Low Vision Care in Canada: The Quebec Perspective.

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While the heated exchanges and friction continue among the three principal sources of eye care specialists—the ophthalmologists, optometrists and opticians—as evidenced by a front page article in the Montreal Gazette November 16th 1981, it is significant that nothing was mentioned of Low Vision Care.

It is significant perhaps, but not surprising, since few persons, including the great majority of these professionals, understand the concept or the practical needs of persons with low vision. For the small percentage of ophthalmologists and optometrists who do possess a reasonable knowledge of this relatively new field, few can afford to participate in the work due to its time-consuming nature and the need for resources and expertise beyond their routine clinical skills.

It is not by accident that most of the largest and most effective low-vision clinics in North America are operated by agencies for the blind. The clinic attached to the New York Association for the Blind known as "The Lighthouse" for example, is one of many excellent agency-run low-vision services in the United States. It has served as model and inspiration for one of Canada's most comprehensive low-vision clinics at the Montreal Association for the Blind.

In Canada, low-vision care is in its infancy. Worthy of mention is the University of Waterloo's School of Optometry in Ontario which runs an excellent low-vision service. It is naturally very strong in its optometric component and is endeavouring to increase its comprehensiveness by incorporating and interacting with other low vision services.

The Baker Foundation in Toronto approaches low vision from the other end of the spectrum, concentrating on the quick and easy access to non-prescription magnifiers, telescopes, and low-vision accessories. They have been experimenting with and designing inexpensive but often effective low-vision devices. An increasing number of hospitals in major cities across the country are beginning to gather a small collection of magnifiers for demonstration to those patients who might be referred following an ophthalmological examination. They generally don't have any devices for loan or purchase; little or no training takes place; few if any non-optical aids such as lamps, reading stands, writing devices or mobility aids are available and no follow-up is given. Usually the patient is given a prescription, often without having tried the aid, and informed of stores or opticians where the aid might be acquired.

The situation is a little brighter in the Province of Quebec where three major centres now serve the rehabilitation needs of the visually-handicapped, including the low-vision requirements of the partially sighted. About five years ago, the Quebec Government, recognizing the absence of adequate service for the majority of Francophone visually-handicapped persons, approached the Montreal Association for the Blind for assistance to develop new services. The MAB helped the Ministère des Affaires Sociales in the hiring and training of staff for the two new Government AMEO Centres of Nazareth-Louis-Braille in the southeast end of Montreal and Centre Louis Hébert in Quebec City. These two new rehabilitation centres, along with the Montreal Association for the Blind, now are able to offer the visually handicapped population of Quebec more rehabilitation and low-vision services than any other area of the country. In addition, all aids and devices, including expensive prescriptions and even electronic visual aids (EVA's) such as closed circuit television systems (CCTV's) are provided free of charge for visually-handicapped persons under 35 years of age. It is estimated that in Quebec alone there are 50,000 persons with a visual acuity of less than 20/70 who might benefit from low-vision services.

What do we mean by "Low Vision"? At the Montreal Association for the Blind, as in many other agency-run low-vision clinics, we are not bound by legal definitions, although the majority of clients have less than 20/70 acuity. Rather, we are concerned with how their reduced vision is causing problems in their everyday activities. If a person expressed unusual difficulty in reading, writing, getting around safely alone, or any other problem associated with a significant reduction in vision, they are welcome to be seen for a low-vision assessment. A thorough low-vision assessment should include the following elements:

1: an ophthalmological examination or recent report to clarify or recommend any pathological question;
2: a low-vision interview to establish and clarify the functional problems and expectations of the client;
3: field tests and colour tests when appropriate;
4: an optometric examination to check the validity of the client's current prescription, refraction, trial of headborne devices for near and distance, and recommendations to low-vision therapists or assistants as to the appropriate power of other aids to examine;

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5: an examination of optical aids such as hand and stand magnifiers, distance aids and monoculars, electronic magnifiers and sun-control devices;
6: an examination of non-optical aids such as lamps and reading stands, large print, talking books on record and cassette, Braille low-vision and talking watches, writing and cheque guide devices, and recreational devices.

A thorough low-vision assessment generally requires 2 to 4 hours and involves 3 to 6 professionals. The assessment, however, is only the beginning. A successful low-vision service should also include the following elements:

1: a loan of aids service to allow the clients an opportunity to experiment with the devices under their real, and often less-than-ideal conditions;
2: a stock of aids for immediate loan or purchase;
3: a period of training and experimentation with the low-vision therapist, both at the clinic, and when possible, in the home;
4: a source of quick and easy referral to other services as required, such as orientation & mobility specialists, rehabilitation teachers and occupational therapists for help in activities of daily living such as typing, writing, Braille and optacon; counselling, and recreational pursuits;
5: a system of regular follow-up.

It is probably clear, from the description of recommended components in a successful low-vision clinic, why the majority of comprehensive low-vision services are found in agencies for the visually handicapped, where most of these services already exist. The need in Canada, however, is too great for agencies alone to supply the majority of the low-vision services. The challenge of meeting the demand for improved low-vision care in this country should be recognized and faced by all professionals who work in the broad field of eye care. Individual practice could include more elements pertaining to low-vision. More frequent referrals to more comprehensive low-vision services could be made. Above all, an increased sensitivity and awareness of the problems of persons with low vision could go a long way to helping Canadians with poor vision get the proper assistance that is within our capability to provide.

Montreal Association for the Blind Low Vision Clinic

Founded in 1908, the Montreal Association for the Blind has continually added to its client services. In 1979, the MAB established an extensive service to provide low vision aids.

What makes the MAB service particularly effective is the fact that it brings together a multi-disciplinary team of experts working cooperatively in one location.

Once the ophthalmological assessment is received, the patient is treated by professionals in the fields of Optometry, Occupational Therapy, Mobility, Rehabilitation and Social Work. A great deal of assessment, counselling and training is given to the client through these allied services. The MAB carries a wide range of optical and non-optical aids which are made available to anyone handicapped by a lack of vision. Overall emphasis is on the team approach, to enable those who are visually impaired or blind to compensate for their visual deficits and to achieve their highest level of self-sufficiency.