Developmental specialists in Europe: comparison between Healthcare and education systems, and Rehabilitation in child disability

Francesco Cerroni[1], Giuseppina Della Corte[1]*, Alison Guarino[2], Andrea Bonifacio[1], Marco Carotenuto[1], Federica Martino[3], Raffaella Salatiello[3], Arianna Pirozzi[4], Paola Alessandra Albano[5]

1. *Clinic of Child and Adolescent Neuropsychiatry, University of Campania "Luigi Vanvitelli", Italy*;
2. *Centro Minerva* (*Napoli*);
3. *Centro Manzoni* (*Napoli*);
4. *Fondazione Istituto Antoniano* (*Ercolano*);
5. *Amica Soc. Coop. Soc.* (*Siracusa*).

* *Corresponding author.*
E-mail address: pinadc.1991@gmail.com

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Abstract

Background and aim of the study
In recent years, there has been significant advancement in policies for the social inclusion of children and adolescents with disabilities to guarantee them, equity and equal opportunities in education, and adequate rehabilitation care in the health field. However, significant disparities persist at the European level about the complex care of disorders in the 0-18 age group. The Neuro and psychomotor therapist of the developmental age (TNPEE) is in Italy the health professional who specializes in the developmental age and carries out prevention, habilitation, and rehabilitation interventions with professional autonomy, configuring a global development project. To identify the professional figures that deal with these disabilities at a European level and compare them with the professional and training profile of the TNPEE, an analysis of the health and educational contexts in which children and adolescents are cared for and assisted has been carried out.

Methods
A comparison of the different public and private health care systems was made, with particular attention to the policies implemented by the individual states taken into consideration, in the management of disability in developmental age and, logically, of the health care, social, and educational/training services present and involved therein.

Results
This review provided an understanding of the advantages and disadvantages of the individual systems to costs, expectations, and equity in access to services for the developmental age, and a certainly not complete but exhaustive picture of the health and non-health professionals (as well as their training) present in the world of childhood rehabilitation, which varied considerably from one country to another.

Discussion and Conclusions
The present discussion leads one to reflect on the different figures who, in various countries, intervene as "Developmental Specialists" in the developmentally disabled child. The examination carried out highlights not merely substantial differences between the profiles analyzed and the healthcare realities in which they operate but also wishes to recognise the value of the TNPEE, as a unique and peculiar healthcare figure in terms of competencies and specificity, and to reason on the hypothesis of its exportation outside the Italian borders.

Introduction

Background and context of reference

The UN Convention on the Rights of Persons with Disabilities, approved on 13th December 2006 and implemented in Italy with law no 18 of 2009, kicked off a set of measures and interventions aimed at ensuring the full participation of persons with disabilities in social life. The support for disability in the health, economic, and social spheres is to be considered one of the fundamental prerequisites for the realization of an inclusive and modern State, and in Italy, even the most recent National Recovery and Resilience Plan (PNRR) has placed considerable attention on policies in favour of persons with disabilities. As regards children and adolescents with disabilities, the investments and measures aimed at them are intended to guarantee the same and equal opportunities in the field of education and appropriate rehabilitative assistance in the field of health; two aspects that must necessarily be combined to foster the realization of the individual as a person. However, at European and world levels the ways in which this support is implemented do not to date guarantee uniformity in terms of service provision, both because of the different models of health organization, the different approaches on which the education systems are based, and also because of

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socio-cultural aspects.
The purpose of this work is to analyse the system of taking charge of children with disabilities in various European countries, offering a synthesis of the health services, and therefore of rehabilitation pathway, as well as of the educational approaches, identifying possible criticalities and opportunities, but above all researching the professional figures that are needed in the complex process of taking charge and which are alternatives to the neuro and psychomotor therapist of developmental age. This latter is a health figure and Italian excellence in the rehabilitation field who, due to the educational pathway and professional profile is to be considered the 'developmental specialist' of the subject in the developmental age.
To achieve this aim, we have established specific micro-objectives that have driven our examination:

- providing an analysis of the health systems operating in the various European countries.
- Comparing the educational models, present in these countries.

The organisation of health services in Europe

The healthcare systems certainly constitute the foundations of modern societies thanks to a characteristic organization of resources and the implementation of territorial socio-economic policies that guarantee all citizens access to essential health services. In European countries, the organization and the provision of services take place through mutualistic-insurance type organizational models with a private orientation (Bismark Model) or with a Public/State orientation through National or Territorial Taxation (Beveridge Model). The Italian National Health System (servizio sanitario nazionale, SSN) disciplined by Law no 833 of 23 December 1978, is founded on the social right to health of the individual citizen and is based on the fundamental principles of universality, equality, and equity, guarantees generalized health care. Specifically, health is understood as a community resource (concept of universality); all citizens are guaranteed equal access, quality and transparency of services concerning equal health needs (concept of equity); finally, through correct and adequate communication of clinical- health information, the citizen's level of education and understanding is respected, not completing any form of distinction and/or discrimination against the individual that might hinder access to services (concept of equality). In addition, the SSN guarantees uniformly to citizens the Essential Levels of Care (Livelli Essenziali di Assistenza-LEA) by applying interventions for the promotion, maintenance and recovery of health through Local Health Authorities, Hospital Authorities and private facilities accredited and /or affiliated with the SSN.
Obviously, in the rest of Europe, the healthcare organization varies among the states. For example, the structuring of primary and specialised care in the Spanish healthcare system is very reminiscent of that in Italy in which prevention and health promotion activities are carried out. General care is also provided in specialised centres and/or hospitals, and the provision of services is separated by dividing the territory into 'Health Areas'- comparable to the health districts in Italy- each of which is administrated each of which is administered according to function, partly by the administrative body of the State, partly by the Autonomous Communities, and partly by local corporations.
The English national health system (National Health Service) is considered exemplary because it is financed almost entirely by the state, through taxes, and aims to provide universal and accessible medical care to all inhabitants of the country, regardless of their social or economic status.
In contrast, the German healthcare system provides healthcare services through welfare insurance and the type of care depends on the policy taken out.
Finally, other countries, such as France, have developed a mixed health care system; although it makes use of statutory (SHI) and voluntary (VHI) insurance. French health care is based on the principles of the Beveridge model, such as those of universality and solidarity.

The School and Socio-Educational System for Disability in Europe: comparing models

The description of the subject's functioning in biopsychosocial terms, and as reported in international classification systems such as the International Classification of Functioning, Disability and Health (ICF), considers the environment, in terms of barriers and facilitations, and its decisive impact on the individual's adaptive processes and, consequently, on inclusion mechanisms. School should undoubtedly be considered one of the fundamental contexts for the social and global development of the individual. The focus on inclusive processes from a pedagogical point of view, highlighted in the 1994 Salamanca Declaration, supports, and promotes a model of 'school' as a system open to all.
However, in Europe, inclusive education, and the treatment of children with disabilities within the school system varies from one country to another with systems, norms, and rules that are profoundly dissimilar from one another, first and foremost, in terms of values and in achieving the goal of integration. Precisely, based on the integration policy adopted in their national territory, the educational systems can be divided within the various European countries into three broad categories, i.e., systems adopting a unidirectional (single), multidirectional (complex), and bidirectional (dual) approach.

School systems with a one-way approach: the examples of Italy and Spain

In Italy, the assessment of the developmental disability condition for school inclusion makes it possible to identify, according to the seriousness of the

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condition, the hours of school support. For people with disabilities, the PEI (Individualised Educational Plan – Piano Educativo Individualizzato) is adopted and drawn up annually, according to Law no. 104 of 5 February 1992, drafted at the beginning of the school year by the teaching staff and the psycho-socio-medical team who jointly outline the educational, socialization, and learning objectives as well as the strategies to achieve them, including assessment methods. The Italian school system includes in the category of 'BES' (subjects with special educational needs - Bisogni educative speciali) students with DSA (Specific Learning Disorders), and those who have difficulties due to socio-environmental, cultural or family causes (Ministerial Directive drawn up by the Miur on BES in 2012). For students with BES, if necessary, the adoption of the PDP (Personalised Learning Plan – Piano Didattico Personalizzato) is envisaged, while for those with DSA (specific learning Disorders – Disturbi specifici dell'apprendimento), it is compulsory and is arranged by the class council for the disciplines involved in the expression of DSA. While in the first school cycle, the plan is valid for promotion to the next class; in secondary schools, according to Article 15 of Ministerial Ordinance no. 90 of 21 May 2001, a distinction is made between a simplified PEI and a differentiated PEI: with the differentiated course, the student is guaranteed attendance, but not the qualification.

The current Spanish education system operates according to the 2002 Law on the Quality of Education (LOCE), which introduced the concept of 'specific educational needs' divided into four subgroups: students with special educational needs who face barriers that prevent access, attendance, and participation in school life due to severe behavioural disorders or a severe disability; students with high intellectual capacity; students with specific learning difficulties; students with late integration into the Spanish education system due to causes such as coming from other countries. Educational establishments define precise procedures and resources to identify at an early stage what are the specific educational needs of students, initiating assistance and educational support to those who need it according to the principles of inclusion.

School systems with a multidirectional approach: the examples of France and England

In France, since 2005, with the adoption of the Law on the Equal Rights of People with Disabilities in schools, universities and work, students with disabilities have been included in ordinary schools. Despite this, the family, in agreement with the child psychiatrist and teachers can still request that their child be placed in a so-called 'special class' with 7-8 other students, usually all with intellectual disabilities, in classrooms adjacent to the other classrooms where a completely different curriculum is taught.

In the UK before 2004, each region had special residential schools specifically dedicated to each type of disability. Today, 50% of pupils with disabilities attend mainstream classes except for those with sensory disabilities.

Nursery, Infant schools, state schools, and local authorities have to identify and assess children with special educational needs and disabilities and support teachers to ensure their inclusion processes by providing them with aids. Based on the assessment of special educational needs, the outlining and personalization of the educational pathway, pedagogical differentiation and the organization of the aids are carried out. Within the collective school, there are the Territorial Units for Inclusive Education (ULIS - Unités localisées pour l'inclusion scolaire) both for first and second-grade school, where subjects with disabilities are also included in ordinary classes, also followed by non-specialised teachers who as a consequence of this, deepen their education. Students with disabilities can also be enrolled in socio-medical institutions, which provide educational and therapeutic services.

Dual school systems: the example of Germany

Special schools in Germany represent a training and educational system parallel to the regular school system. Children with disabilities or learning difficulties are placed in German special schools, called 'Förderschulen'. These are schools for children with special needs or psychophysical disabilities of various degrees, where the children of foreigners who have difficulties with the German language are also often placed. Germany is the only country in Europe where special classes exist for students with Specific Learning Disorders. It is usually the school authorities who propose to families that their children be enrolled in a special school. Different types of tests are offered to the child to ascertain the disability with the parent's consent. Once the diagnosis has been made, the teachers propose a transfer to a special school. The risk for these children placed in support schools is that they do not obtain any qualification, even though opportunities to enter the world of work are offered to them. In Germany, there is another possibility for disabled children, namely 'inclusive schools' (Gesamatschule) where 'Inklusion' is practised and in which children are placed in regular classes but are looked after by support teachers.

Focus on the organisation of the rehabilitation process

As the Ministry of Health reminds us, rehabilitation is part of the healthcare system and it represents the third cornerstone alongside prevention and treatment activities; it is the process through which the disabled person aims to achieve the best possible level of autonomy on a physical, functional, social, and intellectual level. Considering the different organisational approaches in the provision of health

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services among member states, the World Health Organisation (WHO) periodically attract the interest of politicians and national actors to raise awareness and develop a national commitment to rehabilitation. Rehabilitation, defined as '*a set of interventions designed to optimise, functioning, and reduce disability in people with chronic, acute diseases, disorders, injuries, or trauma*' requires continuous prioritisation of health care through flexible planning and allocation of resources combined with a contingent analysis of funding mechanisms.

In Europe, specific rehabilitation for the developmental age varies in the different states according to the presence or absence of medical disciplines specialised in this field.

In Italy, the rehabilitation of individuals between the ages of 0 and 18 years is the prerogative of Child Neuropsychiatry, a specialist medical discipline that deals with evolutionary neuropsychic development. Encompassing various neurological and psychiatric pictures, as well as neurological, neurosensory, neuro-orthopaedic disabilities, language difficulties, cognitive development, learning, psychological, and relational discomforts, the Italian rehabilitation process involves numerous professional figures such as the Neuro and psychomotor therapist of the developmental age (TNPEE), the speech therapist, the psychologist, the social worker, the occupational therapist, the physiotherapist, and teachers. The team outlines an individualised therapeutic project marked by short-, medium- and long-term objectives, by the clarification of methods, intervention strategies, and the most appropriate assessment tools to be used.

In Spain, the figure of the Child Neuropsychiatrist is replaced by the medical figure of the Neuropediatrician, who is in charge of assessing both the motor and psychic development of the child and is also specialised in understanding the possible presence of developmental delays, alterations or disorders. The structure of the rehabilitation intervention varies from one country to another, but, in general, the essential needs of the child population are guaranteed by the 'Early Care' service.

In France, the therapeutic intervention dedicated to the child population mainly takes on a habilitative character with a preventive-early background, in which the child's physical and mental health is promoted, such as screening activities, diagnosis, and therapeutic projects carried out at an early stage, and which aimed at reducing risk factors and promoting protective factors.

In Germany, clinical treatment takes on a preventive-habilitative and rehabilitative-specialist nature through specific psychotherapeutic, pharmacological, complementary, logopaedic, occupational, or psychomotor treatments in the case of an overt or known diagnosis and intensive treatment in child and adolescent psychiatric clinics for very pronounced pathologies that cannot be adequately ameliorated by ambulatory therapy.

The neuro-psychomotor discipline in Europe

The rehabilitation intervention is aimed at the psychophysical well-being of the subject placed in a developmental age through continuous stimulation and/or restoration of residual, proximal or potential functions. In Europe, the knowledge of the therapeutic rehabilitative nature of the neuro-psychomotor discipline varies according to the recognition of the profession from an institutional point of view and the consequent fields of application (health, prevention, research). The heterogeneity of the training pathway and its recognition has, over time, determined an objective difficulty of correspondence between the Member States concerning the Italian figure of the Neuro and Psychomotor Therapist of developmental age (Terapista della neuro e psicomotricità dell'età evolutiva - TNPEE), a health professional specialised in the knowledge and practical skills to intervene in the habilitative, preventive, and rehabilitative spheres on the developing child. This disparity led in 1996 to the creation of a European Forum of Psychomotricity (EEP), which aims to:

- Promoting cooperation between psychomotor specialists from different European countries and regions through mutual exchanges, conferences, project development, formations, and research.
- Coordinating initial formation, continuing education through general guidelines, examinations, and promotion of the harmonization of professional education concerning the recognition by the government.
- Supporting 'psychomotricity' in Europe, in educational, preventive, and therapeutic practice, initial or continuing training, professionalization and scientific research.
- Supporting countries and regions where the psychomotor discipline is not yet well developed.
- Representing the common interests concerning professional politics, social insurance acceptance, level of income, and protection of the initial formation.

Currently, the forum has more than 14 Member States in which 'psychomotricity' is practiced. The most important realities, in addition to Italy, are represented by France and Switzerland, countries in which this profession is recognised by the State and is applied both in education and health fields. The activities promoted have produced several informative documents that have led to the achievement of bilateral agreements, minutes, and official letters approved by the European Commission. The free movement of psychomotricists within the European Union (EU) is regulated by Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005

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on the recognition of professional qualifications. According to that Directive, professionals in the field of psychomotricity, legally recognised in one of the EU Member States, may apply for recognition of their professional qualifications in another Member State, following particular conditions variable/definable independently from country to country and specific procedures. It is necessary to show a professional qualification, which is equivalent to the standards required in the country where recognition is requested (equivalence process). In case of non-completion of this procedure, if practitioners were to carry out the healthcare activities anyway, it would constitute a condition of professional abuse. Since the creation of the European Forum of Psychomotricity, the education, formation, and practices of different countries have come closer together. Thus, the inspiration and willingness to know each other have increased interest in learning from each other. In fact, the EFP with its initiatives and its work is increasing the visibility of psychomotricity at the political and European levels to facilitate the mobility of professionals between the various countries.

In the United Kingdom, psychomotricity is used in both the preventive and therapeutic fields. The approach to psychomotricity can vary depending on the region and the organisations involved. There are several associations involved in promoting psychomotricity in both educational and therapeutic settings such as the British Association of Teachers of Dancing (BATD) or the British Association of Dramatherapists (BADth). There is no specific regulation for the profession of psychomotor therapist, but often the psychomotor approach is used by other health professionals in their therapeutic interventions. The use of this discipline varies depending on the professional and the context in which they work. This knowledge is acquired by attending an Academic Master's Degree Course that lasts two years. There are several therapists specialised in the treatment of children with neurodevelopmental disorders.

In addition to the classic figures involved (speech and language therapists, physiotherapists, and occupational therapists) in the UK they operate in the developmental age:

- Physical Therapists: in charge of bringing out and supporting children in the acquisition of gross motor skills (walking, running, and jumping);
- Behavioral Therapists: in charge of modifying dysfunctional and problematic behaviour by trying to enable the child to learn new skills through the ABA (applied behavioural analysis)
- Neuropsychologists: in charge of assessing cognitive functions to identify interventions based on the child's specific needs.

In Spain, the psychomotor approach originated with the establishment of the Escuela International de Psicomotricidad (EIPS), and although the Spanish territory can boast an active role of the psychomotricist, even today there is no official recognition of the psychomotricist at an institutional level, nor is there a degree course in 'psychomotricity'. To enter this discipline, one must choose from the following options:

- Specific non-regulated training (not recognised by the Ministry of Education), through schools and private centres located throughout the territory. It is possible to enrol after attending any degree course in the health, humanistic, or educational fields; subsequently, depending on the duration of the course, one obtains a specific title/certificate that certifies different qualifications: diploma, specialist, or expert in psychomotricity.
- Through recognised Postgraduate or Master's Degree Courses (Master's in Psychomotricity, International Master's in Psychomotor Education and Therapy, Master's in Psychomotor Intervention, Master's in Psychomotricity, Education and Health) which can only be accessed by those with a health-related degree. This post-graduate training is promoted by the EIPS and is carried out by the Institute of Educational Sciences (ICE) and the specialists of the International School of Psychomotricity. This course provides a qualification that is valid throughout Spain and is compliant with the European level.

The difference between non-regulated training and postgraduate courses is in the academic recognition of the latter by the Ministry of Education, which is valid (according to the European model) throughout Spanish territory because they meet the requirements of the regulation establishing the organisation of Official University Training (RD 1393/ 2007 and its amendment by RD 861/2010). However, with the possession of one of the two titles, in a private or university setting, the professional can work in public or private facilities, providing individual or group treatments, in both educational/preventive and therapeutic settings.

In Germany, psychomotricity develops in the direction of 'educational gymnastics'. For more than fifty years, specialists in the field have focused primarily on the importance of motor skills and have found their correspondence in the motor therapist known as Motopäden: 'motology' and psychomotor skills are thus focused on physicality, corporeity, perception, movement, and play. These motor exercises can be provided to people of all ages, and take place in hospitals, in dedicated studios, in children's homes, but also in hospices and nursing homes. Professionals who wish to continue their training as Motopäden must obtain a degree in exercise science, social science, or medicine. The training lasts one year and at the end of the apprenticeship, professionals are authorised and recognised by the state to practice the profession.

Currently, Germany's main initiatives from a

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psychomotor perspective are the establishment of a three-year university degree course, the national recognition of psychomotor intervention as an independent professional field, and the development of a professional framework that distinguishes psychomotricity from other professional fields, such as the Motopäden. Traditionally, psychomotor approaches have been present in education and recreational activities, as well as in private practice. Today, psychomotor intervention services are increasingly used in counselling and support for the elderly. While state-licensed motor therapy and motology are gaining more recognition in the field of rehabilitation and preventive medicine. To support the availability of psychomotor treatments for the developmental age in Germany, numerous research projects have been initiated in recent years. Finally, the relevant institutions offer psychomotor interventions at the doctor's request.

In France, psychomotricity has its highest expression: the psychomotricity therapist (Therapeute en psychomotricité) is an auxiliary health professional, whose training involves three years of study following the high school diploma, with the State Diploma issued by the Ministry of Health. University training is regulated by Article R-4332-1, and access to these studies requires passing an admission examination set by the psychomotricity training institutes, based on a French language test (text contraction, with questions or discussion) and a biology test (MCQ, exercises, written questions). Since the publication of the Ordinance of 24 March 2017, the State Diploma in Psychomotricity allows direct access to the second year of a medical degree. Psychomotor assistance is carried out on medical prescription by a state-licensed psychomotor therapist. Psychomotor therapists, once they have passed the State examination and obtained their Diploma, are required to register with the regional health agency (ARS) of their place of professional residence, an obligation set out in Article 4333-1 of the Public Health Code. From a legislative point of view, the ministerial decrees that led to the evolution and regulation of 'Psychomotricien' are the following:

- Decree 74-112 of 15 February 1974 establishing the diploma of psycho-re-educator.
- Decree 85-188 of 7 February 1985 replacing the previous name with that of psychomotor therapist.
- Decree 88-659 of 6 May 1988 establishing the intervention frameworks of the psychomotor therapist.
- Decree 95-116 of 4 February 1995 inserting psychomotor therapists in Book IV of the Public Health placing them as auxiliaries to the doctors.
- Article R-4332-1 of the Public Health Code defines the professional competencies of psychomotor therapists and is currently the text that regulates the practice of the profession in France.

In general, the Italian reality finds greater European correspondence with the role of the French psychomotricist and its institutional and professional recognition.

In other European countries, the Neuro and Psychomotor Therapist of Developmental Age (TNPEE), undergoes professional diversifications depending both on the institutional recognition of the profession, as well as the variability of the recognised areas of intervention, the specificity of the training pathway, and on the interest aimed at a certain area of development, a known disorder, or a particular age group. In fact, in the United Kingdom, there is a structuring of three specific professional profiles per area of intervention: Physical Therapists for the acquisition of gross motor skills, Behavioral Therapists for the modification of dysfunctional behaviours, and Neuropsychologists for the assessment of cognitive functions. In Spain, access to the psychomotor discipline is correlated to the educational pathway undertaken (unregulated training or Postgraduate Courses academically recognised by the Ministry of Education) and in Germany the discipline is addressed not only to the developmental age but also to the adult age for a purely motor and physical interpretation (prescription of motor and/or educational gymnastics).

Conclusions

The heterogeneity that has emerged from the study carried out is the mirror of a European Union that recognises a range of values, rights, and ideals, legally recognised and protected, that strives to pursue objectives of equality and integration, but that is fragmented in how the same are applied and pursued. The approach to assessing the health of the child, even in the absence of disability, is increasingly closer to a holistic, biopsychosocial perspective, according to the idea that 'health care must take into account all the dimensions of health: physical, mental, social, cultural, spiritual as established by the WHO' (First Charter of Children's Rights in Hospital).

The life course of the disabled child is profoundly different in educational, habilitation and rehabilitation terms; from the same legal background and the same assessment systems of the global functioning of the subject, profoundly different systems emerge. The complexity of the health and educational approach to the health of children with disabilities made it necessary, at the European level, to draw up the 'European Disability Expertise (EDE)' contract, financed by the Rights, Equality, and Citizenship Programme of the EU, to collect and analyse information on the national policies of individual states concerning the provisions coming from the EU and to provide information on the educational, health, inclusive situa-

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tion experienced by people with disabilities.
In line with the goals of the UN Convention on the Rights of Persons with Disabilities, in March 2021 the European Commission adopted the 'Strategy for the Rights of Persons with Disabilities 2021-2030'; the protected persons include all those with different types of disabilities such as physical, mental, cognitive, and sensory impairments. Specifically, the goal is to ensure that all persons with disabilities in Europe can enjoy their rights with a view to equality and parity, guaranteed by a less limiting environment that is more responsive to the different needs that may arise. This is possible with the implementation of programmes that are inclusive of processes of awareness-raising and cultural enrichment, first and foremost, of those who surround the person with disabilities. The most profound realization of a holistic approach to the subject with disabilities should not exclude the presence, in the life course, of a medical-healthcare figure capable of reading and analysing the complex relationship between all the areas of neuropsychomotor development, to pursue therapeutic objectives (habilitative and rehabilitative) that invest the entire complexity of neurodevelopment. It is also important to emphasise the need for the generalisation of the skills learnt, a condition that can only be formally and substantially achieved by the creation of effective networks between all environments; the complex diversity of educational systems and therapeutic approaches, with boundaries that are not always clearly delineated, could complicate the achievement of this goal.

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