Paediatric vision impairment – the bigger picture

Rasmeet Chadha discusses education, employment and social inclusion in the context of the UK Vision Strategy

The UK Vision Strategy was launched in 2008. It was in response to a World Health Assembly resolution in 2003 which urged the development and implementation of plans to tackle vision impairment now known as ‘vision 2020 plans’. The UK Vision Strategy was developed following a comprehensive consultation process with over 650 organisations and individuals and sets a strategic framework for improvement to the UK’s eye health and outcomes for people with sight loss.1

In 2012 the UK Vision Strategy was reviewed and the outcome of the consultation was that the original aims remain valid, that significant progress has been made and that there is great potential for further advances. A refreshed UK Vision Strategy was launched for 2013-2018 backed by Prime Minister David Cameron.

The three main outcome measures of this refreshed UK Vision Strategy are:

- Everyone in the UK looks after their eyes and their sight
- Everyone with an eye condition receives timely treatment and, if permanent sight loss occurs, early and appropriate services and support and available and accessible to all
- A society in which people with sight loss can fully participate.

Children and Young People (C&YP) have specific mention within this refreshed UK Vision Strategy and concentrating on outcome three (above) there is a key statement relating to C&YP: To ensure that C&YP with sight impairment take their place in society.

This article will concentrate on the areas of education, employment and social inclusion for C&YP with vision impairment (VI). It will concentrate on those with isolated VI or where VI is the main disability. We must be mindful that up to 70 per cent of C&YP with VI have additional disabilities.2

Education

Current RNIB estimates from 20123 report that 67.6 per cent of primary age children and 59.4 per cent of secondary age children with VI are educated in mainstream schools. These C&YP are expected to attain the same standards in education as their normally sighted peers. Once out of education many of them will form economically active members of society and are expected to be equals to those that are normally sighted.

Recent research from Cardiff University4 found that C&YP often did not like to use their optical aids at school as they felt they made them look different, the aids were bulky in design and had poor durability. The children interviewed as part of this focus group work were also frustrated by the slow reading speed with the aids.

It was found5 that there was a 77 per cent increase in regular use of LVAs for children in mainstream school if they were reviewed in a multidisciplinary low vision clinic (optometrist and rehab worker working for education department). We therefore have a key role here as optometrists in liaising with our education and social care colleagues to increase the regular use of LVAs in school. By listening to our patients’ needs we can try to dispense LVAs that are not only suitable for the task in hand but that they will be happy to use.

In 2008 Pavey et al6 reported that it appeared that earlier onset VI is associated with higher levels of educational achievement. They looked at C&YP with VI onset under the age of 17 years and further correlated the age of onset with final educational achievement.
LVAs are better adopted if they don’t highlight the child’s impairment

They go on to say that lower educational attainment with older age of diagnosis may in part be related to the social and emotional impact of loss of vision during adolescence and related to this, loss of vision is likely to bring about sudden and perhaps unexpected problems of access of education. More obviously the newly VI student is likely to have difficulty accessing normal-sized print without having the necessary skills or resources to overcome this new barrier. These barriers also exist for children under age 12, but they and their carers and educators have a greater amount of time to learn the appropriate skills.

Employment
Data from Network 10007 found that only 34 per cent of blind and partially sighted people were in employment compared to 75 per cent of the general population.

There are a number of barriers to finding employment and it is outside the scope of this article to review these. The transition for C&YP from children’s services to adult services is often not smooth.

As optometrists we span both children and adult services and are not usually contractually limited by age. We can therefore have a place in ensuring the YP has regular contact with a healthcare professional (ourselves) during the time when many of the other professionals they come into contact with change. By having built up a rapport with the YP and their family over the years we will be in a strong position to signpost the YP to appropriate support services to help them find and retain work, for example Access to Work, Disability Employment advisers and local voluntary associations for the blind.

The optical needs of the YP may change dramatically when the young person approaches employment age

The optical aids that worked well in education may now need to be changed to better suit the new work environment. For example a more specific intermediate VDU correction or a hands-free option to enable the YP to participate in meetings more naturally.

Social inclusion
The Oxford English Dictionary defines social inclusion as ‘The action or state of including or of being included within a group or structure’.

Sub items within the UK Vision Strategy outcome 3, while not exclusively for C&YP do relate directly to social inclusion:

● 3.5 Provision of benefits that recognise the daily challenges faced by those with sight loss
● 3.6 Access to information in formats of their choice
● 3.7 Leisure activities are fully accessible to everyone with sight loss
● 3.8 Public and commercial buildings are fully accessible
● 3.9 To enable people with sight loss to move around freely and independently
● 3.10 To support transport providers in the delivery of accessible end to end journeys.

As optometrists our direct role in promoting social inclusion of C&YP with VI is more nebulous. We naturally have an obligation under the Equality Act to ensure our premises are fully accessible for all those with disability including those with VI. We are able, through use of the Leaflet of Visual Impairment (LVL) and Referral for Visual Impairment (RVI) to refer our children and YP to rehabilitation officers who can work on developing independent mobility skills. We can signpost our patients to leisure activities that support those with VI such as local audio described theatre.

We have a role in the context of public health to raise awareness of VI among our fully sighted patients so that they in turn have a better understanding of the types of vision loss and the functional implications of this. It may simply be that by raising awareness, members of the public realise that visual impairment does not necessarily mean blindness.

Conclusion
Vision impairment in childhood usually means a lifelong disability. The goals and requirements of C&YP with vision impairment will vary throughout these years.

Supporting C&YP at this vital stage of their life can help set them up to be confident young adults who are economically active and are a key part of our inclusive society. The UK Vision Strategy provides us with strong evidence to develop and be part of a modern sight loss service.

References
5 Rudduck et al. Developing an integrated paediatric low vision service, Ophthal Physiol, 2004; Opt 24, 323-326.
8 Rasmeet Chadha is a hospital optometrist based in Oxford