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## Concerted Practice-Based Actions in Intimate Partner and Family Violence: When the Children's Well-Being Is the Central Concern

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External Editor: Nigel Parton

Received: 22 July 2014; in revised form: 3 September 2014 / Accepted: 16 September 2014 /

Published: 30 September 2014

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**Abstract:** In Canada, the exposure of children to intimate partner violence is, along with negligence, one of the most frequent forms of maltreatment. Intimate partner violence raises important issues with regard to child custody and to the exercising of parental roles. The aid provided for children exposed to intimate partner violence covers a range of programs, in particular community services specializing in intimate partner violence, frontline social and health services, and child protection. However, these resource services do not share the same missions, or the same understanding of the problems and possible solutions, since they often operate in parallel networks. The complex situations of families confronted with intimate partner violence present considerable challenges in terms of collaboration between the different organizations. Action research was employed to develop an innovative concertation strategy that fostered collaboration between practitioners from different family resource services. The strategy, which was implemented in the Québec City region between 2011 and 2013, was then evaluated. This article presents the results of this evaluation as

well as the positive outcomes that the concertation strategy had for the practitioners' practice and for the improvement of family services.

**Keywords:** intimate partner violence; child maltreatment; concertation; children well-being

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## 1. Introduction

Children are often at the heart of family violence situations. In Canada, the exposure of children to intimate partner violence (IPV) is, along with negligence, one of the most frequent forms of maltreatment, representing 34% of the cases taken up by child protection agencies [1]. According to data from the Canadian Centre for Justice Statistics [2], 18,710 children under 17 years old were exposed to intimate partner or family violence in 2010. IPV would seem to be more frequent among couples with children [3]. A study based on a representative population sample of 4549 Americans children under 18 years old [4] showed that one child out of nine (11%) had been exposed to family violence in the last year, and that one out of 15 had been exposed to physical (6.6%) or psychological (5.7%) IPV. If we consider lifetime victimization, 17.9% of young people have been exposed to IPV. The portrait is very similar in the Province of Québec, where a quarter of the children have been exposed to physical, verbal, or psychological IPV [5]. In the last few decades, several studies have shown how IPV exposure can have a deleterious impact on children's development [6–18].

The services provided for children exposed to IPV have evolved considerably since the 1990s [10]. They now include a range of programs, in particular community resources specializing in IPV, frontline social and health services, and child protection services. In the Province of Québec, the Youth Protection Act underwent some changes in 2007, denoting the government's acknowledgement that IPV exposure is a form of psychological maltreatment liable to compromise children's health and safety [19]. The changes made to the law recommend an approach based on a sharing of responsibilities between the different resource services working in maltreatment cases. Nonetheless, the operationalization of this principle is not entirely straightforward, since collaboration between the different services remains awkward. Given that the services for IPV and child maltreatment (CM) have developed in separate networks, the organizations and practitioners do not have the same missions or the same understanding of the problems and possible solutions [20–22]. Action research was recently conducted through a co-construction of knowledge and practices involving researchers and practitioners [23]. This made it possible to identify the main conflicts between the practitioners and to establish a novel concertation [24] strategy for resolving these conflicts. This strategy offers concrete support to practitioners faced with the challenge of collaborating with people from other resource services. The aim is to help practitioners go beyond a simple collective management of risk and broaden their respective views of the needs of children and their families. In so doing, their practice will contribute to a winning partnership that will benefit affected children and families by giving them more continuous, coherent, and integrated support. This strategy, which was implemented in the Québec City region between 2011 and 2013, was evaluated by the participating practitioners. This article presents the results of our testing of this process. The collaborative logic underlying this research project ensues from a professional and organizational desire to be part of a continuum of services that can better meet the overall needs of each and every

family member confronted with IPV and CM. The current state of knowledge concerning the consequences of IPV exposure for children will be presented below, as will its impact on parental roles, and the collaboration issues for the different practitioner groups. The concertation strategy will then be described briefly, followed by the methodology used in this study. Finally, the results will be exposed and discussed with the intention of identifying promising avenues for the future development of knowledge and practices in this field.

## 2. Literature Review

### 2.1. *Consequences for Children of Being Exposed to Intimate Partner Violence*

When children live in a family environment where there is IPV, they are considered to be exposed to it whether or not they directly witness it happening. These children might see or hear episodes of violence, participate more directly by trying to come between the two parents, or witness injuries and police interventions [10,25].

Living in an IPV environment exposes children to numerous risks. Compared to children from the general population, such children present more risk of developing physical health and emotional problems [11,14,26]. With regards to mental health, these children are more likely to suffer from post-traumatic stress [10,15,27,28]. They may also present different types of difficulties, including adaptation, social functioning, cognitive and academic, and interiorized and exteriorized behavioural problems [5,6,10,11,13,15,18,27]. Furthermore, these children might also reproduce the violence in their own intimate relationships, whether it be in adolescence or adulthood [10,13–15,18].

The presence of IPV in the family increases the risk that children will in turn be the direct victims of maltreatment [29–34]. Several studies have shown that exposure to both IPV and direct CM has an even more deleterious effect on children's adaptation [16,17,35,36].

### 2.2. *Direction of Violence and Impact on Parental Roles*

Women make up the large majority of IPV victims: they are twice as likely as men to be at risk [2]. The physical acts of violence of which they are victims are also more frequent, more severe, and more serious in consequence [37,38]. As for men, they make up the large majority of alleged perpetrators of family violence (79%), of IPV [1], and of physical abuse towards children [39]. This is all the more true in cases of severe physical abuse [40,41].

The conjugal context of violence in which some women find themselves increases their risk of developing various physical and mental health problems as well as social functioning and parenting problems [42–45]. Moreover, these women often find themselves isolated or forced to take time off from work due to difficulties at home [44]. IPV also affects the conditions in which parental roles are exercised, in particular by increasing victims' stress [46–50]. While the quality of the relationship between the child and the parent who is an IPV victim constitutes an important protection factor for the former [51–55], studies show that the partner or ex-partner often employs violent behaviour to undermine this relationship [53,56,57]. Negative repercussions on the parenting of these women can be observed [56,58,59]. Despite this, studies have shown that these fathers continue to be present in the lives of their children. Approximately 60% of these children continue to live with their father or to see

him regularly after an IPV episode [60]. This is why, for the social practitioners helping these families, IPV is often associated with parental-ability and child-custody related challenges [61,62].

### *2.3. Collaborative Challenges among Psychosocial Practitioners*

Several people from the health and social services network can be called on when IPV and CM situations arise. Certain kinds of organizations are at the heart of the required actions, such as frontline social and health services, child protection agencies, shelters, organizations working with men who conduct IPV, and supervised visitation and custody exchange services [63].

Given the difference in the organizations' mandates, their services, and in the target populations, practitioners working with families can have widely diverging views about the issues at hand [20,64,65]. Consequently, it would seem that each organization's mission, as well as the target population influence the practitioners' viewpoints. Moreover, the simultaneous presence of IPV and CM often point to complex family situations and violence problems. The distinct needs of each family member can make it more complicated to provide support [62]. In these situations, getting the various organizations to collaborate represents a strategy that can provide these families with a more complete and coherent service [66,67].

Challenges in collaboration nonetheless remain, in particular between child protection agencies and shelters for women who are IPV victims [65,66]. It is seemingly just as difficult to get resource services for violent partners and those for IPV victims and exposed children to cooperate [68]. Even though its importance has been pointed out by several authors, collaboration remains difficult in concomitant situations [20–22,65,69–71].

### **3. Concertation Strategy**

In order to address collaboration issues between practitioners, a concertation strategy has been developed involving all actors from a participatory action research [23]. This strategy took the form of clinical discussions and it called for two concertation meetings, with a three-month interval, between practitioners working with families concerned by IPV and CM. For each clinical situation, the concertation strategy requires three fields of expertise to be systematically represented: services for child protection, IPV victims, and partners with violent behaviour. If one of these branches is not represented for a clinical situation, a practitioner in this field is invited to the concertation meeting so as to share his/her viewpoint. These "external experts" are selected in collaboration with the Project Coordination Committee, which has representatives from each area of expertise. The concertation strategy provides the animation of each encounter by a neutral actor. In the case of our experiment, it was the project coordinator. During the meetings, the practitioners were first invited to introduce themselves and their organization (*i.e.*, mandate and mode of operation). Then, they shared their respective analysis of the family situation, beginning with the family providers. The meeting ended with the proposal of different possible initiatives for each family practitioner so as to ensure the children's safety. A concertation meeting lasted about an hour and a half and involved between three and six practitioners [72].

The innovative nature of this strategy is based on two main aspects. First, although there are existing concertation structures applicable to various situations, these structures are rarely used in IPV. In one hand, this is due to the obstacles already mentioned in the previous section, while in the other

hand it is explained by concertation protocols usually requiring the presence of families, which raises important issues of safety for victims of IPV, who find themselves forced to negotiate solutions with their abuser in a context of unequal power relationships. Thus, there is a risk for the intervention to be used by the abuser as a way to maintain control over the victim before, during or after the concertation meeting, and practitioners least aware of IPV may not be able to detect subtle control strategies. Second, these protocols are generally managed by public services agencies, while IPV expertise lies more in the community services. Therefore, this strategy offers a new approach that allows the recognition of all expertises, thus, helping to equalize the power relationships between practice settings, while providing an answer to security challenges for the concerned family members, who give their consent but do not participate in the meetings [72].

Since the services offered in some organizations are of short duration or have waiting lists for services access, sometimes families do not receive help from two or more practitioners at the same time. Thus, another innovative aspect of this strategy is to provide practitioners with the possibility to consult with practitioners from other fields of expertise in conducting a clinical discussion between him/her and two “external experts”. A practice guideline has been produced for practitioners needing more information about the concertation strategy [72].

#### **4. Methodology**

Since the main objective of this study was to evaluate a concertation strategy for practitioners working in IPV and CM, we opted for a mixed methodology that was both qualitative and quantitative. We will begin by describing the sample and recruitment methods, underlining the ethical concerns, then the data collection tools, and, finally, our analysis methods.

##### *4.1. Population, Sample, and Recruitment Methods*

The study population was composed of practitioners from different organizations working with one or more members of families affected by IPV and CM. This research is based on a total of 115 participants (number of questionnaires that were filled out), including 57 different practitioners, taking into account that some practitioners have participated for more than one clinical situation as a provider or as an external expert. Two strategies were used to recruit these practitioners.

The first strategy consisted in making practitioners who were working with families affected by IPV and CM aware of the project. To do so, we organized presentations for each of the work teams of the seven main organizations in the Québec City region, namely: a child protection agency, two organizations offering frontline health and social services, two organizations working with women and children exposed to IPV, an organization working with men who employ violence, and an organization providing supervised visitation and custody exchange services. We met with 474 practitioners and managers working with affected families to explain the concertation strategy. Managers have been informed of the concertation strategy since they have an important influence to encourage practitioner participation in research. As the recruitment stretched over a two-year period, an e-mail newsletter was created to periodically remind the practitioners about the concertation strategy. Moreover, we were also able to count on a snowball effect that enhanced this recruitment strategy: several practitioners who participated in a concertation meeting saw the benefits and in turn referred another clinical situation to our research

team. When practitioners indicated that they wished to participate in the project knowing that helped family was concurrently receiving services from another organization, they contacted the project coordinator to obtain the information and documentation needed to present the project to parents and ask for their consent for the practitioners to participate in concertation meetings. The project coordinator then contacted the other concerned practitioners to ascertain their interest, then to schedule the concertation meeting.

The second recruitment strategy consisted in obtaining a list of all the children whose reported cases had been retained by the child protection agency because of their IPV exposure and family conflicts. This list was established by the child protection agency and sent to the project coordinator in a secured document. Only the children's user number appeared on the list so as to protect their identity. This list was systematically checked by the project coordinator and the manager of the team of practitioners working with the children so as to determine whether there were two IPV and/or CM services involved with the same family. When situations were identified, the coordinator then contacted the practitioners in question to invite them to participate in the concertation strategy; if interested, the latter would then communicate with the parents to obtain their consent. Concertation meetings were organized by the project coordinator once everyone concerned had given their consent. The evaluation of the strategy was done at the end of each meeting.

#### *4.2. Ethics and Victim Safety*

This project made sure that ethical and safety issues were a priority by ensuring the consent of each party and the anonymity of each family member, and by verifying issues related to the safety of victims of violence through diverse mechanisms, even though it was the practitioners who participated to the concertation strategy.

To begin with, the consent of the parents was obtained and, when present, that of children 14 and over. It is important to note that in Quebec (Canada) the law states that children of 14 and older can provide legal consent. Parents who gave their consent for the participation of their practitioner included both biological parents and, when they lived with the children, the step-parents. The consent of each family member concerned was needed; for example, the consent of only the father or only the mother was not acceptable. It is also worth noting that consent of the two parents was always obtained by the practitioner who was closest to them so as to encourage file confidentiality and victim safety.

With regards to anonymity, the research team never asked for the parents' names if the consent forms were not signed by the latter. When it was necessary to have names, for example, the name list provided by the child protection agency, only the project coordinator had access to the information, which was protected by a password that only she knew. Each member of the research team, like the practitioners in the concertation meetings, had to sign a confidentiality form. It stated the importance of protecting the anonymity of the family members, as well as the confidentiality of those family members with whom they were not working. The names were removed from all the documents and replaced by reference numbers before carrying out the analysis.

The victims' safety was a central concern of the team all throughout the project. To start with, the parents were never invited to participate in the meetings so as not to put the victim in the presence of the partner who employed violence. In certain cases moreover, in particular when the woman was

staying in a shelter, the name of the organization was not mentioned on the consent form signed by the partner or ex-partner in order to protect the victim. There were nonetheless a few occasions where we were confronted with complex situations in which the simple fact of talking about the project with a spouse having violent behaviour might have been prejudicial to the victim's safety. The concertation protocol was then abandoned to ensure the victim's safety.

#### *4.3. Data Collection Methods*

As it was a question of evaluating the concertation strategy, we used a paper questionnaire that the practitioners had to fill out after each of the two meetings. The questionnaire evaluated: (1) the improvement in their knowledge about the situation and related issues; (2) the consensus and divergent opinions identified by the practitioners during the meeting; (3) the overall appreciation of the concertation meeting; (4) the facilitating elements and obstacles in the meeting; (5) their appreciation of the people who were invited to the meeting; and (6) their other concertation experiences in their field. The practitioners could also write down general comments at the end of the questionnaire.

The questionnaire was primarily composed of short-answer questions that made qualitative analysis possible, but also had Likert-scale questions that allowed certain aspects to be measured with a quantitative approach, in particular the practitioners' satisfaction.

The practitioners answered these questionnaires anonymously, while, nonetheless, indicating the organization for which they worked so that the research team could compare the answers based on the practitioners' expertise.

#### *4.4. Analysis Methods*

A theme-based, content analysis method was chosen for the qualitative data [73]. N'Vivo was used to code all of the participants' answers inductively. Two members of the team independently coded all qualitative data using an inductive method involving N'Vivo software. A meeting of the research team then allowed the discussion of the various codes and their definition to agree on a common coding grid, with which the data were recoded by the same two team members, achieving an inter judge agreement score of 99.27%. The analysis was then completed by the team, establishing relationships between the analysis categories.

The aim of the quantitative analyses was essentially to measure the practitioners' satisfaction with the concertation process. The team chose to employ descriptive statistics to do so.

### **5. Results**

#### *5.1. Participants and Attrition Rate*

In total, the concertation meetings covered 29 different clinical situations. Of these, 27 came from the first recruitment strategy (practitioner reference), whereas the other two came from the second (database of the child protection agency).

In 24 other cases, the references received did not lead to concertation meetings. The main reason for refusing these cases was the length of time it took from the moment when the practitioners referred the clinical situation for the project to the obtaining of the necessary consent to start the process, which

took an average of three months. This can be explained in particular by the fact that the actual physical meetings between practitioners and their clients were less frequent or harder to bring about, as well as by the number of consent forms that had to be filled out (generally two, sometimes more). For more than a third of these clinical situations, the cases were closed before obtaining parental consent. For seven other families, their case was not accepted because one of the parents refused that their family situation be discussed in a meeting. For five out of these seven families, the refusal came from the father, whereas, in another two cases, it came from the mother or both parents. Three other family situations were not accepted because: the practitioner refused to take part in the project; the reference came too late for data collection; and the practitioner stated that the safety of the mother and children would be threatened by her participation in the study.

The concertation strategy called for two meetings at a three-month interval. However, for seven of the clinical situations included in the sample, the second concertation meeting could not be held. The reason in these cases was that their file had been closed because the families were no longer meeting a practitioner who could represent them in the concertation meetings.

### *5.2. Practitioners' Satisfaction Regarding the Concertation Approach*

All the practitioners questioned in our study thought that the concertation strategy should be implemented on a larger scale. They greatly appreciated the relevance of this strategy in their work with families with IPV and CM problems, as can be seen by the following quote:

“It was an excellent approach! It’s something that turns out to be very useful in ensuring the children’s well-being, since each parent’s situation is complex. Hearing about the other practitioners’ opinions and approaches is quite enriching. It helps us develop new ways of communicating with each other and being more aware of the issues so that we can ensure the children’s well-being” (practitioner working with women).

The results presented in the Table 1 show that a large majority of the practitioners were satisfied or very satisfied with their participation in the concertation meetings, whereas having attended one or two consultation meetings planned in the protocol.

Close to 100% of the practitioners indicated that they were very satisfied or satisfied about five of the measured indicators, namely: the relevance of concertation discussions for their professional practice (99.2%), freedom of expression during the meetings (96.6%), the feeling that their expertise and skills were acknowledged (97.5%), the group’s openness to hearing and respecting other people’s viewpoints (98.3%), and the facilitator’s work in allowing everyone to express themselves freely (99.2%). As for the other two indicators, 100% of the practitioners noted that they were very satisfied or satisfied about other people’s professional expertise and skill being recognized, as well as about their own contribution to the discussion.



**Table 1.** Practitioners' Satisfaction with the Participation Meetings for Each of the Following Statements.

Indicators Mesured	Very Satisfied	Satisfied	Not very Satisfied	Dissatisfied
(1) Relevance of the discussions for my professional practice.	59.3%	39.83%	0.8%	--
(2) Freedom of expression (I'm comfortable expressing my ideas).	83.3%	13.3%	3.3%	--
(3) Feeling that my professional expertise and skills are acknowledged.	74.2%	23.3%	2.5%	--
(4) Other people's professional expertise and skills seem to be acknowledged (no impression that some people are more of an expert than the others).	81.7%	18.3%	--	--
(5) Openness of the group to hearing and respecting divergent ideas, opinions, and comments.	85.7%	12.6%	1.7%	--
(6) My own contribution to the discussion.	68.7%	31.3%	--	--
(7) Facilitator's work in allowing everyone to express themselves sufficiently.	80.9%	18.3%	0.8%	--

### 5.3. Support for the Psychosocial Workers' Practice

#### 5.3.1. A Better Understanding of Families and Greater Collaboration between Organizations

The concertation meetings, through the support they provided for the different practitioners who took part in the project, were often beneficial for their practice. Accordingly, the results indicated that the meetings gave the practitioners a better understanding of a large majority of the family situations that were discussed there. These meetings gave them a better overall view of family situations by bringing together diverse viewpoints and complementarity information. Several practitioners pointed out that the meetings also gave them a better understanding of the different organizational fields and fostered collaboration between these organizations for most of the family situations.

“[Concertation is a strategy we should develop because it] helps us to check our perceptions and analysis. Because we don't see them in a family context, [concertation] helps us to better understand the clients' situation” (practitioner working with men).

“Having a better understanding of the work of [organization name] and [organization name] helps me to better explain to women why other organizations do the things they do” (practitioner working with women).

“We realize that we don't have the choice but to collaborate. Everyone has their approach, but how do you reach a common viewpoint that doesn't suffer from a silo mentality? [We have to] know the issues surrounding children who are under the care of [organization name], develop good relationships by raising awareness, demystify the role of [organization name] and the associated fears, move forward together, hear everyone's opinion, and be more sensitive to other people's experiences” (practitioner working with women).

The quantitative results strengthen the validity of the observations ensuing from qualitative data. The quantitative data indicated that the concertation meetings helped the majority of the practitioners

to better understand the mandate of the other organizations involved in IPV situations. Accordingly, 96% of the practitioners improved their knowledge of the other organizations' mandate either a small amount (23%), a moderate amount (38%), or a large amount (35%), whereas only 3% indicated that they had learned nothing about these organizations through the concertation meetings.

### 5.3.2. Consensus and Divergence of Opinion among Practitioners

Several practitioners had similar opinions about the family situations. The consensus among practitioners particularly concerned the importance of protecting the children but also of protecting mothers who were IPV victims, as was pointed out by almost all the practitioners participating in the project:

“The practitioner’s legitimate concern for the victim and children’s safety” (practitioner working with men).

“The notion of the children’s safety and well-being [and] the consequences [of IPV]” (practitioner working with women).

Concerning what needed to be done, the practitioners agreed about what should occur in the mid- and short-term. Most of the practitioners pointed to initiatives to put into place for the mothers and their children, whereas some practitioners suggested initiatives for the fathers.

Some divergent viewpoints could be seen among the practitioners. These primarily concerned different readings of the clinical situations, the mandates and roles of each organization, and the initiatives to adopt. The practitioners mentioned that their viewpoints and understanding diverged regarding 12 clinical situations in particular, which mostly involved IPV and its impact on the children:

“There is no consensus about IPV” (practitioner working with women).

“Different discourses. IPV or [domestic] conflict?” (practitioner working with women).

Not all the practitioners agreed about each other’s respective mandates. Some practitioners mentioned that they found it difficult to understand the reasons underlying the actions of the child protection agency, particularly with regard to the legal framework of their practices. Moreover, some of the participants had the impression that the practitioners from the child protection agency did not know the role of their organization and services very well.

On another note, practitioners who did not have access to the same information about a family situation often had an analysis that was biased by the version of the family member with whom they worked most closely:

“[The] lack of information depended on our respective mandates. [It was] difficult to know the truth, everyone has limited information” (practitioner working with men).

“Our understanding of the situation differed. We have a more global view because we have access to all the family members” (practitioner working with children).

The practitioners did not agree about the approach to adopt for seven clinical situations, as can be seen in the following quotes:

“The work with the father: one practitioner was hoping that the father would get closer to his children, while most of the others [practitioners] suggested working with the children to get them to have more realistic expectations about their father” (practitioner, non-specified client).

“[The different opinions] especially concerned what our target should be (direct targeting of the father or not) and the strategy for the child” (practitioner, non-specified client).

It is worthwhile noting that, for 80% of the practitioners, the approach employed here helped to reduce divergence in viewpoints either a moderate amount (37%) or a large amount (43%).

#### 5.4. *Quality of the Client Services*

According to the practitioners, the families also seemed to have benefited from the approach employed in this project because it provided them with better quality services:

“Some of the discussions allowed us to adjust our practices by taking into account other, complementary viewpoints. This enhanced our practices and improved our work with the service recipients” (practitioner working with men).

The provision of better services might have been related to a greater understanding of the IPV and CM problems that the practitioners said they developed through the concertation meetings. As such, the meetings allowed most of the practitioners to better understand the issues at hand; 93% of the participating practitioners indicated that the meetings helped their understanding a large amount (22%), a moderate amount (45%), or a small amount (26%). According to the practitioners, the majority of their clients have benefited from concerted actions that were better adapted to their situation, in particular for insuring child safety:

“[During concertation discussions], we develop and become aware of the importance of assessing the victims’ degree of safety and of foreseeing ways of ensuring the children’s and mother’s safety” (practitioner working with children).

“Given everyone’s expertise and their involvement in the children’s situation, we were able to better determine their situation and make better decisions for them” (practitioner, non-specified client).

“After this meeting, I’m confident that there will be a good ‘safety net’ for the children and that the actions taken will benefit them” (practitioner working with women).

Another positive outcome was consistent with one of the project goals, which was to improve the protection of IPV and CM victims and maltreatment. When they were asked about this, 92% of the practitioners who took part in the project indicated that the concertation practice resulted in a better response to victim safety issues.

## 6. Discussion

One of the evaluation results that is particularly interesting was the impact of the concertation strategy on the practice of psychosocial workers from different fields working with the affected

families. First of all, the results highlight the consensus and difference of opinions concerning the approaches to be taken with these families. Second, they emphasize the concertation structure required to foster collaboration between the different organizations and limit power struggles. Third, they point to different avenues for improving concertation in complex family situations, especially when there is IPV. Finally, they show that concertation can lead practitioners to consider collaborating with their partners in other fields. Thus, this study reveals that, even if collaboration between the concerned fields of practice remains difficult [20–22,65,69–71], it is not an impossible goal to achieve.

### *6.1. Consensus and Divergence*

It would seem worthwhile to take a more general look at the consensus and divergence that were evaluated in the testing of this concertation model. To begin with, the results of this evaluation add support to the findings of a previous study [20], namely that there is consensus among the practitioners about the importance of ensuring the safety of IPV victims, who are often women and children. The triangulation of the qualitative and quantitative data leaves no doubt about this: the practitioners from all the different fields emphasized this point in their comments, and this for more than a third of the concertation meetings.

We believe, furthermore, that an important inverse relation can be established between the practitioners' knowledge of other organizations and their diverging opinions about each other's roles. In some of the meetings, one or more practitioners expressed diverging viewpoints concerning the mandate of other practitioners present. Similarly, a large majority of them (87%) indicated that their knowledge of the other organizations improved moderately or considerably because of the meetings. Everything indicates that a better understanding of the objectives, missions, and issues of the other organizations alongside whom they were working at least partially explained how the concertation meetings contributed to an 80% decrease in disagreements about each person's role. It could be interesting to pursue this point since improving the participants' knowledge of the other organizations in their region working on the same problems is an easy and inexpensive solution. This observation is supported by another finding: the practitioners desired to see other players in the network participate in the concertation meetings, primarily those with expertise in the judicial, mental health, and educational systems, as will be discussed below.

It is likewise relevant to compare the practitioners' reading of the family situations by way of the approach they wish to take in their actions. The practitioners' reading of the family situations was as consensual (13 clinical situations) as it was divergent (12 clinical situations). However, when the practitioners identified the action to be taken, they agreed in a majority of the cases (12 clinical situations) and disagreed in a smaller proportion (five clinical situations). Because the practitioners agreed for the most part about the approach to take, these findings raise the following question: were the practitioners' divergent readings due more to each field's ideologies or to the assisted families' concrete situations? Or did the practitioners relativize these different readings as long as the initiatives involved protected the victims, which was their most common consensus? It would be interesting if future research could examine these questions and concentrate more specifically on these aspects.

## 6.2. Concertation Structure

Making concertation protocols available to the practitioners is not enough; they must also be structured so as to reduce power struggles. As we mentioned above, one of the common problems is that the existing concertation models are often found in public institutions, whereas expertise in this matter has for the most part been developed by community services. It is thus possible that certain concertation protocols accentuate the power imbalance instead of reducing them. Moreover, several authors have documented collaboration difficulties as well as the importance of improving concertation among different resource services [69,71,74].

That being said, the results of this evaluation indicate that several factors related to the methodology and concertation structure developed in this project made for smoother meetings and reduced the power struggles. The main contributing factor that the practitioners identified was the presence of a neutral facilitator who saw to it that the meeting ran smoothly by ensuring that each organization was present, that the length of the meeting and the time limit for each person to speak was respected, that the context was laid out at the beginning of the meeting, and that discussions were helped along when necessary. The second factor identified by a large number of the practitioners as having contributed to well-run meetings was the positive attitude of the practitioners, as noted by more than half of the project participants (52.4%). Various attitudes, such as respect, listening, and open-mindedness, might have been fostered by the very nature of the concertation strategy, which calls for a neutral person who can explain the strategy's characteristics and encourages all the practitioners to participate in the meeting.

Finally, it is worth noting the usefulness in systematically having people at the concertation meetings with the three main types of expertise: child protection, support for IPV victims, and help for violent partners. Systematically having at the least one practitioner from each of these three fields confirmed the importance of each one and, consequently, reduced the power struggles. Moreover, it is important to remind that this feature contributes to the originality of this strategy compared to other existing concertation models.

## 6.3. Complexity of Family Situations

In families where there is both IPV and CM, the practitioners are often confronted with other issues, such as poverty, addiction, and mental health problems [75,76]. Several studies have moreover noted the extent to which complex family situations lead practitioners to divergent readings of the issues and needs of these family members [20–22]. It is, thus, interesting to see how the proposed concertation strategy allowed the practitioners to influence each other in their readings of these situations. Accordingly, the results of our evaluation indicate that, after a concertation meeting, the practitioners were more aware of the usefulness of drawing the largest portrait possible of the family situation so as to better outline the issues and more effectively meet the families' needs.

Some of the practitioners nonetheless deplored the fact that practitioners from other fields who had good knowledge of the situation and who provided services to one of the family members did not participate in the concertation meetings. They considered that the concertation discussions could have benefited from these other viewpoints, particularly in those cases where the expertise was not related to IPV. For example, several practitioners mentioned that organizations that provided drug addiction

services might have improved the understanding of the family situations through their participation. Other practitioners suggested the presence of practitioners from the judicial, mental health, and education systems.

This avenue could however create an additional ethical challenge, especially if these new actors do not have any responsibilities regarding psychosocial assistance. Indeed, they would have access to confidential clinical information that they do not necessarily need to carry out their work. Further reflection on this subject would be useful to identify the ethical issues related to such a practice and to determine how it might take place.

#### *6.4. Participation*

Finally, it is worth noting that several practitioners ( $N = 15$ ) participated in more than one set of concertation meetings in this project, and this, for different clinical situations. In most cases, this was not due to chance: after having participated in one concertation meeting, these practitioners became proactive in recruiting families who met the inclusion criteria. The practitioners saw an opportunity to benefit from the expertise of other practitioners and, thereby, improve their skills.

### **7. Limitations**

This study had three main types of limitations, namely those related to the geographical area where it was implemented, to time, and to the nature of the collected data. First of all, the area where the concertation strategy was implemented, that is the Québec City region, is relatively small, having only a few organizations specialized in intimate partner and family violence. This factor greatly facilitated our implementation of the concertation strategy, in particular as concerns the readiness to work with other organizations, the time needed to disseminate the concertation strategy in each organization, and, above all, the possibility for the researchers to make connections with the organizations' management, which facilitated the different organizations adaptation to the strategy. In a larger region or one where many more organizations were present, it would certainly be more difficult to implement such a practice and, consequently, to reproduce the results obtained in this research project.

Second, time is a precious factor when implementing, such a concertation strategy: before being able to organize the first concertation meeting, several stages had to be completed so as to inform practitioners from different fields about this new practice and have them participate. What is more, an evaluation project, such as the one tested here, usually has to be completed in a given length of time due to the availability of funding, which was three years in the present case. Time was also an important limiting factor in the recruitment of practitioners, because in the case of more than a third of the referred cases, we were confronted with a service termination for a family member, thereby rendering the concertation strategy impossible. In most cases where the second concertation meeting could not take place, it was for this same reason. We compensated for this obstacle by asking practitioners who were still working with certain families to fill out an adapted version of the satisfaction questionnaire so as to collect essential data about them. In doing so, we found that it doesn't seem to be any difference between the benefits they obtained from it compared to those who were able to complete the two concertation meetings.

Finally, a few limitations were related to the collected data. To start with, some practitioners participated in concertation meetings for more than one clinical situation. Each situation being unique, these practitioners had to fill out the questionnaire more than once. However, we were not able to isolate these respondents so as to analyze if they were more, less or equally satisfied with the concertation strategy, comparatively with others who participated only once. In fact, the questionnaire did not include the information about the number of different clinical situations in which they took part in the overall project. Despite this, the results would have benefitted to take into account the possible self-selection biases, since practitioners who liked the strategy or found it congruent with their values may be over-represented, thus, inflating the satisfaction rates. This limitation can nonetheless be seen as a strength of the project since, if practitioners took advantage of this concertation strategy more than once, it is likely that this strategy was useful in their practice the first time around. Furthermore, since the answers to the questionnaire were short and sometimes even composed of a single word (e.g., respect, time), they were more difficult to analyze, because the research team had to be sure it understood the meaning of the answer that the practitioner gave. Finally, because it was impossible to ensure that the practitioners would systematically answer questions, we were confronted with missing data in some of the questionnaires.

## 8. Conclusions

The results of this evaluation suggest that greater knowledge of the different organizations that worked with families with IPV and CM problems made for less disagreement about the mandates of the practitioners from these fields and improved cooperation between them. Interestingly, several quite simple and inexpensive solutions can be developed in this regard. For instance, there are already IPV concertation structures in several regions, both in the Province of Québec and elsewhere, which could assist in developing concrete action strategies.

In keeping with this idea, it would be worthwhile to measure how ideologies influence both the different organizations' readings of the family situations and the approaches proposed by the practitioners. Our results seem to show that, while there were different readings of the family situations that were related to the practitioners' "glasses," there was markedly less difference in the approaches they proposed, which aimed primarily at victim protection.

Finally, with the goal of extending concertation to all the social actors working with these families, it would be worthwhile to look at the ethical issues raised by the circulation of information among psychosocial practitioners and other potentially concerned actors, be it in the educational, medical, or judicial systems. While concertation among all these actors could produce more coherent and precise actions, there are numerous issues that need to be considered concerning power struggles, confidentiality, and the misappropriation of information to benefit a given organization.

In conclusion, the aim of this study was to evaluate an innovative concertation strategy developed from 2004 to 2010 and implemented in the Québec City region from 2011 to 2013. The project worked to foster collaboration between practitioners from different resource services who were working with families with both IPV and CM problems. The results of this evaluation show that the practitioners who participated in the concertation meetings were very satisfied, that they gained a better understanding of complex family situations and better collaboration with the other organizations, and that they felt

that they were able to provide better services to the families with whom they worked. We identified a few avenues for solutions and further discussion that could foster collaboration among practitioners with different forms of IPV and CM expertise. Nonetheless, there is still a considerable amount of work required to develop and above all support this kind of initiative, since power struggles between institutions and community organizations still occur, and the different types of IPV and CM expertise are often still isolated one from the other.

### Acknowledgments

The authors wish to thank all practitioners members of the coordination board who facilitate this research project, especially Yennelys Alcedo, Rhéa Delisle, Marie-France Godin, Lorraine Juneau, Valérie Meunier, Julie Ménard, Mélanie St-Laurent, and Maryline Trottier for their invaluable implication for the recruitment and the development of this project. They would also like to thank Richard Whelan for the meticulous translation of this paper.

### Author Contributions

Geneviève Lessard was the scientific leader of this research project. She designed the aim and the process of the project, constituted the working team and decided about the roles of employees and collaborators. She participated in all steps of the project and furthermore in the writing of this paper. Marie-Eve Drouin (research professional) was the project coordinator. She led every step of the strategy implementation and was the main contact for all concerned actors during the whole process. She led the collection and analysis of data and the redaction of this paper. Anne-Sophie Germain (graduate student) carried out the collection and analysis of data, the literature review, and wrote different sections of this paper. Pamela Alvarez-Lizotte (graduate student) also participated in the collection and analysis of data, and helped for specific requests related to the production of this paper. She read and commented the different versions of this paper, like Pierre Turcotte (co-researcher) also did. All authors approved the final manuscript.

### Abbreviations

IPV: Intimate partner violence; CM: child maltreatment.

### Conflicts of Interest

The authors declare no conflict of interest.

### References

1. Nico Trocmé, Barbara Fallon, Bruce MacLaurin, Vandna Sinha, Tara Black, Elizabeth Fast, Caroline Felstiner, Sonia Helie, Daniel Turcotte, and Pamela Weightman, *et al. Étude Canadienne sur L'incidence Des Signalements de cas de Violence et de Négligence Envers les Enfants*, 2008. Ottawa: Agence de la Santé Publique du Canada, 2010, p. 128.
2. Centre Canadien de la Statistique Juridique. *La Violence Familiale au Canada: Un Profil Statistique*. Ottawa: Ministre de l'Industrie, 2010, p. 58.



3. Renee McDonald, Ernest N. Jouriles, Suhasini Ramisetty-Mikler, Raul Caetano, and Charles E. Green. "Estimating the number of american children living in partner-violent families." *Journal of Family Psychology* 20 (2006): 137–42.
4. Sherry Hamby, David Finkelhor, Heather Turner, and Richard Ormrod. "Children's Exposure to Intimate Partner Violence and Other Family Violence." *National Survey of Children's Exposure to Violence Series*, 1 October 2011. Available online: <https://www.ncjrs.gov/pdffiles1/ojjdp/232272.pdf> (accessed on 18 June 2014).
5. Institut de la Statistique du Québec. *La Violence Familiale Dans la vie des Enfants du Québec, 2012—Les Attitudes Parentales et les Pratiques Familiales*. Québec: Gouvernement du Québec, 2013, p. 146.
6. G. Anne Bogat, Erika DeJonghe, Alytia A. Levendosky, William S. Davidson, and Alexander von Eye. "Trauma symptoms among infants exposed to intimate partner violence." *Child Abuse and Neglect* 30 (2006): 109–25.
7. Chantal Bourassa. "L'exposition à la violence conjugale psychologique et verbale et son effet sur le comportement des adolescents." *Journal International de Victimologie* 5 (2006): 1–14.
8. Kathleen Camacho, Miriam K. Ehrensaft, and Patricia Cohen. "Exposure to intimate partner violence, peer relations, and risk for internalizing behaviors: A prospective longitudinal study." *Journal of Interpersonal Violence* 27 (2012): 125–41.
9. Ko Ling Chan, Douglas A. Brownridge, Elise Yan, Daniel Y.T. Fong, and Agnes Tiwari. "Child maltreatment Polyvictimization: Rates and short-term effects on adjustment in a representative Hong Kong sample." *Psychology of Violence* 1 (2011): 4–15.
10. Geneviève Lessard, Dominique Damant, Louise Hamelin-Brabant, Joannie Pépin-Gagné, and Anne Chamberland. "L'exposition à la violence conjugale." In *La Violence à L'égard des Enfants en Milieu Familial*. Edited by Marie-Ève Clément and Sarah Dufour. Anjou: Les éditions CEC, 2009, pp. 79–92.
11. Sarah E. Evans, Corrie Davies, and David DiLillo. "Exposure to domestic violence: A meta-analysis of child and adolescent outcomes." *Aggression and Violent Behavior* 13 (2008): 131–40.
12. Hilary G. Harding, Diana Morelen, Kristel Thomassin, Laura Bradbury, and Anne Shaffer. "Exposure to maternal and paternal-perpetrated intimate partner violence, emotion regulation, and child outcomes." *Journal of Family Violence* 28 (2013): 63–72.
13. Ryan J. Kelly, and Mona El-Sheikh. "Longitudinal relations between marital aggression and children's sleep: The role of emotional insecurity." *Journal of Family Psychology* 27 (2013): 282–92.
14. Katherine M. Kitzmann, Noni K. Gaylor, Aimee R. Holt, and Erin D. Kenny. "Child witnesses to domestic violence: A meta-analytic review." *Journal of Consulting and Clinical Psychology* 71 (2003): 339–52.
15. Alytia A. Levendosky, G. Anne Bogat, and Cecilia Martinez-Torteya. "PTSD symptoms in young children exposed to intimate partner violence." *Violence against Women* 19 (2013): 187–201.
16. Kathleen J. Sternberg, Laila P. Baradaran, Craig B. Abbott, Michael E. Lamb, and Eva Guterman. "Type of violence, age, and gender differences in the effects of family violence on children's behavior problems: A mega-analysis." *Developmental Review* 26 (2006): 89–112.

17. Kathleen J. Sternberg, Michael E. Lamb, Eva Guterman, and Craig B. Abbott. "Effects of early and later family violence on children's behavior problems and depression: A longitudinal, multi-informant perspective." *Child Abuse & Neglect* 30 (2006): 283–306.
18. David A. Wolfe, Claire, V. Crooks, Vivien Lee, Alexandra McIntyre-Smith, and Peter G. Jaffe. "The effects of children's exposure to domestic violence: A meta-analysis and critique." *Clinical Child and Family Psychology Review* 6 (2003): 171–87.
19. Gouvernement du Québec. "Loi sur la protection de la jeunesse." 1 June 2014. Available online: [http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/P\\_34\\_1/P34\\_1.html](http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/P_34_1/P34_1.html) (accessed on 13 June 2014).
20. Geneviève Lessard, Catherine Flynn, Pierre Turcotte, Dominique Damant, Jean-François Vézina, Marie-France Godin, France Paradis, Rhéa Delisle, Yennelys Alcedo, and Lorraine Juneau, *et al.* "Child custody issues and co-occurrence of intimate partner violence and child maltreatment: Controversies and points of agreement amongst practitioners." *Child & Family Social Work* 15 (2010): 492–500.
21. Christine Potito, Andrew Day, Ed Carson, and Patrick O'Leary. "Domestic violence and child protection: Partnerships and collaboration." *Australian Social Work* 62 (2009): 369–87.
22. Sarah Wendt. "Building and sustaining local co-ordination: An Australian rural community responds to domestic and family violence." *British Journal of Social Work* 40 (2010): 44–62.
23. Geneviève Lessard, Catherine Flynn, Pierre Turcotte, Lorraine Juneau, Rhéa Delisle, Valérie Meunier, Marie-France Godin, Yennelys Alcedo, and Annie Dumont. "Violence conjugale, maltraitance et garde des enfants: Une démarche de recherche-action favorisant la résolution des controverses entre les acteurs et l'émergence d'une pratique novatrice et concertée." *Recherche Qualitative* 31 (2012): 25–51.
24. *Concertation*: /kɔ̃sər'tɛʃər'tʁ. kɔ̃sər'ta'syɔ̃/ noun (especially in European politics) cooperation, as among opposing factions, aimed at effecting a unified proposal or concerted action. Available online: <http://dictionary.reference.com> (accessed on 3 July 2014).
25. George W. Holden. "Children exposed to domestic violence and child abuse: Terminology and taxonomy." *Clinical Child and Family Psychology Review* 6 (2003): 151–60.
26. Yuk-Chung Chan, and Jerf Wai-Keung Yeung. "Children living with violence within the family and its sequel: A meta-analysis from 1995–2006." *Aggression and Violent Behavior* 14 (2009): 313–22.
27. Gillinder Bedi, and Chris Goddard. "Intimate partner violence: What are the impacts on children?" *Australian Psychologist* 42 (2007): 66–77.
28. Patricia K. Kerig, Anne E. Fedorowicz, Corina A. Brown, and Michelle Warren. "Assessment and intervention for PTSD in children exposed to violence." In *Children Exposed to Domestic Violence: Current Issues in Research, Intervention, Prevention, and Policy Development*. Edited by Robert A. Geffner, Peter G. Jaffe and Marlies Sudermann. New York: The Haworth Maltreatment & Trauma Press, 2000, pp. 161–84.
29. David Finkelhor, Richard Ormrod, Heather Turner, and Sherry Hamby. "The victimization of children and youth: A comprehensive, national survey." *Child Maltreatment* 10 (2005): 5–25.
30. Chris Goddard, and Gillinger Bedi. "Intimate partner violence and child abuse: A child-centred perspective." *Child Abuse Review* 19 (2010): 5–20.

31. Sherry Hamby, David Finkelhor, Heather Turner, and Richard Ormrod. "The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth." *Child Abuse & Neglect* 34 (2010): 734–41.
32. Man Yee Ho, and Fanny M. Cheung. "The differential effects of forms and settings of exposure to violence on adolescents adjustment." *Journal of Interpersonal Violence* 25 (2010): 1309–37.
33. Gayla Margolin, Elena B. Gordis, and Anna Marie Medina. "The co-occurrence of husband-to-wife aggression, family-of-origin aggression, and child abuse potential in a community sample." *Journal of Interpersonal Violence* 18 (2003): 413–40.
34. Gayla Margolin, Katrina A. Vickerman, Michelle C. Ramos, Sarah Duman Serrano, Elana B. Gordis, Esti Iturralde, Pamella H. Oliver, and Lauren A. Spies. "Youth exposed to violence: Stability, co-occurrence, and context." *Clinical Child and Family Psychology Review* 12 (2009): 34–54.
35. Myreille Cyr, Andrée Fortin, and Lise Lachance. "Children exposed to domestic violence: Effects of gender and child physical abuse on psychosocial problems." *International Journal of Child and Family Welfare* 9 (2006): 114–30.
36. Renee McDonald, Ernest N. Jouriles, Candyce D. Tart, and Laura C. Minze. "Children's adjustment problems in families characterized by men's severe violence toward women: Does other family violence matter?" *Child Abuse & Neglect* 33 (2009): 94–101.
37. Statistique Canada. *La Violence Familiale au Canada: Un profil Statistique*. Ottawa: Centre Canadien de la Statistique Juridique, 2011, p. 58.
38. Statistique Canada. *Mesures de la Violence Faite aux Femmes: Tendances Statistiques*. Ottawa: Ministre de l'Industrie, 2013, p. 130. Available online: <http://www.statcan.gc.ca/pub/85-002-x/002-x/2013001/article/11766-fra.pdf> (accessed on 18 June 2014).
39. Neil B. Guterman, and Yookyong Lee. "The role of fathers in risk for physical child abuse and neglect: Possible pathways and unanswered questions." *Child Maltreatment* 10 (2005): 136–49.
40. Association des centres jeunesse du Québec. *Bilan des Directeurs de la Protection de la jeunesse/Directeurs Provinciaux 2011*. Québec: Association des centres jeunesse du Québec, 2012, p. 60.
41. Michael N. Stiffman, Patricia G. Schnitzer, Patricia Adam, Robin L. Kruse, and Bernard G. Ewigman. "Household composition and risk of fatal child maltreatment." *Pediatrics* 109 (2002): 615–21.
42. Karen M. Devries, Joelle Y. Mak, Loraine J. Bacchus, Jennifer C. Child, Gail Falder, Max Petzold, Jill Astbury, and Charlotte H. Watts. "Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies." *PLOS Medicine* 10 (2013): 1–11.
43. Organisation Mondiale de la Santé. "La violence à l'encontre des femmes: Violence d'un partenaire intime et violence sexuelle à l'encontre des femmes." 1 October 2013. Available online: <http://www.who.int/mediacentre/factsheets/fs239/fr/> (accessed on 18 June 2014).
44. Diane A. Riou, Maryse Rinfret-Raynor, and Solange Cantin. *La Violence Envers les Conjointes Dans les Couples Québécois, 1998*. Montréal: Institut de la Statistique du Québec, 2003, p. 158.
45. Judith Wuest, Marilyn Ford-Gilboe, Marilyn Merritt-Gray, Colleen Varcoe, Barbara Lent, Piotr Wilk, and Jacquelyn Campbell. "Abuse-related injury and symptoms of posttraumatic stress disorder as mechanisms of chronic pain in survivors of intimate partner violence." *Pain medicine* 10 (2009): 739–47.

46. Chantal Bourassa, Chantal Lavergne, Dominique Damant, Geneviève Lessard, and Pierre Turcotte. "Child welfare workers' practice in cases involving domestic violence." *Child Abuse Review* 17 (2008): 174–90.
47. Megan R. Holmes. "Aggressive behavior of children exposed to intimate partner violence: An examination of maternal mental health, maternal warmth and child maltreatment." *Child Abuse & Neglect* 37 (2013): 520–30.
48. Cathy Humphreys, Audrey Mullender, Ravi Thiara, and Agnes Skamballis. "Talking to my mum: Developing communication between mothers and children in the aftermath of domestic violence." *Journal of Social Work* 6 (2006): 53–63.
49. Alissa C. Huth-Bocks, Alytia A. Levendosky, Sally A. Theran, and G. Anne Bogat. "The impact of domestic violence on mothers' prenatal representations of their infants." *Infant Mental Health Journal* 25 (2004): 79–98.
50. Alissa A. Levendosky, and Sandra A. Graham-Bermann. "Parenting in battered women: The effects of domestic violence on women and their children." *Journal of Family Violence* 16 (2001): 171–92.
51. Cecilia Casanueva, Sandra L. Martin, Desmond K. Runyan, Richard P. Barth, and Robert H. Bradley. "Quality of maternal parenting among intimate-partner violence victims involved with the child welfare system." *Journal of Family Violence* 23 (2008): 413–27.
52. Édith de la Sablonnière, and Andrée Fortin. "Violence conjugale et qualité de la relation mère-enfant: Effet médiateur ou modérateur de la santé des mères?" *Canadian Journal of Behavioural Science* 42 (2010): 212–21.
53. Simon Lapierre. "Striving to be 'Good' Mothers in the Context of Domestic Violence." *Child Abuse Review* 19 (2010): 342–57.
54. Nicole L. Letourneau, Cara B. Fedick, and J. Douglas Willms. "Mothering and domestic violence: A longitudinal analysis." *Journal of Family Violence* 22 (2007): 649–59.
55. Karine Racicot, Andrée Fortin, and Christian Dagenais. "Réduire les conséquences de l'exposition de l'enfant à la violence conjugale: Pourquoi miser sur la relation mère-enfant?" *Les Cahiers Internationaux de Psychologie Sociale* 86 (2010): 321–42.
56. Lundy Bancroft, and Jay G. Silverman. *The Batterer as Parent*. Thousand Oaks: Sage Publications Inc., 2002, p. 241.
57. Simon Lapierre. "Mothering in the context of domestic violence: The pervasiveness of a deficit model of mothering." *Child and Family Social Work* 13 (2008): 454–63.
58. Marilyn Augustyn, Sean Parker, Betsy McAlister Groves, and Barry Zukerman. "Silent Victims: Children who Witness Violence." *Contemporary Pediatrics* 12 (1995): 35–57.
59. Andrée Fortin. "L'enfant exposé à la violence conjugale: Quelles difficultés et quels besoins d'aide?" *Empan* 73 (2009): 119–27.
60. Emily Israel, and Carla Stover. "Intimate partner violence: The role of the relationship between perpetrators and children who witness violence." *Journal of Interpersonal Violence* 24 (2009): 1755–64.
61. Chantal Bourassa, Pierre Turcotte, Geneviève Lessard, Nicole Létourneau, and Michel Labarre. "La paternité en contexte de violence conjugale: Le point de vue de pères participant à un groupe de thérapie." *Revue Internationale de L'éducation Familiale* 1 (2013): 149–67.

62. Geneviève Lessard, Rhéa Delisle, and Catherine Flynn. "L'importance des pratiques de collaboration pour traiter des enjeux liés à la garde des enfants à la fois maltraités et exposés à la violence conjugale." *Intervention* 127 (2007): 29–38.
63. Sonia Gauthier, and Lyse Montminy. *Expérience D'intervention Psychosociale en Contexte de Violence Conjugale*. Québec: Presses de l'Université du Québec, 2012, p. 290.
64. Marianne Hester. "The three planet model: Towards an understanding of contradictions in approaches to women and children's safety in contexts of domestic violence." *British Journal of Social Work* 41 (2011): 837–53.
65. Geneviève Lessard, Chantal Lavergne, Claire Chamberland, Dominique Damant, and Daniel Turcotte. "Conditions for resolving controversies between social actors in domestic violence and youth protection services: Toward innovative collaborative practices." *Children and Youth Services Review* 28 (2006): 511–34.
66. Elizabeth Harper. "Modèles de concertation pour les enfants exposés à la violence conjugale et les membres de leurs familles." In *Enfants à Protéger, Parents à Aider, des Univers à Rapprocher*. Edited by Claire Chamberland, Sophie Léveillé and Nico Trocmé. Québec: Presses de l'Université du Québec, 2007, pp. 278–305.
67. Nicky Stanley, and Cathy Humphreys. "Multi-Agency and Multi-Disciplinary Work: Barriers and Opportunities." In *Domestic Violence and Child Protection: Directions for Good Practice*. Edited by Cathy Humphreys and Nicky Stanley. London: Jessica Kingsley Publishers, 2006, pp. 36–52.
68. Heather Douglas, and Tamara Walsh. "Mothers, domestic violence, and child protection: Toward collaboration and engagement." *Violence against Women* 16 (2010): 537–42.
69. Sandra K. Beeman, and Jeffrey L. Edleson. "Collaborating on family safety: Challenges for children's and women's advocate." *Journal of Aggression, Maltreatment and Trauma* 3 (2000): 345–58.
70. Mary M. McKay. "The link between domestic violence and child abuse: Assessment and treatment considerations." *Child Welfare* 73 (1994): 29–39.
71. Susan Schechter, and Jeffrey L. Edelson. *Effective Interventions in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice*. Reno: The National Council of Juvenile and Family Court Judges, 1999, p. 132.
72. Marie-Eve Drouin, Anne-Sophie Germain, Pamela Alvarez-Lizotte, Yennelys Alcedo, Rhéa Delisle, Marie-France Godin, Julie Ménard, Valérie Meunier, Mélanie St-Laurent, Maryline Trottier, *et al.* "Guide D'implantation Pour une Pratique Concertée en Violence Conjugale et en Maltraitance: Agir Ensemble Pour le Mieux-Être des Enfants." Available online: [http://www.criviff.qc.ca/upload/publications/pub\\_251.pdf](http://www.criviff.qc.ca/upload/publications/pub_251.pdf) (accessed on 29 September 2014).
73. Robert Mayer, and Jean-Pierre Deslauriers. "Quelques éléments d'analyse qualitative: L'analyse de contenu, l'analyse ancrée, l'induction analytique et le récit de vie." In *Méthodes de Recherche en Intervention Sociale*. Edited by Robert Mayer, Francine Ouellet, Marie-Christine Saint-Jacques and Daniel Turcotte. Québec: Gaëtan Morin Éditeur, 2000, pp. 159–90.
74. Janet E. Findlater, and Susan Kelly. "Child protective services and domestic violence." *The Future of Children* 9 (1999): 84–96.
75. Carolyn C. Hartley. "The Co-Occurrence of Child Maltreatment and Domestic Violence: Examining both Neglect and Child Physical Abuse." *Child Maltreatment* 7 (2002): 349–58.

76. Joy D. Osofsky. “Prevalence of children’s exposure to domestic violence and child maltreatment: Implications for prevention and intervention.” *Clinical Child and Family Psychology Review* 6 (2003): 161–70.

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