J Nurs Soc Stud Public Health Rehabil 3–4, 2026; DOI: 10.32725/jnss.2026.017

Original research article

ADAPTATION OF AUTISTIC CLIENTS TO WEEKLY RESIDENTIAL CARE

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Abstract

Objective: To explore how adaptation to weekly residential care unfolds for autistic clients and to identify practices that support clients, family caregivers, and direct-care staff during the transition.

Methods: A qualitative multiple-case study was conducted in a weekly residential social service in the Czech Republic. Two clients – one adolescent and one young adult – were followed during staged adaptation. Data comprised more than 330 structured staff records, four interviews with family caregivers and key workers, routine service documentation, and reflexive records. Analysis combined chronological case reconstruction with reflexive thematic analysis: data-near codes were clustered into candidate themes and iteratively checked across sources and cases. Rating scales were used only to orient the chronology and prompt closer reading of accompanying narrative records.

Results: Four themes were identified: a prepared and adjustable pathway; individualised communication and sensory support; family participation bridging home and service; and staff adaptation supported by psychological safety. One trajectory was smooth, whereas the other included a temporary setback requiring slower pacing and reduced stimulation. Repeated review of information from several actors enabled timely adjustments. Staff uncertainty varied more by role and responsibility than by client.

Conclusion: In these two cases, adaptation appeared to be shaped by a relational and organisational process rather than by client factors alone. Social assessment, gradual exposure, flexible pacing, individualised communication, active family partnership, and accessible support for key workers operated as mutually reinforcing components that merit examination in larger and more diverse samples.

Keywords: *Autism; Family caregiver; Residential social service; Social work; Staff support; Transition*

INTRODUCTION

Autism is characterised by persistent differences in social communication and interaction, together with restricted, repetitive, or inflexible patterns of behaviour and interests. Support needs vary substantially and may change across environments and life transitions (WHO, 2022). Entering residential care can be particularly demanding because it simultaneously changes the physical environment, daily routines, social expectations, and the availability of familiar support. Intolerance of uncertainty, anxiety, sensory differences, and communication barriers may intensify the impact of such changes (Bird et al., 2024; Hadad and Yashar, 2022).

Conceptually, the study treats entry into weekly residential care as an ecological transition rather than a discrete placement event. Ecological accounts of autistic transition emphasise that experiences are produced

through interactions among individual characteristics, family resources, environmental demands, and service systems, rather than by person-level characteristics alone (Crompton and Bond, 2022). Reviews of moving home and residential care likewise connect transitions with autonomy, family concerns, sensory and communication demands, staff knowledge and opportunities for belonging (Crompton et al., 2020; Mason et al., 2023; Nguyen, 2023). This relational-ecological lens is used here as a sensitising framework: it directs attention to the fit among client needs, family knowledge, staff practice, and organisational arrangements, while allowing themes to be developed inductively from the cases.

Residential services are not neutral environments. Their accessibility depends on whether routines, communication, and the sensory environment can be adjusted to the person rather than expecting the person to conform to a fixed institutional regime. Autistic people and their families have emphasised the need for quieter spaces, predictable arrangements, flexible support, and professionals who understand individual forms of communication (Clément et al., 2022; Németh et al., 2024). A scoping review of residential design similarly identifies environmental predictability, sensory regulation, and opportunities for withdrawal as recurring priorities, while also noting a limited evidence base and insufficient direct involvement of autistic adults (Nguyen, 2023). European service data further suggest a gap between recommended residential-service features and what autistic adults report experiencing in practice (Micai et al., 2022). Structured teaching and visual support can be useful, but their effects depend on personalisation and integration with wider relational support (Li et al., 2025; Zhu et al., 2025).

Transitions into care also affect family caregivers. Families frequently hold detailed knowledge of routines, triggers, interests, health needs, and successful communication strategies. At the same time, they may enter the transition after years of intensive care and uncertainty about service availability. Therefore, community and residential support need to address both access and the quality of relationships along the service pathway (Featherstone et al., 2022). Likewise, research on residential care more broadly shows that autonomy, safety, supportive relationships, and meaningful involvement in decisions shape how a placement is experienced (Cameron-Mathiassen et al., 2022). Across residential services for people with intellectual and developmental disabilities, family-professional collaboration has been described as a negotiated process that depends on regular, open, two-way communication and clear roles (Zambrino and Hedderich, 2021).

The organisational dimension is equally important. Direct-care staff must interpret behaviour, coordinate responses, and manage their own uncertainty while establishing a new relationship. Implementation research in residential services for autistic adults indicates that leadership commitment, staff engagement, organisational communication, and continuous supervision can determine whether an individualised model becomes part of everyday practice (Dufour et al., 2026). Psychological safety – the shared belief that questions, uncertainty, and mistakes can be discussed without humiliation – may be especially relevant when staff face unfamiliar or high-responsibility situations (Edmondson, 1999).

Published evidence concerning the initial adaptation of autistic clients to residential social services remains limited, particularly for weekly residential care. In the Czech system, this is a hybrid service in which clients stay in the facility during part of the week and regularly return to their family home. This arrangement preserves family ties but requires repeated movement between two environments. The present study therefore examined two concurrent adaptation trajectories in one specialised service. It asked: How does adaptation unfold from the perspectives of family caregivers, direct-care workers, key workers, and service management? Which practices appear to support or complicate the transition? What roles do family partnership and staff support play?

MATERIALS AND METHODS

Design and setting

A qualitative multiple-case study design was used to obtain a contextualised account of adaptation in everyday practice (Mareš, 2015). The study was conducted in a recently estab-

lished specialised weekly residential social service in the Czech Republic. To reduce the risk of identification, the organisation, locality, capacity, and other unique operational characteristics are not reported. The service used a staged adaptation pathway that began with assessment and preparation, continued through short contacts and progressively longer stays, and ended with regular weekly attendance. Decisions about progression were reviewed after each stage.

The cases were purposively selected because both clients completed the service's adaptation pathway during the observation period. Case A was a verbally communicating young adult who required support with pragmatic communication, selected daily routines, and management of a chronic health condition. Case B was a verbally communicating adolescent who benefited from visual support, direct language, and protection from excessive noise. Both required individualised assistance but were substantially independent in several activities of daily living.

Participants and data sources

The analytical corpus combined perspectives from the two family systems and the staff team. Participants included one family caregiver or legally authorised representative for each client, each client's designated key worker, eight direct-care workers who recorded adaptation contacts, and the service manager/social worker, who was also the principal researcher. The researcher had prior professional knowledge of one case and supervised the participating employees.

Four semi-structured interviews were conducted after the adaptation period: two with family caregivers and two with key workers. Interviews lasted approximately 45–60 minutes, were audio-recorded with consent and transcribed verbatim. The interview guides addressed expectations before entry, preparation, turning points, helpful and unhelpful practices, cooperation, staff support, and perceived outcomes.

Direct-care workers completed a structured record after adaptation contacts. A detailed version was used by the key worker or shift lead, and a shorter version by other workers. Each record included contextual information, open questions concerning what helped, what was difficult, what should change, and four 0–10 ratings: perceived adaptation progress, client wellbeing, staff confidence, and anticipatory stress. More than 180 records were available for Case A and more than 150 for Case B. The rating items were embedded in the service's monitoring forms as pragmatic prompts for repeated reflection; they were not validated psychometric measures and were not intended to define adaptation as a numerical outcome. Their research function was to provide temporal orientation within each case. Changes or divergences in ratings were used to identify contacts requiring closer re-reading of the corresponding open-text record and adjacent records. Because ratings were repeated, workers contributed unequal numbers of observations and the measures lacked validation, values were not averaged across workers or analysed inferentially.

Routine service documents included the initial social assessment, preliminary care and adaptation plans, individual planning records, and minutes from regular review meetings. Clients were not interviewed as research participants, and their statements from routine meetings were not coded as research data. The manager's account was treated as a reflexive insider record rather than an independent participant perspective. Table 1 summarises the corpus.

Data analysis

Analysis proceeded in two linked stages. First, each case was reconstructed chronologically from routine records, interviews, and service documents to identify preparation, progression, turning points, responses, and perceived outcomes. Second, interview transcripts, open-text staff records, and relevant documentary passages were analysed using reflexive thematic analysis (Braun and Clarke, 2022). Coding focused on meaning units relevant to the transition process. Initial codes were kept close to the data – for example, descriptions of overload after increased demands, family-provided alternative explanations, or workers' uncertainty about responsibility – rather than being assigned from a pre-existing codebook.

Codes were developed within each case before cross-case comparison. Related codes were clustered into provisional categories such as pacing and progression, communication demands, sensory conditions, family

Table 1. Data sources used in the multiple-case analysis

Data source	Case A	Case B	Primary analytic contribution
Structured staff records	>180 records	>150 records	Longitudinal context, staff observations, and open-text reflections
Family-caregiver interview	1	1	Preparation, home context, cooperation, and perceived family impact
Key-worker interview	1	1	Direct-care strategies, responsibility, uncertainty, and support
Routine service documentation	Assessment, plans, and review records	Assessment, plans, and review records	Initial needs, planned progression, and documented adjustments
Reflexive insider record	Service manager/ social worker	Service manager/ social worker	Organisational decisions, team processes, and researcher positionality

knowledge across settings, and staff support. The researcher then iteratively merged overlapping codes, split overly broad categories, and compared candidate themes against the full corpus. A theme was retained when it captured a coherent pattern relevant to the research questions, was distinguishable from adjacent themes, and could accommodate divergent or contradictory observations rather than excluding them. The analysis moved repeatedly between coded excerpts, case chronologies, and source types until the four final themes provided the most parsimonious account of similarities and differences across cases. Interpretation was informed – but not determined – by sensitising concepts of predictability, sensory accommodation, family partnership, and staff support.

Data-source comparison served an interpretive rather than confirmatory purpose. Convergence was not treated as proof of objective accuracy; disagreements were retained because they showed how different actors interpreted the same event. Rating-scale trajectories were read alongside the chronologies only to orient attention to possible turning points and were always interpreted through the accompanying narrative material. No correlations, significance tests, or causal inferences were calculated. Reflexive notes documented how the researcher's managerial role could shape what participants reported, how staff records were written, and how themes were interpreted. Table 2 provides representative examples of the analytic pathway from data indication to final theme.

Ethical considerations

The study was conducted in accordance with institutional requirements for qualification research involving people and with the principles of the Declaration of Helsinki. Before data collection, written informed consent was obtained from participating employees

Table 2. Illustrative analytic pathway from representative data indications to final themes

Representative data indication	Initial data-near code	Provisional category	Final theme
Longer stay followed by marked distress; a temporary step back was recommended.	Current pace may exceed tolerance	Pacing and progression	Adaptation as a prepared and adjustable pathway
Too many questions and competing stimuli increased tension; reduced stimulation helped.	Verbal and sensory overload	Communication demands and regulation	Communication and sensory support as individualised practices
Family information suggested illness and peer-group change as alternative explanations for a difficult week.	Family reframes staff interpretation	Cross-setting contextual knowledge	Family participation as a bridge between home and service
Key worker valued being able to ask questions, discuss mistakes, and request another worker to take over.	Uncertainty can be voiced safely	Managerial and team support	Staff adaptation and psychological safety

and family caregivers or legally authorised representatives. Consent covered audio-recording, anonymised analysis of interviews, and use of relevant routine-care records for research and publication. Clients were not recruited for research interviews. Names were replaced by case labels and potentially identifying details were removed or generalised. Because re-identification may remain possible in a very small service population, raw data are not publicly available. Given the principal researcher's role as the employees' line manager, written informed consent was the documented basis for their agreement to participate in the research. However, obtaining consent within this hierarchical relationship does not in itself establish that employees felt free from pressure to participate; this remains an ethical and methodological limitation.

RESULTS

The two cases followed the same formal pathway but differed in rhythm and dominant challenges. Case A showed a generally positive yet non-linear trajectory with a temporary setback. Case B progressed more smoothly, although communication and environmental noise required ongoing adjustment. Four themes captured the mechanisms that connected client experience, family knowledge, staff practice, and organisational decision-making.

Adaptation as a prepared and adjustable pathway

Adaptation began before the first stay. A social assessment in the family home mapped communication, self-care, health, sensory needs, interests, daily routines, and family expectations. The resulting information informed a preliminary care plan, selection of the key worker, preparation of the environment, and anticipated progression. Initial visits were deliberately brief and took place with familiar staff present, before stays were gradually lengthened. Family Caregiver B contrasted this with an abrupt placement, describing the process as "not simply throwing him in at the deep end".

Progression was treated as provisional rather than automatic. After each contact, staff records were reviewed by the key worker and manager, and the next step could be maintained, extended, or slowed. Case A illustrated why this flexibility mattered. Following several weeks of progress, the client displayed marked distress during a longer stay. Staff initially interpreted the change as overload caused by the increased duration and recommended temporarily stepping back. Information subsequently supplied by the family suggested that emerging illness and changes in the peer group were also plausible contributors. The slower pace remained a prudent response, but the episode demonstrated that behaviour could not be interpreted reliably from a single source.

Case B did not experience a comparable crisis. The first overnight stay was the principal anticipated milestone, particularly for the family caregiver, but it was completed without major difficulty. Stays then lengthened gradually until the previous day service was discontinued. Across both cases, successful progression depended less on compliance with a fixed timetable than on the service's capacity to revise the timetable without construing a pause as failure.

Communication and sensory support as individualised practices

Both cases benefited from predictability, but the practical form differed. For Case A, helpful communication involved short sentences, fewer questions, sufficient response time, and calm explanations. Too many questions and competing stimuli increased tension. During difficult periods, staff reduced stimulation, offered access to a quiet or sensory-regulation space, and used familiar calming resources. The client's health-management routine also had to be integrated into daily support without unnecessarily reducing autonomy.

For Case B, workers found that direct wording, use of the client's name, a calm and occasionally humorous tone, repetition, visual support, and a choice between two concrete options facilitated participation. Complex sentences, excessive permissiveness, and attempts to continue activities when the client had reached his limit were less effective. Sudden loud sounds or unexpected encounters could result in withdrawal or refusal. Staff responded by reducing demands, clarifying the immediate goal, and returning to familiar activities.

These differences show why "structured support" should not be treated as one standard package. Written schedules were useful for one client, whereas visual prompts and interactive play were more useful for the other. Direct guidance was regulating in Case B but could have been experienced as overload if combined with multiple questions in Case A. Across cases, the common mechanism was not a specific tool but the fit between the tool, the person, and the moment.

Family participation as a bridge between home and service

Both families entered the process after prolonged caregiving strain. Their accounts described restricted employment, persistent coordination demands, and limited opportunities for rest. Entry into weekly residential care was therefore both a transition for the client and a major reorganisation of family life. Initial relief coexisted with concern about overnight stays, peer relationships, health routines, and whether staff would understand the client.

Family involvement was practical rather than symbolic. Caregivers supplied information about communication, medication or health routines, sensory triggers, interests, and signs of distress. They suggested concrete adjustments and reported changes observed at home. In Case A, family information changed the interpretation of a difficult week. In Case B, the caregiver helped staff understand the likely source of conflict with a noisy peer and advised on the level of direct guidance needed in personal care.

The families also provided external indicators of settling in. Clients began preparing for departure, referring to workers or peers at home, separating from caregivers more easily, and treating the service as a familiar destination. These observations complemented staff records and reduced the risk that successful adaptation would be inferred solely from compliant behaviour inside the service. By the end of the period, both caregivers described substantial relief and regained possibilities in work and ordinary daily life.

Staff adaptation and psychological safety

The records showed that workers themselves underwent an adaptation process (Table 3). Uncertainty was highest when responsibility was greatest or when an unexpected event occurred. A worker who was relatively calm as an ordinary team member reported greater anticipatory stress when acting as a key worker. Conversely, a less experienced key worker began with substantial self-doubt, despite being viewed by the caregiver and manager as well matched to the client.

Accessible managerial support reduced the need to conceal uncertainty. Key workers valued being able to ask questions, discuss possible mistakes, request another worker to take over a difficult interaction, and review decisions without blame. One key worker summarised the helpful condition as knowing that "there was someone I could turn to". Practical modelling by an experienced colleague, shared review of records, and permission to slow the process converted anxiety into usable caution.

Table 3. Cross-case comparison of adaptation processes

Domain	Case A	Case B
Overall trajectory	Positive but non-linear; one temporary setback prompted slower pacing	Gradual and comparatively smooth; no major setback
Main challenges	Health-management routine, competing stimuli, and interpretation of distress	Understanding communication, calibrating demands, and sensitivity to noise
Helpful practices	Short communication, fewer questions, response time, reduced stimulation, and sensory regulation	Direct wording, visual support, two concrete options, humour, play, and clear goals
Family contribution	Detailed health and routine information; alternative interpretation of a difficult period	Communication guidance, interpretation of peer conflict and care-related prompts
Staff-support need	Reassurance around responsibility and risk during difficult periods	Confidence-building for a less experienced key worker and support within the team

Team support was not uniformly experienced. One key worker felt that colleagues questioned her appointment, which increased dependence on managerial reassurance. This tension suggests that individual supervision alone cannot replace work on team roles and inclusion. Nevertheless, the ability to voice uncertainty functioned as a safety mechanism across both cases: it allowed early discussion of risks, prevented rigid continuation of the plan, and supported consistent responses.

DISCUSSION

These two cases suggest that adaptation to weekly residential care is better understood as a relational and organisational process than as a test of whether an autistic person can tolerate a placement. This interpretation is consistent with an ecological view of transition, in which experiences emerge through interactions among individual characteristics, family resources, environmental demands, and service systems (Crompton and Bond, 2022). The client, family, staff, peers, environment, and service routines changed in relation to one another. The same staged pathway produced two distinct trajectories; in this small sample, structure appeared useful only when combined with individualisation and responsive decision-making. The findings should therefore be read as mechanism-oriented propositions rather than evidence of intervention effectiveness.

Preparation and flexible pacing appeared central in both cases. The home-based assessment allowed the service to identify communication and sensory needs before interpreting behaviour in an unfamiliar environment. Gradual contact reduced the number of simultaneous changes, while repeated review allowed progression to be reversed temporarily. This resembles recommendations from multi-expert work on autistic adults entering residential care, in which familiarisation, short visits, and opportunities to meet staff were prioritised (Crompton et al., 2020). It also addresses the evidence gap identified in the systematic review of autistic people's experiences of moving home, which found very few studies directly examining relocation experiences (Mason et al., 2023). The pattern is consistent with evidence that structured teaching can support adaptive functioning, although outcomes vary and personalisation remains essential (Li et al., 2025; Zhu et al., 2025). It also accords with implementation research showing that residential support models must be adapted to the setting and sustained by active management rather than merely introduced as written procedures (Dufour et al., 2026).

The findings further demonstrate the danger of assigning a single meaning to distress. In Case A, staff first attributed a setback to the increased length of stay, whereas family information suggested illness and disruption of familiar peer contact. The decision to reduce demands was still appropriate, but the revised interpretation changed what staff needed to monitor. Challenging behaviour in autism is heterogeneous and strongly context-dependent (Adams et al., 2023). Recording antecedents and responses is therefore useful only when combined with communication across settings and openness to revising the initial hypothesis.

Individual communication and sensory accommodation were prominent in both trajectories. Loud sounds, unexpected events, excessive verbal demand, and poorly calibrated activities affected participation, while quiet space, visual or written structure, predictable choices, and clear language reduced uncertainty. These findings correspond with research describing sensory differences as a major influence on functioning and participation (Clément et al., 2022; Hadad and Yashar, 2022; Patil and Kaple, 2023), and with autistic accounts of overload, shutdown, and the need for others to recognise less visible forms of distress (Phung et al., 2021). A scoping review of residential design likewise identifies sensory modulation, predictability, and opportunities for retreat as recurring design principles, while noting the weak direct evidence base and limited involvement of autistic adults (Nguyen, 2023). The EU-wide ASDEU survey also found that several recommended residential-service features, including environmental adaptation and specialist autism expertise, were experienced by fewer than half of autistic adult respondents (Micai et al., 2022). The present cases do not test those service standards, but they illustrate how environmental and staff-level features can become consequential during an actual

transition. Importantly, the effective combination differed by case; person-centred support requires a repertoire rather than a single "autism method".

Family caregivers functioned as co-producers of support and as interpreters of change across environments. Their contribution extended beyond the provision of history at admission. They helped test staff interpretations, suggested adjustments, and identified signs of belonging that were visible at home. This complements studies showing that families of autistic adults often experience fragmented service systems and value professionals who recognise their experiential knowledge (Németh et al., 2024). It also reflects broader evidence that accessible, flexible, and community-connected pathways are underdeveloped for autistic adults (Featherstone et al., 2022). In the broader residential-disability literature, family-professional collaboration is described as dynamic and sometimes tense, but more workable when roles are negotiated and communication is regular and bidirectional (Zambrino and Hedderich, 2021). At the same time, partnership should not collapse into dependence on unpaid family labour; services retain professional responsibility for decisions and continuity.

A distinctive finding concerns staff adaptation. Uncertainty appeared to vary with responsibility and situational complexity, rather than representing a stable deficit in the worker. Key workers carried anticipatory responsibility for decisions, family communication, and continuity. When they could acknowledge uncertainty and obtain timely support, concern became a source of reflection rather than avoidance. This resembles Edmondson's (1999) concept of psychological safety and supports recent residential-care research emphasising leadership, communication, and staff engagement as implementation conditions (Dufour et al., 2026). Psychological safety was not measured as a team-level construct in this study; the concept is used interpretively to describe conditions under which workers appeared able to voice uncertainty and seek assistance. For practice, the cases suggest that supervision may need to respond not only to seniority but also to role, current risk, and the stage of adaptation.

The study also raises questions about participation. Routine review meetings sought to include clients in service decisions, but the research did not collect client interviews and therefore cannot claim to represent their lived experience directly. Evidence from residential care stresses that autonomy and feeling heard shape the quality of transitions (Cameron-Mathiassen et al., 2022). This limitation also echoes recurrent gaps identified in reviews of residential design and moving home, where autistic adults' direct participation in the evidence base remains limited (Mason et al., 2023; Nguyen, 2023). Future studies should use accessible consent and communication procedures to include autistic clients as research partners wherever possible, rather than relying primarily on proxy and professional accounts.

Strengths and limitations

The principal strength was the combination of longitudinal routine records with caregiver, key-worker, documentary, and managerial perspectives. Comparing two concurrent cases within one service made it possible to distinguish common mechanisms from case-specific strategies. Retaining disagreements between sources also prevented triangulation from being used as a simple claim of confirmation.

Several limitations substantially constrain interpretation. The sample comprised only two purposively selected, ultimately successful cases in one service, and the trajectories occurred concurrently and may have influenced one another. Routine rating scales were not validated, ratings were repeated and unbalanced across workers, and the study was not designed for statistical inference. The principal researcher was simultaneously the service manager and line manager of participating staff. This insider position provided contextual access but created power imbalance, potential social-desirability bias, and a risk of overemphasising managerial support. Coding was conducted primarily by the insider researcher without independent parallel coding. Caregivers' positive accounts may also have reflected relief after prolonged burden. Finally, the absence of research interviews with clients limits claims about subjective experience and successful adaptation.

These limitations mean that the findings are analytically transferable propositions rather than estimates of effectiveness. They

should be examined in larger multisite studies, across unsuccessful as well as successful transitions, with independent researchers, validated longitudinal indicators, and accessible participation by autistic clients.

CONCLUSION

In these two cases, successful progression appeared to arise from the interaction of preparation, gradual exposure, flexible pacing, individualised communication, sensory accommodation, family partnership, and accessible support for key workers. Because the study involved two purposively selected, ultimately successful cases from one service, these elements should be treated as analytically transferable propositions rather than universal requirements or estimates of effectiveness. The contrasting trajectories suggest that pauses, uncertainty, and divergent interpretations can be used as signals for joint review instead of being treated automatically as failure. For social-work practice, the findings support consideration of coordinated, revisable transition plans that integrate client autonomy, family knowledge, and staff capacity to seek support. Their applicability should be tested in larger, multisite studies including unsuccessful transitions and direct autistic participation.

Author contributions

B. Ježková: conceptualisation, methodology, investigation, data curation, formal analysis, and preparation of the original thesis. *A. Hricová:* supervision, methodological consultation, validation, and review and editing of the journal manuscript. Both authors contributed to the preparation of the article, approved the final manuscript, and accept responsibility for the published work.

Acknowledgements

The authors thank the participating caregivers and staff members for sharing their experiences. OpenAI ChatGPT was used to assist in condensing a Czech-language master's thesis into an English journal-manuscript structure and for language editing and reference-format support. The authors reviewed and verified the manuscript and take full responsibility for its content. The tool was not used to generate, analyse, or interpret raw research data.

Data availability

The qualitative materials and routine-care records are not publicly available because the small service population creates a substantial risk of re-identification. Any request for further information would be subject to participants' consent, data-protection requirements, and approval by the responsible organisation.

Conflict of interest

Blanka Ježková was employed as the manager and social worker of the study service during data collection. This dual role is disclosed as a potential non-financial competing interest. Alena Hricová declares no competing interests. Neither author declares a financial conflict of interest.

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Submitted: 2026-07-26 • Accepted: 2026-10-16 • Prepublished online: 2026-10-19
J Nurs Soc Stud Public Health Rehabil 17/3–4: xxx–xxx • EISSN 1804-7181 • ISSN 1804-1868
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