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An Erasmus+ Blended Intensive Programme: Readiness for Interprofessional Learning and Homelessness-Specific Attitudes

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Abstract

Blended Intensive Programmes (BIPs) are increasingly recognized as a key format for international interprofessional education within Erasmus+. However, evidence of their educational effectiveness is still limited. This prospective, single-arm, uncontrolled before-and-after study examined changes in healthcare students' readiness for interprofessional learning and attitudes toward people experiencing homelessness following an inclusion-focused Erasmus+ BIP. A total of 32 undergraduate students from nursing, physiotherapy, and social work completed assessments before, immediately after, and one month post-programme. Readiness for interprofessional learning was measured using the Readiness for Interprofessional Learning Scale (RIPLS), while attitudes toward people experiencing homelessness were assessed using the Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI). Repeated-measures ANOVA with Greenhouse–Geisser correction identified no statistically significant time effect for RIPLS Total ($p = 0.055$). Teamwork and Collaboration showed a nominal time effect ($p = 0.045$), which did not remain significant after Holm adjustment across six outcomes (adjusted $p = 0.269$). No statistically significant time effect was detected for HPATHI, and exploratory analyses detected no significant associations between engagement indicators and changes in the main outcomes. The descriptive increases in readiness scores do not establish programme effectiveness. These findings highlight the need to assess collaborative readiness and homelessness-specific attitudes as distinct outcomes aligned with programme objectives.

Keywords: interprofessional education; Blended Intensive Programme; health professions education

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1. Introduction

The growing complexity of healthcare requires professionals who can collaborate effectively across disciplines, making interprofessional competence an essential outcome

of undergraduate health professions education [1–3]. Interprofessional education (IPE) brings learners from different professions together to learn with, from, and about one another in preparation for collaborative practice. Systematic reviews support its potential to improve interprofessional attitudes, collaborative knowledge, and teamwork-related learning outcomes, while emphasizing the importance of educational context and intervention design [4,5]. Reeves et al. [4] found more consistent evidence for changes in learners' attitudes and reported collaborative knowledge and skills than for changes in professional behaviour or patient outcomes. Shuyi et al. [5] similarly highlighted the need to align teaching strategies, theoretical frameworks, and assessment outcomes. This evidence supports evaluating readiness for interprofessional learning as a distinct educational outcome, while recognizing that self-reported readiness does not establish competence in collaborative clinical practice.

Accreditation frameworks also reflect the expectation that graduates can collaborate across professions. For example, the Australian Pharmacy Council's Performance Outcomes Framework specifies that pharmacy graduates should understand the roles of different healthcare professionals, establish effective interprofessional relationships, and demonstrate teamwork behaviours that support patient care [6]. Such requirements reinforce the need for undergraduate curricula to provide structured opportunities for interprofessional learning.

Beyond promoting collaboration, health professions education now focuses on preparing graduates to deliver equitable, person-centered care to diverse and socially vulnerable populations. Healthcare providers often work with people facing socioeconomic hardship, homelessness, migration issues, disability, or other social exclusions, which demand skills beyond just clinical expertise in a specific discipline. As a result, educational programmes that blend interprofessional learning with topics like inclusion, equity, and social accountability are increasingly valued for preparing students for modern healthcare roles [7–9].

Educational interventions specifically addressing homelessness provide a more direct basis for examining changes in attitudes toward this population. Liu et al. [10] evaluated a semester-long patient navigation elective and reported improved HPATHI scores, particularly in social advocacy, along with increased self-perceived preparedness to care for underserved populations. Mercadante et al. [11] compared medical students who volunteered at a student-run clinic with nonvolunteers and found greater improvement in personal advocacy among volunteers. However, the latter study acknowledged self-selection bias and uncertainty about whether these changes persist. These findings suggest that homelessness-focused education and clinical engagement may be associated with changes in particular attitudinal domains, while highlighting the limitations of self-reported outcomes and nonrandomized evaluations.

Blended Intensive Programmes (BIPs), introduced under the Erasmus+ 2021–2027 initiative, combine virtual collaboration with short-term international mobility. Existing evaluations provide useful insights into their implementation and perceived educational value, but use different approaches and address different outcomes. O'Dowd and Werner [12] surveyed academic coordinators to identify perceived benefits, implementation challenges, and recommended practices. In dental education, Duś-Ilnicka et al. [13] described programme implementation and explored participants' perceptions of educational experiences. Other reports have examined stakeholder collaboration in prison education and evaluated cross-cultural learning experiences involving students and teachers [14,15]. These studies help explain how BIPs can be organized and experienced, but provide limited evidence on changes in specific educational constructs across repeated assessments. The present study addresses this narrower gap by assessing readiness for interprofessional learning and attitudes toward people experiencing homelessness before the programme, immediately afterwards, and at one-month follow-up.

The combination of activities in this programme can be understood through social constructivist and experiential learning perspectives. Collaborative tasks allow students to negotiate shared understanding, compare professional roles, and practise joint problem-solving, providing a rationale for potential changes in readiness for interprofessional learning [1,16]. Intercultural exchanges introduce alternative perspectives on professional practice and healthcare systems, while field visits contextualize inclusion through encounters with barriers to care. Structured reflection offers opportunities to examine these experiences and question existing assumptions [17]. These processes may also influence attitudes toward social exclusion, although broad inclusion-focused learning is less directly aligned with homelessness-specific attitudes than with collaborative learning. Whether these different educational domains show comparable changes following a short-term international programme therefore remains uncertain.

To address these gaps, we conducted a prospective, single-arm, uncontrolled before-and-after study of an international, inclusion-focused Erasmus+ BIP involving undergraduate nursing, physiotherapy, and social work students. Rather than evaluating the programme solely in terms of participant satisfaction, we investigated whether different educational outcomes responded similarly to the same educational intervention. Specifically, we assessed readiness for interprofessional learning and attitudes toward people experiencing homelessness at baseline, immediately after the programme, and at one-month follow-up using established self-report instruments. We additionally explored whether programme engagement—including attendance, assignment completion, and final course performance—was associated with educational gains. We hypothesized that readiness for interprofessional learning and attitudes toward people experiencing homelessness would become more positive following the programme, and explored whether greater programme engagement was associated with larger changes in these outcomes.

2. Materials and Methods

2.1. Study Design

This study was a prospective, single-arm, uncontrolled before-and-after evaluation of an Erasmus+ BIP, with repeated assessments of the same student cohort at three time points: before the programme (baseline; T0), immediately after programme completion (T1), and one month later (T2). It examined changes over time in readiness for interprofessional learning and attitudes toward people experiencing homelessness, without a comparison group. The study was reported in accordance with the Transparent Reporting of Evaluations with Nonrandomized Designs (TREND) guidelines [18]. Because this was a prospective single-arm educational intervention, no allocation or randomization procedures were performed, and all participants received the same intervention. Blinding was not feasible because participants and investigators were aware of the educational intervention, and all outcomes were collected through self-administered questionnaires.

2.2. Setting and Educational Intervention

The study took place as part of the Erasmus+ BIP titled "Inclusion: An Interprofessional and Cultural Approach", coordinated by Victor Babeș University of Medicine and Pharmacy in Timișoara, Romania. It involved collaboration with Thomas More University of Applied Sciences in Belgium and the University of Ioannina in Greece. The programme brought together undergraduate students from health and social care disciplines to foster interprofessional collaboration, intercultural competence, and a deeper understanding of inclusive healthcare through international collaborative learning. The intervention comprised two online sessions held on 10 and 17 March 2026, followed by a six-day face-to-face mobility in Timișoara on 22–27 March 2026. Immediate post-programme assessments were

conducted at programme completion, and one-month follow-up assessments took place in April 2026.

The educational intervention adhered to the Erasmus+ BIP structure, blending online learning with short-term international travel. The virtual component featured two live online sessions before the physical mobility, along with asynchronous tasks completed individually and in small groups. These tasks involved student introductions, intercultural presentations, and explorations of healthcare and social care systems in participants' home countries. This approach encouraged early interaction among international teams before face-to-face activities began.

The physical component took place in Timișoara, Romania, over six days and it focused on active learning methods, prioritizing collaborative, student-centered activities over traditional lectures. Students from nursing, physiotherapy, and social work joined mixed international and interprofessional groups. Activities included visits to health and social care facilities, interactive seminars, case-based learning, collaborative problem-solving, intercultural exchanges, and reflective discussions on inclusion, diversity, equity, and access to healthcare. Fieldwork was combined with structured group tasks to help students compare professional roles, healthcare systems, and approaches to inclusion across participating countries, encouraging them to develop collaborative solutions for real-world issues.

An international, multidisciplinary faculty from various universities delivered the intervention, with expertise in physiotherapy, nursing, social work, and health professions education. Throughout the programme, faculty highlighted collaborative learning, reflective practice, and intercultural dialogue, moving away from traditional lecture methods. Assessment was integrated into the curriculum and aligned with the learning goals. Students participated in a range of individual and group tasks, including developing a personal learning profile, engaging in intercultural group activities, analyzing inclusion in their national healthcare systems, presenting an interprofessional group project based on fieldwork, and writing a reflective report. Success required active participation in all activities and the completion of assignments as specified by the Erasmus+ programme.

2.3. Participants

Participants were undergraduate students enrolled in health and social care programmes at three universities, selected for the Erasmus+ BIP. Eligible disciplines included nursing, physiotherapy, and social work. Participation was voluntary, with all students giving informed consent before their baseline assessment.

Participant recruitment and baseline assessments were conducted before the start of the Erasmus+ Blended Intensive Programme in March 2026.

All eligible students in the Erasmus+ BIP cohort were invited to participate. No formal a priori sample size calculation was conducted, because the available sample was determined by programme capacity. The resulting sample of 32 participants limits the precision of estimates and the ability to detect changes and associations, particularly in exploratory analyses. Nonsignificant results were therefore not interpreted as evidence of no change or no association.

Students qualified if they completed the full BIP and filled out questionnaires at all three assessment points. Those who did not complete all assessments or withdrew were excluded from the long-term analysis. A total of 32 students met the criteria and finished the study, with no participants lost to follow-up.

2.4. Outcome Measures

The main outcomes were readiness for interprofessional learning and attitudes toward people experiencing homelessness, assessed using the RIPLS and HPATHI total scores, respectively.

Readiness for interprofessional learning was assessed using a 19-item version of the Readiness for Interprofessional Learning Scale (RIPLS), a self-report instrument originally developed to assess healthcare students' readiness for shared learning [19]. RIPLS Total was analysed as one of the two main outcomes, alongside HPATHI Total. The four RIPLS subscales—Teamwork and Collaboration, Positive Professional Identity, Negative Professional Identity, and Roles and Responsibilities—were examined as exploratory outcomes. Higher scores on the final scored items indicate greater readiness for interprofessional learning.

Attitudes toward people experiencing homelessness were assessed using the Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI), a 19-item self-report instrument developed to assess healthcare professionals' attitudes toward this population [20]. Higher total scores indicate more positive attitudes. Although the programme addressed inclusion across a broader range of social circumstances, HPATHI results were interpreted specifically in relation to people experiencing homelessness.

Both questionnaires were administered at three key points: before the programme started (T0), immediately after it ended (T1), and one month later (T2).

Programme engagement was described using three indicators from programme records: attendance, assignment completion, and final course grade. Attendance was calculated as the percentage of mandatory activities attended across online and face-to-face sessions. Assignment completion was recorded as the number of required assignments submitted, out of five. Final course grade was recorded on a 0–10 scale according to the programme's assessment framework. These indicators were examined as potential correlates of changes in questionnaire scores in exploratory analyses.

2.5. Ethical Considerations

The study protocol was prospectively registered with the Open Science Framework (OSF; Registration DOI: 10.17605/OSF.IO/QDH9J) before participant recruitment. Ethical approval was obtained from the the Scientific Research Ethics Committee of Victor Babeș University of Medicine and Pharmacy, Timișoara, Romania (approval no. 10/10.02.2026). Participation was voluntary, and all students provided written informed consent before enrolment. Questionnaire responses were anonymized prior to analysis, and all procedures were conducted in accordance with the principles of the Declaration of Helsinki.

2.6. Statistical Analysis

All statistical analyses were carried out using MedCalc Software version 23.4 (MedCalc Software Ltd., Ostend, Belgium). Since all participants completed assessments at baseline (T0), immediately post-programme (T1), and at one-month follow-up (T2), the analysis used the full longitudinal dataset without imputation for missing data.

Continuous variables are presented as mean ± standard deviation (SD) or median with interquartile range (IQR), depending on the data distribution, while categorical variables are reported as frequencies and percentages.

Changes across T0, T1, and T2 were examined using separate repeated-measures ANOVAs for RIPLS Total and HPATHI Total as the main outcomes, with the four RIPLS subscales examined as exploratory outcomes. Greenhouse–Geisser corrections were applied to the degrees of freedom and corresponding p values. Partial eta squared (ηp^2) was reported as an effect-size estimate. Bonferroni-adjusted pairwise comparisons were used to examine differences between assessment points for outcomes with an omnibus p value below 0.05. Because these pairwise adjustments do not address multiplicity across different outcomes, an additional sensitivity analysis was conducted during manuscript revision using the Holm procedure across the six omnibus tests: the two total scores and the four

RIPLS subscales. Both the original and Holm-adjusted p values were considered when interpreting the findings.

To complement the omnibus analyses and partial eta squared estimates, mean within-participant changes from baseline to one-month follow-up (T2 − T0) were calculated for each outcome, with 95% confidence intervals based on the paired differences using the t distribution. These intervals were not adjusted for multiple comparisons and were used to describe the magnitude and precision of the observed changes, rather than to replace the multiplicity-adjusted omnibus tests. Internal consistency was estimated using Cronbach's alpha for RIPLS Total, HPATHI Total, and each of the four RIPLS subscales separately at T0, T1, and T2. Estimates were calculated from the final scored item-level data for all 32 participants at each assessment point.

Exploratory analyses examined associations between programme engagement indicators and changes in questionnaire scores. Pearson's correlation coefficients were calculated between attendance, assignment completion, final course grade, and baseline-to-follow-up change scores (Δ = T2 − T0) for RIPLS Total, HPATHI Total, and Teamwork and Collaboration. These analyses were interpreted cautiously because of the small sample and restricted variation in engagement indicators; nonsignificant correlations were not considered evidence of an absence of association.

Mean scores and 95% confidence intervals (CIs) were calculated for each assessment time point and presented graphically. All statistical tests were two-sided, with statistical significance set at $p < 0.05$.

3. Results

A total of 32 students completed the BIP along with all three assessments (T0, T1, and T2). No participants were lost to follow-up, ensuring complete longitudinal data for all enrolled participants. Table 1 displays the baseline demographic and educational characteristics. The participants had an average age of 20.3 ± 1.3 years and were mostly female (93.7%). The largest professional group was nursing students (43.7%), followed by physiotherapy (37.5%) and social work (18.8%). About one-third had previous international educational experience, while exposure to interprofessional education was rare.

Table 1. Baseline demographic and educational characteristics of participants enrolled in the BIP (N = 32).

Participant Characteristic	Value
Age (years), mean ± SD	20.3 ± 1.3
Female, n (%)	30 (93.7)
Profession, n (%)	
Nursing	14 (43.7)
Physiotherapy	12 (37.5)
Social Work	6 (18.8)
Previous international educational experience, n (%)	11 (34.4)
Previous interprofessional education, n (%)	8 (25.0)
Previous completion of the Readiness for Interprofessional Learning Scale (RIPLS), n (%)	2 (6.3)
Self-rated English proficiency, median (IQR)	3 (2–4)

Abbreviations: RIPLS, Readiness for Interprofessional Learning Scale. Data are presented as mean ± standard deviation (SD), median (interquartile range [IQR]), or number (percentage), as appropriate.

The cohort consisted of students from three health and social care disciplines with limited prior interprofessional education experience, which supports the programme's appropriateness for assessing changes in interprofessional learning outcomes.

Table 2 presents scores for the main outcomes and RIPLS subscales across the three assessment points. Internal consistency estimates at each assessment point are reported in Supplementary Table S2. Cronbach's alpha ranged from 0.835 to 0.908 for RIPLS Total and from 0.713 to 0.810 for HPATHI Total. For the RIPLS subscales, alpha ranged from 0.784 to 0.859 for Teamwork and Collaboration and from 0.836 to 0.853 for Positive Professional Identity. Negative Professional Identity showed lower internal consistency at baseline (α = 0.537) than at T1 and T2 (α = 0.710 and 0.831, respectively). Roles and Responsibilities showed low internal consistency throughout, with alpha values of 0.591, 0.370, and 0.171 at T0, T1, and T2, respectively. Mean RIPLS Total scores increased descriptively over time, whereas mean HPATHI Total scores, reflecting attitudes toward people experiencing homelessness, showed little variation.

Table 2. Scores across the three assessment points and repeated-measures ANOVA results for the main and exploratory outcomes (N = 32).

Outcome	T0 Mean ± SD	T1 Mean ± SD	T2 Mean ± SD	F	Omnibus *p* *	Holm-Adjusted *p* †	ηp^2
Main outcomes							
RIPLS Total	79.19 ± 6.93	79.97 ± 7.83	81.44 ± 7.75	3.35	0.055	0.274	0.098
HPATHI Total	72.56 ± 7.53	73.34 ± 7.01	73.41 ± 6.65	0.48	0.564	1.000	0.015
Exploratory RIPLS subscales							
Teamwork and Collaboration	39.19 ± 3.24	39.72 ± 3.66	40.50 ± 3.67	3.57	0.045	0.269	0.103
Positive Professional Identity	17.38 ± 2.15	17.28 ± 2.22	17.44 ± 2.51	0.15	0.800	1.000	0.005
Negative Professional Identity	11.84 ± 2.16	12.19 ± 1.96	12.47 ± 2.44	1.61	0.216	0.862	0.049
Roles and Responsibilities	10.78 ± 1.88	10.78 ± 1.48	11.03 ± 1.53	0.56	0.487	1.000	0.018

Abbreviations: RIPLS, Readiness for Interprofessional Learning Scale; HPATHI, Health Professionals' Attitudes Toward the Homeless Inventory; SD, standard deviation; ηp^2, partial eta squared; T0, baseline; T1, immediate post-programme assessment; T2, one-month follow-up. * Omnibus *p* values use Greenhouse–Geisser-corrected degrees of freedom. † Holm-adjusted *p* values account for the six omnibus outcome tests in a sensitivity analysis conducted during manuscript revision. Adjustments were calculated from unrounded *p* values. Bonferroni-adjusted pairwise comparisons for Teamwork and Collaboration did not identify statistically significant differences between individual assessment points.

Descriptive statistics for each RIPLS subscale are shown in Supplementary Table S1. The Teamwork and Collaboration scores gradually increased across the three assessment points, while Positive Professional Identity stayed stable. Negative Professional Identity and Roles and Responsibilities experienced modest growth over time. Formal statistical comparisons are presented in Table 2.

The omnibus time effect for RIPLS Total was not statistically significant (Greenhouse–Geisser-corrected $F(1.55, 48.12) = 3.35$, $p = 0.055$, $\eta p^2 = 0.098$). Teamwork and Collaboration showed a nominally significant omnibus time effect ($F(1.61, 49.87) = 3.57$, $p = 0.045$, $\eta p^2 = 0.103$), but Bonferroni-adjusted pairwise comparisons did not identify significant differences between individual assessment points. In the sensitivity analysis accounting for all six omnibus tests, neither RIPLS Total nor Teamwork and Collaboration was statistically significant (Holm-adjusted $p = 0.274$ and 0.269, respectively). The remaining outcomes also showed no statistically significant omnibus time effects.

Mean within-participant changes from baseline to one-month follow-up were 2.25 points for RIPLS Total (95% CI: 0.02 to 4.48) and 0.84 points for HPATHI Total (95% CI: −1.58 to 3.27). For the RIPLS subscales, changes were 1.31 points for Teamwork and Collaboration (95% CI: 0.08 to

2.54), 0.06 points for Positive Professional Identity (95% CI: −0.66 to 0.78), 0.63 points for Negative Professional Identity (95% CI: −0.31 to 1.56), and 0.25 points for Roles and Responsibilities (95% CI: −0.49 to 0.99). These unadjusted intervals describe individual baseline-to-follow-up contrasts and do not account for multiple comparisons; they therefore do not supersede the multiplicity-adjusted omnibus results.

Exploratory analyses examined associations between programme engagement indicators and changes in RIPLS Total, HPATHI Total, and Teamwork and Collaboration scores (Table 3). Attendance ranged from 80% to 100%, and 27 of 32 participants completed all five assignments; the remaining five completed four assignments. Final course grades ranged from 8.6 to 10 on a 0–10 scale. This restricted variation, together with the small sample, limits the ability to detect associations and should be considered when interpreting the correlations.

Table 3. Correlations between programme engagement indicators and changes in study outcomes.

Outcome (Δ = T2 − T0)	Attendance (%) r (*p*)	Assignments Completed r (*p*)	Final Grade r (*p*)
Δ RIPLS total	−0.081 (0.661)	−0.110 (0.550)	−0.081 (0.660)
Δ HPATHI total	−0.036 (0.844)	−0.101 (0.582)	−0.051 (0.782)
Δ Teamwork	0.008 (0.966)	−0.037 (0.841)	0.051 (0.781)

Abbreviations: Δ, change from baseline (T2 − T0); RIPLS, Readiness for Interprofessional Learning Scale; HPATHI, Health Professionals' Attitudes Toward the Homeless Inventory.

No statistically significant correlations were found between programme engagement metrics and changes in RIPLS Total, HPATHI Total, or Teamwork and Collaboration scores.

Figure 1 illustrates the longitudinal trajectories of RIPLS Total, HPATHI Total, and Teamwork and Collaboration scores across the three assessment time points.

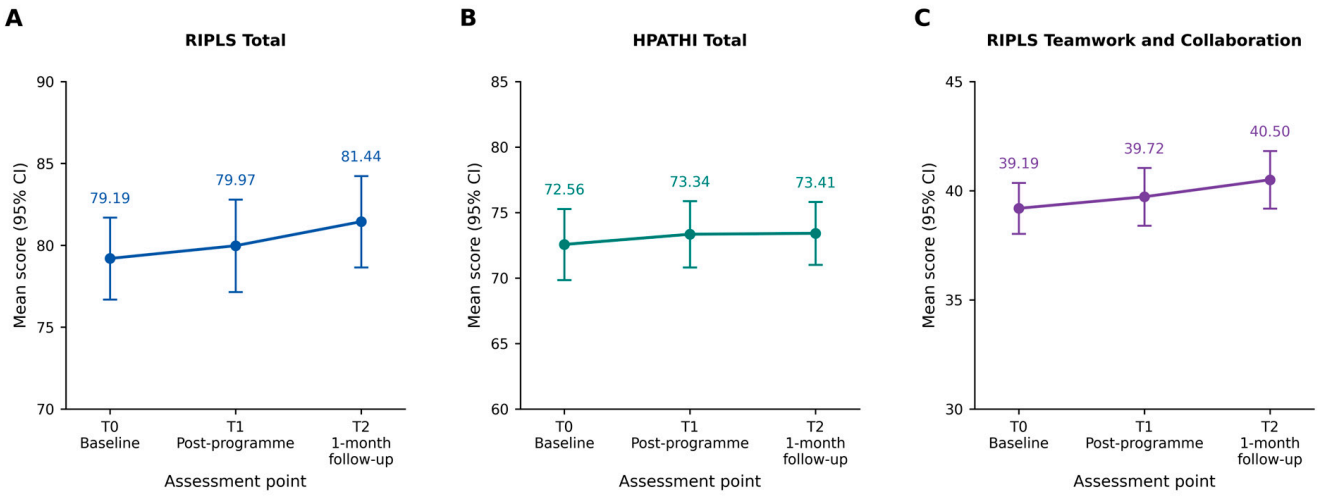


Figure 1. Readiness for interprofessional learning and attitudes toward people experiencing homelessness across the three assessment points. Mean scores are shown for (**A**) Readiness for Interprofessional Learning Scale (RIPLS) Total, (**B**) Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI) Total, and (**C**) RIPLS Teamwork and Collaboration. Assessments were conducted before the programme (T0), immediately after programme completion (T1), and at one-month follow-up (T2). Error bars represent 95% confidence intervals.

4. Discussion

This prospective, single-arm, uncontrolled before-and-after study documented readiness for interprofessional learning and attitudes toward people experiencing homelessness

across three assessment points surrounding an international Erasmus+ BIP. Mean RIPLS Total and Teamwork and Collaboration scores increased descriptively, but the RIPLS Total omnibus test was not statistically significant. The nominal time effect for Teamwork and Collaboration did not remain statistically significant after Holm adjustment across the six outcome tests, and Bonferroni-adjusted pairwise comparisons identified no significant differences between assessment points. HPATHI and the other RIPLS subscales also showed no statistically significant time effects. Exploratory engagement analyses detected no statistically significant associations with score changes. These findings provide a description of the observed trajectories but do not establish programme effectiveness or differential effects across educational domains.

The descriptive increase in Teamwork and Collaboration scores may be considered in relation to the programme's emphasis on shared tasks and collaborative learning. These activities are conceptually aligned with willingness to learn alongside other professions, whereas professional identity and role clarification involve different aspects of interprofessional development. Reviews of interprofessional education emphasize the importance of educational context, teaching strategies, and alignment between activities and assessed outcomes [4,5]. However, the present analyses do not establish that teamwork-related readiness was more responsive than the other outcomes, because no direct comparison of changes between domains was conducted and the nominal teamwork time effect did not remain significant after adjustment for multiple outcomes. The observed trajectories therefore offer hypotheses for future research rather than evidence that a brief BIP selectively improves teamwork or that identity-related outcomes necessarily require longer interventions.

HPATHI scores showed no statistically detectable change across the assessment points. This finding concerns attitudes toward people experiencing homelessness and cannot be generalized to attitudes toward all socially vulnerable populations. One possible explanation is the alignment between the programme's broad inclusion objectives and the narrower construct assessed by HPATHI. Previous evaluations of a homelessness-focused patient navigation elective and student-run clinic participation reported changes in specific attitudinal domains [10,11]. These findings suggest that targeted content and relevant practical experiences may warrant consideration when designing programmes intended to address homelessness-specific attitudes. Relatively positive baseline scores may also have limited the scope for increases, although a ceiling effect was not established. The present findings do not demonstrate that attitudes were unaffected or identify which programme components might influence them.

This study adds repeated assessments of specific educational constructs to the emerging literature on BIPs, extending evaluation beyond participant satisfaction. Its contribution lies in documenting self-reported readiness for interprofessional learning and homelessness-specific attitudes before the programme, immediately afterwards, and at one-month follow-up. The exploratory engagement analyses detected no statistically significant associations between attendance, assignment completion, or final grades and changes in the main outcomes. However, the small sample and restricted variation in these indicators limit interpretation: attendance ranged from 80% to 100%, and 27 of 32 students completed all five assignments. These findings neither establish that engagement is unrelated to educational outcomes nor demonstrate that the quality of participation matters more than its quantity. Future evaluations could assess the nature of collaborative interactions and reflective participation alongside attendance and task completion.

For future BIP design, a practical consideration is the alignment between learning objectives, educational activities, and assessment instruments [5]. Programmes addressing broad inclusion objectives may require several measures to capture distinct outcomes, because a homelessness-specific instrument cannot assess attitudes toward all populations

experiencing social exclusion. Collaborative tasks, intercultural exchanges, and guided reflection provide a rationale for programme design, but the present study cannot determine which components influenced the observed scores. Future evaluations could describe these components more precisely and assess collaborative performance alongside self-reported readiness. Including a comparison group and longer follow-up would also help distinguish programme-associated changes from other influences and examine their persistence.

Strengths of this study include its evaluation of an implemented international educational programme and the availability of complete data for all 32 participants across the three assessment points. Assessing the same students before the programme, immediately afterwards, and at one-month follow-up allowed within-participant changes to be examined without loss to follow-up in the analysed cohort. The participation of students from nursing, physiotherapy, and social work across several European countries provided an interprofessional and intercultural context for the evaluation.

Limitations and Future Research

Several limitations should be considered. Without a comparison group, observed changes cannot be attributed to the programme, because other influences, including repeated questionnaire administration, cannot be excluded. The convenience sample of 32 students from a single BIP limits generalizability and the precision of estimates; non-significant findings do not establish the absence of educationally meaningful changes or associations. Testing multiple outcomes also increases the risk of chance findings, and the nominal Teamwork and Collaboration time effect did not remain significant after Holm adjustment. All outcomes were self-reported and may be affected by social desirability or response bias; readiness scores do not demonstrate collaborative competence in practice. Low internal consistency of the Roles and Responsibilities subscale across assessments and of Negative Professional Identity at baseline further limits interpretation of these exploratory outcomes. HPATHI assesses homelessness-specific attitudes and does not capture the programme's broader inclusion objectives. Engagement analyses were limited by the small sample and restricted variation in participation indicators. Finally, the one-month follow-up does not establish longer-term persistence.

Future research should address these limitations in several ways. Controlled designs, for example, comparing BIP participants with a concurrent cohort of students who do not take part in the programme, would help distinguish programme-associated changes from repeated testing and other influences. Multicentre evaluations across several BIPs, with larger samples and a priori sample size calculations, would increase the precision of estimates and allow comparisons between programme formats, durations, and participant profiles. Self-reported readiness should be complemented by observational or performance-based assessments of interprofessional collaboration. Outcome instruments should be selected to match the learning objectives of each programme; where broad inclusion objectives are pursued, attitudes toward several socially vulnerable populations, and not only people experiencing homelessness, should be assessed. Finally, follow-up beyond one month, combined with qualitative methods exploring the nature of collaborative interactions and reflective participation, could clarify whether any changes persist and which programme components contribute to them.

5. Conclusions

Readiness for interprofessional learning increased descriptively following the inclusion-focused Erasmus+ BIP, while homelessness-specific attitudes showed little variation. However, the analyses accounting for multiple outcomes did not provide sufficient evidence of change in either domain. The study therefore provides an exploratory account of students'

educational trajectories, without establishing programme effectiveness. Its main implication is that evaluation of BIPs should distinguish collaborative readiness from population-specific attitudes and assess each in relation to the programme's learning objectives.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/soc16110384/s1, Table S1: Descriptive statistics for Readiness for Interprofessional Learning Scale (RIPLS) subscale scores at baseline, immediately after the intervention, and at one-month follow-up (N = 32), Table S2: Internal consistency of RIPLS and HPATHI scores at each assessment point (N = 32).

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Informed Consent Statement: Written informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The datasets generated and analyzed during the current study are available from the corresponding author on reasonable request.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

BIP	Blended Intensive Programme
HPATHI	Health Professionals' Attitudes Toward the Homeless Inventory
IPE	Interprofessional Education
OSF	Open Science Framework
RIPLS	Readiness for Interprofessional Learning Scale
TREND	Transparent Reporting of Evaluations with Nonrandomized Designs
T0	Baseline assessment
T1	Immediate post-programme assessment
T2	One-month follow-up assessment

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