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A Qualitative Analysis of Counseling and Nurse Practitioner Trainee Experiences Engaging with an Integrated Behavioral Health (IBH) Training

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Cover Page Footnote

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A Qualitative Analysis of Counseling and Nurse Practitioner Trainee Experiences Engaging With an Integrated Behavioral Health (IBH) Training

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Abstract

Integrated behavioral health (IBH) is recognized as the standard for holistic healthcare, addressing the intersection of mental and physical health. As IBH gains prominence, graduate healthcare programs must equip students with strategies to meet its demands. However, limited research exists on training methods that address diverse professional identities and the unique needs of graduate students. Our novel IBH training incorporates interprofessional education (IPE) through modules and simulations grounded in Bandura's (2001) social cognitive theory. We explored the experiences of 12 counseling, family nurse practitioner, and psychiatric/mental health nurse practitioner students through focus groups. Through interpretative phenomenological analysis (IPA), we analyzed participants' responses and present five themes: (a) role of previous experiences and emotional reactions, (b) interprofessional education and teamwork, (c) identifying the potential of IBH, (d) aligning professional values and fit, and (e) feedback on the training. We provide implications for nursing and counseling educators and scholars as healthcare providers aim to prepare the workforce for IBH.

Significance to the Public

This study highlights the importance of training healthcare graduate students in integrated behavioral health (IBH) through interprofessional education. By analyzing the lived experiences of counseling and nursing students, we identify strategies to better prepare the future workforce for holistic, collaborative care. These findings provide guidance for educators to enhance IBH training and address the growing need for integrated healthcare approaches.

Keywords: integrated behavioral health, interprofessional education, counseling, nursing, social cognitive theory

An estimated 1 in 4 adults (ages 18+) and 3 in 10 high school students (ages 13–17) in the United States live with a mental health condition (Centers for Disease Control and Prevention [CDC], 2024; Substance Abuse and Mental Health Service Administration [SAMSHA], 2024). Individuals living with mental health conditions are at a higher risk of having a chronic physical health condition, leading to lower wellness and quality-of-life reports (QoL) (SAMHSA, 2024). Conversely, the CDC (2024) highlighted the mental health strain of living with a chronic physical health condition, even if it is not a diagnosed disorder. The presence of co-occurring physical and mental health complaints creates a complex issue for providers, as treatment typically requires coordinated efforts to address mental and physical health symptoms (Possemato et al., 2018). In recent decades, integrated behavioral health (IBH) has gained momentum and is increasingly recognized as a preferred healthcare treatment modality for addressing physical and mental health conditions. Hunter et al. (2017)

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defined IBH as integrating mental and behavioral health services within primary care settings to create a holistic, multidisciplinary treatment approach that simultaneously addresses an individual's mental and physical health. To that end, IBH is a systemic shift from healthcare occurring in siloes, resulting in collocated services creating shared assessment, treatment planning, and direct services (Fields, Thompson et al., 2023; Giese & Waugh, 2017).

Research over the last two decades has continued to demonstrate an impact on healthcare outcomes when applying an IBH modality, including a reduction in mental health symptoms (Lenz et al., 2018), increased access to underserved communities (Santos et al., 2024), and promotion of health orientation and general wellness (Chambers et al., 2023; Lenz et al., 2018). Moreover, Lipman et al. (2017) described the financial burden of co-occurring physical and mental health conditions on healthcare agencies and reported savings of around $3.27 for every dollar spent on treating co-occurring conditions through IBH. Over the last two decades, federal efforts, such as the Affordable Care Act, have also recognized the potential for IBH. Notably, Croft and Parish (2013) summarized key implications of the Affordable Care Act for healthcare providers, which include funding incentives for healthcare agencies that can demonstrate an approach to provide colocated or integrated mental and physical health services. Croft and Parish also described the potential to fund training efforts for healthcare providers across multiple disciplines.

To keep pace with the IBH movement, scholars and educators are tasked with training efforts to prepare the next generation of healthcare providers. Healthcare educators engage their students in interprofessional education (IPE), or a multidisciplinary educational approach where students from health and social care professions learn with, from, and about each other to improve collaboration and the quality of patient care (Thistlethwaite, 2012). The available evidence for IPE for healthcare students suggests promise for future IBH practice. Fields, Linich et al. (2023) completed a systematic review of 18 articles reviewing IPE interventions to prepare mental health professionals, including graduate students (n = 11), to work in IBH settings and highlighted that the trainings generally supported clinical skill development, interprofessional collaboration, and self-efficacy for future practice. The only training that did not result in statistically significant results described a 3-day, 1.5-hour workshop series on youth and childhood IBH strategies in the United Kingdom, where the authors suggested more long-term and easily accessible materials to support retainment (Alexander et al., 2018). Moreover, Fields, Linich et al. (2023) described multiple training formats that resulted in positive findings, such as hybrid, virtual, face-to-face, semester-long courses, 2-day intensive workshops, and half-day intensive training. From a medical provider perspective, Strauch et al. (2023) studied an IPE experience for 97 family nurse practitioners (FNPs) and psychiatric/mental health nurse practitioners (PMHNP) to learn more about IBH practice through didactic lecturing and supplementary resources adjunct to the standard curriculum. Like Fields and colleagues' findings, FNP and PMHNP graduate students who received the training were more likely to report improved IBH practices, such as greater assessment skills, inter-professional collaboration, and self-efficacy. Indeed, literature tends to support IPE to enhance IBH knowledge.

IBH Module and Simulation Exercises

Despite promising scholarship connecting IPE in education to future practice in IBH settings, there remains a relative dearth of literature on empirical trainings. Existing scholarship inconsistently addresses the unique needs of healthcare students, raising concern for educators' relevant strategies and suggesting a need to consider additional strategies to meet the flexible schedules of healthcare students and professionals (Fields, Linich et al., 2023). To address the unique needs of healthcare students, we developed an IPE experience with HRSA funding to support mental health counseling (MHC), FNP, and PMHNP students' understanding of IBH. The training

program is grounded in social cognitive theory (SCT; Bandura, 2001), which emphasizes learning through observation, modeling, reinforcement, and imitation by collaborating with others. We selected SCT as the framework, as SCT's focus on social interaction, cognitive processes, and environmental influences makes it an effective framework for IPE. Lastly, SCT promotes student self-efficacy, where learners gain confidence in their skills through practice.

The initial part of our training consists of nine online modules. The modules were designed to provide foundational knowledge of IBH and included topics on an overview of IBH, delivery models, understanding team dynamics, providers' roles, patient roles, treatment planning, and communication strategies. Each module was estimated to take around 18 minutes and includes a pre-and post-test on learning outcomes, a didactic lecture, interactive activities, and resources, enabling learners to reinforce and evaluate their understanding (Bandura, 2001). The short module durations and online accessibility cater to busy schedules, a documented barrier to engaging with training and IPE (Rapport et al., 2022).

After completing the modules, students participated in a virtual role-play exercise with case studies across different age groups (e.g., children, adolescents, young adults, adults, and geriatric), applying IBH skills in a realistic setting. The hands-on approach, aligned with SCT's emphasis on experiential learning, aims to improve self-efficacy and prepare participants to apply IBH concepts confidently in their professional environments (Bandura, 2001). Each role-play was supervised by a faculty member moderator in either MHC, FNP, or PMHNP. The simulated IBH experience lasted 90 minutes and occurred through Zoom breakout rooms.

Current Study

While various frameworks have been employed in IBH training, such as competency-based models (Brown et al., 2021) and experiential learning approaches (Lenz & Watson, 2023), these approaches often emphasize skill acquisition without explicitly addressing the cognitive and social mechanisms that facilitate sustained learning and self-efficacy. Accordingly, we sought to understand how MHC, FNP, and PMHNP students engage with our IBH training, grounded in SCT (Bandura, 2001) underpinnings, compared to existing scholarship on IPE experiences and IBH trainings. Scholars have suggested that exploring lived experiences through qualitative investigations will contribute to student-centered approaches (Fields, Thompson et al., 2023; Li et al., 2023). While the IBH training program was designed using SCT-based instructional strategies, our methodological approach is rooted in constructivism, as we aim to understand how participants interpret and integrate their experiences. Our research question is: *How do MHC, FNP, and PMHNP graduate students make sense of their lived experiences with an IBH training?*

Method

Our research team addressed the proposed research question through interpretative phenomenology analysis (IPA; Smith et al., 2022; Smith & Nizza, 2022). According to Smith et al. (2022), IPA is a qualitative approach that is appropriate for exploring how individuals make sense of their lived experiences. It is characterized by three core elements: phenomenology, hermeneutics, and idiography. First, phenomenology allows for an in-depth exploration of participants' subjective experiences by prioritizing their voices and perspectives. Second, hermeneutics, or the theory of interpretation, acknowledges the double hermeneutic process of IPA, where participants first interpret their own experiences, and researchers then interpret those interpretations. Finally, idiography emphasizes a commitment to detailed, case-by-case analysis before identifying patterns across participants, ensuring that both unique and shared experiences are represented in the findings. Furthermore, our guiding epistemological framework was constructivism. Constructivism is a

paradigm that asserts knowledge is socially constructed rather than discovered, emphasizing subjective experiences and the co-construction of meaning between individuals and their environments (Lincoln & Guba, 1985).

Participants

Participants were eligible for this study if they were (a) 18 years or older, (b) in an MHC, FNP, or PMHNP graduate program, and (c) participated in all aspects of the IBH training. Our final sample included 12 graduate student participants (MHC = 7, NP = 3, PMHNP = 2), which is within Smith and Nizza's (2022) suggested range for IPA. Eleven participants reported identifying as female, with ages ranging from 25–57 (M = 38), and race included Black (n = 1), Latina (n = 1), and White (n = 10). To maintain participant confidentiality, all participants were provided with a pseudonym. Participant pseudonyms and demographics are presented in Table 1.

Data Collection and Procedures

With IRB approval, recruitment began in spring 2024. Students participating in the IBH training received a recruitment letter and were informed of a $25 Visa gift card incentive. Interested participants contacted the first author and completed an informed consent form and a demographic questionnaire, which collected information on professional identity, age, race/ethnicity, gender, prior IBH experience, and scheduling preferences. The participants were split into five focus groups, with two to three participants per group. While we attempted to mix professional identities to encourage interprofessional discussions in each focus group, participants were organized based on availability provided in a Qualtrics survey. Table 1 provides a more detailed breakdown of how focus groups were divided.

Data were gathered through a researcher-developed semi-structured interview protocol administered in focus groups conducted via Zoom by graduate student researchers. We provided group facilitation training to the graduate student researchers, and fidelity was ensured by reviewing session recordings. Specifically, the training included structured lessons on how to conduct focus groups, such as basic group facilitation skills, drawing out, and respecting diverse voices. In total, the training lasted approximately 3 hours. Further, questions were developed with respect to the constructivist epistemological framework. In total, there were 10 questions and each had suggested prompts to further encourage discussion. Sample questions included: (a) What were your initial thoughts on collaborating with other disciplines? (b) What are your general impressions of IBH?; and (c) How might this training influence your future career? We included sample follow-up prompts to provide examples of how to restructure each question. Each focus group lasted approximately 1 hour, ranging from 48–70 minutes. Transcripts were generated using Rev and verified by research team members.

Data Analysis

Our data analysis followed Smith and Nizza's (2022) guidelines for IPA. Accordingly, we completed the following steps: (a) reading and exploratory notes, (b) crafting experiential statements, (c) finding similarities between experiential statements, and (d) grouping experiential statements into themes. After bracketing biases, our core research team reviewed each transcript and started to organize initial ideas about our student participants' experiences. Next, each transcript was individually coded by a core research team member and we refined these statements by systematically grouping them into themes, ensuring alignment with IPA's hermeneutic and idiographic focus while capturing both shared and divergent experiences. Further, we used an internal auditing system of at least one research team member to confirm or challenge experiential statement ideas. Internal auditing involved multiple researchers independently reviewing codes, identifying ambiguities, and resolving discrepancies through team discussions.

After the development of experiential statements from each transcript, we compared statements

across transcripts searching for shared messages. We broadly grouped experiential themes together and provided our findings to the external auditors for a new perspective. We discussed our auditors' feedback and continued grouping experiential statements until each experiential statement was placed into a group experiential theme, indicating full differentiation. Their feedback included suggestions for merging overlapping themes, reconsidering the prominence of certain codes, and clarifying ambiguous participant statements. Agreement on the final themes was reached through a shared decision-making process, ensuring that each theme accurately captured the lived experiences of participants while maintaining fidelity to IPA's idiographic approach.

Table 1

Participant Demographics and Pseudonyms

Focus Group	Pseudonym	Professional Identity	Gender Identity	Racial / Ethnic Identity	Age
1	Reese	FNP	Female	Black	46
1	Bailey	MHC	Female	White	41
2	Olivia	MHC	Female	White	33
2	Becca	MHC	Female	Latina	34
3	Peyton	PMHNP	Male	White	30
3	Quinn	MHC	Female	White	25
3	Dakota	MHC	Female	White	57
4	Robin	MHC	Female	White	41
4	Cameron	MHC	Female	White	46
4	Morgan	PMHNP	Female	White	30
5	Jamie	FNP	Female	White	29
5	Sydney	FNP	Female	White	40

Note. FNP = Family Nurse Practitioner; MHC = Mental Health Counselor; PMHNP = Psychiatric/Mental Health Nurse Practitioner

Research Team and Positionality

In the spirit of IBH practice, our research team is interprofessional and comprised of faculty members in accredited counseling and nursing programs. Our core research team consisted of a White, cis-gender male counselor educator and three White, cis-gender female nursing educators (2 in FNP and 1 in PMHNP). The core research team served as the primary coders and followed each step of the IPA process (Smith & Nizza, 2022). In addition, two research team members served as auditors throughout the IPA process. One auditor is a White, cis-gender female nursing educator, and the other is a White, cis-gender female counselor educator. Furthermore, our research team also serves as core faculty in the participants' training programs and there may be prior relationships with participants. Lastly, each member of the six-person research team is fully licensed and engaged in clinical practice, with prior experience providing direct services in IBH settings. Due to prior experiences in IBH settings and prior research, we acknowledge that we may have a favorable view of IBH, and we advocate for additional efforts for clinical practice and training.

Trustworthiness

To view the data through a constructivist lens, we prioritized trustworthiness and addressing our positionality. First, we bracketed potential biases, which included beliefs about IBH education gaps, the greater prevalence in nursing education, the potential for initial role confusion in IBH, and our personal preference for the IBH model in managing

community healthcare. Following Smith and Nizza (2022), we revisited these biases throughout the IPA process by taking reflexive notes and discussing their influence on theme development. As instructors in the participants' programs, we acknowledged potential preexisting relationships and power dynamics. We recruited four outside graduate students (two MHC and two FNP) to attempt to mitigate these influences to facilitate focus groups. Member checking was also employed to center participants' voices (Glesne, 2016). Lastly, we implemented internal and external audits (Glesne, 2016). Internal auditing involved the core research team reviewing each other's notes and codes during IPA coding to minimize bias. External auditors, blinded to prior procedures, reviewed data and challenged or confirmed codes, statements, and themes at each analysis stage.

Findings

Following an IPA (Smith & Nizza, 2022), we differentiated participants' experiences into five group experiential themes: (a) role of previous experiences and emotional reactions, (b) interprofessional education and teamwork, (c) identifying the potential of IBH, (d) aligning professional values and fit, and (e) feedback on the training.

Theme I: Role of Previous Experiences and Emotional Reactions

The first theme, *role of previous experiences and emotional reactions*, captures our participants' discussions surrounding their perceptions of the IBH training due to life experiences and emotional responses. At the beginning of each focus group, participants typically described prior experiences and reactions to IBH, allowing the group facilitators and core research team to explore potential influences in future responses. For instance, participants discussed prior team-based experiences in clinical settings and the impact of their work experiences on their general feelings toward participating in IBH models. Jamie (FNP) illustrates how her work experience as a nurse influenced her perceptions: "I come from a nursing background, so we rely heavily on teamwork and other disciplines to be successful. So I had positive expectations going into it." Jamie's positive perception further supported her interest in learning about other professions. Sydney (FNP) echoed similar sentiments, adding that she has recognized the importance of mental health support:

> I think all of our patients, to some degree, have some form of mental health that we're trying to work on, but I think that's something that I feel like I need to learn more about and know more about. So I was excited to do it and learn from different perspectives.

Fellow nursing participants, Peyton, Reese, and Morgan, shared similar interprofessional practices and reflected on how prior professional experiences compared to the overall training. Prior difficulties getting patients to follow up with psych providers have frustrated Reese (FNP), who described skepticism when beginning the IBH training: "You have this list of people go through with your insurance and situation within the network, and then patient kind of floats away." However, IBH practice with on-site collaboration challenged this perception as Reese described her ability to work with a psych provider in the moment.

Comparatively, MHC students had less experience providing counseling services through interprofessional practice and more commonly formed their perceptions and biases from observing the healthcare system from other roles. Dakota (MHC) recounted learning about care coordination by observing her clinical supervisor collaborate with a physician:

> [My supervisor] would do individual sessions with the patients, but it was always warm handoffs from the doctor. The doctor would say, come down, this person scored with depressive symptoms or whatever, and then my supervisor would talk to them and set up individual sessions.

Robin (MHC) was the sole MHC student who reported prior experience working in an IBH setting

through her current internship. Robin expressed that she had an "overall positive experience" in her internship, resulting in an "appreciation for the training." To that end, Robin suggested that the training did not fully capture her experience as most of her referrals were through warm hand-offs instead of collaborating with the patient in the room. Further, Becca (MHC) describes her job as a medical interpreter and the influence it had during the training:

> So initially, right before it, I was more open to the possibility of working [in IBH settings]. I even had considered applying at [a local hospital] after graduation to work there …. I'm a medical interpreter, so I work a lot with nurses, with doctors, and … I'm [a Spanish speaker], and sometimes Hispanic populations might feel isolated if they don't talk to the providers in their own language, they talk a lot to me.

However, Becca later noted that the IBH modules and simulation did not match how she previously experienced care coordination.

In addition to the biases and attitudes formed by our participants through their prior experiences, our participants shared their emotional reactions before and during the training. Participants commonly shared feeling nervous or anxious before the simulation. For example, Jamie described her feelings beforehand as "nervous … because you don't want to mess up or make a mistake, even though people are very gracious and understanding." Robin (MHC) expressed how feeling unprepared to work in a medical model and collaborating with other healthcare professionals for the first time contributed to her nervousness:

> I feel like my emotions are a little biased and I was … nervous participating initially, which I mean got better with time, but I felt like a little outnumbered, which I think is just to be expected when you're in a room with so many medical professionals and you are the only nonmedical modeled professional. And I feel like we are schooled minimally on what a medical model is, what it looks like, how it functions.

Moreover, participants reported that their level of preparedness prior to the training also influenced their emotions. While Peyton (PMHNP) shared feeling prepared by the training, supporting his anxiety about the event, Quinn (MHC) and Dakota continued to experience nervousness throughout the event because they did not feel prepared. Participants also recounted moments of excitement or curiosity surrounding IBH before and after the full training. Notably, participants with an overall positive perception of the training also shared a greater intent to practice in an IBH model. Dakota expressed that while she "initially was clueless until it happened and then I was excited."

Theme II: Interprofessional Education and Teamwork

The second theme, *interprofessional education and teamwork*, provides insight into participants' experiences, moving from understanding their emerging role in a chosen profession to understanding the use of simulation and collaboration to care for the client in a team-based setting with emerging insights into client management and professional and colleague roles. Participants across focus groups and professional identities had varying levels of understanding and expectation using a team-based approach. Responses reflect the complexity of transitioning from an individual practice approach to effective teamwork and collaboration. Reese (FNP) defined her role while setting clear, contained professional boundaries based on her current confidence: "I can make a phone call, but I am not going to do anything outside that I feel like I'm not well-trained. I don't have a deep knowledge about mental health." A shift in thinking occurs for a peer, Sydney (FNP), who is recognizing a societal need given a shortage of mental health providers:

> So I thought, oh man, if I want to manage some of this stuff, it might be hard, and maybe I'll have to refer out, but I think doing this made me more comfortable. Maybe you don't need to do that if you're in a situation. You have your resources right there to help you manage patients.

Participants noted that interprofessional education was particularly impactful in understanding how different disciplines contribute to holistic patient care. For instance, Peyton (PMHNP) shared, "Not very often do we get to work with other students outside of our programs, let alone outside of nursing. So, I think that was a good perspective or added perspective, so it was exciting." Peyton also suggested that MHCs "not only know what to ask but also how to ask these really sensitive questions." Furthering the perception of added perspective and patient betterment is Bailey (MHC): "I think it is helpful for all of us to understand how we can respect and honor each role and do it for the greater good of the client." These perspectives reinforce that interprofessional education fosters not only collaboration but also mutual respect and recognition of distinct professional expertise.

The IBH simulation appeared to move the learner from individual problem solving for a client to a collaborative approach, where shared assessments and decision making lead to direction for comprehensive and holistic care. The simulation design positioned the learners to deepen their grasp of client conditions and their roles while gaining insight into the roles of their colleagues. Jaime (FNP) appreciated the contrast in professional approaches and found value in seeing behavioral health professional perspectives in practice: "We got to behavioral health, and she did a great job, and I really liked seeing her perspective because of the way that she handled the patient versus the way we handle the patient was a lot different." Acknowledging her expanding recognition of the importance of holistic, coordinated care, Bailey (MHC) shared:

> I see patients now where they're describing some physical ailments where I believe that those aren't all associated with mental health, that there could be something physical going on. So it would be wonderful to be able to coordinate care and be in contact with the PCP.

Learner critique of one another seemingly leads to a deepening understanding of clinical collegial roles. Morgan (PMHNP) highlights her observed disconnect between behavioral health and other healthcare providers:

> So, coming from a behavioral health standpoint, I was kind of surprised at how some providers viewed, and not the counseling students, but the providers, viewed mental health. Some things I thought were very obvious, such as mental health; they were not picking up on those same things.

Furthermore, learners indicated the modules and simulation supported movement beyond individual problem solving to a more integrated team-based method. As Morgan moves deeper into the interview, there is a description of the gap in mental health knowledge among family practice providers, expressing surprise at their limited preparedness to address mental health issues and highlighting the need for IBH:

> I just was surprised at the lack of mental health knowledge from the family practice because I think the data is nearly 50% of their patients will present with some sort of mental health diagnosis, and I didn't feel like everyone would be prepared for that eventually, I guess. So that further highlighted the importance of integrated care.

Further, Cameron (MHC) demonstrated a nuanced understanding of distinguishing between normal developmental behaviors and pathology, effectively integrating growth and development counseling tenets into clinical practice. Underscoring the importance of resisting the urge to pathologize typical childhood behavior immediately:

> The 8-year-old that we were working with didn't like spiders … and immediately there was that pathology of, okay, we must treat her for this phobia, but taking a step back and going through, no, it's not something that is inhibiting any of her areas, either social or her school or anything. She just doesn't like spiders. So just kind of being there in that reality check of what are we addressing and what's a normal kid.

Theme III: Identifying the Potential of IBH

The third theme, *identifying the potential of IBH*, explores the potential benefits of utilizing IBH beyond the simulation and into future clinical practice. The participants felt that IBH supported the critical need for patients to have access to behavioral health support. Jamie (FNP) said, "I think just definitely knowing that patients benefit from behavioral health therapy and support and knowing that that's a resource and knowing what your resources are is important." Sydney (FNP) expressed concerns that they do not have the time to manage mental health conditions when working in a primary care setting, stating a benefit of IBH is "to be able then to have someone to collaborate with and pass on that can handle those things [mental aspects] is helpful." Dakota (MHC) offered:

> One thing you learn when you're in the mental health side of things is kind of how to quickly assess with the information you have, figure out what information you need, and from there, create a treatment plan pretty quickly, especially in integrated healthcare.

Peyton (PMHNP) added, "So I think even with just having that behavioral health person on board somewhere can really help facilitate that primary care person to not only know what to ask, but how to ask these really sensitive questions."

Participants also noted that IBH has the potential to support chronic disease management through behavioral interventions, leading to better control of symptoms and QoL. Jamie (FNP) corroborated these ideas by saying, "I think there's a definite need for it and a place for it …. People are living longer, they're developing more chronic conditions, which can lead to mental health problems, but then also just having baseline mental health concerns too." Sydney (FNP) highlighted the connection between mental health and physical health conditions, stating: "I didn't realize that a lot of the physical problems that people have also stem from mental problems and needing to talk about things."

Our participants suggested that an IBH model allows patients and providers to feel more supported due to the benefit of collaboration. For instance, Olivia (MHC) felt cohesion and a sense of working well with her IBH group. She said, "[I] really liked my group a lot. I feel like we worked really well together." Sydney (FNP) recognized that the IBH model works well and could set her up for success in the future: "If you're working somewhere where that's already set up, it just sets you up for success and already knowing how that model works and how you can be a part of that team." Participants also suggested that IBH may help build trust with patients to appropriately manage their mental health and primary care symptoms. Sydney (FNP) shared, "To be able then to have someone to collaborate with and pass on that can handle those things is helpful." Finally, IBH can facilitate a greater continuity of care through shared information and networking with other professionals. Peyton (PMHNP) offered the importance of the ability to network and refer:

> I think it is so important that we are making connections and getting experience doing interdisciplinary collaboration. If anything else for networking potentials, I mean, I'm going to have to refer my patients to a therapist at some point. I'm going to have to refer them to a primary care person at some point. Why not be able to establish those kind of working connections right now?

Theme IV: Aligning Professional Values and Fit

The fourth theme, *aligning professional values and fit*, summarizes our participants' discussions surrounding the real-world applicability of our novel IPE experience to their future clinical practice. Participants typically shared visions of their ideal future careers and connected their professional values and interests to the potential for IBH practice. Reese (FNP) initiated a conversation with her focus group about professional values and noted her value of holistic treatment care: "We try to look at the whole picture because, specifically as nurses, we look at that holistic approach, and just in general." Due to her values in holistic care and real-time collaboration, Reese appeared to be more open

to IBH practice in the future. Similarly, Quinn (MHC) expressed interest in working in IBH in the future based on her appreciation for working together as "collaboration is really nice in life."

While some participants suggested interest in IBH due to their professional values, others noted hesitations and questioned if they would continue exploring IBH opportunities. Notably, MHC students expressed values related to building rapport through long-term, therapeutic approaches and expressed concerns about rapport and trust in IBH settings. Becca (MHC) exemplified concerns related to rapport building and stated:

> They were hoping that counselors would work with a patient for 20 to 30 minutes. And that is, I believe, a major problem because … given my own values, convictions, and professional information, I believe that the most important thing in the therapeutic process is the relationship between the client and the therapist. And over the course of 20 minutes, you are not capable of doing anything like that.

Olivia shared Becca's skepticism and questioned if she could fulfill aspects related to the therapeutic process. However, Olivia appeared to be open to exploring her professional fit within IBH, given more understanding:

> I think the idea behind it is a really good thing. I just think that maybe there needs to be some amendments to it possibly, like how [Becca] is talking about only seeing a patient or a client for 20 to 30 minutes does feel a bit [rushed] to try and decide a diagnosis or not.

Sydney (FNP) also expressed concerns about the feasibility of IBH. Specifically, Sydney wondered if her future setting would determine if IBH is feasible and shared, "I think [IBH feasibility] depends on where I would end up practicing kind of thing. But I think if you're more on the private and maybe you could find a good behavioral health group to work with and you refer your patients there, that's one aspect."

Theme V: Feedback on the Training Experience

The final theme, *feedback on the training experience,* summarizes learner feedback about the training modules and simulation experience, including the materials describing the event, its procedural elements, and the event itself. Feedback from the various student learner groups suggested that the time the students had to interact with materials was a factor in enabling their preparedness. For instance, Quinn (MHC) indicated, "I was very stressed out … because I got the materials the night before, so I didn't get through hardly any of it …. This could have been a really great experience, but I didn't have time to prep." Likewise, Olivia (MHC) reported, "I wasn't prepared for the amount of work leading up to the event … it was kind of like, surprise … you have four hours of training to do." Conversely, Peyton (PMHNP) shared, "We got our information … a couple of weeks prior. So, I mean, I had time to go through the case scenario. I did feel that I had adequate time to review the materials." It became clear that participants who felt they had adequate time to review the materials verbalized that this helped them feel prepared for the event.

Students from all professional identities discussed their experiences with the modular learning format. Overall, participants reported that the modules provided a foundation in IBH knowledge. For instance, Bailey (MHC) shared, "There were wonderful trainings offered ahead of time to wrap your head around roles, responsibilities, things like that." Other students, such as Peyton, Olivia, and Jaime, shared Bailey's sentiments. While participants appeared to appreciate having the asynchronous modules before the training, constructive feedback was centered around incorporating clearer expectations for the simulation and additional student-centered consultations. Bailey suggested, "I think it would've been helpful if there would have been an introduction video … what to expect in the simulation." Further, Dakota (MHC) described a prior understanding of IBH and questioned if there was a way to demonstrate competencies to skip

modules: “This is a super minor thing … if you get a hundred percent on the pretest, you still have to watch the video and do the posttest … so it would’ve been nice to have that, an option to skip that.” While an aspect of the training is to ensure standardized education, we noted future development may consider more personalization efforts.

Beyond the modules, our participants provided feedback on the general flow and characteristics of the simulation. Peyton, Dakota, and Quinn agreed that more directions before the simulation and an opportunity to ask questions may have supported their engagement. Peyton shared: “My only thing was that they gave us the scenario … but not really any directions for our patient-identified person on how they were going to act.” In addition, some of our participants provided feedback on the role of the moderator (i.e., faculty supervisor). Student participants who expressed a positive experience with their moderator appeared more likely to describe the benefits of the simulation. Reese (FNP) commended her moderator and shared, “Our moderator was really good yesterday. She was super helpful … she presented a clear vision of this is how I want you to address [working with a kid].” Alternatively, participants who constructively analyzed their moderator were likelier to note concerns in the simulation. For instance, Bailey reported: “I felt like the moderators were learners right along with us, which isn’t helpful. It’s like if they could have been more of a guiding force, I would say that would have helped us all.” Due to unclear directions, the moderator became crucial for Jamie, who shared, “I feel like our positions as mental health professionals are, or in my experience, was similarly kind of forgotten. Our facilitator had to coach [our team] to include me.” To that end, consistency in directions and moderators were viewed as constructive feedback.

In addition, participants from all identities discussed additional training considerations. For instance, participants reflected on the benefits of ongoing IBH training in healthcare education programs. Becca (MHC) offered: “It’s really important for students to learn together before they graduate because it is having an awareness of the value of other professions and also the system values behind other professions.” Olivia shared that she believes training should be universal and stated, “I think this experience is a great opportunity for everybody to learn to work together … to show what each other’s values are.” Next, a few of our participants suggested additional learning environments. Jamie reported, “I think Zoom is great but I honestly think in-person experience might have been more beneficial.” Subsequently, most focus group members suggested having experience more than once to promote their learning of IBH and collaboration practices. Quinn summarized a common discussion concerning frequency, stating: “I also think it could be cool if it were either multiple times or a longer event.” Lastly, participants suggested regular IBH exposure would reinforce their learning. Cameron shared:

> It would be helpful if it wasn’t just kind of one and done, if we were doing this multiple times throughout the semester, so that we can work out … then figure out how we relate to each other over time.

Discussion

Our investigation sought to organize the experiences of MHC, FNP, and PMHNP graduate students who participated in our novel IBH training grounded in SCT principles (Bandura, 2001). Further, we aimed to meet the documented need to explore IBH training through a qualitative lens and understand the first-hand experiences of graduate students, as scholars attempt to keep pace with the growing IBH movement through evidenced-based training (Fields, Linich et al., 2023; Fields, Thompson et al., 2023). To that end, we presented five themes to address our research question.

Theme I summarized our participants’ reports about the potential role of previous experiences and emotional reactions on their perception of the IBH training and IBH practice in general. Addressing interpersonal factors, such as worldview and emotional experiences, is a critical element of SCT

and was recognized by our participants as influential. Similar to previous findings on IPE experiences in healthcare students and providers (Weston et al., 2023), emotional reactions and biases were prominent, especially nervousness and apprehension, largely stemming from the novelty of interprofessional practice or concerns about performance among peers. Participants also entered training with varying exposure to IBH, with MHC students appearing less likely to have experiences with IBH practices than FNP and PMHNP students. Glueck (2015) interviewed mental health care providers working in IBH settings and shared similar experiences, suggesting that MHCs are not adequately prepared for IBH practice. In contrast to previous literature suggesting that prior experience in interprofessional settings enhances confidence in collaborative care (Brown et al., 2021), some participants in our study with prior IBH exposure still expressed apprehension about role clarity and interprofessional dynamics. This indicates that initial familiarity with IBH does not necessarily translate into immediate confidence, suggesting a need for more structured role delineation in training. Ultimately, students' previous experiences and emotional responses appeared to create a foundation, affecting their initial engagement with the training and linking to their openness toward practicing within IBH models.

In addition to interpersonal factors, Theme II captured our participants' experiences with IPE and their understanding of professional scope and responsibilities. Like practitioner experiences in Weston et al.'s (2023) case study of developing IBH clinics, our participants noted a transformative shift from an individualistic approach to a collaborative, team-based model in understanding client care through IPE grounded in SCT. By completing the modules, participants described learning foundational IBH underpinnings and further reinforced various healthcare professionals' unique roles, boundaries, and strengths by engaging in the simulation. Interestingly, while prior research has suggested that behavioral health providers often struggle with integrating into medical models due to role confusion (Fields, Linich et al., 2023; Ogbeide et al., 2022), our MHC participants expressed greater openness to IBH than anticipated. Rather than outright resistance, concerns focused on the feasibility of maintaining rapport within IBH's shorter-term treatment model. This nuance highlights an opportunity for IBH training to more explicitly address how rapport building can be maintained within integrated care settings. Further, nursing participants tended to reflect on their increased comfort with managing patients with mental health needs when supported by an interprofessional team, while MHC participants commonly emphasized the need to better understand medical models. Accordingly, scholars have concluded that an enhanced understanding of professional identity supported engagement in IBH settings, and our participants underscored the need to understand professional roles (Johnson et al., 2021; Johnson & Mahan, 2019).

Next, Theme III summarized our participants' discussions on the potential benefits of the IBH model. The model was seen as meeting critical needs in primary care by providing behavioral health resources, especially for managing chronic conditions that often have both mental and physical health dimensions. With the understanding that primary care may be viewed as the de facto setting for mental health care, participants from each identity suggested that IBH will enhance their ability to meet healthcare consumer needs. Additionally, the opportunity for providers to network and learn from each other's approaches to patient interaction enriched participants' professional development (Brown et al., 2021). By increasing access to care, supporting healthcare providers' professional well-being, and contributing to holistic health, our participants suggested the potential for IBH to support healthcare initiatives, such as the Quintuple aims (Mate, 2022).

Beyond describing the potential benefits of IBH, our participants reflected on their professional values and compared them to their perception of IBH. Theme IV underscored that while IBH may fit well with some healthcare professionals' values, it may not meet all students' career goals or preferred practices, highlighting the importance of flexible implementation in training and practice. Johnson et

al. (2021) posited that educators and supervisors are responsible for supporting professional value development for their students, which may contribute to having a workforce dedicated to IBH principles. Likewise, Schmoyer et al. (2024) suggested that healthcare students who value fast-paced and/or holistic patient care are likelier to practice in IBH settings. Indeed, Risman et al. (2016) concluded that healthcare providers with higher job satisfaction are more likely to promote positive healthcare outcomes and patient satisfaction.

Lastly, Theme V summarized feedback that may contribute to developing our IBH training and related training. To our knowledge, our study is the first to explore feedback on an IBH training grounded in Bandura's (2001) SCT. Participants noted the sequential nature of our training (i.e., transitioning from modules to simulation) promoted their self-efficacy to continue IBH practice. Also, in line with SCT principles, participants proposed incorporating more hands-on IBH training opportunities, with ideas that included in-person sessions, multiple sessions over time, and increased exposure to IBH in clinical practice to strengthen collaboration skills. The feedback surrounding the SCT framework may address suggestions in related IBH training studies, such as repeated training in graduate education, greater accessibility, diversity in voices providing didactic materials, and the ability to be replicated (Brown et al., 2021; Fields, Linich et al., 2023; Glueck 2015; Johnson et al., 2021; Schmoyer et al., 2024). In addition to more IBH training, participants across all tracks suggested that moderator consistency, independent preparation time, and more instructions before interprofessional simulations would enhance the experience. Overall, our findings corroborate the need for additional research on how to meet the unique needs of graduate students for standardized IBH trainings (Fields, Linich et al., 2023).

Implications

Our findings highlight the importance of enhancing IPE for both counselor and nursing educators by incorporating more structured and repeated IBH training simulations. Findings emphasized the need for curricula that allow students to practice in collaborative, team-based scenarios over multiple sessions, giving them time to become more comfortable with interprofessional dynamics. Additionally, the importance of preparation emerged as a crucial factor for student engagement and the perceived efficacy of the training. Providing students ample time and clear expectations regarding training materials and simulation procedures could significantly enhance their readiness. For example, distributing materials earlier and creating introductory videos on simulation expectations may reduce student stress and improve their preparedness. Moreover, moderator consistency was discussed in each focus group. Similar to Schmoyer et al. (2024), we suggest educators and supervisors be well-versed in IBH principles to support the development of their students. Given that participants reported pretraining anxiety and nervousness, future IBH training could incorporate structured reflection exercises or pretraining peer discussions to normalize and address these concerns before the simulation begins. Mentorship pairings, where students connect with a more experienced peer, may also help alleviate initial apprehension.

Outside of replication and adaptation of our IBH training, our participants' experiences suggest implications for general IBH training efforts in graduate education that meet key performance indicators and learning outcomes required by accrediting organizations. Lenz et al. (2018) documented a statistical relationship between the number of diverse providers on a healthcare team and therapeutic healthcare outcomes, and our participants unanimously agreed that they need more education on other healthcare providers' roles and responsibilities. Therefore, we advocate for continued interprofessional partnerships through IPE efforts to promote collaborative practices and IBH workforce development. Additionally, given that participants highlighted how training influenced their professional identity development and career pathways (Theme IV), future IBH programs could explicitly integrate career exploration modules. These could outline how IBH

models function in different healthcare settings, allowing trainees to better envision their potential roles in IBH settings. Lastly, participants expressed concerns about the feasibility of virtual training, particularly regarding interprofessional dynamics and role clarity. Some suggested that fully in-person IBH training may offer a more immersive and engaging learning environment, better simulating real-world collaborative care. Future research should explore whether in-person training enhances perceived role clarity and interprofessional teamwork compared to virtual formats.

Limitations

Despite its contributions, we acknowledge several limitations. First, the composition of our sample posed a limitation, as there was an uneven distribution of professional identities, with more MHC students than FNP and PMHNP students. This imbalance may have influenced the findings, as certain perspectives were represented more heavily than others. Second, participants were recruited from a single academic institution, which may not fully capture regional factors of IBH training. While students comprise rural and urban residencies, our facilities were primarily in urban settings, which may not appropriately account for aspects of rural communities. Additionally, the potential for social desirability bias must be acknowledged, as some participants may have adjusted their responses due to the presence of faculty members in their program. Moreover, our inclusion criteria did not exclude participants with prior IBH or IPE experiences, meaning some students may have entered the training with preexisting familiarity or professional exposure that influenced their engagement and perceptions. Lastly, this study focused on participants' immediate reactions to the IBH training but did not assess long-term impacts on their clinical practice.

Future Directions for Research

Building on this study, future research should explore how IBH training impacts graduate students' clinical practice beyond the immediate training experience. Longitudinal studies could assess whether knowledge gained from SCT-based IBH training translates into increased confidence and competency in real-world settings. Additionally, expanding IBH training to include a more diverse range of healthcare professionals (e.g., social workers, occupational therapists, primary care physicians) would allow for a broader understanding of interdisciplinary collaboration. Further, future studies should explore modifications to IBH training to enhance engagement and retention. Participants in this study suggested that more repeated exposures, in-person training opportunities, and clearer role expectations could improve the learning experience. Research investigating how different training modalities (e.g., hybrid, extended simulations, case-based learning) impact self-efficacy and interprofessional collaboration would be valuable for refining IBH curricula. Finally, given the importance of professional identity in interprofessional collaboration, future research should explore how professional identity shapes trainees' openness to IBH.

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