

Introduction

Tourette Syndrome (TS) is a childhood-onset neurodevelopmental condition, characterised by involuntary movements and sounds known as tics (Martino & Pringsheim, 2018). Symptoms vary widely, from mild and barely noticeable to severe tics that can be painful or physically harmful, particularly when they involve repetitive or forceful movements. Complex motor tics may even result in self-injury (NINDS, 2025; TAA, 2025). Research over the last decade shows it has a genetic basis and often runs in families (NHS UK, 2025; Johnson *et al.*, 2023; Ganos *et al.*, 2018). Symptoms usually emerge between ages 5 and 7, with severity peaking in early adolescence, likely influenced by hormonal changes (Ueda & Black, 2021; Stern, 2018). Although a lifelong condition, longitudinal studies indicate that around half of individuals experience substantial symptom reduction by early adulthood (Ricketts *et al.*, 2022; Gill, 2020), though for some, tics remain persistent and debilitating (Ueda & Black, 2021). Up to 80% of children with TS have co-occurring conditions, most commonly ADHD, OCD, anxiety or autism, which often have a greater impact on daily functioning (Gunturu *et al.*, 2023). Under the *Equality Act 2010*, TS can meet the definition of a disability when tics or comorbidities substantially and long-term affect learning, communication or social participation. As TS does not affect cognitive ability, it is not classed as a learning disability (Martino & Pringsheim, 2018), though children may meet ALN Code criteria under the *ALNET Act 2018* when symptoms create learning difficulties requiring Additional Learning Provision, such as breaks, adapted tasks or reduced pressure (Lund *et al.*, 2023; Gunturu *et al.*, 2023).

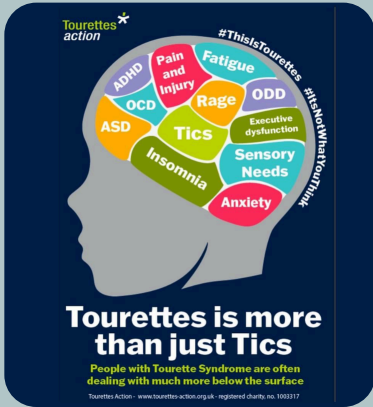
Identification and Diagnosis

Identification of TS is clinical and relies on a detailed history and direct observation of tics. A diagnosis may be made by a neurologist, paediatrician or psychiatrist (Tourette’s Action, 2025), usually from being referred from a GP. Although TS is now understood to have a genetic predisposition, there is currently no blood test, scan or biomarker that can confirm the condition (Gill, 2020).

According to NHS UK (2025), a diagnosis of TS requires:

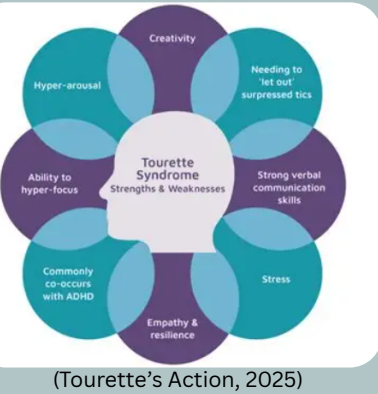
- A child or young person to have multiple motor tics and at least one vocal tic.
- That symptoms persist for more than one year.
- That onset of symptom began before age 18.
- And that these symptoms cannot be better explained by another medical condition.

Although there is no cure for TS, treatment can help manage symptoms, behavioural therapies, such as Habit Reversal Therapy (HRT) and Comprehensive Behavioural Intervention for Tics (CBIT) are recommended as first-line interventions, while medication may be considered in more severe cases or when tics significantly impair daily functioning (NHS UK, 2025; NINDS, 2026).



Prevalence

TS is estimated to affect around 1 in 100 children, meaning it is as prevalent in childhood as autism spectrum disorder (ASD) and childhood epilepsy (Stern, 2018; Tourette’s Action, 2025).



According to the Tourette Association of America (2025), approximately 20% of children and young people will experience some form of tics at some point in their lives.

TS is more common in boys, with estimates suggesting a male-to-female ratio of approximately 4:1, although the reason for this difference remains unclear (Yilmaz and Jankovic, 2025).

Benefit of diagnosis

A clear benefit of receiving a formal diagnosis, beyond access to treatment, clinical support and medication is improved access to community support. When health professionals signpost individuals to face-to-face groups, online communities, and relevant charities, this can significantly enhance support for people with TS and their families (NHS UK, 2025; TAA, 2025). Findings from recent research on online support communities show that these platforms provide valuable information and emotional support, particularly in areas where local services are limited. Such communities help foster a sense of belonging, reduce long-standing social isolation, and contribute to improvements in psychosocial well-being (Perkins, Coulson & Davies, 2020).

Barriers

A significant barrier affecting children with TS is the lack of understanding surrounding the condition. This limited awareness contributes to misconceptions and stigma, which can significantly impact wellbeing (Kallol, 2021; TAA, 2025). Children may feel embarrassed or isolated because of their tics, avoid social activities or suppress their tics in situations where they fear judgement (Ricketts *et al.*, 2022; Perkins, Coulson & Davies, 2020). Suppression can create the false impression that tics are controllable, yet it requires intense effort and often leads to exhaustion, pain and rebound tics (Tourette’s Action, 2025). Great Ormond Street Hospital (2025) emphasises that education for families, peers and teachers should be the first step in supporting a child with TS. This aligns with Ricketts *et al.* (2022), who found that understanding staff, flexible expectations and inclusive practice improve outcomes and reduce pressure to suppress tics.

Another barrier children with TS face is access to clinical support. NHS UK (2025) advises parents to consult a GP if TS is suspected, with referrals made to neurology or paediatrics for assessment and behavioural therapy. However, NICE guidance does not recommend routine referral for tic disorders unless co-occurring conditions are present (NICE, 2023) even though research shows that behavioural therapy can reduce tic severity in around 74% of cases (Ueda and Black, 2021). There are also no dedicated NICE guidelines for diagnosing or treating TS, a gap highlighted by Tourette’s Action and recent parliamentary discussions (UK Government, 2025). In addition, a Freedom of Information request to Cardiff and Vale University Health Board revealed there is no dedicated Tic Disorder clinicians within CYPFHS (NHS Wales, 2024). This reflects a wider national issue highted by Jeayes *et al.* (2023) who found that only two UK regions offer standalone tic services, with most areas providing only signposting to self-help or voluntary organisations.

Strategy

Environmental adaptations in the classroom for children with TS can significantly improve learning outcomes, as tic severity is strongly influenced by stress, sensory load and social pressure (Carter *et al.*, 2020; Wadman, Glazebrook & James, 2016). Small adjustments such as seating a child at the edge of the classroom to reduce self-consciousness, providing access to a quiet breakout space and reducing sudden loud noises helps minimise tic triggers and increase comfort (Tourette’s Action, 2024; Sigalla and Kimario, 2025). Reducing social pressures, allowing movement breaks and offering alternative ways to participate can also lower anxiety (NHS UK, 2025; Lund *et al.*, 2023; Gunturu *et al.*, 2023). For children with physically intense tics, ensuring adequate space, safe equipment and adapted physical activities reduces risk and discomfort (Tourette’s Action, 2024). Whole-school awareness is essential, as informed staff are better equipped to recognise triggers and respond with empathy (NHS UK, 2025). These adjustments help create an inclusive environment that strengthens pupils’ wellbeing and sense of belonging (TAA, 2025). This focus on belonging reflects Maslow’s Hierarchy of Needs, which identifies it as the foundational for learning and self-esteem. It also reinforces Article 23 of the UNCRC (1989) - that children with disabilities have the right to live a full and dignified lives (UNICEF, n.d.). These principles align with Kallol’s (2021) argument, that children who do not feel accepted are more likely to experience academic difficulties.

Conclusion

Tourette Syndrome is a common neurodevelopmental condition, yet children and young people continue to face significant barriers due to misunderstanding, stigma, inconsistent access to specialist support and lack of national guidance. Although many children experience tics at some point in their lives, a lack of public awareness often leads to shame, isolation and harmful attempts to suppress tics, which can worsen symptoms and impact wellbeing. Improving awareness, strengthening referral pathways and ensuring equitable access to specialist support are essential steps in promoting better outcomes for children with Tourette Syndrome.