Johns Hopkins Bloomberg School of Public Health

Bloomberg American Health Initiative

House of Ruth Maryland

Let's Talk:

Support for People at Risk of Using Intimate Partner Violence

Gateway 2 Change:
A Community-Based Hotline Approach to Preventing Intimate Partner Violence

About This Toolkit

The *Gateway 2 Change* Toolkit is based on the nation's first 24/7 hotline designed specifically for people at risk of harming an intimate partner. The model was developed collaboratively by House of Ruth Maryland, Rooted Health Strategies, the Johns Hopkins Bloomberg School of Public Health, and the Bloomberg American Health Initiative. It integrates a behavior-change framework, safety protocols, and targeted social marketing to engage individuals at risk of perpetrating intimate partner violence. To help other jurisdictions adopt or adapt this approach, the project team created a public health-oriented toolkit that synthesizes findings from the theory of change, formative research, and a three-month pilot evaluation. The toolkit emphasizes best practices, provides a readiness assessment, includes a comprehensive theory of change and evaluation metrics (Figures 1 and 2), and offers practical guidance for protocol development, staffing, training, and outreach, accompanied by opportunities for technical assistance and research support.

About the Bloomberg American Health Initiative

The project was supported by the Bloomberg American Health Initiative based at the Bloomberg School. The Bloomberg American Health Initiative, funded by Bloomberg Philanthropies, addresses pressing health issues in five critical areas, including addiction and overdose, adolescent health, the environment, food systems, and violence through education, research, and practice.

About House of Ruth Maryland

House of Ruth Maryland leads the fight to end violence against women and their children by confronting the attitudes, behaviors, and systems that perpetuate it, and by providing victims with the services necessary to rebuild their lives safely and free of fear. Begun in 1977 by a partnership of women's organizations, religious groups, and concerned citizens aware of the growing need to protect victims of domestic violence, House of Ruth Maryland is now the largest and most comprehensive domestic violence service agency in Maryland. Its innovative services span temporary and long-term housing, counseling, legal services for victims of violence, programs for Spanish-speakers, and abuse intervention programs for both men and women.

About Rooted Health Strategies

Rooted Health Strategies is a public health consulting firm committed to advancing health equity through community-driven research, evaluation, and program design. With deep expertise in gender-based violence, maternal health, and the social determinants of health, the firm integrates academic rigor with lived experience to inform strategies that drive meaningful, lasting change.

Authors

Charvonne Holliday Nworu, PhD, MPH
Founder & Principal Consultant, Rooted Health Strategies

Lisa Nitsch, MSW
Chief Operating Officer, House of Ruth Maryland

Recommended citation: Holliday Nworu C, Nitsch L J. *Gateway 2 Change*: A Community-Based Hotline Approach to Preventing Intimate Partner Violence. Rooted Health Strategies; House of Ruth Maryland; Bloomberg American Health Initiative; 2025. Accessed [Month Day, Year]. [americanhealth.jhu.edu/ipvprevention]

Acknowledgments

We are grateful for the insight, dedication, and collaboration of the many individuals and partners committed to ending intimate partner violence. This project was launched thanks to the vision of Dr. Joshua Sharfstein and made possible through the contributions of team members from House of Ruth Maryland, the Johns Hopkins Bloomberg School of Public Health, and Rooted Health Strategies.

House of Ruth Maryland:

Kate Reinhold, Crisis Response Program Manager
Lisa Nitsch, MSW, Chief Operations Officer
Angelique McKoy, LCPC, Associate Director of Training & Engagement
Shanna Norwood, Director of Crisis Response
Angelique Green-Manning, Associate Director of Intervention Services
Selwyn Mendez, MSW, Training Institute Project Coordinator
Ellyn Loy, LCSW-C, Retired Director of Clinical Services

Johns Hopkins Bloomberg School of Public Health/Rooted Health Strategies:

Charvonne Holliday Nworu, PhD, MPH, Principal Investigator
Michele Decker, ScD, MPH, Co-Investigator
Gabriel Feuerstein-Mendik, MSPH, Research Assistant

We are deeply thankful to the Bloomberg American Health Initiative for funding and supporting this project as part of its commitment to addressing violence as a public health issue.

We extend special appreciation to the hotline advocates and the broader staff at House of Ruth Maryland, whose compassion and skill are at the heart of this work. We are also grateful to our local and national partners, including members of the Baltimore City Domestic Violence Coordinating Committee, national experts in crisis response, and the *Gateway 2 Change* callers who generously participated in interviews, strategy sessions, and pilot testing. We are particularly grateful for those survivors who have encouraged this project. The development of this hotline was strengthened and guided by your invaluable input.

The Gateway 2 Change Hotline: **Executive Summary**

Summary.

Gateway 2 Change is a 24/7 anonymous and confidential hotline for people at risk of causing harm to an intimate partner. It offers real-time crisis de-escalation and safety planning aimed at preventing violence, brief motivational interviewing to promote accountability matched with readiness to change, and referrals to services based on the caller's identified need. *Gateway 2 Change* expands House of Ruth Maryland's survivor hotline; it is designed and evaluated using a public-health approach in partnership with Rooted Health Strategies, the Johns Hopkins Bloomberg School of Public Health, and the Bloomberg American Health Initiative. This crisis intervention model is grounded in accountability-focused harm reduction using Motivational Interviewing[2] based on the Stages of Change Model[1] and reaches people at risk of causing harm to an intimate partner through a targeted social marketing campaign.

Significance.

Intimate partner violence (IPV) is a pervasive public health crisis, affecting one in three women in their lifetime[3-5] and contributing to more than half of female homicides, disproportionately impacting Black and American Indian/Alaska Native women.[6] Fatal IPV often follows identifiable patterns, creating opportunities for early intervention before harm escalates.[7,8] While crisis lines have proven effective in reducing suicide risk and other harms, IPV crisis response remains underdeveloped. Existing hotlines primarily serve survivors of abuse; services for people at risk of causing harm are rare, lack established best practices, and have not been rigorously evaluated. Internationally, similar efforts are emerging but remain untested. In the U.S., only one state-level hotline specifically for people at risk of harming a partner operates on a limited schedule, underscoring the urgent need for scalable, evidence-informed models.

Approach.

Gateway 2 Change was developed through a research-practice partnership using a public health approach that integrates prevention science, behavior change theory, and community input. The model was co-designed with men at risk of using IPV, survivors, House of Ruth Maryland staff, local and national domestic violence stakeholders, and a research team to ensure survivor safety and cultural relevance. The project is grounded in accountability-focused harm reduction. Formative research, expert consultation, and audience segmentation informed both hotline protocols and a targeted social-marketing strategy. A three-month pilot was evaluated using mixed methods—call data, readiness and risk indicators, safety plan documentation, advocate surveys and debriefs, and campaign analytics—to assess feasibility, acceptability, and potential for scale.

Innovation and Core Components.

Gateway 2 Change is a 24-hour hotline specifically designed for people at risk of causing harm to integrate a behavior-change framework with safety protocols, targeted social marketing, and a built-in evaluation infrastructure from inception. The model's core components reflect this integrated design and highlight the essential elements needed for effective implementation:

Core Components

- **Trained advocates** skilled in crisis de-escalation, Motivational Interviewing matched to readiness, and culturally responsive practice.
- **Structured call protocol** that guides safety planning, accountability-focused conversation, and connection to appropriate services.
- **Referral pipeline** to House of Ruth Maryland's abuse intervention program, The Gateway Project, and other community-based resources.
- **Targeted social marketing** to reach those not engaged in existing service networks, tailored to readiness and refined over time.
- **Standardized data collection, monitoring and evaluation** to collect and analyze call data, referrals, and outcomes—informing continuous improvement, fidelity to the model, and scalability.

What This Guide Provides.

This guide provides an overview of how to develop and implement a hotline for individuals at risk of causing harm to an intimate partner, based on the *Gateway 2 Change* model. It offers a **practical roadmap**, covering readiness assessment, hotline design and protocol development, staff training, pilot launch, and the use of evaluation findings to enhance and expand the model. Included in this guide is a **comprehensive theory of change and evaluation metrics** to support both implementation and ongoing learning. The **Readiness Assessment Tool** helps organizations evaluate their alignment, infrastructure, protocols, training, marketing capacity, partnerships, and evaluation preparedness, providing a framework for transforming gaps into actionable steps. While this document serves as an overview, organizations are encouraged to contact the *Gateway 2 Change* team for **technical assistance** in intervention development, evaluation, and research support.

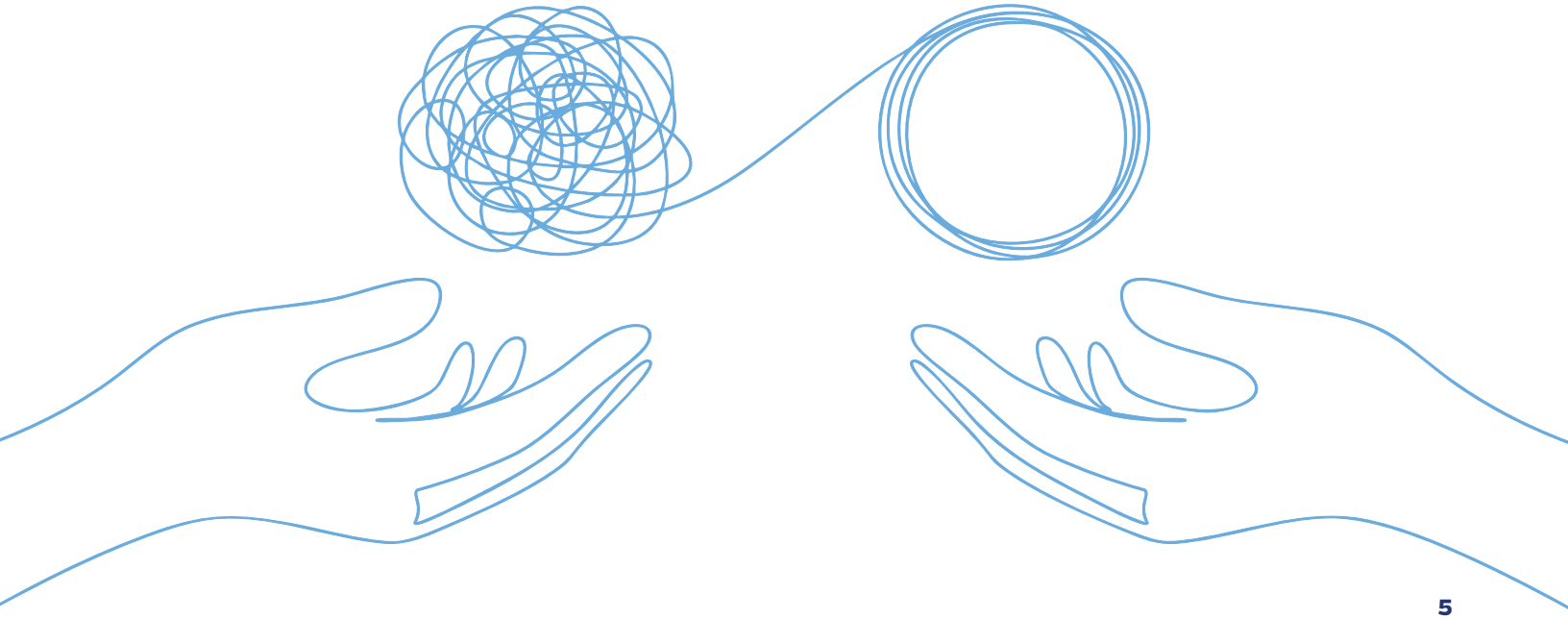


Table of Contents

Background

A Public Health Crisis of Intimate Partner Violence

Intimate partner violence (IPV) is a pervasive public health crisis that threatens the safety, health, and well-being of communities across the United States. One in two women will experience IPV in their lifetime, with women far more likely than men to endure severe forms that span physical, sexual, and psychological violence.[1] Fatal interpersonal injury among women is significantly driven by IPV, with approximately 55% of female homicides being IPV-related.[2] Stark disparities exist—Black and American Indian/Alaska Native women face disproportionately high rates of lethal IPV, reflecting deep structural inequities.[3]

Like other forms of violence, IPV is preventable. The escalation cycle and specific violent tactics that often precede intimate partner homicide are well documented, creating clear opportunities for early intervention before harm escalates.[4] Yet crisis intervention for people at risk of causing harm to an intimate partner remains an underdeveloped and largely untested prevention strategy in the United States.[5]

Core Tenet: Prevention Requires Engaging People Who Use or May Use Violence

For decades, victim-centered crisis services such as hotlines, chatlines, and text-based supports have been a standard of care. However, there is no widely established parallel service for people who have caused harm or fear becoming abusive toward their partner. A confidential, nonjudgmental, and accountability-focused crisis service for this audience could fill a critical prevention gap—offering a safe entry point for change before harm escalates to police involvement, injury, or death.

---

[1] Leemis, R. W., Friar, N., Khatiwada, S., Chen, M. S., Kresnow, M., Smith, S. G., Caslin, S., & Basile, K. C. (2022). The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/nisvs/NISVSReportonIPV_2022.pdf

[2] Petrosky, E., Blair, J. M., Betz, C. J., Fowler, K. A., Jack, S. P. D., & Lyons, B. H. (2017). Racial and Ethnic Differences in Homicides of Adult Women and the Role of Intimate Partner Violence - United States, 2003-2014. Mmwr-Morbidity and Mortality Weekly Report, 66(28), 741-746. <Go to ISI>://WOS:000405913800001 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5657947/pdf/mm6628a1.pdf

[3] Petrosky, E., Blair, J. M., Betz, C. J., Fowler, K. A., Jack, S. P. D., & Lyons, B. H. (2017). Racial and Ethnic Differences in Homicides of Adult Women and the Role of Intimate Partner Violence - United States, 2003-2014. Mmwr-Morbidity and Mortality Weekly Report, 66(28), 741-746. <Go to ISI>://WOS:000405913800001 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5657947/pdf/mm6628a1.pdf

[4] Walker LE. *The Battered woman*. 1st ed. Harper & Row; 1979:xviii, 270 p.

Campbell JC, Webster DW, Glass N. The danger assessment: validation of a lethality risk assessment instrument for intimate partner femicide. *Journal of interpersonal violence*. Apr 2009;24(4):653-74. doi:10.1177/0886260508317180

[5] Holliday, C. N., Morse, S. M., Irvin, N. A., Green-Manning, A., Nitsch, L. M., Burke, J. G., Campbell, J. C., & Decker, M. R. (2018). Concept Mapping: Engaging Urban Men to Understand Community Influences on Partner Violence Perpetration. *J Urban Health*. https://doi.org/10.1007/s11524-018-0297-8

A Public Health Approach to IPV Crisis Intervention

A public health approach to IPV crisis intervention integrates prevention science, behavior change theory, and safety protocols to engage those at risk in timely, supportive, and effective ways. Such an approach recognizes that IPV is shaped by social and structural determinants—poverty, racism, stigma, and limited access to support services—as well as immediate risk factors such as escalating conflict or substance misuse. By offering early, accessible intervention and connecting callers to abuse intervention, mental health, and other supports, we can disrupt patterns of violence and move toward health equity, where everyone can live free from abuse.

Gateway 2 Change builds on this vision by expanding House of Ruth Maryland's 24-hour hotline—long established for IPV survivors—to also serve people at risk of causing harm to an intimate partner. This pilot is the first 24-hour crisis service in the United States dedicated to this audience. It was developed through a research-practice partnership and designed using a public health approach that integrates formative research, behavior change theory, survivor-safety, and cultural responsiveness. The pilot tested hotline protocols, targeted social marketing, and an evaluation framework to assess feasibility, acceptability, and potential for scale. The long-term goal is to expand the reach and uptake of abuse intervention services for people in Baltimore, particularly those not currently connected to formal services but in need of immediate support to prevent imminent violence.

The launch of *Gateway 2 Change* represents a critical step forward in addressing IPV at its roots—the behavior of the individual who is being abusive.

Gateway 2 Change is more than a hotline—it's a proactive public health strategy rooted in accountability, safety, and equity. Research shows that people who are exposed to community violence or adverse childhood experiences are more likely to perpetrate intimate partner violence,[1] [2] as well as those whose attitudes condone IPV[3]. By offering anonymous, trauma-informed support and referrals to those questioning or struggling with their behavior, *Gateway 2 Change* reaches a population that most existing services do not. Importantly, this hotline provides an early intervention model that empowers people to take responsibility, seek help voluntarily, and potentially prevent violence altogether—ultimately protecting survivors who may never engage with traditional support systems or the courts.

[1] Raiford, J. L., Seth, P., Braxton, N. D., & DiClemente, R. J. (2013). Interpersonal- and Community-Level Predictors of Intimate Partner Violence Perpetration among African American Men. Journal of Urban Health: Bulletin of the New York Academy of Medicine, 90(4), 784–795. https://doi.org/10.1007/s11524-012-9717-3

[2] Zhu, J., Exner-Cortens, D., Dobson, K., Wells, L., Noel, M., & Madigan, S. (2023. Adverse childhood experiences and intimate partner violence: A meta-analysis. Development and Psychopathology, 1–15. https://doi.org/10.1017/S0954579423000196

[3] Pulerwitz, J., & Barker, G. (2007. Measuring Attitudes toward Gender Norms among Young Men in Brazil: Development and Psychometric Evaluation of the GEM Scale. Men and Masculinities, 10(3, 322-338. https://doi.org/10.1177/1097184X06298778 (Original work published 2008

Our Public Health Approach to Crisis Response for People at Risk of Using Intimate Partner Violence: Developing the Gateway 2 Change Hotline Model

Evaluation Approach

Gateway 2 Change was built through a formative evaluation and a three-month process evaluation pilot to adapt and expand House of Ruth Maryland's crisis services for people at risk of causing harm to an intimate partner. We began by engaging key stakeholders—people who had used violence, House of Ruth Maryland staff and leadership, local harm-prevention advocates, and national experts in crisis response and abuse intervention—to assess **acceptability** (willingness to use the hotline, trust, readiness to discuss behavior and **feasibility** (infrastructure, staffing, integration with existing survivor services.

Activities included developing a theory of change (Figures 1 and 2, designing a standardized protocol with a violence risk assessment and safety considerations, establishing a referral pipeline based on community resources, and creating a tailored staff training program, including Motivational Interviewing techniques and guidance on engaging trauma-informed, stage-based conversations with people at risk of causing harm to an intimate partner. We reviewed best practices from domestic and international abuse intervention and harm-reduction programs and explored appropriate messaging through a social marketing campaign.

The three-month pilot tested the model in real-world conditions, tracking service reach and uptake, while monitoring for unintended impacts such as resource diversion. Data from hotline usage, staff surveys, focus groups, and leadership interviews provided real-time feedback to refine the model, ensuring it remains practical, effective, and aligned with community needs.

Theory of Change

Gateway 2 Change is built on the premise that providing an anonymous, confidential, and nonjudgmental entry point for people at risk of causing harm—combined with accountability-focused, stage-based harm reduction and motivational interviewing—can interrupt the cycle of violence before it escalates. The approach connects callers to immediate crisis support, safety planning, and tailored referrals that address the underlying drivers of abusive behavior. Our theory of change assumes that when people recognize harmful behavior, feel heard, and have access to practical, nonlegal pathways for support, they are more likely to engage in abuse intervention services, adopt non-violent coping strategies, and sustain commitments to refrain from violence. Through this pathway, the hotline aims to reduce IPV risk in the short term, increase ongoing engagement in supportive services, and ultimately lower the recurrence and severity of violence in the community.

The *Gateway 2 Change* logic model (Figure 1 lays out the pathway from inputs to outcomes. It begins with **resources**—trained hotline staff, House of Ruth Maryland's existing crisis infrastructure, established community relationships, operational protocols, and funding from the Bloomberg American Health Initiative. **Activities** include developing and implementing a social marketing campaign, refining hotline protocols and scripts, tailoring staff training, building a referral database, and engaging experts in harm reduction. These activities produce **outputs** such as expanded hotline infrastructure, a standardized protocol with a violence risk assessment, a resource toolkit for advocates, and call documentation systems. The model links these outputs to **measured outcomes** (feasibility, acceptability, service indicators, and to **anticipated impacts**—from increased early help-seeking and participation in abuse intervention to reduced IPV perpetration and severity over time.

Mechanisms for Change

The hotline's mechanisms for change are designed to move callers from immediate safety toward lasting behavior change. In the short term, this includes reducing imminent risk, improving emotional regulation, increasing readiness for change, and creating safety plans alongside initial service engagement. Over time, these changes build toward sustained use of nonviolent coping strategies, continued engagement in support services, and a reduction in the recurrence and severity of violence.

Core mechanisms include:

- Providing immediate crisis support and de-escalation to lower the risk of harm.
- Helping callers recognize abusive behavior and strengthen their confidence to change.
- Offering a nonjudgmental, listening ear that introduces new perspectives.
- Linking callers to supportive services that address the root causes of violence risk.
- Reducing stigma and fear of legal consequences to make early help-seeking more acceptable.

Problem

- IPV is a significant public health issue
- Dearth of intervention and prevention outlets for people at risk of causing harm to an intimate partner
- Existing programs have limited reach and predominately linked to criminal justice system

Context

- **Needs:** Reduce IPV/ community violence; address entrenched disparities
- **Assets:** Strong crisis support network; government buy-in; HRM community presence
- **Contributing factors:** Economic instability, inequitable access, stigma, limited timely intervention

Inputs

- **Resources:** Staff with training and active hotline experience, established community relationships, and expertise in IPV prevention and research and evaluation
- **Infrastructure:** Call center, phone systems, and related technology
- **Operational protocols:** Established crisis support procedures for violence survivors
- **Training foundation:** Staff training materials for crisis response among violence survivors
- **Funding:** Funding from the Bloomberg American Health Initiative

Activities

Development Phase

Formative Research
- Conduct focus groups, in-depth interviews, and surveys with key stakeholders

Crisis Support Expansion
- **Infrastructure:** Expand phone system to include unique number
- **Protocol:** Develop step-by-step guide for assessing risk, needs, and next actions
- **Scripts:** Develop conversation prompts and guidance for motivational interviewing, stage-based responses, and de-escalation
- **Referrals:** Curate database of supportive services
- **Training:** Develop modules and reference guides on hotline protocols and trauma-informed care for callers at risk of causing harm to an intimate partner
- **Call Documentation:** Develop form for capturing key details of each call for service coordination and evaluation

Expert Engagement
- Host roundtable discussions with leaders of harm interruption programs

Social Marketing Campaign
- Define communication strategy based on health communication theories
- Develop, test, and disseminate campaign materials

Hotline Implementation
- Operate 24/7 hotline for individuals at risk of causing harm to an intimate partner
- Provide de-escalation and safety planning
- Deliver brief motivational interviewing tailored to readiness for change
- Refer callers to abuse intervention programming or other appropriate services
- Document caller interaction

*** See Figure 2*

Output

Knowledge and Planning
- A report summarizing stakeholders' perspectives about the feasibility and acceptability of expanding hotline services for men at risk of causing harm
- Finalized logic model—framework for hotline service delivery and evaluation

Capacity Building
- Separate hotline number for *Gateway 2 Change*
- Trained hotline advocates

Service Tools and Resources
- Hotline advocate resource toolkit (protocol, scripts, referral database, training materials)

Public Engagement
- Social marketing strategy, materials, and dissemination metrics

Hotline Service Data
- Completed call tracking capturing caller type, risk level, abuse status, needs, referrals offered, call length and time
- Hotline service data—number of calls from people at risk of causing harm, number of referrals by type, abandoned calls, wait times, number of calls queued

Outcomes

Current Study Outcomes (Measured)

Feasibility
- Protocols and tools can be implemented safely and consistently by hotline advocates
- Warm handoffs and referrals to community services are feasible
- Existing hotline infrastructure can integrate expanded services without disruption

Acceptability
- People at risk of causing harm to an intimate partner are willing to call the hotline and engage in conversations about harmful behavior
- Reduced stigma regarding intimate partner violence perpetration and help-seeking
- Improved community attitudes toward early intervention and accountability
- Community partners view the hotline as a credible early-intervention option

Preliminary Service Indicators
- Increased connectedness to IPV resources in Baltimore
- Number and type of calls from people at risk of causing harm
- Patterns in caller needs, risk levels, and follow-up
- Increased participation in voluntary abuse intervention

Anticipated Impacts (short- and long-term)
- Increased early help-seeking before violence escalates
- Improved knowledge, attitudes, and beliefs about IPV among service users
- Sustained engagement in abuse intervention and supportive programs
- Reduction in IPV perpetration and severity in Baltimore

Figure 1. *Gateway 2 Change* Hotline Logic Model: A public health approach to engaging people at risk of causing harm to an intimate partner

Gateway 2 Change Philosophy

- Anonymous and confidential; nonjudgmental
- Accountability-focused, stage-based harm reduction using motivational interviewing
- Voluntary alternative to criminal legal system engagement
- Early intervention to prevent violence and escalation
- Trauma-informed and responsive to culture and gender
- Community-based partnerships and warm handoffs for additional services

Key Assumptions

Behavioral — People at risk will use the hotline when risk is high, recognize harmful behavior, accept referrals, and engage in care; the hotline can reduce moderate/severe IPV risk.
Safety — The hotline is safe for callers, partners/survivors, and staff; community services can accept referrals.
Communication — Target audience knows about the hotline; messaging reduces stigma and raises IPV awareness.

Hotline Overview

- 24/7 phone operations
- Voluntary, drop-in abuse intervention
- Crisis de-escalation
- Safety planning and commitments to refrain from violence
- Brief motivational interviewing matched to readiness
- Referrals based on identified needs
- Escalation to an abuse intervention specialist

Mechanisms for Change

- Immediate crisis support and violence de-escalation
- Increased recognition of abusive behavior and greater self-efficacy
- Feeling heard and gaining an alternative perspective from a nonjudgmental listener
- Connection to supportive services that address violence risk
- Reduced stigma and fear related to criminal legal involvement

Short-Term Outcomes

- Reduced immediate risk of harm and emotional volatility
- Increased readiness for change and safety plan development
- Increased openness to violence prevention support
- Increased awareness of abuse intervention services available at House of Ruth Maryland
- Initial connection to supportive services that address violence risk

Intermediate Outcomes

- Ongoing engagement in abuse intervention and other supportive services
- Reduced recurrence/escalation of violence
- Improved/sustained use of nonviolent coping strategies
- Commitment/sustained commitment to refrain from abusive behavior

Figure 2. *Gateway 2 Change* — Practice Framework and Theory of Change

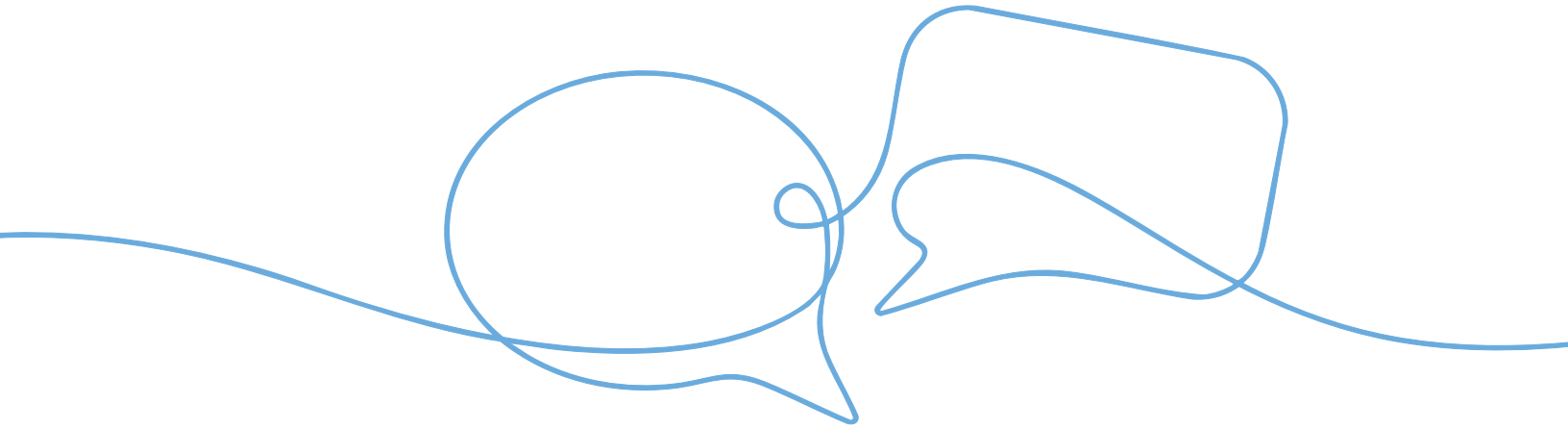
Anticipated Impacts

While not measured in this formative evaluation, *Gateway 2 Change* is designed to produce meaningful short- and long-term impacts in Baltimore and in any community where it is implemented. We anticipate a reduction in IPV perpetration through increased help-seeking, along with improved knowledge, attitudes, and beliefs about IPV among service users. The hotline also raises awareness and may shift community attitudes about the importance and benefits of engaging people who use abusive behaviors as part of prevention efforts.

By expanding the conversation around IPV to include those at risk of causing harm, we are broadening the path to prevention and building a future in which fewer people experience the trauma of IPV. Over time, the model aims to support sustained engagement in abuse intervention and supportive programs, leading to both a decrease in the occurrence and severity of IPV and broader cultural shifts toward accountability and nonviolent behavior. Additionally, *Gateway 2 Change* also holds promise as a restorative practice: whether the caller accepts help or not, the existence of the option itself can inform survivors' choices and sense of agency.

Summary of anticipated impacts (unmeasured)

- Reduced IPV perpetration in Baltimore and other communities.
- Earlier help-seeking before violence escalates.
- Improved knowledge, attitudes, and beliefs about IPV among service users.
- Raised awareness and shifting community attitudes about the importance of engaging people at risk of causing harm to an intimate partner in the prevention efforts.
- Sustained engagement in abuse-intervention and supportive programs.
- Reduced occurrence and severity of IPV over time.



Implementation Road Map

1 Develop call protocol

a. How will callers be greeted?
b. How will safety and risk be assessed?
c. Is the call confidential?
d. What is the safety protocol if callers are escalating?

2 Identify key data elements and associated tracking mechanism

a. What data needs to be collected?
b. Who will be responsible for collecting data?
c. Where will data be stored?
d. How will data be extracted and reported?

3 Identify local resources

a. What increases risk and lethality in people who may cause harm?
b. What local services could address some of these concerns?
c. Do you have relationships, or do they need to be established?

4 Train hotline staff on call processes and procedures

a. Are staff comfortable with call protocol and flow?
b. Are staff trained to assess the caller and engage them in a change process?
c. Have staff had opportunity to observe calls or participate in mock calls?
d. Are staff clear on mandated reporter processes and limitations?

5 Assess hotline staff for interest and confidence

a. Has staff confidence increased after training?
b. Are there staff who may not be right for this project? Why or why not?
c. What continued training and support do staff need?

6 Develop marketing strategy

a. Where is the target audience most likely to be reached?
b. How would the target audience most likely be engaged?
c. Has the strategy been vetted by a sample of the target audience?

7 Pilot hotline

a. What is the initial staffing structure?
b. How will calls be reviewed and debriefed?
c. Who is available to support hotline staff if needed?

8 Assess success

a. What are the measures of success?
b. Who will lead process changes as needed?
c. How will outcomes be reported and shared?

How Gateway 2 Change Works

1

Connect

Give us a call. A live person answers the hotline 24/7. We are here to listen, not judge. You choose what to share.

What to expect: a calm, private conversation where you are heard and we learn what's going on and what you need.
For providers, family, and friends: information and warm referrals are available.

2

Understand Your Starting Point

Talk through what's happening in your relationship. Our team meets individuals where they are, whether they are unsure of their next steps or are ready for support. Together, we understand where you are in the process of being nonviolent.

What this can look like: "It's not that serious" --> "I may need to start doing things differently" --> "I'm planning to do things differently" --> "I am working on changing my behavior" --> "I'm focused on staying on track."

Our Responses: we listen carefully, talk about safer ways to reduce conflict and next steps that fit your goals, explore the impact of your behavior, provide information about House of Ruth Maryland's free abuse intervention program and other requested resources, discuss problems and setbacks, and provide brief coaching to maintain learned skills.

3

Choose Your Next Steps

Share what's most important to you in the moment. We guide callers and connect them with resources that match their individual needs and goals.

Possible Next Steps:

- Information about joining an abuse intervention group
- Safety planning for everyone involved
- Connection to resources you may be interested in
- Skills for de-escalation and accountability

4

Stay Connected

Continue receiving support through drop-in abuse intervention groups, engaging with provided resources, or calling the hotline for immediate support. A hotline advocate is available to speak with you 24/7.

Lessons Learned: What Moved Change

Ready to bring *Gateway 2 Change* to your community? These seven practice-tested moves drive change and are supported by early data.

1 **Confidentiality builds trust and safety.** An anonymous and confidential entry point reduces stigma and opens the door to change.
- *Practice:* 24/7 live answer, clear confidentiality script, and no automatic police involvement, so families have a nonlegal option to address abusive behavior.
- *Key Findings:* People at risk of being violent to an intimate partner called the hotline, disclosed their abuse to an advocate, and sought services related to their needs.

2 **Make it about prevention, not just crisis.** Stage-based conversations guided by Motivational Interviewing build readiness and accountability.
- *Practice:* Use accountability-focused, stage-based harm reduction with motivational interviewing to meet callers where they are and support change.
- *Key Findings:* Callers articulated change goals, participated in voluntary drop-in abuse intervention, and accepted referrals.

3 **Address the root causes of violence perpetration.** Referrals to community-based services address drivers of harm.
- *Practice:* Real-time connections to abuse intervention, mental health, legal support, and other relevant services.
- *Key Findings:* Referrals were offered and accepted, including participation in a drop-in abuse intervention group.

4 **Invest in training skilled and supportive advocates.** Hotline advocates sustain safety and build trust.
- *Practice:* Standard protocols, supervision/debriefs, and supports for secondary traumatic stress.
- *Key Findings:* Consistent protocol use and safe call handling of complex calls without service disruption or adverse survivor impact.

5 **Engage the broader community.** Activating survivors and community partners normalizes help-seeking for abusive behavior.
- *Practice:* Toolkits, scripts, and cross-training for friends, family, and providers to support someone using abusive behaviors.
- *Key Findings:* Survivors and partners viewed the hotline as credible; attitudes shifted toward intervention and accountability.

6 **Build on what works.** Building on experience refines protocols and improves safety.
- *Practice:* Apply lessons from direct work with people using abusive behaviors to sharpen an accountability-focused, stage-based harm-reduction approach with motivational interviewing; update safety checks, de-escalation steps, and referral scripts through ongoing call reviews.
- *Key Findings:* More consistent protocol use, clearer referral recommendations, increased advocate confidence, and safe handling of complex calls without service disruption.

7 **Design–test–adapt.** Build a learning loop using a public health approach.
- *Practice:* Map a clear theory of change; use formative evaluation to tune scripts, safety checks, and referrals; monitor fidelity/referrals/adverse events; adjust.
- *Key Findings:* Faster, safer iterations; tighter protocol fidelity; clearer referrals; no adverse survivor impact.

Next Steps

Building on the findings from the formative evaluation and three-month pilot, *Gateway 2 Change* will continue House of Ruth Maryland's culture of continuous improvement by refining hotline protocols, expanding outreach through targeted social marketing, and strengthening referral partnerships to increase service capacity. Future evaluation efforts will measure long-term outcomes, including changes in IPV perpetration, early help-seeking behaviors, and sustained engagement in intervention programs. We will also explore opportunities to replicate and adapt the model in other jurisdictions, using lessons learned in Baltimore to guide scalability and ensure the hotline remains a safe, credible, and effective early-intervention option for people at risk of causing harm.

Bring *Gateway 2 Change* to Your Community

We're building on what we've learned to strengthen protocols, expand outreach, and grow referral networks. Our goal is to measure long-term impact and bring *Gateway 2 Change* to more communities. **Interested in partnering or adopting the model? Let's connect.**

Gateway 2 Change was designed with scalability in mind. The model builds on existing hotline infrastructure, making it adaptable to different organizational contexts without disrupting survivor services. Standardized protocols, a clear referral pipeline, and tailored training can be integrated into other crisis lines or community-based programs with minimal technology or staffing changes. Because the approach is grounded in evidence-based abuse intervention practices and harm-reduction principles, it can be replicated in communities of varying sizes, provided there is a coordinated network of referral partners. Process and outcome metrics from the Baltimore pilot create a roadmap for other jurisdictions to launch and refine their own early-intervention hotlines for people at risk of causing harm.

Readiness Assessment Tool

Use the Readiness Assessment Tool below to help identify the elements you already have in place for success, where there is more work to be done, and where you may need support. Some considerations are shared to help with your thinking about where you are and where you would like to be. Review your results and consider reaching out to the *Gateway 2 Change* research team for guidance and support or to share your experiences.

Success Element	Status	Considerations
Establish project leadership and staffing	❑ Not yet started ❑ In progress ❑ Completed	• Who will lead the project and take responsibility for project schedule? • Who are key stakeholders and advisors? • Will current or newly recruited staff work on the hotline?
Identify target audience	❑ Not yet started ❑ In progress ❑ Completed	• Will there be gender, age, geographic, or other specifications? • Is primary, secondary, or tertiary prevention prioritized? • Are there secondary audiences to consider?
Identify project partners	❑ Not yet started ❑ In progress ❑ Completed	• Will you work with a research partner? • Which community-based referral services are needed? • Who can help you promote the hotline to your target audience?
Develop a shared theory of change	❑ Not yet started ❑ In progress ❑ Completed	• What is the shared understanding about why people abuse their intimate partners? • What is the shared understanding about when and how people engage in a change process? • What is the shared understanding about what supports someone at risk of causing harm may need?

Success Element	Status	Considerations
Estimate project budget (if any) and identify potential funding source	❑ Not yet started ❑ In progress ❑ Completed	• Will the hotline be answered by new or existing staff? • What training supports are needed? • Should any key stakeholders outside of the organization be compensated for their time?
Call/hotline infrastructure plan established	❑ Not yet started ❑ In progress ❑ Completed	• Will an existing hotline be expanded or a new one created? • If an existing line is used, how will staff know why the caller is reaching out? Is that important to know at the beginning of the call?
Current/potential hotline staff surveyed for interest and confidence	❑ Not yet started ❑ In progress ❑ Completed	• Do staff have lived experience with violence? If so, how will they assess for and address potential transference? • Do they see the value in engaging people who may cause harm? • Do they believe callers have the capacity to change?

By adapting the *Gateway 2 Change* model, organizations can address one of the most persistent gaps in IPV prevention—engaging people who are abusive before legal involvement or further harm occurs. This toolkit provides the blueprint for safe, survivor-centered, perpetrator-focused crisis support that builds accountability, prevents violence, and strengthens communities.

JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

Bloomberg American
Health Initiative

House of Ruth
Maryland