LETTERS TO THE EDITOR

AER Explains Its Role in Vision Rehabilitation

We are writing in response to the October 1995 special issue on low vision of the American Journal of Occupational Therapy to provide an expanded picture of rehabilitation services for consumers who are blind or visually impaired and to offer occupational therapists the opportunity for collaboration with vision rehabilitation specialists.

Contrary to the image portrayed in the special issue, persons with visual impairments are neither only those over the age of 65 nor those with low vision. Visual impairments can be diagnosed at birth and throughout life and span the spectrum of acuity and visual function, which ranges from minimum distortion, such as nearsightedness, to total blindness. Visual impairment is not just the loss of one sense; it affects the functioning of all remaining senses and one’s ability to learn through traditional methods. Low vision aids and devices must be professionally prescribed and require specific training for consumers to successfully use each device for each task.

Vision rehabilitation and education services in the United States began in the 1800s. University preparation programs train rehabilitation teachers, orientation and mobility specialists, low vision specialists, and special education teachers or teachers of children with visual impairments. Rehabilitation teachers use special techniques and adaptations to guide and instruct persons with severe visual impairments to permit independent daily life. They work with consumers in all settings, and instruction is either with the individual person or with a small group, depending on individual evaluation and teaching goals. Instruction can include, but is not limited to, the following:

- Communication skills (e.g., braille, listening, adaptations for reading and writing, abaci, computers)
- Personal management skills (e.g., clothing care and grooming, medications management, eating, social)
- Home management skills (e.g., meal preparation, home mechanics, labeling and record keeping, safety)
- Leisure activities skills (e.g., hobbies, games, handcrafts, community activities)
- Home orientation and movement skills
- Training in use of optical devices (e.g., magnifiers, telescopes, closed-circuit television systems, similar prescribed devices)
- Guidance and counseling (e.g., adaptation to vision loss, community resources, support groups, family support)

Rehabilitation teachers and all vision professionals have national certification through the Association for Education and Rehabilitation of the Blind and Visually Impaired (AER). Some occupational therapists with additional training have qualified for rehabilitation teacher certification. Rehabilitation teachers work in multidisciplinary teams, often with occupational and physical therapists, and their services are reimbursed by insurances and Medicare.

For those readers interested in increasing their knowledge about vision rehabilitation, two professional journals are available: the Journal of Visual Impairment and Blindness from the American Foundation for the Blind and Review from AER. AER also has information about university programs and certifications. We welcome a dialogue with occupational therapists who are interested in better serving their consumers who have low vision. We hope to expand our collaborative efforts to provide the quality services to all consumers who are blind or visually impaired. It is through mutual respect and communication for each profession that consumers will receive maximum benefits.

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Position Paper on Occupational Therapy Aides Gives Wrong Message

Increasing health care costs and increasing societal need for rehabilitation medicine services, including occupational therapy, coupled with changing American values and a changing political climate have put pressures on many of us to be more productive with fewer resources. Managed care increases the need to take maximum advantage of our limited therapy sessions and to demonstrate successful therapy outcomes. Third-party payers also must be repeatedly convinced that we provide a necessary and valuable rehabilitation service for the client. Although these efforts are continuous, the fact that many private practitioners are gaining entry into networks as providers demonstrates our value to society. Our state organizations and the American Occupational Therapy Association (AOTA) have worked hard to maintain visibility in Washington, DC, to keep us included in major legislation as health care providers.

However, an old problem cloaked in new language looms ahead. Twenty years ago, Edith Winsron and many others on Long Island spearheaded efforts for New York State licensure. We were concerned about having untrained persons provide medical treatment and services called “occupational therapy” and how this affected our profession. We were also concerned that consumers often were paying for ineffective, and possibly harmful, services. Consumers were unaware that their so-called therapists could be minimally educated and could legally pro-