Restorative Justice for Domestic Violence Offenders: A White Paper on An Evidence-Informed Assessment

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Executive Summary

This white paper revisits the potential role of restorative justice (RJ) in domestic violence (DV) offender treatment, following the Colorado Domestic Violence Offender Management Board (DVOMB) **2020 conclusion that RJ lacked sufficient empirical support** for widespread use. While evidence remains limited and debate continues, the paper examines whether carefully structured, RJ-informed practices could responsibly complement Colorado's existing DV treatment system—particularly in later treatment phases or in cases involving co-parenting—while prioritizing victim safety.

Colorado's DVOMB model has evolved well beyond traditional batterer intervention programs. It now operates under a structured, individualized, research-informed framework grounded in the Risk-Need-Responsivity (RNR) model. **Crucially, the model has been recognized by experts as strictly adhering to the Principles of Effective Intervention (PEI)**, setting it apart as a model for effective, evidence-based treatment. This framework emphasizes individualized treatment based on risk of reoffending, criminogenic needs, and responsivity factors, while embedding accountability, behavioral change, victim-centeredness, and restorative-aligned practices.

Colorado's statutory and regulatory system provides the framework, support, and enforcement mechanism for this rigor. It includes standardized risk assessments, approved providers, and evidence-informed treatment, thereby providing system-wide regulatory accountability, preventing therapeutic drift. Crucially, the system statutorily limits direct victim participation in offender treatment (e.g., joint sessions), to maintain treatment focus solely on offender accountability (vs. relational dynamics). Nonetheless, victim voice and safety are supported through the mandated use of Treatment Victim Advocates (TVAs), who advise victims and ensure their perspective is represented in coordinated risk management and treatment should they wish. Any victim involvement is entirely voluntary and based on informed consent, ensuring victim choice and autonomy remain paramount.

Effectiveness in DV treatment is multidimensional, encompassing recidivism, engagement, behavioral change, desistance, and victim well-being. Research supports the RNR model's rigor, with meta-analyses of both criminal justice and domestic violence offender treatment program evaluations showing stronger reductions in recidivism when principles are followed. Although Colorado lacks a statewide outcome study, the 2023 launch of a new data collection system provides the infrastructure to assess treatment retention, behavioral change, and—over time—recidivism outcomes.

As both a philosophy and intervention, restorative justice emphasizes healing, accountability, and community engagement. RJ models such as Victim-Offender Dialogue (VOD), Restorative Justice Conferences (RJCs), Circles of Peace (CoP), and Healing Circles (HC) share core requirements: voluntary participation, skilled facilitation, victim autonomy, and thorough

preparation. These requirements are particularly critical in DV contexts, where coercive control and ongoing risks remain high.

The evidence base for RJ in DV contexts is promising but mixed; in most respects, enthusiasm for RJ in DV contexts currently outpaces the strength of the empirical evidence. Some studies report reduced arrests and greater victim satisfaction; however, methodological limitations—including a notable scarcity of evaluations assessing recidivism effects or longer-term victim outcomes—along with small sample sizes, selection bias, inconsistent model fidelity, and lack of comparison groups—limit conclusions and generalizability. Stakeholder perspectives reflect this tension: many see potential for victim healing and enhanced accountability, but concerns persist about victim safety, offender manipulation (a core criminogenic need), and system readiness.

Colorado's victim clarification process is a well-established and regulated aspect of sex offense-specific treatment that provides a practical case study for adaptation. This model operates with strong professional consensus that, when properly structured and implemented with rigorous clinical oversight, it is highly beneficial promoting victim empowerment and offender accountability. This structured, victim-sensitive intervention emphasizes rigorous preparation, clinical gatekeeping, and victim agency. Transferable lessons for DV treatment include the importance of preparation, recognition that not all cases are appropriate, victim choice as central, and strengthened outcomes through multidisciplinary collaboration.

In conclusion, RJ should not replace established DV treatment but may play a **complementary role** within Colorado's tightly regulated framework. Clarification is the most viable entry point: it embeds RJ principles into existing infrastructure, broadens victim choice, and avoids coercion by requiring offender progress, readiness, and victim consent. Policy recommendations include expanding clarification interventions, piloting clarification-based RJ protocols during later treatment phases, establishing clear eligibility and oversight protocols, providing specialized training, and building robust outcome monitoring systems that track process fidelity and victim-centered outcomes. A cautious, incremental approach offers a responsible pathway to advance accountability, healing, and justice in DV cases without compromising victim safety or the rigor of established treatment standards.

Introduction

Why Consider Restorative Justice in Domestic Violence Offender Treatment?

In 2020, the Colorado Domestic Violence Offender Management Board (DVOMB) published a white paper examining the potential role of restorative justice (RJ) in domestic violence (DV) offender treatment. The paper, *Public Safety Considerations and Policy Implications with Restorative Justice in Domestic Violence Cases* was approved by the DVOMB on December 15, 2020. At that time, the Board concluded that despite growing interest, RJ lacked sufficient empirical support to be used as a replacement for, or even a complement to, established DV treatment models. The findings highlighted significant legal, ethical, and safety concerns—particularly regarding the lack of regulatory safeguards and the potential risks to victims.[1] Nevertheless, the Board expressed a commitment to revisiting the issues as additional evidence became available.

Since the publication of that paper, interest in RJ has continued to expand, though the field remains marked by debate and limited empirical evaluation. This ongoing discussion provides an opportunity to revisit RJ's potential role in DV offender treatment. The aim here is not to present RJ as an alternative to existing treatment, nor as universally applicable. Rather, the intent is to examine whether, under specific and well-defined conditions, RJ practices might appropriately complement established treatment models. RJ's focus on accountability, repair of harm, and victim inclusion aligns with values already central to the DVOMB treatment framework, indicating possible areas of alignment worth exploring.

Additionally, a new DVOMB data collection mandate—absent at the time of the original white paper—now creates the capacity for systematic evaluation of modifications to the standards. This development positions the Board to rigorously assess innovations and strengthen evidence-based enhancements to treatment (Collie et al., 2024a, 2025).

Purpose of this White Paper

This revised white paper analyzes the potential relevance of RJ in DV offender treatment, drawing on recent research, stakeholder perspectives, and the Board's reinforced commitment to victim-centered care. Rather than advocating for broad adoption, it explores whether, and under what circumstances, RJ-informed strategies might responsibly enhance offender accountability and victim agency—particularly in later phases of treatment or in cases involving ongoing relationships (e.g., co-parenting). Nonetheless, any consideration of

[1] In many contexts, the term "survivor" is preferred to emphasize resilience and autonomy. However, within the DVOMB framework, the term "victim" is used for consistency with statutory language (e.g., the Victim Rights Act) and established terminology such as Treatment Victim Advocate (TVA).

RJ must remain firmly anchored in an unwavering commitment to victim safety, dignity, and self-determination. Given the inherent power and control dynamics in DV, any RJ practices must be deliberately structured, carefully monitored, and designed to prevent coercion or retraumatization.

Colorado Domestic Violence Treatment Model: A Contemporary Innovative Approach

DVOMB Standards and Guidelines

In exploring RJ as an approach to DV treatment, it is essential to first define what Colorado's DVOMB domestic violence treatment model entails. RJ is often presented as a response to concerns about outdated or overly uniform batterer intervention programs (Cissner et al., 2019; Pennell et al., 2021). However, such comparisons may be less relevant in Colorado which has significantly evolved beyond those early models. The DVOMB has developed a structured, individualized, and research-informed framework that reflects national best practices. **Crucially, the Colorado model has been recognized by experts in the field as adhering to the Principles of Effective Intervention** (Richards et al., 2021; Radatz et al., 2021), setting it apart as a model for effective, evidence-based treatment. The framework and policies are outlined in the *Colorado Domestic Violence Offender Management Board Standards and Guidelines for the Assessment, Evaluation, Treatment, and Behavioral Monitoring of Domestic Violence Offenders.*[2] Its core principles emphasize accountability, behavioral change, and victim safety through clinically guided intervention.

Developed and overseen by the Colorado DVOMB, the state's domestic violence treatment model is a rehabilitative, community-based clinical response, rather than a punitive or carceral one. Since 2010, it has been grounded in the **Risk-Need-Responsivity (RNR)** model, which requires individualized treatment planning based on three core principles that collectively form the most empirically supported framework for reducing recidivism:

- **Risk Principle**: Assess the likelihood of reoffending using validated instruments and match the intensity of treatment and supervision to the individual's risk level. Within the *Standards and Guidelines*, this is reflected in three tiers of treatment intensity, **with higher-risk offenders assigned to levels requiring greater intensity and duration**.
- **Need Principle**: Focus treatment on domestic violence-specific criminogenic needs—clinical problems strongly associated with abusive behavior and recidivism. While non criminogenic needs may involve legitimate clinical concerns, they have little

[2] Hereafter referred to as the *Standards and Guidelines*, for brevity.

demonstrated link to reoffending and should not be the predominant focus of offense-specific treatment.

- **Responsivity Principle**: Maximize effectiveness by tailoring treatment to individual characteristics that influence engagement and response (e.g., learning style, cognitive abilities, motivation, culture, or mental health). In the *Standards and Guidelines*, this may involve adapting the treatment approach or using adjunct services to address barriers to participation and learning. For example, gender-specific groups are required, and providers are encouraged to tailor treatment to participants' primary language and cultural context whenever possible.

In the *Standards and Guidelines*, criminogenic needs are addressed through individualized treatment competencies that set clear expectations for accountability, skill acquisition, and behavioral change, thereby structuring the focus of treatment. This competency-based approach prevents therapeutic drift and ensures that time and resources are focused exclusively on the drivers of domestic violence behavior. This provides a level of rigor often absent in non-mandated community programs that operate without the regulatory oversight and required treatment standards provided by the DVOMB.

Treatment is dynamic rather than static. It is adapted over time through regular reassessment and multidisciplinary team review, integrates trauma-informed practices, and recognizes DV as a pattern of coercive behavior that involves multiple forms of abuse and violence, rather than a one-time incident. The use of treatment competencies guides every phase of treatment. By anchoring clinical decisions in these standards, the model ensures consistency and progress monitoring, and links directly to outcomes that reduce participants' risk of recidivism while also prioritizing victim and community safety.

Key features of the Colorado DV treatment model include:

- **Individualized treatment matching:** Services are aligned with participants' risk levels and criminogenic needs, guided by comprehensive evaluation using the Domestic Violence Risk and Needs Assessment (DVRNA) and other instruments.[3] Treatment competencies link directly to identified needs and behavioral goals.
- **Accountability and behavioral change:** Offenders are expected to confront harmful beliefs, take full responsibility, and demonstrate sustained change through structured cognitive-behavioral strategies. Progress is tracked through ongoing assessment of treatment competencies and reassessment of risk.

[3] The DVOMB requires that evaluations include a comprehensive risk-need assessment using the Domestic Violence Risk and Needs Assessment (DVRNA; Colorado Domestic Violence Offender Management Board [DVOMB], 2016). Additional instruments may be required under specific circumstances, as outlined in Section 4.05 of the *Standards and Guidelines*.

- **Restorative-aligned tools:** When appropriate, practices such as accountability letters and victim-impact role-plays may be integrated into treatment to promote empathy, reflection, and accountability.

- **Embedded victim-centeredness:** While victims are not direct participants in treatment, providers must coordinate with treatment victim advocates, integrate victim input through Multidisciplinary Treatment Teams (MTTs), and prioritize safety planning.

Colorado's DVOMB treatment model already incorporates several principles consistent with restorative justice—such as accountability, harm recognition, and behavioral repair—within a tightly regulated clinical and public safety framework. While not an RJ model, it offers a flexible and principled foundation for exploring complementary practices, provided they are supported by evidence and grounded in victim safety.

Statutory and Regulatory Framework

A notable feature of DV offender treatment in Colorado is its foundation in a comprehensive statutory framework, which provides system-wide regulatory accountability. § 16-11.8-101, C.R.S. established the DVOMB in 2000 as a multidisciplinary board with the authority and responsibility to develop and oversee the statewide *Standards and Guidelines* for domestic violence offender treatment and supervision.

This statutory and regulatory framework establishes several key requirements, including:

- **Standardized Risk Assessment**: All court-ordered DV treatment begins with a comprehensive intake evaluation, including a risk-needs assessment using the DVRNA. This process ensures treatment is individualized and grounded in the RNR model, minimizing arbitrary decision-making.

- **Approved Providers**: Only DVOMB-approved providers may deliver court-ordered DV treatment. Approved providers must meet rigorous qualifications related to education, training, professional licensure, and ongoing supervision, thereby guaranteeing a high level of clinical competence and treatment fidelity across the state.

- **Evidence-Informed Treatment**: Treatment must be grounded in research and best practices. This prevents therapeutic drift by mandating differentiated treatment based on risk level, use of cognitive-behavioral and psychoeducational approaches, and ongoing progress monitoring by a Multidisciplinary Treatment Team (MTT).

- **Treatment Victim Advocates (TVAs)**: Victim advocacy is a required component. Each MTT must include a qualified TVA that serves in a capacity to provide community-based victim advocacy services that are enumerated in § 13-90-107, C.R.S.

They contribute to shared decision-making and coordinated risk management to enhance victim and community safety. TVAs provide a means for victims' perspectives to be represented in the MTT process and also bring forward the broader experiences and concerns of victims, whether or not a specific victim chooses to engage in services.

In addition to establishing treatment protocols, Colorado law imposes specific legal restrictions that shape the scope and structure of DV offender treatment:

- **Limitations on Direct Victim Participation**: Under both statute and DVOMB Standards,[4] victims are not to be directly involved in offender treatment (e.g., joint sessions or mediated dialogues). This restriction is in place to protect victim safety, prevent coercion, and ensure that treatment remains focused on the offender's accountability and responsibility for their violent behavior—not on repairing or managing the relationship.

- **Voluntariness and Informed Consent**: Any non-mandated adjunct process, such as restorative justice, requires informed consent and therefore must be entirely voluntary for all parties. Particular care must be given to victims, as the coercive dynamic typically present in DV cases makes ensuring true voluntariness both complex and critical.[5]

- **Confidentiality and Information Sharing**: The DVOMB framework includes detailed requirements for confidentiality, duty to warn, reporting suspected abuse or neglect of children, and information sharing among treatment providers, TVAs, probation, and law enforcement, and other victim services. For **offender clients**, confidentiality is limited and explicitly defined within the treatment contract to support coordinated risk management and compliance with applicable legal and professional obligations.[6] For **victims**, confidentiality is protected under community-based victim advocacy laws and ethical standards, and information is shared only with the victim's permission or

[4] Per C.R.S. 18-1.3-104(1)(b.5)(I): A defendant is not eligible for restorative justice practices if they have been convicted of any of the following: (i) unlawful sexual behavior (as defined in section 16-22-102(9)); (ii) a crime involving an underlying factual basis of domestic violence (as defined in section 18-6-800.3(1)); (iii) stalking (as defined in section 18-3-602), or (iv) violation of a protection order (as defined in section 18-6-803.5).
[5] §12-43-214, C.R.S. establishes mandatory disclosure requirements for licensed mental health professionals at the outset of treatment, including provisions related to informed consent. Because voluntariness is a fundamental element of giving consent,it follows that voluntariness is both a legal requirement under Colorado law and an ethical responsibility for all licensed mental health professionals.
[6] See Section 10.0 Administrative Standards of the *Standards and Guidelines*.

under legally defined exceptions (e.g., duty to warn, imminent safety concerns, or mandatory reporting).[7]

Implications for RJ in a Regulated Environment

The structured and regulated nature of Colorado's DVOMB treatment model has distinct strengths that could support exploring RJ in this context. Its established infrastructure—qualified providers and TVAs, standardized assessment procedures, standards-based offender treatment, and coordinated victim safety efforts—creates a potential platform for piloting or integrating RJ-aligned practices under careful oversight.

At the same time, any application of RJ must operate within statutory, regulatory, and ethical boundaries. Approaches involving direct victim participation or deviation from the approved treatment framework require particular caution. For RJ to be implemented in DV cases, efforts would need to align with the values and practices embedded in the DVOMB *Standards and Guidelines*. In addition, modifications to the *Standards and Guidelines*—and potentially to statute—would likely be necessary. Such modifications should address eligibility parameters, strengthen practice safeguards, and ensure a robust system of evaluation and monitoring so that safety, voluntariness, and victim-centeredness remain paramount.

Evaluating DV Treatment Program Effectiveness

Understanding what makes DV treatment "effective" is essential. It shapes judgments about Colorado's current DV treatment model and provides a foundation for evaluating whether and how RJ practices could add value. Yet defining and measuring effectiveness in DV treatment is complex. Unlike treatments for general behavioral health issues, DV treatment operates within a criminal-legal framework that prioritizes public safety, offender accountability, and victim protection. Effectiveness must therefore be understood in multi-dimensional terms (Campbell et al., 2024; Capaldi et al., 2016; Gannon et al., 2019; LeBlanc & Mong, 2021; Olver et al., 2011). Typical indicators include:

- **Recidivism**: Reductions in reoffending (short- and long-term), measured through new criminal charges and convictions, probation violations, or protection order breaches.
- **Engagement and Retention**: Consistent participation in treatment, completion rates, and responsiveness to therapeutic tasks.

[7] Section 7.06 of the Standards and Guidelines specifies that TVAs function as community-based victim advocates, as defined in § 13-90-107, C.R.S. and therefore possess the statutory privileges and confidentiality protections established under that statute.

- **Behavioral and Attitudinal Change**: Demonstrated improvements in treatment competencies, including attitudinal change, relationship skills, and reductions in controlling or abusive behaviors.[8]

As well, desistance and victim well-being are also important outcome considerations, although usually harder to capture and not typically part of treatment outcome evaluations (Cheng et al., 2021; McGinn et al., 2016).

Research Review

Adherence to evidence-based frameworks is one means of having confidence in a treatment approach is one means of having confidence in a treatment approach when a direct program outcome evaluation is unavailable (APA, 2002, 2019; Satterfield et al., 2009; Taft & Campbell, 2024). The most widely accepted evidence-based model in offender rehabilitation is the RNR model (Andrews & Bonta, 2010; Bonta & Andrews, 2024). A growing body of meta-analytic research supports its utility in the treatment of DV offenders as well as with offender rehabilitation more generally (Radatz et al., 2021). Travers et al. (2021) conducted a comprehensive meta-analysis of DV treatment that examined RNR adherence as a moderator of treatment effectiveness. Their findings showed that programs fully aligned with RNR principles achieved the strongest reductions in recidivism: two years after treatment, fully adherent programs had a 7% recidivism rate compared to 19.6% in untreated groups. Programs that partially adhered also reduced reoffending, though less effectively, while "one-size-fits-all" programs without adherence to RNR principles showed no significant effects. These results underscore the importance of tailoring treatment intensity and focus to risk, criminogenic needs, and responsivity factors rather than applying generic interventions.

Other meta-analyses reinforce these conclusions. Gannon et al. (2019) found a significant treatment effect for DV programs, with treated offenders showing a 15.5% recidivism rate over five years compared to 24.2% for untreated groups. Importantly, they identified greater effectiveness in programs that maintained strong program integrity, such as consistent involvement of qualified practitioners. Similarly, Cheng et al. (2021) reviewed more recent evaluations and found DV treatment effective in reducing both DV-specific and general recidivism, lending further support to the role of structured intervention. In contrast, Wilson et al. (2021) reported smaller and non-significant effects in their meta-analysis; however, this study relied heavily on pre-2003 evaluations of outdated intervention models, approaches that differ significantly from Colorado's standards-based approach, and have been shown to have minimal impact (e.g., Miller et al., 2013). Taken together, these reviews demonstrate that when DV treatments are contemporary, structured, and adhere to evidence-based models such as RNR, measurable reductions in reoffending are achieved.

[8] These, in turn, are expected to relate to improvements in the risk factors associated with the individual's domestic violence.

While recidivism remains a key benchmark, its limitations are recognized. Official records capture only detected and legally substantiated incidents, underestimating the scope of ongoing abuse, especially non-physical forms such as coercive control, psychological harm, or financial manipulation. Many harmful behaviors may never result in criminal charges, yet still reflect persistent patterns of violence. For this reason, victim-reported outcomes, harder to collect, provide critical insight into whether treatment translates into meaningful change (McGinn et al., 2016). This speaks to the inherent complexity of evaluating DV treatment outcomes and the need for careful consideration and multiple layers of evaluation before deviating from established best practices.

With respect to the Colorado DVOMB, while a formal treatment outcome study has not yet been conducted, important steps have been taken to establish the foundation for such evaluation. In 2022, the Colorado General Assembly approved HB 22-1210, authorizing the creation of a comprehensive data collection system. Pursuant to § 16-11.8-103 (4)(a)(IV) and (5.5), C.R.S., the DVOMB implemented this system on January 1, 2023. The system provides standardized information on the number of individuals who received DV offender treatment in the preceding year and their discharge type (e.g., successful completion, unsuccessful discharge). Initial findings, summarized in the DVOMB 2024 and 2025 Annual Legislative Reports (Collie et al. 2024, 2025), allow for systematic review of treatment retention and indicators of behavioral and attitudinal change.

Even with these advancements, gaps remain, which underscores the importance of ongoing innovation and rigorous evaluation. Within this context, RJ-informed practices may offer value—not as replacements for treatment, but as supplemental tools that promote deeper accountability, reflection, and support healing. However, given the evidence-based rigor of the RNR model and the PEI framework that guides Colorado's *Standards and Guidelines*, any integration of RJ must be rigorously scrutinized. Any such integration must be subject to the same standards of effectiveness that guide existing DV treatment, including demonstrated impact on behavioral change, harm reduction, and adherence to the core principles of safety, equity, and accountability.

Restorative Justice

Principles and Practice Models

Restorative justice (RJ) is both a philosophy of justice and a collection of intervention models that prioritize healing, accountability, and community engagement in response to harm. Rather than emphasizing punishment or legal retribution, RJ focuses on repairing harm through processes that involve victims, offenders, and community members in dialogue and accountability (Campbell et al., 2024). Core principles include:

- **Repairing Harm**: Addressing the impact of wrongdoing on individuals and communities.
- **Direct Accountability**: Encouraging offenders to acknowledge their actions, understand their impact, and take meaningful steps toward accountability.
- **Inclusive Dialogue**: Fostering open dialogue among all affected parties in facilitated settings.
- **Community Engagement**: Involving the broader community in healing, support, and reintegration.

However, in the context of domestic violence, the principle of **direct accountability** must be carefully guarded against offender manipulation and minimization, which are core criminogenic needs. Without mandatory clinical and legal oversight, RJ processes may inadvertently become a platform for offenders to re-establish coercive control or feign remorse to achieve a desired outcome, thereby compromising victim safety and the integrity of the process.

While not a single, uniform program, several RJ models have emerged in both criminal and community contexts (Campbell et al., 2024). Common approaches include:

- **Victim-Offender Dialogue (VOD)**: A structured, face-to-face meeting between a victim and offender, facilitated by a trained mediator, used when both parties voluntarily participate and the offender accepts responsibility.
- **Restorative Justice Conferences (RJCs)**: Meetings involving the victim, offender, family members, and sometimes community representatives, aimed at exploring the impact and agreeing on steps toward repair.
- **Circles of Peace (CoP)**: A community-based model in which offenders, support persons, and facilitators meet over multiple sessions to foster accountability and strengthen connections; in some adaptations, victims or proxies may participate.
- **Healing Circles (HC)**: Rooted in Indigenous or culturally specific traditions, these circles bring together victims, offenders, and their networks in a process of collective problem-solving, reflection, and healing.

Each model varies in structure, cultural orientation, and formality, but all are grounded in RJ principles (Barocas et al., 2020). In sensitive contexts such as DV, successful practice depends on non-negotiable conditions to safeguard integrity and outcomes, including:

- **Voluntary Participation**: All parties, especially victims, must participate freely and without pressure; any coercion undermines legitimacy and safety.

- **Skilled Facilitation**: Trained facilitators are essential to ensure emotional safety, support productive dialogue, and navigate complex relational dynamics.
- **Victim Safety and Autonomy**: Processes must prevent re-traumatization, protect against coercive control, and support the victim's physical, emotional, and psychological well-being.
- **Thorough Preparation**: Careful screening and pre-conference preparation are critical to assess suitability, establish boundaries, and ensure informed consent.

These safeguards are particularly critical in DV cases, where power imbalances, ongoing risks, and complex relational dynamics heighten vulnerability (Gang et al., 2021).

Empirical Research

Program Evaluations

While RJ has been extensively studied in areas such as juvenile justice and non-violent crime (e.g., Islam et al., 2023; Nascimento et al., 2023; Sherman et al., 2015), evidence for its effectiveness in DV contexts remains limited and mixed. Few jurisdictions have systematically implemented or rigorously evaluated RJ programs for DV. Emerging efforts are summarized in Table 1, with key findings highlighted below:

- **Mills et al. (2019)**: One of the only randomized controlled trials conducted, this study examined a hybrid model combining a traditional Batterer Intervention Program (BIP) with Circles of Peace. Offenders in the hybrid program showed a 53% reduction in any new arrests—inclusive of DV arrests—and a 52% reduction in crime severity over 24 months, outperforming BIP alone. However, the study did not separate DV from non-DV recidivism.
- **Mills et al. (2013)**: In an earlier study comparing a standalone Circles of Peace to a BIP, offenders in the RJ program had a lower non-DV rearrest rate over 12 months but no significant difference longer term or in DV recidivism.
- **Lawler et al. (2025)**: Evaluating Phase Three of the Australian Capital Territory (ACT) Restorative Justice Scheme, which included DV and family violence cases, the study found victim satisfaction and increased perceptions of safety, along with significantly lower violent recidivism among adult offenders compared to a matched control. Limitations included a small DV-specific sample, limited evaluation of DV cases, lack of follow-up, and COVID-19 disruptions.
- **Payne (2018) & Davis (2009)**: Both studies reported no significant differences in recidivism among offenders attending RJ and either BIPs or traditional prosecution.

- **Kettrey and Reynolds (2024)**: A meta-analysis incorporating three of these DV recidivism studies and a study involving juvenile sexual assault cases, found a small but statistically significant positive effect of RJ on recidivism reduction.

- **Kerrigan & Mankowski (2021); Zosky (2018):** Studies on surrogate victim panels—used when direct victim-offender dialogue was not feasible—indicated promising effects on participants' awareness and understanding of harm, though little is known about long-term impacts on behavior change, program completion, or recidivism.

Overall, the current evidence base is sparse, with some promising findings but also methodological limitations and inconsistent results. More rigorous, DV-specific evaluations are needed to determine when, how, and for whom RJ may be a safe and effective complement to existing interventions. Further attention is also needed to better understand cases deemed unsuitable, declination rates, no-shows, and their outcomes.

Stakeholder Perspectives

Stakeholders' perspectives provide important insight into the practical and ethical considerations of using RJ in DV cases, with critical studies in this area summarized in Table 2. Across studies, a range of stakeholders have expressed both optimism and caution. Many highlighted RJ's potential to promote victim healing, enhance accountability, and motivate offenders to take responsibility (e.g., Barocas et al., 2024). At the same time, concerns were raised about victim safety, the potential for offender manipulation, and whether systems are adequately prepared to implement RJ with fidelity. These considerations closely mirror the central issues outlined in the original DVOMB white paper, which emphasized the significant legal, ethical, and safety risks to victims, particularly when RJ practices are implemented without clear regulatory standards and oversight.

Campbell et al. (2023) emphasized the institutional and cultural barriers to implementing RJ, including adversarial legal norms and insufficient practitioner training. Complementing these findings, Barocas et al. (2022) and Decker et al. (2022) highlighted widespread frustration with the limitations of traditional BIPs and the broader criminal justice system. Victim perspectives added further nuance, underscoring the importance of RJ models that prioritize safety, choice, and meaningful accountability. In Decker et al. (2022), victims expressed a strong preference for rehabilitative and relational approaches over punitive responses. Community-specific perspectives also emerged: Zakheim (2011) advocated for Healing Circles as a culturally appropriate alternative to BIPs in Orthodox Jewish communities, while Dickson-Gilmore (2014) highlighted both the potential and complexity of RJ in Aboriginal contexts, where historical trauma and communal pressures present unique implementation challenges.

In a comprehensive national survey, Cissner et al. (2019) examined RJ programs employing restorative, Indigenous, and transformative justice approaches to address intimate partner

violence or sexual assault within the United States. Findings revealed wide variation in program scope, structure, and referral pathways. Interventions ranged from single-session models to weekly meetings over 12 months, with an average completion time of 216 days (median = 158 days). While many programs received referrals from criminal justice or child protection systems, it was often unclear whether participants had formal DV convictions or whether intimate partner violence was explicitly identified during service engagement. This variability underscores both the strengths of flexible, community-driven models and the persistent challenges of establishing standardized practices and rigorous evaluation frameworks.

Methodological Limitations

Despite some encouraging findings, the literature on RJ in DV contexts remains constrained by several recurring methodological challenges:

- **Small sample sizes** and **selective inclusion criteria** that limit generalizability.
- **Selection bias**, particularly in studies restricted to voluntary participants deemed "safe" or "low-risk."
- **Inconsistent or unknown fidelity to RJ models**, with wide variation in program structures, durations, and delivery.
- High rates of both **program declination** and **non-completion** are rarely analyzed in depth.
- **Lack of comparison groups** makes it difficult to disentangle the effects of RJ from other programmatic elements or contextual influences.

In addition, most studies focus on short-term outcomes related to participant satisfaction with the RJ process, with little longitudinal data to assess whether RJ contributes to lasting desistance from abuse or sustained victim well-being. This leaves a substantial gap in rigorous, comparative effectiveness research—particularly in relation to established DV treatment models. Victim-centered outcomes such as long-term safety, emotional health, and autonomy remain especially under examined. Few studies assess victim-defined markers of healing or justice, and even fewer incorporate diverse populations or culturally specific approaches.

Further research is needed to explore:

- The integration of RJ as a supplemental component rather than a standalone or diversionary intervention.
- The implementation of RJ within regulated treatment systems that prioritize public safety and clinical accountability.

- The ethical implications of offering RJ in contexts shaped by persistent power imbalances and histories of coercion.

Until these gaps are systematically addressed, findings should be interpreted with caution, and generalizations about the effectiveness of RJ in DV contexts remain premature.

Summary: Assessing Viability

Taken together, current research and stakeholder perspectives reveal a field with considerable promise but limited readiness for widespread adoption. RJ shows conceptual appeal and preliminary evidence of benefits in DV contexts—including increased offender accountability, reduced recidivism in select studies, and high participant satisfaction. Yet its implementation remains uneven, fragmented, and under-evaluated. Most programs operate outside formal justice and treatment systems, shaped by local conditions, resource constraints, and divergent interpretations of accountability. Victim and culturally specific communities continue to call for more relational, healing-centered responses; however, the structures required to deliver these safely and with fidelity are still emerging.

Persistent methodological limitations—such as small samples, lack of comparison groups, inconsistent model fidelity, and limited attention to long-term or victim-centered outcomes—undermine the evidence base. Combined with ongoing concerns about few if any regulatory mechanisms, system readiness, safety, and ethical implementation, these gaps suggest that RJ is not yet appropriate for broad or standalone integration into DV treatment. A cautious, incremental approach may be more viable, such as piloting RJ-informed components within established, regulated treatment frameworks. Moving forward, progress will depend on greater conceptual clarity, more rigorous empirical evaluation, and the development of policy and practice infrastructures capable of supporting safe, victim-centered, and accountable implementation.

Case Study: Colorado’s Sex Offense Specific Treatment

Victim Clarification

The victim clarification process used in Colorado’s sex offense-specific treatment offers a compelling case study for informing incremental and careful RJ applications in DV treatment contexts. Grounded in statutory and treatment standards established by the Colorado Sex Offender Management Board (SOMB), clarification is a structured, victim-sensitive process designed to foster offender accountability while supporting potential healing for victims.

Clarification is a formal therapeutic intervention in which individuals who have committed sexual offenses take full responsibility for the harm they caused (Collie et al., 2024b). The

process typically begins with the preparation of a written letter that acknowledges the abusive behavior and its impact, which may then be shared with the victim. When clinically appropriate, clarification can progress to a facilitated face-to-face dialogue between the offender and the victim. Victim participation is always voluntary; they may choose to receive the letter, attend a clarification session, or decline involvement altogether. Throughout the process, victims are consulted and supported either by the case's designated SOMB Victim Representative and/or their own victim therapist.

The clarification process is deliberately structured to remain victim-centered, prioritizing safety and the victim's best interests. For offenders, it serves as a therapeutic tool to challenge cognitive distortions, deepen empathy, and reinforce accountability. For victims, it may help reduce self-blame, validate their experiences, and provide an opportunity to ask questions and receive acknowledgment. While sharing similarities with restorative justice principles, clarification is firmly grounded in offense-specific treatment and carried out under strict clinical and statutory safeguards (De Maio et al., 2006).

SOMB Standards and Guidelines outline the requirements for clarification and reinforce safeguards, especially in cases involving intrafamilial or ongoing relationships. Participation is always voluntary for victims and contingent on clinical assessment of the offender's progress, remorse, and risk to reoffend. Preconditions include:

- Completion of treatment milestones (e.g., full acceptance of responsibility, internalizing relapse prevention planning)
- Victim readiness and voluntary participation
- Coordination between treatment providers, supervising officers, and the victim representative

Evaluation Insights

A research review and statewide provider survey conducted for the SOMB Victim Advocacy Committee found that although direct research on victims' experience is limited, related studies and clinical feedback indicate clarification can be empowering and beneficial when implemented with care (Collie et al., 2024b). Providers identified several elements critical to positive outcomes, including:

- Offender accountability
- Victim choice
- Thorough preparation
- Strong clinical oversight.

These findings align with De Maio et al. (2006), who reported broad consensus among sex offender treatment providers that clarification, when properly structured, supports victim empowerment.[9] Additional studies (Burns & Sinko, 2023; Harper, 2012; Paige & Thornton, 2015) further highlight the importance of preparation and responsiveness to victim needs.

Although RJ differs from clarification, parallels are evident. Research on RJ with victims of sexual violence (Julich et al., 2010; Koss, 2014) demonstrates that voluntary, well-structured processes can yield high victim satisfaction, reduced trauma symptoms, and increased perceptions of safety. These outcomes were most likely when offenders demonstrated genuine accountability, victims had opportunities to articulate the impact of harm, and trained facilitators provided extensive preparation and support.

What Clarification May Add to Domestic Violence Treatment

As outlined above, enthusiasm for RJ in DV contexts currently outpaces the strength of the empirical evidence. While RJ demonstrates conceptual promise and positive findings in some studies, research remains limited, uneven, and methodologically constrained. In contrast, Colorado's DV treatment system is already highly structured and regulated, guided by established standards and clinical accountability mechanisms. This contrast suggests that the most responsible path forward is not broad adoption of RJ as a standalone alternative, but rather incremental, carefully piloted integration within existing treatment frameworks.

When implemented in appropriate cases with appropriate safeguards, RJ may complement DV treatment in several important ways:

- **Enhanced offender accountability and empathy**: RJ requires individuals to directly confront the impact of their behaviors, which may deepen responsibility-taking and foster genuine empathy.
- **Victim voice and agency**: RJ processes create opportunities for victims to share their experiences, receive acknowledgment, and influence outcomes in ways often limited in traditional justice and treatment systems.
- **Cultural and community responsiveness**: RJ's flexibility allows for culturally grounded adaptations, offering relevance to communities underserved or alienated by the legal system.

RJ also aligns with many elements already embedded in Colorado's DV model, such as the use of TVAs, safety planning, and victim notification. Both frameworks emphasize respect for victim autonomy, recognition of harm, and individualized accountability. Integrating

[9] De Maio et al. (2006) conducted a survey of 386 members of the Association for the Treatment of Sexual Abusers (ATSA) who had experience using victim clarification sessions in cases involving intrafamilial sexual offending.

RJ-informed practices could extend these principles by broadening victim choices, supporting relational healing, and accommodating culturally specific needs.

Still, these potential benefits must be weighed against critical risks:

- **Voluntariness vs. coercion**: DV treatment is court-mandated, while RJ is voluntary. This creates ethical tensions, particularly due to the impact of coercive control.
- **Risk of re-traumatization**: Poorly designed or system-driven RJ may pressure victims to participate or expose them to emotional harm.
- **Misalignment with legal mandates**: Without strong oversight, RJ risks prioritizing offender rehabilitation or system efficiency over victim safety and healing.

Lessons for RJ in DVOMB Treatment

Colorado's victim clarification process in sex offense-specific treatment provides a concrete example of how RJ-aligned practices can be operationalized within a regulated system. Several key lessons are directly transferable to DV contexts:

- **Rigorous preparation and gatekeeping are essential**: Clarification only occurs after offender progress in treatment, careful assessment of offender readiness, victim-informed timing, and thorough preparation. These safeguards are critical to ensuring the process remains safe and effective.
- **Not all cases are appropriate**: While letter-writing is required for all offenders in treatment, face-to-face clarification sessions are carefully screened, selective, and never mandated. This underscores a key lesson for RJ in the DV contexts: victim-offender dialogue should not be assumed to be appropriate in every case, and should only occur when it is clinically justified, safe, and aligned with victim choice.
- **Victim agency must remain central**: Clarification prioritizes voluntary victim participation, with ongoing support from specialist victim representatives or individual victim advocates. This highlights the importance of RJ processes being driven by victim needs and autonomy, rather than by system demands.
- **Multidisciplinary collaboration enhances outcomes**: Standards require collaboration across clinicians, victim advocates, and supervising authorities, supported by clear guidelines and protocols. This integrated oversight promotes accountability, consistency, and victim safety.

In sum, clarification demonstrates how RJ-aligned principles can be adapted responsibly within an evidence-based, highly regulated treatment system. For DV contexts, it highlights a cautious, incremental pathway: piloting RJ-informed components under strict safeguards,

rather than pursuing wholesale adoption. This approach balances the enthusiasm for innovation with the ethical imperative to prioritize victim safety, empirical rigor, and systemic accountability.

Conclusions and Policy Recommendations

Conclusion

RJ is not a substitute for established DV treatment; however, it may play a **complementary role** within Colorado's regulated framework. Current evidence and practice point to clarification as the most viable entry point. Modeled on Colorado's sex offense treatment standards, clarification is structured, clinically monitored, and victim-centered. It provides opportunities for offenders to acknowledge harm while allowing victims to determine their level of participation, including indirect options such as receiving a letter.

This approach bridges RJ principles with established DV treatment by:

- Embedding accountability within an existing statutory and clinical infrastructure
- Expanding victim choice and agency while prioritizing safety
- Avoiding the risks of coercive or premature engagement by requiring offender progress, readiness, and victim voluntariness

Clarification thus offers a stable, evidence-informed platform for cautious innovation. Over time, carefully piloted programs may test hybrid RJ–DV approaches for select populations, but these must evolve incrementally, with victim-led design and rigorous evaluation.

Ethical and Implementation Considerations

Integrating RJ into DV offender treatment raises complex ethical, clinical, and operational challenges. Key considerations include:

- **Voluntariness and informed consent**: Participation must always be voluntary for victims, supported by clear information about risks, benefits, and the right to decline or withdraw.
- **Safeguards against coercion and harm**: Pre-screening, structured preparation, and options for indirect participation (e.g., letters, video conferencing) are necessary to reduce risks of coercion, re-traumatization, or offender manipulation.
- **System readiness and interagency collaboration**: Effective implementation depends on coordinated protocols, shared values across systems, and strong oversight.

- **Specialized facilitator competency**: Practitioners must have expertise in DV dynamics, trauma responses, and victim safety, with ongoing supervision to ensure ethical practice.

- **Model fidelity and outcome monitoring**: A clearly defined model, eligibility criteria, and robust outcome evaluation are essential to maintain accountability and inform continuous improvement.

Without these safeguards, well-intended efforts risk undermining victim safety and autonomy rather than enhancing them.

Policy Recommendations

To support the safe and effective integration of RJ-informed practices in the DVOMB DV treatment model, the following steps are recommended:

- **Expand and formalize clarification interventions** within the existing DV treatment framework

- **Pilot clarification-based RJ protocols** during the later phase of treatment to assess feasibility and outcomes

- **Establish clear eligibility, preparation, and oversight protocols** to guide case selection and ensure ethical practice

- **Provide specialized training** for DVOMB-approved providers and TVAs on the clarification model and its trauma-informed application

- **Develop robust outcome monitoring systems** that are capable of tracking multiple dimensions of effectiveness, including:

    - **Process Fidelity:** Measuring provider adherence to the established clarification protocol and standards

    - **Victim-Defined Outcomes:** Tracking victim satisfaction, perceived safety, reduction in trauma symptoms, and increased autonomy, beyond simple participation rates.

    - **Offender Accountability:** Assessing sustained attitudinal and behavioral change (i.e., long-term desistance) and recidivism

    - **Adverse Events:** Monitoring any adverse events arising during the implementation of the model

In closing, RJ-informed practices may enhance domestic violence intervention systems when implemented cautiously, selectively, and with robust safeguards. Clarification provides the most promising entry point—ethically grounded, victim-sensitive, and adaptable within Colorado's established infrastructure. With continued research, stakeholder collaboration, and policy development, RJ can be explored as a complementary tool for advancing accountability, healing, and justice in DV cases—never as a replacement for the protections and rigor of established treatment systems.

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Table 1. Empirical Evaluations of Restorative Justice in Domestic Violence Cases

Study	Design	Sample	RJ Model	Key Findings	Limitations
Mills et al. (2019)	Randomized Controlled Treatment	222 adult male DV offenders (68% IPV)	BIP + Circles of Peace vs. BIP	53% reduction in new arrests; 52% reduction in severity scores	No victim outcome data; only 24-month follow-up
Mills et al. (2013)	Randomized Controlled Treatment	152 DV offenders (86% IPV)	Circles of Peace vs. BIP	Lower non-DV rearrests in RJ group; CP not inferior to BIP	Small sample; high attrition; arrest data only
Payne (2018)	Quasi-experimental	112 male first-time DV offenders (18–30)	Victim-Offender Mediation vs. BIP	No difference in 24-month recidivism	Intervention details unclear; no victim data
Davis (2009)	Randomized experiment	465 felony DV/family arrest cases	Mediation vs. Court Prosecution	Less fear/anger in mediation group; no difference in recidivism	Short follow-up; dated study
Lawler et al. (2025)	Mixed-method evaluation	160 cases referred; 58 IPV (Australia)	Restorative Justice Conferences	High satisfaction; improved safety; adult violent recidivism reduced	Small IPV sample; pandemic disruptions; limited victim data
Kettrey & Reynolds (2024)	Systematic review/meta-analysis	692 total; 3 DV studies	Various RJ models (Mills, Payne)	Small but significant recidivism reduction; effect weakens in RCTs	High bias risk; no victim well-being data; small N

Table 2. Stakeholder Perspectives on RJ in Domestic Violence Contexts

Study	Stakeholders	Method	Key Insights	Limitations
Campbell et al. (2024)	DV program providers	Focus groups and interviews (n=29)	Mixed opinions; safety concerns vs. healing potential; barriers include policy, funding, legal norms	Regional focus (North Carolina); mostly white female participants
Barocas et al. (2024)	Community members, advocates, offenders	Interviews and focus groups (n=16)	Community is key to change and accountability; Circles of Peace seen as supportive micro-communities	Small single-site sample; unclear impact on recidivism
Barocas et al. (2022)	Court personnel and clinicians	Focus groups and interviews	Criticism of BIPs as one-size-fits-all; support for more inclusive, empathy-driven RJ approaches	Small sample; focused on misdemeanor DV
Decker et al. (2022)	IPV victims	Qualitative interviews (n=26)	victims favored accountability, safety, and rehabilitation; viewed current system as inadequate	Severe IPV sample bias; specific to Baltimore; qualitative only
Wasileski (2017)	Prosecutors and mediators	Interviews (n=18)	Prosecutors resistant to RJ; lacked training and misunderstood IPV dynamics	Small, location-specific sample (Athens, Greece); interpreter issues
Zakheim (2011)	Orthodox Jewish communities	Program commentary and small qualitative study	Healing Circles better align with cultural norms; more effective than BIPs in OJ context	Small sample; no long-term outcome data

Study	Stakeholders	Method	Key Insights	Limitations
Dickson-Gilmore (2014)	Aboriginal communities (Canada)	Experiential analysis and case insights	RJ holds promise but faces risks of coercion, cheap justice, and systemic ambivalence	Anecdotal; lacks empirical data
Islam et al. (2018)	Muslim communities	Theoretical and experiential analysis	RJ aligns with some Islamic traditions; patriarchal norms and community biases are barriers	No empirical data; highly contextual
Cissner et al. (2019)	Staff from U.S. restorative justice programs	Mixed methods: surveys, follow-up interviews, and case studies (n=34 programs)	Most programs adopted RJ due to dissatisfaction with conventional justice approaches. Common models included peacemaking circles (39%), support circles (27%), and family group conferencing (21%). Programs emphasized voluntary participation and agency collaboration (66%); average program completion time was 216 days (median = 158 days), with some requiring only one session.	Selection biases; reliance on self-report; lack of outcome-based evaluations.