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BRIDGING THE RESEARCH-TO-PRACTICE GAP IN SOCIAL AND BEHAVIORAL HEALTH IN THE UNITED STATES: STRATEGIES FOR TRANSLATING EVIDENCE INTO COMMUNITY-LEVEL IMPACT

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ABSTRACT

Interventions with strong evidence in social and behavioral health routinely take years to reach the communities that need them, and many never arrive at all, a shortfall that falls heaviest on the populations already bearing the greatest burden of need. Medication for opioid use disorder, among the most rigorously validated treatments in behavioral health, reached only a fraction of those it could help for years, held back not by doubt about the evidence but by the systems meant to deliver it. This narrative review examines why the research-to-practice gap in the United States persists and what moves evidence into durable, community-level impact. It argues that the gap is not primarily a shortage of evidence, but a downstream failure of uptake, arising where evidence, delivery systems, and communities meet, with much of the attrition built into how research is ordinarily designed. Drawing on work across opioid response, children's and school-based mental health, early psychosis, and interventions for minoritized and immigrant populations, the review organizes the field's responses into four strategies: community engagement and partnership, cultural adaptation and health equity, implementation infrastructure, and the alignment of research with practice and policy. Though typically pursued in isolation, these strategies prove interdependent, each prone to a characteristic failure when applied without the others, so that translation more often stalls the element left out than on those in place. Community-level impact, the review contends, must be judged by reach, fidelity, and sustainment rather than efficacy alone; sustainability and equity in particular are reachable only when the strategies work in combination, assembled deliberately to fit the barriers a given context presents.

Keywords: Implementation science, Dissemination and implementation, Health equity, Community-engaged research

1 INTRODUCTION

The distance between what social and behavioral health research demonstrates and what communities actually receive is one of the persistent problems of the American health system (Studts, 2022). The field's most-quoted figure that roughly seventeen years pass before research reaches practice has been repeated so widely that it now functions more as a slogan than a measurement, and recent critics argue it was never a defensible estimate for social and behavioral service settings in the first place (Brownson et al., 2025). But discarding the number does not dissolve the problem it points to. Interventions with strong evidence still take years to reach the people who need them, and many never arrive; a large share stalls in the pipeline entirely, accumulating in journals while the communities they were designed to serve

go without (Towfighi et al., 2020). The bottleneck is not a shortage of evidence. The catalogue of interventions shown to work under controlled conditions grows every year. The difficulty lies downstream, in the movement from demonstrated efficacy to real-world effectiveness and sustained uptake in clinics, schools, and agencies (Johnson & Beidas, 2023). Brownson et al. (2025) press the field to confront a blunt question about its own output, so what, arguing that implementation science has too often measured success by the sophistication of its frameworks rather than by whether populations are demonstrably better off. That standard governs this review: the measure of translational success is not publication or adoption in a single site, but change that registers at the community level and holds.

The gap is easy to see in the domains where need is most acute. Medication for opioid use disorder is among the most rigorously validated treatments in behavioral health, yet for years it reached only a fraction of the people who could benefit, held back not by doubt about the evidence but by fragmented delivery systems, workforce constraints, and communities that were never brought into the work of implementation (Martinez et al., 2020). The pattern generalizes. Social and behavioral interventions are rarely self-contained; they depend on the behavior of practitioners, the readiness of host organizations, and the fit between a program's assumptions and a population's circumstances (Bennett, 2025). A practice validated in one setting fails in another not because the science was wrong but because the delivery system, the workforce, or the cultural fit was never accounted for (Thier et al., 2020). Pinto, Spector, and Rahman (2019) locate much of this in the separation between researchers who produce evidence and practitioners expected to deliver it, two groups with different incentives, timelines, and standards of proof. Where those relationships are absent, even well-designed programs are adopted thinly or abandoned once grant funding ends.

The consequences fall unevenly. The populations least likely to receive evidence-based interventions are frequently those with the heaviest burden of need: racial and ethnic minority communities, low-income and rural populations for whom standard delivery models were never designed (Nagy, Rivera-Segarra, & Cabassa, 2025; Fernández-Alvarez et al., 2024). Treating the gap as a technical problem of knowledge transfer misses its equity dimension: a framing that ignores who is reached risks perfecting delivery to the already-served while leaving disparities intact, or widening them.

A substantial body of work proposes how the gap might be closed through academic–public partnerships (Towfighi et al., 2020), community-engaged models (Martinez et al., 2020), systematic cultural adaptation (Thier et al., 2020), investment in the training and technical assistance that determine whether frontline staff can deliver a program with fidelity (Acosta et al., 2024), and the deliberate alignment of research with policy (Perkins et al., 2024; Dopp & Lantz, 2020). These strands are often pursued in isolation, which obscures the logic they share and the ways they reinforce one another.

The objective of this review is to synthesize these strategies into a single integrated account of how evidence in social and behavioral health is translated into community-level impact in the United States, and to argue that they function as an interdependent system rather than a menu of independent options. The review is organized around four interlocking strategies: community engagement and partnership, cultural adaptation and equity, implementation infrastructure, and research-practice-policy alignment.

As a narrative rather than systematic review, this synthesis does not follow a formal protocol. Sources were identified through targeted searches of the implementation science and public health literature and selected for their relevance to the translation of evidence-based social and behavioral health interventions in United States community settings. Priority was given to work addressing the four strategies above, with each examined for the barrier it addresses, the conditions under which it succeeds, and its relationship to the others.

1.1 Conceptualizing the Gap

The word "gap" flattens several distinct failures, and closing it depends on knowing which one you mean. This section sets out where the gap sits, why "evidence-based" conceals as much as it reveals, why much of the attrition is built in, and how reordering research and implementation can narrow it.

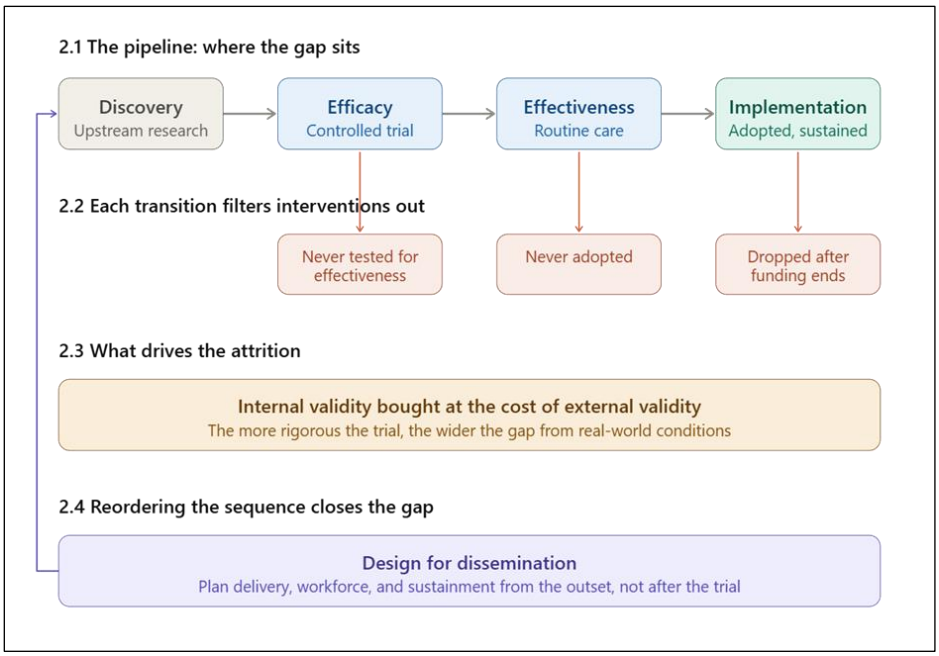

Figure 1: A conceptual framework of the research-to-practice gap. The translational pipeline (2.1) runs from discovery to sustained implementation; interventions are filtered out at each transition (2.2); the internal–external validity tension drives that attrition (2.3); and designing for dissemination reorders the sequence by planning delivery from the outset (2.4)

2 THE TRANSLATIONAL PIPELINE AND WHERE THE GAP SITS

Translational science runs from basic discovery to population impact, and the interventions this review concerns live at the far end, where research meets real practices and communities. But the field's methods, incentives, and prestige cluster upstream, in generating evidence, while the downstream work of getting it used is neglected. Studts (2022) puts the consequence plainly: interventions are routinely developed with no thought to whether they could ever be delivered outside a research setting, so a program can be proven to work and remain, in practice, unusable. Implementation science occupies this neglected end, not producing new efficacy evidence, but asking how established evidence gets adopted and sustained (Johnson & Beidas, 2023). Locating the gap here redirects the response: if the shortfall were missing evidence, the remedy would be more trials; because it is missing uptake, the remedy lies in the conditions of practice.

2.1 Efficacy, effectiveness, and implementation

"Evidence-based" collapses three claims into one. Efficacy asks whether an intervention works under controlled conditions; effectiveness, whether it still works in routine care with ordinary staff and unselected populations; and a third question, the one implementation science exists to answer, whether it will be adopted, delivered faithfully, and sustained once the researchers leave (Studts, 2022; Johnson & Beidas, 2023). Each transition filters interventions out: strong efficacy data may never be tested for effectiveness; proven programs may never be adopted, adopted ones may be dropped within a few years. Calling something "evidence-based" obscures exactly where it has stalled, and therefore what moving it would require.

2.2 Built-in attrition: internal versus external validity

Much of that attrition is designed from the start. The features that make an efficacy trial rigorous, tight protocols, intensive oversight, homogeneous participants, resources no ordinary agency commands, are the same ones that make the resulting intervention hard to deliver anywhere else. Internal validity is bought at the cost of external validity, and the stronger the trial on its own terms, the wider the distance from a community clinic's conditions. This is why faster dissemination cannot close the gap on its own: pushing a research-perfect intervention onto settings that cannot support it does not translate the evidence, it relocates the failure to the point of delivery. The problem compounds at scale, where dozens of ordinary sites present conditions, the original design never anticipated (Koorts et al., 2018).

2.3 Designing for dissemination

The more promising response inverts the sequence. Rather than building an intervention to win a trial and worrying about delivery later, designing for dissemination holds that implementation should be planned from the outset: who

will deliver a program, in what setting, with what resources, and whether it survives the end of grant funding (Studts, 2022). Shaw et al.s (2023), on early childhood intervention, treat developing, implementing, and scaling as one connected enterprise rather than a relay. Frameworks like RE-AIM formalize this, judging impact by reach, adoption, fidelity, and sustainment rather than efficacy alone (Studts, 2022). An intervention that works but reaches two percent of an eligible population, or runs for one funded year and stops, has not succeeded in any sense that registers at the community level, and it is these outcomes that determine whether research delivers the impact Brownson et al. (2025) insist it must show.

3 THEMATIC SYNTHESIS

3.1 Community Engagement and Partnerships

Having established where the gap sits and why it persists, the review now turns to the strategies that address it. The sections that follow examine four in turn: community engagement and partnership, cultural adaptation and health equity, implementation infrastructure, and the alignment of research with practice and policy. Each is presented not as a standalone remedy but as a response to a specific barrier identified above, and each section opens by naming that barrier before arguing toward the strategy as its answer. The four are treated separately for clarity, but the discussion returns to the ways they depend on one another. The first strategy, and the most direct, is community engagement

If the gap forms where evidence, delivery systems, and communities meet, the most direct response is to bring those parties together from the start. This is the logic of community engagement. Across otherwise dissimilar problems including opioid overdose (Martinez et al., 2020), diabetes disparities (Egede et al., 2022), community violence (Banyard et al., 2023), the same claim recurs: interventions imposed on communities underperform those built with them. What unites this work is a shared diagnosis of the barrier it answers, the structural separation between those who produce evidence and those expected to use it.

3.2 The researcher–practitioner divide

Pinto et al. (2019) place this divide at the center of the translation problem, arguing that it is not a communication failure to be solved with better dissemination but a structural one. Researchers and frontline organizations run on different timelines, answer to different incentives, and hold different standards for what counts as adequate proof (Pinto et al., 2019). The consequence surfaces across the partnership literature: when an intervention is handed across that divide as a finished product, it is received as an imposition rather than a resource, which is precisely the failure the HEALing Communities designers set out to avoid (Martinez et al., 2020) and the one Towfighi et al. (2020) sought to forestall by building lasting institutional channels. Partnership reframes the relationship: instead of translating evidence *to* a community, the community becomes a co-author of how evidence is selected, adapted, and delivered, which is also where contextual fit is won or lost (Pinto et al., 2019).

3.3 Community engagement as implementation strategy: the HEALing Communities Study

The clearest demonstration of this at scale is the HEALing Communities Study, the federal response to the opioid overdose crisis. Its core intervention, Communities That HEAL, treats community engagement not as outreach appended to a program but as an implementation strategy in its own right, a structured, data-driven process through which local coalitions select and deploy practices such as naloxone distribution, medication for opioid use disorder, and safer prescribing from a menu of evidence-based options (Martinez et al., 2020). The design rests on an explicit premise: that uptake of these practices had remained low because implementation was done *to* communities rather than *with* them, and that coalitions weighing local conditions could achieve reach that externally imposed programs could not (Martinez et al., 2020). That this remains a design rationale rather than a settled finding matters, but the logic generalizes beyond opioids as it locates the community's authority at the point of selecting and tailoring interventions, the same point at which Pinto et al. (2019) argue fit is decided. The barriers such coalitions must overcome are sharpest in rural and underserved settings, where harm-reduction programs confront distinctive obstacles of distance, workforce shortage, and stigma that urban-centered models rarely anticipate (Musa & Botwe, 2025).

3.4 From project-bound collaboration to standing infrastructure

If engagement is to produce more than a single success, it needs a structure that outlasts the grant that funded it. Towfighi et al. (2020) describe how academic public partnerships built through the Clinical and Translational Science Award network created durable channels between universities and public agencies, converting one-off, grant-bound collaborations into standing infrastructure. The distinction carries real weight. A partnership assembled to execute a single grant rarely outlives it, and the trust and local knowledge accumulated along the way dissolve with it, the same fragility that leaves community coalitions like those in the HEALing Communities model vulnerable once study funding ends (Martinez et al., 2020). Infrastructure that persists across projects lets each new effort begin from established trust

rather than rebuild it from nothing (Towfighi et al., 2020), an advantage that compounds over time and attacks the sustainability problem directly rather than leaving it to each project to solve alone.

3.5 Cross-sector partnership

Partnership also has to reach across sectors, because the determinants of social and behavioral health rarely sit within a single system. Egede et al. (2022) document collaborations between health care systems and community organizations aimed at closing diabetes-related disparities, work that requires coordinating clinics, community groups, and social service agencies that ordinarily operate in isolation and rarely share data, incentives, or accountability (Egede et al., 2022). This is a steeper version of the same coordination the HEALing Communities coalitions attempt within the health sector (Martinez et al., 2020): cross-sector collaboration is harder to sustain precisely because it spans organizations with divergent missions, yet it is often the only configuration capable of addressing problems whose causes are distributed across sectors, as disparities in chronic disease generally are (Egede et al., 2022).

3.6 The costs and limits of engagement

Engagement is not a guaranteed method, and the literature is honest about its strain (Banyard et al., 2023). Community-engaged research is slower than investigator-driven work and asks researchers to cede control over design and pace. Banyard et al. (2023), evaluating a community-building violence-prevention effort, show how much methodological care is needed simply to capture what such partnerships produce, integrating interventionist and action-research approaches because neither alone accommodates both the intervention's logic and the community's own account of its impact (Banyard et al., 2023). The difficulty compounds the further partnership reaches across sectors (Egede et al., 2022) or across the institutional boundaries Towfighi et al. (2020) worked to bridge, since each added party multiplies the coordination cost. The lesson is not that engagement is optional but that it is demanding: partnership staged superficially, as consultation after the real decisions are made, delivers little, whereas partnership that genuinely shares authority is costly, slow, and, on the evidence assembled here, among the more reliable ways to move evidence into settings that will keep using it (Pinto et al., 2019; Martinez et al., 2020).

3.7 Cultural Adaptation and Health Equity

The second strategy takes up where community engagement leaves off. Partnership brings communities to the table; it does not settle what happens to the intervention once they are there. That question, how far an evidence-based practice must change to fit a population it was not designed for, is where the translation problem meets the equity problem most directly and where getting it wrong does the most damage.

3.8 The problem of contextual fit

Most evidence-based practices in social and behavioral health were developed and validated with majority populations in mind, then applied to minoritized groups as though the evidence transferred intact (Thier et al., 2020; Schoenberg & Snell-Rood, 2019). It often does not, because an intervention's effects rest on assumptions about language, family structure, trust in institutions, the meaning of a symptom that hold for the tested population and quietly fail for another. Thier et al. (2020), in a scoping review spanning nearly 5,000 articles, expose a revealing symptom of this gap: the vocabulary of adaptation itself is fluent among researchers but arcane to the practitioners expected to carry it out. When the people delivering an intervention cannot readily parse the terms in which its adaptation is described, disciplined adaptation is unlikely to happen, and contextual misfit passes unnoticed until the program underperforms in the field.

3.9 Adaptation as method, not improvisation

The response is neither to abandon evidence-based practices for underserved groups nor to tinker with them ad hoc, but to adapt them systematically. Markham et al. (2022) show what a disciplined process looks like: using implementation mapping to adapt sexual-health programming for Native youth, they treat adaptation as a sequence of deliberate, documented decisions rather than intuition, specifying which parties are involved at each step and what each adaptation is meant to achieve. The value of a mapped process is that it makes adaptation auditable: later implementers can see not only what was changed but why, which is what allows an adaptation to be replicated or scaled rather than reinvented at each site. The recurring lesson across the adaptation literature is that this is a method with steps: needs assessment, engagement of cultural experts, and principled judgments about which components are core and which may flex, not a matter of swapping images or translating a manual. Done casually, adaptation risks stripping out the very elements that made an intervention work; done rigorously, it preserves what drives effect while changing what governs fit.

3.10 When adaptation meets the organizations that must deliver it

Even a well-adapted intervention still has to be carried by the organizations that serve the intended population, and those organizations are often the least resourced. Porteny et al. (2020), studying the *Positive Minds–Strong Bodies* program, a cognitive-behavioral and exercise intervention delivered in four languages by community health workers to

minority and immigrant elders, found that the decisive barriers were organizational rather than cultural: the community-based organizations best positioned to reach these elders were underfunded and understaffed, which made the leap from a trial-proven intervention to an embedded one precarious. The finding sharpens the equity argument. Cultural fit is necessary but not sufficient; without attention to the capacity of the delivering organization, an adapted intervention reaches the community during the grant and vanishes after it, which is precisely the fate equity-minded translation is meant to prevent.

3.11 Equity as the organizing aim

These threads converge on a larger commitment: that the populations bearing the heaviest burden of need are not, once again, the last to benefit. Nagy et al. (2025) argue for an equity-grounded implementation science that treats the reduction of disparities not as a hoped-for byproduct of wider dissemination but as the explicit objective against which implementation is judged. The distinction has teeth, because an implementation effort indifferent to equity can raise average uptake while widening gaps if the newly reached are drawn disproportionately from the already-advantaged. Schoenberg and Snell-Rood (2019) press the complementary point that a genuine cultural lens attends to the structural conditions (poverty, rural isolation, discrimination) that determine whether an intervention can land at all, rather than treating culture as a set of surface traits to be accommodated. These structural barriers increasingly extend to the digital sphere, as low-income and minority communities face constraints of access, affordability, and trust in the technologies through which interventions are now often delivered (Makut et al., 2026). Taken together, this work reframes adaptation as more than technical fitting: it is the mechanism through which translation either narrows existing disparities or, left unexamined, quietly reproduces them.

3.12 Implementation Infrastructure

However well an intervention is adapted, it still has to be delivered by an organization and a workforce capable of delivering it, frequently the weakest link, and the one Porteny et al. (2020) identified as the binding constraint in under-resourced community organizations. Reaching communities and staying there requires standing capacity that individual projects cannot supply for themselves: training, technical assistance, and frameworks that let a proven program expand beyond the sites that first tested it.

3.13 The workforce and fidelity barrier

The decision to deliver an evidence-based practice is not made by researchers but by frontline practitioners, and they make it under conditions researchers rarely see. Bennett (2025) examines how community-based practitioners actually decide what to implement, and the picture complicates any tidy model of knowledge moving from evidence to practice: practitioners weigh fit with their setting, their own confidence in delivering a program, and the practical demands it imposes, as much as they weigh the strength of the evidence. This is the fidelity problem in embryo. A practice delivered by staff who lack training, time, or confidence will drift from the form that made it effective, and no amount of evidence upstream compensates for that erosion at the point of delivery. The implication is that closing the gap requires investment in the deliverers themselves, not just in the interventions they are asked to deliver.

3.14 Training and technical assistance as standing infrastructure

Training and technical assistance are the mechanisms through which that investment is made, and increasingly they are organized not as one-off workshops but as durable centers. Acosta et al. (2024) describe training and technical assistance centers as a potential mechanism for equitable implementation, pairing an evidence-based technical-assistance process with a framework designed to keep equity in view so that the support these centers provide actively works to reach under-served populations rather than defaulting to the settings easiest to serve. The distinction from a training session is the same one drawn in Section 3 between a grant-bound project and standing infrastructure: a workshop ends, but a center persists, accumulating expertise and relationships that each new implementation can draw on.

The clearest instance of such infrastructure at a national scale is the SAMHSA Technology Transfer Center network, which Reho et al. (2024) examine from within. Established for addiction treatment in the 1990s and later expanded to cover mental health and prevention, the network equips the behavioral health workforce across the country with evidence-based practices and the support to implement them (Reho et al., 2024). Its existence makes a structural point: rather than leaving each clinic or agency to discover and adopt effective practices on its own, a permanent, publicly funded system exists to move those practices into the workforce, and, as Reho et al. show through attention to quality improvement within the network, the value of such infrastructure depends on continuously evaluating whether the support it delivers is actually useful to the practitioners receiving it.

3.15 From single sites to scale

Infrastructure supports delivery in a given setting; a further problem is expansion, because a program that works in a handful of well-supported sites faces different conditions across dozens of ordinary ones. Though developed in Australia, the PRACTIS guide offers a structured, broadly transferable approach to planning for scale-up, treating wider implementation as something to be designed for deliberately rather than assumed (Koorts et al., 2018). Its premise applies directly to the fragmented US delivery landscape and echoes the design-for-dissemination logic of Section 2: the conditions of scale: variable staffing, uneven resources, local differences in population and setting, should inform how an intervention is prepared, not be discovered after expansion falters. Scale-up handled as an afterthought reproduces at wider cost the same misfit that defeats interventions at a single site; scale-up planned for from the outset is what allows an effective program to become a widely available one.

3.16 Research–Practice–Policy Integration

The strategies to this point operate at the level of programs and their delivery, but whether an intervention reaches a whole community and survives once it arrives is often decided above that level: by what gets funded, mandated, and sustained through policy. Dopp and Lantz (2020) put the limit plainly for children's mental health: drawing on a social-determinants framework, they argue that most evidence-based interventions are constrained by their focus on the individual child while the community conditions and public policies that shape mental health go unaddressed. Downstream treatment, however effective, cannot move population-level outcomes when the determinants sit upstream, so closing the gap means directing evidence at policy levers, not only delivering programs better.

Moving evidence into policy requires standing relationships between those who produce it and those who decide. Perkins et al. (2024) show this through a research-practice-policy partnership built around a longitudinal survey of post-9/11 veterans, in which researchers worked with philanthropic and practice partners to turn rigorous data into sustained action rather than a report that ends on a shelf. Translation here is an ongoing relationship, not a hand-off: the partnership shaped what data were collected and carried the findings into decisions over years. The same coordination is needed across the systems through which people actually reach services. Splett et al. (2018) examine how research, policy, and practice must align for students to access behavioral health care through schools, settings that are at once a service site, a policy environment, and a community institution, while Read and Kohrt (2022) make a parallel point through coordinated specialty care for early psychosis, whose success depends on organizing fragmented services around the patient rather than leaving families to navigate alone.

Underlying all of this is the barrier that recurs at every level of this review: sustainability. An intervention adopted but not sustained, a partnership that dissolves when a grant ends, a policy win left unmaintained, each is the gap reopening after it appeared closed. Policy is where translation is made permanent or left to lapse: a practice written into how a system is funded and governed no longer depends on the enthusiasm of individual champions or the life of a single grant (Perkins et al., 2024; Dopp & Lantz, 2020). Aligning research with policy is thus less a separate strategy than the mechanism that gives the others their staying power.

4 DISCUSSION

The four strategies examined here are usually studied, funded, and written about separately, as though a project could pick one and succeed. The weight of the evidence assembled in this review points the other way: they tend to be interdependent, and each is prone to failing in a characteristic way when pursued without the others. Community engagement without adaptation can produce partnerships that select interventions ill-suited to the population they serve. Adaptation without infrastructure can yield a well-fitted program that under-resourced organizations cannot deliver or sustain, the constraint Porteny et al. (2020) found binding. Infrastructure without engagement builds delivery capacity for interventions communities had no hand in choosing. And all three remain vulnerable to lapsing once funding ends unless alignment with policy makes them durable. The pattern across the cases reviewed is that translation more often stalls on the missing element than on the ones present, though the evidence here is a body of largely descriptive and case-based work, and the strength of these interdependencies is a proposition these studies suggest rather than one any of them tests directly.

This helps explain why single-strategy efforts so often disappoint. A coalition empowered to select practices but given no technical assistance, or a sophisticated scale-up plan imposed without local buy-in, each addresses one barrier while leaving others to defeat it. The HEALing Communities model is instructive precisely because it combines elements, community coalitions choosing from an evidence-based menu, supported by data and technical infrastructure (Martinez et al., 2020), rather than resting on engagement alone. Whether that combination delivers on its promise remains to be shown in outcomes, but its design reflects the more general point: a strategy has to be matched to the full set of barriers a context presents, not to whichever barrier a particular discipline is accustomed to seeing.

Reading the strategies together also sharpens what impact should mean and how it should be measured, and here the review's argument converges with a framework offered from within implementation science itself. Brownson et al. (2025) identify four essential domains of implementation impact: speed of translation, sustainability, de-implementation, and equity, as the terms on which the field's contribution should be judged, rather than the academic outputs of citations and grants that carry little direct social value. Two of those domains, sustainability and equity, are precisely the ones that recur across every strategy in this review, and neither is reachable by any single strategy's preferred measure. Partnership satisfaction, cultural fit, training outputs, and legislative wins each capture something real, yet none alone establishes that a community is better served than before. The measures that do, reach into the population that needs an intervention, fidelity of delivery in ordinary settings, and sustainment past the funded period, are properties of the strategies working in combination, which is why an account organized around their integration is better placed to foreground them.

None of this means every project must deploy all four strategies at full strength; few could. It means that a project does well to begin by diagnosing which barriers its context actually presents: an under-resourced delivery system, a poorly fitted intervention, a fragmented service landscape, a policy environment that will not sustain what is built, and to assemble the corresponding strategies deliberately rather than defaulting to the one nearest at hand. The value of a synthesis like this one is to make that diagnostic stance available: to let those doing the work treat the strategies as complementary responses to a shared problem, so that the element most easily neglected is the one most deliberately supplied.

5 CONCLUSION

The gap between what social and behavioral health research demonstrates and what communities receive has been treated too often as a problem of distance, as though sound evidence sat on one side of a divide and needed only a firmer push to reach the other. The evidence assembled in this review points to a different understanding. The gap is not a space to be crossed but a set of conditions to be built: a community with a genuine hand in choosing what it receives, an intervention adapted to fit rather than imposed, an organization and workforce equipped to deliver it, and a policy environment that keeps it in place after the funding that launched it is gone. Where translation succeeds, it succeeds because these conditions were assembled together; where it fails, the failure can usually be traced to the one that was left out.

That reframing carries a demand. It asks researchers to design for delivery from the outset rather than treating implementation as someone else's problem, practitioners to be recognized as partners in adaptation rather than passive recipients of finished programs, and funders and policymakers to underwrite not just the discovery of what works but the far less glamorous work of keeping it working. None of these is easily done, and this review has been candid about the costs engagement is slow, adaptation is demanding, infrastructure is expensive, and policy change is uncertain. But the alternative is the status quo the field already knows: a growing catalogue of proven interventions that the communities bearing the heaviest burden of need are still the last to receive.

The measure of progress, in the end, is not how much evidence is produced but how much of it changes the conditions under which people actually live. Closing the research-to-practice gap in the United States will depend less on generating new proof that interventions work than on the harder, more collaborative labor of ensuring that what works reaches those who need it and stays.

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