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Article

The "Consorcio Latinoamericano de Investigación en Psicoterapia" (CLIP): A Call for Collaborative Research and Practice

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ABSTRACT

Background: Over the past three decades, psychotherapy practice in Latin America has advanced significantly, driven by government reforms and the increasing relevance of clinical psychology. Despite this expansion, mental health systems remain characterized by uneven resource distribution, limited integration between research and practice, and barriers to access to care. **Proposal:** This article explores the potential for implementing routine outcome monitoring as a strategy to bridge the research and practice gap and support data-informed clinical decision-making in the region. It introduces the *Consorcio Latinoamericano de Investigación en Psicoterapia*, as a regional initiative designed to strengthen cooperation among researchers and clinicians, advance evidence-based practices in psychotherapy, and establish a common framework for routine clinical data collection, while fostering contextually relevant evidence in Latin America. **Conclusion:** More than a collaborative platform, this consortium embodies a collective vision for more equitable and effective mental health systems in Latin America. Psychotherapists, researchers, and mental health service providers are encouraged to engage in this initiative, fostering a culture of data-informed practice where research and clinical work come together to enhance the quality of care, improve therapeutic outcomes and inform context-sensitive policy decisions.

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Consorcio Latinoamericano de Investigación en Psicoterapia (CLIP): Una Llamada a la Investigación y Práctica Colaborativa

RESUMEN

Antecedentes: En las últimas tres décadas, la práctica de la psicoterapia en América Latina ha avanzado significativamente, impulsada por reformas gubernamentales y la creciente relevancia de la psicología clínica. A pesar de esta expansión, los sistemas de salud mental continúan caracterizándose por una distribución desigual de recursos, una limitada integración entre investigación y práctica, y barreras en el acceso a la atención. **Propuesta:** Este artículo explora el potencial de la implementación del monitoreo rutinario de resultados como una estrategia para cerrar la brecha entre investigación y práctica, y apoyar la toma de decisiones clínicas informadas por datos en la región. Asimismo, presenta al Consorcio Latinoamericano de Investigación en Psicoterapia como una iniciativa regional diseñada para fortalecer la cooperación entre investigadores y clínicos, promover prácticas basadas en evidencia y establecer un marco común para la recolección rutinaria de datos clínicos, fomentando al mismo tiempo evidencia contextualizada en América Latina. **Conclusión:** Más que una plataforma colaborativa, este consorcio representa una visión colectiva hacia sistemas de salud mental más equitativos y efectivos en América Latina. Se alienta a psicoterapeutas, investigadores y proveedores de servicios de salud mental a participar en esta iniciativa, promoviendo una cultura de práctica informada por datos en la que investigación y trabajo clínico convergen para mejorar la calidad de la atención, mejorar los resultados terapéuticos e informar la toma de decisiones en políticas sensibles al contexto.

Palabras clave:

Monitorización rutinaria de resultados

Investigación en psicoterapia

Red de investigación en la práctica

Investigación orientada a la práctica

Evidencia basada en la práctica

Mental Health Systems and Psychotherapy Research in Latin America

Over the past three decades, the practice of psychotherapy has expanded significantly across various Latin American countries (Fernández-Álvarez, 2017). This growth can be partially attributed to efforts made by Latin American governments to restructure their mental health systems in line with the proposals outlined in the Declaration of Caracas (González & Levav, 1991; Pan American Health Organization & World Health Organization, 1990). These proposals advocated for a mental health model focused on community care instead of a model centered on psychiatric treatment and hospitalization. As a result, in many Latin American countries, policymakers have proposed mental health reforms and plans to promote community mental health centers, outpatient care programs, and to foster the training of professionals in primary mental health care (Caldas De Almeida, 2013). As a result, 81% of countries in the region now have a mental health policy or plan, with over 50% having enacted specific laws to promote mental health. Furthermore, various strategies aligned with community mental health models have been developed and proliferated throughout the region (Mascayano & Montenegro, 2017).

Despite these structural changes, it remains unclear whether these policies have been effectively implemented or have genuinely improved the mental health of the populations they aim to serve (Trujillo & Paz, 2020). This uncertainty is exacerbated by various obstacles that hinder the development of public mental health research, such as lack of interest from health agencies in conducting studies that assess mental health needs and limited material and financial support for research initiatives (Barrantes et al., 2022). Consequently, mental health services in Latin America are restricted by financial limitations and inequities, struggling to meet the rising demand for care despite the increased availability of psychotherapy.

Meanwhile, the growth of psychotherapy practice in Latin America is linked to the increasing prominence of clinical psychology as a specialty. The first programs in psychology in Latin America began in 1946 in Chile and in 1947 in Colombia, expanding to other countries in the following years (Vilanova, 1993). Psychology training in the region began in the 1950s, influenced by the North American Boulder Model, which emphasized a scientist-practitioner model with a strong focus on diagnosis, standardized assessment, and evidence-based intervention within a medical framework (Gallegos & Berra, 2015). In 1974, the First Latin American Conference on Psychology Training took place, which established what is now known as the "Latin American model" for psychology training. This model emphasizes the importance of a "generalist" curriculum that covers foundational training applicable across various fields of practice, in contrast to the Boulder Model´s more specialized and clinically oriented training structure. The Latin American model recognizes psychology as both a science and a profession (Ardila, 1975; Gallegos, 2010; Klappenbach & Pavesi, 1994). In 1994, the MERCOSUR Coordinating Committee of Psychologists was established to harmonize curricula and foster regional academic integration (Penna et al., 2008). In 1998, this mentioned committee, proposed the Framework Agreement for the Training of Psychologist (Penna et al., 2008), aimed at establishing common guidelines for professional competencies, training standards, and academic recognition across MERCOSUR member countries, as a common framework for psychotherapy practice in the region, despite variations in curricular emphasis across countries.

Currently, interest in clinical psychology has increased in Latin America, with scientific and professional emphasis

in areas such as diagnosis, psychotherapy, and mental health promotion (Fernández-Álvarez & Bregman, 2018). This has led to an increase in psychological care services at public and private levels. However, challenges remain, including a lack of professional practice regulations and disparities in the quality of psychotherapy training (Sanchez-Sosa, 2007). In many countries, there are no professional regulations for the field and very few controls over the training standards required to become a qualified psychotherapist. Moreover, this training is largely influenced by treatment programs and care strategies developed in high-income countries, where mental health care realities differ significantly from local ones (Gutiérrez & Landeira-Fernández, 2018). However, it is important to acknowledge that relevant regional developments in psychotherapy training have emerged, reflecting local traditions and needs, particularly in countries such as Argentina (Fierro et al., 2018). Also, due to limited training opportunities in the region, some professionals choose to pursue training in high-income countries. These factors may ultimately limit the development of context-sensitive practices tailored to the characteristics of the local population.

The Gap Between Psychotherapy Research and Psychotherapy Practice in Latin America

Even though the 1998 Framework Agreement highlighted the importance of research training, the fact is that undergraduate curricula have prioritized professional over research training, negatively affecting the development of research in the field of clinical psychology. Despite advances in the creation of online repositories for research generated by university students, there is still a cleavage between research and clinical practice since psychotherapists often fail to integrate the latest findings into their work (Jiménez, 2007; Krause, 2011).

Although the gap between clinical research and practice is often shared with countries of the Global North (Castonguay & Muran, 2015), the latter have shown greater investment in psychotherapy research, fostering the development of strategies that have increasingly helped at covering this breach (Castonguay, 2011; Wakefield et al., 2021). Greater availability of funding for research on mental health has generated an essential development of evidence-based practice. Most evidence has been generated through quantitative studies using randomized clinical trials. This has been the "gold standard" for validating mental health interventions in Europe and the United States of America (Altimir et al., 2022). This stands in stark contrast to the reality in Latin America, where the research-clinical gap is exacerbated by the fact that government investment in research and development does not exceed 0.5% of gross domestic product in most countries in the region (World Bank Group, 2024). Consequently, there is still a limited research culture within mental health services in Latin America, though it has been growing over the past 20 years. Instead, as de la Parra (2013) notes, much of psychotherapy research in the last decades has focused on process-outcome studies using qualitative methods, likely due to lower financial requirements, and often associated with postgraduate university programs or responding to particular initiatives. Similar findings emerged in Krause´s (2023) analysis of research published in Latin American journals over the past decade, revealing that most articles focused on primarily qualitative case studies, while studies assessing outcomes were significantly fewer.

Academic research in Latin America, using case designs and qualitative or mixed methodologies, has considerably expanded our understanding in process and process-outcome research, focusing on micro-processes, macro-processes, or a combination of both (Krause & Altimir, 2016). While these studies often assess therapy outcomes by measuring final results or session-to-session progress, their primary aim is to understand change within single or multiple cases, emphasizing the mechanisms of change in psychotherapy. This body of work has explored change and its trajectory across the therapeutic process (Altimir et al., 2010; Echávarri et al., 2009; Fuentes-Cerda et al., 2023; Krause et al., 2006, 2007, 2015), identified significant transformations through new meaning construction (Capella et al., 2017; Dussert et al., 2017), analyzed the gradual integration of the self (Quiñones et al., 2012), examined the therapeutic alliance's role in facilitating change (Besser & Moncada, 2013; Cruzat-Mandich et al., 2017; Mellado et al., 2018), the therapeutic focus throughout the process (Dagnino & Calderón, 2022) and patient and therapist actions during critical episodes (Altimir et al., 2010; Genise, 2014; Krause et al., 2018) such as rupture and repair moments (Amézaga et al., 2014; Valdés et al., 2018).

Micro-process studies have focused on verbal actions during change and stagnation episodes, such as the use of self-referential language as a change device tool (Arístegui et al., 2009; Gaete et al., 2017, 2019; Reyes et al., 2008), communication aimed at attuning and resignifying during change (Valdés et al., 2011), therapists and clients roles in constructing new meanings during stagnation (Fernández et al., 2012), patient and therapist discursive positions during change episodes (Mellado et al., 2022), and studies have analyzed non-verbal communication within change and rupture episodes (Altimir & Valdés-Sánchez, 2020; Tomicic et al., 2015). Research has also explored factors related to the therapeutic alliance (Roussos et al., 2018; Zilcha-Mano & Errázuriz, 2015, 2017), interpersonal problems (Gómez-Penedo et al., 2019), therapeutic focus change (Dagnino & Calderón, 2022; Juan et al., 2023) and the termination of psychotherapy (Espinosa-Duque et al., 2020; Zapata et al., 2023). Krause (2023) highlights how process research bridges the gap between research and practice by linking micro and macro process changes, offering insights into variables relevant to clinical work in Latin American, such as the alliance-change-outcome sequence and emotional work-meaning change-symptom relief sequence.

Despite these fruitful developments in psychotherapy research in Latin America, fewer studies have evaluated change on a larger scale. In Routine Outcome Monitoring (ROM) research, notable advances include the development of systems for tracking change and providing feedback (Areas et al., 2018; Gómez-Penedo et al., 2023; Valdiviezo-Oña et al., 2023; Zimmermann et al., 2023). Despite uncovering relevant information, large-scale outcome assessments in naturalistic settings remain limited (Valdiviezo-Oña & Montesano, 2024), highlighting a need to bridge gaps in mental health services and systems. These limitations not only restrict the development of context-sensitive knowledge, but also hamper the integration of research findings into routine clinical practice. As a result, there is a pressing need for approaches that can generate clinically meaningful

evidence within real-world settings while supporting decision-making processes in everyday care.

Practice-Based Approaches to Address the Research-Practice Gap

In response to the persistent gap between research and clinical practice in psychotherapy, several practice-oriented approaches have been developed to bridge the divide (Molinari et al., 2024). These approaches seek to generate ecologically valid evidence while enhancing the relevance of research for everyday clinical decision-making.

Numerous efforts have contributed to this goal, leading to innovative approaches that surpass the "empirical imperialism" that controls most of the current research agenda (Castonguay, 2011). One notable effort is Practice-Based Evidence, which emphasizes generating evidence from everyday practice (Barkham et al., 2006; Evans et al., 2003). Related approaches, such as patient-focused research, similarly prioritize the systematic tracking of individual patient progress as a central component of clinical decision-making (Lutz et al., 2015). Together, these practice-oriented approaches place practitioners at the center of the research process, enabling them to collect and use evidence at multiple levels. Evidence from practice may be aggregated into a larger database to expand our knowledge about psychological treatments and/or it may inform individual clinicians' practices to tailor treatments to the needs of patients (Castonguay et al., 2021).

As part of Practice-Based Evidence, Practice-Oriented Research underscores the clinician's active role in designing, implementing, and disseminating research through data collection in day-to-day practice (Castonguay et al., 2015). Within this broader framework, ROM is understood as one of several strategies that support the integration of research and practice by systematically collecting outcome data to track patient progress during treatment in real-world settings (Howard et al., 1996), aligning closely with measurement-based care approaches that emphasize the routine use of standardized measures to inform clinical practice (Delgadillo & Lutz, 2020). However, ROM goes beyond mere measurement; it involves tracking mental health changes over time, interpreting trends, and adjusting treatment strategies accordingly. As a result, ROM provides valuable data that can be used to answer clinically relevant questions in psychotherapy research. This iterative process informs clinical decisions, promoting effective interventions tailored to individual needs.

Establishing a data stream through ROM proves advantageous at various levels. At the clinical level, research demonstrates that users benefit from and accept ROM procedures, particularly when progress reporting is clearly explained and communicated (Barkham et al., 2023). Users often feel more engaged and informed about their treatment, so they become more committed and overall outcomes improve. Besides, ROM data plays a crucial role in influencing decision-making across multiple levels, from individual therapy sessions to nationwide policy. For clinicians, access to real-time data on patient progress allows for more precise and informed adjustments to treatment plans. When this information is systematically provided as feedback to clinicians during the therapeutic process, it has been shown to improve outcomes and reduce the risk of treatment failure (Shimokawa et al., 2010). This responsiveness ensures that interventions are tailored to users´ needs, potentially enhancing the effectiveness of therapy (Delgadillo et al., 2021) and reducing dropout rates (de Jong et al., 2021).

At the administrative and service levels, ROM can enhance the quality of care provided by streamlining procedures and supporting quality control measures (Baggaley, 2020). The development of prognostic models that enhance clinical practice occurs in environments where mental health care systems routinely integrate outcome monitoring into regular care. Additionally, clinicians receive training and are required to consistently measure outcomes (Delgadillo & Lutz, 2020). By systematically tracking outcomes, mental health services can identify areas for improvement, optimize resource allocation, and ensure that treatment protocols are consistently applied (Sytema & van der Krieke, 2013). This level of oversight ensures high care standards as well as in staff training and development.

Aggregated ROM data, compiled across multiple services, informs system-wide improvements and supports evidence-based policymaking. Policymakers and health system authorities can use this comprehensive data to identify trends, evaluate the effectiveness of different treatment approaches, and make informed decisions regarding resource allocation and program development (Kilbourne et al., 2018). This data-driven approach ensures that mental health services are responsive to the community's needs and continually evolve based on empirical evidence.

Moreover, ROM data can enhance broader public health initiatives by providing insights into the prevalence and impact of mental health issues within the community. Understanding these patterns enables policymakers to create targeted interventions and allocate funding more effectively to areas with the greatest need (Roe et al., 2022).

Despite these advantages, the implementation of ROM remains uneven across contexts. In high-income countries with substantial investments in mental health research, ROM has been implemented across various settings for multiple purposes (Burgess et al., 2015; Kisely et al., 2015; Roe et al., 2022; Smith & Baxendine, 2015; Waldron et al., 2018). However, such efforts are limited in low- and middle-income countries (Hung et al., 2020), where funding for mental health services and research remains scarce (Ryan et al., 2020).

This disparity is particularly pronounced in Latin America, where the high rates of mental health issues are met with limited access to adequate care, leading to years of healthy life lost due to disability. According to the Pan American Health Organization (PAHO, 2023), financial, geographical, and systemic barriers, along with stigma and discrimination, hinder access to mental health services. Moreover, limited investments in financial and human resources for mental health exacerbate the inequitable distribution of services across territories, creating considerable gaps in service availability both between and within countries (Sapag et al., 2021). As of 2020, only 3% of the total health budget in the region was allocated to mental health services (PAHO, 2023).

In this context, the limited availability of systematic data collection mechanisms further constrains the development of responsive and equitable mental health systems. Tools such as ROM could provide critical and timely information to guide resource allocation and support more effective mental health policies and services.

However, the implementation of ROM at scale in Latin America requires coordinated efforts, shared infrastructure, and collaborative research networks. These needs highlight the importance of regional initiatives designed to facilitate dialogue and resource sharing among researchers and clinicians.

Towards a Culture of ROM in Psychotherapy in Latin America

The implementation of ROM in psychotherapy offers both challenges and opportunities, especially in the complex social contexts of Latin America. Some studies indicate that using ROM with vulnerable populations can improve treatment outcomes, reduce deterioration rates, and help identify users at greater risk of not benefiting from therapy (Shimokawa et al., 2010). However, most of this evidence comes from the Global North and privileged populations (McAleavey et al., 2024). As mentioned before, Latin America faces significant challenges, including high rates of poverty, violence, and systemic discrimination, which contribute to structural exclusion and inequality (PAHO, 2023). These factors significantly impact mental health and exacerbate access gaps. In this context, the potential contributions of ROM in psychotherapy settings are promising (Fernández-Alvarez et al., 2024). ROM is useful to generate large datasets at the level of mental health systems to promote recovery- and outcome-oriented services tailored to local contexts (Minoletti et al., 2012). This approach can also enhance client and family participation in the health system (Uribe-Restrepo et al., 2017) and leverage additional means, such as technology, to optimize services (Jiménez-Molina et al., 2019). All of these strategies can be further enhanced through continuous and timely feedback. Adopting ROM in regional mental health systems can establish systematic records of mental health issues and improve service delivery, informing local policies. However, low investment in mental health and psychotherapy research indicates that the culture of registering mental health care delivery is still developing and must therefore be enhanced if services attempt to adopt ROM.

Research on outcomes and change in Latin America is expanding. Some researchers advocate for focusing on the region's specific needs and fostering collaboration with other scholars. Additionally, using change measures for continuous evaluation throughout interventions is recommended to capture the diverse social realities of the region (Paz et al., 2021). Collaborative networks are increasingly vital for conducting research across various disciplines globally, especially in Latin American psychotherapy.

Previous research has also identified challenges associated with implementing ROM in the region, including ambiguity in guidelines, limited institutional participation, administrative hurdles, and issues with the format and interpretation of results (Dogmanas et al., 2022; Gómez-Penedo et al., 2023). However, the growing availability of free monitoring systems and enhanced collaboration between institutions and mental health centers may improve the dissemination of these practices (Dogmanas et al., 2022; Gómez-Penedo et al., 2023; Paz et al., 2025; Valdiviezo-Oña et al., 2023).

Besides its benefits in optimizing mental health services, implementing ROM in institutional psychotherapies across Latin America may enhance the understanding of therapeutic interventions for users in high-vulnerability contexts and bridge the gap between the needs of the mental health care system and ongoing research (Paz et al., 2025). This integration promises to improve the quality of mental health care, making it more responsive and effective for those in need. Given the region's limited resources, collaboration is crucial for maximizing ROM's effective implementation. Yet no regional infrastructure currently exists to support such collaboration at scale.

The "Consorcio Latinoamericano de Investigación en Psicoterapia" (CLIP) [Latin American Psychotherapy Research Consortium]

To fill this gap, the CLIP was stablished. The CLIP traces its origins back to 2019, during the 50th International Annual Meeting of the Society for Psychotherapy Research (SPR) in Buenos Aires. During this meeting, pivotal discussions took place regarding the implementation of ROM and the utilization of the CORE (Clinical Outcomes in Routine Evaluation) system in Latin American contexts. These discussions led, for the first time, to a collaboration between researchers affiliated with the Latin American Chapter of the SPR (SPR-LA) and their academic institutions.

Later on, many of the members of SPR-LA aligned themselves with the Latin American Network for Psychotherapy and Change [Red Latinoamericana Psicoterapia y Cambio] and its research interests, finding in ROM a topic of common and helpful interest due to the characteristics of the region. In 2023, this network proposed a series of virtual meetings to foster research and collaboration. As a result, there was a coordinated effort to implement ROM initiatives and to generate Practice-Based Evidence, with active participation from researchers and psychological care centers across the region. After several discussions, the idea of the CLIP consortium emerged, guided by shared goals. The consortium established a foundation to promote a unified approach for conducting research using ROM across the region. Its core mission is to facilitate collaboration, promote evidence-based practices in psychotherapy, and create a standardized framework for routine clinical data collection.

To promote collaboration, the consortium established a *comprehensive dataset that integrates administrative, organizational, and implementation-related information from all member services.* This dataset captures key characteristics of each service (e.g., geographic location, institutional affiliation, service capacity, and target populations), as well as workforce composition, clinical infrastructure, and the range of therapeutic modalities and treatment formats offered. It also documents practices related to training and clinical supervision, patient flow indicators (such as annual caseloads and session averages), and the implementation of ROM, including measurement strategies, assessment frequency, and feedback systems. Additionally, the dataset records members' level of engagement with ROM, their willingness to participate in longitudinal data-sharing initiatives, and the legal, technological, and organizational challenges encountered during implementation, thereby enabling cross-site comparisons and a nuanced understanding of service delivery contexts.

The dataset will be updated annually to track the progress of implementation and ongoing research initiatives. It will also serve as a collaborative platform to foster partnerships among members and to support joint data analysis projects, making it possible to

share insights and expertise. To ensure transparency, the consortium will make member agreements publicly accessible and provide regular updates.

In order to ensure comparability across research datasets, the consortium developed a collaborative agreement for *collecting key variables tailored to generate evidence contextually relevant to Latin America.* This shared framework is based on standardized information derived from the CLIP assessment framework, including service characteristics, therapist variables, client sociodemographic data, and ROM measures. It will guide data collection and contribute to a unified understanding of mental health services in the region. To enhance collaboration further, a digital folder has been created to share references, training materials, and best practices in implementation, allowing members access to tools that can assist them in effectively adopting ROM and improving service delivery. By pooling resources and sharing experiences, the consortium will strengthen its collective capacity to generate meaningful, region-specific research and to improve mental health care across Latin America.

To face the challenge of establishing a collaborative research framework for the region, members of the consortium have been meeting weekly to address some questions and reflections regarding cultural and political characteristics of the countries that participate in the consortium, as well as to analyze sociocultural variables that shape the Latin American context and to explore how they can be captured into data collection.

Over eight months of sustained dialogue, the consortium continuously reflected on the social, economic, and political issues affecting the region, recognizing their significant impact on mental health and psychological well-being. These factors often constitute barriers to accessing mental health care. The instruments developed by the consortium can be found in the supplementary material.

Given the lack of systematic records in some of the participating mental health services as well as differences in intake information among centers, the consortium developed a set of questionnaires to comprehensively reflect the sociocultural variables pertinent to our regional realities. Sociodemographic information is collected through the instrument *CLIP-Sociodemográficos Consultantes* [CLIP Client Sociodemographic Form], which is completed by clients and designed to capture the diversity of social, cultural, and economic conditions that characterize Latin American populations. Our goal was to develop a tool capable of capturing the plurality that defines the region. The construction of the questionnaire emerged from ongoing discussions about integrating various idiosyncrasies that impact mental health, with a focus on economic, political, and territorial challenges.

Key considerations included were ethnic diversity (taking into account Indigenous populations and Latin American *mestizaje*, understood as mixed-heritage and cultural blending), gender diversity, the effects of natural disasters (e.g., earthquakes, floods, and fires), political and social events (e.g., protests, displacement), socioeconomic inequalities, and internal migration processes within and across countries. As a result, the sociodemographic questionnaire has items addressing sexual diversity, migration, and socioeconomic realities, such as precarious work conditions, unpaid care duties, and barriers to accessing treatment.

There are also questions about the diverse trajectories related to therapeutic services patients have received at various mental health institutions, along with the problems and symptoms associated with reasons for consultation. This collaborative effort has led to establishing common standards to advance practice-oriented research.

To gain deeper insights into psychotherapeutic processes, the group developed questionnaires to evaluate treatment-related and clinical variables. Clinical information is systematically collected through the instrument *CLIP-Datos Clínicos Consultantes* [CLIP Client Clinical Data Form], which is completed by therapists based on the information available about their clients within routine clinical practice. In addition, treatment process variables are assessed through *CLIP-Evaluación de Inicio de Terapia* [CLIP Therapy Intake Assessment], which captures referral and initial treatment characteristics, and *CLIP-Evaluación de Fin de Terapia* [CLIP Therapy Termination Assessment], which documents treatment closure and related outcomes. These instruments include information on psychotherapy modality (face-to-face, teletherapy, hybrid), session frequency, total number of sessions, and type of termination, among other factors.

ROM is implemented using standardized outcome measures reported by clients. The Clinical Outcomes in Routine Evaluation - 10 (CORE-10) is used before each session, establishing this as the minimum agreed-upon measure across all consortium centers. Additionally, the Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM) may be optionally administered at the beginning and end of the psychotherapy process. The CORE-OM (Evans et al., 2002) is a 34-item self-report instrument that assesses four dimensions: well-being, problems, functioning and risk. Items are scored on a Likert scale from 0 (never) to 4 (always or almost always). The CORE-10 is a short version of the original scale, consisting of 10 items, and has demonstrated excellent psychometric properties (α = 0.90) (Barkham et al., 2013). The selection of the CORE-OM and the CORE-10 for ROM is based on several factors. These tools have been psychometrically evaluated in various countries across Latin America (Errázuriz et al., 2025; Ortiz et al., 2021; Sosa-Torralba et al., 2020; Valdiviezo-Oña et al., 2024), they have strong psychometric properties, are user-friendly, and they are available at no cost. These reasons make these measures suitable for routine use, particularly within the region's limited mental health infrastructure. Furthermore, these tools cover essential mental health dimensions without focusing solely on specific symptoms, facilitating global collaboration and knowledge exchange to enhance care standards across Latin America.

For future collaboration with the European Psychotherapy Consortium (Gonçalves et al., 2024; Paz et al., 2024), the CLIP has incorporated a single item into the assessment as the European Consortium did. This item, the Emotional and Psychological Outcome (EPO-1), asks users to evaluate their current emotional and psychological state by responding to the question: "At this moment, how well do you feel you are getting along emotionally and psychologically?" Responses are scored on a 5-point scale, ranging from 0 ("Very poorly; I can barely manage to deal with things") to 4 ("Very well; I have no significant complaints").

Additionally, if desired, the Therapeutic Alliance Inventory-Short Form for Patients (WAI-S-P) and Short Form for Therapists (WAI-S-T) (Tracey & Kokotovic, 1989) - can be applied. Both questionnaires are intended to measure the quality of the therapeutic

alliance and consist of 12 items rated on a 7-point scale, ranging from 1 (never) to 7 (always). The Spanish version by Andrade-González & Fernández-Liria (2016) is used for this purpose. Each center may also incorporate other measures aligned with its specific research interests.

The consortium proposed gathering information on therapists and the characteristics of the services in which psychotherapy is delivered. Service-level information is collected through the instrument *CLIP-Información del Centro* [CLIP Service Information Form], which is completed by a representative or administrator of each participating center and provides standardized data on organizational and structural characteristics. The information collected also includes characteristics of the participating centers, such as the types of users treated, whether they are public or private services, whether they serve as training centers or just employ professionals, as well as their research interests as consortium participants.

Furthermore, therapist-related information is collected through the instrument *CLIP-Datos de Terapeutas* [CLIP Therapist Data Form], a self-report questionnaire designed to capture sociodemographic and professional characteristics of therapists across the network. This section of the questionnaire addresses therapist variables through questions regarding their sociodemographic backgrounds, roles (student or professional), years of experience, theoretical preferences, and supervision opportunities in their respective centers. Optionally, this information can be supplemented with the Spanish version of the Personal Style of the Therapist Questionnaire (PST-Q) (Fernández-Álvarez et al., 2003). The PST-Q is a self-report questionnaire for therapists, consisting of 20 items rated on a 7-point Likert scale, ranging from 1 (completely disagree) to 7 (completely agree). The results reflect the therapist's personal style across five dimensions: instructional, expressive, involvement, attentional, and operational.

To provide a clear and structured overview of the assessment framework developed by CLIP, Table 1 presents the full set of instruments included in this framework, detailing the respondent, the frequency and timing of administration, and whether each measure is designated as mandatory or optional within the consortium.

Table 1
CLIP Assessment Framework

Instrument	Respondent	Description	Frequency	Timing (relative to session)	Status
CLIP-Sociodemográficos Consultantes [CLIP Client Sociodemographic Form]	Client (self-report)	Captures sociodemographic and contextual variables of clients.	Once per treatment episode (intake)	Before or at the beginning of first session	Mandatory
CLIP-Datos Clínicos Consultantes [CLIP Client Clinical Data Form]	Therapist (about client)	Collects clinical information, including presenting problems and relevant history.	Once per treatment episode (intake)	At or shortly after initial session	Mandatory
CLIP-Evaluación de Inicio de Terapia [CLIP Therapy Intake Assessment]	Therapist (about client)	Records referral, admission, and initial treatment characteristics.	Once per treatment episode	At treatment initiation	Mandatory
CLIP-Evaluación de Fin de Terapia [CLIP Therapy Termination Assessment]	Therapist (about client)	Documents treatment closure and termination characteristics.	Once per treatment episode	At treatment termination (final session or shortly after)	Mandatory
CORE-10	Client (self-report)	Brief measure of psychological distress for continuous outcome monitoring.	Every session	Before session	Mandatory
CORE-OM	Client (self-report)	Comprehensive measure of psychological functioning.	At intake and termination	Before session	Optional
EPO-1	Client (self-report)	Single-item measure of perceived emotional and psychological state.	Every session	Before session	Mandatory
WAI-S-P	Client (self-report)	Assesses therapeutic alliance from the client's perspective.	Periodic (e.g., selected sessions)	Typically after session	Optional
WAI-S-T	Therapist (self-report)	Assesses therapeutic alliance from the therapist's perspective.	Periodic (e.g., selected sessions)	Typically after session	Optional
CLIP-Información del Centro [CLIP Service Information Form]	Service administrator	Collects standardized information about organizational and structural characteristics of mental health services.	Annually	Not session-based	Mandatory
CLIP-Datos de Terapeutas [CLIP Therapist Data Form]	Therapist (self-report)	Gather sociodemographic and professional information about therapists.	Annually	Not session-based	Mandatory
PST-Q	Therapist (self-report)	Assesses therapists' personal style across five dimensions.	One-time or periodic (optional)	Not session-based	Optional

Note. CLIP: Consorcio Latinoamericano de Investigación en Psicoterapia [Latin American Psychotherapy Research Consortium]; CORE-10: Clinical Outcomes in Routine Evaluation – 10; CORE-OM: Clinical Outcomes in Routine Evaluation – Outcome Measure; EPO-1: Emotional and Psychological Outcome – 1; WAI-S-P: Working Alliance Inventory – Short Form for Patients; WAI-S-T: Working Alliance Inventory – Short Form for Therapists; PST-Q: Personal Style of the Therapist Questionnaire.

The information collected will support the development of a unified framework for routine clinical data collection. Future data-sharing agreements among consortium members will specify that anonymized data may be transferred to shared datasets for various studies proposed by the consortium partners (e.g., comparisons across service types or between countries).

This set of shared tools will fulfill CLIP's mission: unify clinical data collection practices across the region while documenting psychotherapeutic practices and highlighting the region's unique characteristics. This initiative will promote systematic research in everyday settings, enhancing cultural understanding, advancing research efforts, and the systematization of psychotherapeutic practices in Latin America.

Members of the Consortium

Following the example of the European Psychotherapy Consortium (Gonçalves et al., 2024), the first task for the consortium was to conduct a survey to assess the interest of mental health services in Latin America in implementing ROM as well as to understand the diverse realities regarding the use of this practice in the region. Fifteen mental health services across seven Latin American countries (Argentina, Brazil, Chile, Colombia, Ecuador, Peru, and Uruguay) participated in the survey. Please refer to the supplementary materials for detailed information on the mental health services that completed the survey.

These mental health services served approximately 28,545 users annually, with a median of 300 users per center and a range from 25 to 25,000. Eight centers provided services to children, 12 to adolescents, 11 to older adults, and all of them to adults. Fourteen services were outpatient clinics and 11 of these were community mental health centers run by universities. Additionally, two centers offered day treatment and one provided home-based care. All centers offered in-person therapy, while 13 also provided online services. Individual therapy was available in all centers, eight provided couples and family therapy, and 6 offered group therapy. The most common therapeutic approaches were psychodynamic/psychoanalytic ($n = 8$) and systemic ($n = 6$), followed by cognitive-behavioral ($n = 5$), integrative ($n = 4$), and humanistic ($n = 3$), and four centers reported no specific therapeutic orientation. Fourteen services offered psychotherapy training (undergraduate and postgraduate), and all had clinical supervision. The average of professionals per center was 37, ranging from 3 to 140. The number of psychotherapy sessions per client ranged from 1 to 200, with an average of 16 sessions. Three of the centers either served or were located in rural areas.

This diversity in services highlights the wide range of contexts in which mental health care is delivered across the region, reflecting differences in population size, therapeutic approaches, and service modalities. The inclusion of both urban and rural centers, along with the availability of in-person and online therapy, demonstrates the adaptability of these services to meet their communities' unique needs.

The survey also revealed considerable variability in outcome data collection practices. Four centers already collected data routinely, four planned to start, and seven expressed interest in doing so but in the future. These results show a strong interest in ROM, though only a few services were actively implementing it, creating an opportunity to introduce the ROM program developed by the CLIP. The most commonly used pre-post outcome measure was the CORE-OM, employed by four centers. Other measures reported were Young Person's CORE, CORE-10, Systemic Clinical Outcome and Routine Evaluation-15 (SCORE-15), and the Outcome Rating Scale (ORS). Only three services had a feedback system in place for ROM.

Budget constraints, high workloads, management challenges, and a lack of experience or guidance in implementing outcome monitoring are some of the barriers to expanding data collection. Despite these obstacles, all fifteen services expressed interest in joining a data-sharing consortium to enhance therapist training, improve service effectiveness and quality of care, and to compare outcomes across different services. However, participants emphasized the need to address legal, technological, and authorship challenges to ensure the consortium's success.

Discussion

The evolution of psychotherapy practice in Latin America over the past three decades has seen significant strides toward a community-centered approach, driven by government reforms and the increasing prominence of clinical psychology. However, challenges persist, including inconsistent implementation of mental health policies, disparities in resource allocation, and the need for contextually adapted interventions. While there has been a notable rise in qualitative and micro-process research that bridges the gap between theory and practice, the region still grapples with obstacles related to large-scale outcome assessments and systematic monitoring of mental health services.

Addressing the unique sociocultural and economic contexts of Latin America is crucial for developing effective therapeutic strategies, particularly in light of systemic inequalities and the growing challenges associated with migration. The adoption of ROM presents a promising avenue for integrating psychotherapy practice with research in the region. By fostering collaboration among researchers and practitioners and prioritizing the incorporation of research findings into clinical practice, Latin America can continue to advance its mental health systems and to improve community well-being.

The establishment of the CLIP marks a critical step towards enhancing collaboration across the region. By promoting the integration of ROM within psychotherapeutic practices, CLIP aims to address the unique challenges faced by mental health professionals in Latin America. The collaborative framework proposed in this initiative seeks to improve data collection and research, and also aims to create a supportive network that fosters ongoing dialogue among therapists and researchers.

Insights gathered from diverse mental health services across the region may unveil the pressing need for a cohesive approach to mental health care that is contextually relevant and adaptable. CLIP's commitment to collaboratively unify clinical data collection practices will ensure that evidence-based interventions are responsive to the specific needs of various populations, particularly those in high-vulnerability contexts.

As the consortium progresses, leveraging the collective expertise of its members will be fundamental to overcoming existing barriers, such as limited resources and systemic inequities.

By creating a shared repository of knowledge, best practices, and training materials, CLIP will empower mental health professionals to implement ROM effectively, thereby elevating the quality of care provided to users.

CLIP represents more than just a collaborative platform; it embodies a collective vision for more equitable and effective mental health systems in Latin America. We encourage psychotherapists, researchers, and mental health service providers to actively participate in this initiative, fostering an environment where research and practice come together to enhance therapeutic outcomes and inform policy decisions. Collectively, these efforts may contribute to more accessible, effective, and context-sensitive mental health services across the region.

For updated information about the consortium, please visit this link. All centers interested in joining CLIP can register here.

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Conflict of Interest

There is no conflict of interest.

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