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Setting the research priorities for Developmental Coordination Disorder (DCD)/Dyspraxia in the UK

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ABSTRACT

Developmental Coordination Disorder (DCD), also known as Dyspraxia, is a common neurodevelopmental condition associated with lifelong fine and / or gross motor challenges. Despite its prevalence, DCD remains under-researched and no stakeholder-led research priority-setting exercise has previously been undertaken. A James Lind Alliance (JLA) Priority Setting Partnership (PSP) was conducted to identify and prioritise unanswered research questions for DCD in the UK. Individuals with living experience (N = 7), health and education professionals (N = 3) and academics (N = 3) formed a Steering Group. Uncertainties were collected via a national survey, processed and verified against existing evidence and refined into summary questions. An interim prioritisation survey informed a final consensus workshop to agree the Top 10 research priorities. A total of 308 participants contributed 920 uncertainties, resulting in 50 summary research questions across seven overarching themes which were ranked by 222 participants in the interim prioritisation survey. This resulted in 18 high-ranking questions for discussion at the final workshop with adults (N = 9), parents (N = 3) and practitioners (N = 5). Consensus was reached on a Top 10 list of research priorities, which emphasised emotional and social wellbeing, early diagnosis and intervention, non-motor challenges, education, adulthood and ageing, diagnostic pathways, cultural and ethnic influences and needs-based approaches to support. This study establishes the first stakeholder-driven research agenda for DCD. The identified priorities highlight the need for research that adopts a lifespan perspective, addresses psychosocial and non-motor challenges and reflects the living experiences of diverse DCD populations. Aligning future research with these priorities will improve the relevance, coherence and impact of the DCD evidence base.

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1. Introduction

Developmental Coordination Disorder (DCD) is a prevalent neurodevelopmental condition, affecting approximately 5–8% of the population cross-nationally (American Psychiatric Association, 2022). DCD is characterised by persistent difficulties in the acquisition and execution of coordinated movement (American Psychiatric Association, 2022). Individuals with DCD have difficulty performing everyday activities, such as getting dressed, tying shoelaces, using cutlery, printing/handwriting, playing games and sports, or riding a bicycle (Zwicker et al., 2012). DCD is also sometimes referred to colloquially as *Dyspraxia,* although this latter term is preferred by those with living experience in the UK, it does not carry any diagnostic description or criteria. Characteristics of DCD commonly persist into adolescence and adulthood (Blank et al., 2012; Kirby et al., 2014), with evidence demonstrating that DCD exerts a long-term, wide-ranging influence on quality of life across the lifespan (Kumar et al., 2025; Weber et al., 2023), with higher incidences of internalising symptoms, including anxiety, depression and low self-esteem (Cleaton et al., 2020; Engel-Yeger, 2020; Harris et al., 2025; Rathbone & Wilmut, 2025; Tal-Saban et al., 2014). Furthermore, the impact of DCD extends well beyond motor coordination. Research has shown that people with DCD have reduced executive functioning performance compared to neurotypical peers (Fogel et al., 2023; Lachambre et al., 2021; Sartori et al., 2019; Schott et al., 2016; Subara-Zukic et al., 2022) and are more at risk of health-related problems which are linked to physical inactivity as a consequence of reduced participation in social and leisure activities (Cavalcante Neto et al., 2024; Green et al., 2011; Kwan et al., 2013; Silva-Santos et al., 2021; Tan et al., 2022).

Despite its prevalence and enduring impact, DCD remains markedly under-recognised and underfunded relative to other neurodevelopmental conditions (Meachon et al., 2024). Research and investment in clinical services are disproportionately low when compared with the conditions prevalence and impact on those with DCD (Klein et al., 2023; Licari et al., 2021). This results in inequities in service provision and considerable unmet needs (Klein et al., 2024). The absence of an agreed national research agenda risks further fragmentation within the field and impedes coordinated progress in identification, intervention and support.

Establishing a coherent stakeholder-led research agenda is therefore essential to ensure that finite resources are directed towards the most pressing and impactful areas (Fleurence & Torgerson, 2004). Beyond guiding future research funding, setting clear priorities also facilitates the translation of evidence into policy and practice, thereby improving outcomes for those living with and affected by DCD. Furthermore, although research priority-setting exercises have been undertaken for other neurodevelopmental conditions - such as Autism (James Lind Alliance, 2023) - no equivalent initiative has yet been conducted for DCD within the UK or internationally.

A research and knowledge translation priority-setting exercise for DCD was previously conducted in Canada (Camden et al., 2019), identifying key areas for development including improved access to services, enhanced educational support, diagnostic refinement, prevention of secondary consequences, optimised service organisation and implementation of effective interventions. However, the use of a predetermined priority list, developed by the authors and refined by an advisory committee of nine stakeholders, may have constrained the emergence of novel or unexpected themes. A specific priority-setting exercise following a standardised approach was therefore required to ensure that future research aligns with the structures, needs and values of the UK system.

The James Lind Alliance (JLA) is a non-profit, UK based organisation which is funded by the National Institute for Health Research (NIHR). It aims to bring together people with living experience, carers and clinicians to raise awareness of the research questions which

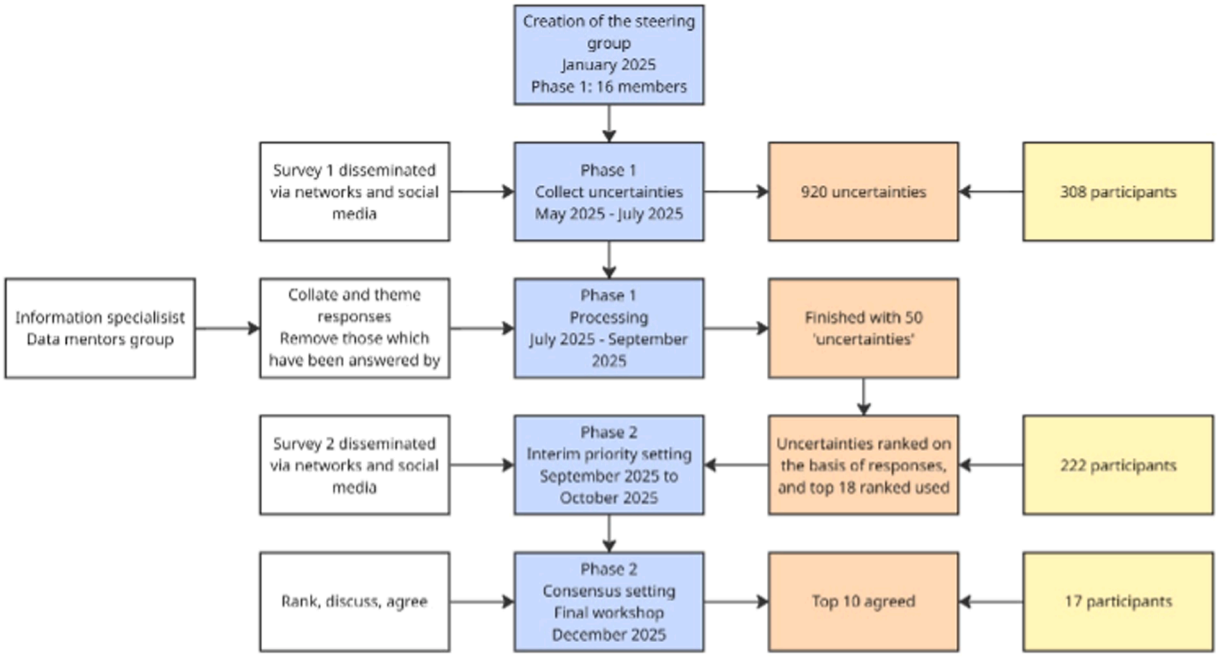

Fig. 1. A flowchart showing the JLA process. The JLA steps are in blue, the tools / actions in white, participants in yellow and outcome in orange.

are of a direct relevance and benefit to those with living experience and the people who care for them. The JLA provides a robust and transparent methodology for identifying and prioritising research questions that are most important to those directly affected by a condition. Through the process of a Priority Setting Partnership (PSP), the JLA approach brings together a Steering Group of individuals with living experience, carers, clinicians, academics and other stakeholders on an equal basis to identify unanswered research questions ("uncertainties") and agree a Top 10 list of research priorities (James Lind Alliance, 2010).

The present study represents the first research priority-setting exercise for DCD, conducted in accordance with the James Lind Alliance methodology. It aimed to: (1) identify the key uncertainties experienced by individuals with DCD, their families, educators, health and social care professionals and academics; (2) develop a comprehensive long list of summary questions and exclude those already addressed by existing evidence; (3) determine the Top 10 most important unanswered research priorities for DCD in the UK and (4) provide guidance for academics, funders and policymakers to align future efforts with these priorities. By undertaking this initiative, the project sought to establish a coordinated, stakeholder-driven research agenda for DCD, ensuring that future research efforts are relevant, equitable and responsive to the needs of those with DCD.

2. Methods and outcomes

2.1. Study design

This study was conducted in line with the James Lind Alliance (JLA) Priority Setting Partnership (PSP) and followed the standard six-stage JLA methodology: (1) establishing a Steering Group; (2) gathering uncertainties; (3) processing, summarising and verifying uncertainties; (4) interim priority setting; (5) final priority setting and (6) dissemination (James Lind Alliance, 2010). The Steering Group is described below (stage 1) and then these stages are reported as Phase 1 (gathering and processing uncertainties, which covers stages 2 and 3) and Phase 2 (prioritisation and consensus setting, stages 4 and 5). Stage 6, dissemination is not described in this academic article but included a disseminated event to stakeholders, various materials explaining the priorities and this academic article. Ethical approval was obtained from the School of Healthcare Sciences Research Ethics Committee at Cardiff University (approval number REC1233). Each of these processes and the outcomes of them are described in turn below, this is also summarised in the flow chart in Fig. 1.

2.2. Step 1: establishing a steering group

The Steering Group, chaired by a JLA Advisor (Wolffs), met 14 times, either in person or via teleconference, between February 2025 and February 2026. Meetings were considered quorate when at least three individuals with living experience or carer representatives, one practitioner and one academic were present.

Between February 2025 and August 2025 (covering Phase 1 and the beginning of Phase 2), the Steering Group comprised 16 members: two males (12.5%) and 14 females (87.5%) and included six individuals with living experience and/or parents and caregivers (60%), three practitioners (30%) comprising one teacher/ALNCO and two occupational therapists and one academic representative (10%). Following the withdrawal of one member with living experience during Phase 2 (August 2025-February 2026), the Steering Group comprised 15 members: one male (6.7%) and 14 females (93.3%). The two PSP leads, the JLA Advisory and PSP coordinator also attended Steering Group meetings.

Core JLA principles were upheld throughout the process, including ensuring equal involvement of individuals with living experience, parents/carers and professionals, maintaining transparency in all methods and preserving a clear audit trail. The JLA Advisor ensured that the Steering Group could contribute equally, emphasising the equal value of living experience and professional expertise during all stages, including during the final priority setting exercise.

2.3. Data collection (phases 1 and 2)

2.3.1. Phase 1, step 2: gathering and processing research uncertainties

2.3.1.1. Gathering uncertainties. In order to collect uncertainties a survey was designed and hosted on JISC online surveys, this was reviewed and refined by the Steering Group ensuring the language of all study materials were accessibility for people with DCD, in line with JLA guidance and the published Priority Setting Partnership protocol Developmental Coordination Disorder Priority Setting Partnership protocol | NIHR JLA.

Respondents were asked, "What aspects of Developmental Coordination Disorder (Dyspraxia) matter to you that could be answered through research?" Participants could submit up to three questions relating to DCD and provide demographic information, including gender, age, ethnicity, geographic location, co-occurring diagnoses and occupation; professionals were asked to indicate the age group (s) they worked with. The demographic information collected varied according to respondent group.

The primary target UK audience were: children with DCD or suspected DCD aged 6–15 years (with parental support where appropriate); adults (aged 16 years and over) with DCD or suspected DCD; parents / carers of children of any age with DCD or suspected DCD; organisations or agencies with experience of DCD (including healthcare practitioners and educators) and academics that had conducted research about DCD within the last five years. Although the inclusion of academics deviates from the standard JLA process, they were included in the PSP to help ensure that identified priorities reflected key evidence gaps relevant to the DCD

community. With regards to individuals with DCD, those who had co-occurring neurodevelopmental conditions were still included (Sugden, 2006), due to significant disparities in the availability of diagnosis of DCD this was not required. Children aged 6–15 years were included with parental permission and support, as diagnosis is unlikely to occur before this age (Sainsbury et al., 2023).

Data collection took place between 14 May 2025 and 14 July 2025 and promotional materials, designed by Starbots Creative, were disseminated through multiple outlets including the Dyspraxia Magazine, the ADHD Foundation, the British Association for Community Child Health, the British Academy for Childhood Disability, relevant Facebook® groups (e.g. "Dyspraxia Support Group"), Mumsnet®, LinkedIn®, X/Twitter®, BlueSky® and Instagram®. Materials were also disseminated through the Royal College of Occupational Therapists, schools and personal contacts of the Steering Group. Additional targeted advertising was undertaken to reach under-served groups, for example: using tailored social media posts. Children were recruited via parents and carers and could complete a child-friendly version of the survey (with parental support if required) or participate in an interview or focus group (online via Microsoft Teams or face-to-face). Simplified information sheets were reviewed by a young person for accessibility.

Participants provided informed consent before completion of the survey and participants aged 16 years and over were invited to enter a prize draw for one of two £ 50 vouchers.

2.3.1.2. Outcomes from gathering uncertainties; participant characteristics. A total of 308 participants contributed to the Phase 1 survey, generating 920 individual submissions, the breakdown of participants is given in Table 1.

Detailed demographic information for each stakeholder group, including age, gender, ethnicity and geographic distribution, is presented in Supplementary Figures S1.

2.3.2. Phase 1, step 3: processing, summarising and verifying uncertainties

Survey responses and identifying information were downloaded from JISC Online Survey. The JLA Information Specialist and the second author (Donnelly) independently classified submissions as in-scope, out-of-scope, or unclear, resolving any disagreements through discussion.

Data processing involved several stages:

1. Incomplete responses were removed and multiple submissions were split so that each uncertainty occupied a single row with demographics preserved.
2. Out-of-scope data, such as requests for information or awareness rather than research, were removed and recorded separately.
3. Eligible data were grouped into themes by clustering similar submissions and formulating summary questions that captured their core meaning. A Qualitative Content Analysis (QCA) (Elo & Kyngäs, 2008) approach was used to identify emerging data-driven themes from the responses. Responses were read and re-read and the coding frame was refined iteratively as responses were reviewed weekly between July and August 2025 during this process, the JLA Information Specialist drafted the initial summary questions and mapped them to the originating responses for Steering Group review.
4. By grouping similar submissions, themes were developed and similar concepts were synthesised into summary questions, while singleton but important concepts were retained. These draft questions were then further examined by the Data Mentors Group (a subgroup of the Steering Group) across four online meetings and one in person meeting in August 2025, where they merged or split questions as necessary and refined wording to ensure clarity and alignment with JLA principles.
5. Each summary question was checked to confirm it represented a genuine research uncertainty. Systematic searches for existing review articles or guidelines were conducted, documenting verification using the JLA Question Verification Form. Searches were conducted in the Cochrane Library, PubMed, PsycINFO and Google Scholar using terms such as "developmental coordination disorder," "DCD", "Dyspraxia," and related synonyms. Systematic reviews, meta-analyses and scoping or narrative reviews on DCD were used to capture both comprehensive and descriptive syntheses. Inclusion criteria were publications within the last ten years; published in the English language; and included people with DCD or equivalent terminology. Each question was classified as "answered" if a relevant review article or guideline from the past ten years provided sufficient, high-quality evidence addressing the topic. High-quality evidence was defined as systematic reviews, meta-analyses, or evidence-based clinical guidelines published within the past ten years and produced using transparent and rigorous appraisal methods. Questions without adequate or up-to-date evidence were retained as unanswered uncertainties and forwarded to the Steering Group for consideration during the next stage of prioritisation.
6. In September 2025, the wording of the questions was collaboratively reviewed by the Steering Group to produce neutral and accurate summary questions. This work culminated in the Steering Group agreeing a final list of 50 summary questions.

Table 1
Frequency of responses across respondent type.

Type of respondent	Number of people	Number of uncertainties (up to 3 uncertainties each)
Adult living with DCD (>16 yrs)	156	475
Child living with DCD (6–16 yrs)	9	23
Health, care or education professional	39	110
Parent / carer	87	262
Academic	17	50
Total	**308**	**920**

2.3.2.1. Outcome of data processing. Of the 920 submissions received, 34 submissions were excluded as unclear, out of scope or too broad (e.g. relating primarily to other neurodevelopmental conditions or just singular words, see supplementary material S2). A further 15 submissions were excluded due to insufficient clarity; this resulted in a total of 871 valid submissions to be processed.

Eligible submissions were grouped and synthesised into 63 summary questions (Supplementary Table S3). These questions reflected the breadth of issues raised across stakeholder groups and were organised into seven overarching thematic categories. Each summary question was checked against the existing literature to determine whether it represented an unanswered research uncertainty, this identified one question that had been sufficiently addressed and was therefore classified as answered.

The Data Mentors Group reviewed the 62 research uncertainties. Following discussion at the final Data Mentors Group meeting, consensus was reached to refine and consolidate these uncertainties, resulting in a final list of 50 research uncertainties. These 50 uncertainties were reviewed and agreed with the Steering Group. Table 2 presents the responses for each theme. The Full list of summary questions is provided in Supplementary Materials S4.

2.3.3. Phase 2, step 4: Interim priority setting

A second JISC survey was created in which participants were presented with the list of 50 summary research questions and were asked to select up to ten that they considered most important for future research. Data was collected between September 2025 and October 2025. As in Phase 1, parallel survey versions were used for children under 16 years and for adults and professionals, with identical survey content and only age-appropriate adaptations to the participant information sheet. The groups that were targeted for data collection were the same as those describe in Phase 1 and our methods of recruitment also remained the same.

2.3.3.1. Outcome, participant characteristics. A total of 222 responses were received for the Phase 2 interim prioritisation survey, see Table 3 for a breakdown across type of respondent. Detailed demographic information for each stakeholder group, including age, gender, ethnicity and geographic distribution, is presented in Supplementary Figures S5.

2.3.3.2. Outcome, data processing. The top ten questions (or 11 where ranks were tied) for each stakeholder group were identified and this resulted in a list of 28 questions. To reduce this list to 18 questions (the number required by the JLA for an online final consensus setting workshop) we selected the questions which appeared in the top 10 of more than one stakeholder group, this gave 14 questions. We then added any additional questions which appeared in the top 5 of a single stakeholder group, this added four additional questions. The breakdown of the top 18 questions and individual stakeholder groups priorities can be found in supplementary material S6.

2.3.4. Phase 2: step 5: consensus setting

A final online consensus setting workshop brought together 17 participants who had completed Phase 1 and 2 surveys and volunteered to take part in the final workshop. Participants were purposively selected to ensure a comprehensive representation from across the UK of adult, parent and practitioner perspectives. They represented adults with DCD (N = 9 aged 16–56), parents and carers (N = 3) and practitioners (N = 5), to reach consensus on the Top 10 research priorities through structured discussion and iterative ranking. The workshop was co-facilitated by three JLA Advisers to ensure fairness, transparency and equal participation.

At the final workshop, participants reached consensus on the Top 10 research priorities for DCD in the UK (see Table 4).

3. Discussion

3.1. Interpretation of the Top 10 research priorities

This study presents the first JLA PSP for DCD. Using a transparent, consensus-driven methodology, the PSP identified a Top 10 list of research priorities that reflect perspectives from individuals with living experience, parents and carers, practitioners and academics. These priorities identify the areas of research that require the greatest attention within the UK context.

The priorities extend beyond motor coordination difficulties to encompass emotional wellbeing, non-motor challenges, education, adulthood and ageing and diagnostic pathways. Taken together, these findings underline that DCD is a multidimensional, lifelong condition in which motor difficulties interact with cognitive, emotional and environmental factors to influence everyday functioning (Blank et al., 2019).

Table 2
High level themes.

Theme	Number of responses	Number of summary questions
Ageing and adults with Dyspraxia/ DCD	66	2
Biology and risk factors	75	2
Diagnosis	107	6
Experience, impact	177	14
Interconnection with neurodivergent and other conditions	193	9
Support	207	13
Awareness, information, education, communications	61	4
No question/unclear/answered/out of scope/insufficient clarity	49	2

Table 3
Respondent type.

Type of respondent	Number of people
Adult living with DCD (>16 yrs)	98
Child living with DCD (6–16 yrs)	11
Health, care or education professional	25
Parent / carer	74
Academic	14
Total	**222**

Table 4
The final Top 10 priorities.

1. How best to support the emotional and social well being of people living with DCD/Dyspraxia, including self esteem, self confidence?
2. How could early diagnosis of DCD/Dyspraxia, and age appropriate interventions, improve outcomes?
3. How do non-motor skill challenges relate to DCD/Dyspraxia, and what strategies are effective for improving or working around these challenges (for example, ways of learning, time awareness, conversation, maths, organisation, planning, and executive function)?
4. How can we better communicate to educators about DCD/Dyspraxia and the individual needs and appropriate adjustments for learners living with DCD/Dyspraxia (for example, training for teachers about study techniques, PE)?
5. How does DCD/Dyspraxia impact and challenge daily life for adults and older adults, and what interventions are effective in supporting them (for example, therapies, practical strategies, and adjustments)?
6. What age appropriate interventions and strategies are effective across the lifespan in supporting independence for people living with DCD/Dyspraxia?
7. How does DCD/Dyspraxia change over the lifespan and at different life stages (for example, puberty, adulthood, older adults)?
8. How can diagnostic pathways and criteria for DCD/Dyspraxia be improved and made consistent, for children and teens?
9. What is the impact of culture and ethnicity on individuals who have DCD/Dyspraxia?
10. How can we move to a needs based assessment approach and support rather than only relying on specific diagnostic criteria and diagnosis for people living with DCD/Dyspraxia or suspected DCD/Dyspraxia?

3.2. Emotional and social wellbeing

The highest-ranked priority 'How best to support the emotional and social wellbeing of people living with DCD/Dyspraxia, including self-esteem, self-confidence?' shows the importance stakeholders place on outcomes beyond motor coordination, positioning emotional wellbeing as a central concern across the DCD lifespan. Despite growing recognition of these difficulties (Cleaton et al., 2020; Engel-Yeger, 2020; Harris et al., 2025; Rathbone & Wilmut, 2025; Tal-Saban et al., 2014), substantial uncertainty remains regarding how emotional and social wellbeing can be effectively supported. Stakeholders identified gaps in evidence about which strategies and interventions can improve emotional and social wellbeing, how support should be tailored across developmental stages and how emotional wellbeing interacts with mental health and motor / non-motor challenges (Klein et al., 2024).

The prominence of this priority suggests that current support pathways are insufficiently addressing emotional outcomes (Mancini et al., 2016). Interventions are often focused on motor skills alone with limited support for children with DCD and their families across healthcare, education and the wider community (Murray et al., 2025), which may contribute to a lack of self-confidence and self-esteem. This gap may contribute to unmet needs, particularly during key developmental transitions such as starting school, adolescence and adulthood (Rihtman et al., 2022).

Meeting this priority demands interdisciplinary research across psychological and health domains, alongside evidence-based training for all stakeholders that is informed by lived experience (Murray et al., 2025). Future studies should consider outcomes meaningful to individuals and families, including self-esteem, self-confidence and wellbeing.

3.3. Lifespan perspectives and adulthood

There is a strong emphasis on adulthood, ageing and life transitions within the Top 10. Although DCD is recognised as a lifelong condition (American Psychiatric Association, 2022), the PSP identified significant gaps in understanding how DCD affects adult daily life, including employment, independence, mental health and quality of life, as well as uncertainty about effective interventions beyond childhood. This corresponds to priority 5. 'How does DCD/Dyspraxia impact and challenge daily life for adults and older adults, and what interventions are effective in supporting them (for example, therapies, practical strategies, and adjustments)?'

The emphasis on ageing and transitions also reflects priority 7. 'How does DCD/Dyspraxia change over the lifespan and at different life stages (for example, puberty, adulthood, older adults)?' The prioritisation of adulthood-focused research highlights limitations in current funding, service provision, particularly around transitions from childhood to adulthood and from education into employment (Kirby et al., 2013). These findings reinforce the need for longitudinal studies and adult-specific research to inform service development and policy across the lifespan (Tal Saban & Kirby, 2018). This aligns with another lifespan-focused priority 6. 'What age-appropriate interventions and strategies are effective across the lifespan in supporting independence for people living with DCD/Dyspraxia?'

3.4. Diagnosis, assessment and support approaches

Several priorities focused on diagnostic consistency, clarity of pathways and the potential value of needs-based approaches to assessment and support, as discussed by (Materula et al., 2025). This includes priority 2: 'How could early diagnosis of DCD/Dyspraxia, and age-appropriate interventions, improve outcomes?' reflecting ongoing challenges in how DCD is identified and managed across settings and developmental stages (Ip et al., 2021). This connects directly to priority 8. 'How can diagnostic pathways and criteria for DCD/Dyspraxia be improved and made consistent, for children and teens?'

Although diagnostic criteria are well established, variability in implementation, access to assessment and post-diagnostic support remains a concern (Eddy et al., 2026; Klein et al., 2024). The prioritisation of needs-based approaches suggests uncertainty about whether diagnostic labels alone are sufficient to guide support and highlights a gap in evidence regarding alternative or complementary strategies that focus on functional impact and individual needs. This is reflected in priority 10. 'How can we move to a needs-based assessment approach and support rather than only relying on specific diagnostic criteria and diagnosis for people living with DCD/Dyspraxia or suspected DCD/Dyspraxia?'

Addressing this uncertainty has important implications for service delivery, particularly in contexts where access to formal diagnosis is limited or delayed (e.g., NHS waiting lists; Public Accounts Committee, 2025).

3.5. Education, professional communication and awareness

Priorities related to education, professional communication and training highlight challenges in translating research evidence into practice (Abu-Odah et al., 2022). Stakeholders emphasised the need for evidence-informed strategies to support learning and participation across educational settings, including physical education. Children and young people prioritised research questions related to informing teachers and education professionals, reflected in the inclusion of an education-focused priority within the Top 10 - priority 4. 'How can we better communicate to educators about DCD/Dyspraxia and the individual needs and appropriate adjustments for learners living with DCD/Dyspraxia (for example, training for teachers about study techniques, PE)?'

This priority indicates variability in professional knowledge, training and confidence regarding DCD among educators and other professionals (Hunt et al., 2021). It highlights the need for research exploring how effective strategies can be integrated into educational systems and sustained through structured training and clear communication.

3.6. Culture and ethnicity

The inclusion of culture and ethnicity as a Top 10 priority demonstrates a critical gap in the current literature. Existing studies have largely focused on predominantly white, Western populations, limiting understanding of how cultural and ethnic factors shape peoples living experiences (Plaisime et al., 2023). This aligns with priority 9. 'What is the impact of culture and ethnicity on individuals who have DCD/Dyspraxia?'

Stakeholders recognised that cultural context influences how DCD is experienced and that disparities in access to assessment and support may persist (Town et al., 2024). It is imperative that future research addresses these dimensions to ensure evidence and interventions are inclusive, equitable and applicable across diverse populations (National Institute on Minority Health and Health Disparities, 2025).

3.7. Comparison with previous priority-setting exercises

The priorities identified in this PSP show areas of overlap with previous exercises, including the Canadian DCD research and knowledge translation study (Camden et al., 2019), particularly regarding early identification, education and service organisation. However, the stronger emphasis on adulthood, emotional wellbeing and diagnostic pathways in the present study may reflect differences in stakeholder experiences and service structures within the UK. These similarities and differences reinforce the value of context-specific PSPs, as research priorities are shaped by healthcare systems, educational frameworks and sociocultural factors.

3.8. Strengths and limitations

Key strengths include rigorous adherence to JLA methodology which included meaningful involvement of individuals with living experience throughout all stages of the process (James Lind Alliance, 2010). Inclusion of multiple stakeholder groups across the lifespan, from all regions across the UK, the use of accessible materials all enhance relevance and credibility.

This study was limited by the underrepresentation of participants from ethnically diverse backgrounds, which may restrict the extent to which the identified priorities reflect experiences and needs across different cultural contexts. Children and young people were also underrepresented compared to adults; however, this was mitigated during interim prioritisation by ensuring that findings from Phase 2 were weighted.

3.9. Implications for future research

The Top 10 priorities provide clear guidance for future DCD research in the UK. Addressing these priorities will require interdisciplinary collaboration across health, education and social care, as well as greater inclusion of adults and diverse populations.

Future studies should consider cultural context, lifespan perspectives and real-world application. Aligning research efforts with stakeholder-identified priorities has the potential to strengthen the relevance and impact of the evidence base and inform policy and practice.

4. Conclusion

This study reports the first JLA PSP for DCD. Through involvement of individuals with living experience, parents and carers, professionals and academics, a transparent and systematic process identified research questions that matter most to those directly affected.

The findings highlight substantial gaps in the evidence base, particularly regarding lifespan perspectives and emotional wellbeing. The prioritisation of culture and ethnicity, alongside underrepresentation of diverse backgrounds, reinforces the need for inclusive research that reflects varied experiences. By establishing stakeholder-driven priorities, this PSP provides a clear roadmap for future research, funding and policy development. Addressing these priorities has the potential to improve the relevance and impact of DCD research and ultimately enhance outcomes across the lifespan.

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CRediT authorship contribution statement

Catherine Purcell: Writing – review & editing, Visualization, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Anna Donnelly:** Writing – original draft, Visualization, Project administration, Investigation, Formal analysis, Data curation. **Helen Bishop:** Writing – review & editing, Visualization, Validation, Data curation. **Annie Dahl:** Writing – review & editing, Visualization, Validation, Data curation. **Judith Gentle:** Writing – review & editing, Visualization, Validation, Data curation. **Elisabeth Hill:** Writing – review & editing, Visualization, Validation, Data curation. **Amanda Kirby:** Writing – review & editing, Visualization, Validation, Data curation. **Abby Mason:** Writing – review & editing, Visualization, Validation, Data curation. **Victoria McQuillan:** Writing – review & editing, Visualization, Validation, Data curation. **Andrea Meek:** Writing – review & editing, Visualization, Validation, Data curation. **Sally Scott-Roberts:** Writing – review & editing, Visualization, Validation, Data curation. **Krystal Shaw:** Writing – review & editing, Visualization, Validation, Data curation. **Tumi Sotire:** Writing – review & editing, Visualization, Validation, Data curation. **Sope Wolffs:** Writing – review & editing, Validation, Supervision, Methodology. **Kate Wilmut:** Writing – review & editing, Visualization, Supervision, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Declaration of Generative AI and AI-assisted technologies in the writing process

Initial drafting and revision by AD used Microsoft M365 Copilot (GPT-5 Chat Model) to support the initial drafting and revision of this manuscript. The tool was used to enhance clarity, structure and grammar and to suggest alternative phrasing. It was not used to generate scientific concepts, interpret findings, or conduct data analysis. All AI-assisted content was critically reviewed, edited and validated by the authors to ensure accuracy and integrity. Subsequent revisions undertaken by co-authors did not involve the use of AI tools.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.ridd.2026.105305.

Data availability

Data will be made available on request.

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