Controversies in Knowledge Translation for Community-Based Drug Treatment: The Need to the End Policies of the War on Drugs and Mass Incarceration of Drug Offenders to Achieve Health Equity

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ABSTRACT *The purpose of this article was to discuss significant challenges to the achievement of urban health, specifically acknowledging numerous controversies in knowledge translation for community-based drug treatment that prevent the achievement of health equity. Seven specific controversies are analyzed in this article. The results of the analysis are recommendations for moving toward the resolution of each controversy. Among the most important recommendations is a call to end the policies of the war on drugs and mass incarceration of drug offenders—as policies reflecting how politics and the misuse of power may derail knowledge translation. The article provides justification for evidence-based policy that supports community-based drug treatment as a public health approach consistent with the goals of health equity, ethical practice, and effective knowledge translation.*

KEYWORDS *Knowledge translation, Drug treatment, Health equity, Urban health, Policy, War on drugs, Mass incarceration crisis, Evidence-based treatment*

INTRODUCTION

With regard to urban health and community-based drug treatment, it is important to acknowledge the negative impact of the United States' policies of the war on drugs and mass incarceration of drug offenders.^{1–3} These policies have undermined the foundations of personal health and well-being² and contributed to health disparities and health epidemics^{4,5} while being costly and wasteful.^{6–8} There is a need for evidence-based policy that supports community-based drug treatment^{9–11} as a public health approach consistent with the goals of health equity,¹² ethical practice,^{13–15} and effective knowledge translation.^{9,16}

This article will review key concepts, followed by an analysis of seven controversies—or areas of disagreement and debate—that prevent effective knowledge translation in community-based drug treatment. The results of the analysis are codified as recommendations to resolve the controversies. Discussion covers how there are some policies driven by politics and the misuse of power that prevent

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knowledge translation. In this regard, a conclusion underscores the rationale for the call to end the policies of the war on drugs and mass incarceration of drug offenders.

CENTRAL CONCEPTS

A few key concepts are worthy of a brief review while highlighting how they relate to community-based drug treatment.

Knowledge Transfer

The Institute of Medicine Committee on Community-Based Drug Treatment identified a major problem in the USA with regard to knowledge transfer of research findings to practice.¹⁷ In response, the United States' National Treatment Plan Initiative—as articulated by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Substance Abuse Treatment (CSAT)—described knowledge transfer; it is a process that ensures research findings are successfully communicated to those who regulate service delivery, as well as to policy makers, and treatment providers—doing so via a structure and format that facilitates understanding and actual use.¹⁸

Knowledge Translation

The concept of knowledge transfer is akin to that of knowledge translation (KT), as are other terms commonly found in the literature (i.e., research utilization, evidence-based practice, implementation, knowledge mobilization, moving knowledge to practice, knowledge to action, impact, linkage and exchange (p. 3)).¹⁶ What may be distilled as essential to KT is the application of knowledge in order to improve health care service delivery, the overall healthcare system, and the health of societal members—as an issue “at the local, national, and international level” (p. 2).¹⁶

CONTEMPORARY CONTROVERSIES IN KT

There are a number of contemporary controversies in KT pertinent to urban community-based drug treatment given the goal of health equity. Seven contemporary controversies are presented and analyzed in this section. The analysis is followed by recommendations intended to foster resolution of the controversy.

Controversy 1: Determining the Focus of Knowledge Development and Who Should Develop Knowledge

Knowledge development is a process that should include community-based drug treatment providers in any national research agenda, such as the one advanced in the USA by SAMHSA and CSAT (p. 109).¹⁸ Knowledge development for the purpose of improving the health of everyone is the mission of the National Institutes of Health (NIH) in the USA (including divisions such as the National Institute on Drug Abuse); however, there is controversy about which health problems deserve the highest priority.¹⁹

Two main categories of KT have been described: in *end-of-grant KT*, “the researcher develops and implements a plan for making users aware of the knowledge that has been gained from the project; in *integrated KT*, stakeholders or potential research users are engaged in the entire process,” including working on the research questions, methodology, data collection, tool development, data interpretation, and

dissemination of findings (p. 6).¹⁶ “This approach, also known by such terms as *collaborative research*, *participatory action research*, *action-oriented research*, and *co-production of knowledge*, should produce research findings that are more likely to be relevant to and used by the end users” (p. 6).¹⁶

Others confirm the importance of integrated KT. For example, there is “often a wide cultural and experiential separation between the professionals who conduct empirical investigations and the men and women who apply research findings in treatment and policy settings” (p. 29).²⁰ The belief was also uncovered that “providers should be involved in research from the beginning to help formulate research questions that were important to them, rather than just serving as a research site for investigating researchers’ ideas” (p. 37).²⁰

Recommendation The wider implementation of integrated KT is recommended to help resolve this controversy, ensuring research users are engaged in the entire process.

Controversy 2: The Surplus of Efficacy Research— As the Gold Standard, the Shortage of Effectiveness Studies, and the Pattern of Spending More Funding on Efficacy Trials

Members of the drug treatment community perceive a surfeit of “efficacy” research (studies conducted under controlled experimental conditions), while there is a shortage of “effectiveness” studies (where treatment modalities are studied under real-world conditions) (p. 39).²⁰ There is movement underway from efficacy studies to effectiveness studies.²¹ Still, the vast majority of NIH behavioral grants continue to be awarded for efficacy trials.²²

It is important to question the types of proposals being funded for knowledge development.¹⁹ Randomized controlled trials (RCTs), or efficacy trials, remain at the top of the hierarchy of knowledge; this emphasis on scientific rigor has resulted in “shortchanging investment in community intervention research” (p. 91).¹⁹ Much needed are procedures for demonstrating respect for community autonomy, distributive justice, and ethics in “allocating scarce public resources fairly across different types of health research”; this is necessary to create new knowledge to improve the health of all, especially in an era characterized by health disparities (p. 81).¹⁹ In “the science of behavioral and psychological therapies,” there is a need to change the present consensus that efficacy studies utilizing RCTs are “the gold standard for evaluating interventions” (p. 63).²²

Codifying a new consensus, the American Psychological Association’s Presidential Task Force on Evidence-Based Practice (EBPP) issued an official policy statement.²⁴ EBPP is defined as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (p. 273).²³ The best available research includes multiple types of evidence (e.g., efficacy, effectiveness, cost-effectiveness, cost-benefit, epidemiological, treatment utilization), and this evidence may arise from multiple types of acceptable research designs (e.g., clinical observation from case studies, qualitative research, systematic case studies, single-case experimental designs, public health and ethnographic research, process-outcome studies, studies of interventions delivered in naturalistic settings or effectiveness research, RCTs or efficacy research, and, meta-analysis or synthesizing results from multiple studies) (p. 273).²³

Recommendation Valuing efficacy research as the gold standard in behavioral and psychological research needs to be replaced with valuing multiple types of evidence and multiple types of acceptable research designs. The equitable use of funds needs to replace spending a majority of funding on efficacy trials while increasing funds spent on effectiveness studies.

Controversy 3: Whether or Not the Products Available for KT are Suitable for Use by the End-User or Implementable in Real-World Settings

Once a substance abuse treatment demonstrates effectiveness through clinical trials, it is up to community-based programs to determine whether the treatment is implemented or not—given stages of discovery, development, and implementation of evidence-based interventions; the fate of the treatment can be decided at the community level.²⁴ There are many issues to be considered before KT proceeds, or before the implementation of evidence-based practices (EBPs) in real-world addiction treatment settings.²⁵ There are problems in generalizing findings from efficacy research into real-world settings.^{21,25} Optimal processes for disseminating empirically based interventions into real-world clinical settings have yet to be identified.^{21,25} Cost and staff training are relevant factors.²⁴ There is also the perception of a gap between providers' experience in real-world settings and that of researchers, so many of "the treatments that receive research attention are resource-intensive interventions studied under rarefied conditions for fixed periods of time" (p. 39).²⁰ Perhaps practice should drive research instead of applied researchers assuming that research should drive practice (p. 64).²²

Recommendation The use of integrated KT would help resolve this controversy.

Controversy 4: Issues Involving the Use of Evidence-Based Treatments with Racial/Ethnic Minorities, Whether Cultural Adaptations of Evidence-Based Treatments are Sufficient, and If Evidence-Based Treatments Are Culturally Relevant

It is generally acknowledged that culturally diverse clients (i.e., subjects from racial and ethnic minority groups) are typically not represented in samples in efficacy trials.²⁶ Thus, it is appropriate to ask: are these treatments valid for minorities?²¹

Numerous sociocultural questions "frame current debate about the role of patient characteristics in EBPP" (p. 278).²³ It is relevant to consider "the extent to which social factors and cultural differences necessitate different forms of treatment or, conversely, the extent to which interventions widely tested in majority populations can be readily adapted for patients with different ethnic or sociocultural backgrounds" (p. 279).²³

Yet, "advocates of cultural competence and empirically supported treatment agree that treatments that have been shown to work with predominantly European American populations should be tried with ethnic/racial minority individuals;" this follows from ethnic/racial minorities in the United States sharing "some cultural characteristics with the mainstream society" (p. 572).²¹ Given some shared characteristics, it is also assumed that "culturally specific interventions developed for ethnic/racial minority groups are effective with other cultural groups, including European Americans" (p. 572).²¹

Much needed are more effectiveness studies which address issues of external validity—versus efficacy studies that emphasize internal validity and fail to include adequate representation of ethnic/racial minorities; furthermore, efficacy studies tend to fail to analyze data by ethnicity/race even when a rare sample includes people of color.²¹ The external validation of empirically supported treatments would also require efficacy and effectiveness research conducted with ethnic/racial minority populations, yet “simply including more ethnic/racial minority patients or clients in efficacy studies is an adequate form of cultural adaptation” (p. 570).²¹

For example, in a meta-analysis of 72 clinical trials of motivational interviewing (MI), the usual analysis was conducted to see what attributes predicted larger effect sizes. To the surprise and pleasure of the researchers, it was found that when the patient population was primarily minority (i.e., mostly Hispanic and African-American), the effect size of MI was doubled; this was relative to the average in white non-minority samples.²⁷

It is also possible to culturally adapt empirically supported treatment with people of color in order to achieve more culturally competent services.²¹ Here, cultural adaptation is defined as engaging in any adjustment “to an evidence-based treatment that involves changes in the approach to service delivery, in the nature of the therapeutic relationship, or in components of the treatment itself to accommodate the cultural beliefs, attitudes, and behaviors of the target population” (p. 571).²¹ Indeed, “significant adaptations are needed in terms of delivery, therapeutic process, and inclusion of cultural knowledge, attitudes, and behaviors to make empirically supported treatments more culturally appropriate” (p. 570).²¹

Investigations show “that standard empirically supported treatments are efficacious with persons of color”—suggesting “that modifications to service delivery may be sufficient cultural adaptations in many cases” (p. 570).²¹ However, others assert that some evidence-based practices are fundamentally culturally irrelevant.²⁸

Recommendation What is needed is the use of integrated KT with the aim of developing culturally relevant knowledge. The results may also include the enhanced cultural competence of researchers, more research with diverse samples, as well as research on cultural adaptations to investigate their evidence base.

Controversy 5: The Practice of Mandating the Selection of Evidence-Based Practices from Lists In Order To Receive Funding Despite a Potential Lack of Cultural Relevance and Risk of Exacerbating Health Inequities

There are an increasing number of federal and state initiatives that emphasize the implementation of EBPs in addiction treatment settings; this emphasis is also increasingly held by stakeholders (i.e., health care regulators, payers of behavioral health care), yet there is no consensus regarding what constitute optimal procedures for identifying practices with sufficient empirical foundation for them to be considered evidence-based.²⁵ In fact, many problems abound with lists of EBPs: there is the danger of overemphasizing in the hierarchy of what constitutes evidence-specific therapy techniques that are overvalued relative to aspects of the therapeutic relationship. Lists vary in the number and types of treatments listed; some lists are not updated, and EBPs on lists may appear for political purposes.²⁵ Regardless, “community-based drug treatment organizations must comply with the directives and regulations of their funders” (p. 40)²⁰

Noteworthy are resultant perceived violations of the right of the community to determine appropriate interventions for their sociocultural context, given the requirement to select from lists of EBPs.²⁸ Representatives of community-based drug treatment programs have described how “many clinical trials exclude the classes of patients that are most prevalent in community-based agencies, and consequently findings from such research do not seem relevant when viewed by treatment providers” (p. 38).²⁰ Furthermore, researchers were found to lack knowledge about community-based treatments (p. 37).²⁰ Deserving of attention is the invaluable role of community-defined evidence, practice-based evidence, and clinical expertise—particularly with regard to delivering treatment to communities of color by agencies with a history of already having done so.²⁸

Moreover, many EBPs on lists lack consideration of cultural competence and failure to include cultural variables; the researchers, themselves, often lack cultural competence to meet the needs of racially and ethnically diverse populations.²⁸ The forced selection of such EBP models from lists may potentially exacerbate health inequities for culturally diverse populations.²⁸

Recommendation The use of integrated KT should result in the development of a knowledge base that includes menus of culturally relevant EBPs from which providers may choose interventions, replacing current problematic lists that reflect cultural irrelevance. Until such culturally relevant knowledge development occurs, there should be no mandates requiring the selection of evidence-based practices from lists in order to receive funding. Instead, providers should be able to present a rationale for interventions selected for use while understanding both the value in using/culturally adapting evidence-based approaches and the multiple types of evidence and research designs they may identify as justifying their selection of interventions (i.e., qualitative research, systematic case studies, studies of interventions delivered in naturalistic settings, or effectiveness research). Also, clinical expertise must remain valued, permitting the exercise of clinician flexibility, including engagement in cultural adaptations of evidence-based approaches.

Controversy 6: The Use of Manualized Evidence-Based Practices that are Standardized in Opposition to the Movement to Preserve Individually Tailored Treatments Based on Ongoing Assessments that Guide the Selection, Integration, and Sequencing of Evidence-Based Practices

The evidence-based movement is striving to standardize therapies by making treatments manual-driven, potentially resulting in poorer quality care, but the treatment system in the USA is not well suited at the current time for the goal of implementing manualized psychosocial EBPs.²⁵ There is a history wherein clinician-delivered therapies were considered most efficacious because they were individualized and dependent upon interaction with clients.²² Thus, there is a more appropriate movement from standardized toward individually tailored paradigms since behavior change is a dynamic process that unfolds over time, involving various stages and principles of change that apply to different stages; this necessitates tailoring interventions to meet the needs of the individual client.²²

“Rather than individual differences being treated as variability that must be controlled, such differences are seen as opportunities for tailoring treatment to the individual’s current needs” (p. 72).²² Instead of “trying to control individual

differences as a threat to validity, tailored interventions can be driven by such differences as a foundation for external validity” (p. 72).²² There is evidence of positive outcomes when using individually tailored interventions with populations often considered difficult, supporting the conclusion that “the problem is not inability to change: the problem is inaccessibility to quality change programs” (p. 72).²² Such quality behavior change programs deliver individually tailored interventions that respond to assessment findings at any given point in time, while assessment continues across time.

Furthermore, what is recommended is treatment for “multiple rather than single behaviors to enhance population health and well-being,” given that the majority of clients actually present with multiple problems (p. 73).²² “The highest risk and highest cost people are those with multiple behavior problems” (p. 73).²² Yet, RCTs, or efficacy trials, “target single specific conditions with a single specific treatment to assess the efficacy of the treatment,” whereas behaviors and psychological treatments “are not specific to specific conditions. Yet, the history of RCTs is that we evaluate them as if they are” (p. 73).²² What are needed are “impacts on multiple behaviors treated by tailored communications” (p. 75),²² while clients with a single condition can still receive a single-behavior approach within a multiple-behavior paradigm (p. 75).²² A more inclusive paradigm for research and practice can produce a more inclusive approach to care that might enhance not only health but also social justice, consistent with the goals of health equity.²²

A multiple-behavior paradigm is an apt description of an approach to urban clients in a community-based drug treatment setting who are characterized as “multi-problem,” i.e., using multiple drugs, presenting comorbidity/multiple mental disorders, and engaging in multiple problem behaviors (e.g., illicit substance abuse, non-adherence to psychiatric medications, high-risk sexual behavior), while often in different stages of change for each behavior.¹¹ Failure to provide access to an evidence-based approach may constitute an injustice, for example, discrimination by practitioners in service delivery and a maladaptive response to client diversity, perpetuating health disparities. The resultant social justice approach seeks to ensure equity in health for all via equal access to evidence-based approaches. The approach relies on clinical expertise, including the ability to exercise both fidelity to some recommended treatments and flexibility in recognizing when the need arises to engage in the adapting and integrating of interventions selected from a menu of options; this is done in light of ongoing assessment findings revealing individual client needs, problems, characteristics, and preferences as they emerge across time in the real-world treatment setting. The result is tailoring treatment for individual clients, including cultural adaptations. This approach implies that the best research evidence may include that which is both evidence-based and considered promising since the evidence base may not as yet exist for clinician integration of two, three, or more approaches (e.g., multiculturalism, positive psychology, the strengths-based approach, and optimistic thinking/learned optimism), as recommended in the model.¹¹ The result is a viable model for tailoring individualized treatment for contemporary community-based drug treatment clients.

The Director of the National Institute on Drug Abuse recently described how the field is moving toward individualized treatment for substance abuse.²⁹ The future of treatment for substance abuse rests in the development of a growing body of evidence-based treatments from which practitioners can select as they identify the most appropriate treatment, or combination of treatments, or sequence of treatments deemed appropriate for an individual client; meanwhile, what is important is

to treat each client as unique, while treatment should address their particular strengths, needs, or circumstances, such as, for example, co-dependencies and co-occurring disorders.²⁹ There is also a role for the administration of assessments along with interventions delivered with fidelity.²⁹ Meanwhile, both clinical observation and research discovery can be a source of new treatments that emerge as evidence-based, once proven effective in clinical trials.²⁹

Of note is that, with this final emphasis on and endorsement of a definitive role for results of clinical trials, the above position raises a main controversy already discussed: controversy 2, the surplus of efficacy research—as the gold standard, the shortage of effectiveness studies, and the pattern of spending more funding on efficacy trials. Meanwhile, the interventions proven to be effective in clinical trials may give rise to manuals that standardize treatments, in opposition to the movement to preserve individually tailored treatments. Thus, an ongoing controversy persists.

Recommendation 6 As opposed to strict adherence to and exclusive use of manualized evidence-based practices that are standardized, clinician flexibility and expertise must be honored in tailoring treatments for individual clients; this should include a process where clinicians select interventions from menus of evidence-based options while they feel free to integrate, combine, adapt, and sequence treatments in light of individual assessment findings obtained across time.

Controversy 7: The Manner in Which Politics and the Misuse of Power May Prevent KT, Yet Guide National Policy, As In the Case of the Policies of the War on Drugs and Mass Incarceration of Drug Offenders

As has been noted, “the selection of a policy position is a highly political process, not a scientific one” (p. 1248).³⁰ An ideological conviction may operate on the part of policy makers.⁹ Reflecting politics and the misuse of power, exposure to evidence-based approaches (i.e., that are properly integrated, adapted, and sequenced) in community-based drug treatment is not prevailing as the predominant response to drug offenders—as a public health approach; instead, the policies of the war on drugs and mass incarceration of drug offenders have dominated for the past three decades,^{1,2,11} promoting health inequities.¹² The role of Presidents of the USA—from Nixon to Clinton—in promoting the war on drugs policy has been discussed in detail elsewhere.¹ By way of brief example, Nixon first called for a war on drugs, while President Reagan officially announced the War on Drugs in October 1982. Under Reagan, funding soared to combat drugs, while a deceptive media campaign was used to “justify” the war on drugs and enable the passage of national anti-drug legislation.¹ Voting members of society are complicit in sustaining the get-tough-on-crime era of zero tolerance for drugs and harsh criminal sanctions.²⁹ There was a mandate for punishment.²

One result of the war on drugs policy is the policy of mass incarceration of drug offenders. By 1991, data showed that “the number of people behind bars in the United States was unprecedented in world history,” with “one fourth of young African American men” being “under the control of the criminal justice system” (p. 55).¹ The USA became the uncontested global leader in rates of imprisonment.² The resultant inequities and massive social injustice included a particularly deleterious impact on racial/ethnic groups, their families, and communities; this involved the trauma of incarceration, forced separation from children, loss of child custody, and dissolution of intimate relationships and families.^{2,11} Opportunities for engaging in work,

accessing housing, and maintaining a cohesive and stable family were destroyed for the millions incarcerated, thereby isolating, stigmatizing, and marginalizing the most economically disadvantaged members of society.² These destroyed opportunities have also been referred to as “invisible punishments” or collateral consequences that followed from the policy of mass imprisonment.⁶ A lack of education, employment, health care, housing, and the right to vote (post-felony conviction) plagues those released from incarceration.³¹

Recommendation 7 Urban health workers and other professionals need to be trained in the strategies of advocacy and taking social action for social justice in order to end the policies of the war on drugs and mass incarceration of drug offenders. Training in such strategies may permit effectively challenging how politics and the misuse of power may prevent KT and lend support to a recommended global civil rights movement to bring about equity in health for all,³² as well as a recommended social justice movement to bring a final end to racial caste systems (i.e., as manifested via the war on drugs and mass incarceration of drug offenders).¹

CONCLUSION

This article has reviewed seven controversies in KT in community-based drug treatment and offered corresponding recommendations that may begin to provide resolution. Powerful support emerged for integrated KT, in particular. A call for an end to the policies of the war on drugs and mass incarceration of drug offenders emerged as more than justified as policies driven by politics and the misuse of power that derail KT.

A public health policy approach needs to prevail that is consistent with the goals of health equity,¹¹ ethical practice,^{13–15} and effective KT,^{9,16} permitting community-based drug treatment to serve as an alternative to the policies of the war on drugs and mass incarceration of drug offenders. Finally, the significance of this contribution rests in the intent to foster advancements in urban health and equity in health for all as a civil right.³³

ACKNOWLEDGMENTS

This work has been funded in part by the Canadian Institutes of Health Research (CIHR) under grant no. 101693, entitled “Power, Politics, and the Use of Health Equity Research.”

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