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The Use of Feedback in Mental Health Services: Expanding Horizons on Reach and Implementation

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This special issue focuses on the practice of measuring and discussing patient progress in psychotherapy to enhance shared decision making between the patient and therapist and to improve alliance, personalization and thus treatment outcomes. We refer to this practice as progress feedback, also known as measurement-based care, feedback-informed treatment, and routine outcome monitoring. Some early studies had delayed progress feedback by a week or more (de Jong et al., 2012; Probst et al., 2014; Slade et al., 2008). However, as the value of measurement feedback systems has been increasingly recognized, and as technology has advanced, real-time feedback available immediately after data collection has become more prevalent in research and practice (Bickman, 2008; Fortney et al., 2017; Rognstad et al., 2023a). A cornerstone of measurement-based care is the feedback provided to the therapist and patient

to ensure progress monitoring is used in real-time to make data-informed decisions (Barber & Resnick, 2023). The use of various terms for progress feedback has complicated our understanding of this clinical practice and hindered our ability to summarize knowledge gained across scholars, countries, and patient populations (Boswell et al., 2023). Variations in naming conventions partly arise from a longstanding tension in psychology between nomothetic measurement approaches, which aim to understand group-level processes, and idiographic or individual-level progress measurement, which focus on informing individual patient care (Piccirillo & Rodebaugh, 2019).

Certainly, the use of standardized symptom measures has been the predominant focus of measurement-based care, feedback-informed treatment, and routine outcome monitoring. However, there are numerous published examples of other progress and outcome measures used, including individualized goal ratings, assessments of patient functioning, quality of life metrics, and therapeutic alliance evaluations. We assert that the focus of our terminology should not be on the measure *type* but rather on how measures are *used* and by *whom*. Patient-reported outcome measures include standardized, norm-referenced, symptom- or functioning-based measures as well as individualized measures such as treatment goal attainment. Going beyond symptom checklists to integrate measures of functioning, quality of life, therapeutic alignment and individualized progress metrics has long been recommended for quality care and precision medicine (Bickman, Lyon et al., 2016; Jensen-Doss & McLeod, 2020; Wolpert et al., 2012). This recommendation is highlighted by work within this special issue (Arora et al., 2024; Connors et al., 2024; Haug et al., 2024; Koementas-de Vos et al., 2024). Moreover, the use of patient-reported outcome measures in aggregate for summative, actuarial information is a hallmark of psychotherapy research, organization-wide quality improvement and clinical science. However, this practice differs from progress feedback, which is used by therapists and patients to direct individual care. For example,

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routine outcome monitoring sometimes refers only to use of aggregate outcomes among large patient groups to understand the effectiveness of psychotherapy services at the system level, and feedback can sometimes refer to feedback only provided to the therapist. In this issue, we focus on the hallmark of feedback which refers to progress data provided to the therapist and/or the patient for the purposes of collaborative progress evaluation, communication, and treatment adjustment within an episode of care (Jonášová et al., 2024).

Progress Made in Feedback Research

In our estimation, significant progress has been made over the past decade to deepen our understanding of feedback. To date, the predominant focus of feedback research has been on its effectiveness on treatment outcomes (de Jong et al., 2024). Indeed, clinical studies have shown that better and faster patient outcomes are achieved when feedback is provided to the provider and patient, and with clinical decision-support tools (de Jong et al., 2012; Lambert et al., 2018). However, the field of feedback was alerted to the importance of therapist support when early feedback studies published alarmingly low implementation rates (Bickman et al., 2016). Fortunately, the last decade of feedback research has concentrated on understanding and overcoming implementation challenges. There is now a greater emphasis on proper training and ongoing support for therapists to ensure effective use of feedback. This renewed focus on therapist training has likely also been aided by the advancement of implementation science in mental health services which has led to more targeted measurement of implementation outcomes and improved understanding of effective training and post-training supports. Five articles in this special issue contribute to our understanding of feedback implementation determinants (i.e., barriers and facilitators) and outcomes (e.g., adoption and fidelity), particularly from the therapist's perspective (Azizian Kia et al., 2024; Douglas et al., 2023; Frissen et al., 2024; Koementas-de Vos et al., 2024; Woodward et al., 2023).

Also, early studies on feedback were challenged by a long delay between data collection and feedback provided (Lambert et al., 2001, 2002). We now know how important immediacy is to feedback processes (Fortney et al., 2017) and all studies now have immediate feedback, in part due to advances in technology and feedback systems. Related, more studies now have at least a signal function to support therapists' interpretation of scores and decisions to adjust treatment when progress is beyond normal or fluctuations are off track further than would be expected. This is consistent with a growing literature base supporting the importance of clinical decision-support tools for effective use of

patient data (Bright et al., 2012; Lutz et al., 2022; Shimokawa et al., 2010).

Optimizing Effect Sizes of Feedback

What we can take away from the papers in this special issue and the current state of feedback research is that, when implemented, it has a small added effect on treatment outcomes (Barkham et al., 2023). However, this is to be expected for several reasons. First, the true effect size of feedback is obscured by a wide range of contributing factors, such as measures used, feedback processes, patient presenting concerns, treatment modalities and settings. Also, feedback is in fact a small component of the treatment intervention and is regarded as a minimal intervention needed for change (Glasgow et al., 2014; Lyon et al., 2017, 2018). Thus, it is expected that feedback must interact with an effective intervention to result in optimal effect sizes. Third, it is well established in the literature that large effect sizes of feedback are primarily for patients not progressing as expected, meaning those who respond to the front-line intervention as expected will not have a large effect from feedback. Fourth, and noted below in future directions, mechanisms of action on outcomes vary by measurement system. For example, alliance measures are intended to target treatment retention and therapist-patient communication, whereas symptom-based outcome measures focus on symptom reduction. Other theoretical models of feedback also position proximal mechanisms of treatment fit, engagement, and alliance on the pathway to distal outcomes of patient satisfaction, functioning and symptoms (Connors et al., 2024).

As feedback has been found to result in a wide range of treatment effect sizes across various studies, several aspects need to be optimized to ensure its effect. First, we argue that feedback is more than frequently monitoring outcomes or measuring care; it requires the therapist to view and discuss the results with the patient and adjust care accordingly. In this sense, it is an added intervention to treatments. Related, the "intervention" of feedback has a wide range of measures, feedback systems, decision support tools, clinical practices of data collection and discussion intervals, and actual adjustments made because of the data and other information. All of this variation introduces a good bit of "noise" or variation in meta-analyses or other methods to summarize the effects of feedback. Second, feedback is a tool that should be used in the broader context of providing evidence-based personalized treatments, which entails formulating a case conceptualization, hypotheses about the person's problems, setting goals and applying interventions that fit with these goals to help reduce symptoms and improve functioning. Feedback is not a standalone intervention but must be integrated into

the therapist's and organizational vision and work process. This leads to the final takeaway that the effectiveness of feedback is dependent on its use and implementation. Time and again, and as some of the papers in this special issue show, implementation is key and requires commitment on all levels (patients, therapists, managers, etc.). Commitment also entails being accountable as a therapist and organization for using feedback. Therapists require training in feedback and support to use feedback, and this requires organizational investment. The issue of commitment also raises the question of whether it should be mandatory from the viewpoint of providing the best care possible as a profession.

Special Issue Overview

The response to this special issue is an indicator of the energy and investment in the field of psychotherapy and implementation research to advance knowledge on this topic; with 19 articles from 11 countries, this is the largest special issue in *Administration and Policy in Mental Health and Mental Health Services Research* to our knowledge. Seventeen original articles and two points of view cover a wide range of topics within feedback research including a narrative review of the current evidence of progress feedback effectiveness (de Jong et al., 2024), feedback in novel settings such as group treatment (Koementas-de Vos et al., 2024), partial hospitalization (Donelan et al., 2024), and schools (Haug et al., 2024); feedback with specialized populations such as older adults (Frissen et al., 2024), personality disorders (van Geffen et al., 2024), children (Connors et al., 2024; Donelan et al., 2024; Haug et al., 2024), and persons of color (Arora et al., 2024; Barber et al., 2024); the role of measurement based care on potentially reducing burnout among therapists (Barber & Resnick, 2024), the influence of patient-therapist matching on gender and race/ethnicity on trust (Duong et al., 2024), and therapists' experience using measures for feedback (Hall et al., 2024; Jonášová et al., 2024). One-third of the papers in this special issue is dedicated to implementation, including a significant focus on understanding implementation determinants that predict adoption and use of measures (Azizian Kia et al., 2024; Douglas et al., 2023; Frissen et al., 2024; Rognstad et al., 2023b; Valdiviezo-Oña et al., 2024) as well as strategies to influence use (Jensen-Doss et al., 2024; Woodard et al., 2023). Our goal with this special issue is to feature international research representing the current state of feedback literature and direct readers to key questions that remain to be explored. Together, these studies advance our understanding of the reach of feedback to specialized settings and populations, the potential mechanisms of feedback and pave the way to unpack the black box of implementation.

Expanding the Reach of Feedback to Specialized Settings and Populations

Most literature on feedback to date has focused on its effectiveness in outpatient psychotherapy provided in traditional specialty mental health settings. Continued research is needed to understand the implementation and effectiveness of feedback as its reach expands to increasingly specialized populations, which may present unique concerns and settings. This issue includes studies on feedback in diverse contexts such as group treatment, schools, partial hospitalization programs, as well as child and geriatric populations and persons of color.

The study by Koementas-de Vos and colleagues on the use of feedback-informed treatment in short-term cognitive behavioral groups for adults with anxiety and depression adds to the small but growing literature base exploring the range of measurement tools, clinical practices, training and coaching, and clinical decision supports associated with therapist and patient preferences, group processes such as cohesion and engagement, and patient outcomes. This special issue also includes a factorial study on the use of a feedback system in group interventions delivered to 701 children in 58 schools in Norway, which adds to nascent scholarship on feedback in groups, delivered in schools, and with children (Haug et al., 2024). Although the mean Implementation Index was lower than prior studies and a dose-response relation was not found, the clarity of reported methods, measures, results and limitations related to studying feedback systems in this context and setting lays a seminal foundation for continued research. Jill Donelan and colleagues published a detailed case study of measurement-based care implementation by phase and customized strategies to support leadership, workflow integration and coaching in a youth partial hospitalization program, which adds to emerging scholarship on feedback in acute treatment settings. This implementation coincided with the COVID-19 pandemic and served as a source of organizational resilience by using feedback loops and a culture of learning through a period of rapid change. A unique aspect of feedback with child populations is the integration of caregiver-reported measures to inform caregiver engagement and shared decision-making in treatment adjustments, which is featured in Donelan and colleagues' case study and Connors' and colleagues' practical guidance outlined for youth-serving therapists. On the other end of the lifespan, a Dutch study by van Geffen and colleagues explored the relative utility of a generic symptom severity measure and personality functioning measure for 996 patients receiving treatment for 24 months. While 24-month outcomes were comparable across both measures, the outcome trajectories were different by cluster and time frame. Furthermore, the study by Linda Frissen and

colleagues shows there is ample room for future growth to understand age-related factors influencing the use of progress feedback with older adults in psychotherapy. Finally, the special issue includes several studies exploring the use of feedback with persons of color and the role of therapist-patient matching on gender and race/ethnicity in the United States. Barber and colleagues propose how measurement-based care in its standard format has features that may address mental health treatment disparities that are experienced by communities of color in usual care. Arora and colleagues propose that standard measurement-based care can and should be optimized for populations of color. As such, they present a culturally-modified version of measurement-based care for adolescents of color experiencing depressive symptoms and/or suicide risk. Their model emphasizes the importance of clear and customized rationale for the use of progress measures, feedback with treatment expectations measures at the start of care, use of individualized and alliance measures, and cultural competence training.

In terms of future directions, there are other populations and settings not represented in this special issue which we are hoping to see future applied research generated. This includes patients with severe mental disorders, such as people with schizophrenia or bipolar disorder who may not receive treatment focused on complete “recovery” or remission of symptoms, but rather improvements in functioning and other quality of life related treatment targets. Another specialized population underrepresented in current feedback literature is individuals with personality disorders, with open questions about types of measures that are appropriate for this population and benchmarking in the context of longer-term psychotherapy. One recent study on the use of feedback with patients with a personality disorder (Janse et al., 2024) is published in the sister special issue on Treatment Personalization and Precision Mental Health Care (Moggia et al., 2024). Additional feedback scholarship is also needed for children and adults with developmental disabilities such as autism spectrum disorders. Many standardized measures necessitate emotional self-awareness and expression, and feedback itself is an interpersonal process, all of which may require different measures and/or adjusted use of measures to suit those with social communication challenges. Individuals with intellectual disabilities may also need customized measures and/or clinical practices with feedback, as one study in the Netherlands estimated that around 40% of patients in specialized care have a low IQ (Nieuwenhuis et al., 2021). Finally, most of our feedback research is conducted in high-income countries. The Ecuadorian study by Valdiviezo-Ona and colleagues in this issue was conducted in a middle-income country and adds to scant literature on feedback in low- and middle-income countries. These authors comment on the importance of

conducting more research in Latin American countries and having regional networks or consortiums to promote regionally specific and cross-cultural shared learning related to ROM (Valdiviezo-Oña et al., 2024).

Unpacking the Black Box of Implementation

Implementation science methods have long regarded the identification of multi-level contextual factors, in the form of barriers and facilitators (i.e., determinants), as the first step to selecting or designing implementation solutions for any novel practice (Nilsen & Bernhardsson, 2019). Indeed, numerous papers in this special issue studied determinants of feedback in various clinical settings, mostly from the perspective of therapists as implementers (Azizian Kia et al., 2024; Douglas et al., 2023; Frissen et al., 2024; Hall et al., 2024; Jensen-Doss et al., 2024; Jonášová et al., 2024; Rognstad et al., 2023a; Valdiviezo-Oña et al., 2024; Woodard et al., 2023).

Several papers assessed determinants generally, which can be done before or after an implementation effort. One example of anticipated barriers and facilitators assessed prior to implementation is the Ecuadorian study of 20 therapists who reported their expectations prior to implementing ROM (Valdiviezo-Oña et al., 2024). Barriers were consistent with others in this issue such as Kia and colleagues (Azizian Kia et al., 2024) but assessing determinants on the front end is imperative for needs assessment and implementation strategy selection. Also, therapist expectations before implementation will of course vary from their experiences following exposure to an implementation effort. An example of assessment determinants after an implementation effort is that of the qualitative study by Frissen and colleagues (2024). Assessing determinants may be particularly beneficial in unique settings or contexts from which little of our current feedback literature is derived. This issue includes a paper by Susan Douglas and colleagues who developed a qualitative coding scheme from interviews with clinical staff, managers and leaders from two Dutch, three Norwegian and four American mental health organizations. The authors provide their semi-structured interview guide, detailed codebook and guidance on how to apply this multi-dimensional coding scheme to assess barriers and facilitators of progress feedback. Tools like this are important to make it easier, faster and more consistent for applied researchers and clinical leaders to assess determinants of feedback in their setting.

Another approach is to look at determinants through the lens of actual implementation, based on comparing and contrasting reported experiences of therapists who did and did not implement reports. From this we can extrapolate what might be levers to increase the number of therapists who

implement. For example, Amanda Jensen-Doss and colleagues found that therapists' self-reported self-efficacy with MBC practices and perceived practicality of MBC significantly predicted higher rates of MBC utilization. Interestingly, perceived clinical value was not that predictive. Implementation was low despite various implementation supports across clinics, and findings suggest that future trainings should perhaps emphasize how to make feedback more practical for therapists in cases where they are already open to the idea of using it and see the clinical value. These findings were consistent with those of Hall and colleagues, where all therapists viewed feedback and most cited it as important, but only about half discussed it with their patients. Recommendations to make feedback more clinically useful related to making the feedback more personalized (e.g., patient specifies details about a standardized item) and to include more clinical decision-support tools. Similarly, Kia and colleagues conducted a qualitative study of 23 therapists who did and did not use progress feedback in two clinics in the Netherlands in which progress feedback was mandatory. Therapists in both groups had positive attitudes toward progress feedback (like the prior studies noted), but they reported numerous themes related to not using progress feedback at the patient, therapist, and organizational level.

Facilitators of feedback are arguably more important than barriers to uncover empirically, as they can inform individual, system and contextual factors as levers to promote feedback implementation. Jonášová and colleagues published a qualitative meta-analysis of therapists' experiences with ROM from 21 studies. Their in-depth findings are a tremendous advancement in how we understand the clinical utility of and range of clinical practices with ROM. According to their findings, ROM served three main purposes; (1) providing valuable information that otherwise might be overlooked; (2) a communication tool for clinically essential conversations; and (3) a structure to help therapists and patients stay focused on therapy goals and to promote a flexible and dynamic approach to care. Of note, these purposes may be achieved differently by various measures and feedback systems which means there can be different mechanisms of action. For example, measures and systems that focus on alliance regard the relationship as a mechanism to patient outcomes, whereas a focus on tracking symptoms or goal ratings regard treatment adjustment or personalization as the mechanism to outcomes. The positive impact of feedback for therapists is relatively understudied to date. Barber and Resnick published a commentary in this issue on the potential for measurement-based care to combat therapist burnout. They propose that measurement-based care can improve alliance with patients and enhance the therapist's sense of personal accomplishment when they have clear

feedback about how therapy is going and the opportunity to adjust care for better outcomes. This is consistent with other findings in this issue from therapists who cited the positive effects of feedback on their confidence about the care they were providing (Azizian Kia et al., 2024).

Overall, findings on determinants of progress feedback in this issue are consistent with prior research in this area (Lewis et al., 2019), although they add substantial depth and breadth across settings and populations. A critical next frontier to advance the actual implementation of feedback among therapists is to leverage the research on determinants to inform actual implementation strategy selection or development and evaluation. Rognstad and colleagues conducted a review of 39 MFS studies to assess what process and implementation elements are associated with therapist adoption and implementation. Unfortunately, they found substantial underreporting of implementation across studies, including lack of detail on readiness assessment and components of the implementation plan including training or preparation for therapists or leadership. In 21 studies, the actual use of feedback as an implementation outcome was either not mentioned or there were no procedures for monitoring how measures were used. This study should be a call to action for clearer specification of implementation supports and implementation outcomes in all feedback literature.

The paper by Woodard and colleagues focuses on the effects of post-training consultation as an implementation strategy. This is consistent with other research investigating the value, dosage and content of post-training consultation to promote clinician use of feedback (Lyon et al., 2022; Marriott et al., 2023). Woodard and colleagues found that the specific value of consultation dosage and therapists' rate of viewing feedback was associated with improved administration and viewing of the measures. The authors astutely note that as consultation included the use of feedback reports, future research is needed to disentangle the effect of consultation and the viewing rate as mechanisms of action for implementation. Also, as aforementioned about the variation of feedback within effect size calculations across studies, there are numerous components of feedback that can vary by context, setting and study. Therefore, although feedback is a relatively simple intervention, we do see a need to specify the core features and clinical practices within feedback as well as the range of measures and practice options. Specification of feedback interventions, including components and practices, will support future research on mechanisms of action and implementation strategies for specific feedback barriers, components or problems of practice.

Future Directions in Feedback

The papers in this special issue have yet to answer all the questions we initially set out. Although the future directions in feedback are expansive, there are three areas we regard as particularly important and underrepresented in the research so far.

First, to truly support practicing therapists and their diverse patients seeking care, we must continue to broaden the progress and outcome measures and clinical decision-support tools available to therapists. Clinical decision-support tools refer to measures that help therapists troubleshoot which factors in therapy are contributing to a lack of change in patients who are not progressing or worsening (de Jong et al., 2023). Extant research on feedback documents various decision support tools and their clinical value for therapists (Bone et al., 2021; Lutz et al., 2015). Using feedback with patients to inform collaborative decision making in the context of a strong working alliance is arguably the most important function of feedback, and the array of decisions or treatment adjustments for a patient not progressing is vast. Therapists benefit from suggestions to inform whether they should change their hypotheses about the patient's presentation, target problem(s), treatment goals, and/or interventions. Measurement feedback systems increasingly include actionable feedback but this progress is slow, in part due to measures, clinical guidelines and practices to optimize feedback that are still in development. Decision support would ideally adjust for life circumstances, social influencers of health, social support, sociocultural factors, and risk and protective factors that our typical symptom measures do not account for (De Jong et al., 2023). Related, more investigation is needed on the best ways to handle negative feedback from alliance and/or progress measures, requiring a deeper understanding of what happens during sessions.

Second, we see an untapped opportunity to include pre-service training on feedback in graduate programs across a range of disciplines in human services (e.g., psychology, social work, professional counseling, psychiatry, psychiatric rehabilitation and nursing). Most feedback implementation efforts seem to be a significant practice change for therapists once they are in the field, without the scaffolding of learning about feedback during their graduate coursework, field placements and supervision. This places implementation scientists, consultants, care organizations, and therapists in a position of swimming upstream to install a core practice of psychotherapy that should have been embedded from the beginning of someone's career. We believe that collecting and using patient-reported progress measures to adjust treatment - based on collaborative decisions between the patient and therapist - should be part of the code of conduct of being a good therapist across disciplines. Graduate

training programs are sometimes preparing students for this, and ethical guidelines for most if not all human service professionals include some form of progress monitoring or feedback, but we need to train a generation to use and expect this. This is one of many system-level interventions we recommend to meaningfully advance the adoption and reach of feedback.

Third, we notice an ironically missing perspective in feedback research – the patient's voice. There are some notable exceptions, including but not limited to studies of patient experiences with routine outcome monitoring and measurement feedback systems (Mayworm et al., 2020; Solstad et al., 2019). Some studies include therapists and patients to understand the impact of feedback on those providing and receiving psychotherapy (Solstad et al., 2019). Despite some hesitation by therapists about how patients will respond to progress data collection and use, studies have found little to no resistance among patients to completing measures if they are brief, relevant, and used by providers (Carfora et al., 2022; Recinos et al., 2017). However, more studies are needed to document the patient's experience of psychotherapy with and without feedback to inform future directions to optimize person-centered care. Creating the space for patients to speak up about their experience in care, with or without measures, is an important therapist skill and applied researchers should similarly create space for the patient's experience of psychotherapy to be more explicitly represented in psychotherapy research. There is a growing movement to ensure patients are owners of their data, and to empower patients to ask their therapists about how progress will be monitored, and their role in that process. Increasingly, digital mental health is headed in this direction, feedback systems are building real-time feedback to patients following completion of measures, and psychoeducational materials are being developed and disseminated to help patients be more informed consumers and self-advocates when they seek care (see Making Therapy Better, 2023).

A Vision for System Change and Sustainability of Feedback

While we envision the long-term implementation and broader reach of feedback to have great potential for impact on psychotherapy quality and outcomes, ongoing maintenance and sustainability of this practice is still out on the horizon. As a field, our current task is to better understand implementation levers for system change. We recommend promoting the true spirit of feedback by promoting systems changes that (1) identify and evaluate implementation strategies beyond therapist training and consultation; (2) study

mechanisms of both implementation and patient outcomes; and (3) interrupt attempts to use patient-reported data to monitor or evaluate therapist performance or compliance.

To date, implementation determinants are mainly studied at the therapist level, and articles in this special issue exclusively focus on therapists' experience of feedback. However, barriers and facilitators of feedback, as with any innovation or practice, occur at multiple levels from the care recipient, implementer, organization, and healthcare system (Lewis et al., 2019). We are concerned that an over emphasis on therapist training as our primary implementation strategy places undue burden on therapists and misses opportunities to use a wider array of over seventy implementation strategies at our disposal that better match barriers at the patient, organization, and system levels (Waltz et al., 2014). Therapist training often serves to increase knowledge, and even the most effective consultation or supervision is likely to improve skills only at the therapist level and when therapist attitudes toward feedback are favorable. Other determinants of practice change such as staff retention or turnover, administrative ease or burden, and fit of measures with the patient population require different strategies such as implementation teams or champions, embedding the feedback system into the organizational context, and patient-informed selection of measures. Ultimately, a culture of feedback must be present at the organizational level to promote the success of any therapist- or patient-level implementation efforts, not just in the organizational attitude towards feedback, but also by creating policies, and ensuring financial and technical resources (de Jong et al., 2023). Implementation support should also be considered at the level of a care system in any given country. At the governmental level, rewards and penalties are the typical strategies available. We regard the rewards as acceptable and perhaps helpful but not to the level that they should be the main driver of implementation.

Explicit attention to the mechanisms of implementation strategies; that is, how we expect strategies to work and affect actual implementation outcomes of feedback - specifically, how we expect these strategies to function and influence actual implementation outcomes of feedback - is critical for the future of feedback. Effectiveness studies of new feedback systems on patient outcomes often result in mixed findings on effect sizes that are difficult to interpret without a clearer explication of what the systems include, the implementation process, and the variation of adoption rate across therapists. Continued research on mechanisms of feedback on patient outcomes, such as alliance, treatment adjustments, or patient attunement, for example, must be measured and tested as mediators or moderators of patient symptom or functional improvement. Otherwise, we are repeating effectiveness studies without advancing our

knowledge on how to implement feedback and/or how feedback influences patient outcomes.

Finally, we recognize a need for feedback scholars and organizational leaders to interrupt attempts to use patient-reported data to monitor or evaluate therapist performance or compliance. Requirements from governments or payors to use feedback to receive third-party reimbursement are not producing the desired results. The Netherlands is an illustrative example where ROM requirements and a focus on benchmarking did not land well for the provider community and were subsequently rolled back substantially (de Jong & Janse, 2018; Hafkenscheid & Van Os, 2018). Also, concerns about misuse of patient-reported outcome measures in the UK were documented a decade ago (Wolpert, 2014). Indeed, the value-based care and payment movements have yet to show how quality care is prioritized over cost containment based on narrow metrics of diagnoses, patient populations, and care systems. We must remain focused on the central purpose of using patient-reported data and feedback processes between patients and therapists: to improve outcomes for individuals. We are concerned that this purpose is getting completely lost on therapists in systems where the progress data are intended to be used to evaluate, penalize, and/or pay the therapist. Using patient data and feedback for multiple purposes across patient care, therapist support, and organizational quality improvement is likely only viable within a very supportive organizational culture without penalties (Connors et al., 2021). Barber and Resnick are careful to state that measurement-based care may protect against burnout in the context of thoughtful implementation, where therapists are adequately supported, feedback is truly person-centered for the value of clinical care, and outcomes are not aggregated or otherwise used for therapist evaluation. Mandatory use of feedback can be positively received by clinicians when it is part of the broader culture (e.g., Calgary Counselling Centre) and with intentional, phased implementation throughout the organization (Donelan et al., 2024). It is our hope that the more therapists are exposed to feedback in supportive organizations intentionally integrating and perhaps even requiring this practice, the more they may go on to future settings where they ask about or are champions for feedback. The use of feedback data for therapist evaluation or reimbursement will only continue to confuse the goals of the data, reinforce therapists' negative attitudes and suspicions, and thus thwart the forward momentum of feedback implementation.

Conclusion

Feedback is increasingly becoming of interest, encouraged, and in some countries and systems even required as part of high-quality care across the globe. Use of feedback in mental health services is implemented and studied globally, but terminology, practices, delivery systems and implementation strategies are rarely collated across countries to optimize shared learning of innovation and best practices. The goal of this special issue is to highlight the use of feedback in mental health services in a wide array of settings and stimulate current and future examination of implementation strategies, mechanisms and outcomes to expand the reach and implementation of feedback in real world settings.

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