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Mental Health Professionals in Children's Advocacy Centers: Is There Role Conflict?

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Two recent chapters in professional books have criticized children's advocacy centers for creating role conflict for mental health professionals because of their work with criminal justice and child protection professionals in children's advocacy centers as part of a coordinated response to child abuse. This article argues that these critiques misunderstand children's advocacy center practice and overestimate the risk of role conflict. Children's advocacy center standards set a boundary between forensic interviewing and therapy, which in most children's advocacy centers are done by separate professionals and never by the same professional for a given child. Many mental health professionals serve children's advocacy centers as consultants with no treatment role. Children's advocacy center therapists are rarely involved in investigation, and their participation in multidisciplinary teams focuses on children's interests and well-being.

KEYWORDS *child sexual abuse, child abuse, children's advocacy centers, children's mental health professionals*

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Children's advocacy centers (CACs) are specialized programs designed to provide the most effective professional response to reports of child sexual abuse or other serious child abuse. More than 700 CACs have been established across the United States, with at least one in each state (according to the National Children's Alliance website [<http://www.nationalchildrensalliance.org/index.php>]), and 45 out of the 50 largest American cities have CACs as of this writing (Cross, 2010). CACs provide comprehensive investigation and intervention services for thousands of children every year. Coordinating criminal justice, mental health, child welfare, medical, victim advocacy, and other professionals is perhaps the most important function of CACs. It demands careful attention to establishing both appropriate linkages and appropriate boundaries among different disciplines. Recent publications have criticized CACs for creating "role conflict" for mental health professionals because of their work with criminal justice and child protection professionals in CACs (Connell, 2008; Melton & Kimbrough-Melton, 2006). Mental health professionals include professionals with a range of different training, including licensed clinical social workers, psychologists, psychiatrists, psychiatric nurses, and licensed mental health counselors. This article examines CAC practice and assesses the risk of role conflict for mental health professionals. It argues that Connell's and Melton and Kimbrough-Melton's critiques misunderstand current CAC practice and overestimate the risk of role conflict for mental health professionals in CACs.

Several sources of information were used for this article. In part, it is based on the authors' professional experiences with CACs. Cross, Jones, and Walsh have conducted a multisite evaluation of CACs (see e.g., Cross et al., 2008). Fine has been a director of two CACs, has previously served on the Standards Committee of the National Children's Alliance (NCA), the membership organization of CACs, and currently serves on the NCA Board of Directors. Fine and Cross also serve on the board of directors of a state chapter of the NCA. In addition, the current NCA standards governing CAC practice were reviewed (see National Children's Alliance, 2008) as was a CAC directors' manual on mental health services (Child Welfare Committee, National Child Traumatic Stress Network, & National Children's Alliance 2008) that was developed by a joint committee of the NCA and the National Child Traumatic Stress Network, an organization devoted to improving care for traumatized children. Finally, we interviewed the executive director of the NCA and three current or former CAC directors involved in writing the current NCA standards. These key informants were provided copies of the Melton and Kimbrough-Melton and Connell articles to review and were queried about the potential for role conflict of mental health professionals in current CAC practice.

CONCERNS ABOUT ROLE CONFLICT

The Melton and Kimbrough-Melton (2006) and Connell (2008) publications expressing concerns about role conflict for mental health professionals in CACs are both chapters in professional books in fields relevant to child sexual abuse. These authors argue that mental health professionals involved in CACs serve in multiple roles, both providing children with mental health treatment and also serving as (a) forensic evaluators of reports of abuse and (b) collaborators with criminal justice and child protection professionals on gathering evidence for court actions. These latter roles conflict with their role as treatment providers. The court actions referred to include criminal prosecution of child abuse and civil court actions regarding child placement, custody, visitation, and other decisions about the child. Melton and Kimbrough-Melton and Connell argue that these role conflicts interfere with mental health professionals' responsibility to provide effective and ethical mental health services.

Melton and Kimbrough-Melton explain their concern about role conflict as follows:

Because of their presumed skill in interviewing children, the mental health professionals may conduct many or all of the investigatory interviews on which CPS [child protective services], police and prosecutors rely. Even when mental health professionals in such settings do not themselves conduct the investigatory interviews, they are likely to participate as team members in prosecutorial decision-making, and information that they gather in therapeutic interviews may be used in the team process. Thus, clinicians directly or indirectly participate in the gathering of evidence to determine, among other possible decisions, whether child maltreatment has occurred, a dependency petition will be filed in family court, criminal or juvenile charges will be brought against a suspect, the child will be placed into an emergency shelter or foster care, restrictions will be placed on the child's contact with parents, or both. Besides often acting directly as therapists and advocates to help alleviate a crisis, mental health professionals become actively engaged as prosecutorial investigators and decision makers. (p. 36)

Melton and Kimbrough-Melton express concern about two different possible consequences of the role conflict they describe:

First, if a mental health professional becomes concerned with gathering evidence and helping the prosecution to make its case (whether for conviction and incarceration of an incestuous father or civil adjudication of abuse, placement of the child in foster care, and ultimately termination of parental rights), will the clinician's ability to function as a therapist for the child or the family be compromised? Indeed, will the slippage into law enforcement activities compromise that clinician's ability—or even

other clinicians' ability—to help other children and families? Second, will adoption of an explicit stance of children's advocate compromise mental health professionals' ability to act as unbiased experts? (p. 37)

Melton and Kimbrough-Melton's concerns are not just about the involvement of the mental health professional in the CAC's multidisciplinary team but also about their employment in an organization affiliated with the prosecutor:

Although these multiple roles (or a subset of them) can arise no matter what the auspice for the clinician's work, employment in a prosecution-affiliated facility makes the potential role conflicts explicit. Even if investigatory staff are physically separated from therapeutic staff as mentioned by Congressman Cramer, the problems persist of (a) possible spillover effects from proximity and contact with investigative staff on perceptions of clinicians among clients and the general public and (b) at least the appearance of bias in clinicians' judgments. The former possible effects can impede the clinicians' ability to act as effective therapists; the latter can affect adversely their objectivity as experts and clinical evaluators. (p. 37)

The other chapter that expresses concern about role conflict of mental health professionals in CACs is Connell's (2008) chapter on children's advocacy centers in a guidebook on evaluation of sexual allegations. Connell (p. 436) quotes Faller and Palusci (2007, p. 1027), who say that "more success in prosecution" is "a primary goal of the CAC movement." Connell then warns about conflict between mental health professionals' need to be neutral and objective regarding the question of alleged abuse and CACs' interest in prosecution:

Truth-seeking, prosecuting, protecting and treating, then, are in some ways incompatible undertakings. In an environment charged with protecting children by increasing prosecutions, there may be an inherent bias toward perceiving children as victims or as suspected victims of sexual abuse. If this bias exists, a child who has not been abused may be caught in a situation where denial of abuse is less likely to be believed. (p. 439)

Connell also cites Melton and Kimbrough-Melton (2006) to argue for the risk of role conflict and gives the issue of role conflict a prominent place in her conclusion section. Connell writes:

The overarching concern with the CAC model is the fundamental problems of diverse goals of the disciplines represented in the CAC effort. As Melton and Kimbrough-Melton (2006) noted, there may be inherent

problems in combining advocacy efforts with truth-seeking, particularly when successful advocacy is measured by increased prosecutions. (p. 443)

In a boxed set of bullet points titled “Guidelines” at the end of the chapter, Connell is less tentative: “There are inherent role conflicts of the multidisciplinary team approach” (p. 445).

In her chapter, Connell also expresses concern about extended forensic evaluation, a model employed in less than 10% of CACs in which children who do not disclose abuse to investigators but exhibit behaviors that are strongly suggestive of victimization and/or trauma are referred for specialized multisession evaluations. In addition, she raises questions about maintenance of official records of forensic interviews in CACs. Connell’s other concerns are beyond the scope of this article.

HOW CACs WORK

To consider the risk of role conflict in CACs, it is important to understand concretely how CACs work and how different professionals actually participate in them. CACs are usually independent, nonprofit organizations, but sometimes are a program of a prosecutor’s office, hospital, or other nonprofit agency. They are required to be housed in a dedicated, child-friendly setting and designed to be physically and psychologically safe for clients.

To be an accredited CAC, a center must follow a set of practice standards developed by the National Children’s Alliance. Accreditation is not only prized as an indication of professional competence and quality but is also tied to the distribution of federal dollars to CACs through state NCA chapters. The first set of accreditation standards took effect in 2000 and an updated set were developed in 2008 and took effect January 2010. The standards address the following 10 areas: multidisciplinary team, cultural competency and diversity, forensic interviews, victim support and advocacy, medical evaluation, mental health, case review, case tracking, organizational capacity, and child-focused setting.

The following seven types of professionals at a minimum participate in a CAC: law enforcement, child protection, prosecution, medical health, mental health, victim advocacy, and CAC (i.e., a dedicated staff member of the CAC). Other professionals beyond this core group may also be involved. Professionals who collaborate with the CAC are usually employed by and accountable to their primary agencies, although some participate as private practitioners. Each professional does his or her specific job but also shares information and coordinates activities as appropriate with other professionals in the CAC.

Multidisciplinary Teams

The central mechanism for coordinating professionals is the multidisciplinary team (MDT), which the NCA standards describe as the “foundation” of a CAC. Through MDTs, the CAC coordinates the efforts of multiple professionals from the first report of the case to the center to case closing. This coordination is designed to reduce stress to the child and family by eliminating redundant interventions (e.g., multiple investigative interviews by multiple professionals) and providing greater coherence and a focal point of contact for the family while allowing each agency and professional to pursue its own mission. The MDT aims to foster improved communication among agencies and facilitates the sharing of important information. In addition, the MDT is thought to enhance the quality of decision making because multiple professionals with different expertise and knowledge learn from one another and help clients receive critical information and services. Individual MDT members and their parent agencies are ultimately responsible for their own decisions; the MDT simply provides a method for making informed decisions.

There is considerable ambiguity about the term *multidisciplinary team*. The term does not refer to a fixed group of people or committee but instead to a general, multidisciplinary approach to addressing a variety of needs that arise within and across cases over time. The specific professionals involved in a MDT will vary from case to case depending on what agencies are involved and who is assigned the case; moreover, which professionals make up the MDT for a given case can change over time depending on the needs of a case. The number of individuals who participate in MDTs across cases can be substantial, if, for example, the CAC serves an area with 10 different police agencies, three different CPS offices, and four hospitals or clinics that serve child victims. Smaller jurisdictions may have more consistent teams.

The Investigation Team

One important MDT in a CAC is the multidisciplinary investigation team, which will typically convene on the child and family’s entry to the CAC. At a minimum, the investigation team includes a specialized child forensic interviewer, a police investigator, and an investigating caseworker (if CPS is involved). Sometimes the investigating officer or caseworker has the specialized training to conduct the child forensic interview and those two functions will be performed by one person. Often prosecutors, victim witness advocates, and medical professionals will participate as well. Mental health professionals may be involved at this point, as we’ll discuss in more detail.

For verbal children, a key part of the investigation team’s work is the child forensic interview, which is designed to elicit as much information regarding the allegations as possible in a nonleading manner to assist

in providing additional direction for the criminal and child protective investigations. While the child forensic interviewer talks to the child, the multidisciplinary investigation team typically observes the interview through a one-way mirror or closed circuit television. A forensic interview typically serves the investigative needs of both law enforcement and child protective agencies and also informs the clinical assessment of the child. Following the interview, the team is responsible for coordinating a comprehensive response plan with the actual interventions being carried out by individual professionals.

The Forensic Interviewer

In many CACs, the forensic interviewer is a dedicated specialist employed by the CAC. In other CACs, forensic interviews are conducted by trained professionals of agencies with a statutory responsibility for investigation: CPS investigative caseworkers or law enforcement officers. CAC forensic interviewers must receive specialized training in reliable forensic interview techniques, child development, question typologies, and the cognitive and emotional impact of trauma (refer to Olafson, this issue, for a discussion of current practice in child forensic interviewing). The NCA standards (2008) clearly distinguish between the role of the forensic interviewer and the role of the therapist (see also, Child Welfare Committee et al., 2008). NCA standards state that "Every effort should be made to maintain clear boundaries between these roles and processes" (p. 26) and require each CAC to document in writing how the forensic process is separate from mental health treatment. Standard practice in CACs is for these two functions in a case to be carried out by different professionals. Indeed, in our experience and that of our informants, in the overwhelming majority of CACs forensic interviewers never provide treatment to CAC clients, and therapists working with CAC clients never conduct forensic interviews. In a very small number of CACs, mental health professionals conduct forensic interviews on some cases and provide treatment on others, but even then, the same professional does not perform both functions with the same child due to some of the concerns stated in the Connell and Melton and Melton-Kimbrough chapters.

While some forensic interviewers have a mental health professional background, most do not. Data from 468 professionals who were trained in forensic interviewing between February 2008 and July 2010 at the National Children's Advocacy Center in Huntsville, Alabama, one of the largest training centers in the country, show that only 9.6% identified themselves as mental health or treatment professionals (Leith, 2010). Others may have had a mental health educational background (e.g., a BSW or MSW) but identified their discipline as forensic interviewer or child protective services worker. When such professionals do have a mental health professional background, they typically fit the description of the forensic specialist that Melton

and colleagues describe as pivotal in a system that maintains appropriate boundaries, that is, “mental health professionals whose work *primarily* or *solely* consists of conducting evaluations for the legal system” (Melton and Kimbrough-Melton, 2006, p. 30; see also Melton, Petrila, Poythress & Slobogin, 1997).

Case Review

CACs also conduct regular multidisciplinary team case review meetings to share information and discuss what needs to be done on a case. According to the NCA Standards (NCA, 2008), the case review process performs the following functions, depending on the needs of the case:

1. Review interview outcomes.
2. Discuss, plan, and monitor the progress of the investigation.
3. Review medical evaluations.
4. Discuss child protection and other safety issues.
5. Provide input for prosecution and sentencing decisions.
6. Discuss emotional support and treatment needs of the child and nonoffending family members and strategies for meeting those needs.
7. Assess the family’s reactions and response to the child’s disclosure.
8. Review criminal and civil dependency case disposition.
9. Make provisions for court education and court support.
10. Discuss cross-cultural issues relevant to the case. (p. 29)

The CAC can continue to be involved with a family regarding investigation, often intermittently, over an extended period of time, if, for example, criminal and child protection proceedings take time. CACs will often provide support to families if and when the case goes to court and the child needs to participate.

Mental Health Professionals’ Involvement in CACs

Different communities make different choices about how and when mental health professionals are involved in the CAC. An important distinction is that sometimes a mental health professional is involved in a multidisciplinary team because he or she is the therapist of a child served by a CAC, and sometimes a mental health professional serves purely as a consultant, with no therapeutic relationships with CAC clients.

Therapists are not involved in the initial investigation team. A few CACs involve mental health consultants in the investigation team, but most CACs do not have this resource. A mental health consultant’s expertise in such areas as child development and trauma response may help a forensic interviewer frame questions to the child in the interview or help the team

understand the child's responses; they can also help assess the mental health needs of family members and assist with referrals.

Mental health professionals are more frequently involved in CAC multidisciplinary teams during case review. Because case review meetings usually consider multiple cases, the mental health professional is typically a consultant. However, given signed consent from the child's legal guardian, a therapist may attend for that portion of the meeting in which the team discusses the child the therapist is treating. Some CACs have linkage agreements with clinics or private practitioners who are external to the CAC but who participate in multidisciplinary teams. Other CACs employ therapists who provide mental health treatment to children at the center.

Involvement of the mental health consultant and/or the child's therapist in multidisciplinary team can legitimately advance children's best interests (Child Welfare Committee et al., 2008). Mental health professionals are often the best qualified to advise other team members about the emotional impact of their actions on children and families. Mental health consultants can also help team members take into account children's level of development when interpreting children's behavior and when communicating with them. Therapists' involvement is likely to be limited to confirming that the child is involved in therapy, communicating the child and family's concerns related to the response of other agencies, and, like the consultants, suggesting steps to prevent further harm to the child. Therapists can also learn about next steps that prosecutors, child protection agencies, and others are planning to take and thereby can better help families cope with these actions.

Mental health professionals may be called on to testify in criminal or civil court, but this would not be a function of their involvement in the MDT or CAC, although that may make prosecutors more knowledgeable about them. They may testify as expert witnesses about such matters as the behavioral effects of abuse. The law is likely to prevent them from talking about what the child says in treatment or assessment (hearsay evidence), and it certainly will not allow them to speak to the ultimate issue of whether or not abuse occurred, which is a matter for the judge or jury to decide. There is more flexibility about what mental health professionals can say in child protection cases, although even here they are enjoined from speaking about the ultimate issue. Mental health professionals perform this function in court because of their expertise, with or without MDTs and CACs.

ANALYSIS OF CONCERNS ABOUT ROLE CONFLICT

The review of CAC practice above provides a basis for analyzing the concerns about role conflict expressed by Melton and Kimbrough-Melton (2006) and Connell (2008). Below we examine these authors' arguments in light of current knowledge of CAC practice.

Mental Health Professionals as Forensic Interviewers

Melton and Kimbrough-Melton (2006) state that “mental health professionals may conduct many or all of the investigatory interviews on which CPS, police and prosecutors rely” (p. 36). However, the available data show that this is rarely true. Leith’s (2010) training data suggest that only a small percentage of professionals engaged in forensic interviewer training are mental health professionals. And even when mental health professionals *do* conduct forensic interviews, role conflict is not a concern because they are not functioning as treatment providers. In line with the NCA Standards requiring a clear boundary between conducting forensic interviews and providing treatment, CACs have separated these two functions. In the vast majority of CACs, these functions are provided by dedicated specialists who do not perform the other function.

In a small number of CACs, there are mental health professionals who do forensic interviews with some children and provide therapy to others. About this circumstance, Melton and Kimbrough-Melton express concern about a “slippage into law enforcement activities” (p. 37) that will compromise the therapist’s capacity to help *other* children and families. This sounds plausible, but it is also plausible that reasonably well-trained professionals can maintain appropriate boundaries as they work with different cases. Ultimately this is an empirical question. Its relevance for making judgments about CACs is limited, however, given the infrequency with which any mental health professionals conduct forensic interviews and also provide treatment to children in a CAC.

Mental Health Professionals as Prosecutorial Investigators

Melton and Kimbrough-Melton express concern that, through their participation in CACs, mental health professionals will be influenced to assist investigation, prosecution, and other court-related actions in a way that will conflict with their primary mission. There are several grounds on which to question Melton and Kimbrough-Melton’s argument. First, their text seems to convey the assumption that mental health professionals involved in a CAC/MDT response to a child would necessarily have a treatment relationship with that child. They use the terms *mental health professional*, *clinician*, and *therapist* interchangeably and ask “will the clinician’s ability to function as a therapist for the child or the family be compromised?” (p. 37). As discussed above, however, mental health professionals often participate in MDTs as consultants without serving as clinicians. These professionals are unlikely even to have direct contact with children and families. Because the child’s best interest is the primary principle guiding the MDT, the mental health consultant will make recommendations to promote the child’s well-being but can also help investigators without any possibility of role conflict because they do not have a treatment relationship with the child and family.

Second, even when the child's therapist participates in the MDT, the involvement is limited and the chances of a role conflict are therefore less than Melton and Kimbrough-Melton suggest. Children's therapists rarely, if ever, participate in the investigation team, which typically includes only professionals with dedicated investigation responsibilities. When therapists participate in case reviews, it often is for a limited period of time, and their focus is on the child's well-being and not on the investigation. Most prosecutors keep some distance between prosecution and children's therapy, both to protect children's privacy and to avoid defense attorneys obtaining information from the therapy through discovery and using it to raise questions about children's credibility.

Third, in some circumstances, therapists' assistance to criminal justice and child protection professionals is *not* role conflict but instead good practice in children's interest. Their perception that justice has been done is important to child victims (see Melton, 1992; Melton & Limber, 1989), and child victims and nonoffending caregivers often have an interest in prosecuting offenders, which can help children feel safer and support their credibility. Good therapists are not removed from the legal process but instead explore with children and families the purposes and potential outcomes of legal intervention and help them weigh the pros and cons of participating in the criminal justice system. As Melton and Limber (1989) recommend, "the general strategy should be to make children partners in the pursuit of justice" (p. 1227). Therapists can also assist children and families in better understanding various goals of participating in the system in addition to, or instead of, a criminal conviction. This may or may not comport with the prosecution's goals. Child victims and families may similarly favor certain child protective interventions, and therapists can also play a role in assisting families in decision-making related to these.

If therapists have assessed children's and caregivers' wishes and their interests accurately and secured children's assent and nonoffending caregivers' informed consent, there are circumstances in which it is appropriate for therapists to join with the family to assist prosecution and child protection professionals. It would be misleading and an overstatement to describe this as being "actively engaged as prosecutorial investigators" (Melton & Kimbrough-Melton, 2006, p. 36) since it mostly involves either appropriately sharing information or supporting children and families in the legal process. With the child and family's consent and support, therapists may be able to share information from the treatment that would assist investigation or prosecution, such as observations of child behavior that might reflect the impact of abuse. Therapists may also be able to assist both children and prosecutors appropriately if cases go to trial. For example, therapists may advise prosecutors about when children may be emotionally ready to testify and may suggest strategies to help prepare a child for the courtroom experience. They may serve as an extra support person in

court for the child and, at sentencing, may work with victim witness advocates and the child to prepare a developmentally appropriate victim impact statement.

Truth-Seeking and Prosecution

Connell suggests that “truth-seeking” and “prosecuting” are “in some ways incompatible undertakings.” By this she implies that truth-seeking is secondary for prosecutors filing criminal charges. The suggested dichotomy is false. Indeed, Connell impugns prosecutors by suggesting that prosecuting and truth-seeking are incompatible. The CAC investigation method assumes that the accuracy of the allegation is unknown at the outset. This is a principle that is critical to criminal prosecution given the high standard of proof and the ensuing potential consequences (loss of liberty) for those accused. Truth-seeking serves the goal of successful prosecution and is not undermined by it.

Connell’s concern may to some degree reflect misunderstanding of current prosecution practice in CACs. CACs are not as prosecution-oriented as the two chapters might suggest. Melton and Kimbrough-Melton focus on the National Children’s Advocacy Center, the first CAC and one that was formed under the leadership of the district attorney. However, most CACs are independent, nonprofit organizations, and many are hospital-based or part of larger nonprofits. Only a minority of CACs are based in prosecutor offices.

While former District Attorney Robert “Bud” Cramer is considered the “father” of the CAC model, criminal prosecution was never considered the overriding goal of the multidisciplinary team model. Connell cites Faller and Palusci (2007) on successful prosecution as “a primary goal of the CAC movement” (Connell, 2009, p. 436), but it is not *the* primary goal, nor is it likely that Faller and Palusci meant to suggest that prosecution was such an important goal that it supersedes the need to seek the truth. While offender accountability has been an increasing focus in child abuse cases over the past three decades, both in and out of CACs, it is not the driving force behind most CAC interventions regardless of CAC sponsorship or venue. Research suggests that CACs vary considerably in the importance they place on prosecution and the range of cases they think should be prosecuted (Walsh, Jones, & Cross, 2003). In any CAC, prosecution is a fairly uncommon intervention. Connell (2008) cites NCA data that 10% of cases are accepted for prosecution, which is consistent with a meta-analysis that shows that only a minority of cases referred to district attorneys’ offices are prosecuted (Cross, Walsh, Simone, & Jones, 2003). In fact, in the majority of cases in which prosecution does not ensue, the prosecutor assumes an inactive role on the team while those responsible for protective and treatment services coordinate for the duration of that individual case. References to a prosecution versus a therapeutic model are contrary to the core concepts of a CAC—it

is not *either/or* but *both/and*. Apart from prosecution, most CACs measure themselves as much if not more by the delivery and effectiveness of child protection, victim advocacy, and treatment services, along with the degree to which victims and their nonoffending family members are afforded their rights and participate meaningfully in the process.

Inherent Role Conflict

Connell's statement that "there are inherent role conflicts of the multidisciplinary team approach" (p. 445) needs close analysis. If a role conflict is "inherent" to the multidisciplinary team approach, then this might cast doubt on the use of multidisciplinary teams altogether, and any professional who participates in an MDT would wittingly or unwittingly compromise his or her professional integrity. Connell and Melton and Kimbrough-Melton do not really discuss the process through which involvement in the multidisciplinary team meeting is supposed to lead to role conflict. Presumably therapists' interactions with criminal justice and child protection professionals influences them to a degree that overwhelms their attention to their ethical responsibilities. Even if such influence-through-interaction occurs, is it actually more likely to happen in a multidisciplinary team? There is a sparse research literature on professionals in multidisciplinary child abuse teams, and it is not very helpful on this question. Studies like those of Kolbo and Strong (1997) and Jensen, Jacobson, Unrau, and Robinson (1996) found that professionals reported satisfaction with their experiences in multidisciplinary teams but lack data on professional behavior. Bell (2001) found that prosecution staff participated significantly more than other professionals in MDTs in 15 multidisciplinary child protection teams in New Jersey and that mental health staff were among the professionals who participated least, but there were no data on effect on mental health staff's behavior or decision making.

Therapists could circumvent the possibility of influence by other professionals by avoiding all contact with criminal justice and child protection professionals, but such contact may be necessary for the child's treatment (e.g., when the therapist needs to know what the child will be asked to do in court), and such avoidance would do a disservice to the child. Clearly therapists are sometimes obliged to talk to police and CPS. When they do, role conflict is also possible when therapists are solo professionals or working in agencies with little connection with prosecution and child protection agencies. Indeed, therapists working in well-functioning multidisciplinary teams may be in a better position to avoid role conflict. The group process in the MDT can develop an overarching attention to the best interests of the child that supersedes any one agency's agenda. The MDT has developed protocols with input from all disciplines that reflect the responsibilities and ethical principles of all team members and govern communication and

decision making. Full involvement of all the disciplines may allow for each professional on the MDT to focus more comfortably on his/her own specific function. Individual members of the team could be supported by the group against any effort by one team member to dominate. Agencies involved in MDTs may have greater experience dealing with other disciplines. Clearly there is nothing intrinsic in how a multidisciplinary team works nor any data that suggest that role conflict would be *inherent* in a multidisciplinary team.

Employment in a Prosecution-Affiliated Facility

Melton and Kimbrough-Melton express concern about “spillover effects from proximity and contact with investigative staff on perceptions of clinicians among clients and the general public” (p. 37) when therapists work in a CAC that is a “prosecution-affiliated facility” (p. 37). They cite the example of the National Children’s Advocacy Center (NCAC) in Huntsville, Alabama, that has a separate small set of therapy offices as part of the CAC. There are several factors, however, that should reduce concern about spillover effects. First, the actual proximity of and contact between therapists and investigative staff in CACs is generally more circumscribed than the NCAC example might suggest. In the vast majority of CACs, criminal justice and mental health staff work in different locations. Most CACs are *not* based in investigative agencies, and most do *not* have mental health professionals on staff. Those CACs that are based in prosecutors’ offices are particularly unlikely to have therapists on staff, both because these agencies are neither skilled nor invested in providing treatment services and because many are interested in maintaining some distance from treatment professionals, as discussed above.

Second, even when there is proximity and contact between therapeutic and investigative staff, such as when CACs provide on-site mental health services, it seems unlikely that it would affect “perceptions of clinicians among clients and the general public” in the vast majority of cases. In many cases, as we have discussed above, child victims and nonoffending caregivers will have an interest in pursuing investigations and will perceive no conflict in an agency that houses both trauma-related mental health services and investigation functions. In fact, locating therapeutic services in CACs and thereby making them available and logistically and financially accessible may increase the number of child victims who receive treatment. Second, most of the public has little or no knowledge about CACs. The vast majority of referrals to CACs come from child protective, law enforcement, and health organizations. While CACs respond with empathy and assistance if families call, the CAC is usually a second-line responder. To the extent that members of the public know about CACs, they typically have a global view of CACs as centers that help child victims, and they endorse in general the goals of effective treatment and investigation. Members of the public who know about CACs probably have limited understanding of the participants in an

MDT and the interaction among them. Given this reality, it seems unlikely that the proximity and contact between therapeutic and investigative staff will have much of an effect on public perception of therapists working in CACs.

Melton and Kimbrough-Melton also express concern that employment in a prosecution-affiliated facility would impair mental health professionals' "objectivity as experts and clinical evaluators" (p. 37). As we have noted above, forensic interviewers are rarely mental health professionals, and a child's therapist does not conduct the forensic interview for that child. But let us consider any situation in which a mental health professional working in a CAC, therapist or not, applies his or her expertise and clinical judgment on behalf of a child. Could his or her objectivity be impaired by employment in a prosecution-affiliated facility? This is only plausible if we assume that prosecutors are at special risk for losing objectivity and then influence their CAC colleagues in other disciplines to stray from objectivity as well. This is unlikely.

NEED FOR RESEARCH

One of the difficulties of assessing Connell's and Melton and Kimbrough-Melton's claims about role conflict is that empirical data are not available about how CACs are structured and how professionals function within them. As Connell's (2008) review makes clear, research on CACs has been limited. Ultimately the degree of risk of role conflict in CACs is an empirical question, and we agree with Connell (2008) that studies are needed in this area. Surveys of CACs could be conducted to produce descriptive statistics on how mental health professionals participate in MDTs and other CAC functions and specifically how CACs maintain clear boundaries between the roles of forensic interviewer and therapist. Semistructured interviews could be conducted with samples of mental health professionals in CACs to explore how they manage practice in CACs and in what ways they communicate and collaborate with other disciplines. Observational methods could examine patterns of interaction in team meetings. One component of survey or interview studies might be to solicit examples of cases or events in which role conflict occurred or there was a risk of role conflict and study the resulting sample of case examples.

CONCLUSION

In summary, a review of how CACs work suggests that Melton and Kimbrough-Melton (2006) and Connell (2008) overestimate the risk of role conflict for mental health professionals working in CACs. CAC standards set

a boundary between forensic interviewing and providing therapy, functions that are never conducted by the same professional for a given child and in most CACs are conducted by separate sets of professionals. Few forensic interviewers are mental health professionals or provide treatment services. Many mental health professionals in CACs are consultants and do not risk role conflict because they do not treat children through the CAC. Child therapists are rarely involved in the investigation, and their participation in MDTs is typically focused on children's interests and well-being. Truth-seeking serves the goal of successful prosecution and is not incompatible with it. There are no data to suggest that role conflict is inherent for multidisciplinary teams. CACs are not as prosecution-oriented as the two chapters might suggest, since only small percentages of cases are prosecuted, and most CACs measure themselves as much if not more by service delivery and promoting victims' rights and participation than by prosecuting or obtaining convictions. Substantial concern about real or apparent role conflict for mental health professionals employed at prosecution-affiliated facilities is not warranted, because contact between prosecutors and therapists is circumscribed, prosecutors share an investment in objectivity, and the public is unlikely to consider therapist involvement as role conflict.

Although we argue that a number of factors mitigate the risk, it is impossible to rule out altogether the possibility of role conflict for mental health professionals in CACs. The National Children's Alliance has and should continue to identify specific CAC practice situations in which mental health professionals might be at risk for role conflict and offer strategies for avoiding or appropriately addressing such conflicts. In some situations, therapists, or law enforcement professionals for that matter, may need to recuse themselves from participating in certain meetings or from portions of certain meetings. While we cannot account for all current MDT and CAC practices throughout the country, the importance of clear boundaries between forensic interviewing and therapeutic intervention is central to the CAC model. It is codified in national accreditation standards and reinforced through training and dissemination of best practices by NCA and its affiliates. Given all the potential benefits of the involvement of mental health professionals in children's advocacy centers, undue concern about role conflict, which might lead to decreased participation of mental health professionals in CACs, could work against the best interests of children.

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