When care management for people with disabilities was initiated in Kent in 1991, it was assumed that some of the 25 occupational therapists employed by the SSD would apply for the new care management posts. After all, the occupational therapists seemed eminently qualified with their extensive knowledge of the medical, psychological and social aspects of physical disability and their practical and organisational skills. In the event, they showed little interest in the new posts. So a different way of using their skills had to be found.

The outcome was the establishment of the County Occupational Therapy Bureau, managed as an independent unit outside the care management structure and providing a discrete equipment and adaptation service across the county.

There have been considerable advantages in the development of equipment and adaptation service in this way. It has provided the opportunity for the occupational therapy service, previously easily marginalised, to develop strategically and to attract resources. It has also enabled occupational therapists to concentrate their activities in areas in which they are most skilled. This has helped both with the recruitment and retention of staff and with efficiency.

The way the service has been structured seems to work well for occupational therapists. They have a well-developed career structure and a voice in the department that is heard more clearly than ever before.

They are also able to use their expertise to most effect and do not have to carry out additional care-management activities. It would seem that the system works well for care managers too. They do not have to get involved with large numbers of referrals which relate to people who would not be considered eligible for a care management service. To these people the Occupational Therapy Bureau offers an assessment on behalf of the social services department and makes all necessary provision.

Indeed, 70 per cent of the Occupational Therapy Bureau’s cases do not pass through the care management system. Nor do care managers need to develop the extensive expertise required to assess people who might need complex pieces of equipment or large adaptation schemes.

However, what is obviously more important is whether the Kent model works for people with disability requiring a service. The effectiveness of the service depends heavily on the working relationship established between care manager and occupational therapists. This in turn depends on a thorough understanding of each other’s skills and limitations at practitioner and management levels.

Where lack of understanding exists, it is probably not simply a symptom of professional jealousy or insecurity, but is the result of what seem to be basic differences in the approach and objectives of the two groups. Occupational therapists view care
managers as organisers of "care" for people with disabilities whereas they see themselves as aiming to provide solutions which obviate or lessen the need for "care" by enabling people to maximise their independence.

Commonsense would suggest, and certainly users in Kent have confirmed, that people tend to prefer different solutions to different kinds of problems. For example, independence is seen as more important for highly personal activities such as bathing and using the toilet, but help in the form of a care worker would be more appreciated for activities such as household tasks, preparation of meals or shopping. The care management and occupational therapy approaches cannot be seen as alternatives but must be complementary.

Unless occupational therapists and care managers can develop total understanding and trust in each other's abilities, there is the danger that users may find their access to services determined by their point of entry into the system rather than by their preference for one kind of service over another. The process of developing this understanding needs to be consistently and actively promoted by both sides and must permeate all levels of responsibility.