated via the routes of organisational culture and social connections. As noted, the strong personal and professional attachments shared between the counsellors, permanent staffers and the centre, had resulted in a blanketing effect on management's control and surveillance of their counsellors i.e., the permanent staffers did not see these acts of management as that, but instead acts of commitment and loyalty to the centre and responsibility to their counsellors. Moreover, because these counsellors worked on a voluntary basis, permanent staff members could not implement the same level of discipline and control that a paid staff situation could afford. Once again, the impulse to enact management to its full extent was stayed, as the centre's heavy reliance on volunteers would result in its downfall, if they were to ever turn their backs on it, and in extension the organisation. Thus, the centre – and permanent staffers – promoted itself as an organisation of choice, via attentive and sensitive implementation of management practices with its counsellors and thus publicising itself as a good workplace for prospective volunteers.

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Appendices

Appendix A: Letter of Consent

Research information and Informed Consent Form

My name is Kerina Veeriah, a Masters student in the Department of Sociology and Social Anthropology at the University of Stellenbosch, South Africa. As part of my postgraduate programme, I am conducting research at MhASA entitled, *How Human Resource departments manage suicide prevention call centre operators, the case of a prominent anxiety and suicide prevention organisation,* and would really appreciate it if you would be willing to participate. I am particularly interested in what it means to be a call centre manager at MhASA.

If you agree to participate, you will be asked to answer various questions relating to your occupation. The interview should take no more than an hour and will be arranged at a time and place convenient to you. Participation in this research is voluntary and participants are free to withdraw at any time or to skip questions they are uncomfortable answering. No payment will be made for your participation.

Your identity will be kept anonymous and will not be revealed through the study. Pseudonyms will be used when reporting on findings to ensure that responses cannot be traced to individual respondents. With your permission, the interview will be audio-taped for ease of accurate recording of data; however, you are free to participate in the interview without being recorded and/or to request that the recording device is switched off at any point. Data that is collected from participants will only be used for the purposes of this study. The data will be kept in a secure manner. It will not be made available to third parties other than to my supervisor for the purposes of my study. Once the study is complete, an electronic copy will be available through the library of the University of Stellenbosch.

If you feel that you need to talk to someone, after the interview, you can either call the helpline at 0800 567 567 or speak to Dr Colinda Linde at the organisation.

If you have any questions or concerns about the research, please feel free to discuss them with me. My contact details are;

Kerina Veeriah

Email: 19338511@sun.ac.za

Cell phone n**umber**: 082 319 1842

You may also contact my supervisor, Dr Ilana van Wyk, in the Department of Sociology and Social Anthropology, University of Stellenbosch, South Africa, at ilanavw@sun.ac.za.

RIGHTS OF RESEARCH PARTICIPANTS: You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

You have right to receive a copy of the Information and Consent form.

If you are willing to participate in this study, please sign the attached Declaration of Consent and hand it to the Interviewer.

Thank you for your time and attention.

DECLARATION BY PARTICIPANT

By signing below, I ……………………………………………. agree to take part in a research study entitled……………………………………………………. and conducted by ………………………………. (Name of Researcher)

I declare that:

- I have read the attached information leaflet and it is written in a language with which I am fluent and comfortable.

- I have had a chance to ask questions and all my questions have been adequately answered.

- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

- All issues related to privacy and the confidentiality and use of the information I provide have been explained to my satisfaction.

Signed on ……………………..

………………………………………………………………

Signature of participant

SIGNATURE OF FACILITATOR

I declare that I explained the information given in this document to _____ [*name of the participant*] [*He*/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [*Afrikaans/*English/*Xhosa/*Other*] and [*no translator was used/this conversation was translated into* _____ by _____].

_____   _____

Signature of Interviewer   **Date**

Appendix B: Aide Memoire

1. How long have you been a [participant's role/position]?

2. Did you start off as a [participant's role/position]?

3. What previous roles did you fulfil in the organization?

3a. Were you ever a call centre operator?

4. What are the qualifications necessary to be a [participant's role/position]?

5. What sort of training did you receive as a [participant's role/position]?

6. How does this organisation employ call operators? Do you advertise openings? Do people volunteer?

7. What are the qualities (or qualifications) that you look for in a call centre operator?

8. Generally, what would you say are the characteristics of an operator?

9. What does a typical shift look like for your call centre operators?

10. How many calls would each operator generally take per shift?

11. Do you receive any nuisance calls? How are they handled?

12. What is considered problematic/ difficult calls?

13. How do you deal with traumatic calls?

14. Are there any debriefing sessions for operators?

15. What are some of the general employee complaints about being an operator?

16. Literature suggests that suicide prevention call centres produce high stress environments, do you believe this to be the case here? How so?

17. How high is your employee turnover in the call centre? Could you explain it?

Appendix C: Schedule for interviews

The schedule for Monday	
10: 30 – 11: 00	Introduction to the organisation
11: 00 – 11: 30	Interview with Michael
12: 00 – 13: 00	Admin/write up
13: 00 – 13: 30	Interview with Valerie
13: 30 – 14: 30	Admin/write up
14: 30 – 15: 00	Lunch
15: 00 – 16: 00	Interview with Amy
16: 00 – 16: 30	Admin/write up
The schedule for Tuesday	
11: 00 – 12: 00	Interview with Lavender
12: 30 – 13: 00	Admin/write up
13: 00 – 14: 00	Interview with Nora
14: 00 – 15: 30	Admin/write up
15: 30 – 16: 30	Interview with Lucas
16: 30 – 17: 00	Admin/write up