FASD and sleep

A guide for permanent and adoptive carers

Sleep difficulties are common in children and young people with FASD, and can affect the whole family. Your child may:

- have trouble falling asleep
- wake throughout the night
- have trouble getting back to sleep
- wake early.

Studies have found clinically significant sleep problems in 55–85% of children with FASD.

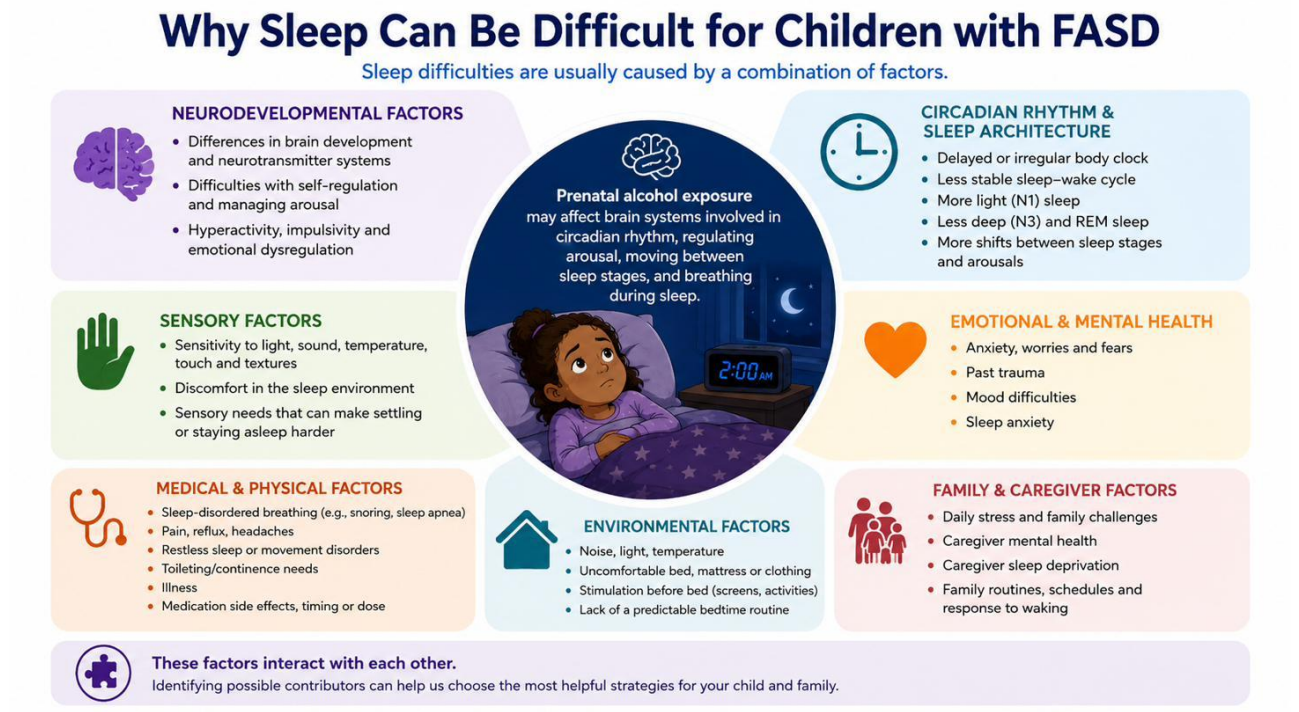
Why sleep can be difficult

Sleep difficulties in FASD are not necessarily caused by poor routines or inconsistent parenting.

Prenatal alcohol exposure may affect brain systems involved in:

- circadian rhythm – the body's sleep–wake cycle
- regulating arousal and moving between awake and asleep states
- the organisation of light, deep and REM sleep
- breathing during sleep.

Other contributors may include sensory sensitivities, anxiety, trauma, pain or health conditions, medication effects and the sleep environment. Daily events and family stress can also interact with sleep, while ongoing sleep disruption increases stress for the whole family.



On average, children with FASD sleep less, and less efficiently, than other children:

- other children sleep around 8 hours a night, and are asleep for about 80% of the time they spend in bed
- children with FASD sleep around 7 hours a night, and are asleep for about 68% of the time in bed, with more light sleep and less deep or REM sleep.

> *Time in bed is not always the same as time asleep. Some children with FASD obtain less sleep, and more fragmented sleep, even when they spend an appropriate amount of time in bed.*

Limitations of typical sleep strategies

Standard sleep advice can help, but it has limits for children with FASD:

- there can be a biological basis for poor sleep, and even with sleep, some children do not wake feeling rested
- shifting from a preferred activity to getting ready for bed can be difficult
- a routine may suddenly stop working once the child becomes bored of it
- attempts to reinforce a bedtime routine can increase arousal or lead to conflict
- a child may get stuck thinking about something, which interferes with getting to sleep.

General good sleep hygiene

Simple routines and environmental supports can improve sleep for many children. They are a helpful foundation, though persistent FASD-related sleep difficulties may need further assessment.

Some strategies that may help children with FASD:

- keeping the same bedtime during holidays
- some children need the room dark; others prefer a nightlight
- audiobooks, white noise, music or meditation, set on a timer or controlled by the carer using a Bluetooth speaker
- speaking to a doctor about medication such as melatonin.

Tracking sleep

A doctor's review of your child's sleep will often start with sleep tracking. Recording sleep, behaviours, medication and possible triggers helps clinicians see patterns and review the effects of medication. This can be hard for busy, tired carers to keep up.

It can help to keep a sleep diary for two to four weeks, recording:

- bedtime and estimated time asleep
- waking during the night
- early morning waking
- naps
- medication
- illness, pain or continence concerns
- unusual behaviours or events during sleep.

Difficulty falling asleep

The child may take a long time to settle, become increasingly active or distressed at bedtime, repeatedly leave the room or say they are not tired.

Helpful strategies may include:

- keeping bedtime and morning waking times reasonably consistent
- using a short visual bedtime routine
- completing stimulating tasks, such as showering and toothbrushing, earlier
- placing quiet, familiar activities closer to bedtime
- reducing stimulating screen use before bed
- checking lighting, noise, temperature, bedding and clothing
- reducing questions, instructions and negotiation once the routine begins
- addressing specific worries or fears
- reviewing the timing and possible side effects of medication with a clinician.

Difficulty staying asleep

The child may wake repeatedly, stay awake for long periods, move around the house or seek food, screens or interaction.

Consider whether waking may be related to:

- pain, reflux or illness
- toileting or continence needs
- sensory discomfort
- anxiety or trauma-related arousal
- restless sleep or unusual movements
- medication effects
- snoring or breathing difficulties.

When the child is genuinely awake, a low-arousal approach can help:

- keep lighting dim
- keep verbal interaction calm and minimal
- respond in a predictable way, and avoid arguing, correction or consequences for being awake
- offer one or two safe, quiet activities
- keep clear limits around unsafe or highly stimulating activities
- protect other family members' sleep where possible
- return to the sleep routine when the child begins to appear sleepy.

> *Sometimes the immediate goal is not to make the child sleep. It is to manage wakefulness safely and calmly while giving sleep the best opportunity to return.*

When a young person cannot get off devices at night

Devices may be doing more than providing entertainment. They may help a young person:

- regulate anxiety or uncomfortable feelings
- avoid lying awake with nothing to do
- connect with friends
- manage boredom during long periods of wakefulness
- block out noise, thoughts or sensory discomfort
- follow a habit that has become difficult to interrupt.

For young people with FASD, stopping may also require shifting attention, judging time, remembering an agreement and resisting an immediate reward, all of which can be harder when tired.

What might help:

- agree on a realistic night-time plan before bedtime
- reduce stimulation rather than expecting an immediate switch-off
- use device settings such as dim light, reduced volume, notifications off and restricted apps
- offer a quieter alternative activity that meets the same need
- use external cues, such as timers, visual prompts or automatic Wi-Fi and device settings
- keep instructions brief and avoid arguing late at night
- focus first on safety, sleep and not disturbing others.

Early morning waking

Where the child regularly wakes very early and cannot return to sleep:

- use an agreed "morning starts" cue, rather than relying on the child to judge the time
- keep the environment quiet and dim before that time
- provide safe, low-demand activities

- review whether early light or household noise is contributing
- record the pattern in a sleep diary
- seek clinical advice where a circadian rhythm problem is suspected
- adjust daytime expectations following a very early start.

Early waking can have a substantial effect on caregiver wellbeing and family functioning.

Sensory needs

Noise, light, temperature, bedding, clothing or internal body sensations may interfere with sleep. Sensory strategies need to be individualised, as something that calms one child may be uncomfortable or alerting for another. Trial one change at a time and note whether it makes a difference. An occupational therapist can help identify sensory factors and support carers to trial and review strategies.

Other sleep difficulties

Some children experience other sleep difficulties, including:

- nightmares
- sleep talking
- unusual night-time behaviour
- snoring or noisy breathing
- sweating or very restless sleep
- morning headaches.

Persistent symptoms need to be reviewed by a GP or paediatrician, with possible referral for a sleep study.

GPs and paediatricians can:

- assess sleep and breathing difficulties
- prescribe melatonin or other medications
- refer to specialist sleep clinics.

Melatonin may help some children, particularly where there is difficulty falling asleep or a circadian rhythm problem. Timing and formulation matter, and it should be prescribed and reviewed by an experienced clinician.

Support from allied health

Allied health providers, such as occupational therapists, can:

- help carers work out which activities help their child wind down
- trial sensory strategies, including bedding, clothing, light and temperature
- work on routines, visual schedules and strategies to manage wakefulness
- advocate for carers, and provide evidence of the impact of sleep difficulties on family life.

Sleep and daytime behaviour

Tiredness in children with FASD may not look like lying down or appearing sleepy. It may look like:

- increased activity
- impulsivity
- irritability
- anxiety

- aggression or emotional intensity
- reduced tolerance of ordinary demands
- greater difficulty with attention, memory and regulation.

Sleep difficulties have been associated with emotional problems, conduct difficulties, aggression and disruptive behaviour, attention and executive functioning difficulties, and daytime sleepiness. The relationship is likely to work in both directions: FASD-related regulation difficulties can interfere with sleep, while insufficient or fragmented sleep can further reduce a child's capacity to cope.

Supporting carers and families

Sleep disruption affects the whole family. Carers have described the toll of repeated sleep loss: functioning like a "zombie", having no time for themselves, and managing severe daytime behaviour after very little sleep. Professionals have identified sleep disruption as a major reason families seek respite, and as a factor that reduces coping and places family stability at risk.

You may be doing everything possible and the child may still have ongoing sleep difficulties. When sleep cannot be fully resolved, useful goals may include:

- keeping the child safe
- reducing distress and conflict
- helping the child remain quiet during periods of wakefulness
- protecting the sleep of other family members
- arranging practical support or respite
- adjusting expectations after a disrupted night.

What carers can do:

- recognise that some factors may not respond to typical sleep strategies
- encourage the professionals around your child to read about FASD and sleep
- work with allied health providers to try different strategies
- keep track of sleep difficulties
- reduce expectations when your child is tired
- consult your GP or paediatrician
- talk to other carers, and seek support from NOFASD.

> *The aim is not perfect sleep every night. It is to understand the problem, address what can be changed and reduce its effect on the child and family.*

Further Reading

- FASD Hub Fact Sheet for health professionals: Sleep problems among children with FASD
- How to manage sleep problems in children with FASD
- Webinar: Sleep in Children with FASD

Journal articles to share with health providers

- Gale et al (2025) Sleep disturbance in children with prenatal alcohol exposure: a systematic review and meta-analysis
- O'Rourke et al (2024) Sleep Disturbance in Children with Fetal Alcohol Spectrum Disorder and the Relationship to the Neurodevelopmental Profile
- Ipsiroglu et al (2012) "They silently live in terror…" why sleep problems and night-time related quality-of-life are missed in children with a fetal alcohol spectrum disorder
- Hayes et al (2020) Parent-reported sleep problems in school-aged children with fetal alcohol spectrum disorder

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