

SLEEP AND NEURODIVERGENCE · 12.5

Paediatric Sleep in Autism: Sensory and Routine Factors

Sleep difficulty affects 50 to 80 percent of autistic children. The biological mechanisms (melatonin synthesis, sensory hyperarousal, cognitive carry-over) are reasonably well-characterised, and most children improve with the right combination of sensory environment, predictable routine, and where appropriate, melatonin.

FOR

Parents of autistic children

AUDIENCE AGE

6-17

REVIEWED

18 May 2026

PART OF

The NeuroFX resource library

IN SUMMARY

Paediatric Sleep in Autism: Sensory and Routine Factors

What it looks like

- **Long latency, night waking, early waking, fragmented sleep.** Even when tired, falling asleep often takes much longer than 30 minutes. Night waking is often with full alertness around 3am or 4am; early waking at 5am is common.
- **Bedtime sensory friction is often the actual problem.** Specific textures, sounds, smells or light that have been fine for years suddenly become intolerable. The seam in the pyjamas, the radiator click, the streetlight outside the window.
- **School-day knock-on is significant.** Under-slept autistic children show up as worse sensory tolerance, more meltdowns, lower social capacity, more difficulty with school transitions.

What helps at home

- **Sensory audit is the highest-yield intervention.** Sound, light, touch (bedding texture, pyjama seams, duvet weight, weighted blanket where appropriate), temperature, smell. The Cuomo 2017 meta-synthesis confirms sensory-environmental modification is consistently the most effective non-pharmacological intervention.
- **Predictable routine, same order, every night.** Predictability is doing the work. Departures cost more than they look like they should. Visual schedules help many autistic children.
- **Longer wind-down than for typical-development children.** 60 to 90 minutes of low-stimulation time before bed. Transitions need scaffolding: five-minute warnings, a song that signals the next step.
- **Weekends and holidays matter more than you think.** The disruption of late weekend bedtimes often costs the whole following week. The same routine is more important for autistic children than for typical-development children.
- **Hold the line for weeks, not days.** Sleep behaviours take two to four weeks to shift. Consistency is the variable that produces the change.

How we can help

- **GP or paediatrician for the Slenyto conversation.** Slenyto (paediatric prolonged-release melatonin) is licensed in the UK for insomnia in autistic children aged 2 to 18 where sleep hygiene measures have been insufficient. Prescription-only; not available over the counter. Maras 2018 supports long-term use.
- **SleepFX for structured support.** NeuroFX's sister product SleepFX is a structured paediatric sleep programme designed for neurodivergent children. The right next step where parent-led work has not produced enough change.
- **Sleep medicine referral for the specific signs.** Snoring with pauses (sleep apnoea, over-represented in autistic children), restless legs, very late natural sleep onset, severe parasomnias, or significant daytime sleepiness all warrant GP referral.

WHEN TO SPEAK TO A PROFESSIONAL

Speak to your GP or paediatrician if the standard environmental and routine work has been genuinely tried for several weeks and the picture has not shifted, particularly if your child shows daytime sleepiness, severe bedtime distress, or signs of a specific sleep disorder (snoring with pauses, restless legs, very late onset, parasomnias). NeuroFX offers paediatric autism assessment where the diagnostic picture is not yet clear; SleepFX offers structured sleep-programme support for neurodivergent children.

SOURCES

Devnani & Hegde 2015; Cuomo 2017; Bruni 2018 JCPP; Maras 2018; NICE Slenyto; BNFC; NAS

NEXT STEPS**Speak to NeuroFX**

Private ADHD and autism assessment for adults and children aged 6 and upwards.
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