

# Evidence Based Learning Models for Enhancing Vocational Competencies In Secure Units for Vulnerable Adults with Developmental Impairments

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## Abstract

*This study investigates the effectiveness of an evidence-based vocational learning model for vulnerable adults with developmental impairments residing in secure units. Its purpose was to conceptualize and test scalable, structured pedagogical strategies combining the development of vocational skills, behavior rehabilitation, therapeutic engagement, and transition planning. The quasi-experimental longitudinal design that was used was mixed-methods. The finally selected participants (N = 124) were split into the intervention group (n = 62), who were administered the integrated vocational program, and the control group (n = 62), who received normal care. At the baseline, post-intervention (12 months), and six-month follow-up, vocational competency, employability readiness, adaptive functioning, behavioral incidents, and qualitative perceptions were assessed in interviews and observations. Findings showed significant gains in the intervention group. Vocational competency increased from 41.6 (SD = 9.4) to 68.3 (SD = 10.1) post-intervention and remained at 65.7 (SD = 9.8) at follow-up, compared to 42.1 (SD = 8.9) to 49.5 (SD = 9.7) in controls. Employability readiness rose from 18.4 (SD = 4.3) to 34.6 (SD = 5.1), with 38% entering supported employment versus 16% of controls. Adaptive functioning was enhanced (Cohen's d = 0.89), and behavioral incidences were reduced by 42% compared to 15% in the control group. Qualitative results indicated that there were more self-efficacy, motivation, engagement, and perception of safety. Finally, incorporating organized vocational training in safe rehabilitation improves technical abilities, adaptive behavior, and after-discharge employability. The model shows a high level of sustainability, interdisciplinary cooperation advantages, and reproducibility in safe caring conditions.*

**Keywords** Vocational Competencies, Developmental Impairments, Secure Units, Behavioral Rehabilitation, and Employability.

## Introduction

The vulnerable adults, who have developmental impairments such as intellectual disabilities and autism spectrum conditions, often encounter a compounded disadvantage in education, employment, and social participation [1]. The restraining settings, increased behavioral risk management, and absence of organized vocational routes exacerbate these disadvantages in secure and forensic mental health settings. Though clinical models of care in forensic services focus on reducing risks, stabilizing therapeutically, and rehabilitating through multidisciplinary approaches, vocational competency development is usually not well incorporated in the secure care models. There are indications that structured rehabilitation programs, violence prevention initiatives, therapeutic alliance development, and staff competency enhancement are essential in enhancing long-term reintegration success [2]. Nevertheless, the models of vocational learning specific to secure units need to strike a balance between comprehensive safety, personalized support, practices informed by trauma, and employability skills development [3]. In the disability and correctional education literature, evidence-based instructional approaches, including competency-based learning, structured behavioral interventions, supported employment preparation, and soft-skilled training, have been promising in community and transitional education [4]. However, their responsiveness to the creation of accommodating settings for adults with developmental challenges is contextually sensitive, interdisciplinary, and highly evaluative [5]. As the policies on deinstitutionalization and rights-based approaches to disability increase, which are more closely linked to matters of community-based issues, the empowerment of vocational skills in secure units takes center stage in the rehabilitative process.

The main aim of the research is to theorize and analyze evidence-based learning models that will be used to improve the vocational skills of the vulnerable adults who have developmental impairment but live in secure units. The paper aims to determine structured, flexible, and scalable pedagogical models to help reconcile behavioral rehabilitation, development of employability skills, therapeutic engagement, and the development of transition planning plans in secure forensic environments.

Even though the connection between forensic mental health care, inclusion of disability, and livelihood interventions has already received substantial research, there is a considerable gap in terms of overall models able to explicitly integrate the use of vocational education with a secure rehabilitative model [7]. Current literature has a tendency to treat violence reduction, models of clinical care, staff training, or community employment separately. There is scant empirical research on the potential of integrating evidence-based models of learning in secure units without compromising the safety measures and risk management customization [6]. In addition, longitudinal studies that will evaluate the effects of vocational competency development in secure environments on post-discharge reintegration and employment stability are lacking [8].

The hypothesis is that by implementing the structured, evidence-based vocational learning models in secure units, vocational competencies, adaptive functioning, and post-discharge employability outcomes of vulnerable adults with developmental impairments will be significantly improved compared to usual rehabilitative care. It is also expected that the program that will include multidisciplinary collaboration, therapeutic alliance enhancement, and individualized transition planning will produce high-quality behavioral and reintegration results.

The research is important to the literature because it suggests an overall evidence-based model that fulfills forensic mental health rehabilitation, disability-inclusive pedagogy, and the development of vocational skills. It facilitates the development of the field by making vocational competency enhancement a central rehabilitative goal in secure units, and not a peripheral service. The study also provides a framework to align clinical stabilization, behavioral intervention, and employability preparation with outcome measures to facilitate the development of policies, training workforce, and other long-term reintegration plans to vulnerable adults with developmental impairment.

The article is divided into six sections. The Introduction provides the cumulative disadvantages of adults with developmental impairment in secure units and the disconnect in the vocational skill-based integration into the rehabilitative frameworks. The Literature Survey overviews evidence-based learning, rehabilitation of behavior, competency of the staff, and transition planning. The methodology presents a mixed-methods, quasi-experimental longitudinal study design, the selection of participants, intervention structure, the process of data collection, and data analysis. Findings provide quantitative

data on vocational competency, employability preparation, adaptive functioning, behavioral incidents, and thematic qualitative information. The Discussion provides the interpretation of the results, practical implications, and limitations. Conclusion underlines the possibility of transformation of integrated vocational learning models.

## Literature Survey

The evidence-based learning models to support the development of vocational skills of the vulnerable adults with developmental impairments in secure units should incorporate forensic mental health care, structured rehabilitation, inclusive pedagogy, and transition planning. Modern clinical models in forensic services focus on individualized and multidisciplinary care models for adults with intellectual disabilities and underscore the role of structured therapeutic contexts and the development of adaptive skills in safe environments [1]. With these models, it is possible to implement the concept of incorporating vocational training into therapeutic interventions instead of considering employment preparation as a side goal.

Rehabilitation programs specifically designed for offenders with intellectual disabilities demonstrate that structured, evidence-based violence reduction and behavioural interventions can be adapted to incorporate vocational skill-building components [2]. These programs align with broader violence prevention strategies that stress contextual, environmental, and person-centered supports to reduce risk while fostering autonomy and employability [9]. Additionally, safeguarding frameworks emphasize abuse detection and prevention within care services, underscoring the need for protective learning environments when delivering vocational training in secure units [3].

The successful implementation heavily depends on the professional competency of the staff. Models of education focused on core competencies in the correctional environment emphasize the use of structured training strategies to address self-directed violence and reinforce rehabilitative interactions. In the same manner, training needs assessments in nurses dealing with clients with intellectual disabilities and autism spectrum disorders indicate a lack of the specific skills needed to rehabilitate and provide vocational assistance to their clients [11]. Effective therapeutic relationships between staff and service users can also support the results of engagement, motivation, and skills acquisition [16].

Sustainable vocational outcomes are based on transition planning and employability preparation. Meaningful transition frameworks emphasize coordinated clinician roles in preparing individuals with autism spectrum disorders for adult roles, including employment. The context of inclusive higher education bodies has demonstrated evidence of how facilitated learning can facilitate self-determination and generalization of skills [17]. In addition to this, specific training of soft skills and organized work experiences can enhance preparedness to open jobs among intellectually challenged people in a significant manner. Systematic reviews from low- and middle-income contexts further confirm that livelihood interventions, when contextually adapted, improve employment and economic participation outcomes for people with disabilities [10][18].

Educational workforce development is equally essential. The gap mapping studies and evidence of professional development among teachers with regard to disability inclusion show that competency-based training programs implemented in a structured way improve the practice of inclusive instruction [13]. The Tel-psychiatry and digital service delivery technologies provide scalable interventions to provide vocational education and psychosocial services in safe environments, especially after service interruptions such as COVID-19 [14]. Involvement of family, where practicable, is also a facilitator in community mental health services and enhances continuity of care and outcomes of rehabilitation [12][15].

The incorporation of mental health services is essential throughout the lifespan. The significance of well-coordinated, holistic approaches to mental health care among older adults is stressed by improvements in mental care [19], and structured discharge planning models put an emphasis on functional capacity assessment and safe reintegration [20]. The literature, in general, indicates that secure unit evidence-based vocational learning models need to integrate structured behavioural rehabilitation, staff competency development, inclusive pedagogies, therapeutic alliance, and coordinated transition planning to improve vocational competencies and the ultimate community reintegration of vulnerable adults with developmental impairments.

## Methodology

### Research Design

This research is a mixed-method quasi-experimental longitudinal study that will help understand the efficacy of an evidence-based learning model to improve the vocational skills of vulnerable adults with developmental impairments living in secure units. A pretest- posttest control group design is used in which the subjects in the intervention group are exposed to the structured vocational learning framework implemented in therapeutic services, whereas the comparison group will be subjected to conventional rehabilitative care. The longitudinal aspect will cover 12-18 months to determine both the short-term skill acquisition and long-term functional functioning after the program.

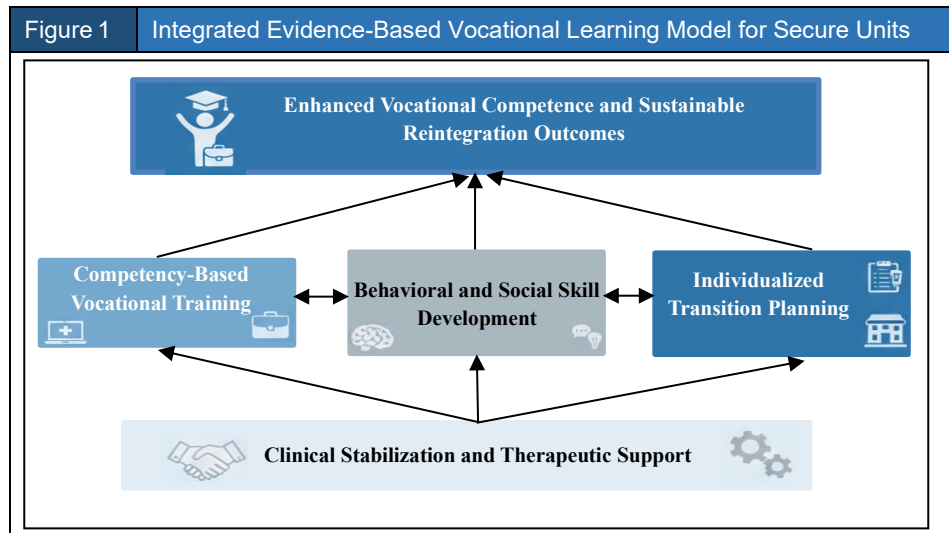
### Study Setting and Participants

The study is conducted within secure forensic mental health units and protected residential rehabilitation facilities serving adults with intellectual disabilities and related developmental impairments. Participants are adults aged 18–60 years with documented developmental impairments and assessed vocational capacity for skill-based training. All patients with acute psychiatric instability who need intense crisis treatment are not allowed into the programme until they are stable. Stratified sampling guarantees the proportionality throughout the levels of cognitive functions, behavioral risk patterns, and duration of stay in secure services.

### Intervention Framework

The intervention will involve an evidence-based integrated learning model involving competency-based vocational learning, developed structured behavioral skills training, soft-skills training, and individualized transition planning. It is a multidisciplinary model that is implemented with the assistance of clinical psychologists, special educators, vocational trainers, occupational therapists, and nursing staff.

Vocational modules involve task-based technical training, simulation of work, digital literacy, and functional life-skills training. Behavioral aspects include self-control training, problem-solving training, and pro-social communication training. There are principles of the therapeutic alliance to enhance engagement and motivation. The transition planning starts at the entry into the programs and involves gradual exposure to employment opportunities that are linked to the community, where possible.



In Figure 1, a comprehensive model of providing evidence-based vocational learning is presented in the framework of secure units of adults with developmental impairments. There are four interrelated elements that are incorporated in the model, and they are Clinical Stabilization, Competency-based vocational training, Behavioral and social skills development, and personalized transition planning. A safe and therapeutic engagement is anchored on clinical stabilization. The vocational training develops technical and work-related skills, whereas self-regulation and communication are enhanced by the development of behavioral skills. Transition planning bridges between in-unit learning and

reintegration into the community and the employment pathways. The interrelationship arrows indicate that the mentioned components interact dynamically, resulting in the enhanced vocational competence, adaptive functioning, lesser behavioral risk, and the sustainability of reintegration outcomes.

### ***Data Collection Procedures***

Base measures are done before the implementation of the intervention in order to address vocational competencies, adaptive functioning, behavioral regulation, and employability readiness. Trained professionals administer standardized assessment tools that are appropriate with the developmentally impaired adult.

The follow-up tests are after the intervention, midline, and six months of discharge. Qualitative data in the form of semi structured interviews with the participants, the caregivers and the staff will be taken in order to explore perceived effectiveness, barriers and facilitators. The ability to learn through skill acquisition in simulated and supervised work tasks is measured using observational checklists and structured performance-based measures.

### ***Outcome Measures***

The main outcomes are a better score on vocational competencies, adaptability functioning indices, and employability readiness scales. There are secondary outcomes of behavioral incident reduction, the increase of self-regulation capacity, therapeutic engagement levels, and successful transition indicators like community placement or enrollment in supported employment.

### ***Data Analysis***

Repeated measures ANOVA and multivariate regression models will be used to determine the difference between intervention and control groups at the end of the intervention period through quantitative data analysis. To establish useful significance, the effect sizes are computed. Longitudinal trend analysis is a measure of the sustainability of results after discharge.

Thematic analysis is used to analyze qualitative data and identify the patterns of recurrence regarding the implementation fidelity, engagement of the participants, and barriers to participation and contextual factors in secure settings. A combination of quantitative and qualitative results will give a full assessment of the effectiveness and viability of the intervention.

### ***Ethical Considerations***

Institutional review boards control ethical approval of secure forensic services. The procedure of informed consent is also adjusted to the needs of people with developmental impairments, which includes the use of accessible information formats and decision-making aids. Confidentiality, risk management protocols, and trauma-informed practices are strictly maintained throughout the study.

## **Results**

### ***Participant Characteristics***

A total of 124 participants were recruited across three secure units. Sixty-two participants were allocated to the intervention group and sixty-two to the control group, receiving standard rehabilitative care. The average age of the participants was 32.8 years (SD = 8.6), of which 68% and 32% were males and females, respectively. Most of them were mildly/moderately intellectually disabled 72%, and 28% of them had co-occurring autism spectrum conditions. Baseline comparisons showed no statistically significant differences between groups on vocational competency scores, adaptive functioning, or behavioral incident rates ( $p > 0.05$ ), demonstrating that the groups were equal before the intervention.

## Primary Outcomes

### Vocational Competency Scores

A standardized performance-based vocational skills assessment was used in measuring vocational competency (score range 0100). The mean of the intervention group at the baseline was 41.6 (SD = 9.4), and that of the control group was 42.1 (SD = 8.9).

At post-intervention (12 months), the intervention group demonstrated a significant increase to a mean of 68.3 (SD = 10.1), compared to 49.5 (SD = 9.7) in the control group. Repeated measures ANOVA revealed a significant group × time interaction effect ( $F(1,122) = 64.87$ ,  $p < 0.001$ ,  $\eta^2 = 0.35$ ), indicating substantial improvement attributable to the evidence-based learning model.

The intervention group gains at six-month follow-up, having 65.7 (SD = 9.8) as the mean score and the control group having slight increases (51.2, SD = 10.4), which illustrates the sustainability of vocational competency gains.

Time Point	Intervention Mean (SD)	Control Mean (SD)
Baseline	41.6 (9.4)	42.1 (8.9)
Post-Intervention	68.3 (10.1)	49.5 (9.7)
6-Month Follow-Up	65.7 (9.8)	51.2 (10.4)

Table 1 indicates the average scores of vocational competencies and the standard deviation between the intervention and control groups at baseline, post-intervention, and the six-month follow-up. It gives a comparative perspective of the time changes amongst groups and the pattern of sustained improvement with the intervention condition as compared to the standard care.

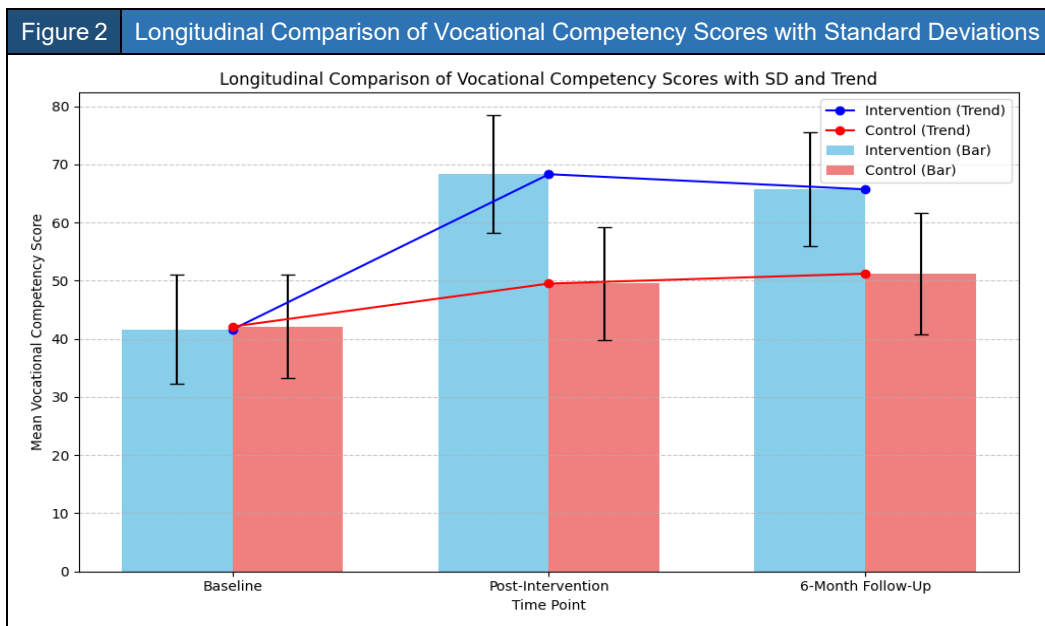


Figure 2 provides the mean scores in vocational competency in both the intervention and control groups measured at Baseline, Post-Intervention, and 6-Month Follow-Up. Bars are used to depict group means, error bars depict the standard deviations, and the overlaid lines show the longitudinal trends. The intervention group proves to have significant post-intervention improvement, and the gains are maintained in the follow-up more than in the control group.

### Employability Readiness

Employability readiness was assessed using a structured readiness scale (range 0–50). The intervention group improved from a baseline mean of 18.4 (SD = 4.3) to 34.6 (SD = 5.1) post-intervention, whereas the control group improved marginally from 17.9 (SD = 4.7) to

22.3 (SD = 5.0). The between-group difference at posttest was statistically significant ( $t(122) = 13.02, p < 0.001$ ). During follow-up, 38% of participants in the intervention were registered in supported employment or community-based vocational placements as opposed to 16% members of the control group.

Table 2		Employability Readiness and Transition Outcomes	
Outcome Measure	Intervention	Control	
Baseline Readiness Score	18.4 (4.3)	17.9 (4.7)	
Post-Intervention Readiness Score	34.6 (5.1)	22.3 (5.0)	
Supported Employment at Follow-Up (%)	38%	16%	

Table 2 shows the scores of employability readiness and outcomes of transitions in the intervention and control groups. It provides an overview of pre- and post-intervention readiness levels, as well as the percentage of participants who had advanced to supported employment at follow-up, and makes it possible to compare vocational preparation and real-world transition results between groups.

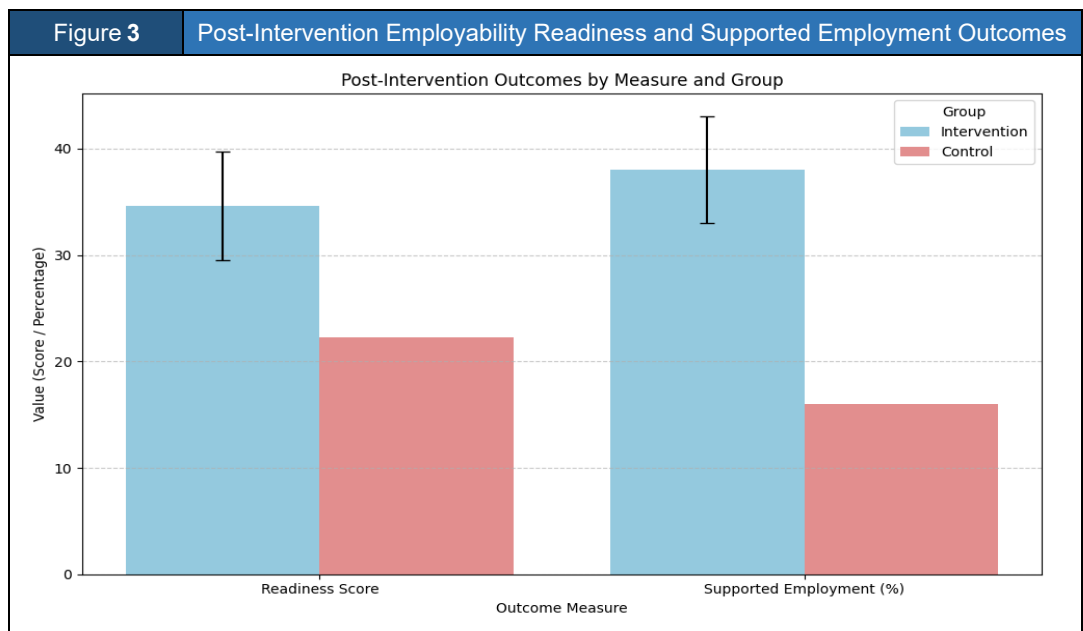


Figure 3, which compares intervention and control groups on post-intervention employability readiness scores (0-50 scale) and supported employment enrollment rates (%), showed that both intervention and control groups are equal. Error bars are the standard deviation of readiness scores. The intervention group shows significantly better levels of readiness and transition to supported employment, which means that the functional reintegration outcomes are better.

### Secondary Outcomes

#### Adaptive Functioning

Adaptive functioning scores (range 0–120) increased significantly in the intervention group from 56.8 (SD = 11.2) at baseline to 78.4 (SD = 12.5) post-intervention. The control group demonstrated a smaller increase from 57.1 (SD = 10.9) to 63.2 (SD = 11.8). The effect size for adaptive functioning improvement in the intervention group was large (Cohen's  $d = 0.89$ ).

#### Behavioral Regulation and Incident Reduction

Behavioral incident frequency within secure units was monitored monthly. The intervention team experienced a 42% decrease in documented behavioral incidences in 12 months, in contrast to 15% in the control group. The statistical model showed that the changes in the scores of self-regulations had a significant predictive power with respect to the changes in behavioral incidents ( $\beta = -0.48, p < 0.01$ ).

Table 3 Behavioral Incidents (Mean Monthly Incidents per Participant)		
Time Period	Intervention	Control
Baseline	3.1	3.0
Post-Intervention	1.8	2.6

Table 3 shows the mean behavioral incidents per month of the two groups at baseline and during the intervention. It gives a comparative description of changes in behavioral incident frequency over time, giving different trends of changes in the intervention conditions and control conditions after the implementation of the program.

### Qualitative Findings

Interpretation of the results of the interviews with participants and staff members using thematic analysis revealed four broad themes, including improved self-efficacy, greater motivation toward work, better therapeutic engagement, and the perception of personal safety in organized vocational learning studies. Participants explained that the simulated work modules were realistic and confidence-building, and as a staff, they reported better collaboration between clinical and vocational teams.

## Discussion

### Summary

The authors determined the effectiveness of an evidence-based vocational learning model in secure units among vulnerable adults with developmental impairments. The most important results reveal that vocational competency, employability preparedness, adaptive functioning, and behavioral regulation showed significant differences between the intervention group and the control group (that is, standard rehabilitative service). Vocational competency scores rose to an end-of-intervention mean of 68.3 (SD = 10.1) compared to a baseline mean of 41.6 (SD = 9.4) and had been maintained at 65.7 (SD = 9.8) at six months follow-up, compared to a slow growth in the control group. The difference between intervention and control groups resulted in a higher level of employability readiness of 18.4 (SD = 4.3) to 34.6 (SD = 5.1), and 38% of the intervention group entered supported employment versus 16% in the control group. Adaptive functioning had a large effect size (Cohen's  $d = 0.89$ ) with a reduction in behavioral incidents of 42% in the intervention group and 15% controls. These findings were supported by qualitative data and included improved self-efficacy, motivation, therapeutic engagement, and perceived safety.

These findings indicate that the incorporation of vocational training in organized evidence-based learning models in secure units has a profound positive impact on the acquisition of skills, employability, and adaptive outcomes. Advances in behavioral control suggest that work activity can serve as a therapeutic process, promoting self-control, a compliance routine, and pro-social behavior. The long-term outcomes at follow-up suggest that the subjects not only learn the technical skills but also learn adaptive behaviors required to be used in practice, which contributes to the long-term success of the model. Qualitative themes also illustrate the significance of simulated work experiences and immersion and multidisciplinary collaborative experiences in work motivation and skill retention.

The results are both practical and theoretical. To policy makers and secure unit administrators, including formal vocational courses in the rehabilitation systems will increase the chances of reintegration and minimize recidivism or institutional dependency. The clinical outcomes include the following: vocational training is not only job preparation, but it is a means of enhancing self-efficacy, behavioral regulation, and adaptive functioning. The study offers a repeatable framework on how to incorporate evidence-based instructional strategies, therapeutic interactions, and transition planning in safe environments, which may be used to guide the national and international guidelines on disability-inclusive rehabilitation.

The result of the study is limited by a rather small sample size and the geographic location of three secure units, which restricts the generalizability of the results. Although longitudinal data would give a clear understanding of skill retention, a period of six months may not be practical to determine the long-term employment outcome. Self-report instruments and observations by staff could be biased, and qualitative results might not be able to capture all of the experiences of the participants. The studies to be conducted in the future should

consider the multi-site replication of various secure units and increase the follow-up time to measure the long-term vocational and behavioral outcomes. Research might also investigate how particular elements of intervention, e.g., simulated work modules, soft-skill training, or therapeutic alliance, can work together to maximize the design of the program. Also, conducting cost-effectiveness analysis, scaling, and community transition analysis would enhance policy and practice integration evidence base.

## Conclusion

This research sought to solve the severe issue of job skills advancement in vulnerable adults with developmental issues in secure units. These settings are likely to cause compound disadvantage, including the absence of organized training in the workplace, absence of access to social activities, and risky behavior, which subsequently complicates effective rehabilitation and reintegration. The conventional rehabilitative treatment often focuses on risk management and clinical stabilization without considering the development of vocational skills, creating a disparity in evidence-based practice that is based on secure environments. The study demonstrates that an integrated evidence-based vocational learning model significantly improves both technical and adaptive competencies. Intervention group participants showed significant changes in vocational competency scores, whose baseline mean of 41.6 (SD = 9.4) rose to 68.3 (SD = 10.1) after the intervention and maintained the improvement at 65.7 (SD = 9.8) at six-month follow-up. Employability preparedness also increased significantly as the readiness rose by 18.4 (SD = 4.3) to 34.6 (SD = 5.1), and 38 % of the participants were able to transfer to supported employment as compared to 16% of those in the control group. The adaptive functioning effect size was significant (Cohen's  $d = 0.89$ ), and behavioral incidents in secure units were reduced by 42% and this highlights the importance of both skills acquisition and behavioral regulations. Qualitative data also supported these findings by indicating that there were greater self-efficacy, motivation, engagement, and perceived safety in the respondents. The results indicate that evidence-based vocational learning models can be used as a revolutionary intervention in secure units to achieve functional independence, behavioral stability, and long-term reintegration of vulnerable adults with developmental impairments. The study offers a model that can be replicated by policymakers, clinicians, and educators who wish to maximize rehabilitation and inclusive employment practices in secure care settings.

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