

GARC

GLOBAL AUTISM RESEARCH CENTER

PRACTICAL TOOLKITS SERIES | NO. 09

AUTISM TRANSITION TO ADULthood TOOLKIT

A Practical Evidence-Informed Guide for Person-Centred Planning, Education, Employment, Health, Independent Living and Community Participation

For autistic young people • families & supporters • education • healthcare & social care • employers • transition teams



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Purpose and audience

This toolkit supports autistic young people, families and supporters, schools and colleges, universities, healthcare and social-care teams, employment services, employers, community organizations and transition coordinators who are preparing for the move from adolescence into adult life.

Scope

The toolkit covers person-centred transition planning, education and training, employment, healthcare transition, independent living, housing, money and administration, transport, relationships, safety, family role changes, decision support, service handover and outcome tracking. It is designed for international use and must be adapted to local law, service structures, age thresholds, benefits systems and eligibility rules.

Rights, legal and clinical notice

This is an educational and institutional practice resource, not legal, financial, benefits, safeguarding or medical advice. Legal adulthood, consent and capacity rules, guardianship or supported-decision-making arrangements, eligibility for adult services, education entitlements and benefits vary by jurisdiction. Organizations should use current local law and professional guidance when implementing any tool in this document.

Language and autonomy

The toolkit generally uses identity-first language ("autistic person") while recognizing that individuals may prefer different terminology. Adulthood should not be defined by a single model of independence. Some people will live, work, study and make decisions independently; others will use ongoing personal assistance, supported decision-making or intensive services. The goal is a life with maximum agency, access, safety and participation for the individual.

Evidence approach

The framework is informed by WHO guidance on autism and developmental disabilities, the UN Convention on the Rights of Persons with Disabilities, NICE guidance on autism and transition, and structured healthcare-transition approaches. It translates these principles into practical planning tools without replacing jurisdiction-specific requirements.

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FOREWORD

Foreword

Transition to adulthood is not one birthday, one meeting or one transfer letter. It is a multi-year change in expectations, services, relationships, rights and daily life. Education may become less structured. Child health teams may end. Employment decisions become real. Families may be asked to shift from directing decisions to supporting them. Housing, transport, money, community participation and personal safety become more visible parts of the plan.

For autistic young people, this period can be especially demanding because several systems may change at the same time. A person may be academically capable but need support with executive functioning, transport or self-advocacy. Another may require lifelong daily support but still have strong preferences about where they live, who supports them and how decisions are made. Transition planning must therefore be individualized, concrete and coordinated.

The practical objective is not to make the young person resemble a standard adult pathway. It is to build a pathway around the person: their strengths, communication, culture, ambitions, support needs, sensory profile, health, relationships and preferred level of independence. Preparation should start early enough to practice skills, test options and correct gaps before services end.

This toolkit provides a 10-point framework, 15 thematic sections and a set of reusable tools that can support planning meetings, handovers and quality improvement. It is written so that a young person or family can use individual pages, while institutions can use the full framework to build repeatable transition processes.

Core principle

A successful transition is not measured only by whether a referral was made. It is measured by whether the young person can actually access, understand, use and continue the adult-life supports that matter to them.

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Practical Toolkits Series

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Use individual sections independently or follow the full pathway from early planning to adult-life follow-through.

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Quick navigation

Young people and families may begin with Sections 3, 4, 5, 6, 7, 8 and 13. Health and social-care teams should focus on Sections 8, 14 and 15. Education and employment teams should use Sections 5, 6, 12 and the tools in Appendix A.

HOW TO USE THIS TOOLKIT

Three Levels of Use

Level	Primary users	Use
Individual	Autistic young people, young adults, families	Clarify goals, strengths, support needs, choices and next actions.
Team	Schools, colleges, clinicians, social care, employment services	Coordinate responsibilities, practice skills, make handovers and close service gaps.
System	Leaders, commissioners, institutions, transition programs	Build a repeatable process, track outcomes, audit accessibility and improve continuity.

Use transition as a process, not a deadline

Start with the person’s desired adult life and work backward. The relevant domains may include learning, work, health, housing, transport, money, communication, relationships, leisure, community, safety and decision support. Not every domain requires the same level of planning.

Use local law and service rules alongside this toolkit

Age of majority, education rights, healthcare consent, disability benefits, social-care eligibility, employment protections, housing rules and decision-making law vary by country and sometimes by state, emirate, province or local authority. Replace generic prompts with verified local pathways before operational use.

Keep one live transition record

Fragmented plans create avoidable risk. Use one controlled transition record or coordinated set of records that shows goals, named leads, deadlines, evidence of referrals, accepted services, unresolved gaps and follow-up dates. Share information only with appropriate authorization and privacy controls.

Do not confuse skill-building with worth

A person does not have to achieve conventional independence to have a successful adult life. Support can be a valid, rights-respecting route to autonomy when it reflects the person’s will, preferences and needs.

SECTION 01

Why Transition Quality Matters

The move into adult life changes systems as well as responsibilities.

Transition is cross-system

Education, health, social care, employment, benefits, housing and community participation may all change on different timelines. A plan that covers only one service can leave critical gaps elsewhere.

The person is the constant

Services come and go; the young person remains. Goals, communication preferences, sensory needs, health information, decision supports and practical accommodations should travel with the person.

Timing matters

Planning too late leaves little opportunity to practice skills, visit settings, resolve documentation, find adult providers or arrange funding. Planning too rigidly can also be harmful if it fixes goals before the person has had real opportunities to explore.

Continuity matters

A referral is not the same as an accepted service. Transition quality depends on whether the receiving service has the information, capacity, funding, accommodations and follow-up needed for continuity.

Outcomes should be meaningful

Measure participation, belonging, continuity of care, satisfaction, safety, choice, access to education/work and stability of supports - not only whether forms were completed.

Transition risk signal

If several systems are ending or changing within the same six-month period, treat the transition as a coordinated risk-management task rather than a collection of separate referrals.

SECTION 02

GARC 10-Point Autism Transition Framework

A practical standard for person-centred transition across systems.

1. Start early

Begin before a crisis or service ending point; use the available years to explore, practice and adapt.

2. Centre the person

Use the young person's goals, communication and preferences as the organizing point for planning.

3. Make the future visible

Explain timelines, age-related changes, eligibility, appointments and decisions in accessible formats.

4. Build capability with support

Teach and practice skills while also arranging the assistance and accommodations the person may continue to need.

5. Plan across life domains

Connect education, employment, health, living, money, transport, relationships, community and safety.

6. Coordinate handovers

Name sending and receiving leads, transfer records safely and verify that the receiving service has accepted responsibility.

7. Protect rights and decision-making

Use accessible information and supported decision-making where appropriate; do not assume incapacity because of diagnosis or support needs.

8. Preserve accessibility

Carry forward communication, sensory, scheduling, environmental and digital accommodations into adult settings.

9. Rebalance family roles

Support families to move from doing for the person to supporting the person in ways that fit their preferences and needs.

10. Track outcomes and revise

Use scheduled reviews, feedback and measurable outcomes to close gaps and update the plan as adulthood unfolds.

#	Domain	Practice standard
1	Start early	Begin before a crisis or service ending point; use the available years to explore, practice and adapt.
2	Centre the person	Use the young person's goals, communication and preferences as the organizing point for planning.
3	Make the future visible	Explain timelines, age-related changes, eligibility, appointments and decisions in accessible formats.

#	Domain	Practice standard
4	Build capability with support	Teach and practice skills while also arranging the assistance and accommodations the person may continue to need.
5	Plan across life domains	Connect education, employment, health, living, money, transport, relationships, community and safety.
6	Coordinate handovers	Name sending and receiving leads, transfer records safely and verify that the receiving service has accepted responsibility.
7	Protect rights and decision-making	Use accessible information and supported decision-making where appropriate; do not assume incapacity because of diagnosis or support needs.
8	Preserve accessibility	Carry forward communication, sensory, scheduling, environmental and digital accommodations into adult settings.
9	Rebalance family roles	Support families to move from doing for the person to supporting the person in ways that fit their preferences and needs.
10	Track outcomes and revise	Use scheduled reviews, feedback and measurable outcomes to close gaps and update the plan as adulthood unfolds.

SECTION 03

Start Early and Build a Person-Centred Transition Plan

Build the pathway from the person's preferred future, not from available services alone.

Start with a life picture

Ask what the young person wants more of, less of and differently in adult life. Use concrete options, visits, trials, examples and visual choices when abstract future planning is difficult.

Map strengths and support needs together

A transition profile should include interests, capabilities, communication, sensory needs, routines, health, daily living, executive functioning, travel, self-advocacy and support networks. Do not create a deficit-only file.

Turn goals into observable steps

Replace "be independent" with specific outcomes such as "travel to the college route with agreed support," "book one routine health appointment using the preferred communication method," or "complete a supported work trial in a chosen sector."

Assign ownership

Every action needs a named lead, date, dependencies and evidence of completion. Young people should own actions where appropriate, but responsibility should never be shifted onto them without the needed support.

Review on a predictable cycle

Transition plans should be live. Revisit them after major changes, failed referrals, new diagnoses, changes in capacity/support, education decisions or emerging adult goals.

SECTION 04

Voice, Choice and Supported Decision-Making

Preserve agency while matching support to each decision.

Make information accessible

Use plain language, visual choices, written summaries, AAC, interpretation, extra processing time and repeat explanations where needed.

Support decisions rather than replacing them

A supporter can help compare options, understand consequences, communicate a preference or remember information. Support should be proportionate and should not become automatic substitution of another person's preference.

Treat capacity as decision-specific

Legal standards vary. Autism, intellectual disability or communication difference should not automatically be treated as proof that a person cannot decide. Follow the applicable legal framework and professional requirements.

Record will and preferences

For important domains - healthcare, money, housing, work, education, privacy and relationships - document how the person wants to receive information, who they want involved, and what support helps them decide.

Plan for disagreement

Families and professionals may have legitimate safety concerns. Use structured risk discussion, accessible evidence, trial periods and escalation pathways while keeping the young person involved to the greatest extent possible.

Practice standard

Ask first: "How does this person best understand options and express a preference?" Then provide the communication and decision support needed for that specific choice.

SECTION 05

Education, Training and Lifelong Learning

Prepare for the learning environment the person is moving into, not only for admission.

Compare pathways

University, college, vocational education, apprenticeships, supported learning, certification and community education can all be valid routes. Compare demands, support, cost, travel, sensory environment and flexibility.

Plan the accommodation transfer

School supports may not transfer automatically. Identify what documentation is required, how the adult institution handles disability support, and when the student must self-disclose or request adjustments.

Practice hidden curriculum

Time management, email, deadlines, group work, navigating campuses, asking for help, office hours and changes in routine may matter as much as academic ability.

Protect continuity during gaps

If there is a wait before the next program, create a structured interim plan for learning, work experience, health, routines and community participation.

Keep lifelong learning open

Transition planning should not assume that education ends at a specific age. Many adults change direction, return to study or learn through vocational and community routes.

SECTION 06

Employment and Vocational Development

Move from generic employability to real work exposure, job fit and sustainable supports.

Start with job fit

Match interests, skills, sensory profile, communication, pace, routine, travel and social demands to actual work tasks and environments.

Use real-world trials

Work shadowing, internships, volunteering, project work, job carving and supported employment can reveal strengths and barriers that questionnaires miss.

Teach the practical sequence

Application, interview, onboarding, schedules, breaks, task clarification, feedback, workplace communication, pay, transport and asking for accommodations each require explicit preparation.

Plan accommodations before problems escalate

Possible adjustments include clear written instructions, predictable routines, reduced sensory load, alternative communication, structured supervision, task sequencing or flexible interview formats. Local employment law governs entitlements.

Measure sustainability

A placement is not successful simply because it started. Track retention, hours, wellbeing, task fit, support quality, progression and the worker's own view of the role.

SECTION 07

Independent Living, Daily Life and Housing

Define independence as having control over daily life, with the right level of support.

Assess daily life by task

Break broad concepts into concrete areas: meals, medication, laundry, cleaning, hygiene, shopping, scheduling, sleep, home safety, communication, technology, appointments and managing unexpected changes.

Distinguish can do from can sustain

A person may complete a task once but not reliably initiate, sequence or recover from it without prompts, visual supports or assistance. Planning should reflect real-world consistency.

Explore housing based on preference and support

Options may include living with family, independently, shared living, supported housing or other local models. The key questions are choice, safety, location, affordability, support quality, privacy and community access.

Build environmental fit

Sensory characteristics, neighborhood noise, travel options, proximity to services, predictable routines and access to quiet space can materially affect housing success.

Plan for changes in family support

Even when the young adult will continue living with family, identify what happens if a key supporter becomes unavailable, ill or unable to provide the same level of care.

SECTION 08

Healthcare Transition and Adult Services

Transfer information, responsibility and access - not just the medical record.

Start transition preparation early

Healthcare transition includes moving toward an adult approach to care, learning about one's health, participating in decisions and, where relevant, transferring to adult clinicians.

Create a concise health summary

Include diagnoses, medications, allergies, communication, sensory needs, pain/distress presentation, current specialists, important history, preventive care, emergency information and the person's preferred decision support.

Find the receiving service before the sending service ends

Confirm referral criteria, waiting times, acceptance, accessibility and who will prescribe or monitor ongoing treatments during the transfer period.

Practice healthcare self-advocacy at the right level

Skills may include describing symptoms, showing a health passport, requesting an adjustment, understanding a prescription or identifying a trusted supporter. Some people will continue to need substantial assistance.

Close the loop

Do not assume transfer succeeded after sending records. Verify first appointment, medication continuity, follow-up responsibility and unresolved investigations.

Healthcare transition

Health care transition is broader than changing doctors. It includes planning, readiness, transfer and successful integration into adult-centred care.

SECTION 09

Mental Health, Wellbeing and Crisis Prevention

Protect continuity, predictability and early support during a high-change life stage.

Track baseline and change

Record the young person's usual communication, sleep, routines, activity, appetite, social contact, sensory tolerance and stress signs so meaningful deterioration is recognized early.

Plan around cumulative load

Multiple transitions at once - leaving school, losing familiar staff, starting work, moving home or changing clinicians - can create overload. Sequence changes where possible and preserve stabilizing routines.

Create an accessible support plan

Identify preferred coping strategies, communication methods, environmental adjustments, trusted contacts, early warning signs and routes to urgent help.

Avoid diagnostic overshadowing

New distress, withdrawal, agitation, sleep change or loss of function should not automatically be attributed to autism. Physical health, mental health, environment and social factors may all need assessment.

Use local crisis and safeguarding pathways

Emergency and mental-health services differ by jurisdiction. Plans should identify the actual local contacts, thresholds and legal requirements before a crisis occurs.

SECTION 10

Relationships, Sexuality, Safety and Social Inclusion

Adulthood includes intimacy, friendship, privacy, identity, boundaries and belonging.

Teach rights and boundaries explicitly

Concepts such as consent, privacy, personal space, online behavior, coercion, unsafe requests and how to say no may need direct, concrete teaching adapted to the person.

Support relationship goals without stereotypes

Some autistic adults want romantic or sexual relationships; others do not. Some prioritize friendship, family or community. The role of support is to increase knowledge, safety and choice, not to impose a social norm.

Address digital safety

Online communities can support belonging but may also involve scams, exploitation, harassment or oversharing. Build skills around privacy settings, money requests, meeting people, image sharing and reporting concerns.

Protect confidentiality

As a young person becomes an adult, families and professionals may need new consent arrangements for information sharing. Discuss this proactively rather than after a conflict.

Build community participation

Belonging may come through interests, faith communities, sport, volunteering, gaming, arts, advocacy, peer groups or structured programs. Quality and choice matter more than attendance alone.

SECTION 11

Money, Benefits, Legal and Administrative Readiness

Prepare the paperwork and decision supports that make adult systems usable.

Create an adult administration checklist

Depending on jurisdiction this may include identity documents, bank access, insurance, benefits, disability documentation, education records, healthcare portals, transport concessions, tax or employment records and emergency contacts.

Teach money through real routines

Budgeting is more meaningful when tied to actual income, transport, food, subscriptions, shopping and saving. Use visual or digital tools when helpful.

Verify benefits and eligibility locally

Benefits, disability pensions, education funding, social-care packages and income thresholds vary widely and can change. Use official local sources before making decisions.

Plan legal decision support carefully

Powers, guardianship, supported decision-making and representation rules are jurisdiction-specific. Use the least restrictive, rights-respecting option available under applicable law and obtain qualified advice where necessary.

Protect against exploitation

Money skills should include recognizing scams, pressure, identity theft, unsafe lending, account security and how to get help if a transaction feels wrong.

Jurisdiction check

Do not publish a universal age, benefit amount, guardianship rule or entitlement in a global toolkit. Verify the current local source for the person's country and service system.

SECTION 12

Transport, Community Mobility and Digital Independence

Access to adult life often depends on being able to move, navigate and communicate.

Map essential journeys

Education, work, health, shopping, recreation and family visits may each require different routes and levels of support.

Practice predictable routes first

Use travel training, visual sequences, landmarks, GPS, rehearsal at low-demand times, contingency plans and a way to ask for help.

Plan for disruption

Missed stops, cancellations, road closures, lost phones, crowds and delays can be difficult. Build fallback options and clear contact steps.

Include digital functioning

Adult systems increasingly use portals, QR codes, email, messaging, digital forms and multi-factor authentication. Assess whether the person can access, understand and safely manage them or needs support.

Do not equate driving with independence

Walking, public transport, supported travel, ride services, family transport and mobility support can all be legitimate routes to community participation.

SECTION 13

Family Role, Carer Transition and Changing Responsibilities

Support families to change roles without withdrawing essential support.

Name the shift

Families may move from managing appointments, school communication and daily routines toward coaching, prompting, supported decision-making or targeted assistance. The pace should fit the person, not an arbitrary age.

Separate support from control

Help can be intensive while still respecting privacy, choice and dignity. Clarify which decisions the young adult wants to make independently, which they want help with and what information may be shared.

Plan for caregiver sustainability

Long-term support should consider carers' health, employment, ageing, respite, finances, emergency backup and future housing/support arrangements.

Use transition conversations, not assumptions

Discuss changes in curfews, money, privacy, household responsibilities, transport, relationships and health access explicitly. Written agreements can reduce ambiguity.

Prepare for the family's own adjustment

Parents and siblings may experience anxiety, grief, relief or uncertainty as established routines change. Family support is valuable when it does not displace the autistic person's voice.

SECTION 14

Higher Support Needs, Intellectual Disability and Complex Needs

Transition must remain person-centred even when support is intensive.

Preserve communication access

Identify reliable communication methods, partners, AAC, signs, objects, pictures, behavior-as-communication patterns and how preferences are shown.

Plan around continuity of essential care

Map personal assistance, therapies, medications, equipment, feeding, mobility, epilepsy care, sleep support, behavioral support, day activities and respite where relevant. Any service gap should have a contingency plan.

Use meaningful choice

Choice can be supported through concrete options, observation of consistent preferences, accessible experiences and trusted communication partners. Do not assume absence of speech means absence of preference.

Strengthen safeguarding without removing agency

Higher dependence can increase vulnerability to neglect, abuse or exploitation. Use vetted services, clear reporting routes, privacy protections, staff training and independent oversight where available.

Plan beyond the primary carer

Document essential routines, preferences, risks, health information and support instructions so continuity does not depend on one family member's memory.

Dignity and agency

High support needs can increase the amount of assistance required; they do not remove the need to seek preferences, protect privacy and create opportunities for meaningful choice.

SECTION 15

Coordination, Handover and Transition Outcomes

Make accountability visible across the boundary between child and adult systems.

Create a transition team and one named coordinator

The role may be formal or locally defined, but someone should be responsible for maintaining the plan, following up referrals and escalating unresolved gaps.

Use a handover standard

A strong handover states what is transferring, what is not, who accepts responsibility, what information was shared, consent status, risks, accommodations, next appointment and what happens if the plan fails.

Verify receipt and activation

For every critical service, track referral sent, referral received, eligibility decision, service accepted, first contact, first appointment and ongoing lead.

Track outcome domains

Possible indicators include continuity of healthcare, education participation, employment, living stability, community participation, unmet support needs, wellbeing, safety incidents, waiting times, family burden and the young adult's own experience.

Keep transition open after transfer

The first months of adult services are part of the transition. Schedule follow-up after major transfers and use feedback to correct problems quickly.

APPENDIX A

Practical Tools and Templates

These tools are designed to be copied, adapted and used in transition meetings. They are not diagnostic instruments and do not replace local assessment, legal or clinical documentation. Institutions should add local service names, consent language, privacy notices and mandatory fields before implementation.

Tool	Purpose
A1	My Adult Life Vision and Priorities
A2	Strengths, Preferences and Support Profile
A3	12-24 Month Transition Action Plan
A4	Decision-Support and Information-Sharing Plan
A5	Education and Training Pathway Comparison
A6	Employment Readiness and Job-Fit Map
A7	Adult Healthcare Transfer Summary
A8	Independent Living and Daily-Life Support Map
A9	Housing Exploration Questions
A10	Money and Adult Administration Checklist
A11	Transport and Community Mobility Plan
A12	Relationships, Online Safety and Community Support Plan
A13	Wellbeing, Distress and Crisis Prevention Plan
A14	Family Role Transition Conversation
A15	Service Handover and Continuity Matrix
A16	Young Person Meeting Preparation Sheet
A17	Transition Outcomes Tracker
A18	Institutional Transition Quality Self-Assessment

TOOL A1

My Adult Life Vision and Priorities

A person-led page for identifying what matters before building the service plan.

Name or preferred identifier _____

Date _____

Preferred communication method _____

People I want involved _____

What I want more of in adult life

Learning / study _____

Work / contribution _____

Friends / relationships _____

Community / activities _____

Home / living _____

Health / wellbeing _____

Other _____

My top three priorities for the next 12 months

1. _____

2. _____

3. _____

Things I want adults/services to understand about me

Communication _____

Sensory / environment _____

Routines / predictability _____

Support that helps _____

Support that does not help _____

TOOL A2

Strengths, Preferences and Support Profile

Capture capability and support needs together.

Domain	Strengths / preferences	Support / accommodation that helps
Communication		
Learning / executive functioning		
Sensory / regulation		
Health		
Daily living		
Travel		
Social / community		
Work / study		
Decision-making		
Safety / risk		

TOOL A3

12-24 Month Transition Action Plan

Turn broad goals into accountable actions.

Goal	Action	Lead	Due	Evidence / status

TOOL A4

Decision-Support and Information-Sharing Plan

Document how the young person wants to understand choices and who may be involved.

Decision area _____

How I want information presented _____

Who I want to help me understand options

How I show my choice / preference _____

- ☐ I want to receive a copy of key plans and decisions.
- ☐ Ask me before sharing information beyond the agreed team, unless law or immediate safety requires otherwise.
- ☐ Use my preferred communication method in meetings.
- ☐ Give me time to process major decisions.
- ☐ Explain if a decision cannot be followed and what review or appeal route exists.

TOOL A5

Education and Training Pathway Comparison

Compare real demands, supports and fit - not prestige alone.

Option	Entry / cost	Support & accessibility	Travel / environment	Fit / concerns
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TOOL A6

Employment Readiness and Job-Fit Map

Use real tasks and environments to identify sustainable job fit.

Area	Works well	Needs support / trial
Preferred tasks		
Pace / workload		
Instructions / feedback		
Social demands		
Sensory environment		
Schedule / breaks		
Travel		
Interview / onboarding		
Technology / communication		

Next real-world experience

Work trial / shadowing / volunteering _____

What we want to learn from the trial _____

Review date _____

TOOL A7

Adult Healthcare Transfer Summary

A concise transfer record to use alongside official medical documentation.

Current clinician/service _____

Receiving adult clinician/service _____

First adult appointment _____

Current medications / allergies _____

Key diagnoses / health risks _____

Preferred communication _____

Sensory / access adjustments _____

How pain or distress may present _____

Who I want involved in decisions _____

Urgent / emergency information _____

TOOL A8

Independent Living and Daily-Life Support Map

Distinguish independent performance, prompting and ongoing assistance.

Task	Independent	Prompt / tool	Direct support	Notes
Meals / food				
Medication				
Hygiene				
Laundry / cleaning				
Shopping				
Appointments				
Scheduling / time				
Home safety				
Sleep / routine				
Technology / portals				

TOOL A9

Housing Exploration Questions

Use before committing to a living arrangement.

- ☐ Does the person want to live here?
- ☐ Is the location close to work, study, health and community activities?
- ☐ What staffing or personal assistance is available, when and from whom?
- ☐ How are privacy and visitors handled?
- ☐ What happens at night, during illness or if a supporter is absent?
- ☐ How are sensory needs addressed?
- ☐ What costs are included and what funding is secure?
- ☐ How are safeguarding concerns reported?
- ☐ Can support increase or decrease as needs change?
- ☐ What is the exit plan if the arrangement is not a good fit?

TOOL A10

Money and Adult Administration Checklist

Localize every item to the relevant jurisdiction.

- ☐ Identity documents are current and safely stored.
- ☐ Banking access and account security are arranged at the appropriate level.
- ☐ Benefits / disability support eligibility has been checked using official local sources.
- ☐ Health insurance / coverage status is understood.
- ☐ Education or employment records are available.
- ☐ Emergency contacts are current.
- ☐ Digital accounts, passwords and multi-factor authentication have a safe management plan.
- ☐ Transport concessions or accessibility schemes have been checked where relevant.
- ☐ Legal decision-support arrangements have been reviewed under local law if needed.
- ☐ There is a plan for scams, unusual payments or suspected exploitation.

TOOL A11

Transport and Community Mobility Plan

Plan the route, the backup and the communication steps.

Journey	Usual route / support	What can go wrong	Backup plan
Study / work			
Healthcare			
Shopping			
Community / leisure			
Family / social			

TOOL A12

Relationships, Online Safety and Community Support Plan

A respectful prompt sheet for boundaries, safety and belonging.

People and places that matter

Trusted people _____

Communities / activities _____

Who I contact if I feel unsafe _____

Topics to review at the person's level of understanding

- ☐ Consent and personal boundaries
- ☐ Privacy and information sharing
- ☐ Online friendships and meeting people
- ☐ Money requests, scams and coercion
- ☐ Image sharing and digital permanence
- ☐ Harassment, blocking and reporting
- ☐ Romantic / sexual health information where relevant
- ☐ Safe transport and getting home

TOOL A13

Wellbeing, Distress and Crisis Prevention Plan

Record early signs and preferred support before a crisis.

Area	My baseline / early signs	What helps	Who to contact
Sleep / energy			
Communication			
Sensory tolerance			
Routine / activity			
Mood / distress			
Safety concerns			

Local urgent / crisis contact _____

Emergency contact _____

Important health / medication information

TOOL A14

Family Role Transition Conversation

Clarify changing roles while protecting needed support.

Area	Young adult wants to lead	Support requested	What family will stop / change
Appointments			
Money			
Travel			
Home routines			
Education / work			
Relationships / privacy			
Health information			
Major decisions			

TOOL A15

Service Handover and Continuity Matrix

Track each critical transition until the receiving service is active.

Service	Sending lead	Receiving lead	Referral / acceptance	First contact	Gap / action

TOOL A16

Young Person Meeting Preparation Sheet

Use before transition, education, health, employment or social-care meetings.

Meeting _____

Date _____

Why we are meeting _____

People I want there _____

What I want to say

My first priority _____

Something that is working _____

Something that is difficult _____

A question I want answered _____

A decision I do not want made without me

Meeting access

- ☐ Agenda sent in advance
- ☐ Written / visual information
- ☐ One speaker at a time
- ☐ Breaks
- ☐ Extra processing time
- ☐ AAC / interpreter / communication partner
- ☐ Remote attendance option
- ☐ Written summary after meeting

TOOL A17

Transition Outcomes Tracker

Track lived outcomes as well as completed process steps.

Outcome domain	Baseline	Current status	Person's view	Next review
Education / training				
Employment / activity				
Healthcare continuity				
Living / daily life				
Transport / mobility				
Community / relationships				
Wellbeing / safety				
Unmet support needs				

TOOL A18

Institutional Transition Quality Self-Assessment

A quick audit for schools, health systems, social-care teams and transition programs.

Standard	Not yet	Partial	Consistent	Evidence / action
Transition planning begins before service exit				
Young person's goals and communication are documented				
One coordinator / accountable lead is named				
Adult-service eligibility is checked early				
Receiving services confirm acceptance				
Accessibility adjustments transfer with the person				
Health handover and medication continuity are verified				
Education / employment planning includes real-world trials				
Families are supported to rebalance roles				
Higher-support-needs pathways have contingency plans				
Outcomes are followed after transfer				
Young people provide feedback on the process				

Suggested use

Review quarterly during implementation. Select no more than three improvement priorities at a time and assign a named owner, deadline and evidence of completion.

APPENDIX B

90-Day Implementation Roadmap

This roadmap is for institutions that want to convert transition principles into a repeatable operating process. Adapt the timing to local structures and governance.

Period	Priority actions	Outputs
Days 1-30	Map current transition pathway; identify service exit points; name accountable lead; gather young-person and family feedback; identify legal/local requirements; select core tools.	Current-state map; gap register; named governance lead; localized toolkit set; priority risks.
Days 31-60	Pilot person-centred planning and handover tools; create health and service continuity checks; train staff on accessible communication and supported decision-making; define referral tracking.	Pilot cohort; standardized transition record; handover matrix; staff briefing; referral tracker.
Days 61-90	Audit first cases; resolve failed handovers; begin outcome tracking; establish feedback loop with adult services; document escalation route; approve next-quarter improvement plan.	Audit report; corrected workflows; outcome dashboard; feedback process; 90-day improvement plan.

Minimum implementation indicators

- Percentage of eligible young people with a current transition plan.
- Percentage with a named transition coordinator or accountable lead.
- Percentage of critical adult-service referrals accepted before the sending service ends.
- Percentage with documented communication and accessibility needs transferred.
- Percentage with healthcare transfer completed and continuity verified where relevant.
- Percentage reporting that they understood major transition decisions and were involved in them.
- Number of service gaps, failed handovers or urgent escalations identified and resolved.

Implementation test

A process is not complete because a form exists. Test whether a young person can actually enter and use the adult service, setting or pathway as intended.

APPENDIX C

References and Further Reading

1. World Health Organization. Autism. Fact sheet, updated 17 September 2025. <https://www.who.int/news-room/fact-sheets/detail/autism-spectrum-disorders>
2. World Health Organization & UNICEF. Global report on children with developmental disabilities: from the margins to the mainstream. Geneva: WHO, 2023. <https://www.who.int/publications/b/69686>
3. National Institute for Health and Care Excellence (NICE). Transition from children's to adults' services for young people using health or social care services. NG43. Published 24 February 2016. <https://www.nice.org.uk/guidance/ng43>
4. National Institute for Health and Care Excellence (NICE). Autism spectrum disorder in under 19s: support and management. CG170. Published 2013; last updated 2021. <https://www.nice.org.uk/guidance/cg170>
5. National Institute for Health and Care Excellence (NICE). Autism spectrum disorder in adults: diagnosis and management. CG142. Published 2012; last updated 2021; reviewed 2026. <https://www.nice.org.uk/guidance/cg142>
6. United Nations. Convention on the Rights of Persons with Disabilities, including Articles 12, 19, 20, 24, 25 and 27. <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities>
7. Got Transition. Six Core Elements of Health Care Transition 3.0. National Alliance to Advance Adolescent Health. <https://www.gottransition.org/six-core-elements/>
8. Got Transition. Transition readiness and transition planning resources. <https://www.gottransition.org/>

Evidence and localization note

The sources above provide principles and structured transition guidance but do not create uniform legal entitlements across countries. Before operational use, replace generic references to benefits, consent, legal capacity, housing, education or employment protections with verified local sources. Services should also review current national autism strategies, disability law, safeguarding requirements, data-protection rules and local adult-service pathways.

Suggested citation

Global Autism Research Center (GARC). (2026). GARC Autism Transition to Adulthood Toolkit: A Practical Evidence-Informed Guide for Person-Centred Planning, Education, Employment, Health, Independent Living and Community Participation. Edition 1.0.

ABOUT GARC

Global Autism Research Center

Global Autism Research Center (GARC) develops research, evidence resources, practical toolkits, frameworks, partnerships and knowledge products intended to strengthen autism-related policy, practice and institutional capacity internationally.

GARC Practical Toolkits Series

The series translates evidence and rights-based principles into practical resources for families, schools, universities, workplaces, healthcare systems, researchers and community institutions.

No.	Publication
01	School Community Autism Toolkit
02	Family & Caregiver Autism Toolkit
03	Educator Autism Toolkit
04	Early Years Autism Toolkit
05	University & Higher Education Autism Toolkit
06	Workplace & Employer Autism Toolkit
07	Healthcare Professional Autism Toolkit
08	Autism Research Participation Toolkit
09	Autism Transition to Adulthood Toolkit

Next in the series

10 - GARC Community Inclusion Autism Toolkit: a practical guide for public spaces, community services, cultural and recreational settings, civic participation and inclusive local communities.

Website

globalautismresearch.org.uk