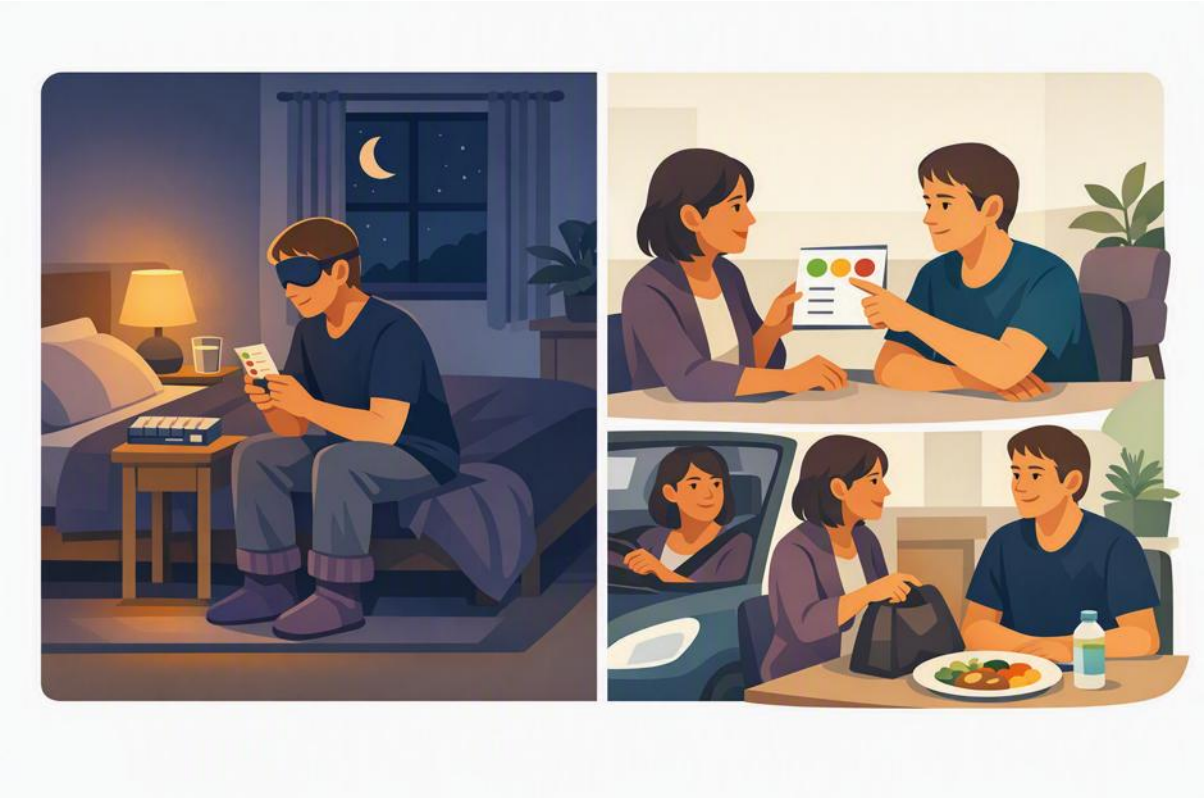
Building an FASD-Informed Sleep Plan

A practical guide to sleep, daytime capacity and consistent support



FASD-INFORMED PRACTICE GUIDE

Predictable routines • Sensory safety • Co-regulation • Capacity-responsive support

Contents

Why sleep matters: Restorative sleep is essential for brain development, learning, memory, attention, regulation, sensory processing, physical health and emotional recovery. Sleep difficulties appear to be common in people with known or likely prenatal alcohol exposure, including those with confirmed or suspected Fetal Alcohol Spectrum Disorder (FASD), and poor sleep may further reduce executive functioning and daytime capacity. A person may therefore need more support after disrupted sleep - not more pressure, blame or an assumption that the difficulty is deliberate.

How to use this plan: Complete it with the person and, where appropriate, their family, carers, education or placement staff and relevant health professionals. Record the person's usual sleep pattern, individual signs of fatigue, possible

contributors, supports that help and the adjustments needed the following day. Agree a simple way to share current capacity, name who will activate each response and review the record regularly for patterns. Use it as a practical communication and support tool - not as a diagnostic checklist, a way to police bedtime or a substitute for medical assessment. Persistent or concerning sleep difficulties should be discussed with an appropriately qualified health professional.

Understanding FASD Severity

FASD is a lifelong neurodevelopmental condition that can have severe and far-reaching effects on brain and body development, functional capacity and everyday life. It may affect learning, memory, attention, processing, communication, executive functioning, emotional regulation, sensory processing, impulse control, adaptive functioning, health, safety and independence.

Severity and presentation vary between individuals and across settings. A person may have strengths, fluent speech or periods of apparent independence while still experiencing substantial difficulty with judgement, sequencing, working memory, regulation, risk awareness and daily living. Needs are not always visible, and capability on one occasion does not establish consistent capacity.

Sleep debt, stress, illness, sensory load, transitions and unfamiliar demands can further reduce functional capacity. Support should therefore be based on assessed and evidenced need, reviewed across time and environments, and adjusted to the person's current capacity rather than reduced because of age, appearance, behaviour, verbal ability or one successful day.

Severity principle: *FASD should never be minimised because difficulties are inconsistent or hidden. The right environment, skilled support and reasonable adjustments can improve participation and safety, but they do not remove the underlying lifelong neurodevelopmental need.*

Understanding FASD Sleep Debt and Capacity

Sleep debt can quietly reduce capacity long before adults recognise what is happening.

In FASD, tiredness may affect regulation, attention, memory, processing, sensory tolerance, impulse control, transitions and emotional recovery—changing what a child, young person or adult can manage today. They may appear more reactive, avoidant, forgetful, distressed or unable to cope when their brain and body are carrying sleep debt.

Sleep debt can build quietly over days or weeks, particularly with broken sleep, late settling, early waking, nightmares, sensory discomfort, anxiety or difficulty switching

off. Looking beyond behaviour and asking about sleep and recovery first helps adults adjust support before increasing demand.

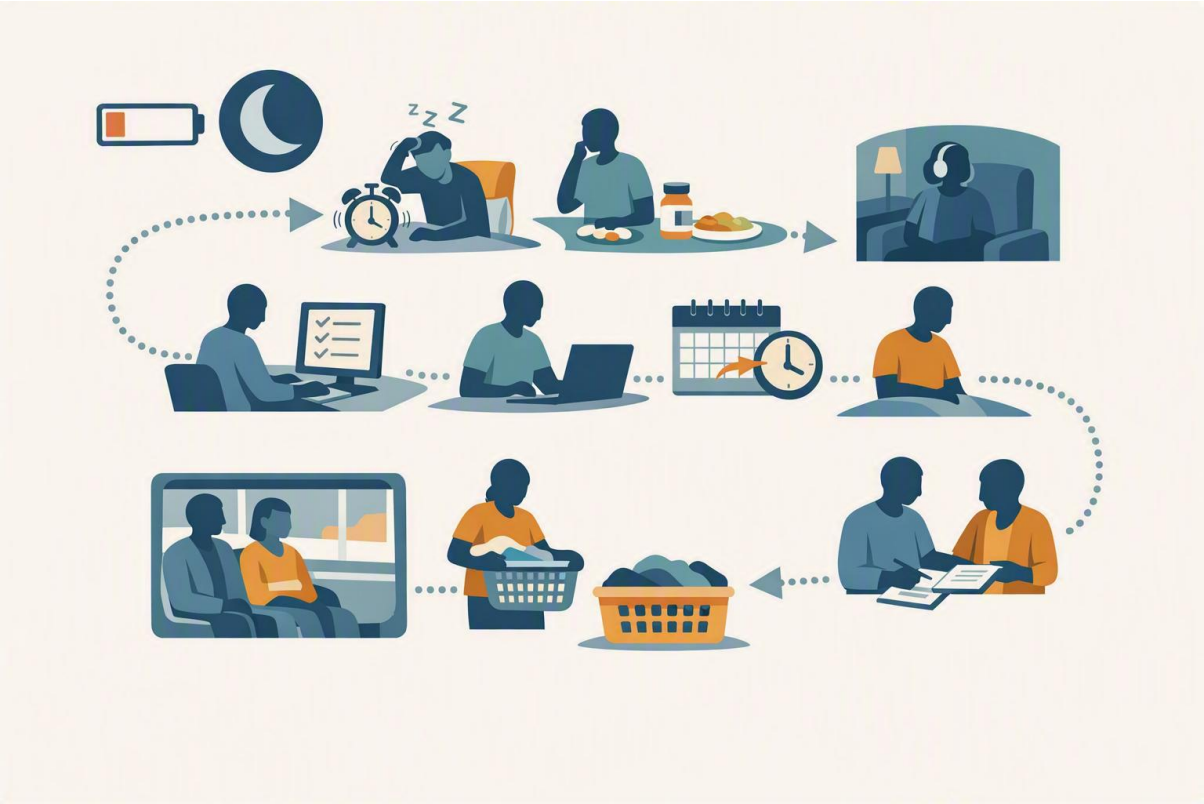
Across the lifespan: These principles apply to children, young people and adults. Support should reflect the person's current functional capacity rather than their age or apparent independence.

Recovery principle: Recovery from accumulated sleep debt may take time. Expectations should not automatically return to normal after one improved night.

This is not poor motivation, a bad attitude or deliberate non-compliance. It is a brain-based and body-based support need.

Medical advice and melatonin: *A study of children and adolescents with FASD identified abnormal melatonin secretion profiles in many participants, suggesting that circadian regulation may be disrupted.*

Persistent sleep difficulty should be medically assessed rather than assumed to be behavioural.



Adult-focused FASD-informed sleep support: predictable night-time routines and respectful daytime scaffolding can protect dignity, autonomy, safety and recovery when sleep debt reduces capacity.

Sleep Debt in Adults with FASD

For adults with FASD, sleep debt may be overlooked because the person is expected to manage routines, work, appointments, money, travel, relationships and household tasks independently. An adult may also keep going while tired or have difficulty noticing, interpreting or communicating fatigue until capacity has fallen significantly. Sleep loss can further affect executive functioning, including starting tasks, planning, working memory, judgement, emotional regulation and switching between activities.

- **Possible signs:** difficulty waking, missed medication or meals, repeated questions, losing track of steps, slower processing, reduced tolerance of noise or change, impulsive decisions, withdrawal, conflict, increased anxiety or being unable to begin familiar tasks.
- **Daily living:** simplify the day, use one-step prompts, prepare food and clothing, reduce decisions, postpone non-essential administration and provide practical help with sequencing rather than assuming the adult is unwilling.
- **Work, training and appointments:** consider later starts, reduced workload, written prompts, fewer transitions, quiet recovery time, remote access or rescheduling. Capacity may vary even when skills and motivation have not changed.
- **Safety:** review driving, independent travel, cooking, medication, financial decisions, caring responsibilities, machinery and lone working when alertness or judgement is reduced. A safer plan may require temporary support, accompaniment or postponement.
- **Recovery:** avoid expecting full performance after one improved night. Maintain adjustments until the adult's functional capacity - not just the clock or timetable - shows meaningful recovery.
- **Health review:** encourage appropriate clinical advice where poor sleep is persistent, daytime sleepiness is significant, or there is loud snoring, breathing pauses, unusual movements, pain, restless legs, marked changes after medication, or falling asleep during daily activities.

Adult-centred principle: Support should preserve dignity and choice while recognising that apparent independence does not remove the need for scaffolding. Agree in advance who the adult wants involved, what may be shared, and which adjustments can be activated without requiring repeated explanation when capacity is low.

Level of support: Some adults may be assessed as needing constant support and supervision to maintain safety, meet daily living needs, manage health or medication, and participate in home, community, education or work settings. This should be based on evidenced functional need, reviewed collaboratively, and provided in the least restrictive way that preserves dignity, choice and involvement in decisions.

Practical action: *Ask how sleep, fatigue and recovery are affecting capacity today before increasing demands, expecting emotional regulation or interpreting behaviour as intentional.*

- **Current sleep pattern:** usual settling time, waking time, night waking, early waking, naps and differences between weekdays, weekends and holidays.
- **Communication and observation:** how the person shows tiredness, discomfort, pain, anxiety or reduced capacity when they cannot explain this reliably.
- **Possible contributing factors:** sensory needs, temperature, light, noise, bedding, hunger, pain, nightmares, anxiety, transitions, routines, physical health and medication.
- **What helps:** predictable wind-down routines, visual or practical prompts, reduced language, sensory adjustments, calming activities, reassurance, co-regulation and preferred sleep supports.
- **Low-capacity day adjustments:** later or slower starts, reduced demands, fewer transitions, recovery time, adapted attendance, quiet spaces and additional adult support.
- **Safety planning:** supervision or postponement of travel, road use, cooking, medication, machinery, practical placements and other safety-critical tasks when alertness or judgement is reduced.
- **Home, education and placement communication:** what information should be shared, with consent where appropriate, who records it and who is responsible for activating agreed adjustments.
- **Health advice:** when persistent sleep difficulties, breathing concerns, pain, medication effects, unusual movements or significant daytime sleepiness should be discussed with an appropriate health professional.
- **Recovery:** recognition that accumulated sleep debt may take more than one improved night to resolve, with support increased or reduced according to functional capacity.
- **Review and evidence:** patterns over time, adjustments tried, what improved safety or participation, the person's and family's views, named responsibilities and an agreed review date.

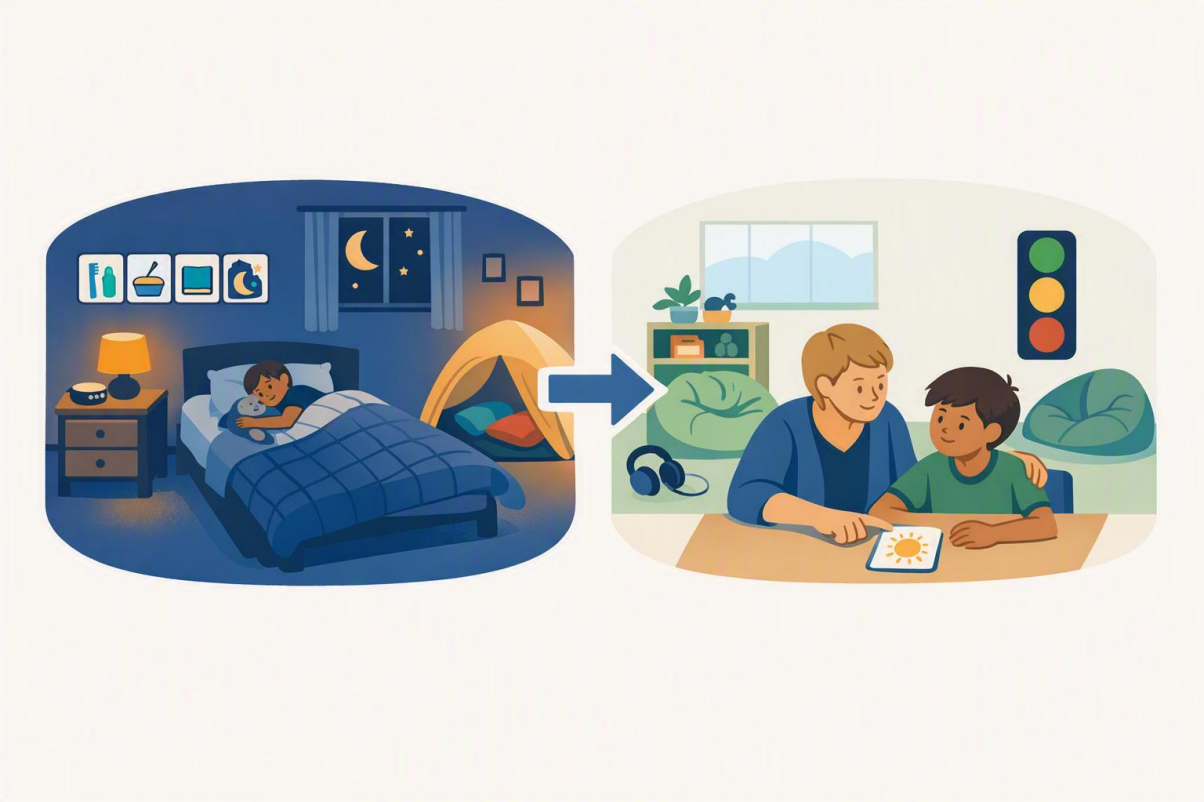
Tips to Reduce Sleep Debt

Use these as flexible supports, not rigid rules. Choose one or two changes at a time, adapt them to sensory and communication needs, and keep what genuinely improves settling, sleep quality or recovery.

- **Keep daily anchors predictable:** Aim for broadly similar waking, meal, medication, activity and wind-down times, including weekends, while allowing flexibility when rigidity increases distress.

- **Use morning light and daytime movement:** Offer daylight and suitable activity earlier in the day to support the body clock. Match activity to current capacity and avoid highly stimulating exercise close to bedtime.
- **Protect a low-arousal wind-down:** Use the same short sequence each evening, with dimmer light, reduced language, familiar activities and fewer decisions. Where possible, reduce stimulating screen use before bed.
- **Make the sleep environment sensory-safe:** Review light, noise, room temperature, bedding, clothing, smells, door position and white noise. Individual preference matters more than a standard bedroom rule.
- **Plan food and drinks:** Avoid going to bed very hungry or uncomfortably full. If appropriate, offer a familiar light snack and reduce caffeine later in the day, including tea, coffee, cola and energy drinks.
- **Externalise worries and tomorrow's tasks:** Use a brief written or visual plan before bedtime so the person does not need to hold reminders, changes or concerns in working memory overnight.
- **Respond consistently to night waking:** Keep lighting low, language brief and reassurance familiar. Avoid introducing new choices, lengthy explanations or problem-solving unless safety requires it.
- **Prevent further overload after poor sleep:** Reduce non-essential demands, transitions and sensory load the next day. A slower pace and planned recovery can help prevent another highly activated evening.
- **Avoid trying to "catch up" through pressure:** Recovery may take several nights. Maintain helpful adjustments until functional capacity improves rather than expecting an immediate return to the usual routine after one better night.
- **Track patterns without blame:** Briefly record settling, waking, naps, pain or discomfort, medication timing, environmental changes and daytime capacity. Review what helped before adding more strategies.
- **Seek health advice when concerns persist:** Discuss ongoing sleep difficulty, marked daytime sleepiness, loud snoring, breathing pauses, unusual movements, restless legs, pain or possible medication effects with an appropriately qualified health professional. Do not start, stop or change sleep medication without clinical advice.

FASD-informed reminder: *The aim is not to make the person "try harder" to sleep. Adults should reduce barriers, provide co-regulation and adjust daytime expectations while the brain and body recover.*



Child-focused FASD-informed sleep support: predictable routines, sensory safety, co-regulation and capacity-matched adjustments can reduce overload after disrupted sleep.

Tips for Managing Sleep Debt in Children with FASD

When a child is carrying sleep debt, focus first on safety, co-regulation and reducing load. The aim is not to make the child push through tiredness, but to prevent further overload while the brain and body recover.

- **Learn the child's early signs:** Notice individual changes such as repeated questions, louder speech, tearfulness, silliness, pacing, slower responses, sensory distress, refusal or difficulty beginning a familiar task. Respond before the child reaches crisis.
- **Make the morning smaller:** Use a slower start, fewer words and choices, familiar food, one instruction at a time and extra practical help with washing, dressing, medication and packing. Flexible or later arrival may be more supportive than rushing.
- **Use a simple capacity signal:** Agree a green, amber or red update with the child, family and school. Adults should activate the matching support without requiring the child to repeatedly explain or prove tiredness.
- **Reduce demands without removing connection:** Postpone non-essential homework, chores, outings and difficult conversations, while maintaining calm adult presence, predictable care and opportunities for low-pressure participation.
- **Protect after-school recovery:** Offer a drink, familiar snack, quiet or sensory space and a period without questions or demands. Allow the child to regulate before expecting conversation, homework or transitions.

- **Keep the wind-down short and predictable:** Repeat the same manageable sequence each evening using visual cues, dimmer light, familiar activities, reduced language and a consistent bedtime phrase. Introduce changes gradually rather than all at once.
- **Match the environment to sensory needs:** Check light, noise, temperature, bedding, clothing, smells, door position and comfort items. A night-light, familiar audio or white noise may help some children; individual response should guide the plan.
- **Respond calmly to night waking:** Keep lighting low, language brief and reassurance familiar. Avoid arguments, lengthy explanations or new choices unless safety requires them.
- **Avoid using sleep as a battleground:** Do not shame, punish or repeatedly warn the child about not sleeping. Supporting regulation and reducing barriers is more useful than increasing pressure.
- **Adjust school expectations:** On low-capacity days, consider flexible arrival, a trusted-adult check-in, reduced written and verbal load, fewer transitions, quiet recovery time, movement breaks and postponement of tests or safety-critical practical activities.
- **Review daytime safety:** Provide closer supervision for road use, cooking, bathing, medication, swimming, climbing, cycling, online activity and other tasks when alertness, impulse control or judgement is reduced.
- **Allow recovery to take time:** Maintain helpful adjustments across several days if needed. One better night does not always restore regulation, processing, memory or sensory tolerance immediately.
- **Keep a brief, non-blaming record:** Note settling, waking, early waking, naps, pain or discomfort, medication timing, sensory factors and daytime capacity. Use the record to identify patterns and helpful supports—not to police bedtime.
- **Seek clinical advice for persistent or concerning signs:** Discuss ongoing sleep difficulty, marked daytime sleepiness, loud snoring, breathing pauses, unusual movements, pain, restless legs or possible medication effects with an appropriately qualified health professional. Do not start, stop or change sleep medication without clinical advice.

Child-centred reminder: *What looks like refusal or difficult behaviour may be a sign that the child's capacity has fallen. Change the environment, pace and adult support before increasing consequences or expectations.*

Sleep Debt: Examples for Parents, Carers and Professionals

Morning example: A child, young person or adult who had broken sleep may need a slower start, reduced language, fewer choices and extra co-regulation before school, college, placement, work or daily expectations begin.

It is okay to be late - understanding capacity matters more than keeping pace.

Home example: After several nights of poor sleep, the family may use a minimum-demand day with simple food, familiar routines, reduced outings and more regulation support.

Health signpost: Persistent or severe sleep difficulties should be discussed with an appropriate health professional. Seek advice particularly where there is loud snoring, pauses or difficulty in breathing, unusual movements during sleep, ongoing pain, medication concerns or significant daytime sleepiness. These signs should not be assumed to be part of FASD without further assessment.

Immediate-safety example: When sleep debt reduces alertness, memory, judgement or impulse control, additional support may be needed around travel and road safety, cooking, medication, machinery, practical placements and other safety-critical activities. A task may need to be paused, supervised or rescheduled rather than completed at the usual pace.

Practical Examples for Completing the Sleep Plan

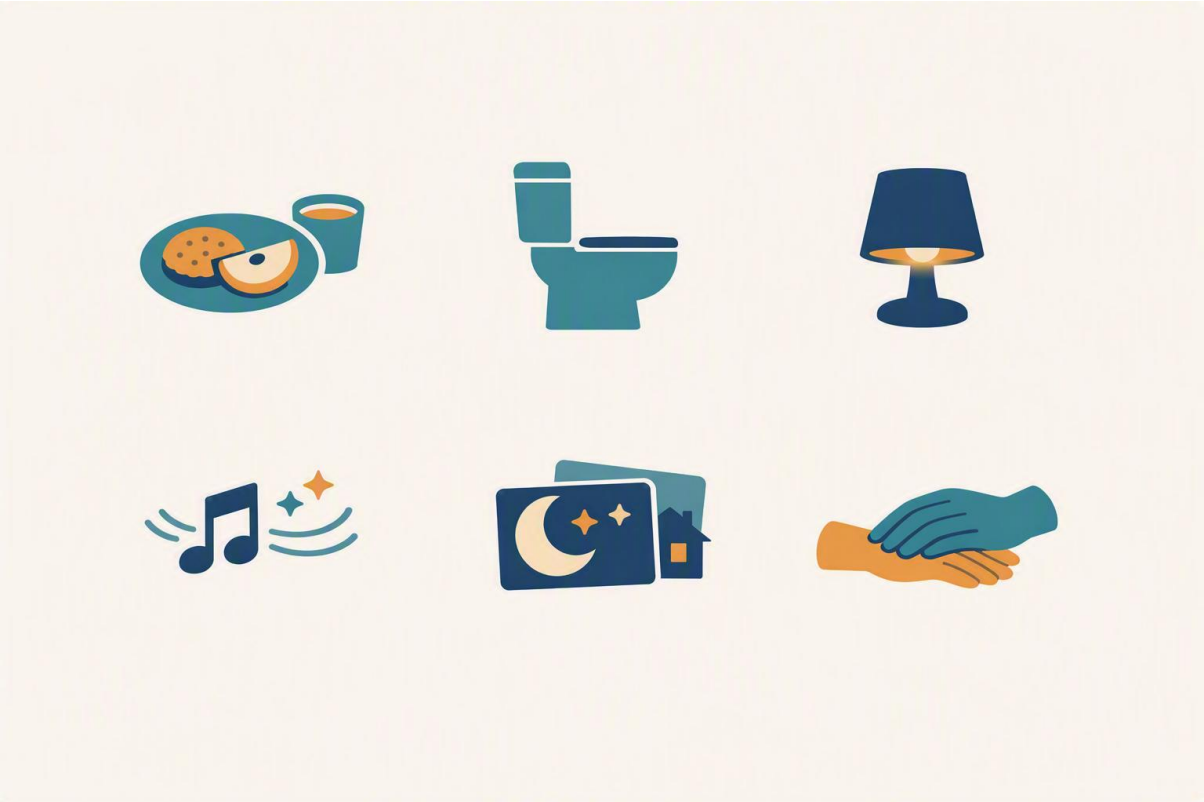


Figure 2. A short, repeatable bedtime sequence can reduce processing demands and support safer settling.

- **Current sleep pattern:** “Usually settles between 10.30 and 11.30 pm with an adult nearby, wakes twice most nights and is often awake before 5.30 am. Capacity is usually lower after two disrupted nights.”
- **Communication and observation:** “Tiredness may show as repeated questions, louder speech, tearfulness, pacing, slower responses or saying ‘no’ to familiar tasks rather than saying ‘I am tired’.”

- **Possible contributing factors:** “Sleep is more difficult after a late transition, a noisy evening, physical discomfort, an unexpected change or a day with high sensory and social demand.”
- **What helps at night:** “Use the same short wind-down sequence: snack, toilet, low lighting, familiar audio, visual ‘sleep’ cue and one calm repeatable phrase. Keep questions and explanations brief.”
- **Low-capacity morning:** “If sleep was broken, offer a slower start, simple breakfast, one instruction at a time and flexible arrival. Delay non-essential tasks until the person has settled.”
- **School, college or placement adjustment:** “On a red-fatigue day, reduce written or practical workload, provide a quiet recovery space and familiar adult check-in, and reschedule safety-critical activities.”

College or supported internship example: A young person arriving after broken or insufficient sleep may need a later or slower start, fewer instructions, reduced travel or placement demands, a quiet recovery space, additional job-coach support and flexibility to pause or reschedule higher-risk practical tasks. Tiredness-related reduced capacity should not be interpreted as poor motivation or lack of commitment.

- **Safety plan:** “If alertness or judgement is noticeably reduced, an adult supervises medication, cooking, travel and road use. Machinery or higher-risk placement tasks are paused and rearranged.”
- **Communication example:** “Home sends a simple green, amber or red capacity update by an agreed time. The named member of staff activates the matching adjustments without asking the person to repeatedly explain.”
- **Health escalation:** “Seek appropriate health advice if loud snoring, breathing pauses, unusual sleep movements, ongoing pain, medication concerns or significant daytime sleepiness are noticed or recorded.”
- **Recovery and review:** “Maintain reduced demands until functional capacity improves, rather than ending support after one better night. Review the record fortnightly to identify patterns, helpful adjustments and actions for the named adults.”

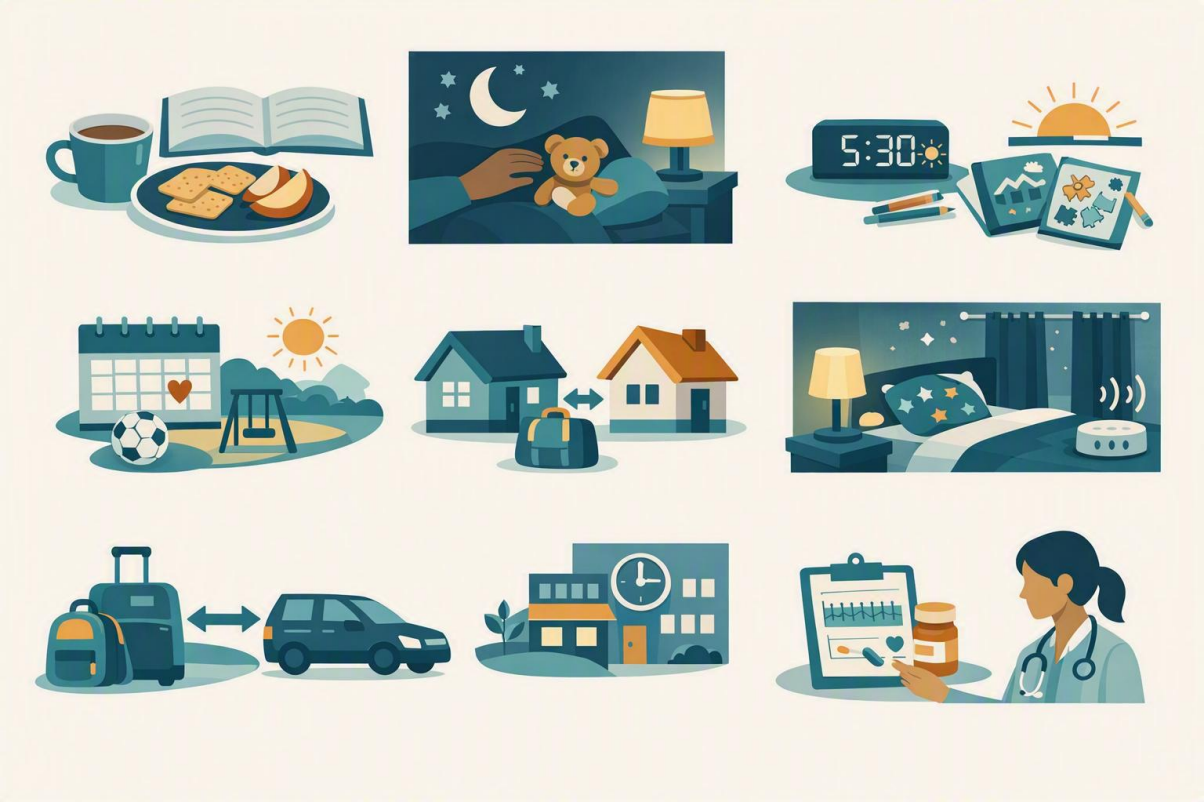


Figure 3. Practical sleep-plan supports can be adapted across routines, environments, homes, travel, appointments and health review.

Further Practical Sleep Plan Examples

- **After-school recovery:** “On amber or red fatigue days, no questions, homework or chores are introduced for the first 45 minutes. Offer a drink, familiar food, low lighting and access to the usual quiet space.”
- **Night waking:** “If the person wakes, use the same low-light route, minimal language and familiar reassurance. Avoid problem-solving or introducing new choices unless safety requires it.”
- **Early waking:** “Provide a prepared quiet activity, drink and visual showing when the household day begins. Keep morning demands low if the person has been awake for an extended period.”
- **Weekend and holiday routine:** “Keep key anchors—medication, meals, wind-down and waking times—predictable, while allowing flexibility where a rigid timetable increases distress.”
- **Shared-care or two-home arrangement:** “Use the same short sleep sequence, key visual, comfort item and recording method in both homes. Adults share only the information needed to support sleep and daytime capacity.”
- **Sensory environment:** “Record whether blackout curtains, a dim lamp, white noise, door position, bedding texture, clothing, room temperature or reduced household noise improve settling or reduce waking.”
- **Communication script:** “Adults use one calm phrase, such as ‘Your body is safe; it is sleep time,’ rather than repeated questions, explanations or warnings.”
- **Appointments and important events:** “Where possible, book appointments later in the day after a disrupted night, reduce waiting time and tell the professional in advance that fatigue may affect processing, recall and tolerance.”

- **Travel:** “After significant sleep loss, review whether independent travel is safe. Offer accompanied travel, a later journey, a simpler route or remote participation where appropriate.”
- **Medication recording:** “Record the time medication was taken, any observed change in settling, waking or daytime alertness, and share concerns with the prescribing professional rather than changing medication without advice.”
- **Named adult response:** “The named adult checks the capacity update on arrival, confirms the agreed colour level and quietly puts the matching support in place without requiring repeated explanation.”
- **Review measure:** “Record whether the agreed adjustment improved attendance, safe participation, regulation, task completion or recovery. Note what did not help and what should be changed next time.”
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Using the Sleep Plan at Home

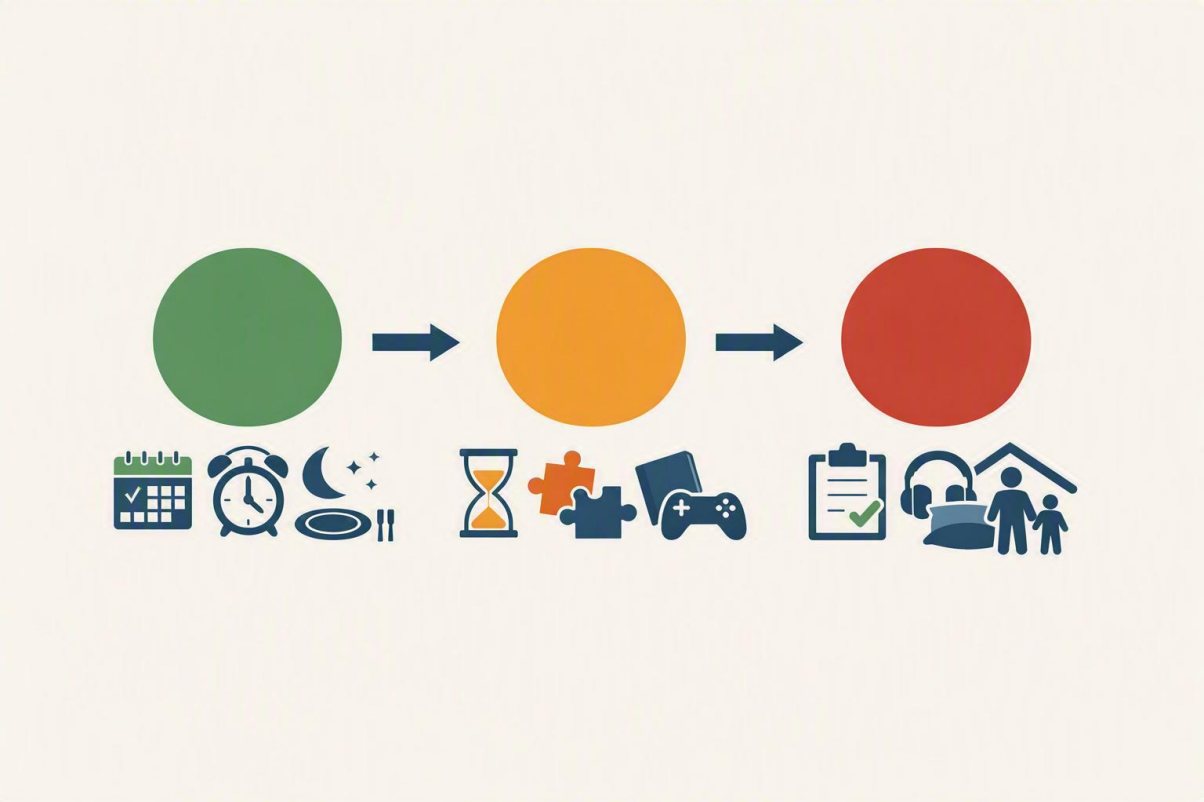

Figure 3. Green, amber and red capacity levels help adults adjust routines, demands and supervision after disrupted sleep.

- **Morning capacity check:** A carer records whether sleep was green, amber or red and uses the matching home plan - for example, the usual routine on green, a slower start and fewer choices on amber, or essential tasks only with extra supervision and recovery time on red.
- **Shared adult response:** Everyone supporting the person uses the same short phrases and agreed adjustments, so the person is not repeatedly questioned or expected to explain why they are tired.
- **After-school or after-college plan:** The sleep plan identifies what happens first on arrival home, such as drink, familiar food, low lighting, no questions and access to a quiet or sensory space before chores, homework or conversation.

- **Reducing evening load:** After a low-capacity day, carers postpone non-essential outings, difficult discussions and new tasks, while keeping meals, medication and the wind-down sequence predictable.
- **Night-waking record:** Carers briefly note when the person woke, possible pain or sensory discomfort, what support was used and how settled they appeared the next morning, without turning the record into blame or surveillance.
- **Home safety adjustment:** When alertness or judgement is reduced, a carer supervises cooking, medication, bathing, road use or online activity and pauses higher-risk tasks until capacity improves.
- **Preparing for the next day:** Clothes, bag, food, medication prompts and visual plans are prepared in advance so the morning requires less memory, sequencing and decision-making.
- **Reviewing what helps:** The family checks the plan regularly and records which changes improved settling, daytime regulation or recovery, then shares useful patterns with relevant professionals where appropriate.

Actions for Supported Living, a Residential Home or Residential School to Consider

- **Named night-time lead:** Identify who coordinates the sleep plan, checks that agreed supports are available and ensures day, evening and night staff use the same approach.
- **Consistent handover:** Record settling time, waking, possible pain or distress, support used and likely daytime capacity. Share only information needed for safe, consistent support.
- **Predictable evening routine:** Use the same sequence, visual cues, lighting, language and familiar items across staff shifts. Avoid unnecessary changes, lengthy conversations or repeated demands close to bedtime.
- **Night waking response:** Agree a low-arousal response with minimal language, low lighting, familiar reassurance and clear safety checks. Avoid introducing new choices unless they are necessary.
- **Environment check:** Review corridor noise, doors, alarms, staff movement, room temperature, bedding, light, smells and whether checks or personal-care routines are unintentionally disrupting sleep.
- **Individualised observations:** Record how the person shows tiredness, pain, illness, anxiety or sensory discomfort, particularly if they cannot reliably explain what is wrong.
- **Morning flexibility:** After a disrupted night, offer a slower start, later breakfast, reduced verbal load, fewer transitions and flexible attendance or learning expectations where possible.
- **Low-capacity day plan:** Use agreed green, amber or red adjustments, including quiet recovery space, reduced activities, extra familiar-adult support and postponement of non-essential demands.
- **Safety-critical decisions:** Review whether travel, cooking, medication, machinery, community access, practical lessons or independence tasks need additional supervision, adaptation or rescheduling.
- **Health escalation:** Follow agreed pathways for concerns such as breathing pauses, significant snoring, unusual movements, pain, medication effects or severe daytime sleepiness, and record who was informed and what action was taken.
- **Family and professional communication:** Agree what is shared with family, education, health and social care, with consent where appropriate, and avoid asking the person to repeat information to multiple adults.

- **Review after incidents:** Where distress, absence, conflict or a safety concern occurs, check whether sleep debt contributed before interpreting the event as deliberate behaviour or non-compliance.
- **Staff training and oversight:** Ensure permanent, agency and waking-night staff understand the FASD-informed sleep plan, know the agreed scripts and adjustments, and can access a concise version during every shift.
- **Review arrangements:** Use sleep and daytime-capacity records to review what helps, what disrupts sleep and whether staffing, routines or environmental adjustments need to change.

Actions for Schools to Consider

Figure 4. FASD-informed school adjustments can support access, learning, regulation and safety on low-capacity days.

- **Named school lead:** Identify who receives sleep or fatigue information, activates the agreed plan and ensures relevant staff know which adjustments are needed that day.
- **Simple morning update:** Agree a brief green, amber or red message from home. The named adult quietly puts the matching support in place without requiring the pupil to repeatedly explain.
- **Flexible arrival:** After a disrupted night, allow a later or slower arrival, a familiar entrance, reduced questions and time with a trusted adult before classroom demands begin.
- **Low-capacity start:** Offer breakfast or a drink where appropriate, a quiet space, familiar activity, body-needs check and one simple first step rather than an immediate full timetable.
- **Adjusted learning:** Reduce written output, verbal load, working-memory demands and the number of tasks. Provide visuals, modelling, one instruction at a time and additional adult check-ins.

- **Prioritise essential learning:** Decide what genuinely needs to happen that day and postpone non-essential homework, tests, catch-up work or sanctions where sleep debt is reducing capacity.
- **Transitions:** Give earlier warning, use a quieter route, reduce words and allow recovery time after movement between lessons, break, lunch, transport or different adults.
- **Sensory adjustment:** Review noise, lighting, seating, assemblies, lunch halls, crowded corridors and uniform discomfort. Offer agreed sensory tools and access to a low-arousal space.
- **Movement and rest:** Build in short movement, regulation or recovery breaks before attention and behaviour deteriorate, rather than waiting for distress.
- **Attendance response:** Record the impact of sleep and fatigue on attendance and punctuality. Avoid treating lateness linked to evidenced sleep difficulty as poor motivation; focus on safe access and an achievable return to learning.
- **Assessment and exams:** Consider timing, rest breaks, separate or quieter rooms, reduced waiting and other agreed access arrangements where fatigue affects processing, recall or stamina.
- **Safety-critical activities:** Review whether PE, swimming, science practicals, food technology, machinery, off-site visits, road use or independent travel require extra supervision, adaptation or rescheduling.
- **Medication and health:** Follow the individual health-care plan and record unusual daytime sleepiness or relevant observations. Raise persistent concerns through agreed health and safeguarding pathways rather than assuming they are simply part of FASD.
- **Behaviour and safeguarding review:** Before applying sanctions or interpreting refusal, conflict, leaving class or reduced work as intentional, check whether sleep debt affected regulation, memory, impulse control or sensory tolerance.
- **Home-school communication:** Share concise information about capacity, adjustments used and what helped, without placing responsibility on the pupil or requiring families to repeatedly justify an agreed need.
- **Staff consistency:** Ensure teachers, support staff, lunchtime staff, transport staff and supply staff can access a short version of the plan and know the agreed response.
- **Recording and review:** Record which adjustments improved attendance, regulation, learning, transitions or safety. Review patterns with the pupil, family and relevant professionals at an agreed interval.

Assumptions and Safeguarding Risk

A likely mistaken assumption is that a person can function consistently despite sleep debt, rather than recognising that capacity may vary with sleep quality, fatigue, sensory load, stress, context and the support available.

If this need is misread, or support is withdrawn too soon, the person may be blamed, exposed to avoidable failure, or left unable to recognise, communicate or respond to risk.

Particular safeguarding attention may be needed around travel, road safety, cooking, medication, machinery, practical placements, personal care, eating, sleep and sensory overload. A calm, curious response should consider brain-based and body-based differences and unmet need, not presume wilful non-compliance.

Support must be based on evidenced functional need and reviewed collaboratively over time, rather than reduced because of age, fluent speech, apparent compliance, behaviour, one successful occasion or one better night's sleep.

Tips for Staff Training on Sleep Debt

- **Begin with the key reframe:** Train staff to ask, "Could sleep debt be reducing capacity today?" before interpreting lateness, refusal, irritability, forgetfulness, withdrawal or incomplete work as deliberate behaviour.
- **Explain variable capacity:** Use examples showing that a person may cope after one night but struggle after several disrupted nights, and that one improved night may not immediately restore capacity.
- **Teach observable signs:** Help staff recognise individual signs such as repeated questions, slower responses, pacing, tearfulness, louder speech, shutdown, increased sensory sensitivity or difficulty starting familiar tasks.
- **Use real scenarios:** Practise responses to late arrival, sleepiness in class, missed work, difficult transitions, practical lessons, medication, travel and after-school collapse.
- **Rehearse agreed scripts:** Staff might use, "We will make today smaller," "Let us start somewhere quiet," or "Your capacity looks lower today; I will help with the first step."

Meeting phrase: *"Sleep debt is affecting capacity, regulation and tolerance. We need to adjust expectations and support recovery rather than treating tiredness-related dysregulation as behaviour."*

- **Link training to the plan:** Make sure every staff member can locate the concise sleep plan, understands the green, amber and red adjustments and knows who has authority to activate them.
- **Include all relevant staff:** Training should reach teachers, teaching assistants, pastoral and residential teams, lunchtime and transport staff, job coaches, agency staff, waking-night staff and regular supply staff.
- **Distinguish support from diagnosis:** Staff should record observations and follow agreed health pathways, not diagnose a sleep condition or assume persistent difficulties are simply part of FASD.
- **Cover safety decisions:** Train staff to pause and review travel, roads, cooking, medication, machinery, practical lessons, placements and other higher-risk activities when alertness or judgement is reduced.
- **Avoid shame and public correction:** Practise private, low-arousal responses to lateness, fatigue and reduced output. Avoid comments such as "You should have gone to bed earlier" or asking the person or family to repeatedly justify an agreed need.
- **Use short knowledge checks:** Ask staff to identify early signs, choose an adjustment from a case example and explain who they would inform if breathing concerns, pain, unusual movements or severe daytime sleepiness were reported.
- **Observe implementation:** Training should be followed by brief practice checks, coaching or supervision to confirm that agreed adjustments are being used consistently rather than remaining only in written guidance.
- **Learn from records:** Review anonymised patterns showing which adjustments improved attendance, regulation, learning or safety, and use this evidence to refine staff practice.

- **Refresh after change:** Repeat training when the person's needs, medication, placement, timetable, staffing or sleep plan changes, and include it in induction for new staff.
- **Include the person and family:** Where appropriate, invite their views on what tiredness looks like, what helps, what feels blaming and which responses staff should avoid.

The plan should be individual, practical and reviewed collaboratively. It should support sleep and daytime capacity rather than blame the person or family, and it should not replace assessment or advice from an appropriately qualified health professional.

EHCP Evidence, Provision and Outcomes

EHCP evidence prompt: Record patterns between sleep, fatigue, regulation, learning, attendance, transitions, sensory tolerance and after-school collapse, including what support helped on low-capacity days.

EHCP phrase: "[Child/young person] requires support that recognises the impact of sleep debt on regulation, attention, processing, memory, sensory tolerance and emotional recovery. Provision should include adjusted expectations, reduced verbal load, visual supports, co-regulation, recovery time and home-school communication about sleep and fatigue."

EHCP objective: "By the end of the review period, [child/young person] will be supported through agreed sleep-debt adjustments so that staff consider sleep, fatigue and recovery before expecting full regulation, learning, transition tolerance or independent task completion."

EHCP outcome for college or supported internship: "By the end of the review period, [young person] will access college learning or their supported internship through an agreed sleep-debt plan. College, placement and job-coach staff will check current fatigue and capacity, adjust start times, travel, verbal and practical demands, provide access to recovery space and additional adult support, and postpone safety-critical tasks where necessary. Progress will be evidenced through improved supported attendance and engagement, fewer fatigue-related incidents or unfinished tasks, and consistent recording of the adjustments that enabled safe participation."

Measurable provision prompt: "Success will be measured by consistent recording of sleep and fatigue patterns where relevant; reduced escalation linked to tiredness and rushed demands; increased use of agreed low-capacity day supports; and evidence that expectations are adjusted when sleep debt is affecting capacity."

Key Points from the Sleep Debt Section

- **Sleep debt is cumulative.** Broken, shortened or poor-quality sleep can build over several days or weeks, and one better night may not immediately restore capacity.
- **Sleep affects the whole day.** In FASD, tiredness may further reduce attention, memory, processing, regulation, sensory tolerance, impulse control, transitions and emotional recovery.
- **Behaviour may communicate reduced capacity.** Lateness, refusal, distress, forgetfulness, withdrawal or incomplete work should not automatically be interpreted as poor motivation or deliberate non-compliance.
- **Support should match today's capacity.** Helpful adjustments include slower or later starts, fewer words and choices, reduced workload, visual support, quiet recovery spaces, co-regulation and postponing non-essential demands.

- **It is okay to be late.** Understanding capacity and enabling safe participation matter more than keeping pace.
- **Safety must be reviewed.** Sleep debt may affect judgement and alertness around travel, roads, medication, cooking, machinery, practical lessons and placements.
- **Persistent sleep concerns need health advice.** Loud snoring, breathing pauses, unusual movements, pain, medication concerns or marked daytime sleepiness should be discussed with an appropriate health professional.
- **A sleep plan should be individual and collaborative.** It should record patterns, observable signs, possible contributors, helpful supports, low-capacity adjustments, health escalation, named responsibilities and review arrangements.
- **Communication should be simple and consistent.** A green, amber or red capacity update can help home, school, college, residential settings and placements activate agreed support without repeated explanations.
- **EHCP provision should be specific and measurable.** Evidence should show how sleep affects attendance, learning, transitions, regulation and safety—and which adjustments enabled participation.
- **Staff need training and consistency.** Everyone involved should understand variable capacity, recognise signs of fatigue, use agreed scripts and implement the plan without blame or public correction.
- **The guiding principle is:** change the expectations and support—not the blame.

FASD-informed sleep support brings together recovery, sensory safety, co-regulation, communication, health review, safeguarding and capacity-responsive planning.

Editable FASD-Informed Sleep Plan Template

Complete this plan collaboratively with the person and, where appropriate, their family, carers, education, placement, residential staff and relevant health professionals. Type directly into the blank cells, use plain language, record what is observed rather than assumed, and review the plan whenever needs, routines, medication, setting or support arrangements change.

1. Personal details and plan ownership	
Name / preferred name	Click or tap here to enter text.
Date of birth / age	Click or tap here to enter text.
Preferred communication	Click or tap here to enter text.
People involved in this plan	Click or tap here to enter names and roles.
Plan coordinator / named lead	Click or tap here to enter text.
Date completed	Click or tap here to enter a date.
Review date	Click or tap here to enter a date.
Consent and information-sharing arrangements	Click or tap here to enter what may be shared, with whom and how.

2. Usual sleep pattern and recovery	
Usual wind-down start	Click or tap here to enter text.
Usual settling time	Click or tap here to enter text.
What helps settling	Click or tap here to enter text.
Night waking pattern	Click or tap here to enter frequency, timing and support needed.
Early waking pattern	Click or tap here to enter text.
Naps or daytime sleep	Click or tap here to enter text.
Weekday / weekend / holiday differences	Click or tap here to enter text.
How long recovery usually takes after poor sleep	Click or tap here to enter text.

3. How tiredness shows and what may contribute	
Early signs of tiredness or reduced capacity	Click or tap here to enter observable signs.
Signs that capacity is becoming significantly reduced	Click or tap here to enter observable signs.

How the person communicates pain, discomfort, anxiety or fatigue	Click or tap here to enter text.
Sensory factors	Click or tap here to enter light, noise, temperature, bedding, clothing, smells or other factors.
Physical or health factors	Click or tap here to enter pain, illness, breathing concerns, restless legs or other factors.
Emotional, routine or transition factors	Click or tap here to enter text.
Medication timing or possible effects	Click or tap here to enter observations; medication changes require clinical advice.

4. Helpful sleep and night-time supports	
Helpful wind-down sequence	Step 1: Click or tap here. Step 2: Click or tap here. Step 3: Click or tap here. Step 4: Click or tap here.
Helpful words, visuals or prompts	Click or tap here to enter text.
Preferred sensory supports	Click or tap here to enter text.
Food, drink or medication routine	Click or tap here to enter text.
Response to night waking	Click or tap here to enter the agreed low-arousal response.
Response to early waking	Click or tap here to enter text.
Approaches to avoid	Click or tap here to enter words, demands, environments or responses that increase distress.

5. Daytime capacity and agreed response		
Capacity level	**What this may look like**	**Agreed support and adjustments**
Green	Click or tap here to enter the person's usual signs.	Click or tap here to enter the usual routine and support.
Amber	Click or tap here to enter signs of reduced capacity.	Click or tap here to enter slower starts, fewer choices, reduced demands, recovery time or other adjustments.
Red	Click or tap here to enter signs of significantly reduced capacity.	Click or tap here to enter essential tasks only, increased supervision, postponement, quiet recovery and other supports.

6. Adjustments across settings	
Morning and getting ready	Click or tap here to enter text.
Home and after-school / after-work recovery	Click or tap here to enter text.
School, college, work, placement or day service	Click or tap here to enter arrival, workload, communication, breaks, attendance and transition adjustments.
Appointments and important events	Click or tap here to enter text.
Travel and community access	Click or tap here to enter text.
Shared care, residential or supported living	Click or tap here to enter text.

7. Safety and health escalation	
Tasks needing review when alertness or judgement is reduced	Click or tap here to enter travel, road use, cooking, bathing, medication, swimming, machinery, online activity, caring or other tasks.
Agreed supervision, adaptation or postponement	Click or tap here to enter text.
Signs requiring health advice	Click or tap here to enter individual concerns and include persistent sleep difficulty, marked daytime sleepiness, loud snoring, breathing pauses, unusual movements, pain or possible medication effects where relevant.
Who should be contacted	Click or tap here to enter names, roles and contact arrangements.
Urgent or emergency action	Click or tap here to enter the setting's agreed emergency procedure.

8. Communication, responsibilities and review	
How current capacity will be shared	Click or tap here to enter the agreed method, such as green, amber or red.
Who sends or records the update	Click or tap here to enter text.
Who receives the update	Click or tap here to enter text.
Who activates adjustments	Click or tap here to enter named people or roles.

What information may be shared	Click or tap here to enter text.
How effectiveness will be measured	Click or tap here to enter attendance, safe participation, regulation, learning, daily living or recovery indicators.
Next review meeting	Date: Click or tap here. People invited: Click or tap here.
Changes agreed at review	Click or tap here to enter text.

9. Short sleep and daytime capacity record				
Date	**Settling / waking summary**	**Capacity: green, amber or red**	**Adjustments used**	**What helped / follow-up**
Enter date	Enter summary	Enter level	Enter adjustments	Enter notes
Enter date	Enter summary	Enter level	Enter adjustments	Enter notes
Enter date	Enter summary	Enter level	Enter adjustments	Enter notes
Enter date	Enter summary	Enter level	Enter adjustments	Enter notes
Enter date	Enter summary	Enter level	Enter adjustments	Enter notes
Enter date	Enter summary	Enter level	Enter adjustments	Enter notes
Enter date	Enter summary	Enter level	Enter adjustments	Enter notes

Reminder: *This plan is a support and communication tool. It should not be used to blame or police sleep, and it does not replace assessment or advice from an appropriately qualified health professional.*

A collaborative FASD-informed sleep plan connects individual patterns, practical adjustments, health and safety, communication and regular review.