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SLEEP AND NEURODIVERGENCE · 12.4

Paediatric Sleep in ADHD: What Parents Can Actually Try

Sleep difficulty is one of the most common parental concerns in childhood ADHD, and one of the parts of the picture that has solid evidence-based interventions parents can actually deliver.

FOR
Parents of children with ADHD

AUDIENCE AGE
6-17

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PART OF
The NeuroFX resource library

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IN SUMMARY

Paediatric Sleep in ADHD: What Parents Can Actually Try

What the picture looks like

- **Real and measurable, not perceptual.** Cortese 2009 meta-analysis confirmed substantially worse sleep on both subjective and objective measures in children with ADHD versus controls. Sleep efficiency is often lower than time-in-bed suggests; what looks like nine hours functions as six.
- **Common patterns: long latency, night waking, morning exhaustion.** Bedtime resistance, protracted routine ending in conflict, child in bed but not asleep for an hour or more, multiple night wakings, school-day knock-on as worse attention and emotional regulation.
- **The bedtime conflict is often the family stressor itself.** Parents arrive exhausted and resentful, the child is wide awake at 10pm, and the next day everyone starts behind.

What parents can actually try

- **The Hiscock RCT is the evidence anchor.** The 2015 BMJ trial of a structured behavioural sleep intervention in children with ADHD reported improvement in sleep, ADHD symptoms and parental mental health, sustained at 12 months. Around 60 to 70 percent of children responded substantially.
- **Consistent age-appropriate bedtime and wake time.** Same across weekdays and weekends. A 7am wake-up needs an older child asleep by around 9pm, younger by 8pm. Work backward; bedtime starts 30 minutes earlier.
- **Predictable routine, same every night.** Same order, same duration. Predictability is doing real cognitive work; departures cost more than they look like they should.
- **Screens off at least one hour before bed.** Both the light and the cognitive engagement matter. Bedroom designed for sleep: cool, dark, low-stimulation, no TV.
- **Hold the line for weeks, not days.** Sleep behaviours take two to four weeks to shift. Inconsistency in week one resets the clock.

How we can help

- **GP or paediatrician for medication and sleep-disorder review.** If behavioural moves over four to six weeks have not shifted the picture, the conversation moves clinical. Paediatric obstructive sleep apnoea is substantially over-represented and often missed (Sedky 2014).
- **Medication timing review with the prescribing paediatrician.** Stimulant timing matters. Many parents notice sleep improves once medication is appropriately titrated because the bedtime experience is calmer.
- **SleepFX for structured support.** NeuroFX's sister product SleepFX is a structured paediatric sleep programme designed for neurodivergent children, drawing on the same RCT evidence base. The right next step where parent-led behavioural moves have not produced enough change.

WHEN TO SPEAK TO A PROFESSIONAL

Speak to your GP or paediatrician if behavioural sleep work over four to six weeks has not changed the picture, if your child shows daytime sleepiness or functional decline, if you suspect a specific sleep disorder (loud snoring with pauses, restless legs, very late natural sleep onset), or if the bedtime conflict has become a significant family stressor. NHS sleep medicine referral routes vary by region. NeuroFX offers paediatric ADHD assessment and prescribing where the NHS wait is not workable, and our SleepFX sister product offers a structured paediatric sleep programme for neurodivergent children.

SOURCES

Cortese 2009 JAACAP; Hiscock 2015 BMJ; Sciberras 2020 Psychol Med; Hvolby 2015; BNFc; NICE NG87; Sedky 2014

NEXT STEPS

Speak to NeuroFX

Private ADHD and autism assessment for adults and children aged 6 and upwards. CQC-registered. Bedford Consulting Rooms, 4 Goldington Road, Bedford MK40 3NF.

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