Updated guidance on the assessment of DCD/dyspraxia

Dr Amanda Kirby recently convened DCD consensus meetings to provide a forum for developing the UK aspects of the EACD guidelines and adapt them, where appropriate, to the UK health and education systems. The meetings were attended by a wide range of professionals, including occupational therapists, educational psychologists, doctors, and SpLD assessors and tutors working in the field, and a new definition for DCD/dyspraxia has been agreed.

> **Definition of Developmental Co-ordination Disorder**
> Developmental Co-ordination Disorder (DCD), also known as Dyspraxia in the UK, is a common disorder affecting fine or gross motor co-ordination in children and adults. This lifelong condition is formally recognised by international organisations including the World Health Organisation. DCD is distinct from other motor disorders such as cerebral palsy and stroke and occurs across the range of intellectual abilities. Individuals may vary in how their difficulties present; these may change over time depending on environmental demands and life experience.
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> An individual's co-ordination difficulties may affect participation and functioning of everyday life skills in education, work and employment. Children may present with difficulties with self-care, writing, typing, riding a bike and play as well as other educational and recreational activities. In adulthood many of these difficulties will continue, as well as learning new skills at home, in education and work, such as driving a car and DIY. There may be a range of co-occurring difficulties which can also have serious negative impacts on daily life. These include social and emotional difficulties as well as problems with time management, planning and personal organisation and these may also affect an adult's education or employment experiences.

In order to reach a conclusion of DCD/dyspraxia the assessor **must** provide evidence of a history of motor co-ordination difficulties, and it is vital therefore that a detailed case history is taken (including difficulties as a child). The assessor should explore these through the use of an in-depth interview and/or questionnaire. The assessor can therefore form an opinion about these based on the student's responses.

An assessor needs to take account of both the physical and educational aspects of DCD/dyspraxia. As noted in the definition there may well be co-occurring difficulties. It may be these co-occurring difficulties that are the dominant issues, particularly when working with young adults. Issues of poor motor coordination, in general, do not impact on educational achievement to the same extent that cognitive factors do [and may for the most part have already been addressed when looking at adults].

If the primary needs of the student are largely educational rather than physical, an assessment of individuals age 16 or older, carried out by an appropriately trained practitioner psychologist or specialist teacher assessor which looks at educational

strengths and weaknesses would be appropriate and can identify dyspraxia. Such an assessment should provide advice on educational intervention and support and suggest appropriate educational adjustments. [Note: It is very important that children with motor coordination difficulties be recommended to be seen by a medical practitioner.]

Information which can be gained from detailed case history includes:

- lateness in reaching milestones of childhood
- gross motor co-ordination skills (questions about posture/fatigue/balance/hand-eye co-ordination/integration of two sides of the body/rhythm)
- fine motor co-ordination skills (questions about manual dexterity and manipulative skills)
- organisational skills
- speech (questions about organising the content and sequence of their speech/word pronunciation/word retrieval)
- sensitivity to light, noise, touch and smell
- social interaction
- emotional difficulties
- daily living difficulties
- obsessional behaviours
- orientation and sequencing
- tracking
- visual perception
- spatial awareness
- sense of time
- sense of direction
- accuracy
- concentration
- memory

Assessors working with adults should follow the usual process for an SpLD assessment choosing appropriately from the battery of tests in the DfES Guidelines as updated by STEC/SASC.

- Where visual-perceptual skills and fine motor skills/handwriting difficulties are suspected tests of visual-perceptual skills and fine motor skills tests should be considered. These tests can support their conclusion or help direct the assessor to consider another SpLD.
- Planning and spatial ability difficulties can be highlighted through the non-verbal tests from the WAIS-IV or the WRIT.
- Motor co-ordination difficulties highlighted through
  - the Symbol Digit Modalities Test and processing speed tests from the WAIS-IV
  - specific tests of motor skills such as the Beery Buktenica Developmental Test of Visual-Motor Integration and the DASH 17+

- In addition there is also likely to be slower than average information processing (oral or written) so tests of reading speed, writing speed and naming are useful.

In the summary of a report the assessor could use a range of phrases eg. ‘is dyspraxic’; shows ‘dyspraxic tendencies’ or shows ‘significant features of dyspraxia’, shows ‘a profile of dyspraxia’ or ‘has SpLD with traces of dyspraxia’, or state any combination with other SpLDs.

Deteriorating motor function or deterioration in a skill in the past 6-12 months in anyone should alert assessors to encourage the individuals to see their doctor for further assessment. There are some aspects of dyspraxia that only health professionals can assess such as motor control and co-ordination, poor muscle tone and skeletal abnormalities. Where a medical diagnosis of DCD is made the individual [or parent/guardian for children] should be made aware that there might be accompanying educational difficulties. All professionals identifying DCD/dyspraxia should note that there can be impacts on other aspects of life.

It should be noted that dyspraxia can be diagnosed by a doctor or an occupational therapist, in either of these cases they would not be submitting a report in the form described for SpLDs.