

Sleep Difficulties, Bedtime and Restful Nights

A detailed parent guide for looking beyond 'won't go to sleep' and understanding the many reasons an ADHD child may struggle to settle, stay asleep, wake well and function the next day.

Sleep difficulties are common in families living with ADHD, but there is no single ADHD sleep problem. One child may be physically tired but mentally alert. Another may resist the transition away from an absorbing activity. Another may fall asleep but wake repeatedly. Anxiety, sensory needs, restless legs, breathing problems, medication timing, inconsistent routines, delayed body-clock patterns and other health conditions can also affect sleep.

This means that simply making bedtime stricter may miss the problem. Good sleep support begins with noticing the pattern: when difficulty starts, what the child's body is doing, what happens overnight and how the next day is affected. A routine can help, but persistent sleep difficulties deserve individual attention rather than being dismissed as behaviour.

Different sleep difficulties need different questions

Pattern	What parents may notice	Questions worth exploring
Difficulty falling asleep	Child lies awake, talks, moves, asks repeated questions or says their brain will not stop.	Is bedtime aligned with actual sleepiness? Is there anxiety, stimulation, discomfort or difficulty switching activity?
Repeated waking	Child wakes several times or needs an adult repeatedly to return to sleep.	Is there noise, temperature, pain, nightmares, breathing difficulty, hunger or a sleep association involved?
Very late sleep pattern	Child seems naturally alert late at night and extremely difficult to wake in the morning.	Is the sleep-wake rhythm consistently shifted later? Discuss persistent patterns with an appropriate clinician.
Restless sleep	Constant movement, kicking, unsettled sleep or complaints about uncomfortable legs.	Record the pattern and seek medical advice if persistent; physical causes should not be assumed to be ADHD.
Morning exhaustion	Irritability, slow waking, headaches, falling asleep in daytime or major difficulty functioning.	Look at sleep quantity and quality, not only bedtime behaviour.

Sleep starts before the child gets into bed

A child cannot always move from high stimulation, conflict, homework or gaming directly into sleep. Think of bedtime as a runway rather than a switch. A predictable reduction in demands, light, noise and stimulation can help the body recognise that the active part of the day is ending. Keep the sequence short enough that the family can sustain it.

The difference between 'bedtime' and 'sleep time'

If a child is routinely put to bed long before they are physiologically ready to sleep, bed can become associated with frustration and conflict. Keep a simple record of when the child gets into bed and when they appear to fall asleep. Persistent difficulty should be discussed with a health professional rather than solved by continually moving bedtime without guidance.

What may be keeping the brain and body awake?

Parents often see only the final behaviour - calling out, getting up, refusing to lie down - while the child may be experiencing several overlapping barriers. Looking at the whole picture can reveal support that is more useful than another reminder to sleep.

Busy thoughts and anxiety	Worries often become louder when the day becomes quiet. Use a short check-in earlier in the evening and a 'tomorrow list' for thoughts that do not need solving tonight.
Sensory discomfort	Check bedding texture, seams, temperature, light, household noise, smells, clothing and whether the child prefers particular pressure or space.
Difficulty stopping	An absorbing activity can create a hard transition. Agree the endpoint beforehand and use warnings connected to a natural stopping point rather than only a clock.
Need for connection	Some children repeatedly seek a parent because separation, worry or accumulated stress appears at bedtime. Build a predictable connection point into the routine.

Night waking

When a child wakes, notice what they need in order to return to sleep. Is it reassurance, a drink, the toilet, help after a nightmare, relief from discomfort or the recreation of the same conditions present when they first fell asleep? Keep responses low-key and predictable where possible. Frequent waking, pain, breathing concerns or major daytime consequences should be medically reviewed.

Snoring, breathing and sleep quality

Sleep can be long enough in hours and still be poor in quality. Loud or persistent snoring, gasping, pauses in breathing, unusual sleeping positions, marked daytime sleepiness or morning headaches are reasons to seek medical advice. Do not assume tiredness and concentration problems are simply ADHD when sleep quality may be contributing.

Restlessness and physical discomfort

If a child describes uncomfortable legs, an urge to move, persistent restlessness, pain, itching, reflux or other physical symptoms, record what happens and discuss it with a clinician. Avoid starting supplements or medication for a suspected cause without appropriate individual advice.

Medication deserves an individual conversation

ADHD medication can interact with sleep in different ways. If sleep changed after medication was started, stopped, adjusted or taken at a different time, record the pattern and discuss it with the prescriber. Do not alter prescribed medication based on a general resource.

Screens: relevant, but not the whole explanation

Late or highly engaging screen use can reduce sleep opportunity and make stopping harder. A predictable device-down point may help. But removing screens will not treat anxiety, breathing difficulties, pain, sensory discomfort or a persistent sleep disorder. If sleep remains difficult, keep looking.

A practical bedtime and night-time framework

The best routine is one the family can repeat without turning the evening into a long list of demands. Start with a few anchors and adjust according to the child's age, needs and professional advice.

1. Daytime foundations	Notice wake time, daylight exposure, movement, naps where relevant, meals and how tiredness presents across the day.
2. Transition cue	Use the same broad signal that active time is ending: a time cue, lights changing, a familiar phrase or the end of a particular activity.
3. Short routine	Keep washing, teeth, clothes, toilet, medication if prescribed as directed, and calming activity in a predictable order.
4. Sensory check	Make the room and clothing as comfortable as reasonably possible. Ask the child what they notice rather than assuming.
5. Thought parking	Write worries, reminders and ideas somewhere safe for tomorrow so bedtime does not become a planning meeting.
6. Night response	Keep necessary support calm, brief and predictable while responding appropriately to fear, illness, pain or safety needs.
7. Morning information	Notice how the child wakes and functions. The morning can tell you important things about the quality of the night.

When bedtime has become a battleground

If parent and child are both arriving at bedtime expecting conflict, change the goal from 'make sleep happen' to 'make the route to rest calmer and more predictable'. Reduce unnecessary negotiation, decide boundaries earlier in the day, and avoid lengthy teaching during escalation. Once the pattern is calmer, you can evaluate what still needs clinical or practical support.

Protecting parents too

Sleep difficulties can leave parents chronically depleted. If there is another safe caregiver, share predictable parts of the routine or night response where possible. Keep the routine sustainable and seek help when the family's sleep is persistently affecting health, functioning or safety. Parents do not have to prove that they can manage severe sleep disruption alone.

Do not measure success only by 'slept perfectly'

Useful progress might be fewer arguments, a shorter settling period, the child recognising a body cue, less anxiety about bedtime, fewer prolonged wakings, better morning functioning or clearer information to take to a clinician. Sleep support often improves through pattern recognition and gradual adjustment rather than one dramatic change.

Sleep Pattern and Support Plan

Use this for one to two weeks if helpful. It is not a diagnostic tool. Its purpose is to help you see patterns and provide clearer information if you need professional support.

Usual wake time	_____
Daytime tiredness, naps or energy changes	_____
When the wind-down begins	_____
When the child gets into bed	_____
Approximate time they actually fall asleep	_____
What happens in the hour before bed	_____
Main difficulty at bedtime	_____
Any night waking - time and what happened	_____
Snoring, breathing, movement or physical discomfort noticed	_____
What helps the child settle or resettle	_____
Medication timing or recent changes to discuss with prescriber	_____
How the child feels and functions the next morning	_____
What we changed and whether it helped	_____
What we want to ask the GP/prescriber/other professional	_____

When to seek medical or professional advice

Seek advice when sleep problems are persistent, severe or substantially affecting the child's daytime functioning or family life. Discuss concerns such as loud persistent snoring, gasping or breathing pauses, significant daytime sleepiness, unusual movements, persistent leg discomfort, pain, major anxiety, frequent nightmares, medication-related changes or a markedly shifted sleep pattern. Seek urgent medical help for acute breathing difficulty or another immediate health emergency.

A message for parents

A child who cannot sleep is not necessarily a child who will not sleep. The behaviour you see at 10 p.m. may be the surface of a body clock, a busy mind, sensory discomfort, anxiety, physical symptoms or an exhausted nervous system that is struggling to change state. Calm routines matter, but so does curiosity. If the usual advice is not working, that is a reason to look more closely - not simply to blame yourself or your child.

Further reading and guidance

Useful starting points include NHS sleep information, NHS ADHD information, NICE guideline NG87 and ADHD Foundation resources. Persistent or concerning sleep problems should be discussed with an appropriate health professional. This resource is educational and does not replace individual medical, psychological, educational or safeguarding advice.

Space to Breathe Therapy

ADHD Parent Support Series - Part 20