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UK therapist views of barriers and facilitators to evidence-based CBT practice: A qualitative inquiry using the Theoretical Domains Framework

Abstract

Consistent uptake and implementation of evidence-based CBT (EB-CBT) in clinical practice remains challenging. Understanding key barriers and facilitators experienced by CBT therapists is essential for developing effective implementation strategies to enhance adoption of EB-CBT practices. This study applies the Capability Opportunity Motivation-Behaviour (COM-B) and Theoretical Domains Framework (TDF) to provide a theoretically driven exploration of perceived barriers and facilitators to implementing EB-CBT reported by CBT therapists. A cross-sectional survey design incorporating qualitative open-ended questions was used to gather in-depth insights from 228 UK-based CBT therapists. Data were analysed using reflexive thematic analysis. Inductive analysis identified ten barriers and eight facilitators, which were deductively mapped onto the COM-B and TDF to identify key determinants affecting practice at the individual therapist or broader organisational level. At the therapist level, barriers identified were understanding of evidence-based decision making, skepticism about EB-CBT as being rigid, based on flawed evidence, and lacking client centredness, and a preference for intuitive eclecticism. Therapist facilitators included skills in research literacy and formulation, guided self-reflection as a behaviour regulation strategy, and reinforcement through positive outcomes. Organisational barriers were limited or complex research/guidelines, difficulty accessing knowledge, lack of training/supervision, and service constraints. Organisational facilitators comprised external monitoring as a behavioural regulation strategy, fostering communities of practice, gaining knowledge through resources, and access to training/supervision. Key perceptions as well as misconceptions around using EB-CBT in practice were identified, highlighting the need for multi-level strategies addressing both individual and organisational factors to enhance therapists' capability, motivation, and opportunity to adopt EB-CBT practices.

Key Words: evidence-based practice, cognitive-behavioural, CBT, implementation, qualitative, COM-B.

Key learning aims

As a result of reading this paper, readers should:

1) Understand the key barriers UK therapists perceive as hindering the implementation of evidence-based CBT practices.

2) Understand the key factors UK therapists perceive as facilitating and enhancing the implementation evidence-based CBT practices.

3) Be able to use the COM-B and TDF model to map key determinants affecting adoption of evidence-based CBT practice at both the individual therapist and broader organisational level.

4) Consider theoretically driven implementation interventions which could be used to target identified individual and organisational factors to improve sustained adoption of EB-CBT.

Introduction

A large body of research has shown Cognitive Behavioural Therapies (CBT) to be effective in reducing symptoms and relapse rates across a range of psychological difficulties (Butler et al., 2006; Hofmann et al., 2012), prompting a drive to increase implementation of CBT into routine practice (Clark, 2011; McHugh & Barlow, 2010). Central to the success of CBT implementation programmes is the local adoption of Evidence-Based Practices (EBP), an approach to making informed treatment decisions based on integration of the best available research evidence, therapists' own expertise, and client values and characteristics (APA, 2006; Spring, 2007). However, there are increasing reports of major gaps between what is known about effective CBT practice and what is actually implemented in routine practice, with Evidence-Based CBT (EB-CBT) often being unavailable or delivered sub-optimally (Dobson & Beshai, 2013; McHugh & Barlow, 2010; Shafran et al., 2009). Indeed, even therapists who initially utilise EB-CBT may not continue to adopt such practices, a process known as 'therapist drift' (Waller &Turner, 2016; Wilcockson, 2022). It is, therefore, important to better understand factors facilitating or impeding therapists in working within an EB-CBT framework, to promote ongoing successful implementation of CBT within routine practice.

Effective implementation of EBP requires a multi-level approach incorporating evidence-based policy and practice at the community, organisational, and practitioner level

(Durlak & DuPre, 2008; Greenhalgh et al., 2004). Pragmatic, educational, and attitudinal factors at each level influence adoption of EBP and facilitate or hinder the success of implementation programmes (Damschroder et al., 2022; Dobson, & Beshai, 2013). At community level these include political and institutional policies, procedures, and regulations. Organisational level factors include cultural and functional climate, such as access to training and supervision, service delivery constraints, and goals and values of service leaders. Finally, at individual practitioner level attitudes towards EBPs, knowledge and understanding of EBP, and practical issues. To date, studies have highlighted key barriers to the use of EB-CBT as pragmatic organisational factors (e.g. time constraints, high caseloads, lack of supervision, limited control over clinical schedules, poor communication with clinical leaders), and therapist attitudes (e.g. belief of centrality of the client, a preference for relying primarily on experience) (Gyani et al., 2014; Gyani et al., 2015; Kauth et al., 2010; Kjoge et al., 2015; Lewis & Simons, 2011; Stewart et al., 2012; Wilcockson, 2022). Whilst this research is informative, it lacks a clear theoretical underpinning from which barriers and facilitators can be meaningfully identified and used to inform the development of theory driven intervention strategies to promote successful use of EB-CBT practices. The current research builds upon previous research by contextualising factors influencing the adoption of EB-CBT within a UK healthcare setting and drawing upon behaviour change theory to offer a more structured, theoretically driven approach to understanding and targeting mechanisms that influence EB-CBT implementation.

There is a need for multi-level, targeted, and specific strategies to address barriers to the adoption of EB-CBT and support therapists to work effectively within an EBP framework. Promoting the adoption of EB-CBT practices across organisations and services requires both individual and collective behaviour change. A behaviour change strategy grounded in implementation theory can identify barriers and facilitators, offering insights into the mechanisms of change and helping explain how individual and organisational factors influence the adoption of EB-CBT, thus guiding the development of targeted interventions and helping organisations allocate resources effectively (Eccles et al., 2005). Several behaviour change tools have been developed to facilitate effective implementation of therapies into route practice.

The Capability Opportunity Motivation-Behaviour (COM-B) Model and aligned Theoretical Domains Framework (TDF) implementation frameworks have been suggested as being well suited to developing complex interventions to reduce the gap between practice and evidence by providing a structured, theory-driven approach for identifying and addressing contextualised individual level and organisational factors influencing behaviour change in applied healthcare settings (French et al., 2012). The COM-B conceptualises behaviour as a function of an individual's capabilities (individuals' capacity to engage in behavioural modifications), opportunities (environmental factors that influence individual behaviours), and motivations (willingness for change) (Michie et al., 2011). The TDF expands on the COM-B model, identifying fourteen theoretically driven sub-domains influencing behaviour: knowledge, (2) skills, (3) memory, attention and decision processes (4) behavioural regulation (5) beliefs about capabilities, (6) social/ professional role and identity, (7) beliefs about consequences, (8) emotions, (9) goals, (10) intentions, (11) reinforcement, (12) optimism/ pessimism, (13) environmental context and resources, and (14) social influences (see Figure 1 for an overview), (Cane et al., 2012).

The COM-B model and TDF have been found to be predictive of a range of health behaviours and have been widely applied within qualitative research to support effective implementation of evidence-based healthcare practices by facilitating comprehensive assessment of behavioural determinants (Atkins et al., 2017; McGowan et al., 2020). These frameworks are particularly well-suited to support the implementation of complex evidence-based healthcare practices because they offer a comprehensive, theory-driven method for identifying and addressing the behavioural determinants of change (Atkins et al., 2017; McGowan et al., 2020). By integrating individual and contextual factors and demonstrating predictive utility across a wide range of health behaviours, they provide a robust foundation for designing targeted, effective implementation strategies. Applying COM-B and the TDF in this study therefore provides an integrative framework for understanding barriers and facilitators to the adoption of EB-CBT experienced by individual therapists, whilst also recognising the impact of the broader organisational and community contexts within which they are situated.

Insert figure 1 about here

The current study used the COM-B and TDF to identify key determinants of UK therapists' use of EB-CBT practices. Because it is important that implementation interventions are relevant and meaningful to the people they are aimed at, the study will focus on CBT therapists' own views about the factors which influence the adoption of EB-CBT. Inductive themes will be mapped onto the TDF and COM-B frameworks to offer insight into the barriers and facilitators UK therapists perceive as inhibiting or enhancing the adoption of EB-CBT practices, thereby guiding the development of targeted, relevant, and acceptable implementation intervention strategies which promote successful use of EB-CBT practices.

The following research question was addressed within this exploratory study: what are the perceived barriers and facilitators to implementing EB-CBT reported by CBT therapists in the UK?

Method

Design

The study adopted a cross-sectional survey design to explore the opinions and experiences of implementing EB-CBT amongst UK therapists. This paper reports qualitative findings from open-ended survey questions to examine how therapists conceptualised EB-CBT practice and perceived barriers and facilitators to implementing EB-CBT. The Consolidated Criteria for Reporting Qualitative Research (COREQ-32) checklist was used to guide this qualitative investigation and reporting (Tong et al., 2018).

Materials

Drawing from a realist lens, a multi-method survey including five qualitative questions was developed to explore a varied range of therapists' views about the factors perceived to influence the adoption of EB-CBT (Braun & Clarke, 2021; Wiltshire & Ronkainen, 2021). First, participants were asked to explain what evidence-based practice meant to them. Second, to describe any factors they found helpful in supporting them to use EB-CBT in their practice and to explain how and why these were helpful. Third, to describe any barriers they experienced to using EB-CBT in their practice and to explain how and why these barriers hindered them. Fourth, to outline what they felt would help support the delivery of EB-CBT in their practice in the future. Fifth, to provide any other comments or experiences relating to the use of EB-

CBT that they would like to share. Asynchronous survey responses were submitted at participants' convenience; length of responses to questions ranged from 2 lines of text to 15 lines of text.

Participants

Participants were therapists practicing CBT (broadly defined as individuals who self-identified as using CBT within their clinical practice) based in the United Kingdom. Three recruitment methods were implemented. First, 1054 therapists who identified as practicing CBT were contacted through public websites of professional therapeutic organisations (British Association for Behavioural and Cognitive Psychotherapies, British Association for Counselling & Psychotherapies, and British Psychological Society). Second, the study was advertised on social networks (Twitter and Facebook) and professional networks and societies (CBT focussed special interest groups, regional psychology networks, therapy today). Third, participants were asked to share information with other interested colleagues to support snowball sampling.

The survey was completed by 228 therapists. The majority described their primary form of therapeutic practice as cognitive behavioural (*N* = 188). The remaining identified their therapeutic practice as including cognitive-behavioural methods, but primarily as integrative (*N* = 27), humanistic (*N* = 4), psychodynamic (*N* = 2), and 'other' (described as psycho-social model *N = 1;* CBT informed physical rehabilitation*;* EMDR *N* = 2, integrative / CBT *N* = 1; third wave CBT *N* = 1; trauma-focussed CBT *N* = 1). The sample comprised of therapists across 11 different professions: NHS Talking Therapies for Anxiety and Depression (NHS TTAD: formerly IAPT) High Intensity Therapist (*N* = 55), Clinical Psychologist (*N* = 55), Psychotherapist (*N* = 31), CBT Psychologist (*N* = 25), Psychological Wellbeing Practitioner (*N* = 24), Psychiatric Nurse (*N* = 18), Counselling Psychologist (*N* = 12), Counsellor (*N* = 4), Health Psychologist (*N* = 2), Arts Therapist (*N* = 1), Social Worker (*N* = 1). In terms of highest level of qualification: 64 participants held a Doctoral Degree, 84 held a Master's Degree, 66 held a Postgraduate Diploma, and 14 held a vocational health profession Bachelor's Degree. Participants primarily working context was in the National Health Service (*N* = 164), private practice (*N* = 47), charitable sector (*N* = 7), academic institution (*N* = 6) and 'other' (NHS funded business *N* = 2,

dual NHS & private *N* = 1, ministry of defence *N* = 1). The sample consisted of 176 females and 51 males, with one participant preferring not to state gender. The mean age was 39.93 (*SD* = 11.88, range 23-74).

Procedure

Participants were invited to take part, with emails and adverts including a summary of the study and a link to the online survey hosted by JISC Online Surveys. Participants completed an online information and consent form and an initial screening question confirming that they were a UK-based therapist who used cognitive-behavioural interventions in their practice. Participants were offered a financial incentive in the form of a prize draw to win £50 vouchers. Ethical approval was granted by the University of Worcester Institute of Health and Society research ethics committee (ref HCA16170014). Authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS and informed consent from participants was obtained.

Analytic Approach

Reflexive thematic analysis was conducted within a realist framework to identify factors which therapists perceived as barriers and facilitators to implementing EB-CBT (Braun & Clarke, 2021). Justification for adopting this approach to analysis was two-fold, in that reflexive thematic analysis allowed flexibility in the iterative process of theme development, to hold space for codes and themes to develop and evolve as the researchers gained deeper understanding of the data. Secondly, the realist framework allowed the researchers to uncover objective truth beyond surface level interpretation of experiences and behaviours, by simultaneously acknowledging pre-existing assumptions and biases that may influence interpretation of the data to promote deep engagement with the analysis (Braun & Clarke, 2021).

Analysis was conducted by three researchers (KM, EW, and KS) and followed Braun and Clarke's (2021) reflexive TA guidelines, integrating an initial inductive data-driven approach, followed by a deductive theory-driven mapping of themes (Atkins et al., 2017; McGowan et al; 2020). Data from across the qualitative survey responses was pooled and analysed together. Researchers worked independently to identify and code initial descriptive features

in the data, capturing key elements associated with adoption of EB-CBT. Researchers then worked together to review these descriptive codes for similarity in meaning to create interpretative codes that captured more nuanced meaning associated with adoption of EB-CBT practices. Interpretative codes were then clustered according to common underpinning meaning into potential themes to construct more coherent theme structures. Clusters were re-assessed, reviewing whether the meaning attributed overlapped with one another. This re-assessment continued alongside review of the data based on the codes applied and the original data set, until a final thematic framework was agreed by all researchers. Inductive themes were then deductively labelled as barriers or facilitators and were mapped to a pre-defined matrix, comprising of the overarching capability, opportunity, and motivation domains within the COM-B model (Michie et al., 2011) and the 14 sub-domains within the TDF (Cane et al., 2012). In moving from an inductive to a deductive approach, all themes mapped onto the theoretical matrix as they had been identified inductively, with no amendments or re-construction of themes required. Two themes were mapped to the framework in tandem to ensure agreement across researchers in the mapping strategy. Subsequent mapping was conducted independently, with researchers meeting regularly to discuss the process and any challenges identified. Themes that were mapped in different domains by researchers were discussed to establish consensus.

Reflections on the analytical process

The research team acknowledges that our professional training, disciplinary backgrounds, and shared commitment to evidence-based CBT (EB-CBT) shaped the design, analysis, and interpretation of this study. The project emerged from a collective aim to support more effective implementation of EB-CBT in routine practice and was conducted by a team of academic researchers with experience in qualitative research and varied but complementary areas of expertise. KM is a Senior Lecturer whose research focuses on the implementation of EB-CBT in routine care settings. EW is a Health Psychologist (DHealthPsy) with experience delivering CBT in NHS TTAD services and a particular interest in applying behaviour change models in clinical contexts. KS is a Senior Lecturer in occupational psychology and LR-D is a Senior Lecturer in psychology and education. Both are Chartered Coaching Psychologists with expertise in workplace and educational settings.

Our academic and professional experiences likely influenced our conceptualisation of EB-CBT and our analytic interpretations, including a shared belief in the value of evidence-based practice in healthcare and in organisations. These perspectives, while offering insight into the topic, also present a potential for bias, which we sought to acknowledge through regular team discussion and critical reflection during engagement with the data, conduct of the analysis, and theoretical application. Given the relatively small size of the professional field, some members of the research team had pre-existing working relationships with a small number of participants (e.g., through shared workplaces). We acknowledge that this may have influenced participants' decisions to participate or shaped the content of their responses.

Findings

Inductive analysis of CBT therapists' accounts identified ten perceived barriers and eight perceived facilitators to the use of EB-CBT. Nine themes fell within therapist (i.e., CBT 'provider') level (see figure 2) and nine within organisational level (i.e., stemming from the broader healthcare system) (see figure 3). Themes were deductively mapped onto a combined matrix including the COM-B and TDF. A summary of each theme is presented below, with an overview and illustrative quotations in Table 1.

Insert Figure 2 About Here

Insert Figure 3 About Here

Insert Table 1 About Here

1. Capability (COM-B)

Within the COM-B capability system, three linked TDF domains (knowledge, skills, and behavioural regulation) were described.

1.1. Knowledge (TDF)

Knowledge refers to an awareness of the existence of something (Atkins et al., 2017). Lack of knowledge at individual therapist and organisational level were identified as barriers.

Barrier - A narrow view of EBP (therapist level)

This theme captures a lack of consensus about what it means to work within an EBP framework. Well accepted definitions typically highlight EBP as being a decision-making process drawing upon "three pillars": research evidence, clinical expertise, and client needs and preferences (Spring, 2007). Although some therapists spoke of the need for balancing research evidence with client needs or clinical expertise, therapists rarely expressed this integrated view of EBP. Instead, many therapists reported a much narrower view of EBP, dominated by the research component. Evidence-based practice was not only equated with the application of research to practice, but there was also a sense for some that working in a way that was not "proven" *P4* by a large body of research to be effective would be disapproved of or prohibited.

Barrier - Lack of guidance (organisational level)

This theme refers to perceived gaps in EB-CBT guidance, which sometimes left therapists feeling unsure of the most appropriate ways of working. This was particularly the case in relation to populations requiring adaption from standard CBT protocols (e.g. children and young people, people with learning disabilities, older adults), more complex presentations (e.g. co-morbidity, eating disorders, long-term health conditions), and novel CBT approaches (e.g. third-wave, transdiagnostic). When working in these areas, therapists highlighted the need to work outside of clear EB-CBT guidance. This involved drawing on broader knowledge for "filling in the blanks" *P7* and making adaptations to "off the shelf" *P206* interventions. Participants who felt they did not have the experience or broader knowledge needed to work in this way were left without a clear understanding of when, how, and why such adaptations should be made.

1.2. Skills (TDF)

Skills includes abilities or proficiencies acquired through practice (Atkins et al., 2017). Two facilitators identified refer to skills developed by therapists, which therapists felt supported the use of EB-CBT.

Facilitator - Research literacy (therapist level)

This theme reflects research literacy skills required to access, make sense of, and apply research evidence and guidelines within clinical practice. These skills include knowing how to search and access appropriate literature, critically reviewing articles and guidelines, and understanding the process of research evidence development. These skills were acquired through postgraduate training, involvement in research, and research-informed supervision.

Facilitator - Formulation skills (therapist level)

This theme relates to the acquisition, development, and maintenance of formulation skills, which were felt to be central in guiding implementation of evidence-based techniques appropriate to individual client needs and preferences. Therapists reported that a carefully considered and co-constructed formulation provided a way of applying theoretical understanding of CBT principles to make sense of and explain a particular individual client's difficulties. This offered both clients and therapists "a shared map" *P227* which could be drawn upon to guide therapy. The formulation gave therapists confidence to work flexibly within an evidence-based framework, balancing research evidence and guidelines with responsiveness to client needs. Therapists highlighted the importance of developing and then maintaining formulation skills to prevent "robotic" P179 application of interventions or drift away from EB-CBT. Experiential training and supervision, clinical feedback, and modelling by experienced therapists all helped to foster formulation skills.

1.3. Behavioural regulation (TDF)

Two behavioural regulation strategies aimed at managing or changing actions (Atkins et al., 2017) were identified as facilitating EB-CBT, one externally driven and the other internally driven.

Facilitator - External monitoring (organisational level)

This theme reflects the facilitative role of supportive service or organisational level monitoring of practice, such as service evaluation, accreditation reviews, and other 'continuing professional development' reporting activities. This external monitoring prompted and encouraged on-going self-reflection on current ways of working, including

whether these were in alignment with up-to-date evidence-based guidance. Monitoring also highlighted further support and development needs.

Facilitator - Guided self-reflection (therapist level)

This theme includes a number of self-directed strategies for reflecting on implementation of evidence-based practice. These included protecting time and space away from hectic and busy work schedules for engaging in reading, training, reflecting, and informed decision making. Peer support and supervision were also seen as a supportive context for self-reflection. Routine outcome monitoring; self, peer, and supervisor feedback on recorded sessions; and use of role-plays within supervision were particularly drawn upon to support self-reflection.

2. Opportunity (COM-B)

Within the COM-B opportunity system, one TDF domain (environmental context and resources) was described.

2.1. Environmental context and resources (TDF)

This domain includes any situational or environmental circumstances encouraging or discouraging skill development, independence, social competence, or adaptive behaviour (Atkins et al., 2017). Three facilitators and four barriers fell within this category.

Facilitator - Community of practice (organisational level)

This theme illustrates the importance of a supportive learning community in facilitating engagement with evidence-based practices. Networks of trusted peers and colleagues came together to offer mutual support, both in person and online. These spaces were used for sharing ideas, research, materials, discussing cases, overcoming obstacles, practicing skills and group reflection. They were most beneficial when senior leadership from within the organisation actively encouraged and supported participation.

Facilitator - Knowledge through resources (organisational level)

This theme reflects the crucial role of access to evidence-based practice resources. This included research articles and conference attendance, which supported up to date knowledge

of current evidence and guidance. Treatment manuals and guidelines about *how* to implement EB-CBT treatments were highlighted as especially helpful. Case studies and practice magazines were also deemed useful resources for sharing clinical knowledge and experience.

Facilitator - Access to training and supervision (organisational level)

Central within this theme is access to good quality training and supervision. This was understood to be informed by research evidence and guidance, encouraging of self-reflection, providing opportunities for experiential learning, and offering support and feedback from more experienced therapists. Such training and supervision helped therapists focus, reflect, problem-solve, avoid drifting from best practice, consider new up-to-date ways of working, build confidence, and feel inspired. A solid foundation of training and access to supervision was seen as fundamental when first developing understanding and skills in EB-CBT. Therapists also highlighted the importance of ongoing and regular access to quality training and supervision.

Barrier - Complex research and guidelines (organisational level)

Barriers were faced by therapists in finding relevant and good quality resources from the plethora of information available. The complex way in which research evidence and guidelines were presented, the varying quality of information, and the conflicting viewpoints made it difficult to draw meaningful conclusions, with therapists left feeling unsure how to apply these ideas to their clinical practice.

Barrier – Barriers to accessing knowledge (organisational level)

Therapists highlighted facing significant barriers in terms of having the time and ability to access research and guidance to inform their EB-CBT. Research paywalls and a lack of published manuals and materials made it more difficult and time consuming to keep up to date with and understand how to implement the evidence base.

Barrier - Lack of training and supervision (organisational level)

Therapists within private, NHS, and charitable settings felt it was difficult to maintain evidence-based practice without regular, consistent, and high-quality training and supervision from an experienced and supportive CBT oriented therapist. Yet these vital developmental opportunities were often not available due to accessibility (e.g. time and location of training or supervision), resource implications (e.g. financial costs and time to attend), availability (e.g. lack of experienced or CBT oriented supervisors), or lack of service-level support.

Barrier - Service constraints (organisational level)

A variety of service constraints were highlighted within this theme, all of which meant that therapists felt they were left with no choice but to do "what is possible" *P9*, rather than what they considered best practice. This included offering fewer treatment sessions, feeling compelled to move people along in therapy, and not implementing some techniques (e.g. behavioural experiments and exposure-based interventions). A combination of limitations on the number, length, and location of sessions within the service, high caseload demands, and a focus on targets created a challenging environment which left some therapists feeling pressured and overwhelmed. The issue of suitability of referrals was highlighted as particularly challenging. Therapists felt that a 'one size fits all' approach compelled them to work with clients they did not feel met suitability criteria for their service, or for whom they did not feel CBT was appropriate for. Within some settings this was further compounded by a lack of encouragement and at times even discouragement from colleagues, supervisors, and management to work within an EB-CBT framework.

3. Motivation (COM-B)

Within the COM-B motivation system, two TDF domains (beliefs about consequences and reinforcement) were described.

3.1. Beliefs about consequences (TDF)

Four themes reflect beliefs and preferences held by therapists which served as barriers to EB-CBT. These fell within the beliefs about consequences domain, referring to beliefs about truth,

reality, or validity about outcomes of a particular behaviour in each situation (Atkins et al., 2017).

Barrier – Perception of rigidity (therapist level)

This theme reflects the belief that EB-CBT involves working within rigid and inflexible protocols, manuals, and guidelines which fail to account for the client's needs and goals and therefore can damage the therapeutic relationship. It was felt that sometimes a softer, more personalised, and less structured approach which focussed on building a strong therapeutic alliance was needed and that this was not possible within the rigidity of an evidence-based practice framework.

Barrier - Doubts about flawed evidence (therapist level)

This theme highlights a lack of confidence in the quality, rigour, and relevance of research evidence, reducing therapists' motivation to engage with research evidence and use it to inform their practice. Concerns centred around a perceived lack of effectiveness research, lack of lived experience research, lack of long-term follow-up, lack of transparency, and failure of replicability. Therapists particularly noted that research was reductionist and focussed too heavily on diagnosis, thus failing to reflect the complexity of clients in clinical reality. The resources available within research trials was also felt to be unrepresentative of the clinical organisations within which therapists worked.

Barrier - Belief that EBP is not client centred (therapist level)

This theme reflects therapists' belief that EB-CBT is not always "patient-centred" P197. Therapists reported that clients' expectations of CBT therapy, aversion to techniques deemed unhelpful or unnecessarily challenging, and poor previous experiences of CBT sometimes meant that clients were reluctant to engage in EB-CBT therapy. This made working within evidence-based practice guidelines challenging. For some, this prohibited working within an EB-CBT framework at all, as this approach was not seen as aligning with client preferences, goals, and values.

Barrier - Preference for intuitive eclecticism (therapist level)

This theme characterises the belief that clinical intuition should be the primary driver for treatment decisions and that this is not always possible within the framework of EB-CBT practice. Some therapists preferred to rely on their clinical judgement and experience to work with an individual in a way that draws upon a range of therapeutic modalities and treatment techniques. This eclectic, or integrative approach to therapy was preferred over working exclusively within an EB-CBT framework.

3.2. Reinforcement (TDF)

Reinforcement increases the probability of a response through a relationship between the response and resulting rewards, incentives, or punishment (Atkins et al., 2017). One facilitative theme was identified as providing reinforcement for EB-CBT.

Facilitator - A tried and tested method (therapist level)

This theme illustrates a range of experiences which reinforce working within an evidence-based practice framework. Personal experience of seeing positive change in clients is a rewarding and satisfying experience which promotes continued use of EB-CBT. Similarly, seeing research evidence also increases confidence in using these ways of working as they are "tried and tested" *P184*. In contrast, therapists reflected that when they had drifted from using evidence-based practice in the past, this was sometimes unhelpful for clients and thus encouraged them to return to evidence-based practice.

Discussion

This study provided a theoretically driven approach to exploring barriers and facilitators associated with the adoption of evidence-based cognitive-behavioural therapy practices (EB-CBT) within a UK healthcare setting. Inductive analysis identified ten barriers and eight facilitators, which were deductively mapped onto the Capability Opportunity Motivation-Behaviour (COM-B: Michie et al., 2011) and Theoretical Domains Framework (TDF: Cane et al., 2012) to identify key determinants affecting EB-CBT practice. These factors can be categorised as falling at the individual therapist (i.e., CBT 'provider') and organisational level (i.e., stemming from broader healthcare systems). At the therapist level, barriers included knowledge of EBP and beliefs about consequences of EB-CBT (perceptions of rigidity, flawed

evidence, lack of client centredness, preference for intuitive eclecticism). Therapist facilitators included skills in research literacy and formulation, guided self-reflection as a behaviour regulation strategy, and reinforcement through positive outcomes. Organisational barriers included limited EBP guidance and environmental context issues (complexity of research/guidelines, difficulty accessing knowledge, lack of training/supervision, service constraints). Organisational facilitators included external monitoring as a behavioural regulation strategy and environmental context issues (fostering communities of practice, gaining knowledge through resources, access to training/supervision).

Individual therapist level factors

Therapists in this study, like those in previous research (Gyani et al., 2014; Safran et al., 2011), preferred decision-making based on clinical experience over research, citing concerns about research quality and relevance as well as a preference for drawing intuitively on clinical experience from across modalities. This mistrust of research evidence is concerning, as attitudes toward research correlate with delivering empirically supported treatments (Speers et al., 2022). Therapists in this study also identified research literacy as a factor supporting their use of EB-CBT. More firmly embedding research literacy across all levels of therapist education may help address this mistrust, by better equipping therapists with the critical scientific reasoning required to become autonomous and informed research consumers who can actively engage in evidence-based practices (Norcross et al., 2016). However, researchers must also directly address therapist concerns by making research more relevant, accessible, and practice-oriented and therefore bridging the research-practice gap evident within CBT. Bridging this gap may require a paradigm shift in research focus (towards transdiagnostic processes; mechanisms of action; efficacy of specific therapeutic techniques; implantation research), method (collecting longitudinal data to monitor individual patient trajectories; using innovative causal inference methods), process (participatory approaches involving non-scientists; fostering reciprocal practice research links), and dissemination (clearer reporting; user friendly clinician focussed guidelines; increased sharing of findings across stakeholders), (Berg et al., 2024; Dobson & Beshai, 2013; Shafran et al., 2009).

Therapists reported common beliefs that EB-CBT is rigid, inflexible, and non-client-centred (Gyani et al., 2015; Speers et al., 2022), reflecting broader scepticism about the clinical

decision-making process. This scepticism may stem partly from a perceived lack of EBP guidance, as highlighted in this study. Some therapists also equated EB-CBT solely with research, suggesting misunderstandings about its framework and providing an explanation as to why some felt reticent to work within a framework perceived as restrictive, undervaluing therapist experience, and lacking flexibility to meet individual client needs. Yet this restrictive view is not reflective of original descriptions of the 'three pillars' approach to EB decision-making, which integrates clinical expertise and client needs or preferences with the best available evidence (Spring, 2007). While EBP training is a core component of the scientist-practitioner model in professional psychology and CBT programs, its coverage varies across graduate training (Hunsley, 2007). This study highlights the need to strengthen training in higher-order metacompetencies, such as formulating relevant questions, acquiring and appraising evidence, integrating client context and preferences with available resources, and continuously assessing outcomes (APA, 2006; Roth & Pilling, 2007; Spring, 2007). Given the variability in training routes for CBT therapists in the UK, embedding these competences in continuing professional development and supervision is essential.

As reported in previous research (e.g. Addis & Krasnow, 2000; Waller et al., 2013), some therapists in this study were reluctant to follow protocols, manuals, and guidelines they perceived as rigid and inflexible. Addressing these concerns may require greater emphasis on formulation skills when working with guidelines. CBT case formulation involves therapist and client working together to develop a coherent set of theory-routed explanatory inferences about factors causing and maintaining client's presenting issues, thus guiding appropriate adaptation of interventions to individual client needs, context, and preferences while maintaining fidelity to core CBT principles (Kuyken et al., 2011). Therapists in this study reported that formulation skills allowed them make decisions about when, how, and why to adapt current EB-CBT guidelines. Despite being a core CBT competency (Roth & Pilling, 2007), some therapists in this study reported that formulation skills were insufficiently covered in larger-scale national CBT training programmes. Previous research emphasised the need for ongoing training and targeted supervision to enhance formulation training in larger scale CBT training courses (Zivor et al., 2013) and this study adds further weight to this argument.

Therapists in this study highlighted guided self-reflection as a facilitator to EB-CBT, involving self-monitoring strategies such as goal setting, action planning, and feedback from peers and supervisors to track, manage, and adjust their use of EB-CBT. In line with best practice guidelines, relationship-based support and development opportunities within supervision can enhance these behavioural regulation strategies by facilitating collaborative goal setting, ongoing practice monitoring, and corrective feedback (Milne, 2017). Experiential learning including live feedback strategies may be particularly effective in promoting behaviour change by providing instant performance-based feedback tailored to individualised therapist goals (Alfonsson et al., 2018).

Engaging in ongoing monitoring of CBT treatments within practice-based datasets can boost therapists' motivation to adopt EB-CBT (Hogue et al., 2008; Loeb et al.,2005). Participants in this study were more motivated to use EB-CBT after witnessing its beneficial effects firsthand. According to the COM-B model, motivation and behaviour are mutually reinforcing (Michie et al., 2011), meaning positive experiences with EB-CBT increase motivation to continue using it. If therapists see EB-CBT as relevant and useful, their motivation and intention to apply it in practice will increase (Van Eerde et al., 2008). Providing easy access to routine outcome measures and training in their use can encourage regular monitoring, enabling therapists to track clinical changes and reinforce positive outcomes for both clients and therapists alike (Jonášová et al., 2024).

Organisational level factors

Therapists in this study highlighted the importance of resources like clinician-facing guidelines, research articles, and case studies for maintaining up-to-date EB-CBT knowledge. However, these resources were often inaccessible due to paywalls, limited clinician materials, complex systems, and technical research findings. Access to published articles varies based on the subscription budgets of academic institutions or healthcare services (Lawson & Meghreblian, 2015). Restricted access to scientific knowledge increases social and economic inequalities for therapists and their clients, creating a need for greater transparency and open access to research findings and supporting clinical materials (Cheng & Hampson, 2008). Research findings should be presented in user-friendly formats and synthesized into clear guidelines, which can be actively promoted to therapists through media promotion, high-

traffic websites, and specialist magazines in a range of easy to access and digest formats such as podcasts, blogs, webinars, and mobile apps (Forman et al., 2016). Training providers and accrediting bodies, such as the British Association for Behavioural and Cognitive Psychotherapies (BABCP), could play a useful role in sharing and promoting these resources.

Therapists in this study reported that regular, research-informed, experiential, feedback-informed training and supervision from experienced CBT therapists facilitated EB-CBT. Benefits included improved focus, self-reflection, problem-solving, confidence, exploration of innovative approaches, inspiration, and prevention of therapist drift. However, as the most effective model, format, or dosage of training and supervision remains unclear (Alfonsson et al., 2018; Henrich et al., 2023), the optimal way for training and supervision to support EB-CBT is uncertain. Research suggests that ongoing, interactive, experiential training and supervision supports therapists in maintaining competences required to deliver EB-CBT gained within initial training (Henrich at al., 2023; Rakovshik & McManus, 2010). While didactic methods may effectively convey theory, skills-based experiential strategies such as modelling, role play, and corrective feedback are likely required to support ongoing skilful delivery of EB-CBT (Bearman et al., 2013). Ongoing supervision is needed alongside training to promote adoption of EB-CBT (Henrich, et al., 2023; Schoenwald et al, 2013) and supports the intention to transfer knowledge from training, with supervisor attitudes predicting uptake of EB practices by supervisees (Speers et al., 2022) and supervisory support impacting motivation and perceived importance of EB-CBT for supervisees (Salas & Cannon-Bowers, 2001). Given the importance CBT therapists place on supervision in supporting clinical decision making (Gyani et al., 2014), supervision may also be used to scaffolding decisions about when, how, and why to adapt evidence-based CBT interventions in practice, facilitating flexible fidelity. This study particularly highlights the need for this support for therapists with less knowledge, experience, or confidence, as well as those working within complex or novel areas which lack clear research evidence or practice guidelines.

Despite perceived benefits, the quality and availability of supervision for therapists in both training and practice settings is variable (Speers et al., 2022). Concerns about insufficient access to training and supervision have been previously identified as barriers to EBP (Stewart et al., 2012; Pagoto et al., 2007) and were echoed in this study across private and NHS, clinical

and training settings. Therapists in this study highlighted several obstacles, including limited time, accessibility, resource constraints, supervisor availability, and insufficient service-level support. Developing supportive organisational cultures and managerial backing is crucial, as these factors influence prioritisation and implementation of training and supervision within clinical settings (Zammel & Hashana, 2023). A research priority should be enhancing evidence around effective training and supervisory practices to provide decision makers with evidence to support greater financial investment. Given training methods differ greatly in their cost profiles (Henrich at al., 2023), exploring more cost-effective, accessible, less intensive training options is also necessary.

Therapists in this study identified several workplace conditions hindering EB-CBT, including limitations on the number, length, and location of sessions within the service, high caseloads, target-focused work, and pressure to treat clients who may not meet suitability criteria. Previous research has highlighted similar barriers, including lack of control over clinic schedules, conflicts with other duties, and lack of time with clients (Kauth et al, 2010). Such service level restrictions imposed by wider healthcare systems (NHS Trusts, Clinical Commissioning Groups) and local services may limit the degree therapists feel able to deliver EB-CBT, particularly in terms of treatment duration and use of time-intensive or practically complex techniques like behavioural experiments and exposure-based interventions. Such concerns about sub-optimal CBT delivery due to service limitations have been voiced by UK CBT practitioners (e.g. Roscoe, 2019). Thus, it seems essential to foster supportive organisational climates that promote the importance of EB-CBT and rewarded therapists for engaging skilfully in EB-CBT practices (Williams et al., 2022). A positive climate promotes clinician engagement with EB-CBT, improving attitudes towards it and increasing both self-reported and observed use of EBP (Williams et al., 2018; Powell et al., 2017). Participants in this study also highlighted the role of supportive communities of practice in promoting EB-CBT. Organisations can foster this climate through policies, procedures, and reward systems that encourage EB-CBT behaviours. This may involve structures that support a culture of continuous learning, set individual learning goals, provide personal development opportunities, offer chances to apply acquired skills, reinforce learning achievements, provide constructive feedback, and facilitate social and peer support (Banerjee et al., 2017; Cheng &

Hampson, 2008). Leadership training strategies should also be adopted within postgraduate psychology training provision to ensure policies and procedures are implemented and communicated appropriately by clinical leaders to foster positive shared climate perceptions, especially as therapists take on more leadership roles (Hunt et al, 2024; Williams et al., 2022).

External oversight and evaluation can support EB-CBT by offering feedback that identifies areas for additional skill development and reinforcing positive behaviours. Waller and Turner (2016) argue that there is a need for increased monitoring of therapists' adherence to EBP throughout their careers to prevent therapist drift. Although there are concerns such monitoring could be seen as punitive, therapists in this study found external oversight from services and accrediting bodies to be helpful for self-reflection and motivation. UK CBT therapists value non-mandatory BABCP accreditation (Parkinson & Marks, 2017), and this study underscores the role of such professional bodies in supporting EB-CBT. External oversight involving formal evaluation of behaviour in the form of competence assessments based on direct observation of therapists' skills within treatment sessions or role-plays may be particularly beneficial in providing reinforcement, corrective feedback, and identifying training needs (Muse et al., 2022).

Limitations

Whilst an inductive approach examining therapists' views about what influences adoption of EB-CBT supports development of meaningful implementation interventions, it is important to recognise potential inaccuracies associated with self-reported use of EB-CBT (Hogue et al., 2014). A qualitative survey was used to explore therapists' views. Whilst this method of data collection facilitates inclusion of views across a broader and more diverse sample of therapists, this method can compromise depth of data obtained.

The study employed a broad recruitment strategy to promote inclusivity of therapists working across diverse clinical contexts and professional roles, reflecting the varied settings in which CBT is delivered and providing an overarching understanding of how implementation barriers and facilitators operate in practice. However, this inclusive approach also introduces variety and ambiguity in the sample in relation to CBT training, qualifications, and practice. Although most therapists held a postgraduate qualification (*N* = 214, 94%), the professional training

completed by therapists was variable. The sample was predominantly NHS TTAD therapists (HIT N = 55, 24%; PWP N = 24, 11%) and clinical psychologists (*N* = 55, 24%). However, a number of therapists identified their current profession as psychotherapist (*N* = 31, 14%), counsellor (*N* = 4, 2%), and CBT Psychologist (*N* = 25, 11%). Given that these professional titles are not protected, there is variability in training, qualifications, and scope of practice among therapists who self-identify with these titles. As the survey did not prompt therapists to indicate more specific details of their EB CBT training and professional body affiliation this depth of information was not captured. Participants predominantly worked in the NHS (*N* = 164, 72%) and private practice (*N* = 47, 21%), with academic and charitable sectors being less well represented. There is an increasing trend towards therapists identifying their therapeutic orientation as integrative (Norcross et al., 2005), which is also reflected in our sample (*N* = 27, 12%). Integrative practice is conceptualised in diverse ways, encompassing theoretical integration, technical eclecticism, assimilative integration, and the common factors approach (Fiexas & Botella, 2004; Finnerty & McLeod, 2019). Given this conceptual ambiguity, the degree to which integration reflects evidence-based delivery of interventions in a theoretically coherent way that aligns with the empirical grounding is unclear. Ultimately the sample recruited will have shaped the barriers and facilitators reported in this study. As therapists across professional backgrounds and clinical settings may differ in their approach to EB-CBT (Gyani et al., 2014; Stewart et al., 2012; Wilcockson, 2022), future research could usefully explore and unpick the way in which these experiences and contexts influence therapists views towards and adoption of EB-CBT practices.

This study captured influences on the broad constellation of interrelated behaviours involved in EB-CBT. This approach aligns with behaviour change research examining complex health interventions involving sequential delivery of multiple discrete components over time in a way that is individually tailored (De Leo et al., 2021). Although less precise in behavioural terms, this approach offers broad insights into factors influencing the adoption of EB-CBT across a range of settings. However, it may also be fruitful to explore whether unique barriers and facilitators influence adoption of discrete EB-CBT practices which may be underused in clinical practice (e.g. use of exposure interventions, use of behavioural experiments, imagery work etc.).

Conclusions

The barriers and facilitators identified in this study offer insights into challenges that need to be addressed and best practices that can be leveraged to enhance the uptake of EB-CBT. At the individual therapist level, interventions should focus on developing therapists' capability and motivation to work within an EB-CBT framework. Capability-enhancing strategies should promote higher-order knowledge of evidence-based decision-making, strengthen research literacy and formulation skills, and encourage guided self-reflection. To enhance motivation, a paradigm shift towards more relevant, accessible, and practice-oriented research may be needed within research to addresses concerns about research flaws, perceptions of EB-CBT as rigid or non-client-centred, and a preference for intuitive eclecticism. Enhancing opportunities for routine outcome monitoring may also improve motivation by supporting reflection on positive outcomes of EB-CBT. At the organisational level, collaborative efforts from leaders, policymakers, and funding bodies are crucial to enhance therapists' capability and opportunity to engage in EB-CBT. Organisations must improve access to understandable research and practice-based resources, enhance access to high quality training and supervision, foster a supportive organisational climate, and facilitate supportive external monitoring of EB-CBT practices.

Given the complex interactions between individual therapists and their organisational environments in shaping EB-CBT adoption (Becker-Haimes et al., 2019), multi-level intervention strategies are likely to be more effective in driving lasting practice changes. Furthermore, as factors which influence the adoption of EB-CBT practices are likely to differ between therapists within different service contexts (Fixsen, 2005), combined interventions which target the specific set of barriers and facilitators evident within that unique service context may be more effective than generic interventions (Kauth et al., 2010). The use of implementation facilitators to conduct bespoke needs assessments and implement individualised strategies to support change efforts may, therefore, be a cost-effective and pragmatic method of enhancing EB-CBT practices (Kauth et al., 2010).

Key practice points

1. Barriers therapists identified as inhibiting use of EB-CBT were understanding of evidence-based decision making, skepticism about EB-CBT, a preference for intuitive eclecticism, limited or complex research/guidelines, difficulty accessing knowledge, lack of training/supervision, and service constraints.
2. Facilitators therapists identified as enhancing their use of EB-CBT were research literacy and formulation skills, guided self-reflection, seeing positive outcomes, external monitoring, fostering communities of practice, gaining knowledge through resources, and access to training/supervision.
3. Strategies to enhance individual therapists' capability and motivation to engage in EB-CBT could include enhancing higher-order knowledge of evidence-based decision-making; strengthening research literacy and formulation skills; encouraging guided self-reflection; enhancing routine outcome monitoring; and making research more relevant, accessible, and practice-oriented.
4. Organisational level strategies to enhance therapists' capability and opportunity to engage in EB-CBT could include improving access to understandable research and practice-based resources; availability of high-quality training and supervision; fostering a supportive organisational climate; and external monitoring.

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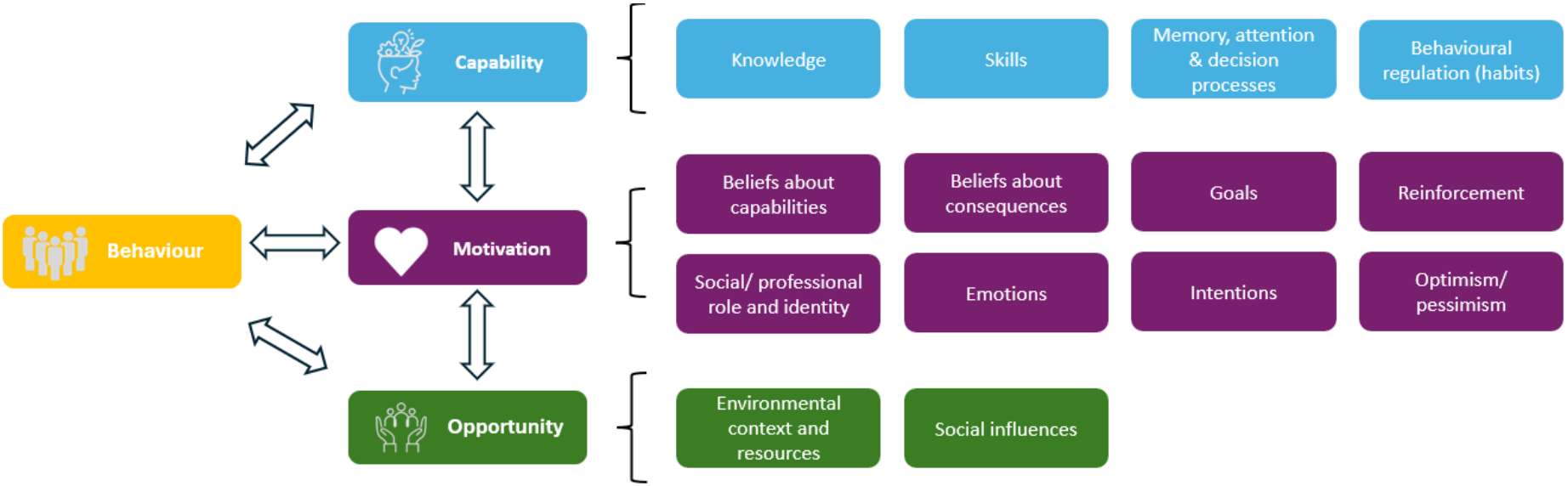

Figure 1. Map of the Theoretical Domains Framework (TDF) showing different types of individual barriers and facilitators therapists may experience when delivering evidence-based CBT. These are mapped onto the Capability, Opportunity, Motivation model of Behaviour (COM-B), indicating the key constructs required to allow therapists the opportunity to change behaviour. The figure was adapted from Michie et al., (2024).

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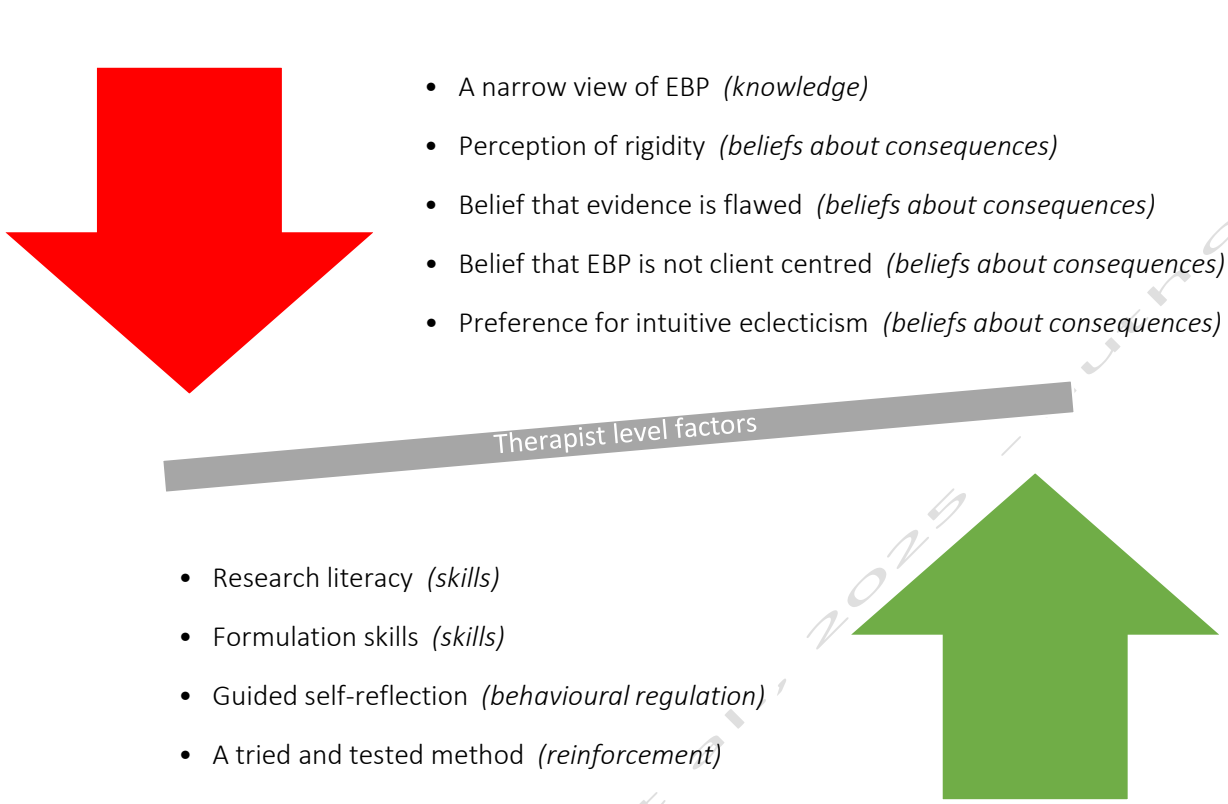

Figure 2. Perceived therapist (i.e., CBT 'provider') level barriers and facilitators impacting the use of evidence-based CBT practice aligned to the theoretical domains framework (TDF).

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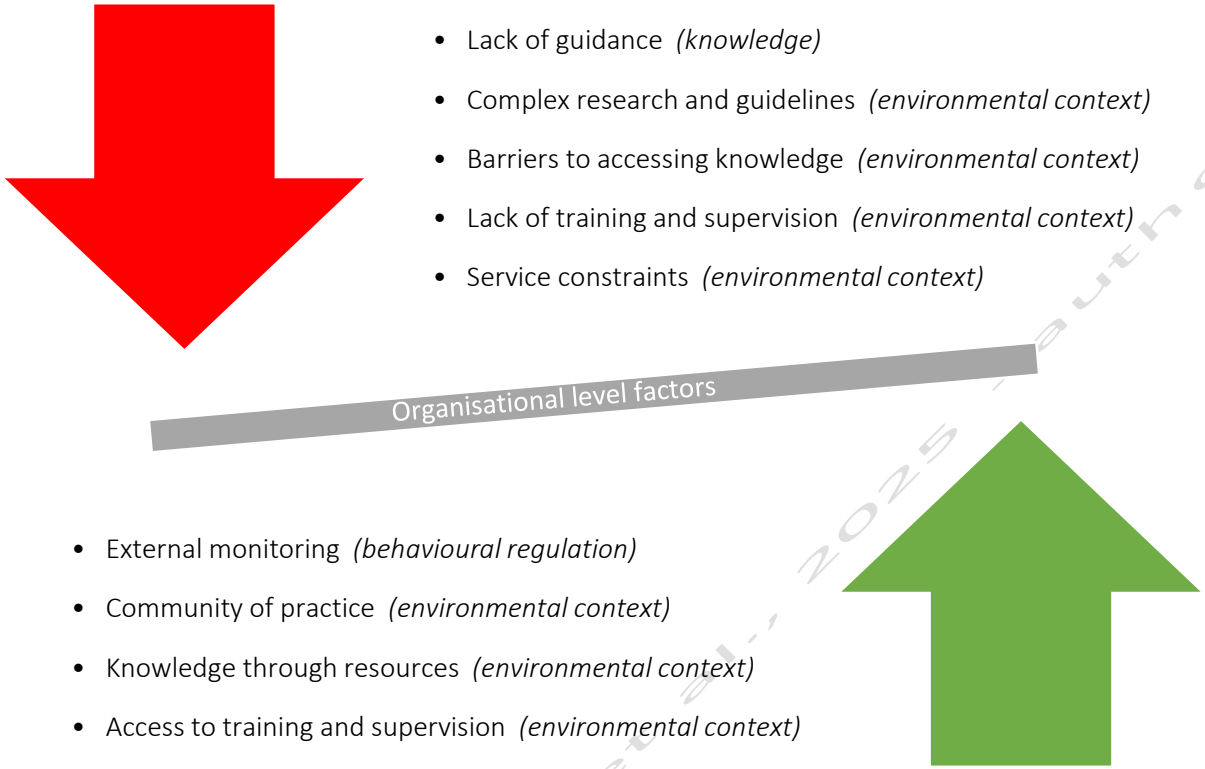

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Figure 3. Perceived organisational level (i.e., stemming from the broader healthcare system) barriers and facilitators impacting the use of evidence-based CBT practice. Themes are aligned to the theoretical domains framework in brackets (*TDF domain*).

Table 1

Summary of perceived barriers and facilitators linked to the theoretical domains framework (TDF) and the Capability, Opportunity, and Motivation- Behaviour model (COM-B) as determinants of use of evidence-based CBT practice with illustrative quotations.

Barrier or Facilitator	Theme Title	Illustrative Quotations[1]	TDF [2] Construct
COM-B[3] System: Capability			
Barrier	**A narrow view of EBP**	"It means that if it ain't been proven to work over and over again thou shalt not touch it." P4 "A way of working that has been proven to be effective in getting the best outcomes" P88 "Using techniques that have high quality research backing them" P20 "Using established protocols and research to inform the delivery of therapy" P21	Knowledge
Barrier	**Lack of guidance**	"The nature of our clients (complex adult mental health) means that sometimes guidelines don't exist or the research is in the preliminary stages of whether CBT is appropriate. And so we have to adapt and try techniques/ideas from other research areas/particular diagnoses." P171 "It can be difficult to find an 'evidence-based' way of adapting the research findings to clients with comorbid disorders or more complex presentations" P24 "Unable to follow a set protocol, not understanding why you are doing what you are doing. Having to make independent decisions not based on evidence." P110 "Gaps in research mean 'filling in the blanks'" P7	Knowledge

Facilitator	**Research literacy**	"During my MSc I learnt how to evaluate research. That was a real eye opener." P18 "My own academic background . . . has been hugely helpful, as I have the skills to access and understand journal articles." P108 "Participation in research is immensely beneficial to understanding the processes." P188	Skills
Facilitator	**Formulation skills**	"The IAPT training itself does not encourage this - they teach you protocols and this means you get stuck when you meet a patient that does not fit the protocol. Understanding CBT as a more adaptable formulation approach understanding the psychological principles behind it is more helpful." P108 "Robust formulation with a clear understanding of the underlying psychology of the individual. The problem in CBT is not the interventions but that they are at times applied without a considered formulation, in IAPT training the 'protocols' are taught well but formulation skills are less so." P101 "I use formulation to make sense of each person's difficulties and then apply the available evidence to addressing the maintaining cycles captured in the formulation." P206	Skills
Facilitator	**External monitoring**	"Working in our inpatient setting we have case review meetings every [*week]*. We are asked why we are using what treatment we have been from the following week. We are closely monitored and asked why etc." P96 "We have a good service that provides and supports its staff to deliver evidence based treatment in line with NICE guidelines, which is regularly monitored and reviewed." P53 "Being an accredited CBT practitioner keeps CBT training on the agenda." P208	Behavioural regulation
Facilitator	**Guided self-reflection**	"I make time to make decisions as a I feel it is the ethically responsible way to approach making decisions" P3 "Attending training courses and workshops is always very helpful. It is good to get away from the busy IAPT service setting and be able to reflect on your practice and gain new skills and insights" P117 "CTSR assessments - ensure my practice is in line with the evidence based treatment" P124	Behavioural regulation

COM-B[1] system: Opportunity			
Barrier	**Complex research & guidelines**	"It would also be easier to digest CBT literature if it had more consistency and so was comparable, as it currently feels that there is a wealth of information and studies but it is often difficult to draw conclusions from multiple, often conflicting, sources." P78 "I believe a barrier is the complex presentation of research making this difficult to incorporate into a therapist busy schedule, meaning that keeping up to date on evidence based research is rarely prioritised" P117 "Simplified presentations of research without all the jargon - presenting what is actually useful to daily practice." P128 "Sifting-me being made aware of what is most relevant out of the masses of papers that are constantly being printed." P157	Environmental context and resources
Barrier	**Barriers to accessing knowledge**	"Not having access to the manuals used in research trials- sometimes the techniques or programme of evidence-based therapy isn't transparent from the published paper." P12 "Biggest barrier is knowing where to access the info, and then not having an account / the funds to subscribe to a site that enables access to academic papers." P172 "Having worked on research trials I also think it takes a lot of reading and supervision to be competent and confident that you are delivering what is evidence based and we are usually not given that time as NHS clinicians." 197 "Time! When you work full-time seeing 23 people a week plus case management supervision, team meeting, and a lot of admin, it is very hard to even have suitable time to reflect on and plan for your clients let alone update yourself on research." P143	Environmental context and resources
Barrier	**Lack of training & supervision**	"Not accessing regular CPD via the service, as this feels like it has to be completed in own time" P35 "(we need) more affordable, regular training sessions that NHS is able to fund" P38	Environmental context

		"Not having a supervisor who uses CBT, or even perceives it to be worthwhile." P28 "Clinical supervision is every 4-6 weeks and we finish with clients in 6 weeks so its rare you would be able to discuss the same person more than once and for some clients you may be at the end of your treatment by the time you get supervision." P74	
Barrier	**Service constraints**	"There is a pressure for session numbers to be shorter in our service. There is a pressure to move people quicker through therapy which may mean making protocols briefer." P52 "Local service constraints such as availability of clinical space, regularity of appointments, non-attendance, policies on not leaving the clinic room, etc. are examples of practical barriers which result in deviation from evidence-based protocols." P32 "Complexity within caseload; often required to work out of my remit which means I struggle to know what evidence-based CBT interventions would be appropriate." P145 "Lack of understanding of the importance of EBP in service delivery and a culture of resistance to EBP….. A culture of trying new interventions without a clear rationale because they're sexy, leads to criticism of EBP as being "old hat"" P84	Environmental context and resources
Facilitator	**Community of practice**	"Supervision, both clinical and peer, as it helps me to further understand why I am doing what I am doing and how to adapt my practice when necessary to meet the needs of the population I am serving" P45 "Working in a team of CBT practitioners, where there is opportunity to share current findings and discuss the current caseload." P78 "Having a supervisor who uses and works within and supports use of the evidence base in this area. This helps me feel supported to use methods and confident I am applying things correctly." P197 "I have the support of my team and my placement service also. The atmosphere in these services makes it easy for me to ask questions if I need direction or support." P212	Environmental context and resources

Facilitator	**Knowledge through resources**	"NICE guidelines - reading the evidence for the research and identifying the source of the evidence for further reading and understanding." P27 "Having the protocols to hand, especially when I was learning and newly qualified as you cannot always remember everything." P46 "BABCP are good at updating you on available training, they hold conferences too which can be accessed and send recent published research papers." P53 "It has been helpful to attend training and be directed to resources, such as videos and books about delivering CBT for specific difficulties or populations." P130	Environmental context and resources
Facilitator	**Access to training and supervision**	"Engaging in CPD, which provides fresh knowledge and increases enthusiasm." P31 "Having clinical supervision from someone who is more experienced in using evidence-based CBT helps to reinforce and guide evidence-based practice." P32 "I find regular training helpful. It allows me to focus on myself and my practice. Often you know it but it is helpful to be reminded." P123 "Supervising trainees in CBT served reciprocally to ensure my practice was evidence based and encouraged me to read, train and ensure my CBT practice was adhering to evidence based guidance and in turn trainees introduced me to new resources, research articles, books and manuals and kept me reading/learning." P229	Environmental context and resources

COM-B[1] system: Motivation			
Barrier	**Perception of rigidity**	"Sometimes it can feel too rigid and prescriptive and doesn't always tap into what is most important to the patient." P13 "Some clients in my experience prefer to understand more about their particular issue and evidence-based practice sometimes does not allow enough space for this kind of exploration with this client group" P92 "Too rigid manualised treatments sometimes are a bad fit for the client" P106 "On its own, CBT can be a very prescriptive and top-down approach to working with clients and their difficulties." P109	Beliefs about consequences
Barrier	**Doubts about flawed evidence**	"I would also like to see more evidence developed from the concrete realities of working in the public sector, not in the clinical settings where much of the evidence comes from." P49 "Clients far more complex than those in research trials. Often several comorbidities and dual diagnoses…. CBT is highly effective but the evidence base paints an idealistic image of clients that is not reflective of real practice." P160 "Acknowledgement across NHS and NICE that patients do not fit neatly into boxes and that DSM criteria are inherently flawed." P139 "Manuals tend to cite evidence that supports their model but not always the evidence that is inconclusive or might contradict this" P81	Beliefs about consequences

Barrier	**Belief that EBP is not client centred**	"I think often therapists (myself included) feel unable to apply evidence because it does not feel like it would meet the person's aims for therapy (they will often come with many problems) or their lives (they are often ambivalent about therapy or have other things going on in their lives) or themselves (they may not be able to grasp a formulation; it may take a long time to get to that point; they may be unwilling to try techniques like behavioural experiments. . ." P197 "It seems not to be very useful for my private clients who ask for value for money. Many of them have a very poor experience of the protocol run treatment they have received in the NHS" P7 "Patients who think that they've had CBT when in fact they haven't has led to reduced expectations and a belief that they can't be helped" P84	Beliefs about consequences
Barrier	**Preference for intuitive eclecticism**	"I no longer use a manualised approach due to favouring a more eclectic approach." P78 "It is more likely that in the future I will pursue working in a more relational, process-oriented therapeutic approach, such as short-term psychodynamic therapy, integrating some techniques of CBT when clinically appropriate." P162 "I have also received multiple training approaches, CBT is only one. I have combined some elements of these in my practice that I find 'the best' based on my clinical experience." P3	Beliefs about consequences
Facilitator	**A tried and tested method**	"When I first started I found them to be overly prescriptive and I feared that I was not following my intuition or the patients' needs closely enough. However, once I used the treatments correctly I was impressed with the results and that helped to build my confidence in using them." P210 "When I have drifted away from the evidence base in the past, I have found that it has had a negative impact on clinical outcomes." P57 "We also in this meeting hear how other clinicians are progressing with their clients and you can see that evidence based therapies help clients" P96	Reinforcement

[1] *Quotations marked with an ellipsis . . . represent removal of text from the quotation.

[2] Theoretical domains framework (TDF)

[3] Capability, Opportunity, and Motivation- Behaviour model (COM-B)

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